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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on, **19 October 2015 at 7.30 pm.**

John Lynch
Head of Democratic Services

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Despatched : 9 October 2015

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury (Vice-Chair)
Councillor Raphael Andrews
Councillor Osh Gantly
Councillor Mouna Hamitouche MBE
Councillor Gary Heather
Councillor Nurullah Turan
Councillor Tim Nicholls

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Donovan
Councillor Alex Diner
Councillor Jean Roger Kaseki
Councillor Jenny Kay
Councillor Una O'Halloran
Councillor Alice Perry
Councillor Dave Poyser
Councillor Clare Jeapes

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have
a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to **all** members present at the meeting.

5.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 6
7.	Chair's Report	

	The Chair will update the Committee on recent events.	
8.	Public Questions	
9.	Health and Wellbeing Board Update	
B.	**Items for Decision/Discussion**	**Page**
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11.	Procurement of GP Premises - Verbal	
12.	Scrutiny Reviiew - Health Implications of Damp Properties - Witness evidence - Verbal	
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14.	Work Programme 2015/16	205 - 208

The next meeting of the Health and Care Scrutiny Committee will be on 23 November 2015

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Monday, 14 September 2015

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Monday, 14 September 2015 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Chowdhury (Vice-Chair), Andrews, O'Halloran, Heather, Turan and Nicholls
Also Present:	**Councillors**	Janet Burgess
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

125 **INTRODUCTIONS (ITEM NO. 1)**

Members of the Committee and officers presenting reports introduced themselves to the meeting.

126 **DECLARATIONS OF INTEREST (ITEM NO. 2)**

None

127 **APOLOGIES FOR ABSENCE (ITEM NO. 3)**

Councillors Osh Gantly, Mouna Hamitouche and Dave Poyser

128 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 4)**

Councillor O'Halloran stated that she was substituting for Councillor Hamitouche

129 **ORDER OF BUSINESS (ITEM NO. 5)**

The Chair stated that the order of business would be as per the agenda items as listed

130 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**

A revision to minute 123 - SID – Health Implications of Damp Properties was laid round for Members.

RESOLVED:

That, subject to the above amendment, the minutes of the meeting of the Committee held on 2 July 2015 be confirmed and the Chair be authorised to sign them

131 **CHAIR'S REPORT (ITEM NO. 7)**

The Chair stated that he had circulated a framework for presenters for reports to the Committee and he was pleased to note that all contributors that evening had followed this framework which would assist Members in their consideration of the items.

The Chair added that there would be a CQC inspection at the Whittington NHS Trust on 08 December and if Members had any submissions they wished to make they could make them direct to the CQC or forward comments to him for submission.

The Chair also referred to a letter that he had received from the NHS Property Company concerning the future of the Finsbury Health Centre site and that the response had been reasonably positive and he would keep the Committee updated on developments.

The Chair stated that following discussion at the last meeting he would be taking up the issue of some of the recommendations of the GP Appointments scrutiny not being adopted with the relevant Executive Members.

132 **PUBLIC QUESTIONS (ITEM NO. 8)**

The Chair outlined the procedure for dealing with Public questions and the filming and recording of meetings

133 **HEALTH AND WELLBEING BOARD UPDATE - VERBAL (ITEM NO. 9)**

Councillor Janet Burgess, Executive Member for Health and Wellbeing, was present and outlined the recent developments of the Health and Wellbeing Board during which she made the following main points –

- The Carers hub contract has been agreed
- The Mitchison street GP practice was now working well and there were temporary GP's in place and it may take up to a year before permanent staff were in place
- A Health and Wellbeing Board would be taking place on Wednesday and they would be considering the Joint Strategic Needs assessment which has shown that the population has grown in the borough from 202,000 to 224.600 since the last census in 2011. The Chair requested that a copy of the report be circulated to Members of the Committee and Councillor Ismail

The Chair thanked Councillor Burgess for attending and her update

134 **NHS TRUST - WHITTINGTON HOSPITAL - QUALITY ACCOUNTS - PRESENTATION (ITEM NO. 10)**

Siobhan Harrington, Whittington Hospital NHS Trust and Ron Jacob, Governor Whittington NHS Trust were present for discussion of this item.

The Quality Accounts Whittington NHS Trust report for 2014/15 was laid round (copy interleaved) and Siobhan Harrington outlined the main points of the report and made a presentation to the Committee (copy interleaved).

During consideration of the report the following main points were made –

- The key highlights included – New TB centre and Ambulatory Care service, sign up to safety campaign, improved medicines management, District Nursing service – mobile smart working with i Pads, JAG accreditation for the Endoscopy unit, Hospital at Home service, Infection rates and low SMHI score, smoking cessation and alcohol harm prevention CQUIN's, and RTT 18 week waits and cancer access targets
- Quality Priorities for 2015/16 include – Improve patient experience for Learning Disabilities and improve staff training and recognition, Reduce the number of inpatient falls that result in harm by 50%, achieve outcome measures in Sepsis and AKI CQUIN's and effectively record performance, reduce the amount of pressure ulcers, increase the number of NIHR programmes and increase participation in inter professional events and improve patient experience and response rate to FFT and data capture in diabetic and frail elderly services
- In response to a question it was stated that the Trust had been disappointed with the staff survey results and the problem areas were being addressed
- The Committee noted that there is a new library and resource areas for students

- It was stated that the response rate to the FFT in the previous year was 37% for inpatients and 17% for the emergency department. i Pads were now being given to patients to improve FFT responses however feedback was good on patient experience of the Trust
- FFT results were being displayed on the ward but the Trust were looking at other methods of displaying results
- In response to a question it was stated that there is currently a 10% nursing vacancy rate and the Trust, were having to conduct a rolling recruitment programme, however recruitment problems were an issue for most London Trusts
- A Member referred to the new structure introduced in terms of clinical services in July and that this should address some of the concerns raised in the staff survey and there was now more clinical ownership across the organisation and staff would feel more informed and connected
- It was noted that temporary and 'bank' staff, some of whom had been employed for a considerable time were not included in the staff survey and the Trust stated that they would investigate whether these staff could be included in the future
- The Trust stated that there should be improvements in the areas of information governance in the coming year and that FFT feedback was regularly reported to staff and concerns addressed
- The Lead Governor stated that given the financial pressures on the Trust he was encouraged by the progress, however it was his view that whilst the FFT is important it is a fairly superficial process and that a more in depth survey should be undertaken to look at patient experience of an integrated care organisation and how services were accessed and any problem areas

The Chair thanked Siobhan Harrington and Ron Jacob for attending

135 **HOSPITAL DISCHARGES - PRESENTATION (ITEM NO. 11)**

Jonathan Fielden, UCLH Foundation Trust and Siobhan Harrington and Carol Gillen Whittington NHS Trust were present for discussion of this item and made presentations to the Committee thereon.(Copies interleaved).

During discussion the following main points were made –

- The Committee noted that UCLH felt that there were more delays and difficulties in discharging Islington residents since a new system had been introduced in May
- UCLH were of the view that L.B.Camden had a better system of liaising and co-ordinating discharges and that the system in L.B.Islington meant that there was a weekly Panel meeting which could lead to delays
- L.B.Islington is one of the main users of UCLH@home
- The Executive Member for Health and Wellbeing indicated that she was not aware of these concerns and that she would ensure that liaison took place with UCLH to improve the position and that the results of these discussion could be reported to Committee
- UCLH indicated that whilst they did have a good working relationship with Islington they felt that the relationship with Camden was better
- The Whittington indicated that the Trust were seeing more complex medical conditions, especially with elderly patients, and this is one of the reasons for delayed discharge
- Delayed discharges had peaked in October/November 2014, but this had now reduced

- There is daily teleconferencing of cases with Islington and readmission rates were looked at on a regular basis and work is being undertaken with social care and other organisations to reduce readmission rates, however this is often difficult due to complex conditions. Being an integrated care organisation did assist in this
- The Director of Commissioning, Islington CCG stated that he would be happy to discuss with UCLH the problems and work with social care organisations to look at the different practices in operation in London Boroughs, in order to try to obtain some kind of consistency that would assist the discharge process for Trusts
- The view was expressed that delayed discharge also impacted on the ability of the patient to quickly adapt back to normal everyday life and often affected their quality of life
- It was also stated that a number of patients had mental, as well as physical health problems, and often this may lead to delayed discharge

RESOLVED:
That discussions take place with regard to the problems referred to above and consistency of approach to discharges from social care providers and this be reported back to the Committee. In addition, a response from the Director of Housing and Adult Social Services should be submitted to the Committee on the particular problems referred to above in relation to UCLH

The Chair thanked Jonathan Fielden, Siobhan Harrington, Carol Gillen and Ron Jacob for attending

136 **111/OUT OF HOURS SERVICE SPECIFICATION (ITEM NO. 12)**

Kath McClinton, Islington CCG, Dr.Paul Sinden, Director of Commissioning Islington CCG and Dr.Jo Sauvage, Vice Chair Islington CCG were present for discussion of this item during which the following main points were made –

- The Committee noted that there had been a delay to the timetable and the CCG were not yet in a position to bring the final service specification to the Committee
- The publication of the National Standards are awaited and the development of the service specification continues and the draft specification already prepared has been widely circulated for comment and it would be developed in the light of national guidelines but is felt to be on the right lines
- The Committee were informed that it is hoped that the final version of the service specification would be available at the end of September and could be reported to the Committee in November
- There had been a second market event held in August to talk to interested bidders about the service model and there is interest from a wide range of bidders, including GP collaboratives, organisations, NHS Trusts, social enterprises and the private sector and all bidders would need to be registered or in the process of being registered and bidders would be aware of this
- In response to a question it was stated that potential bidders would be accessing a similar cohort of GP's
- Discussion took place as to the emphasis that would be placed in the service specification on local knowledge and it was stated that quality would be covered in the specification and that following analysis of the comments received the proposed working could be brought back to Committee for consideration
- In response to a question it was stated that quality was an important aspect and the definition of local knowledge is important, however the contract would be across North Central London

- There was a need to ensure that any process built in safeguards on recruitment and training and the ethos of the service expected and is subject to ongoing scrutiny and there is a facility for smaller providers bidding in a collaborative approach
- Given that there is a finite GP resource there is a need to look at the most intelligent use of resources with the use of IT and the sharing of records and that 3 new GP hubs had been set up out of hours that were open in the evenings and outside normal GP surgery hours
- It was noted that the new service should commence in October 2016

RESOLVED:
That the draft service specification and consultation responses be submitted to the Committee in November for consideration

The Chair thanked Dr.Sinden, Dr.Sauvage and Kath McClinton for attending

137 SCRUTINY REVIEW - HEALTH IMPLICATIONS OF DAMP PROPERTIES - PRESENTATION/SID (ITEM NO. 13)

Heer Matianda Baljeer, Public Health and Damian Dempsey, Housing and Adult Social Services were present for discussion of this item and during consideration of the report the following main points were made –

- The Committee welcomed the excellent report produced
- There is a great deal of work being carried out in Islington in terms of insulation of properties and the recent works on the Holly Park Estate were in the process of being evaluated. The Committee indicated that it would be useful if this evaluation is submitted to a future meeting of the Committee
- The Chair referred to paragraph 7.7 of the report and queried the effectiveness of spending £2m in addressing dampness in properties and £10m in improving energy efficiency to help relieve these problems. It was stated that a more detailed breakdown of the figures could be made available
- It was stated that there were 2 main hotspots in Islington for dampness problems, the Andover and Girdlestone Estates and problems were being addressed as part of the cyclical repair programme and by the use of surveys. It had been found that there were a number of problems that had been found particularly in relation to where garages had been converted into flats which had led to dampness problems. A combination of methods were being used to eradicate the problems and the work carried out to date had been encouraging
- It was stated that there is a need to explain to tenants how best to operate their heating and ventilation systems efficiently, however the view was expressed that if properties were properly insulated and the design of the property is good these problems would not occur
- In response to a question as to whether garages were still being converted into flats and whether this would not cause future problems it was stated that new garage developments had more rigorous design specifications, which had not been the case with the conversion of the Andover Road Estate garages
- In response to a question as to whether good practice was being shared with Housing Associations and other social landlords it was stated that this currently did not take place
- The Chair referred to paragraph 6.4 of the report and that the 2008 Islington Private Sector stock condition survey estimated that 869 owner occupied and privately rented homes had a Category 1 Damp and Mould hazard, indicating that the extent of dampness and mould growth was likely to be harmful to health. This is an estimate of those where the Council would be required to take action under the Housing Act 2004 and there are likely to be a further number of lower level Category 2 hazards. The Chair enquired whether how

often the Council took action under the Housing Act 2004 and it was stated that this information would be provided to the Committee

- A Member enquired if, when Council officers identified dampness when they went into properties, they would report this for action to be taken. It was stated that this would be investigated and reported back to Committee as to current practice but he did not think this had been done historically apart from where rainwater egress was identified
- The view was expressed that there was a need to continually monitor the work carried out and in particular in relation to older and young people

RESOLVED:
(a)That the Director of Housing and Adult Social Services be requested to report back to the Committee as to whether Housing officers visiting properties reported dampness where it is identified
(b)That the results of the evaluation of the Holly Park Estate insulation works effectiveness be reported to the Committee when this is available

(c)That the Director of Housing and Adult Social Services be requested to report back on how many enforcement actions had been taken against landlords as a result of the Housing Act 2004

138 **WORK PROGRAMME 2015/16 (ITEM NO. 14)**

RESOLVED:
That, subject to the addition of the 111/Out of Hours service specification and consultation responses item being added to the agenda of November meeting of the Committee, the report be noted

MEETING CLOSED AT10.25p.m.

Chair

Agenda Item 10

London Ambulance Service NHS

NHS Trust

Annual Report 2014/15

Strategic report

Who we are and what we do

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the UK providing healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

Our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we provide a range of care to them, recognising that many have complex problems or long-term medical conditions.

We also run a patient transport service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the emergency bed service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously-ill patients.

We are led by a Trust Board made up of 12 members – a non-executive chairman, five of the Service's executive directors, including the Chief Executive, and six non-executive directors.

As an integral part of the NHS in London, we work closely with hospitals and other healthcare professionals, as well as with other emergency services. We are also central to planning for, and responding to, large-scale events or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than eight million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2014/15 we handled over 1.8 million emergency calls from across London and attended more than one million incidents.

We are committed to developing and improving the service we provide to the people who live in, work in, and visit London.

Chairman Richard Hunt's views

What kind of a year has it been for the Service?

It has been the most difficult year we have experienced for a long time. A significant shortage of frontline staff exacerbated the pressure on the Service as well as further increases in demand which has risen year on year in recent times.
Given this, and with continued high levels of utilisation, we weren't able to achieve as in recent years the national performance target of reaching 75 per cent of Category A (most seriously ill and injured) patients within eight minutes, and while we maintained a safe level of service, we also have to recognise that we couldn't always provide the quality of service that we would have liked for other groups of patients with less serious conditions.
In addition it has also been a year of senior level management change with our Chief Executive and some directors leaving the Service during the year.

What progress was made with recruiting new staff?

Dealing with maintaining our full time strength has been, in turn, extremely difficult as there was during the year, and continues to be, a national shortage of paramedics. This has made recruitment a major challenge and this may well last for some time. Consequently we launched a new national and international recruitment campaign during the year which continues into 2015/16. So far as a result of this programme we have now recruited over 250 new frontline staff. In terms of paramedics we are increasing our strength by:

- Offering eligible staff within our Service the opportunity to train to become paramedics
- Actively advertising across the UK
- Recruiting from overseas – Australia, Ireland and Denmark
- Increasing our intake of paramedics from universities

What were the key achievements last year?

One of our biggest achievements during 14/15 was the launch of our Shockingly Easy campaign which established 1,007 extra defibrillators in high footfall areas, shops, businesses and gyms across the capital within the course of the year. This, for example, compares to just 240 new defibrillators established by the Service in the previous financial year.

Over the course of the campaign at least 31 lives have been saved by a public access defibrillator in London and we're awaiting the outcome of a further 23 patients whose lives may also have been saved as a result. This exceeds the previous maximum number of 18 lives saved in a year.

We have seen significant investment in the Service over the last year including more than £8m spent on over 100 new ambulances to improve our fleet and reduce break downs which make a significant impact on the number of vehicles being out of service.

We also secured £2.8m in funding from the Local Education and Training Boards to support the clinical education of our staff.
We look forward to an improving position over the next twelve months. My thanks to everyone for their tremendous efforts over the past year.

Chief Executive Fionna Moore's views

What are your priorities for this year?

Over the next 12 months, our key priorities will be to improve our service to patients, making it easy for Londoners to get the urgent and emergency care they need quickly. We will also continue to recruit more frontline staff and offer a clear clinical career progression so that we have a motivated, stable and engaged workforce.

Staff retention has been an issue – what are your plans to improve this?

Our highly skilled clinicians are in demand by other parts of the NHS, and many have chosen to leave London and work in other roles.
We're working very hard to encourage our staff to stay with us. We have:

- Developed a clinical career structure to offer our clinicians the opportunity to progress from emergency ambulance crew to paramedic, senior paramedic, clinical team leader, advanced paramedic, paramedic consultant and have a paramedic sitting on our board of directors
- Worked with Local Education and Training Boards to secure significant investment for next year to further train and develop our staff. We have increased paramedic places at Universities from 150 to 500.
- Recruited more staff which will reduce the pressure on our existing staff

We have learnt that we often don't do enough to value our staff across all parts of the Trust and have therefore recently introduced an awards scheme that will see staff recognised for their hard work and dedication.

We are also looking at introducing a number of initiatives to encourage staff to stay with the Service, including improving staff benefits like lease cars and cycle-to-work schemes.

We are also giving better appraisals, personal development and supportive line management for all staff. Finally, we are working with commissioners to reduce the pressure on our staff so they attend fewer incidents per shift.

What improvements have patients seen?

Although it has been a difficult year it is very pleasing to see that more people who suffer a cardiac arrest, when their heart stops beating, are surviving because of the care we provide. Owing to the quality of care provided by our staff, patients who suffer an out-of-hospital cardiac arrest have some of the highest survival to discharge rates in the country.

We are also providing clinical assessments to more patients over the phone with less serious illnesses and injuries. The number of patients we manage over the phone is the highest in the country.

Our vision and strategic goals

Our vision is to be a world-class service, meeting the needs of the public and our patients, with staff who are well-trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards people who live and work in London having health outcomes that are among the best in the world.

Our strategic goals for 2014/15 were:

- Improve patient care
- Improve recruitment and retention
- Implement the modernisation programme
- Achieve sustainable performance
- Develop our 111 service
- Simplify our business processes
- Increase organisational effectiveness and development

Our values in 2014/15 were:

Care: Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

Clinical excellence: Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Commitment: Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; Learning and growing to deliver continual improvement

Looking ahead, we are now in the process of developing a longer term strategy to take the organisation forward to 2020.

We have also continued to work with the NHS Trust Development Authority on a timeline to become an NHS foundation trust.

Strategic Report Issues

Sustainability report

Our plans to reduce our carbon footprint

We remain committed to making improvements in all aspects of our environmental performance.

		2010/11 tC02e (Baseline)	2012/13 tC02e	2013/14 tC02e	2014/15 tC02e	Financial data 10/11 (Baseline)	Financial data 12/13	Financial data 13/14	Financial data 2014/15
Finite resource	Water	43	49	51	48	£83,605	£96,026	£98,242	£92,825
	Electricity	1,173	1,346	1,376	1,187	£1,123,224	£1,252,862	£1,263,162	£1,261,614
	Gas								
	Fuel	1,807	1,929	1,828	1,576	£5,830,895	£6,223,459	£5,898,479	£5,084,291
Procurement	Procurement	16,729	24,613	26,734	30,086	£49,938,931	£65,692,407	£68,037,159	£77,552,998
Total		19,754	27,938	29,990	32,898	£56,976,655	£73,264,754	£75,297,042	£83,991,728

NB: the carbon footprint has been estimated using DEFRA emission factors, using data provided by Finance, and is therefore based on spend rather than usage.

Environmental monitoring and reporting enables us to quantify the environmental and social effects of delivering our service; to improve both our management of any associated adverse environmental and social impact, and our overall environmental performance; and to work towards achieving the targets in the NHS Carbon Reduction Strategy.

In 2012, the Carbon Trust reviewed and approved our five-year carbon management plan which sets out how we will reduce our carbon footprint as part of our contribution to tackling climate change. A carbon footprint is measured in tonnes of carbon dioxide equivalent (tCO_2e). This is based on a baseline for the Service of 19,754 tonnes CO_2e that was calculated in 2010/11.

There are three areas in which we will focus our activity – fuel consumption, energy use and procurement. We aim to reduce our energy and fuel consumption by 25 per cent over the five-year period, and by focusing on procurement we will cut indirect emissions from products and services by 10 per cent. As the data we are using becomes more reliable, we are able to better assess our carbon footprint and to identify areas where additional efforts are required.

Measuring our fuel consumption in 2014/15 against the baseline in 2010/11 we have managed to reduce our fuel consumption by 12%.

Environmental impact performance indicators

Fuel consumption: Our core business means that we have high levels of fuel consumption.

In 2014/15 we used over 3.7 million litres of fuel, compared to 4.2 million litres in 2013/14 this was effectively a decrease of 18%.

In 2014/15 the Trust received a total 1,892,343 calls. We responded to a total of 1,025,836 incidents[1] with 34.0%[2] of patient calls being resolved without the need to transport to hospital and 11.0% of patient calls being resolved with telephone advice only.

We are managing our fleet to ensure it will be compliant when the Ultra-Low Emission Zone is introduced in London in 2020.

We are managing our fleet to ensure we will become compliant to the new regulations relating to the Ultra-Low Emission Zone in 2020.

Energy use:

Although over half of our 70 ambulance stations are more than 50 years old, when measured against other ambulance services we score well in our energy consumption per square metre.

In partnership with SALIX the Trust has ring fenced funding for investment in a number of initiatives that have seen our energy consumption reduce year on year, which in times of rising prices ensure that the Trust is achieving good value for money. Nineteen projects have been completed, delivering 5,429 tonnes savings over the lifetime of the equipment and lifetime savings of £951,813 with an average payback of 3.9 years.

In addition we recycled 99 per cent of our waste, with non-recyclable material being treated to deliver energy from waste.

The Trust has worked in partnership with our energy suppliers to install SMART metering for gas on 80% of our properties and 95% of our properties in regards to electricity. This will enable us to more effectively manage energy consumption; measure improvements from initiatives such as LED lighting etc.

Procurement:

Our use of St John Ambulance and other private ambulances is captured in the procurement spend. In 2014/15 we spent less on such providers than in 2013/14, from £9,590,220 to £9,052,948. We

[1] A decrease of 6% on 2013/14 (1, 090,277 incidents).

[2] Quality Dashboard 2013/14 and 2014/15.

also spent less on computer software licences through the use of an enterprise licence agreement which saw costs reduce from £1,346,491 to £874,074.

Comparing 2013/14 and 2014/15 there was an increase in spend in the following areas: vehicle lease costs (from £3,877,371 to £4,074,397); consultancy services (from £1,526,960 to £4,315,980); subsistence (from £3,471,366 to £3,686,322); conference calls (from £15,470 to £88,951) and uniform (from £1,133,156 to £2,466,420) and course and conference fees (from £619,580 to £2,401,517).

In 2014 the Trust tendered contract for a taxi service in order to provide transport for those who call us, who need to be taken to a point of treatment but who do not require emergency or urgent care. This ensures we can despatch responses such as ambulances and cars to those patients who require the clinical skills of our Paramedics and Ambulance Emergency Crews. The Taxi Service engaged provides a Toyota Prius (whenever possible) to undertake the journeys, which from August 2014 to March 2015 accounted for 15.7 tonnes of $CO_{2,}$ covering 63,023 miles.

Looking ahead to this and future years, our environmental priorities will include:

- Further investment in energy conservation works to reduce carbon emissions from energy use across our estate, which will include investment in photovoltaic on a number of our ambulance stations.
- Continuing to raise staff environmental awareness
- Reviewing procurement arrangements to identify opportunities for carbon reduction and cost savings
- Working with suppliers to minimise waste and identify opportunities for associated carbon reduction.

Equality and inclusion

We welcome our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to the Trust from any background, who are committed to providing an excellent service to the richly diverse communities we serve. As the ambulance service for London, we have a very diverse community of patients, service users and staff. Our aim is to become a world-class ambulance service for London, providing innovative and responsive healthcare which meets the needs of all our diverse community, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination and we want to ensure that:

- Patients and service users receive fair and equal access to our healthcare services
- Everyone is treated with dignity and respect
- Staff experience fairness and equality of opportunity and treatment in their workplace

As a provider of healthcare to the people living, working in and visiting the city, we seek to provide state of the art care which addresses the individual needs of our diverse patients and service users. We aim to ensure that:

- Our patients and service users are aware of our services and that those services are accessible to all
- Our governance arrangements are welcoming and inclusive of all
- Our buildings and information are accessible to all
- We enable our diverse communities in London to be involved in the development and monitoring of our policies and services

We want to become an employer of choice, attracting the best and most talented people from all walks of life to a career with us where they can develop to their full potential to the benefit of their fellow staff, patients and service users. We aim to:

- Celebrate and encourage the diversity of our workforce and create a working environment where everyone feels included and appreciated for their work
- Promote our training and employment opportunities without regard to the protected characteristic background or any other aspect of an individual person's background
- Foster creativeness and innovation in our working environment, to ensure that each member of staff can give of their best and move the Trust forward in its equality and inclusion goals

As a procurer of services, we are committed to:

- Ensuring that contractors from whom we procure goods and services are aligned with our equality and inclusion values.
- Actively considering supplier diversity as a key aspect in our contract management

During this last year the Trust featured again for the third year running as a Top 100 Employer on the Stonewall Workplace Equality Index and as a Top Ten Performer on the Stonewall Health Care Equality Index. Both show our continuing commitment to equality and inclusion and to enable everyone regardless of protected characteristic group to have the confidence to be themselves at work or when receiving care from our staff.

We currently have four Staff Diversity Forums – the Deaf Awareness Forum, LGBT Forum, ADAMAS (Association of Diverse and Minority Ambulance Staff) and Enable – our staff forum for disabled staff and carers. We are keen to support our forums in the initiatives they undertake as well as to encourage their input into our policy and service development and involvement as "critical friends" in our equality analyses.

We are members of Stonewall's Diversity Champions Programme We are also members of Opportunity Now, the leading UK employers' equality forum promoting gender equality, aiming to transform the workplace by ensuring inclusiveness for women, and Race for Opportunity, the leading UK employers' equality forum committed to improving employment opportunities for ethnic minorities across the UK We are also members of the Business Disability Forum, the leading UK Employers' Forum on Disability, promoting best practice and working with organizations to set and influence policy so it benefits both organizations and disabled people, and Carers UK, the UK's national membership charity for carers, campaigning for proper recognition and support for carers.

In 2014, following engagement with a wide range of service users, staff and other stakeholders across the protected characteristic groups, we produced our new Equality and Inclusion Strategy 2014-19, which sets the direction the equality and inclusion work of the Trust will be taking over the coming years. Our progress on this will be monitored in our Annual Equality Reports by our Executive Management Team and Trust Board as well as by our stakeholders and a formal review carried out in 2019.

Strategic Goals

Our achievements during 2014/15

Strategic goal: Improve patient care

We have an increasingly important role to play in improving the health outcomes of patients in London.

Our objectives are:

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illnesses or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets.

In 2014/15 increasing levels of demand again made it more difficult to always attend those with less serious conditions as quickly as we would have wanted to, and we will continue to look to improve the ways in which we manage and respond to these calls.

As well as time-based targets, all ambulance services were measured against a set of clinical indicators that help assess the quality of care provided to patients.

Full details on these and other patient care issues can be found in our Quality Account, which will be published in the summer.

Improving the experience and outcomes for patients who are critically ill or injured

Trauma care:
Patients with serious injuries are taken directly to one of four major trauma centres where they can receive immediate care from specialists that aren't available at local hospitals.

Data analysed to date from April to December 2014 shows that 99% of patients who needed to be transported directly to a major trauma centre were identified by our crews and taken to the right hospital for their injuries. Direct admission to a major trauma centre has been shown to save lives and reduces long-term disability.

Cardiac care – heart attack:

There are eight specialist centres in London where patients who are diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, can be taken directly by ambulance staff. They can then undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

One of the national clinical indicators looks at the percentage of those patients who receive this treatment within two and a half hours of the 999 call being received. The latest available figure for the Service - from April to December 2014 - was 95 per cent[1], compared to 93 per cent for the full 2013/14 year.

Cardiac care – cardiac arrest:

Thanks to the quality of care provided by our staff, the survival rates of patients who suffer an out-of-hospital cardiac arrest continue to rate as some of the highest in the country, and our published figures are also among the best in the world.

Our crews attended approximately 10,000 cardiac arrest patients in 2014/15. Owing to the quality of care provided by our staff, patients who suffer an out-of-hospital cardiac arrest have some of the highest survival to discharge rates in the country.

Provisional figures published for April to December 2014 show that approximately 55 per cent of patients who were witnessed to suffer an out-of-hospital cardiac arrest of cardiac cause with an initial shockable rhythm were successfully conveyed to hospital with a pulse, and 30 per cent survived to leave hospital.

Thanks to the Shockingly Easy campaign there are now a record number of public defibrillators across the capital, thus increasing the chances of survival for patients experiencing a cardiac arrest in a public place.

Stroke care:

We take patients who we diagnose with stroke symptoms directly to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke – which occurs when the blood supply to part of the brain is cut off.

During the year, we took approximately 11,000 stroke patients to a hyper acute stroke unit, equating to around 99 per cent of patients taken appropriately.[3]

One of the national indicator measures is the percentage of stroke patients who arrive at a specialist centre within 60 minutes of us receiving the 999 call. Figures available from April to December 2014 show that we achieved this in 59 per cent of cases.

Full details of our performance against all the national ambulance quality indicators can be found in our 2014/15 annual quality account.

- ***Improving the experience and providing more appropriate care for patients with less serious illnesses and injuries***

During 2014/15, we treated a wide range of patients presenting with less serious conditions.

Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we continued our work to identify suitable alternative destinations where appropriate care can be provided away from the traditional hospital environment.

These include minor injuries units, urgent care centres and walk-in centres, some of the latter being provided as part of the services at some larger GP practices. Frontline staff have received training and guidance to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

Clinical telephone assessment: We have provided clinical telephone assessment to 159,508 patients during the year.

This includes patients who were called back and given further assessment by clinicians from our clinical hub, those who were referred elsewhere, for example NHS 111 and patients who did not require an emergency ambulance and immediate medical treatment. A taxi was sent to take them to an urgent care centre or emergency department after they were clinically assessed over the phone.

Care of mental health patients: We have continued to work with mental health trusts across London to develop arrangements so that any mental health patients who we attend can be taken to the right place for treatment.

Improving our care to all mental health patients, including those with dementia, is a priority for us in 2015/16, and our commissioners have made additional funding available for training so that we can increase our frontline staff's awareness and understanding of mental health and dementia, and equip them with the skills to enable them to decide on the best care for these patients.

We also continued to examine complaints with a mental health component, and where possible are meeting with mental health trusts to agree personalised care plans for their patients, and the options available to them apart from calling for an ambulance.

End-of-life care: We continued to work with both NHS and hospice-based end-of-life care providers to provide appropriate care and support. We also continued to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

Patients with pre-arranged hospital appointments: As well responding to emergency calls, we offer pre-arranged transport for patients to and from their hospital appointments.

We carried out 125,988 of these journeys during the year, compared to 184,092 in 2013/14.

We delivered patients to hospital on time for 92 per cent of the journeys, which compares to 93 per cent in 2013/14.

In terms of departing from hospital, we left on time in 92 per cent of cases (93 per cent in 2013/14).

Ninety six per cent of our patients had a journey time of less than an hour in 2014/15, compared with ninety eight per cent last year.

Strategic goal: Improve recruitment and retention

We want all staff on the frontline to have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

We also want to improve the diversity of our workforce, and focus on engaging with our staff more so that they are motivated and feel valued, and have a greater say in how we improve our service.

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population, and
- engage with our staff to improve patient care and productivity.

- ***Developing our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population***

Our workforce: At the end of March 2015, we had a workforce of 4,577 staff, made up of 2,576 men and 2,001 women.

This was broken down as follows:

Staff in post as at 31 March 2015:

Staff Group	Male	Female	Total
Director	9	6	15
SMP	277	146	423
Other	2290	1849	4139
Total	**2576**	**2001**	**4577**

Over the course of the year, a total of 647 people left the Service – a turnover rate of 14.3 per cent, compared to 10.7 per cent in 2013/14.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in higher numbers than usual, over 212 paramedics left during 2014/15.

As well as offering eligible staff within our Service the opportunity to train to become paramedics and increasing our intake of graduates from universities, we have started to look overseas and have been approved to sponsor work visas for non-European paramedics.

The average workings days lost in was 14.52 (2013/14 13.36). The data is based on calendar years January to December.

- ***Engaging with our staff to improve patient care and productivity***

Employee involvement: We recognise that an engaged workforce is key to improving our services and productivity, and we are committed to communicating and engaging with staff to achieve this.

Our staff engagement score, informed by the 2014 NHS staff survey, was 2.78 (based on a score range from 1 to 5). This was calculated from findings related to staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Service as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

Staff survey findings: The NHS staff survey was sent to all staff at the end of 2014, with a response rate of with a response rate of 35.7 per cent, slightly lower than 2013 which had a response rate of 40.8 per cent.

The results showed a number of areas of concern, and work has already started to address a number of the areas which staff have highlighted, but it is clear that there is still much more to do. This includes continuing to recruit more staff to fill vacancies and relieve pressure, providing better career progression opportunities for all, and increasing educational investment.

Opportunities for giving feedback and sharing ideas: We continued to use 'temperature check' surveys for staff to give feedback and suggestions on how to make improvements for the benefit of patients and their own working lives.

We also set up a closed social networking site, where staff can discuss issues and ask questions of managers. This now has around 2,200 staff as registered users.

Health and well-being: Staff volunteering as part of the LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative continued to provide support to colleagues on issues from work-related stress to family and social problems.

Health and safety: All staff are also encouraged to report any incidents or near misses, such as those involving patient safety or abuse or violence that they may themselves have experienced from patients or members of the public.

The reports are collated by the Health, Safety and Risk department and information is reported to the Clinical Safety Development and Effectiveness committee and in the integrated performance report to the Trust Board – please see the Annual Governance Statement for more information.

Partnership working with the unions: We continued to use our long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. These arrangements helped to support the introduction of a number of different initiatives and ways of working to maintain levels of patient care over the winter period.

We consulted on the major issues, opportunities and challenges facing the Service, and we plan to maintain these working relationships when we become a foundation trust.

The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status.

Representation on our Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives. This is separate from, and in addition to, the seat for a staff side representative from the Staff Council.

Strategic goal: Implement the modernisation programme

Last year we created the new Emergency Ambulance Crew (EAC) role to replace Emergency Medical Technicians. The first, fully trained EACs joined the service on 19 January 2015.

In September, we introduced 200 new frontline rosters. This change affected over 3000 staff across 70 ambulance stations. Working in close partnership with staff and trade unions, these new rosters were designed by locally and we were pleased that only 6 rosters had to be implemented without local agreement on all aspects. This was a significant change as many rosters had not been changed for nearly a decade, and we were pleased to see that the unrest and local disputes seen in other ambulance were not experienced in London.

Strategic goal: Achieve sustainable performance

The 2014/15 performance improvement plan achieved a great deal of positive change impacting on overall Trust performance throughout the year. These achievements include:

- Multiple attendance of vehicles to incidents was reduced, releasing the equivalent of 80 WTE staff capacity back onto the frontline
- The largest recruitment campaign in the Service's history was launched resulting in more than 250 new frontline staff joining us before the end of March 2015
- New and revised contracts were developed for Private and Voluntary Ambulance Services, to improve productivity and value for money, which supported us to better meet demand whilst we recruit permanently to vacancies
- The new LAS "Bank" system was launched, and is actively recruiting members so that we have access to a flexible, non-permanent workforce to support peaks in demand

- A new facility was set up in our control room to respond to calls from the Metropolitan Police Service. This has resulted in more than 500 fewer vehicle dispatches each week to incidents that are now managed and resolved remotely
- Through the multidisciplinary Clinical Hub we have seen the overall weekly Hear and Treat numbers peak at 5323 with a weekly average of 3652. This has allowed us to target our frontline resources more appropriately

Strategic goal: Develop our 111 service to meet the need of CCGs

We have made strong progress with our 111 services over the year. Our South East London 111 Service has constantly met national targets and is the highest performing 111 services in London and one of the best nationally. To ensure we constantly improve our Service, we worked with our 111 commissioners during the year to redesign our service to meet their changing needs and cost expectations. We have also been preparing for the re-commissioning of 111 services across London over the next 12 months across London.

Last year we handled 311,449 calls, with 96.2 per cent answered within 60 seconds against a target of 95 per cent.

In the same period, 10.6 per cent of patients had to be called back as their query could not be directly dealt with at the time of it being received, and when this did happen 68.3 per cent of call backs were made within 10 minutes.

Performance

- ***Meeting response times routinely***

We received a total of 1,892,343 emergency calls during the year, up 9.1 per cent on 2013/14.

From these, we responded to 1,025,836 emergency incidents, down from 1,090,277 in the previous 12 months.

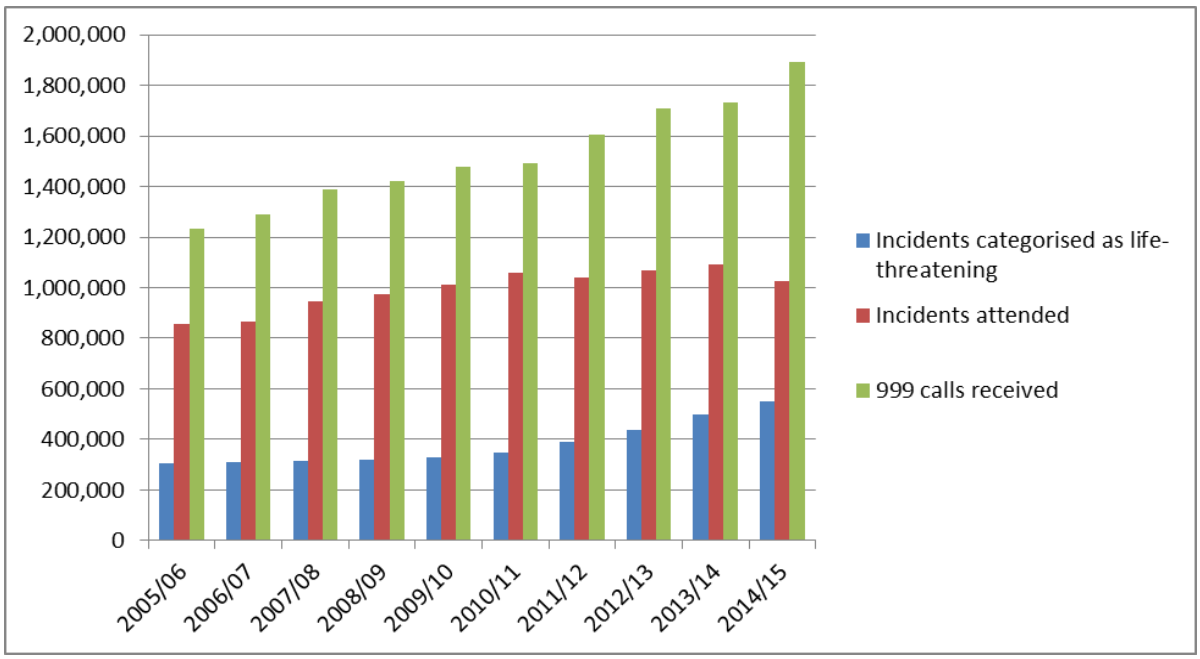
We took 674,771 patients to a hospital accident and emergency department, compared to 748,531 in 2013/14.

A further 262,198 patients were attended by our staff but were not taken anywhere for further medical treatment.

Category A: Of the total calls received, 551,831 were treated as life-threatening (Category A), compared to 496,348 in 2013/14.

We attended a total of 490,175 Category A incidents, compared to 460,615 in 2013/14, and we reached 59.2 per cent (293,702) of these patients within eight minutes.

We arrived at 92.2 per cent (451082) of Category A patients within 19 minutes, against the target of 95 per cent.



Category C: All other calls fall into one of four C categories. We received 1,302,577 calls to Category C (lower priority) patients compared to 1,227,879 last year. A total of 535,258 were responded to by ambulance crews or single responder conveying crews (compared to 629,156 in 2013/14) and we reached 68.46 per cent of these patients within our target time of 60 minutes, compared to 82.69 per cent in last year.

Governance of our organisation

Our Trust Board manages risk through our risk management policy and strategy, corporate risk register and board assurance framework.

The board assurance framework and corporate risk register are presented at each meeting of the Trust Board, and further scrutiny is applied through the Quality Governance and Audit Committees. The risk register is reviewed in detail by the Senior and Executive Management teams each month.

Full details can be found in our annual governance statement on page 21 of this document.

Our use of feedback to make improvements

We continue to use feedback from patients, their families and the public as an important way of driving improvements to our service. This is captured by our Patient Experiences team who identify any emerging themes and report these through the Trust's governance structure to the executive management team and the Trust Board.

The number of complaints we received this year rose to 1403, up from 1060 in 2013/14. This increase reflected the unprecedented increase in demand to the 999 service with the most frequent cause of a complaint once again being a delay in an ambulance being sent, especially to patients assessed as less seriously ill or injured; and changes in how we manage 999 calls, with some callers being referred to NHS 111 or other care providers. We also now monitor patient feedback websites and respond to complaints made via social media. The Patient Experiences team also managed around 3500 enquires.

Some of the changes we have arising from complaints and service-user feedback include the following:

- We historically used a tape recorded exit message at the end of some 999 calls which explained what the caller needs to do next. Following patient feedback, this was stopped and callers always now speak to a call handler.
- We have introduced a procedure to identify particularly vulnerable patients who now received an automatic upgrade to the call priority every 60 minutes, when there is a delay in an ambulance being sent, regardless of whether we are told that their condition has changed. This has meant that patients have not waited as long as they otherwise might have.
- Patients told us that they don't like not being kept up to date with the progress of their call, so we now offer information about the approximate time a caller may have to wait before an ambulance can be sent.

Principles for Remedy

We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, Principles of Remedy. This includes:

- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.
- Our website and all our staff can offer information about how to make a complaint about the service we provided.
- Activity and themes arising from complaints are regularly reported to the Trust Board
- Our Learning from Experience Group reviews the themes and issues emerging from complaints and the action taken to improve services and the experience of patients.

Directors' report

Our Trust Board

In 2014/15 our Trust Board was made up of 12 members – a non-executive chairman, five of the Service's executive directors, including the Chief Executive, and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. All executive appointments are permanent and subject to normal terms and conditions of employment. The non-executive directors are appointed by the same method through the NHS Trust Development Authority.

There were a number of changes to the executive membership of the Trust Board during the year.

Ann Radmore, Chief Executive, left the Service in January 2015 to take up a national programme role with NHS England.

Fionna Moore, Medical Director, was appointed as interim Chief Executive (voting member of the Trust Board) in January 2015.

Fenella Wrigley, Deputy Medical Director, was appointed as interim Medical Director (voting member of the Trust Board) in January 2015.

Steve Lennox, Director of Nursing and Quality (voting member of the Trust Board) left the Service in November 2014.

Zoë Packman was appointed as Director of Nursing and Quality (voting member of the Trust Board) in November 2014.

David Prince, Director of Support Services (non-voting regular attendee of Trust Board) left the Service in November 2014.

Mike Evans, Director of Business Development (non-voting) left the Service in October 2014.

Jane Chalmers, Director of Modernisation (non-voting and interim position) left the Service in July 2014.

The Board has six formal sub-committees: the Strategy Review and Planning Committee, the Quality Governance Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee.

The Strategy Review and Planning Committee is made up of all the board members and is chaired by the Chairman.

Four non-executive directors and six executive directors made up the membership of the Quality Governance Committee, which was chaired during the year by non-executive director Robert McFarland.

The membership of the Audit Committee comprises three non-executive directors and was chaired by non-executive director John Jones.

The Finance and Investment Committee was chaired by non-executive director Nick Martin and has three non-executive directors and five executive directors as its members.

The Remuneration and Nominations Committee was chaired by the Trust Chairman and all non-executive directors are members.

The membership of the Charitable Funds Committee was reviewed and updated during 2014/15 and comprises the Trust Chairman Richard Hunt, who chairs the committee, and one executive director.

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009. He was formerly the International President of the Chartered Institute of Logistics and Transport, and has experience extending across the aviation, logistics, international oil and brewing sectors. Richard is a former Chief Executive of Aviance Ltd which handles logistics at UK airports, and he was Chief Executive of EXEL Logistics Europe, the largest UK transport and logistics business. He has also served as a non-executive on the Highways Agency Advisory Board. Richard was appointed CBE for services to logistics and transport in the 2004 New Year Honours.

Jessica Cecil took up her post on 1 December 2010. She has over 20 years of experience working in broadcasting on flagship television programmes such as *Newsnight*, *Panorama* and *Tomorrow's World*. She is Controller, Make it Digital at the BBC, and was formerly Chief of Staff to the Director-General. Jessica is the vice-chair of LAS. She is a member of the Quality Governance and Finance and Investment committees.

John Jones started as an associate non-executive director in October 2012, and took up his substantive role on 1 January 2013. He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status. John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy. He is the chair of the Audit Committee, and a member of the Finance and Investment Committee.

Nicholas Martin took up the post in October 2012. He has thirty years' experience of corporate finance advising a wide range of companies from different sectors. He has served on a number of boards and governing bodies in executive and non-executive roles, including Cambridge University, City of Westminster College, Hammersmith Hospitals NHS Trust, NHS City & Hackney Primary Care Trust and NHS Haringey Primary Care Trust. Nick is a barrister, a Chartered Fellow of the Chartered Institute of Securities & Investment, and a former Cabinet Special Adviser. He is the chair of the Finance and Investment Committee and a member of the Quality Governance Committee.

Robert McFarland took up his post in May 2013, as an associate non-executive director. Robert worked as a Consultant General and Vascular Surgeon for over 20 years and recently retired from St George's Healthcare NHS Trust. Throughout his career he has worked in both district hospitals and regional teaching hospitals. In 2007, Robert was appointed as Clinical Director for Trauma and Emergency Surgery at St George's Hospital, which opened as one of four major trauma centres serving London and Surrey in 2010. Robert was also Clinical Director of the South West London and Surrey Trauma Network and was a member of the Clinical Advisory Panel, London Trauma System. He is the chair of the Quality Governance Committee and attends the Audit Committee.

Fergus Cass joined us in March 2014. He was a non-executive director of NHS North West London until the replacement of primary care trusts in 2013 and previously served on the board of NHS Kensington and Chelsea. He worked for the multinational consumer goods company Unilever for 36 years, initially in finance and later as a general manager, heading businesses in Africa and South Eastern Europe. He holds degrees in economics and is a qualified accountant. Fergus is a trustee of Hospices of Hope, which supports palliative care in Romania and neighbouring countries, and of Book Aid International. He is a member of the Quality Governance and Audit Committees.

Theo de Pencier joined the Service in March 2014. Theo is the Chief Executive of the Freight Transport Association (FTA) representing industry's freight interests by road, rail, sea and air. The FTA has over 14,000 members who operate more than 200,000 trucks (half of the total in the UK), consign 90 per cent of rail freight and 70 per cent of visible exports. Theo's early career was spent in sales and marketing with brand leading food and drink manufacturers Heinz and Diageo. He has over 30 years' Board level experience in the logistics and supply chain industry working for NFC and Danzas before joining Bibby Line Group in 1999 as Managing Director of Bibby Distribution. He joined FTA in July 2007. He is a member of the Audit and Finance and Investment Committees.

London Ambulance Service NHS Trust
Organisation Code: RRU

Governance Statement

Scope of responsibility

The Board is accountable for internal control and, as Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding quality standards and public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a governance structure, processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

As part of London's health economy we work with our partners to minimise the risks to patient care. To do so we have met routinely with our lead commissioners and with the portfolio team at the NHS Trust Development Authority (TDA) in order to progress and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London.

In 2014/15, we managed increased demand across London, two national strikes, an increased terrorist threat level, and the busiest winter on record. We also experienced our lowest performance against national ambulance standards, high frontline staff turnover and low levels of staff satisfaction evidenced in our disappointing staff survey results. There are a number of reasons for our under performance last year including increased activity; slow recruitment to vacancies during the first half of the year; high utilisation which makes it difficult for us to respond to peaks in activity; an aging fleet due to historic underinvestment; national shortages of Paramedics at a time when career and market opportunities have opened up for them. The Trust is in the middle of an improvement programme supported by NHS England and the TDA and it is clear that we must continue our drive and pace of change, to tackle these issues and improve our organisation and performance.

Whilst facing these challenges, our primary concern has been and continues to be the safety of the service we provide. It is essential as an organisation that we learn from what we weren't able to deliver and apply that learning to improve services moving forwards. Managing and mitigating against any potential performance impact on patient quality and safety is our fundamental priority. To that end LAS conducted an internal safety review in October 2014 and an external safety review in December 2014 conducted by NHSE, TDA and Clinical Commissioning Groups.

Our ambulance service Emergency Operations Centre (EOC) continues to be the busiest in the world with our strength in this area reflected once again by receiving two prestigious awards this year; MPDS Centre of Excellence (2014) and the Cabinet Office's Customer Services Excellence Accreditation (2014) demonstrating the organisation's ability to continue delivering quality and excellence despite increasing demand on our services. The Trust participated in the National Trauma Pre-Hospital Peer Review with a positive outcome report.

2014/15 has seen an extensive programme of change undertaken addressing the major challenges that we are currently facing developed in close consultation with Commissioners: recruit, train, retain, motivate, invest.

The Trust has implemented a challenging programme of national and international recruitment for front line staff during 2014/15 and into 2015/16. New roles have been introduced – Emergency Ambulance Crew and Senior Paramedic – and a new clinical career

structure introduced. We have continued to increase the number of calls we handle and resolve through hear and treat and the Clinical Hub has continued to develop to enhance the service provided through the emergency operations centre in order to provide safe patient care. The Clinical Hub is operated by senior paramedics and provides enhanced clinical assessments to support hear and treat dispositions for appropriate patients and also provides clinical support and expertise for operational ambulance crews and non-clinical staff within the control rooms.

The Trust reviewed its strategy in 2014/15 for the next five years and introduced 'Caring for the Capital: A strategy for London Ambulance Service towards 2020'. The strategy sets out our direction for the next five years and includes our purpose and values. Achieved through working with staff and stakeholders, the strategy explains what we will do together for patients, how the organisation will develop and invest in its workforce and what actions we will take to improve how we do things as a Service. It builds on our achievements and recognises the challenges that we, and the rest of the NHS are facing. We are the busiest ambulance service in the country and the only pan-London health provider, providing urgent and emergency services for people in London. National and local issues and challenges affect everything we do. The strategy articulates the new values for the Trust and its staff:

Our values

In everything we do, we will provide:

• **Care:** Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

• **Clinical excellence:** Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

• **Commitment:** Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

The governance framework of the organisation

Information on the Trust Board committee structure and the attendance records of members is attached (annexes 1 to 7).

Each Board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required.

The Strategy Review and Planning Committee reviewed the governance structure in September 2014, informed by the annual effectiveness review of the Trust Board. It was agreed that, as performance and workforce were currently the most significant issues facing the Trust and were likely to be ongoing, they should be the responsibility of the Executive Management Team. The Finance and Investment Committee would take an oversight role of performance reporting.

Following the review of its function and remit, the revised terms of reference for the Quality Governance Committee were implemented in August 2014. The Committee has taken on more of a clinical focus with membership revised to include the three clinical director leads – Medical, Nursing & Quality and Paramedic Education & Development. The reporting committee structure was reviewed and a new structure implemented from August 2014. An overarching terms of reference for Clinical Safety, Development and Effectiveness was introduced comprising of three strands: Clinical Safety; Professional Development and Education; and Effectiveness and Experience; with each strand reporting to the next meeting of the Quality Governance Committee. This reporting structure is under further review and will be updated in the first quarter of 2015/16 following approval through the Quality Governance Committee.

The Trust Board reviews its effectiveness annually along with that of the reporting committees providing governance oversight and assurance on quality, safety and risk. Risks are reviewed by the Senior Management Team before being added to the corporate risk

register for review and oversight by the Audit Committee. The Trust Chair and Director of Corporate Affairs/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time has been allotted to agenda items and effective contribution and scrutiny given. The Board agenda, papers and practice are continuously reviewed and adapted to ensure that reporting is appropriate and timely. The Board agenda is informed by the forward planner which is reviewed and updated after each meeting.

The annual board effectiveness review has regard to the principles set out in the Corporate Governance Code and other recommended good practice on board governance, such as Monitor's Code of Governance, and The Healthy NHS Board 2013.

The Trust Board receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities. The NHS Trust Development Authority operates a system of monthly submissions of self-certification of compliance with a set of board statements and Monitor's compliance framework.

Attendance by board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. Attendance at key board committees is also monitored and recorded by the Committee Secretary.

The Trust Board understands its responsibilities for discharging the statutory functions and takes assurance from the Audit Committee that systems are in place and that these are legally compliant.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board following each Audit Committee meeting. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from counter fraud. The role of the Audit Committee is to focus on the controls and related assurance that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee met five times during the year with the internal and external auditors present, with two meetings without auditors.

At the Trust Board meeting on 2 June 2015 the Audit Committee chair provided assurance to the board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

The Quality Governance Committee has oversight of quality governance on behalf of the Trust Board, including review of the annual Quality Account, prior to its publication. The reporting committee structure provides assurance to the Quality Governance Committee on clinical audit, never events and serious incidents including the lessons drawn from these and the action being taken to mitigate future risk. The committee also receives assurance on the Trust's response and actions taken to address coroners' recommendations on preventing future deaths.

The Chair of the Quality Governance Committee provides a report to the following meeting of the Trust Board. This report includes the committee's assessment of quality as taken from the reports and evidence presented to the committee, including the corporate risk register. The committee receives assurance from its reporting committees: Clinical Quality Safety and Effectiveness and Learning from Experience; and in the latter part of the year from the successor committee, Clinical Safety Development and Effectiveness. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At the Trust Board meeting on 2 June 2015 the Quality Governance Committee chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee met five times during the year and is reviewing the frequency of meetings for 2015/16.

The Chair of the Finance and Investment Committee provides a report to the following meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year, and oversight on performance management reporting. At the Trust Board meeting

the chair of the committee reports on the cash position, cash management, liquidity, CIP progress, and capital expenditure. The committee met six times during 2014/15 and also held a seminar for committee members.
The Trust Board works within the remit of the standing orders and standing financial instructions and the scheme of delegation. These were reviewed and approved by the Trust Board on 25 November 2014.
The Trust was subject to a number of external independent reviews during 2014/15:
NHS England (London) commissioned a review of clinical safety in December 2014 with no significant concerns raised; and KPMG undertook an independent investigation into an anonymous whistleblowing allegation regarding 'systematic cheating' on the paramedic training programme run by the Trust from 2008-2012. The outcome report will be published in June 2015. Although there was a lack of governance around examination processes during the period in question the external investigation was unable to provide evidence of cheating.
The Trust has been working with a number of external consultancies in the review of its operational performance and modelling and in the preparation of a business case to commissioners for investment for the period 2015/16-2016/17. External consultancy support has also been commissioned with regard to IM&T strategy and workforce support.
The Trust received unconditional registration from the Care Quality Commission (CQC) in March 2010 to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures.

The Trust can confirm that all premises which we own, occupy or manage had fire risk assessments that complied with the Regulatory Reform (Fire Safety) Order 2005. We also achieved compliance with the Department of Health Fire Safety Policy.

Risk assessment

The organisation's major risks relate to safety, performance, finance and workforce as described in the Board Assurance Framework.
The Risk Management Policy and Strategy defines the risk management process which specifies the way risk (or change in risk) is identified, assessed and managed through controls. It describes the process for embedding risk management throughout the Trust and during 2014/15 we have made further progress with managing local risk register processes. The corporate risk register is reviewed by the Audit and Quality Governance Committees and by the Trust Board as it contains the highest level of risks facing the organisation. Risks can be escalated to the Senior Management Team for discussion and addition to the corporate risk register if required. We align project management risks with the corporate risk register. The policy and strategy was updated and re-formatted in 2014/15.
KPMG undertook a review of risk management in August 2014 and stated that risk management arrangements at London Ambulance Service NHS Trust ('the Trust') had reached an overall assessment of '*Partial assurance with improvements required*'. The key areas for improvement related to: ensuring a clear framework for identification, monitoring and reporting of local risks; risk reporting and review by complexes (stations); movement in relation to aged risks; full completion and risk registers and SMART actions; the escalation of corporate risks and maintaining local risk registers. The Strategy Review and Planning Committee undertook a strategic risk review in September 2014 incorporating risk management training for executive directors and senior management team. Top down risks are identified through the risk register, board assurance framework and programme work.
Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the safety and risk team, using a risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the Senior Management Team or monitored at a local level. The Serious Incident Group

meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents.
New risks with a net severity rating of High (over 15) are added to the corporate risk register and the board assurance framework which are reviewed by the Executive Management Team, Audit Committee and the Trust Board on a quarterly basis. 20 risks were added in 2014/15 and 13 were archived having reached their target level or being closed as they were no longer relevant. A list of the new risks is attached as an annex to this statement (annex eight).
The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.
There were 19 lapses of data security in 2014/15 and none of these reached the threshold for reporting to the Information Commissioner.
The Trust achieved 84% against the Information Governance toolkit and is at level two overall. Significant progress has been made since the appointment of the Information Security Manager who works closely with the Information Governance Manager. The Information Governance Group moved to quarterly meetings in quarter 4 of 2014/15.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The format of the board assurance framework shows the key risks facing the Trust during the quarter, mapped to the strategic objectives and annual priorities. The Audit Committee oversees the board assurance framework and corporate risk register and provides assurance to the Trust Board on the effectiveness of the risk and control arrangements. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met.
The Senior Management Team manages the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board, Quality Governance Committee and Executive Management Team receive an integrated performance report and a quality dashboard showing monthly performance and any identified risks, from which improvements and mitigations will be sought.
Systems in place to deter risk include standing orders, the scheme of delegation and standing financial instructions, NHS counter fraud measures, an anti-bribery policy, and a register for declaring directors' and managers' interests.
The local counter fraud specialist (LCFS) attended five meetings of the Audit Committee in 2014/15 and monthly executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013.

The internal auditors attended five meetings of the Audit Committee during 2014/15 and work closely with the Governance and Assurance team to execute the annual audit work plan. Internal audit also attend meetings of the Quality Governance Committee and the committee has input to the development of the annual audit work plan. This work is also informed by the executive team. KPMG have provided the internal audit service to the Trust since April 2013.

Pricewaterhouse Coopers are the external audit provider.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive management team within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the performance information available to me. My review is also informed by

comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

The Trust has experienced significant performance challenges during 2014/15 and has been unable to achieve the requisite targets since May 2014. The Trust Board has submitted a qualified statement to the TDA each month against Monitor's Governance Statement 10: '*the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NHS Trust Development Authority oversight model; and a commitment to comply with all known targets going forward*.'

We experienced high frontline staff turnover and were slow to recruit during the first half of the year. A national shortage of paramedics combined with new markets and career opportunities added to the workforce challenge which had an impact on performance and contributed to the Trust not achieving the requisite targets. This also created a risk to the implementation and delivery of the business plan.

The Trust has continued to improve its internal processes for the identification and management of serious incidents and declared 45 to commissioners in 2014/15 for further investigation, reporting and learning within the context of responding to 1.025m incidents during the year. The overriding theme relates to delays in response times. We have worked closely with NHS England and commissioners in the development of a business case to address utilisation rates and productivity. This has resulted in significant investment for the period 2015/16-2016/17 in order to increase resources, and improve productivity and the response to demand. An external clinical review of the Service, led by NHS England in December 2014, confirmed assurance of the safety of the service and the response provided to patients.

Following receipt of an anonymous whistleblowing allegation into 'systematic cheating' on the paramedic training programme run by the Trust from 2008-2012, we commissioned an independent investigation through KPMG's forensic team. The investigation took place from May to September 2014 with the final report completed in March 2015 and due for publication in June 2015. The investigation identified that there had been a lack of governance of examination processes during the period in question and serious failings in the way an internal investigation had been undertaken in 2011, but was unable to find evidence of systematic cheating.

The Trust is undergoing the CQC Chief Inspector of Hospitals Inspection in June 2015 and has self-assessed compliance performance against the five domains as follows:

- Safe - Requires improvement
- Caring – Good
- Effective – Requires improvement
- Responsive – Requires improvement
- Well-led – Requires improvement.

Internal audit undertook eight reviews during 2014/15 of which five received positive assurance. Of a total of 40 recommendations, eight were determined as high priority within the following reviews:

- Risk management – 1 high priority recommendation

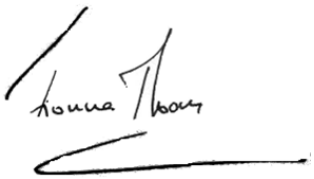
- Fleet management – 5 high priority recommendations
- Arrangements for staff absence and TOIL – 2 high priority recommendations.

There was one high priority recommendation outstanding from 2013/14 in relation to recruitment. There are robust plans in place to address this early in 2015/16.

The Head of Internal Audit's opinion is one of 'Substantial assurance with minor improvements required'. 'Our work has confirmed that there is general a sound system of internal control which is designed to meet the Trust's objectives, although we had identified areas where the controls in place could be enhanced or improved.'

Accountable Officer : Fionna Moore, interim Chief Executive

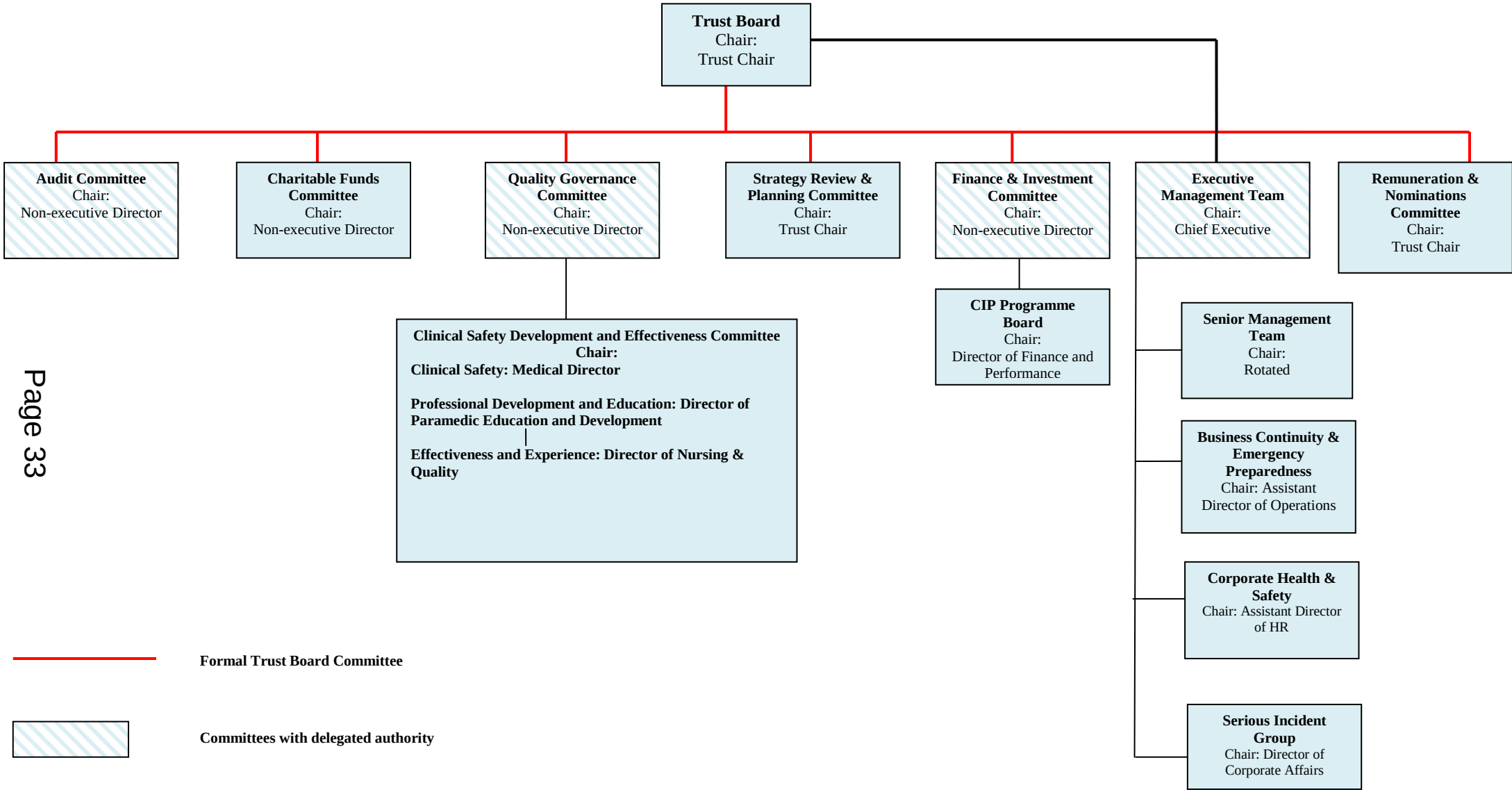
Organisation: London Ambulance Service NHS Trust (RRU)



Signature:

Date: 2 June 2015

Annex 1 Governance Structure - February 2015



Annex 2 Committee membership

Formal Trust Board committee	Chair	Current members
Audit committee	Non-executive director, John Jones	John Jones (non-executive director) Theo de Pencier (non-executive director) Fergus Cass (non-executive director)
Charitable funds committee	Trust Chair, Richard Hunt CBE	Richard Hunt (Trust Chair) Andrew Grimshaw (Director of Finance and Performance)
Quality governance committee	Non-executive director, Bob McFarland	Jessica Cecil (non-executive director) Nick Martin (non-executive director) Fergus Cass (non-executive director) Fionna Moore to January 2015; Fenella Wrigley from January 2015 (Interim) (Medical Director) Steve Lennox to November 2014; Zoe Packman from November 2014 (Director of Nursing and Quality) Mark Whitbread (Director of Paramedic Education and Development) Sandra Adams (Director of Corporate Affairs) Jason Killens (Director of Operations) David Prince to November 2014 (Director of Support Services)
Finance & investment committee	Non-executive director, Nick Martin	John Jones (non-executive director) Jessica Cecil (non-executive director) Theo de Pencier (non-executive director) Andrew Grimshaw (Director of Finance and Performance) Sandra Adams (Director of Corporate Affairs) Steve Lennox to November 2014; Zoe Packman from November 2014 (Director of Nursing and Quality) David Prince to November 2014 (Director of Support Services) Karen Broughton (Director of Transformation and Strategy) Paul Woodrow (Director of Performance) Mike Evans to October 2014 (Director of Business Development) Kevin Hervey (Interim Deputy Director of Finance)
Strategy review and planning committee	Trust Chair, Richard Hunt CBE	All board directors, voting and non-voting.
Remuneration and Nomination committee	Trust Chair, Richard Hunt CBE	All non-executive members of the Trust Board

Annex 3 – Attendance at Trust Board meetings

	3rd June 2014	24th June 2014	29th July 2014	30th September 2014	25th November 2014	16th December 2014	27th January 2015	24th March 2015	Comments
Trust Board members (voting)									
Richard Hunt (Non-Executive Chair)	x	x	x	x	x	a	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	a	x	x	C	a	x	C = Chair
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	x	x	x	
Nick Martin (Non-Executive Director)	x	x	x	x	x	x	x	x	
Bob McFarland (Non-Executive Director)	x	x	x	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	x	x	x	
John Jones (Non-Executive Director)	x	x	x	x	x	x	x	x	
Steve Lennox (Director of Nursing and Quality)	x	x	x	x	a				Left the Trust in November 2014
Jason Killens (Director of Operations)	x	x	x	x	x	x	x	x	
Zoe Packman (Director of Nursing and Quality)						x	x	x	Commenced November 14
Fionna Moore (Medical Director)	a	x	x	x	x	x	x	x	Commenced as interim Chief Executive in January 2015
Ann Radmore (Chief Executive)	x	x	x	x	x	x			Left the Trust in January 2015
Fenella Wrigley (Deputy Medical Director)	x						x	x	Attended for Fionna Moore in June 2014; commenced as interim Medical Director in January 2015
Non-voting									
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	x	x	
Karen Broughton (Director of Transformation and Strategy)	x	x	a	x	a	x	x	x	
Jane Chalmers (Director of Modernisation)	x								Left the Trust in June 2014
Mike Evans (Director of Business Development)									Attending by invitation only
Tony Crabtree (Assistant Director of HR)									Attending by invitation only
Charlotte Gawne (Director of Communications)									Attending by invitation only
David Prince (Director of Support Services)	x	x	x	a	x				Left the Trust in November 2014
Mark Whitbread (Director of Paramedic Education and Development)	x	x	x	x	x	x	x	a	
Paul Woodrow (Director of Performance)	x	x	x	x	x	x	x	a	
Vic Wynn (Acting Director of Information Management and Technology)									Attending by invitation only

Annex 4 – Attendance at Quality Governance Committee meetings

	23rd April 2014	18th June 2014	27th August 2014	29th October 2014	13th January 2015	Comments
Quality Governance Committee members						
Bob McFarland (Non-Executive Chair)	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	a	x	
Nick Martin (Non-Executive Director)	a	x	x	a	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	
Ann Radmore (Chief Executive)				x		
Steve Lennox (Director of Nursing and Quality)	x	x	x	x		Left November 2014
Fionna Moore (Medical Director)	a	x	x	x	x	
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	a	x	x	x	x	
Zoe Packman (Director of Nursing and Quality)					x	Commenced November 2014
Jason Killens (Director of Operations)	x	a	a	x	a	
David Prince (Director of Support Services)	x	x	a	x		
Paul Woodrow (Director of Performance)	x	x		a		Attending by invitation only
Mark Whitbread (Director of Paramedic Education and Development)	a	x	x	x	a	

X = attended a = apologies

Annex 5 – Attendance at Audit Committee meetings

	17th April 2014	22nd May 2014	2nd June 2014	8th September 2014	10th November 2014	16th December 2014	2nd February 2015	Comments
Audit Committee members								
John Jones (Non-Executive Director)	x	x	x	x	x	x	x	
Fergus Cass (Non- Executive Director)	x	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	a	x	x	
Attending								
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	a	x	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	a	x	
Ann Radmore (Chief Executive)	x		x					By invitation

X = attended a = apologies

Annex 6 – Attendance at Strategy Review and Planning Committee meetings

	9th September 2014	28th October 2014	24th February 2015	Comments
Trust Board members (voting)				
Richard Hunt (Non-Executive Chair)	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	
John Jones (Non-Executive Director)	x	x	a	
Nick Martin (Non-Executive Director)	a	x	x	
Bob McFarland (Non-Executive Director)	x	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	
Steve Lennox (Director Nursing and Quality)	x	x		Left in November 2014
Jason Killens (Director of Operations)	a	a	x	
Fionna Moore (Medical Director)	x	x	x	
Ann Radmore (Chief Executive)	x	x		Left in January 2015
Zoe Packman (Director Nursing and Quality)			a	Commenced in November 2014
Fenella Wrigley (Deputy Medical Director)			x	Commenced as interim Medical Director in January 2015
Non-voting				
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	
Karen Broughton (Director of Transformation and Strategy)	x	x	x	
Mike Evans (Director of Business Development)	x			
Charlotte Gawne (Director of Strategic Communications)	x	a	x	
David Prince (Director of Support Services)	x	x		
Mark Whitbread (Director of Paramedic Education and Development)	x	x	a	
Paul Woodrow (Director of Performance)	x	a	x	
Vic Wynn (Acting Director of Information Management and Technology)				Attending by invitation only
Briony Sloper (Deputy Director of Nursing)			x	On behalf of Zoe Packman

X = attended a = apologies

Annex 7 – Attendance at Finance and Investment Committee meetings

	22nd May 2014	24th July 2014	24th October 2014	24th November 2014	26th January 2015	19th March 2015	Comments
Finance and Investment Committee members							
Nick Martin (Non-Executive Director)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	a	a	x	x	x	x	
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	a	x	x	x	
Attending							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	a	
Karen Broughton (Director of Transformation and Strategy)							By invitation
David Prince (Director of Support Services)							By invitation
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	x	
Steve Lennox (Director of Nursing and Quality)							By invitation
Paul Woodrow (Director of Performance)							By invitation

X = attended a = apologies

Annex 8 - New Risks Added to the Trust Risk Register in the Period 2014 – 2015

Risk ID	Headline Risk
388	Increase in turnover rates leading to staff reducing by significant numbers
394	CIPS may not be identified or delivered – impacting our credibility with the NTDA and DH plus impact on FT application
396	No disciplines exist for planning ahead could impact on our credibility with the NTDA and DH plus impact on FT application.
398	Acquiring timely supplies of printed material namely PRFs, controlled drugs registers, controlled drugs daily check sheet books, LA3 and LA5. (Archived)
399	Lack of essential equipment on ambulances may impact on the crew's ability to respond.
400	(SatNav) units in fleet vehicles will become unserviceable resulting in vehicle out of service or delayed response.
401	Current age profile of the LAS Vehicle Fleet will result in increased downtime impacting on operational performance
402	Current age profile of Fleet Workshop Managers and Technicians will impact on the future resilience of the Fleet Operation
403	A number of Ambulance and Fast Response Units may not be road worthy as their average service intervals have extended beyond 16 weeks, the average time taken for brake pads to wear. (Archived)
404	Accurately and efficiently capturing errors and incidents and process them in accordance with national guidelines and within specified internal procedures
408	The air-conditioning mechanical plant at HQ 220 Waterloo Road may fail during warm weather this failure would threaten the viability of the Data Centre and Emergency Operations Centre suite. (Archived)
409	The main power distribution board serving HQ 220 Waterloo Road may fail. Impacting on HQ accommodation, electrical light and power for an extended period. (Archived).
410	Patient safety for category C patients may be compromised due to demand exceeding available resources
416	Not satisfying IGT 11-313 requirements concerning network security. (Archived)
417	Unauthorised access and threats to the Trust's network not being detected after a breach potentially impacting on the operational delivery of services.
426	Failure to meet our obligations of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to meet the increased workload.
433	Lack of commitment to staff engagement in terms of time and focus resulting in the disengagement and lack of motivation of staff to play a part in improving the performance of the organisation.
434	Focus on internal performance improvement preventing senior operational managers from focussing on external stakeholder engagement, impacting on stakeholder engagement and support.
439	Support staff not receiving statutory and mandatory training appropriate to their role.
440	LAS may not be in a position to win new NHS 111 contracts as stated in the five year strategy.

2014/15 Introduction to the Annual Accounts

Financial Review

NHS Trusts have a number of financial duties. This section of the annual report outlines the financial performance of the Trust for the financial year ended 31 March 2015 and the results outlined in this section relate to the full 12 month period of 1 April 2014 to 31 March 2015. A copy of the full statutory audited accounts is included in this annual report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial Duties Review

Break-even duty

NHS trusts have a regulatory duty to break-even in each and every financial year.

The seven year break-even performance is set out below. The figures for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Break-even performance

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000
Retained surplus/(deficit) for the year	725	-420	740	2,527	-417	1,525	6,326
Adjustments for impairments	0	1,845	262	247	723	-1,235	-237
Adjustments for impact of policy change re donated grants asset	0	0	0	-23	-44	11	5
Absorption Adjustment	0	0	0	0	0	-39	-46
Break-even in-year position	725	1,425	1,002	2,751	262	262	6,048
Break-even cumulative position	2,569	3,994	4,996	7,747	8,009	8,271	14,319
Break-even cumulative position as a percentage of turnover	0.98%	1.43%	1.76%	2.75%	2.64%	2.72%	4.42%

The surplus in 2014/15 led to an improvement on the cumulative position for the fourteenth year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

On income and expenditure we reported a surplus of £6.0m for the year, and therefore performed better than the break-even target set by the Department of Health for 2014/15. The reported surplus was £5m better than planned due to the receipt of additional funds from commissioners in respect of the 2015/16 transformation case. The underlying surplus in 2014/15 was in line with plan at £1m.

External Financial Limit

The External Financing Limit (EFL) is the means by which the Treasury, via the Department of Health and NHS London, controls public expenditure in NHS trusts. This is a statutory financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. Exceeding these limits requires prior approval.

Most of the money spent by us is generated from our service agreements for patient care and income generation (income from operations). The EFL determines how much more (or less) cash we can spend in a year than is generated from our operations.

Each year, we are allocated an EFL as part of the national public expenditure planning process.

The trust achieved its external financial limit (EFL) of £12.6m for the year.

Capital Cost Absorption Duty

The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. We are required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the average relevant net assets of the trust. To meet this duty, we must achieve a rate between three per cent and four per cent.

A return on assets (the capital cost absorption duty) of 3.5% was achieved. This was within the permitted range of 3% to 4%.

Capital Resourcing Limit

The Capital Resourcing Limit (CRL) is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit. The CRL is accruals based as opposed to the cash-based EFL in NHS trusts.

Under spends against the CRL are permitted and overspends against the CRL are not permitted.

A capital resource limit controls the amount of capital expenditure that a NHS body may incur in the financial year.

In the capital programme £14.9million was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall, we under spent by £1.0m against our capital resource limit, which we are permitted to do. The capital programme was funded using earned income.

Apply the Better Payment Practice Code

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days.

We were able to pay 90.36% and 77.07% of our non-NHS and NHS trade invoices respectively within 30 days, which was an improvement on 2013/14 but below the 95% target set by the Department of Health.

Balance sheet

The largest item on the Trust balance sheet is £145.3 million of fixed assets (£134 million in 2013/14) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. Investment in capital assets is funded through our capital programme. In 2014/15 we invested £14.9 million (£6.9 million in 2013/14). The most significant additions related to the replacement of ambulances, projects to improve estates and new technology.

As at 31 March 2015, the Trust has net working capital of £5.0 million (£3.9 million in 2013/14) and long-term creditors and provisions of £10.1 million (£12.3 million in 2013/14). In addition to this, cash balances total £14.7 million (£6.4 million in 2013/14).

In 2010/11, we obtained a loan of £107,275 from Salix Finance Ltd to support our capital investment in technical measures to improve energy efficiency. The loan was drawn down in August and December 2010

for £60,000 and £47,275 respectively. It is an interest free, unsecured loan with two to five year repayment terms.

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital totals £62.5 million (£62.5 million in 2013/14). This represents the Department of Health's investment in the LAS and annual dividends are payable on this sum. A further £47.4 million (£40.7 million in 2013/14) is held in a revaluation reserve representing the accumulated increase in value of our estate.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 9.6 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2015/16

We have formally submitted a plan for 2015/16 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a deficit of £9.5 million.

Detailed financial planning work is in progress in preparation for our Foundation Trust application.

Financial risk

We monitor financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

The Treasury announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRS) from 2009/10. That was the first year that we prepared our accounts under IFRS, resulting in the rework of 2008/09 results to act as prior year comparators in the 2009/10 accounts.

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2015 for all land and buildings. The net gain on revaluation was £8.2 million and the total impairments were £0.2 million.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £4.7 million for the current financial year (£3.7 million in 2013/14).

Subsequent events after the balance sheet date

There was no important event occurring after the financial year end that has a material effect on the 2015/16 financial statements.

Other information

Pricewaterhouse Coopers LLP was our external auditor for the year ended 31 March 2015. We paid £95,000 (£95,000 in 2013/2014) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. PricewaterhouseCoopers LLP have not undertaken any non-audit work during the year ended 31 March 2015.

The directors confirm that, as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware and that they have taken all the steps that they should have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS body's

auditors are aware of that information.

We conform to the Treasury's guidance on setting charges for information supplied to the public or commercial organisations.

The London Ambulance Service is a NHS trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of the NHS trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014-15 NHS Manual for Accounts issued by the Department of Health.

The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

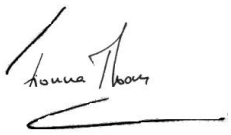
- value for money is achieved from the resources available to the Trust;

- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of HM Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.



Signed Chief Executive

Date: 2 June 2015

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of HM Treasury;

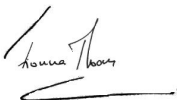
- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Chief Executive  Date: 2 June 2015

Finance Director  Date: 2 June 2015

Independent auditors' report to the Directors of the Board of London Ambulance Service NHS Trust

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

- give a true and fair view, of the state of the Trust's affairs as at 31 March 2015 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by London Ambulance Service NHS Trust, comprise:

- the Statement of Financial Position as at 31 March 2015;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Changes in Taxpayers' Equity for the year then ended;
- the Statement of Cash Flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as being relevant to the National Health Service in England.

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances and senior managers and related narrative notes on page 45 of the Annual Report; and
- the table of pension benefits of senior managers and related narrative notes on page 47 of the Annual Report.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England

Independent auditors' report to the Directors of the Board of London Ambulance Service NHS Trust (continued)

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Trust Development Authority's Guidance or is misleading or inconsistent with information of which we are aware from our audit;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Statement of Directors' Responsibilities set out on page 40 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England.

Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 44 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS bodies) published by the Audit Commission in April 2014, and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission on 13 October 2014, we are satisfied that, in all significant respects, London Ambulance Service NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

What a review of the arrangements for securing economy, efficiency and effectiveness in the use of resources involves

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission on 13 October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Independent auditors' report to the Directors of the Board of London Ambulance Service NHS Trust (continued)

Our responsibilities and those of the Trust

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission on 13 October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the financial statements of London Ambulance Service NHS Trust in accordance with the requirements of Part II of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Heather Ancient(Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
London

3 June 2015

(a) The maintenance and integrity of the London Ambulance Service NHS Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000	2013-14 £000
Gross employee benefits	9.1	**(217,034)**	(208,717)
Other operating costs	7	**(97,284)**	(90,005)
Revenue from patient care activities	4	**313,925**	302,273
Other operating revenue	5	**10,127**	1,554
Operating surplus/(deficit)		**9,734**	5,105
Investment revenue	11	**178**	112
Other gains	12	**40**	41
Finance costs	13	**(282)**	(381)
Surplus for the financial year		**9,670**	4,877
Public dividend capital dividends payable		**(3,390)**	(3,391)
Transfers by absorption - gains		**46**	39
Net gain on transfers by absorption		**46**	39
Retained surplus for the year		**6,326**	1,525

Other Comprehensive Income

	2014-15 £000	2013-14 £000
Impairments and reversals taken to the revaluation reserve	**199**	(1,247)
Net gain/(loss) on revaluation of property, plant & equipment	**8,179**	9,614
Total comprehensive income for the year	**14,704**	9,892

Financial performance for the year

Retained surplus for the year	**6,326**	1,525
Impairments (excluding IFRIC 12 impairments)	**(237)**	(1,235)
Adjustments in respect of donated government grant asset reserve elimination	**5**	11
Adjustment re absorption accounting	**(46)**	(39)
Adjusted retained surplus	**6,048**	262

The notes on pages 47 to 77 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	14.1	**134,668**	121,627
Intangible assets	15.1	**10,634**	12,296
Total non-current assets		**145,302**	133,923
Current assets:			
Inventories	19	**3,026**	3,498
Trade and other receivables	20	**33,813**	22,804
Cash and cash equivalents	21	**14,701**	6,436
Sub-total current assets		**51,540**	32,738
Non-current assets held for sale	22	**101**	0
Total current assets		**51,641**	32,738
Total assets		**196,943**	166,661
Current liabilities			
Trade and other payables	23	**(39,303)**	(22,840)
Provisions	27	**(7,357)**	(4,750)
Borrowings	24	**(2)**	0
DH Capital Loan	24	**0**	(1,244)
Total current liabilities		**(46,662)**	(28,834)
Net current assets		**4,979**	3,904
Total assets less current liabilities		**150,281**	137,827
Non-current liabilities			
Trade and other payables		**0**	0
Other liabilities		**0**	0
Provisions	27	**(9,963)**	(9,114)
Borrowings	24	**(107)**	(107)
DH capital loan		**0**	(3,099)
Total non-current liabilities		**(10,070)**	(12,320)
Total assets employed:		**140,211**	125,507
FINANCED BY:			
Public Dividend Capital		**62,516**	62,516
Retained earnings		**30,746**	22,675
Revaluation reserve		**47,368**	40,735
Other reserves		**(419)**	(419)
Total Taxpayers' Equity:		**140,211**	125,507

The notes on pages 47 to 77 form part of this account.

The financial statements on pages 43 to 77 were approved by the Board on 2 June 2015 and signed on its behalf by

Chief Executive:  Date: 2 June 2015

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	NOTE	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2014		**62,516**	**22,675**	**40,735**	**(419)**	**125,507**
Changes in taxpayers' equity for the year ended 31 March 2015						
Retained surplus for the year		0	6,326	0	0	**6,326**
Net gain on revaluation of property, plant, equipment	14.1	0	0	8,179	0	**8,179**
Impairments and reversals	14.1	0	0	199	0	**199**
Transfers between reserves		0	1,745	(1,745)	0	**0**
Net recognised revenue for the year		**0**	**8,071**	**6,633**	**0**	**14,704**
Balance at 31 March 2015		**62,516**	**30,746**	**47,368**	**(419)**	**140,211**
Balance at 1 April 2013		**62,516**	**20,053**	**33,426**	**(419)**	**115,576**
Changes in taxpayers' equity for the year ended 31 March 2014						
Retained surplus for the year		0	1,525	0	0	1,525
Net gain on revaluation of property, plant, equipment	14.2	0	0	9,614	0	9,614
Impairments and reversals	14.2	0	0	(1,247)	0	(1,247)
Transfers between reserves		0	1,058	(1,058)	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs		0	39		0	**39**
Net recognised revenue for the year		**0**	**2,622**	**7,309**	**0**	**9,931**
Balance at 31 March 2014		**62,516**	**22,675**	**40,735**	**(419)**	**125,507**

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Operating surplus		**9,734**	5,105
Depreciation and amortisation	14 & 15	**12,101**	15,202
Impairments and reversals		**(237)**	(1,235)
Interest paid	13	**(108)**	(168)
Dividend paid		**(3,556)**	(3,406)
(Increase)/Decrease in Inventories		**472**	(234)
Increase in Trade and Other Receivables		**(10,985)**	(6,733)
Increase/(Decrease) in Trade and Other Payables		**11,466**	(609)
Provisions utilised	27	**(1,201)**	(924)
Increase in movement in non cash provisions		**4,657**	3,264
Net Cash Inflow from Operating Activities		**22,343**	10,262
Cash Flows from Investing Activities			
Interest Received		**199**	82
Payments for Property, Plant and Equipment		**(9,321)**	(6,277)
Payments for Intangible Assets		**(615)**	(1,112)
Proceeds of disposal of assets held for sale (PPE)		**0**	41
Net Cash Outflow from Investing Activities		**(9,737)**	(7,266)
Net Cash Inflow before Financing		**12,606**	2,996
Cash Flows from Financing Activities			
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(4,343)**	(1,244)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	(816)
Net Cash Outflow from Financing Activities		**(4,343)**	(2,060)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**8,263**	936
Cash and Cash Equivalents at Beginning of the Period		**6,436**	5,500
Cash and Cash Equivalents (and Bank Overdraft) at year end	21	**14,699**	6,436

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the HM Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

Under the provisions of IFRS 10 *Consolidated Financial Statements* , those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements* , restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust Charitable Funds are not considered material and therefore not consolidated with the Trust financial statements for 2014-15.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5.1 Critical judgements in applying accounting policies

There were no critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset Valuations

All land and buildings are restated to fair value by way of professional valuations. Full revaluation will be provided every five years. In the intervening years the fair values are updated by way of annual desktop revaluations. For the desktop revaluation the specialised operational values are updated in line with the current Tender Price Index published by the Building Cost Information Service (BCIS). The value of the land, non specialised assets and market values are reviewed by the valuer in line with analysis of market movements during the period.

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.11 and the carrying values of property, plant and equipment and intangible assets in notes 14.1 and 15.1 respectively.

Provisions

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 27.

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2015. The carrying value of the accrual is £4.27m (31 March 2014 £3.77m) within note 23 under accruals and deferred income.

Injury Cost Recovery Scheme Accrual

The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on "management estimates supported by the number of cases" supplied by hospitals. The carrying value of the receivables is £3.1m within note 20.1 under non-NHS accrued income.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.7 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● the item has cost of at least £5,000; or
● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Notes to the Accounts - 1. Accounting Policies (Continued)

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Notes to the Accounts - 1. Accounting Policies (Continued)

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

The estimated useful lives are as follows:	Years
Medical equipment & engineering plant & equipment	5 to 15
Furniture	10
Set up costs in new buildings	10
Fork Lift Trucks	10
A&E Ambulances	7
Other Vehicles	7
Command Point	7
Defibrillators Lifepak 15	7
Defibrillators Lifepak 12	5
Rapid Response Vehicles	5
Office Equipment	5
PTS Vehicles	3
Information Technology Equipment	3
Internally Generated Software	3 to 7
Second-Hand Vans	2

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with the Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Donated income is deferred only where conditions attached to the donation have not been met.

1.13 Government grants

The value of assets received by means of a government grant are credited directly to income. Government grant income is deferred only where conditions attached to the grant have not been met.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.18 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.5% in real terms (1.3% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 27. The provision for clinical negligence claims is included in the financial statements of the NHSLA and is not included in these financial statements.

1.20 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.24 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.25 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.28 Subsidiaries

The Trust Charitable Funds are not considered material and are therefore not consolidated with the Trust financial statements for 2014-15.

1.29 Other reserve

This reserve was created when London Ambulance Service became an NHS Trust. The negative reserve balance was caused by the legal title of the property not being properly transferred from NHS Estates when the Trust was created. Once the error had been identified, the London Ambulance Service NHS Trust purchased the property from the NHS estates and thereby created a negative reserve.

1.30 Heritage assets

The London Ambulance Service NHS Trust Museum has a collection of vintage radio equipment, memorabilia from both World Wars and a photographic and document archive. There is also a collection of more than 20 vintage vehicles. The museum is currently closed to members of the public. The value of these assets cannot be obtained at a cost commensurate with the benefits to the users of the financial statements and therefore have not been included in the Statement of Financial Position.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the undermentioned Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Operating segments

The Trust Board considers that the Trust has only one segment which is the provision of accident and emergency services.

3. Income Generation Activities

The Trust undertook income generation activities of £54k (2013/14 £64k) during the financial year.

4. Revenue from Patient Care Activities

	2014-15 £000	2013-14 £000
NHS Trusts	**119**	4,989
NHS England	**9,918**	13,853
Clinical Commissioning Groups	**299,602**	276,800
Foundation Trusts	**76**	1,549
Department of Health	**0**	915
NHS Other (including Public Health England and Prop Co)	**4**	12
Non-NHS:		
Local Authorities	**14**	0
Injury costs recovery	**1,391**	1,288
Other	**2,801**	2,867
Total Revenue from patient care activities	**313,925**	302,273

5. Other Operating Revenue

	2014-15 £000	2013-14 £000
Recoveries in respect employee benefits	**546**	499
Patient transport services	**5,953**	0
Education, training and research	**3,574**	991
Income generation	**54**	64
Total Other Operating Revenue	**10,127**	1,554
Total operating revenue	**324,052**	303,827

Income arising on patient transport services amounting to £7,707k was shown within Revenue from Patient Care Activities in 2013/14, but has been reflected in Other Operating Revenue in 2014/15 because it does not relate directly to patient care.

6. Revenue

	2014-15 £000	2013-14 £000
From rendering of services	**324,052**	303,827

7. Operating Expenses

	2014-15 £000	2013-14 £000
Trust Chair and Non-executive Directors	**60**	61
Supplies and services - clinical	**8,039**	7,690
Supplies and services - general	**3,349**	1,538
Consultancy services	**4,316**	1,668
Establishment	**9,666**	7,929
Transport	**33,643**	32,617
Business Rates	**1,763**	2,135
Premises	**14,979**	14,755
Insurance	**812**	808
Legal Fees	**(71)**	1,635
Impairments and Reversals of Receivables	**881**	440
Depreciation	**9,533**	12,834
Amortisation	**2,568**	2,368
Impairments and reversals of property, plant and equipment	**(237)**	(1,235)
Audit fees*	**66**	95
Other auditor's remuneration (relates to the National Fraud Initiative)	**1**	0
Clinical Negligence	**917**	833
Education and Training	**2,588**	622
Change in Discount Rate	**530**	482
Other	**3,881**	2,730
Total Operating Expenses (excluding employee benefits)	**97,284**	90,005

*The Trust received a rebate of £25k during 2014/15 from the Audit Commission relating to earlier years.

Employee Benefits		
Employee benefits excluding Board members	**216,280**	207,763
Board members	**754**	954
Total Employee Benefits	**217,034**	208,717
Total Operating Expenses	**314,318**	298,722

8. Operating Leases

The Trust rents various properties in London which are used as either ambulance stations or administrative offices. The Trust leases cars and ambulances on 3 year and 5 to 6 year terms respectively.

8.1 Trust as lessee	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 £000
Payments recognised as an expense					
Minimum lease payments				**6,642**	6,547
Total				**6,642**	6,547
Payable:					
No later than one year	24	2,021	3,848	**5,893**	6,504
Between one and five years	95	5,708	2,708	**8,511**	11,116
After five years	213	4,542	0	**4,755**	6,678
Total	**332**	**12,271**	**6,556**	**19,159**	24,298

9. Employee Benefits and Staff Numbers

9.1 Employee benefits

	Total £000	2014-15 Permanently employed £000	Other £000
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	**181,042**	172,548	8,494
Social security costs	**14,400**	14,400	0
Employer Contributions to NHS BSA - Pensions Division	**20,357**	20,357	0
Termination benefits	**1,235**	1,235	0
Total employee benefits	**217,034**	**208,540**	**8,494**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**217,034**	**208,540**	**8,494**

Employee Benefits - Gross Expenditure 2013-14	Total £000	2013-14 Permanently employed £000	Other £000
Salaries and wages	173,437	168,424	5,013
Social security costs	13,882	13,882	0
Employer Contributions to NHS BSA - Pensions Division	20,581	20,581	0
Termination benefits	817	817	0
Gross Employee Benefits excluding capitalised costs	208,717	203,704	5,013

9.2 Staff numbers

	Total Number	2014-15 Permanently employed Number	Other Number	2013-14 Total Number
Average Staff Numbers				
Ambulance staff	**3,269**	3,269	0	3,387
Administration and estates	**1,262**	1,139	123	1,138
TOTAL	**4,531**	**4,408**	**123**	4,525

9.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	63,166	58,717
Total Staff Years	4,351	4,394
Average working Days Lost	14.52	13.36

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**8**	8

	£000s	£000s
Total additional pensions liabilities accrued in the year	**704**	700

9.4 Exit Packages Agreed in 2014-15

	2014-15			2013-14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	1	1	2	0	0	0
£10,000-£25,000	0	1	1	0	0	0
£25,001-£50,000	3	1	4	0	2	2
£50,001-£100,000	0	1	1	0	9	9
£150,001 - £200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost	**4**	**4**	**8**	1	11	12
Total resource cost (£s)	**127,014**	**126,578**	**253,592**	157,408	659,343	816,751

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous year.

9.5 Exit packages - Other Departures Analysis

	2014-15		2013-14	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000**	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	11	659
Contractual payments in lieu of notice	3	86	0	0
Exit payments following Employment Tribunals or court orders	1	41	0	0
Total	**4**	**127**	11	659
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**1**	**35**	0	0

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous year.

One non-contractual payment was made to an individual where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosures of exit payments payable to individuals named in that Report.

9.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10. Better Payment Practice Code

10.1 Measure of compliance

	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**56,336**	**82,145**	55,639	71,850
Total Non-NHS Trade Invoices Paid Within Target	**50,905**	**73,348**	47,874	57,223
Percentage of NHS Trade Invoices Paid Within Target	**90.36%**	**89.29%**	86.04%	79.64%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**410**	**3,263**	402	2,794
Total NHS Trade Invoices Paid Within Target	**316**	**2,165**	277	1,570
Percentage of NHS Trade Invoices Paid Within Target	**77.07%**	**66.35%**	68.91%	56.19%

The Better Payment Practice Code requires an NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11. Investment Revenue

	2014-15 £000	2013-14 £000
Interest revenue		
Bank interest	**131**	82
Other loans and receivables	**47**	30
Sub-total	**178**	112
Total investment revenue	**178**	112

12. Other Gains and Losses

	2014-15 £000	2013-14 £000
Gain on disposal of assets other than by sale (PPE)	**40**	41
Total	**40**	41

13. Finance Costs

	2014-15 £000	2013-14 £000
Interest		
Interest on loans and overdrafts	**108**	140
Interest on obligations under finance leases	**0**	28
Total interest expense	**108**	168
Provisions - unwinding of discount	**174**	213
Total	**282**	381

14 Property, Plant and Equipment

14.1 Property, Plant and Equipment

2014-15	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2014	**47,371**	**50,330**	**3,762**	**17,340**	**37,415**	**15,905**	**66**	**172,189**
Additions of Assets Under Construction	0	0	**2,913**	0	0	0	0	**2,913**
Additions Purchased	0	1,816	0	1,381	6,671	1,277	17	**11,162**
Reclassifications	0	121	(3,271)	564	2,333	231	0	**(22)**
Reclassifications as Held for Sale and reversals	(63)	(39)	0	0	0	0	0	**(102)**
Disposals other than for sale	0	(49)	0	(4,628)	(3,894)	(4,939)	0	**(13,510)**
Upward revaluation/positive indexation	4,236	1,081	0	0	0	0	0	**5,317**
Impairments/negative indexation	0	(110)	0	0	0	0	0	**(110)**
Reversal of Impairments	192	117	0	0	0	0	0	**309**
At 31 March 2015	**51,736**	**53,267**	**3,404**	**14,657**	**42,525**	**12,474**	**83**	**178,146**
Accumulated Depreciation								
At 1 April 2014	**0**	**0**	**0**	**10,885**	**28,353**	**11,258**	**66**	**50,562**
Reclassifications	0	0		22	(22)	(22)	0	**(22)**
Reclassifications as Held for Sale and reversals	0	(1)		0	0	0	0	**(1)**
Disposals other than for sale	0	(49)		(4,614)	(3,894)	(4,938)	0	**(13,495)**
Upward revaluation/positive indexation	0	(2,862)		0	0	0	0	**(2,862)**
Impairments	0	38	0	0	0	0	0	**38**
Reversal of Impairments	(18)	(257)	0	0	0	0	0	**(275)**
Charged During the Year	0	3,135		1,816	2,529	2,053	0	**9,533**
At 31 March 2015	**(18)**	**4**	**0**	**8,109**	**26,966**	**8,351**	**66**	**43,478**
Net Book Value at 31 March 2015	**51,754**	**53,263**	**3,404**	**6,548**	**15,559**	**4,123**	**17**	**134,668**
Asset financing:								
Owned - Purchased	51,754	53,263	3,404	6,548	15,530	4,123	17	**134,639**
Owned - Donated	0	0	0	0	29	0	0	**29**
Total at 31 March 2015	**51,754**	**53,263**	**3,404**	**6,548**	**15,559**	**4,123**	**17**	**134,668**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	22,239	18,496	0	0	0	0	0	**40,735**
Movements (specify)	4,428	2,205	0	0	0	0	0	**6,633**
At 31 March 2015	**26,667**	**20,701**	**0**	**0**	**0**	**0**	**0**	**47,368**

Additions to Assets Under Construction in 2014-15

	£000
Buildings excl Dwellings	47
Plant & Machinery - Transport Equipment	2,866
Balance as at YTD	**2,913**

14.2 Property, Plant and Equipment - prior year

2013-14	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2013	45,045	44,575	1,543	18,116	44,131	14,981	109	**168,500**
Additions of Assets Under Construction	0	0	3,527	0	0	0	0	**3,527**
Additions Purchased	0	509	0	12	925	932	0	**2,378**
Reclassifications	0	0	(1,308)	829	226	214	0	**(39)**
Disposals other than for sale	0	(130)	0	(1,617)	(7,867)	(222)	(43)	**(9,879)**
Upward revaluation/positive indexation	2,923	6,691	0	0	0	0	0	**9,614**
Impairments/negative indexation	(491)	(756)	0	0	0	0	0	**(1,247)**
At 31 March 2014	**47,477**	**50,889**	**3,762**	**17,340**	**37,415**	**15,905**	**66**	**172,854**
Accumulated Depreciation								
At 1 April 2013	0	23	0	10,515	29,310	9,583	48	**49,479**
Reclassifications	0	0	0	0	0	(9)	0	**(9)**
Disposals other than for sale	0	(105)	0	(1,607)	(7,867)	(221)	(42)	**(9,842)**
Impairments	112	235	0	0	0	0	0	**347**
Reversal of Impairments	(6)	(1,576)	0	0	0	0	0	**(1,582)**
Charged During the Year	0	1,982	0	1,977	6,910	1,905	60	**12,834**
At 31 March 2014	**106**	**559**	**0**	**10,885**	**28,353**	**11,258**	**66**	**51,227**
Net Book Value at 31 March 2014	47,371	50,330	3,762	6,455	9,062	4,647	0	121,627
Asset financing:								
Owned - Purchased	47,371	50,330	3,762	6,455	9,027	4,647	0	**121,592**
Owned - Donated	0	0	0	0	35	0	0	**35**
Total at 31 March 2014	**47,371**	**50,330**	**3,762**	**6,455**	**9,062**	**4,647**	**0**	**121,627**

14.3 Property, Plant and Equipment - revaluation

A professional revaluation was undertaken on all land and buildings at 31 March 2015

The valuation was carried out by the District Valuers of the Revenue and Customs Government Department. The valuation was carried out in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS), insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health.

The market value was used in arriving at fair value for the operational assets subject to the additional special assumptions that:

a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;

b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest;

c) regard has been had to appropriate lotting to achieve the best price.

The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.

Economic Life of Assets	**Years**
Buildings	5 to 99
Plant and machinery	5 to 15
Transport equipment	2 to 10
Information technology equipment	3 to 5
Furniture and fittings	10

14.4 Gross carrying value of fully depreciated assets still in use:

The gross carrying value of fully depreciated assets still in use:

	£m
Furniture & fittings	0.1
Transport equipment	20.2
Plant and machinery	1.4
Information technology	2.8
	24.5

15 Intangible Assets

15.1 Intangible Assets

2014-15	IT - in-house & 3rd party software £000	Computer Licenses £000	Development Expenditure - Internally Generated £000	Total £000
At 1 April 2014	**15,892**	**2,366**	**316**	**18,574**
Additions Purchased	160	181	519	**860**
Reclassifications	33	160	(171)	**22**
Disposals other than by sale	(172)	(250)	0	**(422)**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	46	0	**46**
At 31 March 2015	**15,913**	**2,503**	**664**	**19,080**
Accumulated Amortisation				
At 1 April 2014	**4,596**	**1,682**	**0**	**6,278**
Reclassifications	(8)	30	0	**22**
Disposals other than by sale	(172)	(250)	0	**(422)**
Charged during the year	2,230	338	0	**2,568**
At 31 March 2015	**6,646**	**1,800**	**0**	**8,446**
Net Book Value at 31 March 2015	**9,267**	**703**	**664**	**10,634**
Asset Financing: Net book value at 31 March 2015 comprises:				
Purchased	9,267	703	664	**10,634**
Total at 31 March 2015	**9,267**	**703**	**664**	**10,634**

15.2 Intangible Assets - prior year

2013-14	IT in-house & 3rd party software	Computer Licenses	Development Expenditure - Internally Generated	Total
	£000	£000	£000	£000
Cost or valuation:				
At 1 April 2013	15,492	1,906	167	17,565
Additions - purchased	267	451	288	1,006
Reclassifications	133	45	(139)	39
Disposals other than by sale	0	(36)	0	(36)
At 31 March 2014	15,892	2,366	316	18,574
Accumulated Amortisation				
At 1 April 2013	2,417	1,520	0	3,937
Reclassifications	0	9	0	9
Disposals other than by sale	0	(36)	0	(36)
Charged during the year	2,179	189	0	2,368
At 31 March 2014	4,596	1,682	0	6,278
Net book value at 31 March 2014	11,296	684	316	12,296
Net book value at 31 March 2014 comprises:				
Purchased	11,296	684	316	12,296
Total at 31 March 2014	11,296	684	316	12,296

The Trust does not revalue its intangible assets.

Economic lives of intangible assets

	Years
Software licences	3 to 7
IT: in-house and third party software	3 to 7

15.4 Gross carrying value of fully depreciated intangible assets still in use:

The gross carrying value of fully depreciated intangible assets is £1.95 million.

16. Analysis of impairments and reversals recognised in 2014-15

	2014-15 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Departmental Expenditure Limit	**0**
Changes in market price	(237)
Total charged to Annually Managed Expenditure	(237)
Total Impairments of Property, Plant and Equipment changed to SoCI	**(237)**
Total Impairments charged to SoCI - AME	(237)
Overall Total Impairments	**(237)**

	Total £000	Property Plant and Equipment £000
Impairments and reversals taken to SoCI		
Changes in market price	**(237)**	(237)
Total charged to Annually Managed Expenditure	**(237)**	(237)
Total Impairments of Property, Plant and Equipment changed to SoCI	**(237)**	(237)

17. Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015 £000	31 March 2014 £000
Property, plant and equipment	**3,045**	477
Intangible assets	**605**	533
Total	**3,650**	1,010

18. Intra-Government and Other Balances

	Current receivables £000	**Non-current receivables £000**	**Current payables £000**	**Non-current payables £000**
Balances with Other Central Government Bodies	2	0	4,385	0
Balances with NHS bodies inside the Departmental Group	25,902	0	883	0
Balances with Bodies External to Government	7,909	0	34,037	107
At 31 March 2015	**33,813**	**0**	**39,305**	**107**
prior year:				
Balances with Other Central Government Bodies	13,344	0	692	0
Balances with NHS bodies inside the Departmental Group*	1,559	0	528	0
Balances with Bodies External to Government	7,901	0	21,620	0
At 31 March 2014	22,804	0	22,840	0

* At 31 March 2014 the descriptor for this disclosure was "Balances with NHS Trusts and FTs".

19. Inventories

	Drugs £000	Consumables £000	Work in Progress £000	Energy £000	Total £000
Balance at 1 April 2014	**44**	**3,454**	**0**	**0**	**3,498**
Additions	721	15,005	0	0	**15,726**
Inventories recognised as an expense in the year	(700)	(15,498)	0	0	**(16,198)**
Balance at 31 March 2015	**65**	**2,961**	**0**	**0**	**3,026**

20 Trade and Other Receivables

20.1 Trade and Other Receivables

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
NHS receivables - revenue	**22,011**	4,528	**0**	0
NHS prepayments and accrued income	**3,718**	6,654	**0**	0
Non-NHS receivables - revenue	**831**	808	**0**	0
Non-NHS receivables - capital	**0**	1	**0**	0
Non-NHS prepayments and accrued income	**7,907**	8,074	**0**	0
PDC Dividend prepaid to DH	**175**	0	**0**	0
Provision for the impairment of receivables	**(2,062)**	(1,181)	**0**	0
VAT	**1,000**	683	**0**	0
Interest receivables	**9**	32	**0**	0
Other receivables	**224**	3,205	**0**	0
Total	**33,813**	22,804	**0**	0
Total current and non current	**33,813**	22,804		

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

20.2 Receivables past their due date but not impaired

	31 March 2015 £000	31 March 2014 £000
By up to three months	**602**	4,391
By three to six months	**0**	188
By more than six months	**0**	272
Total	**602**	4,851

20.3 Provision for impairment of receivables

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	**(1,181)**	(741)
Amount recovered during the year	**335**	0
(Increase)/decrease in receivables impaired	**(1,216)**	(440)
Balance at 31 March 2015	**(2,062)**	(1,181)

21 Cash and Cash Equivalents

	31 March 2015	31 March 2014
	£000	£000
Opening balance	**6,436**	5,500
Net change in year	**8,265**	936
Closing balance	**14,701**	6,436
Made up of		
Cash with Government Banking Service	**14,694**	6,372
Commercial banks	**0**	57
Cash in hand	**7**	7
Cash and cash equivalents as in statement of financial position	**14,701**	6,436
Bank overdraft - Commercial banks	**(2)**	0
Cash and cash equivalents as in statement of cash flows	**14,699**	6,436

22. Non-current Assets Held for Sale

	Land	**Buildings, excl. dwellings**	**Total**
	£000	**£000**	**£000**
Balance at 1 April 2014	0	0	**0**
Plus assets classified as held for sale in the year	63	38	**101**
Balance at 31 March 2015	**63**	**38**	**101**
Balance at 1 April 2013	0	0	**0**
Balance at 31 March 2014	0	0	0

The assets comprise two radio transmitter sites which are surplus to requirements due to technology advances. No sale had been agreed by 31 March 2015 but it is anticipated that the sites will be sold during 2015/16.

23. Trade and Other Payables

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
NHS payables - revenue	**791**	685	**0**	0
NHS accruals and deferred income	**92**	81	**0**	0
Non-NHS payables - revenue	**5,536**	4,032	**0**	0
Non-NHS payables - capital	**5,853**	856	**0**	0
Non-NHS accruals and deferred income	**19,802**	16,726	**0**	0
Social security costs	**2,311**	374	**0**	0
Tax	**2,074**	75	**0**	0
Other	**2,844**	11	**0**	0
Total	**39,303**	22,840	**0**	0
Total payables (current and non-current)	**39,303**	**22,840**		
Included above:				
Outstanding pension contributions at the year end	**2,834**	6		

24 Borrowings

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
Bank overdraft - commercial banks	**2**	0	**0**	0
Loans from Department of Health	**0**	1,244	**0**	3,099
Loans from other entities	**0**	0	**107**	107
Total	**2**	**1,244**	**107**	**3,206**
Total other liabilities (current and non-current)	**109**	**4,450**		

Borrowings/Loans - repayments of principal falling due in:

	31 March 2015	
	Other Entities £000	**Total £000**
0-1 Years	2	**2**
2 - 5 Years	107	**107**
TOTAL	**109**	**109**

25. Deferred Revenue

	Current	
	31 March 2015 £000	31 March 2014 £000
Opening balance at 1 April 2014	**56**	92
Deferred revenue addition	**56**	56
Transfer of deferred revenue	**(56)**	(92)
Current deferred Income at 31 March 2015	**56**	56
Total deferred income (current and non-current)	**56**	56

26. Finance Lease Commitments

The Trust had no finance leases at 31 March 2014, and has not entered into any new finance lease arrangements during the year.

27. Provisions

	Total	Early Departure Costs	Legal Claims	Other	Redundancy
	£000	£000	£000	£000	£000
Balance at 1 April 2014	**13,864**	8,091	664	4,450	659
Arising during the year	**6,084**	751	851	2,761	1,721
Utilised during the year	**(1,201)**	(500)	(464)	(172)	(65)
Reversed unused	**(2,131)**	0	(205)	(1,332)	(594)
Unwinding of discount	**174**	146	0	28	0
Change in discount rate	**530**	484	0	46	0
Balance at 31 March 2015	**17,320**	**8,972**	**846**	**5,781**	**1,721**
Expected Timing of Cash Flows:					
No Later than One Year	**7,357**	491	846	4,299	1,721
Later than One Year and not later than Five Years	**2,544**	1,890	0	654	0
Later than Five Years	**7,419**	6,591	0	828	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2015	21,456
As at 31 March 2014	14,770

The Early Departure Costs provision of £8,972k (2013/14 £8,091k) comprises pensions relating to claims for Personal Injury Benefits. The amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of 1.8% is applied.

The Legal Claims provision of £846k (2013/14 £664k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

The Other provision of £5,781k (2013/14 £4,450k) includes £2,109k for support received from the Police and Armed Forces during periods of industrial action in 2014/15, £1,524k for changes in VAT rules, and £1,644k in respect of pension payments due to employees made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees.

The Redundancy provision relates primarily to an ongoing Operational Management Restructure. There are additional provisions for A&E support staff who have been issued with redundancy notices and other specific support staff groups and individuals whose posts have been removed.

28. Contingencies

	31 March 2015	31 March 2014
	£000	£000
Contingent liabilities		
NHS Litigation Authority legal claims	**(296)**	(272)
Net value of contingent liabilities	**(296)**	(272)

Following a recent case taken to the Employment Appeal Tribunal in relation to Working Time Regulations, the Trust has identified that there may be a historic liability relating to statutory annual leave arising on compulsory overtime worked by employees. Due to uncertainty as to how this may affect the Trust and which employees may be affected, the quantum of any potential liability cannot be determined accurately and at the year end the Trust is unable to determine the level of contingent liability that should be disclosed.

29. Financial Instruments

29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue derives from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note 20.1.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not therefore exposed to significant liquidity risks.

29.2 Financial assets

	Loans and receivables	Available for sale	Total
	£000	£000	£000
Receivables - NHS	22,011	0	**22,011**
Receivables - non-NHS	831	0	**831**
Cash at bank and in hand	14,699	0	**14,699**
Other financial assets	7,066	0	**7,066**
Total at 31 March 2015	**44,607**	**0**	**44,607**
Receivables - NHS	4,504	0	4,504
Receivables - non-NHS	2,853	0	2,853
Cash at bank and in hand	6,436	0	6,436
Other financial assets	7,439	0	7,439
Total at 31 March 2014	21,232	0	21,232

29.3 Financial liabilities

	Other	Total
	£000	£000
NHS payables	791	**791**
Non-NHS payables	11,389	**11,389**
Other borrowings	109	**109**
Other financial liabilities	22,682	**22,682**
Total at 31 March 2015	**34,971**	**34,971**
NHS payables	766	766
Non-NHS payables	4,944	4,944
Other borrowings	4,450	4,450
Other financial liabilities	20,901	20,901
Total at 31 March 2014	31,061	31,061

30. Events after the end of the reporting period

There have been no events after the reporting period that need to be disclosed in the financial statements.

31. Related Party Transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the London Ambulance NHS Trust.

The Department of Health is regarded as a related party. The Trust obtained a £10m capital investment loan from the Department in 2009-10; the loan was fully paid off during the year. It also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where receipts exceed £10m:

	2014/15 Payments to related party £000	2014/15 Receipts from related party £000	2014/15 Owed to related party £000	2014/15 Owed by related party £000
Barnet CCG	0	10,652	0	139
Brent CCG	1	14,289	0	3,617
Bromley CCG	0	10,538	0	152
Camden CCG	0	11,394	0	2,469
Central London CCG	0	14,015	0	3,965
City & Hackney CCG	0	10,404	0	644
Croydon CCG	0	13,101	0	785
Ealing CCG	0	10,561	0	128
Enfield CCG	0	10,012	0	136
Hillingdon CCG	0	10,897	0	130
Lambeth CCG	0	12,005	0	135
Lewisham CCG	0	10,112	0	113
Newham CCG	0	11,005	0	504
Southwark CCG	0	14,664	0	2,980

	2013/14 Payments to related party £000	2013/14 Receipts from related party £000	2013/14 Owed to related party £000	2013/14 Owed by related party £000
Barnet CCG	0	10,473	0	127
Brent CCG	0	13,097	23	2,625
Bromley CCG	0	11,618	169	0
Central London CCG	0	10,316	0	125
Croydon CCG	0	12,131	0	142
Ealing CCG	0	10,500	0	126
Hillingdon CCG	0	10,503	0	124
Lambeth CCG	0	11,235	0	132
Newham CCG	0	10,702	0	227
NHS England	0	13,898	0	3,456
Southwark CCG	0	11,059	0	147

The Trust has a number of staff who do voluntary work for the St John Ambulance Service. The transactions with St John Ambulance Service during the year comprised expenditure of £1,521k (2013/14 £1,631k) and the amount owed by the Trust as at 31 March 2015 was £nil (31 March 2014 £116k).

Theo de Pencier, a non Executive Director, who joined the Trust on 1 March 2014, is also the Chief Executive of Freight Transport Association Limited from whom the Trust purchased services to the value of £13k (2013/14 £13k) during the financial year. There were no amounts owing at 31 March 2015 (31 March 2014 £nil).

32. Losses and Special Payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £	Total Number of Cases
Losses	1,783,364	1,016
Special payments	724,170	67
Total losses and special payments	2,507,534	1,083

There were no cases totalling over £300k individually.

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £	Total Number of Cases
Losses	1,644,140	1,287
Special payments	1,433,966	25
Total losses and special payments	3,078,106	1,312

33. Financial Performance Targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

33.1 Breakeven performance	**2005-06 £000**	**2006-07 £000**	**2007-08 £000**	**2008-09 £000**	**2009-10 £000**	**2010-11 £000**	**2011-12 £000**	**2012-13 £000**	**2013-14 £000**	**2014-15 £000**
Turnover	215,947	215,941	236,130	261,532	279,864	283,617	281,731	303,109	303,827	**324,052**
Retained surplus/(deficit) for the year	1,258	113	398	725	(420)	740	2,527	(417)	1,525	**6,326**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	1,845	262	247	723	(1,235)	**(237)**
Adjustments for impact of policy change re donated/government grants assets*	0	0	0	0	0	0	(23)	(44)	11	**5**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	**0**
Absorption accounting adjustment	0	0	0	0	0	0	0	0	(39)	**(46)**
Other agreed adjustments	0	0	0	0	0	0	0	**0**	0	**0**
Break-even in-year position	**1,258**	**113**	**398**	**725**	**1,425**	**1,002**	**2,751**	**262**	**262**	**6,048**
Break-even cumulative position	**1,333**	**1,446**	**1,844**	**2,569**	**3,994**	**4,996**	**7,747**	**8,009**	**8,271**	**14,319**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability on a year to year basis.

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**	**2012-13 %**	**2013-14 %**	**2014-15 %**
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.58	0.05	0.17	0.28	0.51	0.35	0.98	0.09	0.09	**1.87**
Break-even cumulative position as a percentage of turnover	0.62	0.67	0.78	0.98	1.43	1.76	2.75	2.64	2.72	**4.42**

33.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

33.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15	2013-14
	£000	£000
External financing limit (EFL)	**(12,606)**	(1,983)
Cash flow financing	**(12,606)**	(2,996)
Unwinding of discount adjustment	**0**	213
External financing requirement	**(12,606)**	(2,783)
Under spend against EFL	**0**	800

33.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15	2013-14
	£000	£000
Gross capital expenditure	**14,937**	6,911
Less: book value of assets disposed of	**(15)**	(37)
Charge against the capital resource limit	**14,922**	6,874
Capital Resource Limit	**15,900**	10,250
Underspend against the capital resource limit	**978**	3,376

34. Third Party Assets

The Trust held cash and cash equivalents of £nil at 31 March 2015 (£nil at 31 March 2014) relating to monies held on behalf of patients or other parties.

Remuneration report

Our Remuneration and Nominations Committee consists of the Chairman and the six non-executive directors. The Chief Executive is usually in attendance but is not present when his own remuneration is discussed.

The Remuneration and Nominations Committee is responsible for advising the Board about appropriate remunerations and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirement of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 79 to 81**.**

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2014/15 was in the range of £200,001 to £205,000. This was 5.27 times the median remuneration of the workforce, which was £38,662. In 2013/14, the banded remuneration of the highest paid director £216,001 to £220,000. This was 5.63 times the median remuneration of the workforce, which was £38,415.

In 2014/15, as in the previous year, none of the employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The change in ratio was due to:

- a change to the remuneration of the most highly-paid individual through a reduction in pay received in 2014/15
- a change in the workforce composition in 2014/15 leading to a small decrease in median pay.

The appointment and remuneration of the Chairman and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our external auditors.

Salary and pension entitlements of senior managers

A) Remuneration 2014/15

Name and Title	Salary (bands of £5000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Ann Radmore, Chief Executive (to 23rd January 2015)	£135,001-£140,000	£0	£0	£0	£0	£135,001-£140,000
Andrew Grimshaw, Finance Director	£130,001-£135,000	£0	£0	£0	£0-£5,000	£135,001-£140,000
Jason Killens, Director of Operations	£110,001-£115,000	£2,000	£0	£0	£30,001-£35,000	£145,001-£150,000
** Fenella Wrigley, Acting Medical Director	£10,001-£15,000	£0	£0	£0	£55,001-£60,000	£65,001-£70,000
* Stephen Lennox, Director of Nursing and Quality	£65,001-£70,000	£0	£0	£0	£45,001-£50,000	£115,001-£120,000
** Zoe Packman, Acting Director of Nursing and Quality	£20,001-£25,000	£0	£0	£0	£20,001-£25,000	£45,001-£50,000
*** Fionna Moore, Medical Director (Acting Chief Executive from 24 January 2015)	£120,001-£125,000	£0	£0	£0	£0	£120,001-£125,000

The figures shown under the heading 'expense payments' refer to the provision of lease car.
* The following director left the Trust: Stephen Lennox on 21st November 2014.
** The following director joined the Trust: Zoe Packman on 24th November 2014, she is an employee of Croydon Health Services NHS Trust. Fenella Wrigley was appointed acting Medical Director on 24th January 2015 and is seconded from Barts Healthcare NHS Trust.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works full-time for the London Ambulance Service as Medical Director (Acting Chief Executive from 24th January 2015).

Remuneration 2013/14

Name and Title	Salary (bands of £5000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Ann Radmore, Chief Executive	£190,001-£195,000	£0	£0	£0	£167,501-£170,000	£355,001-£360,000
Andrew Grimshaw, Finance Director	£135,001-£140,000	£0	£0	£0	£55,001-£57,500	£195,001-£200,000
Jason Killens, Director of Operations	£55,001-£60,000	£3,700	£0	£0	£42,501,45,000	£105,001-£110,000
Stephen Lennox, Director of Health Promotion & Quality	£90,001-£95,000	£0	£0	£0	£0	£90,001-£95,000
Fionna Moore, Medical Director	£80,001-£85,000	£0	£0	£0	£0	£80,001-£85,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2015 (bands of £5,000)	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 March 2014	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**	
Nicholas Martin, Non-Executive Director	**	**	**	**	**	**	**	
John Jones, Non-Executive Director	**	**	**	**	**	**	**	
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**	
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**	
Ann Radmore, Chief Executive	£0-£2,500	£0-£2,500	£65,001-£70,000	£200,001-£205,000	£1,383,084	1,347,564	£3,357	
Andrew Grimshaw, Director of Finance	£0-£2,500	£2,501-£5,000	£30,001-£35,000	£95,001-£100,000	£550,998	£509,077	£21,505	
Jason Killens, Director of Operations	£0-£2,500	£5,001-£7,500	£25,001-£30,000	£75,001-£80,000	£359,360	£314,495	£26,563	
Fenella Wrigley, Acting Medical Director	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£80,001-£85,000	£439,011	£381,544	£6,306	
Stephen Lennox, Director of Nursing & Quality	£2,501-£5,000	£7,501-£10,000	£35,001-£40,000	£115,001-£120,000	£703,438	£624,871	£45,374	
Zoe Packman, Director of Nursing & Quality	£0-£2,500	£0-£2,500	£40,001-£45,000	£120,001-£125,000	£741,296	£857,764	£0	
Fionna Moore, Medical Director	*	*	*	*	*	*	*	

* Fionna Moore has opted out of the NHS pension scheme.

** As non-executive directors do not receive pensionable remuneration, there are no disclosures in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

“A change in the Government Actuarial Department’s (GAD) actuarial factors has occurred during the year, following revised guidance from HM Treasury. NHS Pensions are using the most recent set of actuarial factors produced.”

Reporting of other compensation schemes – Exit packages Note 10.4

	2014-15			2013-14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	1	1	2	0	0	0
£10,000-£25,000	0	1	1	0	0	0
£25,001-£50,000	3	1	4	0	2	2
£50,001-£100,000	0	1	1	0	9	9
£150,001-£200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost	**4**	**4**	**8**	1	11	12
Total resource cost (£000s)	**127**	**127**	**254**	157	659	817

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Reporting of other compensation schemes – Exit packages Note 10.5

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirements contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	3	86
Exit payments following Employment Tribunals or court orders	1	41
Non-contractual payments requiring MHT approval	0	0
Total	**4**	**127**

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Off-Payroll engagements - Table 1

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	11
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	7
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	2

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Off-Payroll engagements - Table 2

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	2
Number of new engagements which include contractual clauses giving the London Ambulance Service NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number of new engagements for whom assurance has been requested	2
Of which:	
Assurance has been received	2
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	None
Number of Individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	23

Accountable Officer: Fionna Moore, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature: 

Date: 2 June 2015

A copy of our full accounts is available from the Head of Financial Services at the following address:

Head of Financial Services
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Appendix - Glossary of Terms

(This glossary does not form a part of the statutory accounts)

STATEMENT OF COMPREHENSIVE INCOME

Statement Of Comprehensive Income (Income And Expenditure) Under UK GAAP used to be called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Revenue From Patient Care Activities Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

Income and Expenditure
Often called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Income from activities
Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

Other operating income
Income from non-patient care services such as commercial training, research funding etc.

Operating surplus
The surplus generated by the normal operations of the Trust before taking into account interest, depreciation and amortisation.

Depreciation
When a fixed asset is purchased, the cost of that asset needs to be charged to the income and expenditure account over the life of the asset to recognise the contribution of that asset to the work of the Trust in each year of ownership. On purchase of a fixed asset, the expected life is assessed and the cost is spread over that life. The value of the asset therefore diminishes, or depreciates, over time.

Amortisation
Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets, such as loans to the Trust.

Profit / (loss) on disposal of fixed assets
The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

Public Dividend Capital (PDC)
PDC originated in NHS Trusts as the difference between the valuation of its assets and liabilities on establishment as an NHS Trust. This originating debt is deemed an asset of the Secretary of State, and equates to taxpayers equity in the organisation. The Trust has to make a return on this capital equivalent to 3.5% per annum, and this amount has to be paid over to the Treasury. The original debt can increase over time due to the allocation of additional capital funds, and is repayable over time.

STATEMENT OF FINANCIAL POSITION

Fixed Asset / Non-Current Assets
An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods – as opposed to current assets, which are realisable immediately or in the next accounting period. Fixed assets are typically equipment or buildings.

Current Assets
These are assets that are held on the balance sheet of the organisation that have an immediate cash value. These include stocks, that could be sold and realise cash quickly, debtors that can be collected quickly to realise cash or cash held in a bank account.

Stock / Inventories
Material held as stock which could be sold to realise cash quickly. Can either be valued at cost where stock is valued in the books at the purchase price or, net realisable value where stock is valued in the books at a value that it could reasonably be expected to fetch if it was sold on open market today.

Debtors / Receivables
Money owed to the Trust for services provided.

Creditors / Payables
Money owed by the Trust for goods and services received.

Total Taxpayers' Equity
See Public Dividend Capital

NOTES TO THE ACCOUNTS

Historical Cost Convention
The value of an asset carried in the balance sheet is the amount paid for it on the purchase date.

Accruals Convention
The accounts are prepared taking account of all income received and receivable, and all expenditure paid and payable for the goods and services delivered and received in the period, and are not based on cash receipts and payments in the period.

Off Balance Sheet
Refers to fixed assets that are in use by the trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership.

Liquid Resources
Resources that can be released quickly to enable the organisation to settle debts. Typically, cash in hand or in the bank in short term accounts.

Prepayment
Where the Trust has paid in advance for goods
or services – for example, quarterly payment in advance for telephone rentals.

Deferred Income
Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

Reserves
Funds set aside in recognition of a future event, project or change, where the need has been recognised but the event has not happened.

TERMINOLOGY

Going Concern Basis
The accounts are prepared on the basis that the Trust will still be in existence in the next financial year, and that it will therefore be in a position to recover any debtors due to it, and that it will be around to cover its long term liabilities. If it is likely that an organisation will not be in existence beyond this set of accounts, then long term liabilities would become immediately due, and the position of long term debtors would be called into question, resulting in the need to recognise that in the results presented in this set of accounts.

Capital Expenditure
The amount expended by the Trust that enhances the value of fixed assets whose useful life extends beyond the current accounting period.

Revenue Expenditure
Expenditure on the day to day operations of the Trust, pay and rations as opposed to capital expenditure.

Consumables
Non pay expenditure on items that have a life of less than one year and are therefore not fixed assets. The term relates to everything from drugs, uniform, stationery through to pieces of disposable equipment.

CCGs - Clinical Commissioning Groups
New organisation established from 1st April 2013.

Liability
A situation where an organisation has an obligation to pay for something that has already occurred, and around which there is certainty, but is not yet physically paid for.

Provisions
An allowance in the accounts for a known item, but where the value or timing of the event giving rise to it is uncertain. An example may be where a pay award from 1 January in a given year has not yet been agreed, and the settlement date is uncertain. The organisation would typically provide an estimate for inclusion in the accounts to ensure that the relevant charge to Income and Expenditure is made in the correct year.

Contingent Liability
A situation where a financial obligation to pay for something that has already happened may arise, but where there is uncertainty or where the final value is difficult to quantify due to dependencies on other things. For example, an outstanding legal claim against the organisation, where if the verdict goes against the organisation, there will be an obligation to pay for an unquantifiable amount. Amounts carried in the accounts under this heading will inevitably be estimates based on the best information available at the time.

Value Added Tax (VAT)
May be in the form of output tax – VAT charged on sales, or input tax – VAT paid on purchases. In the NHS, normal NHS healthcare activity does not attract VAT.

Post Balance Sheet Event
Something that is recognised after the accounts have been finalised, but before publication, which impacts on the results as they are presented, and has a significant impact on how the results should be interpreted.

Risk Pooling Scheme
This is essentially the NHS insurance scheme, where we pay an annual premium to cover any insurance claims that may arise during the year.
The scheme covers all the usual insurance risks around buildings, equipment, fire etc, as well as clinical negligence issues.

NHSLA
The NHS Litigation Authority is the body responsible for handling negligence claims against NHS organisations. The NHSLA also advises NHS organisations on risk management.

Losses and Special Payments
Any payments made in respect of bad debts, stock write offs, insurance excesses or compensation payments that are not considered a part of the normal business of the Trust.

HART
Hazardous Area Response Team

RRV
Rapid Response Vehicle

PTS
Patient Transport Service

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London Ambulance Service NHS Trust

The London Ambulance Service NHS Trust 2013/14

The annual quality account

The London Ambulance Service NHS Trust Annual Quality Account 2013/14

An account on the quality of service provided by the Trust and the identification of improvement priorities for 2014/15

Incorporating an end of year review of the DH Ambulance Quality Indicators

Acknowledgements
Images of London courtesy of www.London-GB.com

Contents

Introduction
Statement on quality from the Chief Executive

This is the fifth Quality Account published by the London Ambulance NHS Trust. It acts as a written review for the public of our Quality during 2013-14.

Like all years, 2013-14 was to be a challenging year and we saw significant change and achievement within the service. But unlike other years it was not simply due to the on-going challenges of balancing resources with demand. In 2013-14 we saw a culmination of events that possibly brought about the biggest challenges ever seen in 65 years of the NHS.

The year saw the introduction of the health reforms designed by the previous Secretary of State Andrew Lansley. The vision of local clinical commissioning with the requirements to become more locally focused and locally responsive have given us real opportunities to work differently with local clinicians on the issues for their groups of patients. However, as a pan-London provider it is significantly challenging to respond to 32 commissioners and deliver a consistent pan-London service.

We are doing a number of things to respond to these propositions but they all produce their own challenges. We are responding to this by restructuring our operational teams to mirror local Clinical Commissioning Clusters; by developing links locally with commissioners; by thinking about how we engage with patients differently; and by ensuring our data becomes more locally focused.

The year also saw the publication of the Francis Report. This heralded the biggest criticisms of quality ever of the NHS and in turn led to a number of subsequent reviews on quality. All these together asked any NHS trust to reflect hard on how they run the organisation and relate to staff and patients. We are now implementing the necessary changes from these reviews. These include, a review of organisational culture, introduction of Duty of Candour (being open), and we are reviewing how we engage with our patients and with our staff. During the year we launched a programme of staff engagement called Listening in Action; we held a number of events with our staff that allowed us to listen to their concerns and identify a range of improvement measures that would make a difference to them.

We also launched our own two-year Transformation Programme which would see some of the biggest changes in the way we deliver our services for many years.

All of this culminated to become a year of significant change. We have risen to these challenges and have demonstrated a real resilience. We delivered, for the eleventh consecutive year, the target to reach 75% of our most urgent patients within 8 minutes. Whilst we now believe it is time to reflect and ask if this is the best measure of quality it is still the benchmark on which others judge us and we are proud of this achievement. Inevitably we have lost some of our staff either directly through these changes or through frustration regarding some of the problems we are now trying to change. This has revealed a new issue regarding a shortage of registered clinicians across the country and we are focusing on recruiting more talented and skilled clinicians to the service during 2014-15.

We have maintained good cardiac care and London is now one of the world‟s leading cities in which to survive a cardiac arrest. We also have one of the fastest call answering services in the world and external scrutiny of this continues to rate it highly with an excellent satisfaction rate with this aspect of our service.
In addition, London saw a major incident with the collapse of seating in a large West End theatre venue. We were able to demonstrate our emergency preparedness for Londoners.

This year also saw our services grow into a new area of care as we took on responsibility for NHS 111 services in South East London. We report on this in our Quality Account as we believe this service has been well received by patients and commissioners.

This Quality Account details some of our other achievements during 2013-14. We have tried to present a balanced view. Not all of our aspirations have delivered the results we wished but I hope you agree that this has been a challenging but successful year for the service.

Ann Radmore
Chief Executive

What is a Quality Account?
The purpose of the Quality Account

Since the introduction of the Quality Account in 2009 all NHS Trusts are required to publish quality accounts in accordance with the annual reporting guidance from NHS England. By publishing data, supported by explanation, the aim is to improve transparency for patients and service users on what is working well and what needs further improvement. The key is to provide a balanced report.

Monitor, the regulator of NHS Foundation Trusts, state four main aims of Quality Accounts:

A focus on quality improvements in each organisation: the reports provide an opportunity to set out how the Trust intends to improve its own quality.

Board ownership: this can lead to ambitious board-driven quality improvement priorities, measures and programmes of work.

Engagement with clinicians and patients: the priorities and metrics included in the Quality Account must be relevant and credible to clinicians within the organisation and help form a narrative that is credible to patients and the local public. Broad engagement in the development of quality reports is needed to meet these requirements.

A wider quality debate: Quality Accounts should provide an opportunity for providers to describe their performance and their improvement goals.

The Quality Account is required to follow a template and report on a set of mandatory items. We have divided our Quality Account into four distinct sections.

Section 1 contains a statement on quality from the Chef Executive and this introductory explanation.

Section 2 looks back at the previous year and reports against a set of mandatory measures. The section also reports progress made against the priorities we identified for improvement in the 2012/13 Quality Account.

Section 3 looks forward to the year ahead and identifies new priority improvements.

Section 4 is where we share the written feedback we have received on the 2013/14 Quality Account.

In order to give a more comprehensive view on quality we have made the decision to report beyond the minimum requirements. In addition, where possible we have also reported comparative data from other Ambulance Trusts in England.

Involving patients, staff, commissioners, and stakeholders in the creation of our Quality Account.

Section 4 contains the formal feedback we have received from stakeholders on the finished Quality Account In particular, we have actively sought the opinion of others in identifying what improvements we need to make in 2014/15.

This journey started with our staff. Our clinical staff have been telling us that they often feel unable to deliver a satisfactory service to patients requiring mental health care and have asked us for more training. In addition, the Patient Forum suggested mental health care as a potential area for improvement.

During the course of the year we considered the suggestion to have mental health care as an improvement priority for 2014/15 to other groups.

As an aspirant Foundation Trust we have a membership which has over 8,000 representatives. In February 2014 we invited them to a dedicated event where we discussed mental health care. At the event we shared a number of suggestions on how we could improve mental health care and these were widely supported by those who attended the event.

This proposal was also discussed with the management of “Healthwatch Southwark” who were supportive of the initiative as Mental Health services was also one of their priority areas

In April 2014 we also presented the main themes within this Quality Account to the London Borough of Hillingdon External Services Scrutiny Committee.

During the course of the year we have been working with the Metropolitan Police in identifying specific improvement actions for mental health in 2014.

Finally, the Trust formally meets with commissioners monthly. This has representation from across London commissioning and at every meeting we discuss quality. These discussions continuously shape our improvement plans and they have supported mental health as being our primary improvement priority.

Vision and Values
Our Strategic direction and our values

Our vision for 2013/14 was the same as the previous year; to be a world class service meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.

During 2013/14 we recognised the need to undertake a comprehensive review of our strategy, our vision, and our values. Consequently we streamlined our three strategic goals to help bring some immediate clarity to our strategic priorities. These are:

To improve the quality of care we provide our patients

To deliver care with a highly skilled and representative workforce

To provide value for money

This was supported by identifying four clear service priorities which were designed to provide focus during the year. These are:

The Trust‟s Modernisation Programme

Communication and engagement

Sustain performance to ensure safe services to patients

Building a sustainable financial position for 2014 and beyond

Progress on the Transformation Programme is reported on within this Quality Account as it was identified as a specific Quality Improvement for 2013/14. Progress against other strategic and service priorities is outlined in our 2013/14 Annual Report.

Our values

Our values in 2013/14 were the same as the previous year. These are:

Clinical Excellence

We will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients‟ needs.

Respect and courtesy

We will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy.

Integrity

We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.

Teamwork

We will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.

Innovation and flexibility

We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.

Communication

We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

Accept Responsibility

We will be responsible for our own decisions and actions as we strive to constantly improve.

Leadership and direction

We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

We will be consulting with our staff and stakeholders during 2014 on our new strategy and values provisionally called Right Response, Right Care.

Prioritising Quality
How we prioritise and monitor quality

As an NHS Trust we are required to spend time on a number of different priorities. However, we are continually seeking opportunities to strengthen the priority we place on quality and we use a number of sources and influencers to shape our quality focus.

The Experience of other NHS Providers

In 2013/14 the NHS saw a number of high profile and increasingly critical publications regarding quality within the NHS.

These have formed the backbone on how we are reviewing and prioritising quality. The following highlights what we consider to be the main areas of learning for the Trust,

The second Francis Report into the Mid Staffordshire NHS Trust was published in February 2013. The report calls for a fundamental change in culture whereby patients are put first and goes on to make 290 recommendations covering a broad range of issues relating to patient care and safety in the NHS.

Sir Robert Francis called for *"patients to be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and must be protected from avoidable harm and any deprivation of their basic rights"*.

On the publication of the Francis Report, the Prime Minister David Cameron commissioned Professor Don Berwick, an expert in patient safety, to consider what needs to be done "*to make zero harm a reality in our NHS*". The Berwick Report was published in August 2013.

Berwick called for a culture of learning and a clear message that goals and incentives are clear and in patients" best interests

Key recommendations from the Francis Report include the following;

The introduction of a new statutory 'Duty of Candour. This requires all NHS staff and directors to be open and honest when mistakes happen.

Only registered people should care for patients. A registration system should be created under which no unregistered person should be permitted to provide direct physical care to patients.

Hospitals (and possibly other providers) should review whether to reinstate the practice of identifying a senior clinician. This asks to clearly identify who is in charge of a patient's case.

Directors should be subject to a new fit and proper person test. Such a test should include a requirement to comply with a prescribed code of conduct for directors.

The complaints systems within Trusts need to be strengthened The Health Service Ombudsman will increase the number of complaints that she considers for review.

GPs need to undertake a monitoring role. GPs, on behalf of their patients who receive acute hospital and other specialist services will monitor their care. From April 2014 there will also be a named accountable clinician for all vulnerable older people in out of hospital care.

He suggested that connecting with patients and the frontline was fundamental. Leaders need first-hand knowledge of the reality of the system and the patient voice must be heard and heeded at all times

He reinforced Francis' view that the complaints system need to be continuously reviewed and improved.

Transparency must be complete, timely and unequivocal

The third key review of the year was the Keogh Review of 14 NHS Trusts.

The review team led by Professor Keogh acknowledged that in the 14 Trusts there were a set of common themes that were leading to challenges in delivering a high quality service right across the Trusts.

These themes included a lack of awareness of the power of listening to the experience of patients, carers and staff to understand and improve services.

On the whole it was felt that not enough value is placed on the input of frontline clinicians who have constant interaction with patients and who are regarded as having natural innovative tendencies.

We have undertaken a thorough review of these publications and whilst they were primarily written from the hospital perspective we believe there are direct transferrable lessons to the London Ambulance Service.

We have developed three key themes that arise from these reports. The first theme is to "*develop a culture of learning*". This is being taken forward within our new Quality Strategy which we will publish in 2014/15. This will clearly set out how we plan to transform into an organisation that learns through experience and strives for continuous improvement.

The second theme is the need to "*value and listen to our staff*". Prior to the publication of these reports we had already acknowledged the need to enhance the engagement with our staff and we are now planning how we can develop this further within our organisational development plan.

The final third theme is "*Valuing and including the patient voice".* This is a challenging theme as we do not have a dedicated patient group living in a catchment area and, whilst we do have a number of patients who depend upon us to assist in the management of their life long condition, the majority of patients will use us just once or twice in their lifetime. Nevertheless, we recognise the importance of engaging patients and are developing an engagement strategy. The patient voice will also feature highly within our new engagement strategy

Commissioners

The relationship with our commissioners has evolved during the year. As both commissioners and the Trust have become more familiar with the new process the challenge and associated accountability has also strengthened.

Consequently we have implemented a temporary operational structure that mirrors the way commissioning is organised. We have divided into seven functional areas. This has allowed us to develop stronger relationships with local commissioners and to become more responsive to local needs. We still have some distance to travel before we are able to truly call ourselves integrated into local services but we have every intention of becoming more responsive to local need. This means in the future we will be better placed to undertake local quality improvement work.

In addition, each year we work with our commissioners to identify commissioning intentions. These act as advance notice as to what areas our commissioners are expecting us to address in the coming year. These then influence the final contract, the key performance indicators and the final projects identified within the Commissioning for Quality and Innovation Framework (CQUIN).

The Trust Board

The Trust Board is accountable for ensuring the Trust consistently provides a safe and high quality service and this is demonstrated by the following

Nominating the Director of Nursing and Quality as being responsible for bringing quality issues to the attention of the Trust Board and acting as the custodian to quality issues.

Prioritising quality on the agenda by ensuring there are, wherever possible, placed at the top of the agenda.

Inviting a patient, or member of staff, to every Trust Board to meet the Trust Board and present a patient or staff experience of the London Ambulance Service NHS Trust.

Having a Board level committee nominated to focus on quality that has the same status as the audit and finance committees.

Monitoring the quality of care provided across all our services and routinely measuring and benchmarking services internally and externally where this information is available.

Proactively looking at any risks to quality and taking prompt mitigating action.

Challenging poor performance or variation in quality and recognising quality improvement.

Building a quality culture across the organisation.

Working to ensure our workforce is valued and motivated and able to deliver high quality care.

Government Policy

For the fourth year the government has published an NHS Outcomes Framework. This gives guidance to the wider NHS on what Quality outcomes have been identified as critical to achieving the national priorities for health improvement.

The NHS Outcomes Framework states that measuring and publishing information on health outcomes helps drive improvements to the quality of care people receive. The White Paper: Liberating the NHS outlined the Coalition Government's intention to shift the NHS from a focus on process targets to a focus on measuring health outcomes.

The national objectives and outcomes for 2014/15 are the same as 2013/14. Therefore they remain within the five domains presented in our 2013/14 Quality Account:

Domain 1. Preventing people from dying prematurely

Domain 2. Enhancing quality of life for people with long term conditions

Domain 3. Helping people to recover from episodes of ill health or following injury.

Domain 4. Ensuring that people have a positive experience of care

Domain 5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Our Quality Strategy will embrace the shift in emphasis from having defined targets with associated Red, Amber, Green colour ratings, and will look for continuous improvement.

The Expectations of our Regulators

Our quality regulator is the Care Quality Commission (CQC). They are responsible for setting the minimum standards for quality and safety that people have the right to expect whenever they receive NHS funded care.

The CQC then monitor the provision of healthcare and stipulate a range of minimum standards which are observed through their monitoring programme.

We regularly benchmark ourselves and ensure we are meeting these fundamental standards.

The NHS Trust Development Authority

The NHS Trust Development Authority is the body who oversees the transition of NHS Trusts to NHS Foundation Trust status. As a NHS Trust the London Ambulance Service has a relationship with this body. We are required to undertake monthly meetings to assure that our quality governance meets the expectations of the NHS Trust Development Authority and is fit for purpose as we progress through the Foundation Trust pathway.

Monitoring Quality in 2014//15

We are currently reviewing our quality governance arrangements and the sub committee structure that sits under the relevant Board Committee.

As part of this review we plan to strengthen the governance and monitoring and improve the degree of challenge and scrutiny that is applied to the various functions that sit under the umbrella of quality.

We will also redesign our internal quality dashboard with the aim of promoting continuous improvement.

Review of the Year 2013/14
Measuring quality in 2013/14

We use a wide range of indicators to give us a measure of the level of quality we are providing and these are specifically reported later in this publication. However, we also use a number of other indicators to help us triangulate the information. Some of these measures are reported within this section.

Complaints and Patient Advice & Liaison (PALS)

Patient experience and feedback is a rich source of information that allows us to understand whether our services meet the expectations of the patient. We take all patient feedback very seriously and do our best to undertake a fair and thorough investigation so that we can clearly identify the lessons and use these to improve our service, where necessary.

During 2013/14, concerns raised through the PALS and complaints process was reported to every Trust Board meeting. During the course of 2014/15 we will be adopting the recommendation made by Francis and will be publishing more detail from complaints on the Trust‟s website.

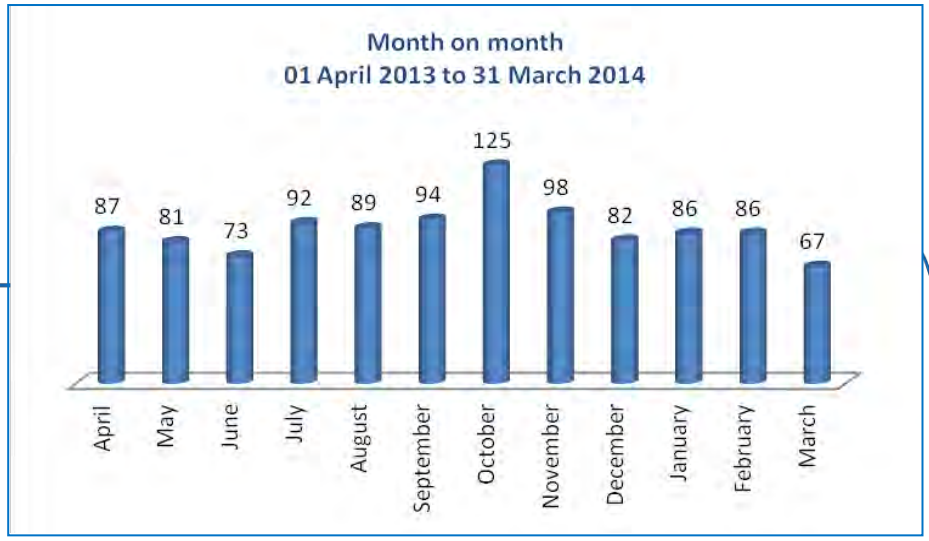
We work to the Health Service Ombudsman‟s *„Principles of Remedy'* and our complaints policy and procedure complies with the NHS complaints regulations.

For each complaint we receive, we appoint a case officer to identify the key themes. This can involve arranging an evaluation of the 999 call management, liaison with local managers, and comprehensive clinical reviews of the care provided.

Once our investigation is complete, we provide a full explanation and, where appropriate, an apology together with details about recourse to the Health Service Ombudsman and the independent advocacy assistance available.

All our responses are approved by the Director of Nursing & Quality and the Chief Executive.

The following table demonstrates complaint volumes in 2013/14 when we received 1060 complaints and over 6000 PALS enquiries.



The main issues arising from complaints are similar to previous years and are broadly within five categories: delayed response, staff attitude , driving and road handling, treatment & care, non-conveyance to hospital.

Complaint themes are reviewed by the Trust"s Learning from Experiences Group which comprises multi-disciplinary membership.

Throughout the year we have identified a small number of themes regarding our management of 999 calls. These are:

1. We use a tape recorded exit message at the end of some calls which explains what the caller needs to do next. Some patients do not like this aspect of our service and it can cause some callers to call us back.

2. Some calls appear to be unnecessarily referred to our clinicians in our call taking area. For example calls where the Emergency Medical Dispatcher already knows that a resource will be sent because the patient is situated in an outside location.

3. Patients have told us that they don"t like not being kept up to date with the progress of their call.

We will work on improving these issues for our patients in 2014/15.

Based on feedback from the previous year we have made some improvements to the service we provide. These improvements include:

1. The way we manage calls from patients who have harmed themselves through overdose.

2. Upgrading calls that are made by elderly patients who have fallen.

We have also implemented a number of initiatives in 2013/14 to improve the way that we manage complaints: These include:

1. Cases are now graded by a Patient Experiences Manager by using a tool to assist in the prioritisation. This allows a more rapid identification of serious issues that need raising with the Trust"s executive management team.

2. We now routinely distribute a weekly update on all current concerns to individual Area Assistant Directors of Operations. This ensures that they are aware of outstanding issues and matters awaiting resolution.

As a result of the Francis Report the Ombudsman is now investigating an increasing number of cases across the NHS. This reflects a small increase in the number of cases the Ombudsman has looked into; with 22 cases being considered in this way.

Serious Incidents

In total across the year 32 incidents were deemed to meet the criteria to be declared as serious to NHS England (London). Each of these 32 has been investigated thoroughly, with a root cause of the incident identified, and recommendations to mitigate any future occurrences of the same situation.

19 out of 32 serious incidents related to incidents where the patient had died and the investigation looked at the root cause to determine whether this was as a result of patient harm and/or a preventable outcome.

Whilst the numbers declared is an increase on those for 2012/13 (17 was the declared total), it is felt that this reflects both an improved understanding on the need for reporting incidents internally, as well as the impact of increasing demand on the Trust.

It is this increased demand on the service which has been a recurrent theme across a number of serious incidents during 2013/14. This has resulted in an inability to provide some patients with a response within the target assigned on triage of the call.

The Trust is undergoing a significant two-year transformation programme to ensure we are able to meet this increased demand and progress is reported later in this Quality Account.

Towards the end of 2013/14, a review of the internal process for the management of serious incidents was undertaken. From this, steps to improve the decision-making structure and reporting format have been implemented – both of these will contribute to improved investigation and report writing.

Patient Engagement

During 2013/14 we participated in 717 community events.

These events included school and college visits, cub and scout groups, Junior Citizen Schemes, career and job fairs, first aid training, gang and youth violence events, and health and safety days. We have taken part in health events, including some for deaf people, and given talks to “over 50s” and “over 60s” groups.

We also ran a patient involvement event to find out about the experiences and views of lesbian, gay and bisexual service users in support of our Stonewall application.

In June 2013 we invited our Trust membership to learn more about our plans for the future. We have also held member events on first aid technique, cardiac care, trauma care, and mental health care. The mental health event included presentations from the Croydon charity Hear Us. They told the 40-strong audience about how they were diagnosed with different illnesses, including schizophrenia and depression, as well as their experiences of calling for help from the ambulance service.

The findings of last year‟s non-conveyed patient and staff survey were presented to the Patient Forum and to the Trust‟s Learning from Experience Group and this has fed into this year‟s quality improvement work which is reported later in the Quality Account.

A Safeguarding conference was held in June 2013, and included two patients talking about their personal experiences.

The National Ambulance Service Patient Experience Group worked with the CQC and Picker to develop a national Hear & Treat survey. The telephone surveys were carried out during the winter months, and the results will be available in May 2014. This should provide some comparison between patients‟ experiences of hear and treat services across the country.

The Staff Voice

In 2013/14 we commenced a programme of staff engagement. We ran a number of events and workshops that gave our staff the opportunity to work with the management team to identify a range of issues that needed addressing.

These workshops were well received by the staff and a number of short "quick win" projects were adopted as a result of the programme.

We also launched the staff Facebook page. This is an electronic platform that allows our staff to raise issues and participate in discussion.

In addition we commenced a series of sessions using a web-based teleconference facility that allows a number of staff working across London to participate in the event.

The Student Voice

Our students are a significant part of our workforce and we recognised the need to strengthen their voice. This work is continuing but we have appointed a Director of Paramedic Education and Development who will strengthen they way students are represented in decision making and in our quality monitoring.

The 2013/14 Quality Indicators

This was the third year of the national Ambulance Service Quality Indicators. They are designed to consider the speed of response and the quality of care offered to patients.

The indicators are specific to the ambulance service but are designed to be read alongside the indicators for Acute Trusts that have Accident & Emergency departments. They measure elements of patient safety and patient outcomes.

We monitor these indicators monthly as part of our quality dashboard and a fuller report is contained within this Quality Account.

Patient Feedback (Stonewall)

As one of the first national Stonewall Health Champions, the Trust takes part in the annual Stonewall Healthcare Equality Index. Part of the assessment criteria includes feedback from our patients.

The Stonewall Healthcare Equality Index shows how individual organisations are improving the health and expectations of Lesbian, Gay, and Bisexual patients.

A total of forty-four health care organisations across England entered in 2013/14. Submissions to the Healthcare Equality Index are assessed against specific criteria. The criteria includes: policy and practice, staff training, engagement, communication, data collection, and patient feedback.

The patient feedback is provided through a confidential web link giving access to the Stonewall Patient Feedback Survey. This survey enables patients and service users of health care organisations entering the Index to comment on their experience of using that service.

Responses to the survey enable Stonewall to gain further information which can help inform organisations of key areas they may wish to work on.

Questions include whether patients feel comfortable disclosing their sexual orientation to the respective healthcare organisation, questions about organisational policy around sexuality and non-discrimination, and also whether patients and service users felt they were treated with dignity and respect while using that service, and whether they would recommend the service to friends and family.

For two years running the Trust has been recognized as a Stonewall Healthcare Equality Index Top 10 Performer.

Our 2013/14 Quality Priorities
Progress against our Improvement Priorities

In 2013/14 we identified that, in order to meet the challenge of a rise in over 100,000 calls in the previous year, we would need to embark on an extensive transformation programme (which we called Modernisation in last year's Quality Account). This was to be our main Quality Improvement Priority for 2013/14.

Modernisation/Transformation Programme

The London Ambulance Service Modernisation Programme was launched on 24 April 2013. The programme consisted of 9 projects which will be delivered over a period of 2 years.

Year one has seen the following projects start to deliver their benefits to both patients and staff:

Increasing Vehicle Availability

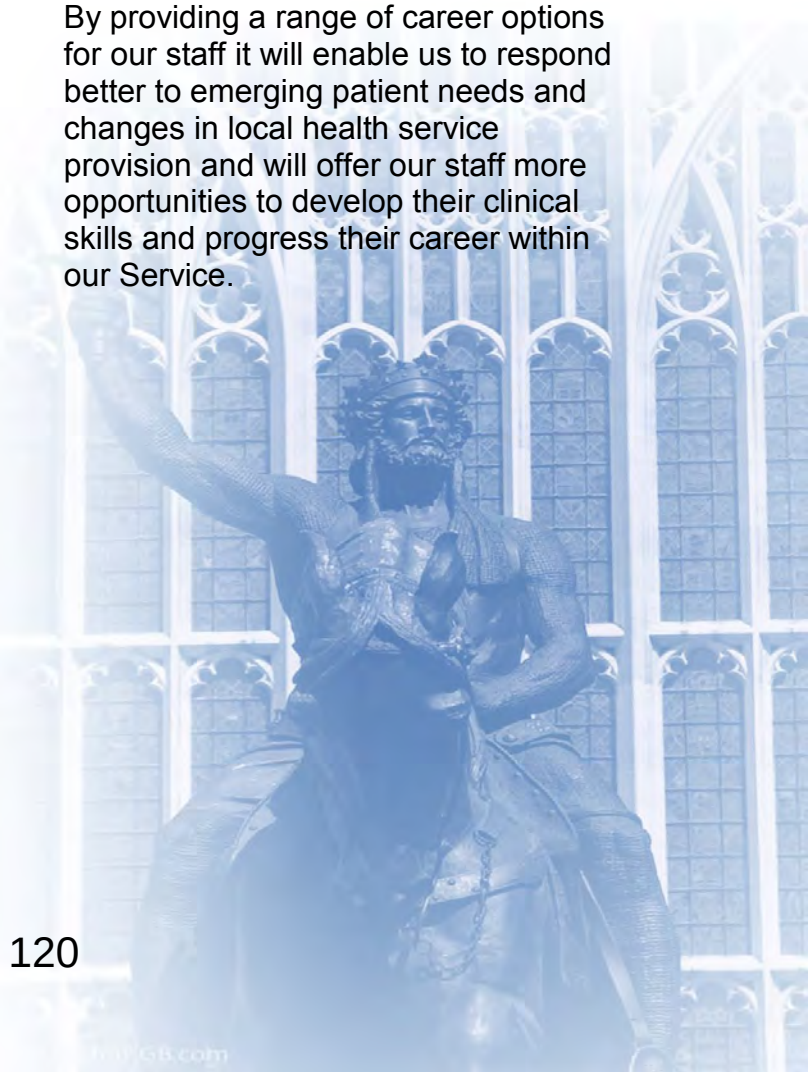
By having more vehicles available we are able to offer a better service to patients. This project went live in June 2013.

Clinical Hub (Hear and Treat)

Many of the 999 calls which the Trust receives are from patients who do not have life threatening injuries and illnesses, and who do not need an ambulance crew to attend. Instead they can be given a full clinical assessment over the phone and safely be offered advice, or redirected to other healthcare providers. In 2013/14 we increased the number of paramedics who worked within the clinical hub. These registered healthcare professionals provide an enhanced clinical triage service over the telephone for those patients who are categorised with less serious conditions.

Clinical Career Structure

By providing a range of career options for our staff it will enable us to respond better to emerging patient needs and changes in local health service provision and will offer our staff more opportunities to develop their clinical skills and progress their career within our Service.



In 2013/14 we introduced the new role of Advance Paramedic Practitioner. These now respond to the most serious 2% of life-threatening incidents involving patients with complex medical conditions. Twelve of these posts have been recruited in year and a further 24 are planned for over the next 2 years.

We have revised the job description for our clinical team leaders and have finalised arrangements for a new skill mix on our ambulances from Spring 2014. This will see a new role being introduced into the service which will be able work alongside our paramedics and will mean that all of our front line staff will be able to respond to a full range of calls which has not been the case to date. This will increase the flexibility of our workforce to respond to patients across the full spectrum of urgent and emergency care.

Other Priority Areas

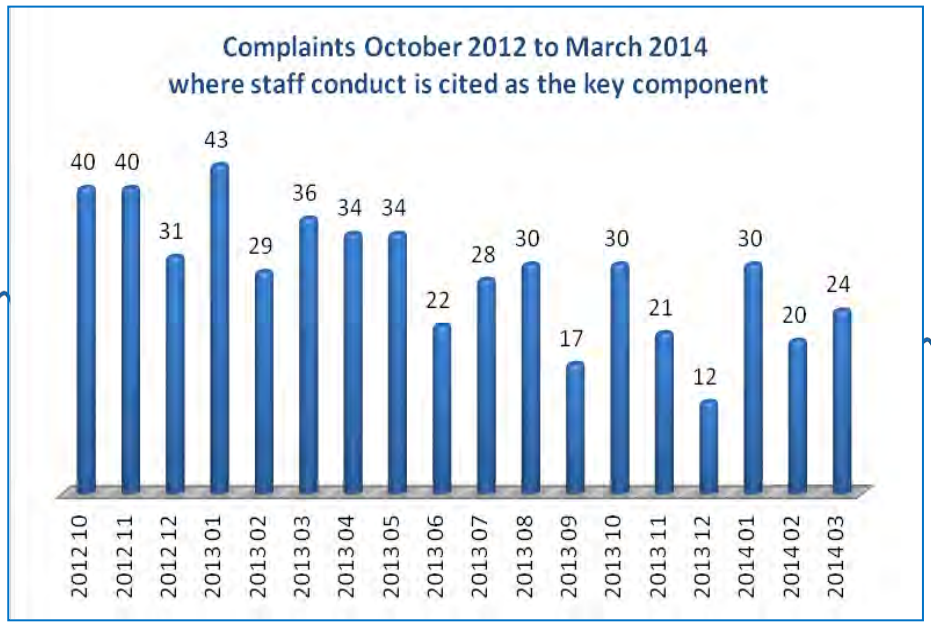
In addition to the transformation agenda we identified four additional priority areas where we aimed to make improvements:

- Reducing the number of complaints regarding attitude & behaviour
- Improving the experience of patients subjected to a delay.
- Improving the experience of patients referred to Alternative Care Pathways
- Reduce the incidence of Missing Equipment

Reducing the number of complaints regarding attitude & behaviour

We have had mixed success with this improvement measure. Our ratio of dissatisfaction due to poor attitude compared to the number of patients calling us is extremely low. Nevertheless we wanted to try and make further improvements.

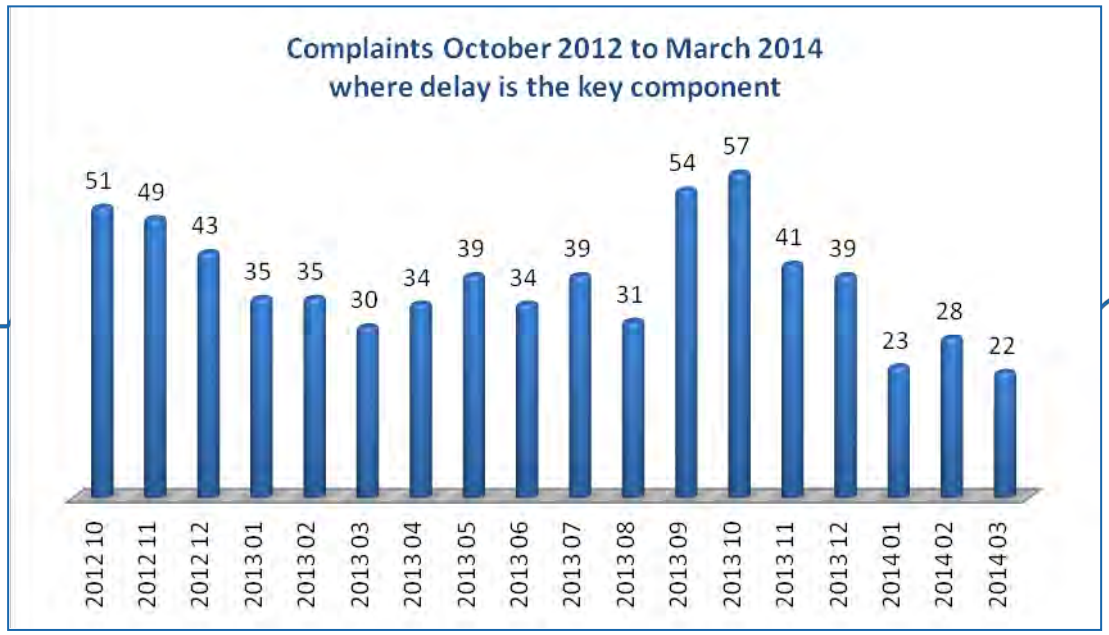
The Assistant Directors of Operations developed an action plan; although this was not fully implemented during the year its development helped raise awareness across the Trust. There was a drop in the number of complaints.



Improving the experience of patients subjected to a delay.

We are very successful in providing a quick response to patients who are seriously ill. But this does mean that less urgent patients wait longer than we would like. Our Transformation programme will help us release more capacity into the system and improve this in the future.

Patients who do wait often tell us that it is not the actual wait that is the issue but the poor communication between us and the waiting patient. Therefore, during the year we implemented an improved system for ringing patients back and undertaking a welfare check. We believe this has reduced the sense of abandonment and this has started to impact on the number of complaints we receive regarding a delay.



Improving the experience of patients referred to Alternative Care Pathways (ACP)

Emerging from our complaints analysis in 2012/13, and from our patient survey, was a theme where patients were appearing less satisfied when they were not conveyed to hospital. So we developed an action plan to see if we could understand this in more detail. The action plan included:

- Carrying out an audit of current ACP usage: find out which of the agreed ACPs are being used.
- Involving staff in work to identify and understand the barriers to using ACPs: we know that some staff are reluctant to use ACPs and some of the reasons for this. However there may be more to find out.
- Develop key messages for patients, the public and staff about ACPs, including:
    - 111
    - Walk-in centres etc.
    - Mental Health and other specialist pathways
    - Treatment at home

This is a challenging area for the Trust to improve as many patients have often made up their mind that they

wish to go to Accident & Emergency before they call 999.

Reduce the incidence of Missing Equipment

During 2011/12 we identified an increasing trend in the number of vehicles that were not equipped beyond the basic minimum and embarked upon a programme to reduce this trend in 2012/13.

One work-stream was to move from a pooled source of equipment and introduce equipment that was issued personally to our clinical staff.

Personal issue kits that record patient blood glucose were introduced six months into the year and this made a dramatic reduction. The low number of reported losses is being maintained.

Personal issue thermometers were purchased in the last quarter of 2013/14 and we are due to implement this during April 2014. This will ensure that all staff have access to basic diagnostic equipment and we should see a reduction in the number of reported shortages of these items.

During the last quarter of 2013/14 other initiatives were put in place to address the reported equipment shortages. Funding was provided to purchase additional medical equipment and during the period 3rd to 6th February 2014, 26 "shells" were equipped with the key pieces of equipment that are required for a vehicle to be available to respond.

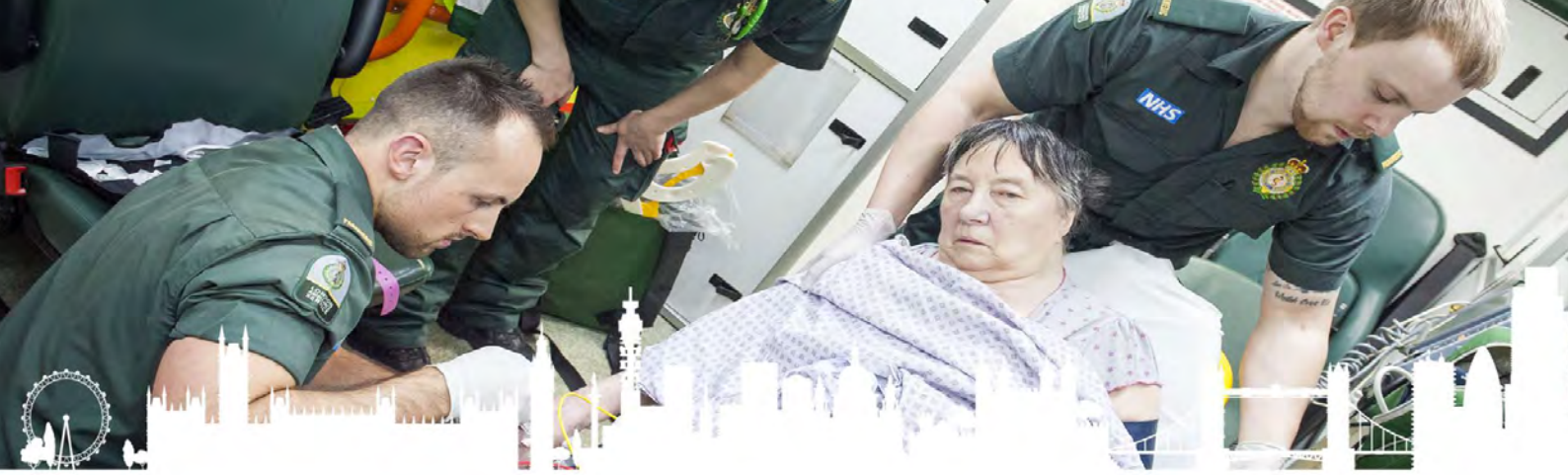
Also operations have been working to reduce the number of "shells" reported each day by equipping vehicles from equipment sourced from ambulance stations.

The majority of the additional equipment ordered in the last three months of the financial year has now been delivered and this will be issued during the first quarter of 2014/15.

To ensure that the equipment is used to replace missing items on vehicles and equip "shells" the Logistics Department will be working in conjunction with the Vehicle Preparation contractors and Vehicle Resource Centre to ensure a structured approach is taken to make best used of the additional equipment.

Previously, stations have been expected to pay for equipment repairs and this has in some instances caused delays in the repair of equipment and its return to service. From April 2014 the cost of repairs will be funded by Logistics budgets which will improve turnaround times for equipment repairs. In additional Equipment Support Personnel will be exchanging the majority of equipment immediately when visiting stations instead of bringing it back to the Logistics Support Unit for repair or exchange. This will also improve equipment availability, especially for defibrillator accessories.

The last quarter of 2013/14 has seen an increase in the reports of drug pack shortages from a number of ambulance stations. Whilst the number of packs in circulation should more than cover the daily requirement, additional drug packs have been ordered and will be distributed across the Trust to increase stocks held on stations and improve availability. Additional packs will be issued based on existing stock levels on stations and requirements.



Mandatory Assurance Statements
Statements mandated by NHS England

Each year we are required to report a number of mandatory statements. These are reported in this section.

Statement Area 1: Data Review

During 2013/14 the London Ambulance Service NHS Trust provided three NHS Services and has reviewed the data available to them on the quality of care in these services.

Statement Area 2: Income

The income generated by the NHS services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2013/14.

Statement Area 3: Clinical audit

During 2013/2014, two national clinical audits and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audits that the London Ambulance Service NHS Trust was eligible to participate in during 2013/14 are as follows:

Department of Health Ambulance Clinical Quality Indicators covering:

- Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
- Outcome from cardiac arrest – Survival to discharge
- Outcome from acute ST-elevation myocardial infarction (STEMI)
- Outcome from stroke.

National Clinical Performance Indicators (CPI) programme covering:

- Hypoglycaemia
- Asthma
- Lower leg fracture
- Febrile convulsion.

The national clinical audits that the London Ambulance Service NHS Trust participated in during 2013/14 are as follows:

Department of Health Ambulance Clinical Quality Indicators:

- Outcome from cardiac arrest –ROSC
- Outcome from cardiac arrest – Survival to discharge
- Outcome from acute STEMI
- Outcome from stroke.

National Clinical Performance Indicators (CPI) programme covering:

- Hypoglycaemia
- Asthma
- Lower leg fracture
- Febrile convulsion.

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a)2735 b) 393	a)2735 b) 393	100 %
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 2675 b) 369	a) 2675 b) 369	100 %
DH ACQI: Outcome from acute STEMI b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	b) 960 c) 1948	b) 960 c) 1948	100 %
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 4413 b) 7199	a) 4413 b) 7199	100
National CPI: Hypoglycaemia a) Blood glucose before treatment b) Blood glucose after treatment c) Treatment for hypoglycaemia recorded (oral carbohydrates, glucagons, IV glucose) d) Direct referral made to an appropriate health professional e) Care bundle	600	600	100
National CPI: Asthma a) Respiratory rate recorded b) PEFR recorded (before treatment) c) SpO_2 recorded (before treatment) d) Beta-2 agonist recorded e) Oxygen administered f) Care bundle	600	600	100
National CPI: Lower leg fracture a) Two pain scores recorded b) Analgesia administered c) SpO_2 recorded (before treatment) d) Oxygen administered e) Immobilisation of limb recorded f) Assessment of circulation distal to fracture recorded g) Care bundle	56	56	100
National CPI: Febrile convulsion a) Blood glucose recorded (before treatment) b) Temperature recorded (before treatment) c) SpO_2 recorded (before treatment) d) Oxygen administered e) Anti convulsant administered f) Temperature management g) Appropriate discharge pathway recorded h) Care bundle	513	513	100

In addition, the London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to seven patient groups (see box below) and quality assures the documentation on 2.5% of all clinical records completed.

Information: Clinical Performance Indicators (CPIs) are designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. The areas of care included are: acute coronary syndrome, cardiac arrest, difficulty in breathing, glycaemic emergency, stroke, mental health, patients that are treated and left at scene (non-conveyed) and general documentation. The delivery of care to these patient groups is routinely fed back to staff on a one-on-one basis by clinical supervisors so that staff are able to discuss how they can improve their performance. Through this system we have been able to ensure continuous improvement in clinical care and this has been demonstrated in the newest CPI – care for mental health patients – which has shown enhanced assessment of this patient group since the CPI was introduced last year.

We also undertake four continuous audits that monitor the care provided to every patient who suffers a cardiac arrest, STEMI or stroke, or who have been involved in a major trauma incident.

The report of two national clinical audits were reviewed by the provider in 2013/14 and the London Ambulance Service NHS Trust has taken the following actions to improve the quality of healthcare provided:

- Supplied each member of staff with their own blood glucose monitoring kit to increase the measurement of blood glucose levels for patients presenting with hypoglycaemia.
- Purchased peak flow tubes with a one way valve to increase the number of patients with asthma who have their peak flow rate measured before treatment.
- Developed an acute coronary syndrome aide memoire to highlight all elements of the STEMI care bundle as well as ECG interpretation and the correct pathways for this group of patients.
- Created a multimedia stroke training package in collaboration with other NHS Trusts.

The reports of six local clinical audits were reviewed by the provider in 2013/2014 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Adrenaline as a treatment for anaphylaxis and acute asthma

- Through training ensure staff are able to distinguish anaphylaxis from major and minor allergic reactions, and features that differentiate between acute asthma and COPD
- Reduce drug related errors by introducing a “Check and Challenge” system.

Chronic Obstructive Pulmonary Disease

- Ensure staff are able to recognise the signs of carbon dioxide retention and the associated risks by revising current training materials.

Patients who have taken Overdose

- Ensure patients who have taken an overdose do not deteriorate whilst waiting for an ambulance by introducing an enhanced clinical telephone assessment
- Determine whether pre-hospital administration of activated charcoal is feasible to enable eligible patients to receive treatment sooner.

Hydrocortisone as a treatment for acute severe and life threatening asthma

- Clarify administration guidance with national guideline publishers to remove confusion regarding time interval prior to hydrocortisone administration
- Survey staff to determine why hydrocortisone is being underused
- Consider oral prednisolone as an alternative to hydrocortisone.

Recognition of Life Extinct (ROLE)

- Improve ROLE form completion by revising the current form and providing further completion guidance to remind staff of the correct procedures when performing ROLE
- Replace the „purple +" illness code with „obviously deceased" to avoid confusion between terms.

Diazepam to terminate seizures

- Publish an article in the internal clinical newsletter and revise training materials to remind staff to: exclude causes of seizure activity; to monitor patients for respiratory depression and hypotension following administration, and to obtain prompt IV access for all adults presenting with seizure activity.

Statement Area 4: Research

Participation in clinical research demonstrates the London Ambulance Service NHS Trust"s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep up to date with the latest possible treatment options and their active participation in research leads to improved patient outcomes.

The London Ambulance Service NHS Trust was involved in conducting four clinical research studies in pre-hospital care during 2013/14. There were 333 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2013/14. These staff participated in research focused upon the medical speciality of cardiac care and the care of elderly people who have fallen. These studies were:

- DANCE (high risk acute coronary syndrome): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.

- Paramedic SVT: RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.

- AMICABLE Study: A prospective observational study comparing the effectiveness of prehospital airway strategies on patient outcomes following cardiac arrest.

- SAFER 2: Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 85.

It is important to note that as well as recruiting patients, we also conducted research involving staff and student paramedics as participants. The total number of LAS staff and student paramedics who were themselves recruited as research participants in 2013/14 was 98, with a further 390 staff involved in follow up aspects of existing projects.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2013/14 are displayed in the following table.

Study name 2013/14	Participants recruited 2013/14	Total no. of Participants recruited to study	LAS clinical staff involved
NHS REC approved studies involving patients			
Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER2)	-^	284	2
High risk acute coronary syndrome (ACS) (*formerly known as 'DANCE'*)	8^	100	250
Safety and efficacy of paramedic treatment of regular supraventricular tachycardia (ParaSVT)	14^	71	80
Airway management in cardiac arrest – basic, Laryngeal Mask Airway, endotracheal intubation study (AMICABLE)	63	-	1
Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review)*			
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	-^	390	-
Do not attempt cardiopulmonary resuscitation (DNACPR) decisions	5	-	-
Antidote use and medical management of chemical incidents casualties – How much do emergency responders know?	54	-	-
Developing leadership in the UK"s ambulance service: A review of the consultant paramedic role.	1	-	-
What do ambulance service personnel consider to be the „process of" and „issues with" inter-hospital transfers?	7	-	1
Blue light responders, evacuation and pets: An exploratory, inter-professional study into emergency responders" perspectives on Companion Animal/pet owners" reactions in an evacuation.	16	-	-
How the London Ambulance Service manages absence	13	-	-
A study of major system reconfiguration in stroke services	2	-	-

^ *Patients recruited in study during previous years were actively followed up in 2013/14.*

**From 1st September 2011, research involving NHS staff no longer requires NHS REC review unless there is a legal requirement for review as specified in 'Governance arrangements for research ethics committees: a harmonised edition.*

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In addition to the above mentioned research projects, the LAS also undertook a number of descriptive, feasibility and evaluation projects to provide evidence of the best ways to treat patients and to achieve the best possible outcomes.

Within the last three years 25 papers have been published in peer-reviewed journals as a direct result of the London Ambulance Service"s participation in clinical research.

These papers include: *'Increases in survival from out-of-hospital cardiac arrest: A five year study'* published in Resuscitation journal; *'Survival of resuscitated cardiac arrest patients with ST-elevation myocardial infarction (STEMI) conveyed directly to a Heart Attack Centre'* also published in Resuscitation journal, and *'Does use of the Recognition Of Stroke In The Emergency Room stroke assessment tool enhance stroke recognition by ambulance clinicians'* published in Stroke journal.

These publications demonstrate our commitment to transparency and desire to improve patient outcome and experiences across the NHS. Also, through these publications we have been able to share our knowledge and contribute to evidence-based clinical practice. Our engagement with clinical research also demonstrates the London Ambulance Service NHS Trust"s commitment to testing and offering the latest medical treatments and techniques.

Other activities which demonstrate our commitment to research as a driver for improving the quality of care and the patient experience include our Evidence for Practice Sessions and Advice Surgeries. During 2013/14, we held three Evidence for Practice Sessions for ambulance clinicians where they reviewed published papers that discussed the use of therapeutic hypothermia following cardiac arrest, appropriate care for traumatic cardiac arrests and the use of feedback to encourage improved pre-hospital resuscitation and the implications for clinical practice.

Through our monthly Advice Surgeries we provide guidance to staff interested in undertaking research and help them to develop new research protocols. In addition, all staff are kept up to date with published literature and emerging research evidence with the circulation of journal contents pages and the facilitation of access to electronic journals. Findings from our research studies are disseminated to staff via our internal clinical newsletter and advertised on our intranet. We also present our research findings at conferences to share our learning and influence clinical practices as far afield as possible.

We have an extensive collaboration portfolio for the forthcoming 2014/15 period, which includes the following studies:

- Safety and efficacy of paramedic treatment of regular supraventricular tachycardia (ParaSVT): RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine versus conventional management.
- Identifying emergency personnel at risk of post traumatic stress disorder (PTSD): Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics.
- rAAA: An observational trial that investigates whether an electronic prehospital triage tool can aid identification of ruptured aortic abdominal or thoracic aortic aneurysm (rAAA).

- Stroke mimics: An investigation of the incidence and diagnoses of stroke mimics, and differences in responses of strokes and mimics to the ROSIER assessment tool.
- Exercise-related sudden cardiac arrest in London: A retrospective analysis of cases where cardiac arrest occurred during or after exercise to investigate incidence of, and factors related to survival from, exercise-related cardiac arrest.
- An explorative assessment of London‟s 999 frequent callers and the effectiveness of interventional strategies employed by the London Ambulance service‟s patient centred action team: A retrospective analysis aiming to i) profile this group of patients, ii) examine the impact of the LAS Patient Centred Action Team‟s interventional strategies on frequent caller behaviour.
- Out-of-hospital cardiac arrest outcomes project: Development of a national cardiac arrest registry and use of statistical modelling to understand variability in outcomes and contributory factors to survival.
- Prehospital Assessment of the role of adrenaline: measuring the Effectiveness of drug administration in cardiac arrest (PARAMEDIC2): A randomised control trial to investigate whether adults that have an out of hospital cardiac arrest treated with adrenaline have improved survival rates and neurological outcomes.
- Airway management in cardiac arrest – basic, laryngeal mask airway, endotracheal intubation study (AMICABLE): A prospective observational study to assess the effect of prehospital airway strategies on the outcome of patients who experience an out of hospital cardiac arrest and are conveyed to a Heart Attack Centre.
- Immediate coronary angiography after ventricular fibrillation out-of-hospital cardiac arrest (ARREST): A randomised control trial of immediate coronary angiography versus current standard of care after ventricular fibrillation out-of-hospital cardiac arrest.
- The impact of alcohol misuse on the London Ambulance Service: This questionnaire based study will explore clinical staff members view‟s on the impact of alcohol misuse in London.
- Alternatives to face to face contact: This study explores the impact of the introduction of hear and treat services within the ambulance service.
- Understanding variation in rates of non-conveyance to an emergency department of emergency ambulance users: This study will explore the variation in non-conveyance rates between the 11 ambulance services within England.
- Activated charcoal: A study to explore the feasibility of using activated charcoal in the prehospital setting.
- Stroke outcomes: A study linking prehospital data with hospital data from hyper-acute stroke unit to identify the accuracy of stroke recognition using the face, arm and speech test (FAST).
- Risk of sudden cardiac death in epilepsy: A retrospective analysis of data from patients in cardiac arrest with a history of epilepsy to identify whether patients with epilepsy are at higher risk of cardiac arrest.

In addition to the above, we have developed a number of research protocols for which we are awaiting external funding decisions.

Ambulance Quality Indicators Care Bundle

The percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle

The London Ambulance Service NHS Trust submitted the following information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2013/14 and 2012/13

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	2013-14 *		2012-13	
	LAS average	**National average** (Range)	**LAS average**	**National average** (Range)
STEMI patients	76.1	80.5 (67.4 – 89.6)	66.8	77.6 (66.8 – 94.7)
Stroke patients	94.7	96.3 (92.1 – 99.4)	93.8	95.7 (90.9 –100)

At the point of preparation of this Quality Account, NHS England reported data for April to December 2013.

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: this data is captured by the Trust from clinical records completed by ambulance staff attending patients as part of ongoing clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The London Ambulance Service NHS Trust has taken the following actions to improve the percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle, and so the quality of its services, by:

- Continued clinical education provided to staff through materials such as clinical webinars, training updates, updated aide memoires, and reminders in bulletins and newsletters.
- Ensuring that staff have the necessary equipment to perform patient assessments with the provision of personal issue kit where applicable.

Statement Area 5: CQUINS

A proportion of the London Ambulance Service NHS Trust"s income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The details of the agreed goals for 2013/14 are as follows:

1. To undertake the delivery of training to staff to enable a change to two-tier working: 100% of eligible A&E support staff to have commenced the conversion course to enable front-line working. (CQUIN achieved - approximate value £1.7m)

2. Development of new roster patterns for all appropriate complexes and teams: rosters to cover all relevant staffing groups within the operational and control room environment will be developed in line with modelling results.
(CQUIN achieved - approximate value £2.3m)

3. Implementation of enhanced clinical triage process: completion of recruitment process and training of staff commenced for new specific roles with the Clinical Hub (CHUB) targeted at delivering Hear and Treat services for patients (CQUIN achieved - approximate value £780k)

4. Implementation of a new response model: changes to the CommandPoint™ despatch protocols to be made to enable recommendations made regarding the allocation of resource type to calls under the new workforce skill mix model. (CQUIN achieved - approximate value £800k)

5. Engagement exercise and communications strategy delivered: completion of a series of staff engagement events, including the delivery of comprehensive information pack to staff. (CQUIN achieved - approximate value £600k)

The details of the agreed goals for 2014/15 are as follows:

1. Friends and Family Test: implementation of Friends and Family Test according to the national timetable. (valued at £1,289,609)

2. Emergency Care Pathways – End of Life Care: improving the quality of care delivered to people on an end of life care pathway by supporting the plan agreed with the patient. (Valued at £967,207)

3. Emergency Care Pathways – Community Life Support and Defibrillation for Cardiac Arrest: improving return of spontaneous circulation (ROSC) rates following cardiac arrest through Community and Partnership Engagement. (Valued at £644,084)

4. Emergency Care Pathways – Enhanced falls Service: ensuring that people who are at risk of falling, or have a history of falling, have an appropriate response model from LAS (Valued at £644,084)

5. Staff awareness and education - mental health and dementia: improving the care for people with mental health needs and dementia. (Valued at £967,207)

6. Embracing technology to improve care - clinical applications and accessible information: develop a technological solution to ensure that ambulance crews have access to information sources that exist in healthcare settings (e.g. summary care record, Directory of Services, Capacity Management System, Decision Making Software). (Valued at £967,207)

7. Embracing technology to improve care: eAmbulance development. (Valued at £967,207)

Statement Area 6: Care Quality Commission

The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is “registered”. The London Ambulance Service NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The London Ambulance Service NHS Trust during 2013/14.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2013/14.

An unannounced inspection took place in Summer 2013 and the Trust was found to be compliant in the areas inspected.

Statement Area 7 Data Quality

The London Ambulance Service NHS Trust will be taking the following actions to improve data quality:

At the time of writing the Quality Account the Trust was in discussion with the internal auditors as to what aspects would feature within the audit programme. Data Quality will feature in at least one audit project.

Statement Area 8 NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics.

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score for 2013/14 was 81% and was graded at level 2.

Statement area 10 Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission


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Ambulance Quality Indicators
A review of the 2013/14 Quality Indicators

2013/14 was the third year of the national ambulance quality indicators. These are a set of measures that allow individual Ambulance Trusts to look where they lie in comparison with other NHS ambulance providers.

It is not always possible to draw direct comparisons as services differ slightly across the country but it allows Ambulance Trusts to use the information analytically.

The graphs on the following pages illustrate the London Ambulance Service NHS Trust year end position in the quality measures that we are mandated to report on. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking, therefore the data from April to December 2013 is included in these measures.

Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is an acronym meaning 'ST (a particular segment) Elevation Myocardial Infarction', which is a type of heart attack. Early access to cardiac intervention is considered an important element in reducing the mortality and morbidity associated with a STEMI and we are monitored on our time but we are also monitored on the care that STEMI patients receive from our staff.

There are a number of elements that are considered a “care bundle”. These are to record when aspirin is given; when Glyceryl Trinitrate (GTN) is given; when 2 pain scores are recorded; and when a patient has received analgesia of either Morphine or Entenox.

Percentage of patients suffering a STEMI who receive an appropriate care bundle (Year to date)

		Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust		862	1,127	76.5
East of England Ambulance Service NHS Trust		1,125	1,322	85.1
Great Western Ambulance Service NHS Trust				0.0
Isle of Wight NHS PCT		47	62	75.8
London Ambulance Service NHS Trust		1,677	2,204	76.1
North East Ambulance Service NHS Trust		505	598	84.4
North West Ambulance Service NHS Trust		1,592	1,844	86.3
South Central Ambulance Service NHS Trust		633	939	67.4
S. E. Coast Ambulance Service NHS Foundation Trust		725	932	77.8
S. Western Ambulance Service NHS Foundation Trust		1,305	1,456	89.6
West Midlands Ambulance Service NHS Trust		883	1,173	75.3
Yorkshire Ambulance Service NHS Trust		698	830	84.1
Overall for period	**Higher is better**	10,052	**12,487**	**80.5**

Our compliance for 2013/14 is 76.1 %. Last year our compliance was 66.8% and the previous year it was 61.7% suggesting we have made sustained improvements in this quality indicator.

Outcome following stroke for ambulance patients

Patients should be arriving at an appropriate place as soon as possible following the onset of a stroke. Time to confirmed diagnosis and treatment is key to reducing mortality associated with a stroke and we are monitored on this element of performance.

However, similar to the STEMI care there is also a “care bundle” that we are asked to monitor.

The care bundle should include the completion of a stroke diagnostic test (called a FAST test), the checking of a patient"s blood glucose and a complete blood pressure taken.

Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle (Year to date position)

		Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust		6,903	7,084	97.4
East of England Ambulance Service NHS Trust		5,430	5,666	95.8
Great Western Ambulance Service NHS Trust				0.0
Isle of Wight NHS PCT		152	156	97.4
London Ambulance Service NHS Trust		7,781	8,219	94.7
North East Ambulance Service NHS Trust		2,501	2,547	98.2
North West Ambulance Service NHS Trust		9,121	9,177	99.4
South Central Ambulance Service NHS Trust		4,666	4,742	98.4
S. E. Coast Ambulance Service NHS Foundation Trust		5,913	6,421	92.1
S. Western Ambulance Service NHS Foundation Trust		6,971	7,169	97.2
West Midlands Ambulance Service NHS Trust		6,791	7,206	94.2
Yorkshire Ambulance Service NHS Trust		5,662	5,876	96.4
Overall for period	**Higher is better**	61,891	**64,263**	**96.3**

Our compliance for 2013/14 is 94.7. Last year our compliance was 93.8% and the previous year our compliance was 91.3% suggesting a slight sustained improvement.

Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and records only those who are most in need of an emergency ambulance. It is divided into two measures. The first is the length of time taken to respond within an eight minute window and the second measure is the time taken to respond in a 19 minute window. The first 8 minute response is divided into two subdivisions known as Red 1 and Red 2. Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse and other severe conditions.

A Red 2 call is used for conditions which are less serious and less immediately time critical and cover conditions such as stroke and fits.

Category A 8 Minute Response Time (Year end position) for Red 1.

		Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust		13,842	19,424	71.3
East of England Ambulance Service NHS Trust		9,634	13,094	73.6
Great Western Ambulance Service NHS Trust				0.0
Isle of Wight NHS PCT		239	298	80.2
London Ambulance Service NHS Trust		11,060	14,296	77.4
North East Ambulance Service NHS Trust		2,817	3,661	76.9
North West Ambulance Service NHS Trust		22,197	29,260	75.9
South Central Ambulance Service NHS Trust		6,464	8,162	79.2
S. E. Coast Ambulance Service NHS Foundation Trust		4,501	5,863	76.8
S. Western Ambulance Service NHS Foundation Trust		10,067	13,763	73.1
West Midlands Ambulance Service NHS Trust		6,143	7,681	80.0
Yorkshire Ambulance Service NHS Trust		15,273	19,738	77.4
Overall for period	**Higher is better**	102,237	**135,240**	**75.6**

Element 1. Graph 15: Category A 8 Minute Response Time (Year end position) for Red 2.

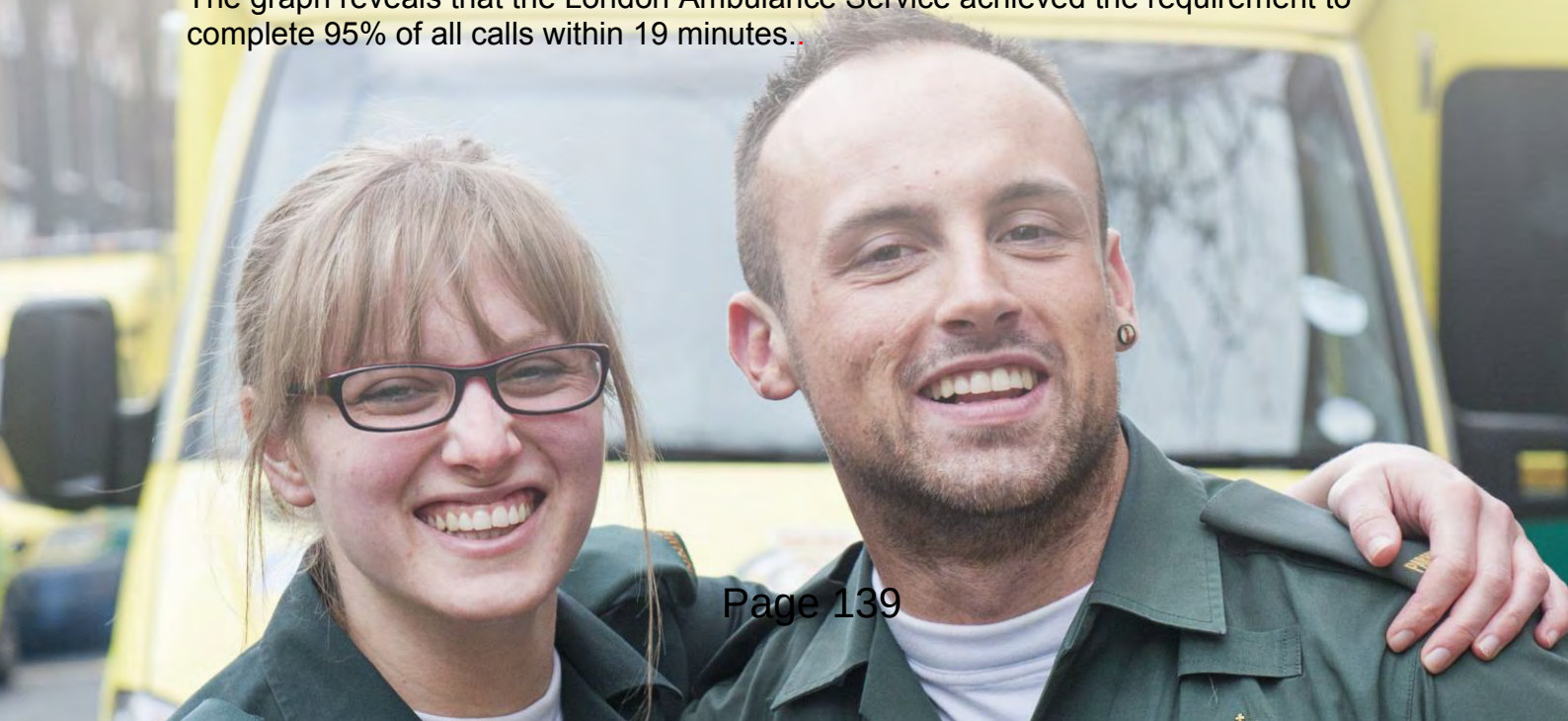
		Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust		161,493	226,126	71.4
East of England Ambulance Service NHS Trust		173,954	250,617	69.4
Great Western Ambulance Service NHS Trust				0.0
Isle of Wight NHS PCT		5,175	6,802	76.1
London Ambulance Service NHS Trust		336,090	446,319	75.3
North East Ambulance Service NHS Trust		129,553	165,274	78.4
North West Ambulance Service NHS Trust		278,026	359,079	77.4
South Central Ambulance Service NHS Trust		94,916	125,368	75.7
S. E. Coast Ambulance Service NHS Foundation Trust		189,477	256,413	73.9
S. Western Ambulance Service NHS Foundation Trust		228,226	295,515	77.2
West Midlands Ambulance Service NHS Trust		262,977	357,397	73.6
Yorkshire Ambulance Service NHS Trust		186,209	247,979	75.1
Overall for period	**Higher is better**	2,046,096	**2,736,889**	**74.8**

The graphs reveal that the London Ambulance Service achieved the requirement to complete 75% of all A8 calls within eight minutes.

Element 2. Graph 16: Category A 19 Minute Response Time (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust		230,018	245,190	93.8
East of England Ambulance Service NHS Trust		243,622	262,192	92.9
Great Western Ambulance Service NHS Trust				0.0
Isle of Wight NHS PCT		6,861	7,100	96.6
London Ambulance Service NHS Trust		448,271	458,073	97.9
North East Ambulance Service NHS Trust		162,894	168,048	96.9
North West Ambulance Service NHS Trust		371,219	387,532	95.8
South Central Ambulance Service NHS Trust		127,285	133,426	95.4
S. E. Coast Ambulance Service NHS Foundation Trust		254,430	262,276	97.0
S. Western Ambulance Service NHS Foundation Trust		295,208	308,283	95.8
West Midlands Ambulance Service NHS Trust		354,292	365,078	97.0
Yorkshire Ambulance Service NHS Trust		259,727	266,967	97.3
Overall for period	**Higher is better**	2,753,827	**2,864,165**	**96.1**

The graph reveals that the London Ambulance Service achieved the requirement to complete 95% of all calls within 19 minutes..



Other Services
Our Patient Transport Services

Patient transport is an important part of our core business and whilst this service has its own dedicated management team it is fully integrated into our quality governance processes.

How do we keep our Patient Transport Staff up to date with changes?

We have continued to employ two fulltime Work Based Trainers who have been delivering new entrant and refresher training to our staff.

The Work based Trainers have been delivering refresher training on key topics such as oxygen therapy, diabetes and dynamic risk assessment as well as rolling out new core skills of pulse oximetry, and new vehicle training.

A total of 573 training sessions have been delivered to our total workforce of 149 staff.

What have we done to update our vehicles?

During 2013 we took delivery of fifteen new vehicles to a new Small Wheelchair Capable (SWC) specification. These vehicles are designed specifically for the conveyance of wheelchair and walking patients and are therefore smaller and less obtrusive that the larger ambulance sized vehicles. These additions to our fleet, along with disposal of older stretcher vehicles have seen the average age of our fleet reduce to 5.21 years.

How have the new vehicles benefited patients?

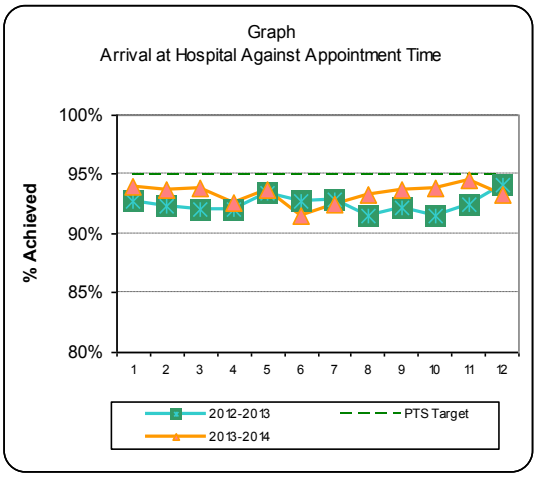
These new vehicles bring enhancements to patient and passenger safety and comfort such as all wheelchair capable vehicles having the facility to offer all wheelchair occupants a three-point seatbelt (with upper anchor point). Previously this was only available for the primary wheelchair position while the secondary wheelchair position lacked the upper anchor point.

We have made improvements to our fleet of three specialist bariatric vehicles with the addition of a revised stretcher that increases the capacity from 318kg (50st) to 450kg (70st) whilst also offering a wider patient surface area, and a new motorised tracked chair to convey seated patients up or down stairs that has a capacity of 227kg (35st).

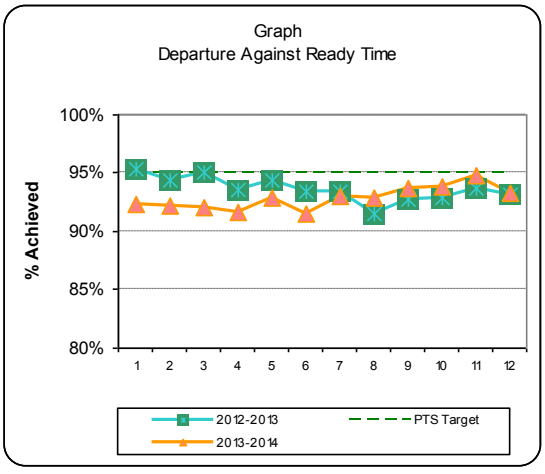
How have we performed against our contracted quality standards?

There are three Key Performance Measures that are common across all contacts. These are as follows:

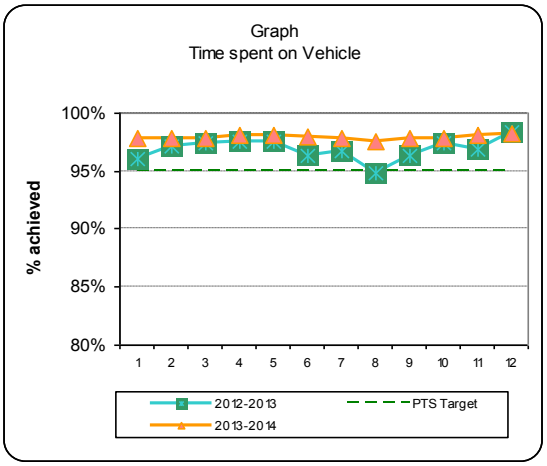
Appointment Time This is the arrival of a patient for their appointment within a time window as specified by the trust



Ready Time. This is he collection of a patient after their appointment within a time window specified by the trust



Time on Vehicle. This is the amount of time a patient spends from collection to drop off against a target specified by the trust



Overall we have seen a steady rise in our performance in all three of these targets (as shown in the chart below), and our performance is currently at its highest level over the preceding five years, this is set against a backdrop of the changing nature of healthcare provision within London such as the marked increase in on the day bookings where the patients is required to be collected within one hour of the request being made.

Table. To illustrate performance against the quality indicators in the contract over time.

Quality Standard	Appointment Time	Ready Time	Time on Vehicle
2009/2010	91.25%	92.81%	94.89%
2010/2011	90.22%	93.21%	95.47%
2011/2012	91.72%	92.69%	95.27%
2012/2013	92.49%	93.62%	96.89%
2013/2014	**93.37%**	**92.85%**	**97.92%**

Other Services
Our 111 Service at South East London (Beckenham)

We became responsible for the provision of 111 services to South East London (Beckenham) on 19 November 2013. Therefore, this section covers the period from 19 November 2013 to 31 March 2014.

Incidents

Incidents relate to a range of issues at LAS111. The majority since November have been relating to staff errors. The errors have been without any clear trend. However, one issue has been staff putting the wrong contact details into the computer system. This has been dealt with in terms of individual and wider learning. Other incidents have related to technical issues that have been addressed and resolved.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the ambulance crews and the GP Out of Hours (OOH) providers.

The majority of feedback was related to the perceived inappropriateness of the referral and whilst several have been upheld, many have occurred due to a poor understanding of the 111 system.

Staff Incidents

We have had very few staff incidents reported and they have all been very minor in their nature with the exception of two episodes of extremely abusive patients, both requiring Police intervention.

Authorised Confidentiality Breach

Authorised confidentiality breaches are logged when a patient has been referred to a service without their consent and /or knowledge. The breaches are used for patients where it is deemed not safe to leave them without further assistance or in the case of safeguarding, not safe to notify them i.e. domestic abuse where the assailant is still on the premises. The breaches are authorised at the time of the incident by a senior clinician within the call centre. We are currently working on a system to ensure that the clinical decision making relating to these calls is consistent across the clinicians.

Call Quality & Monitoring

Since 19th November we have exceeded the required standard for 1% percent of call audits every month with the exception of November when we had difficulty with the technology on site.

The compliance percentage has remained static and Call Handler figures have remained higher than clinicians each month. We have been working to understand the issues for the clinicians.

All staff are now logged on our new audit tool which is offers increased access to data for trend analysis on individual and group development and this will be reported on in the future.

Call Audit Data	Nov -13	Dec -13	Jan -14	Feb -14	Mar -14
Calls answered at 111	7505	21,426	23,411	22,722	26,053
% Call audits % (target 1%)	0.5%	2.1%	1.74%	1.94%	1.34%
No. Call audits	41	462	409	441	349
No. Call Handler audits	5	229	204	235	157
No. Clinical Advisor audits	36	233	205	206	192
% Compliance (target >86%)	85%*	72.7%	76.3%	76.8%	80.23%

*Data reflects period following Step-in 19-30 November 2013 only.

Call Handler Data	Nov -13	Dec -13	Jan -14	Feb -14	Mar -14
No. Call Handler audits	N/A	N/A	N/A	235	157
No. achieving compliance	N/A	N/A	N/A	196	139
% Compliance (target >86%)	N/A	N/A	N/A	83.4%	88.5%

Clinical Advisor Data	Nov -13	Dec -13	Jan - 14	Feb -14	Mar -14
No. Clinical Advisor audits	N/A	N/A	N/A	206	192
No. achieving compliance	N/A	N/A	N/A	143	141
% Compliance (target >86%)	N/A	N/A	N/A	69.4%	73.4%

End to End Call Audits

Monthly end to end call audits are undertaken at LAS111. The audits are attended by the clinical leads for the service. The subjects that have been reviewed thus far are:

- Non-conveyed ambulance referrals
- Calls that received an Emergency Department disposition
- 999 referrals and their appropriateness
- Calls relating to the CHIME service (see explanation) below in general governance activity

The end to end audits have all highlighted areas of good practice but also areas that require some improvement and we have been working consistently on them. Key areas for improvement were clinicians undertaking a systematic assessment considering the „whole patient picture" to make an appropriate decision within a timely overall call length.

Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 95 people in total to Social Services which equates to circa 0.09%. We have received three feedback reports from Social Services in total since November 2013.

Patient Experience

There is a requirement to survey 1% of patients that have called 111 for assistance. Due to technical and logistical issues, the 111 patient surveys did not start to be sent out until April 2014. We have not received any responses to date and therefore are unable to produce any data relating to patient satisfaction; however our patient concern /complaint level has remained low.

Language Line use has been low and this is in line with figures provided by the previous provider. We have taken steps to remind staff of the availability of language line and have recently added this area to the call audit information in order to ensure staff receive feedback.

Training

We have now commenced emergency life support courses for all staff at Beckenham. Staff are really keen to get involved and it will help them to understand some of the advice that they are giving as well as addressing issues that have been historically raised through incidents.

We have also had our first refresher training on Mental Health facilitated by the Trust‟s Mental Health Advisor. We are initially asking clinicians to attend and will then amend the session to enable Call Handler refreshers. We are still reviewing capacity tools for telephone use to assist with clinician decision making.

All staff have undertaken two periods of mandatory training since November 2013 relating to the changes to our software; Pathways. This has all been achieved within the required timescales. Staff have also completed the mandatory training elements relating to adult and child safeguarding and Information Governance.

Quality Measures

We have a number of Quality Measures that we use to monitor the service. These are as follows:

26% of calls were referred to a clinician - within acceptable parameters

2% offered a call back (no clinician available for immediate transfer) - target 98%

80% received call backs in less than 10 minutes (average 7 minutes /longest 1.18 hour) -target 100%6 patients waited for over 1 hour for a call back -no target

9% of dispositions were ambulance dispatch and 81% of those calls were conveyed by the ambulance service - this is favourable when compared to national performance standards and is used for monitoring trends rather than aiming for an exact target


London Ambulance Service
NHS Trust
NHS
Date 17 DECEMBER 2013
Pay THE MAYPOLE PROJECT
TWENTY NINE THOUSAND, FIVE HUNDRED
AND TWENTY THREE POUNDS ONLY
£ 29,523
London Ambulance Service
NHS Trust
171213 £29.523
Chief Executive

2014/15 Quality Priorities
Our improvement priorities for 2014/15

In our 2013/14 Quality Account we outlined how we were going to rise to the challenge in meeting the continuing increase in demand of over 100,000 calls a year. This was to be met through a comprehensive two-year transformation programme. An end of year report has been provided within this Quality Account. 2014/15 will be the second year of this programme.

The transformation programme is a large programme of work and it will affect everyone working in the service. However, we have also identified a number of other improvement priorities that will be taken forward in 2014/15.

The remaining actions in the transformation programme and the other priorities are described on the following pages.

Our Transformation Programme

Changing our Front Line Workforce

During 2014/15 we will be changing the way we staff our ambulances. Currently a small proportion of our ambulances can respond to only a limited number of calls because of the skill levels of the members of staff who work on the those ambulances.

To provide a better service to our patients and to allow us more flexibility we have developed a more skilled role which will enable all our ambulances to respond to a full range of calls. We expect this new role to be introduced during the summer of 2014

Changing the way we respond to patients

Historically, we have sent a single responder as well as an ambulance crew to many calls in a bid to achieve our response time targets. This is not the best way to use our resources; it does not necessarily benefit our patients and it means that staff are regularly cancelled when they are on their way to a call.

In 2014/15 we are going to reduce the number of resources we send to individual incidents. We estimate that by responding differently we can reduce the number of occasions on which we send 2 or more resources to incidents which will in turn enable us to have more capacity to treat other patients who would otherwise have to wait longer.

These changes will be introduced when our new front line workforce model has been implemented.

Aligning resources to meet demand

In 2014/15 we will be introducing new on duty rosters for all our front line staff. These rosters will ensure that we more closely match the number of ambulances and solo responders (cars and motorcycles) we have available to the peak periods of demand for our services.

We are planning to introduce the new rosters during the summer of 2014.

Recruitment and retention

There are some national challenges in recruiting registered clinicians to the ambulance service and London has some unique factors, such as accommodation and transport costs, that make this additionally challenging.

We are putting together a comprehensive plan for recruitment and retention and have made this a corporate priority.

Strengthening the Patient Voice

We recognise the need to strengthen the way we involve patients in our decision making and our service design.

During 2014/15 we will be publishing our new five year strategy and this is an ideal opportunity in involving patients and stakeholders in the strategic decisions contained within the strategy.

In addition, we will seek further opportunities to involve patients by moving towards a culture of “no decision without us”.

Our intentions will be outlined within our engagement strategy.

Strengthening the staff Voice

We recognise the need to involve our staff in the decisions we make and establish stronger processes for obtaining staff feedback.

We strengthened our staff involvement last year through our Listening into Action programme. We will reflect on this during the year and identify further opportunities.

Improving the care of Mental Health Patients

We have decided to revisit mental health care as an area for quality improvement during 2014/15. This will be our main clinical priority and will roll into 2015/16.

Mental healthcare is moving up the agenda nationally and continues to do so within the Trust. In line with the national mental health agenda, we have identified four specific areas of improvement this year.

While we continue to have mixed results this year there is evidence of improvement in the delivery of high quality responses and care when people with a mental illness urgently need help.

Training & education

Last year we undertook mental health training within our control environment and at some of our local stations. This training was unique for us in that it was undertaken by patients with mental health conditions. It was hugely successful and we wish to build upon this in 2014.

This year we are concentrating on improving the internal clinical interventions and management of a mental health crisis. As part of the main training programme for 2014/15, the Mental Health Module provides the opportunity to review and refresh existing knowledge and to provide further information and guidance for a variety of scenarios.

A new session on dementia and a mental health risk awareness tool has been added to the programme.

We have also focused on delivering face to face training for our Clinical Team Leaders and Advanced Paramedic Practitioners with sessions including issues on the national agenda including the national section 136 protocol.

This year we also aim to improve the knowledge and skills of our staff working in the control room by introducing mental health nurses into that area.

Patient engagement and learning from patients

We have decided we need to work with patient representative groups to determine what good looks like and identify areas of improvement that are important to our patients.

The Trust has been working closely with Hear Us, a mental health charity in the previous year. We intend to continue this engagement process with the support of our Community Involvement Officers in the development of a patient experience action plan to monitor the impact of any changes.

Data recording for mental health patients

The Trust recognises that we capture and generate a tremendous amount of information which is only useful if it can be applied to create knowledge within the organisation. We would like to improve the way we capture and record mental health data to ensure that are capturing the right information

so that we can measure the impact of future canges.

We plan to review mental health coding on the patient report form to allow a more meaningful data analysis.

We want to ensure that mental health complaints and incidents are captured and readily available and to ensure that Appropriate Care Pathways are coded and captured correctly to allow for monitoring and evaluation.

This will allow the Trust to make more effective use of the mental health data we hold and use accurate information to inform decisions.

Effective partnership working

In the previous year we have rolled out mental health alternative care pathways that were agreed with all ten Mental Health Trusts across London which have allowed to reduce the number of patients inappropriately conveyed to the Emergency Department.

Whilst there has been improvements in this area we would like to further improve our relationship with Mental Health Trusts. We want to ensure representation at other key groups in cementing the role of the Trust as a mental health partner.

Feedback
Comments from our partners and stakeholders

We are obligated to give stakeholders the opportunity to comment on our Quality Account and to then publish their comments in full.

This year we invited the following organisations/groups to respond.

- Southwark Healthwatch
- Hillingdon Oversight & Scrutiny Committee
- The London Ambulance Service Patients" Forum
- The London Ambulance Service Commissioners

We would like to thank those organisations/groups for taking the time to read and respond. Their comments are published in this section.

healthwatch Southwark

London Ambulance Service Quality Account 2013/14

Healthwatch Southwark is pleased to provide the following comment to the London Ambulance Service (LAS) Quality Account for the second year running and are in agreement with the priorities for 2014/15. The comment contains a brief review of the performance relating to the quality priorities for 2013/14.

The account contains reference to the Modernisation Programme and the challenges relating to commissioning across 32 boroughs, the scale and challenges of which are appreciated. Any work that goes towards increasing the quality & safety of services as well as increasing excellent patient experience is welcomed.

With regards to the review of the 2013/14 priorities it is encouraging to see that the numbers of complaints regarding staff conduct has decreased. It would be useful to know whether LAS believe this is a result of the staff training.

Regarding the less urgent patients waiting longer than LAS would like we concur with patients that it would be beneficial to work out a way that patients who are waiting are kept up-to- date with progress on their call. We understand that resources are an issue however the complaint regarding poor communication could be resolved and we endorse LAS‟s move to improvement this. Patient education and information provision is crucial for LAS to undertake as you have a reach to thousands of people each year. Each part of the health system needs to play its part in helping people to understand the range of services available such as 111 and Urgent Care Centres.

We note and applaud the improvements below and look forward to further improvements being reported:

Outcome from acute ST-elevation myocardial infarction (STEMI) the improvement in compliance from 67.3% to 76.1 % in 2013/14.

Outcome following stroke for ambulance patients the compliance for 2013/14 is 94.7 where the year it was 94.1%. Though this is a slight improvement as is written it is still to be applauded as a step in the right direction. Last year we requested an explanation for the difference in the percentage of patients suffering a STEMI who receive an appropriate care bundle i.e. in London (67.3%) as compared to the highest percentage of the Great Western Ambulance Service (94.1%) and this is still an issue we would like to discuss.

Category A8 minute response time LAS achieved the requirement to complete 75% of all A8 calls within eight minutes and achieved the requirement to complete 95% of all calls within 19 minutes.

STEMI and Stroke patients appropriate care bundle provision the improvement from 2012-13 figures to the 2013-14 data is commended however this is still below the national average. This is an area that we would like to explore with LAS to find out the reasoning behind this.

Regarding the **priorities for 2014/15** Healthwatch Southwark agrees with the LAS that these should be the focus for this year. We look forward to the new patient and public engagement arrangements that LAS will be putting into place which includes local Healthwatch and the current Patient Forum. As Mental Health service quality improvement is also one of our priority areas we look forward to joining forces with LAS on this issue.

There are a number of subject areas in the report that Healthwatch Southwark and not doubt other local Healthwatch would like to discuss with the LAS including Patient transport, patient experience and the use of the language line within the 111 service. We look forward to further improvements in the way in which we work with the London Ambulance Service.

Healthwatch Southwark

THE LONDON AMBULANCE SERVICE NHS TRUST
Consultation on the Trust's Quality Account - 2013/2014
Response on behalf of the External Services Scrutiny Committee at the London Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust‟s 2013/2014 Quality Account report and acknowledges the Trust‟s commitment to attend its meetings when requested. The Committee commends the Trust for the excellent service that it provides and notes that a lot of work has been undertaken by the LAS to ensure that plans and actions are being put in place to improve those areas where concerns have been identified

Although it is understood that the format and content of the Quality Report is largely predetermined, the Committee believes that it would benefit from the use of more digestible language and less "organisational speak". In addition, Members believe that the report could be strengthened by the use of better time serialised data going back five years to identify trends and show a course of direction. Nonetheless, the Committee applauds the LAS for the range of indicators that it measures which will help the Committee to monitor the organisation's progress in improving its performance over the next year.

Over the last year, the findings detailed within the Francis Report, Berwick Report and Keogh Review were primarily written from the hospital perspective. However, the Committee is pleased to note that the Trust is keen to learn from directly transferable lessons – this has led to proposed improvements such as the introduction of a Duty of Candour and the development of a patient engagement strategy. Furthermore, these publications‟ findings will inform the development of the Trust‟s new Quality Strategy which we look forward to seeing in 2014/2015.

Members are pleased to note that, for the eleventh consecutive year, the LAS has delivered on its target to reach 75% of its most urgent patients within 8 minutes. However, the Committee is concerned that other road users are frequently hindering the emergency vehicles' progress to their destination. It is suggested that consideration be given to how the Members could possibly help to raise awareness of the implications of this type of inconsiderate driving. The Committee believes that this could help reduce the number incidents where the Trust is deemed to take too long to get to an incident.

Mental healthcare is moving up the agenda nationally. As such, it is encouraging to note that mental healthcare has been identified as the main improvement priority for the Trust during 2014/2015, identifying four specific areas for improvement: training

and education; patient engagement and learning from patients; data recording for mental health patients; and effective partnership working. It is anticipated that further improvements in these areas will result in a reduction in the inappropriate use of resources.

There have been a number of recent reports in the media in relation to the number of patients being held in ambulances outside Accident and Emergency departments as, for various reasons, they are unable to be transferred into the building. Although, the Committee is aware that this is in no way the fault of the ambulance service, Members felt that it would have been useful to mention this issue within the report as it is clearly a threat to the availability of resources and therefore the quality of service provided by the LAS.

There is a continuing problem where members of the public are still presenting at Accident and Emergency departments for minor ailments that could be seen by a GP – these individuals are using the service as a first resort rather than for emergencies only. Furthermore, ambulances are also being used by some people as a convenient way to get to hospital rather than making their own arrangements. With the rapidly growing demand on the Trust‟s limited resources, Members feel that further consideration could be given to working in partnership to re-educate the public about a more appropriate use of the health services that are available to them. To this end, Members are pleased to note that the LAS is routinely asking those patients with minor ailments whether they are able to get to the hospital under their own steam.

Overall, the Committee is pleased with the continued progress that the Trust has made over the last year and the excellent service that it continues to provide, but notes that there are a number of areas where further improvements still need to be made. We look forward to receiving updates on the progress of the transformation programme and the work to support the priorities outlined in the report over the course of 2014/15.

Hillingdon Oversight & Scrutiny Committee

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

QUALITY ACCOUNT FOR 2013-2014

Thank you so much for inviting the Forum to contribute to your Quality Account for this year. We present below our contribution to the LAS"s Quality Improvement Priorities for the Quality Account.

1) **OUR RELATIONSHIP WITH THE LONDON AMBULANCE SERVICE**
   The Patients" Forum values continuous engagement with the LAS in relation to discussions about all aspects of LAS performance and clinical care. This engagement takes places at the seven internal LAS committees on which the Forum is represented: Patient and Public Involvement, CQSEC, Learning from Experience, Equality and Inclusion, Mental Health, Infection Prevention and Community Responder. We also actively engage with the Trust Board at their meetings and at meetings with leaders of the LAS. The Forum also values the contributions by the Chair, Chief Executive, Directors, the Head of Patient & Public Involvement and Public Education and other LAS leaders to our monthly Forum meetings held in the LAS Conference Room. Close regular contact with the commissioners for the LAS also enables the Forum to exercise influence in relation to the quality and performance of LAS services.

2) **QUALITY ACCOUNT FOR 2012-2013 - REFLECTIONS FROM BERWICK**
   We have received no formal feedback to the Quality Account Statement we submitted for the previous period.

3) **PROTECTING PATIENTS FROM AVOIDABLE HARM – THE HIGHEST PRIORITY**
   We welcome the LAS"s commitment to take all patient feedback very seriously, and their review of the management of the investigation of serious incidents. In keeping with the priorities highlighted by the Francis and Berwick Reports, providing the safest and most effective care for patients must be the highest priority for the LAS. Reporting, investigating and learning from patients safety incidents and complaints must be fundamental to ensuring patient are safe and evidence produced that learning on incidents and accidents is constantly taking place. Patients must always be told when they have been harmed due to clinical errors. The LAS should ensure that all ambulances carry equipment that is clean and sterile; shortfalls in infection control are always taken seriously and acted upon; required clinical equipment is always available, e.g. tympanic thermometers, when needed, is intact and up to date.

   WE RECOMMEND that the LAS publishes in the public arena the outcome of all incidents, complaints and accidents investigated, where there are recommendations for service improvement; with evidence demonstrating enduring improvements to service quality and safety, and

evidence of staff and organisational learning and implementation of recommendations.

4) **PRE-HOSPITAL DEMENTIA CARE WILL BE TRANSFORMED**

The Forum is pleased that the LAS has started to focus more specifically on the need of patients with cognitive impairment. The LAS should develop clear effective dementia pathways with the LAS commissioners (CCGs), acute hospitals and where possible community care professionals to ensure „right care first time" for patients with dementia and cognitive impairment. LAS should continue the development of its Clinical Support Desk to ensure its capacity and expertise to advise clinical staff on meeting the needs of people with dementia, especially with regard to assessing cognitive impairment and pain.

WE RECOMMEND the LAS should produce evidence to demonstrate that front line staff have continuous education and training in this area. This should include access to Health Education England training resources. See also section on mental health (4) below. Access to appropriate care pathways for patient with cognitive impairment must become fundamental to providing right care, first time.

5. PATIENTS WHO FALL SHOULD ALWAYS RECEIVE INTEGRATED CARE

The Forum welcomes to decision of the LAS to upgrade calls from patients who have fallen, and their participation in research into the need of these patients (SAFER 2). When patients fall and do not require access to hospital acute care, paramedics should have direct access to local Falls Teams, in order to ensure expert clinical advice and care for these patients and avoid inappropriate transfers to A&E. We welcome the CQUIN for an Enhanced Falls Service for 2014/5

WE RECOMMEND that the LAS ensures care for people who have fallen is provided within appropriate time-scales, and includes agreed care pathways and integrated care plans, with clear governance mechanisms to ensure care plans are fully implemented, enable appropriate access to services and demonstrate clear outcomes for the patient.

6. CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS MUST BE TRANSFORMED

We commend the LAS for the considerable progress that has been made in the prioritization of care for people with mental health problems. However, we are concerned that E-learning approaches have been adopted as the main vehicle for training of staff. We are very pleased that work is developing with mental health Trusts to create effective mental health pathways which should help to divert patients away from A&E departments, to more appropriate community care – however, this approach needs to gather pace and speed to ensure implementation in the short term. We are very pleased that the Chief

Executive is providing leadership by chairing the LAS Mental Health Committee to ensure implementation of this improvement priority.

WE RECOMMEND that the LAS develops a specialist front-line team of paramedics and nurses who are expert in the care of patients with a mental health diagnosis. All paramedics and A&E support workers should be continuously and dynamically trained in the care of people with mental health problems, bearing in mind the special needs of people with learning difficulties and the need focus on cultural, language and age related issues. A significant proportion of this training should be live rather than via e-learning, as interpersonal skills and attitudes appropriate to this group of patients need to be practiced, evaluated and demonstrated.

7. EXCELLENT END OF LIFE CARE MUST ALWAYS BE PROVIDED

The LAS should continue to develop its excellent work with Advance Care Plans (ACP), End of Life Care (EoLC) and CoOrdinate My Care (CmC). Protocols should be developed between the LAS and London‟s CCGs and GPs to ensure that CoOrdinate My Care (CmC) is fully developed to meet the needs of people who have an Advance Care Plan. We welcome the CQUIN for End of Life Care for 2014/5.

We RECOMMEND that the LAS enables far greater number of people to access appropriate care through CoOrdinate My Care (CmC). The LAS should publish examples of good practice in 'end of life care' for front line staff, together with evidence of outcomes showing the effectiveness of appropriate and compassionate care for these patients.

8. DELAYS IN PROVIDING URGENT AND EMERGENCY CARE ARE NOT ACCEPTABLE

We congratulate the LAS on the achievement of its Category A targets. Vulnerable patients who have requested emergency care must never be left waiting for LAS care.

Patients requiring a slightly lower level of care, who are vulnerable, who are in pain, who have fallen, or taken an overdose, should not have to make repeated calls to the LAS to get help. Such delays suggest a significant breakdown in care provision and are the cause of many complaints to the LAS. This particularly concerns patients categorised as needing care classified as C1 and C2. We understand the limitations caused by a shortage of staff and resources.

WE RECOMMEND that urgent action is taken to promote recruitment to the LAS front line from schools, universities, job centres and religious/cultural centres in London. The work-force must be enlarged to ensure that the Category C targets which follow are always met:

Category C1 – 90% within 20 minutes, 99% in 45 minutes (from Clock Start)
Category C2 – 90% within 30 minutes, 99% in 60 minutes (from Clock Start)

Achievement of targets in 2013/4 were as follows:
Category C1 – reached in 20 minutes – 72.88% (target 90%)
Category C2 – reached in 30 minutes – 66.88% (target 90%)

9. STAFF SHIFT PATTERNS SHOULD BE FULLY EVALUATED

There is considerable national and international research pointing to the deleterious effects of shift work, including shift work patterns on both short and long term physical and mental health. Some staff members are not suited to shift work and able to remain healthy as well, but are excellent front line clinicians.

WE RECOMMEND that the impact of long shifts on front line staff is fully evaluated by the LAS, especially in relation to the impact of 12 hour shifts, without adequate meal breaks and rest on: clinical care; the health of staff; training and complaints against staff, e.g. in relation to attitude and behaviour. Staff should be interviewed about the effects of shift work on their health and clinical practice during annual appraisals, and be involved in development of improved alternatives.

10. APPROPRIATE CARE PATHWAYS SHOULD BECOME FULLY OPERATIONAL

It is critical for the LAS to work with partners across health and social care to integrate services so that patients get better, more appropriate care and experience better clinical outcomes. „Right Care First Time" should become the norm.

WE RECOMMEND that care pathways are developed by the LAS in conjunction with CCGs, acute trusts and providers of community care that are robust enough to give confidence to LAS crews, patients and carers that these pathways are available when required, clinically appropriate, fully-funded, subject to regular clinical audit and tests of reliable and continuous access, i.e. effective governance.

11. LAS SHOULD ACTIVELY SEEK TO BE INFLUENCED BY PATIENTS AND THE PUBLIC IN ALL THAT IT DOES

We welcome the decision of the LAS to involve patients and stakeholders in the development of their strategy and a new culture of "no decision about us, without us". The recent meeting on the PPI strategy was exemplary. The LAS should secure public involvement in the planning, development and consideration of all significant proposals for changes and decisions affecting the operation of the LAS.

WE RECOMMEND:

- **Engagement with FT members, the Patients' Forum, patient groups, the voluntary sector and Healthwatch to ensure patient involvement in all aspects of the LAS's work.**
- **Holding wider public engagement around prioritisation and service re-design.**
- **Promoting the public education role of the LAS.**

- **Developing a wide range of methods to seek public views on LAS services and providing feedback.**
- **Acknowledging the value that the LAS places on the knowledge, insight and understanding of the contribution of patients and carers.**
- **Trust Board members should enhance their public accountability by listening more to and meeting the public and acting on what they say.**

12. EQUALITY AND DIVERSITY

Excellent work has so far been done in relation to LGBT colleagues and the employment of women. Reflecting on the LAS workforce and comparing its diversity to the current diversity of London and its future growth demonstrates a substantial need for development. We have argued this point for several years but have seen little change in the diversity of the LAS workforce and no change in the ethnic and cultural diversity of the LAS Board. We would not be satisfied to be told this matter will be dealt with in the post 2020 period bearing in mind that the difficulties experienced by the LAS to recruit locally, despite the very fulfilling professional opportunities for front line staff, and the need to recruit from Denmark and New Zealand.

WE RECOMMEND that the LAS embed diversity into all aspects of public education, recruitment and training and ensure full inclusion and sensitivity toward patients and staff with any protected characteristics, not solely LGBT. Changes must be made at all levels in the LAS, including the Board, to embed these duties.

ISLINGTON

Housing & Adult Social Services
7 Newington Barrow Way, London N7 7EP

Report of: Corporate Director of Housing & Adult Social Services

Meeting of	Date	Agenda Item	Ward(s)
Health & Care Scrutiny	19 October 2015		All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Safeguarding Adults Partnership Board Annual Report 2014/15

1. Synopsis

1.1. This report sets out highlights and progress of the council's leadership of adult safeguarding arrangements in the borough.

1.2. The published Annual Safeguarding Review, attached as appendix 1, describes this in more detail.

2. Recommendation

2.1 To note the contents of this report and to commend adult social services staff for their commitment to preventing abuse where possible and responding to concerns of abuse or neglect of vulnerable Islington residents.

3. Background

3.1 Under the Care Act 2014, Islington Council has a statutory responsibility to lead the borough in safeguarding adults.

3.2 Key achievements

- We delivered training to 1876 people (an 18% increase on the previous year).
- Deprivation of Liberty Safeguards applications surged. In spite of this, we managed to turn around most applications within timescales although we had to take on extra staff to do this.
- The Government has asked the Law Commission to look at how deprivations of liberty can be improved. Consultation on draft proposals began in July 2015 and will continue until

November 2015. A draft bill is expected in 2016. Current proposals consider extending local authorities' responsibilities for authorising Deprivation of Liberty Safeguards (DoLS) in community settings for example supported living placements. Presently these need to be authorised by the Court of Protection. It is not known what will survive into the draft bill.

- We checked whether partners have appropriate policies, procedures and practices in place on non-engagement, refusal of services, carers and domestic violence.
- In addition to the range of safeguarding adults leaflets in already available in community languages, a Chinese leaflet is now available.
- More information about the work of the Board is now available in easy read format.
- The views of Islington residents have been sought, both formally and informally, with a significant focus on how partners handled and responded to complaints.
- We got assurance from health partners on work being done to link pressure sores with possible safeguarding concerns.

The annual report further details progress on delivering the Islington Safeguarding Adults Board's 3-year strategy and annual plan.

3.3 The review compares the statistics from 2014/15 with the previous year 2013/14. There has been no change in the number of safeguarding alerts from the previous year (1165 alerts). Investigations have increased 12% on last year. This is a positive trend in that it shows people are getting slightly better at knowing when to report concerns about neglect and abuse.

3.4 Physical abuse, financial abuse and neglect have remained the top three categories for several years. The picture is similar across the country.

3.5 The percentage of cases which were substantiated or partially substantiated (that is, the abuse was likely to have taken place) has risen by 20% in the last year.

3.6 Key Developments

- The Care Act 2014 came into effect. New categories of abuse have been recognised in the Act: modern slavery, domestic violence and self-neglect.
- Islington had its first serious case review for a number of years. The serious case review report has been published and can be downloaded here. We are working on an action plan to learn the lessons from this case.

4. Implications

4.1 Financial implications

The Safeguarding Adults Unit 2014/15 gross expenditure outturn was £565k. Of this, £87k was funded through the Islington Clinical Commissioning Group (ICCG).

The Safeguarding Adults Unit 205/16 gross expenditure budget is £1.02m. This includes a net increase of £450k on the 2014/15 budget due to the recent Supreme Court judgment in the 'Cheshire West' case which extended the definition of the Deprivation of Liberty Safeguards (DoLS), and has meant the number of people eligible for DoLS assessments has increased significantly.

There are no financial implications arising as a direct result of this report.

Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

4.2 **Legal Implications**

The Care Act 2014 (the Act) which came into force in April 2015 established the first statutory framework for adult safeguarding. Sections 42-47 of the Act set out the provisions for safeguarding adults at risk of abuse and neglect. Section 42 of the Act imposes a duty on each local authority to establish a Safeguarding Adults Board (SAB) for its area, Paragraph 4 of Schedule 2 of the Act requires the SAB to prepare an annual report, and specifies the matters that must be included in the report. The Act did not introduce additional arrangements for SAB's but put the arrangements before April 2014 on a statutory footing.

The Government has asked the Law Commission to look at how deprivations of liberty can be improved. Consultation on draft proposals began in July 2015 and continues until November 2015. A draft bill is expected in 2016. Current proposals consider extending local authorities' responsibilities for authorising Deprivation of Liberty Safeguards (DoLS) in community settings for example supported living placements. Presently these need to be authorised by the Court of Protection. It is not known what will survive into the draft bill.

4.3 **Equalities Impact Assessment**

The council must have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

Appendix B of the full annual review (attached) sets out the equality impact of work to safeguard adults who are at risk in Islington.

4.4 **Environmental Implications**

There are no major environmental impacts associated with the Safeguarding Adults Board. Minor impacts such as transport-related emissions and office-based resource usage (energy, paper etc.) are managed by staff by actions including not printing documents unless absolutely necessary, using video-conferencing and encouraging walking, cycling and the use of public transport. Some work has the potential to benefit the environment, such as reducing fire risk or referring service users to the SHINE service, which gives advice to residents on saving energy.

5. Conclusion and reasons for recommendations

The annual safeguarding review sets out the main achievements in safeguarding vulnerable and disabled adults in Islington and details our aims for achieving our strategy and annual plan.

Attachments:

Appendix 1: Islington Safeguarding Adults Board Annual Review 2014-15

Final report clearance:

Signed by:

Corporate Director – Housing and Adult Social Services Date: 13 August 2015

Received by: Head of Democratic Services Date:

Report author: Elaine Oxley
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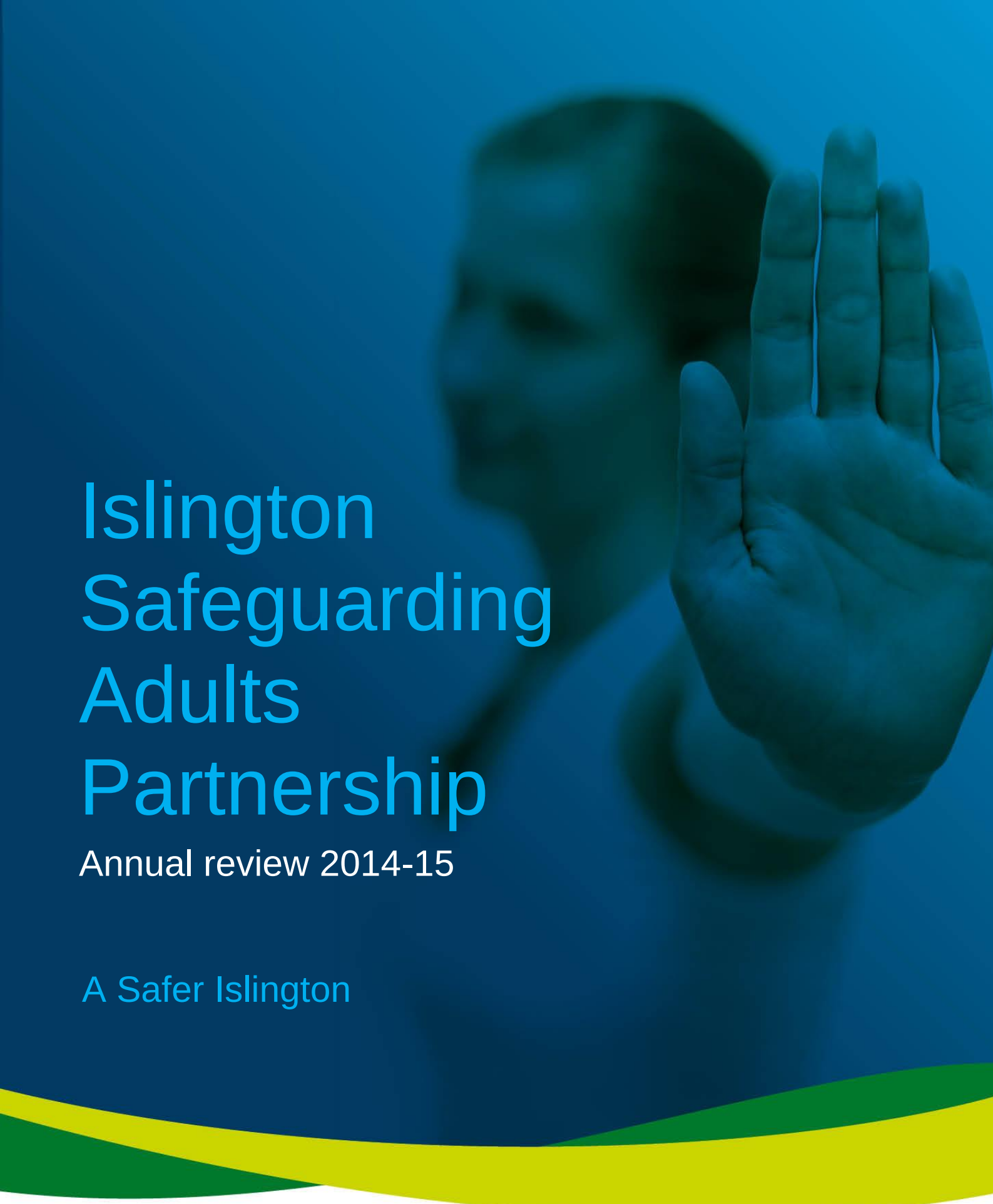


Islington Safeguarding Adults Partnership

Annual review 2014-15

A Safer Islington

NHS

METROPOLITAN POLICE

ISLINGTON
Working in partnership

Foreword

Thank you for your interest in safeguarding adults in Islington. As independent chair of the Adult Safeguarding Board I am pleased to be introducing this Annual Report. This has again been a challenging year for the partnership with all partner organisations experiencing significant challenges in this period of austerity. Nonetheless we have done everything we can to ensure we keep adults at risk as safe as possible.

The partnership has continued to strengthen this year and the contributions of all partners are detailed in this report. Islington Clinical Commissioning Group has been a great support in helping to ensure good quality services are available in Islington, particularly by providing advice on good medical and nursing practice. Their work has helped to greatly improve the quality of care provided in nursing homes in Islington. The Metropolitan Police continue to play a key role in the partnership and their support and advice has been greatly valued. The local NHS Trusts have all helped to provide examples of good practice and contributed willingly to the work of the Board. The voluntary sector partners and Healthwatch help us to keep in touch with the wider community in Islington. The London Fire Brigade has been key to helping us with our preventive work. This year we have also involved Probation and the local prisons with our work. I am very grateful for the support of all partner organisations and the safeguarding team in developing our work.

We have continued to raise public awareness about what adult safeguarding is and how people can report concerns they may have about an adult at risk. All partners have contributed to this work and ensured that information about adult safeguarding is included in their public events. The number of referrals for investigation as adult safeguarding enquiries continues to increase year on year. Financial abuse is a significant issue in Islington representing a quarter of all referrals and we will work with financial institutions and the police to minimise this. We have heard nationally in recent years of cases where adults have suffered harm in care homes and hospitals. We continue to work with Clinical Commissioning group to monitor the quality of these services in Islington. More than half of the alleged abuse in Islington occurs in peoples own homes and we rely on the vigilance of local organisations and people to bring these to our attention.

I would particularly like to thank Sean McLaughlin Director for Housing and Adult Social Services at Islington Council for his support, thoughtfulness and enthusiasm. I would also like to thank the Councillors in Islington for their interest and encouragement. Particular thanks are due to Councillor Janet Burgess whose unfailing support and dedication is hugely valued. Lastly I would like to thank the people of Islington for their vigilance.

Marian Harrington
Independent Chair
July 2015

Contents table

About us

We are a partnership of organisations in Islington all committed to working together. All our work is centred on safeguarding adults at risk from any kind of abuse and neglect.

Who makes up the partnership?

Age UK Islington – Andy Murphy, Chief Executive Officer

Camden and Islington NHS Foundation Trust – Claire Johnston, Director of Nursing

Camden and Islington Probation Service – Senior Probation Officer

Care Quality Commission – Jane Ray, Compliance Manager

Crown Prosecution Service – Borough Prosecutor

Healthwatch – Geraldine Pettersson

Independent Chair – Marian Harrington

Islington Clinical Commissioning Group – Martin Machray, Director of Quality and Integrated Governance (and Vice Chair)

Islington Clinical Commissioning Group - Dr Rathini Ratnavel

Safer Islington Partnership – Alva Bailey, Head of Service, Community Safety, Islington Council

Islington Council – Sean McLaughlin, Corporate Director for Housing and Adult Social Services

Islington Safeguarding Children Board – Wynand McDonald, Board Manager

London Ambulance Service, Islington – Patrick Brooks, Community Involvement Officer

London Fire Brigade, Islington – Patrick Goulbourne, Borough Commander

Metropolitan Police, Islington – Paul Cheadle, Detective Chief Inspector

Moorfields Eye Hospital NHS Foundation Trust – Tracy Luckett, Director of Nursing & Allied Health Professionals

Notting Hill Housing Trust – Lyn Lewis, Head of Operations

Single Homeless Project – Liz Rutherfoord, Chief Executive

Whittington Health NHS Trust – Christine Dyson, Deputy Director of Nursing & Patient Experience

Introduction

This review looks at what we, the Islington Safeguarding Adults Partnership, have done in the last year to safeguard adults at risk in Islington.

Anyone can be vulnerable to abuse or neglect, but adults who have disabilities, mental health needs, who are ill for a long time or are older, are particularly vulnerable to abuse or neglect.

Safeguarding in the Headlines

In April 2015, **The Care Act 2014** came into effect. This Act requires Local Authorities to set up Safeguarding Adults Boards and for the first time gives a clear legal basis for taking action to safeguard adults.

The Act also puts in place a legal framework so that key organisations and individuals can agree on how they work together, for example, the local authority, the NHS and the police as well as a range of other local organisations. In Islington, we have been preparing for our new responsibilities under the Care Act. We are confident that we have in place a Safeguarding Board which represents a range of different organisations who play a key role in safeguarding adults. We have been negotiating a new **Constitution** for our partnership to better reflect the work we will be doing together under the Care Act.

We are positive that the new legislation will strengthen and enhance the work that we have already been doing with adults at risk who have been exploited or abused.

New categories of abuse have been recognised in the Care Act. They are:

- Modern slavery
- Domestic abuse
- Financial abuse
- Self-neglect

Under the new legislation, carers' vulnerability to abuse must also be considered.

Other developments

Over the last year there have been many other developments across the country relevant for safeguarding adults. Here are just a few:

- The Care Quality Commission has a new model for inspecting care homes, hospital and other providers. The new standards have a greater focus on dignity and compassion.
- A Fit and Proper Person test has been introduced for managers of care provider organisations.
- An independent review into creating an open and honest reporting culture in the NHS has been conducted by Sir Robert Francis. The report includes recommendations on how to encourage whistle-blowing in the NHS.
- Much attention has been given to the Government's national and global Dementia Challenge – a programme of action to transform the health care of those with dementia.
- The Department of Health is collecting different data on safeguarding adults. This means we are able to report more fully on what steps we are taking to safeguard adults at risk of abuse and neglect.

- The Modern Slavery Act has passed into law. It is the first of its kind in Europe to specifically address slavery and trafficking in the 21st century.

News on prosecutions

For the first time in the UK, a female genital mutilation case was prosecuted. The case was brought against a doctor working in the Whittington Hospital but he was found not guilty.

Significant cases

The so-called 'Cheshire West' case has triggered a surge in Deprivation of Liberty applications across the country. This has placed pressure on all councils and social workers and frontline staff as they have had to deal with the increase in demand. Islington is no exception to this. Read more about how we are dealing with this in Section 11.

The Government has asked the Law Commission to look at how deprivations of liberty law could be improved. Consultation on draft proposals will begin in July 2015 and a draft bill is expected in 2016. It is likely that the bill will extend local authorities responsibilities for authorising Deprivation of Liberty Safeguards (DoLS) in community settings, for example supported living placements. Currently these need to be authorised by the Court of Protection.

You said, we did

We listened to what you told us. You asked us to do more to raise awareness about safeguarding adults and seek out people who might be harder-to-reach.

So, we focused our attention on 'Safeguarding Week' in early June 2014. Every year, we hold a community conference, but we wanted to make sure that we connected with a wider audience too and had more impact on people who would not otherwise come to an event such as our Community Conference. To do this, we held two community outreach events alongside our usual community conference.

Community outreach

We took safeguarding to the public by having:

- An information stall at the **Whittington Hospital NHS Trust**. This busy hospital was an ideal place to capture the through traffic of patients and staff. Patients were interested in our safeguarding work; and staff showed interest in our Mental Capacity Act and Deprivations of Liberty Safeguards work.

- An information stall in **Chapel Market**. This proved very popular and we spoke to a large number of people raising awareness of neglect and abuse, particularly financial abuse. Many people discussed their personal concerns and worries with us.

Community Conference

Themed 'Safer You, Safer Community, this year's **Community conference** was well received. The conference is generally well attended and this year was no exception (84 people) .The target audience was service users and members of the general public who were older people. There were presentations from:

- Age UK on how they support older adults who may feel unsafe in their community
- Trading Standards who raised awareness about the latest scams and doorstep crimes and,
- The Community Safety Partnership. 'Your Life, Your Say', a service user drama group based at Outlook Islington presented the conference with a dramatized scenario called 'Vulnerable Street'. The drama scenario explored concepts of safety in the community and sources of support.

Progress with our strategy

We are working harder than ever to safeguard adults from abuse and neglect in Islington. Our aim is to keep adults in Islington safeguarded from harm and at the forefront of all our activity.

We keep our vision statement in mind: “to improve safety and people’s feelings of safety by promoting the right of all who are vulnerable to abuse to live free from abuse and negelct”.

To ensure that we are effective in our efforts, we work to a 3-year strategy, with an annual delivery plan. Our strategy is based on 6 key areas of work. These 6 key areas are shown in the diagram below. For each key area, we agreed we would work on several actions. Our progress in achieving these is set out below.

Each member organisation in our partnership shares in implementing our strategy. Although Islington Council leads on safeguarding adults in Islington, all of our partners are expected to, and do, contribute to our overall strategy. On the next page is a list of specific pieces of work our partners have undertaken during the year:

Moorfields Eye Hospital NHS Foundation Trust - To ensure that patients are kept at the centre of safeguarding action, Moorfields completed a policy review to ensure that patients/service user's preferred outcomes are recorded in patient records. Learning from the review was shared with staff.

Whittington Health NHS Trust – To help embed the Mental Capacity Act (MCA) in everything they do, a barrister delivered six Mental Capacity Act training sessions to staff, including junior doctors. The MCA code of practice document is now available in every clinical area of the Trust. Whittington Health has made progress on integrating various reports and developing information systems relevant to safeguarding adults, including the use of Datix information. They are also reviewing their Incident Policy and Complaints Policy. The Whittington safeguarding lead now attends the Pressure Ulcer forum. To embed safeguarding in staff supervision, Whittington Health NHS Trust now has a weekly multi-disciplinary team meeting in the emergency department to discuss complex cases. This promotes good practice through sharing. Training materials have also been updated and adult safeguarding training has now been delivered to 70% of staff. Mental Capacity Act training has now been delivered to 150 staff members. Whittington Health have updated their PREVENT (anti-radicalisation) policy. PREVENT is now involved in Level 2 safeguarding training for staff.

Camden & Islington Mental Health Foundation Trust – An action plan has been developed and is being implemented to ensure embed the Mental Capacity Act in everything they do.

Islington Clinical Commissioning Group – To ensure that all commissioned services comply with the Mental Capacity Act, a set of key performance indicators (standards) are now included in all contracts. These standards will be monitored by the Designated Professional. The CCG has also commissioned Islington Council to provide the Mental Capacity function on its behalf.

London Metropolitan Police - In order to be able to show how they hold perpetrators of abuse and neglect to account, the Police have started to provide the partnership with data on some police actions. The Police have reviewed the way Vulnerable Adult cases are flagged on the Police crime recording system. This generates more reliable data and improves understanding of this group of people's access to criminal justice.

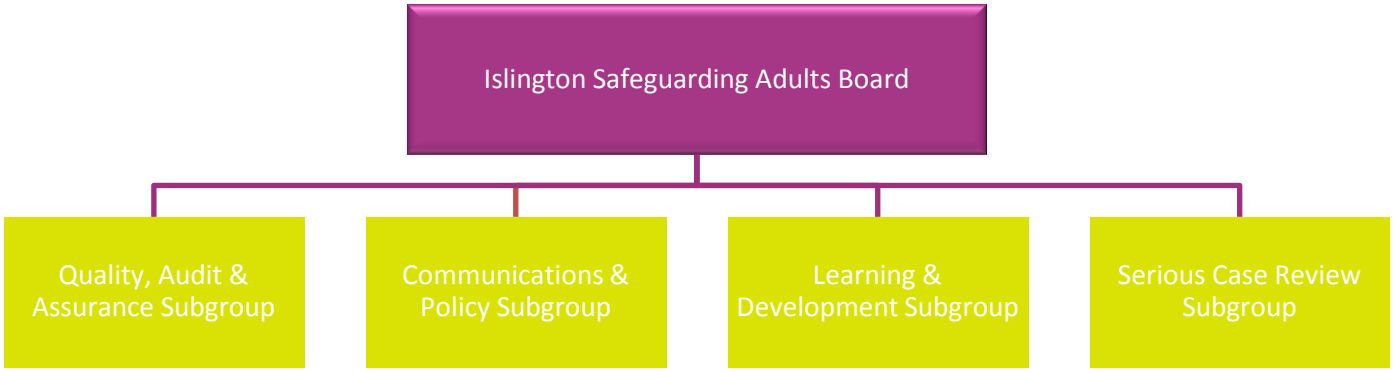
Islington Council – The Safeguarding Adults Unit continues to support front-line practice through the Leaders in Safeguarding Group. To help practitioners feel more confident about the role they play in securing justice, the Council's Internal Audit Service gave them advice and information on how to investigate financial abuse better.

The Safeguarding Adults Unit held two stalls, one in Chapel Market and one at Whittington Hospital to engage with the public and make it easier for people to report safeguarding concerns. A public awareness survey was conducted and learning from this was shared with relevant staff.

Single Homeless Project (SHP) – They have promoted safeguarding in supervision by revising their safeguarding procedure to ensure that safeguarding is added to all staff supervision agendas. SHP is mid-consultation with their clients on simplified leaflets that explain the safeguarding process, making it easier for them to understand the process.

London Fire Brigade – 1747 Home Fire Safety checks were carried out in homes of Islington residents. More than 90% of these visits were to people considered to be adults at risk of abuse and neglect. Thanks to partnership work between agencies, London Fire Brigade have been able to target residents identified as hoarders to ensure that preventative measures are put in place and the risk of fire death reduced where possible.

Much of the work towards achieving our strategy is done together. While the Board oversees the work, four board subgroups carry responsibility for implementing many aspects of the strategy. In many ways, the subgroups are the 'work horses' of the partnership. Dividing up the work and bringing partners together in subgroups makes sense. It allows for efficient and effective use of expertise and experience. The achievements of each subgroup during the last year are set out below.



1. Quality, Audit & Assurance

Key parts of the strategy for this subgroup include:

- Adults are protected from harm when they need to be
- Skilled staff and volunteers spot abuse and take timely, compassionate and proportionate action to ensure protection

As part of its work towards achieving the Boards strategy, the Quality, Audit and Assurance (QAA) subgroup considered various ways in which partners have sought the views of residents in Islington. Both formal and informal methods were looked at, with a significant focus on how partners handled and responded to complaints. The subgroup is looking at using partner data to better understand the service user/patient experience.

The QAA subgroup also got assurance from health partners on the work being done to link pressure sores with possible safeguarding concerns. London-wide protocols on pressure ulcers have been adopted and subgroup will keep a watch on how these protocols are being implemented.

Following on from the Inquiry into abuse at Winterbourne View, the QAA subgroup has continued to check that the government recommendations are being implemented locally.

Martin Machray
Chair
Quality, Audit & Assurance Subgroup

2. Communications & Policy

Our Communications and Policy subgroup focuses on:

- Making sure people in Islington know what to do if abuse happens
- Preventing abuse of people with care and support needs where possible.

Accessible information has been a continuing area of work for this subgroup. In addition to the range of leaflets in community languages, a safeguarding leaflet is now available in Chinese. More information about the work of the Board is now available in easy read format.

Creating a culture of compassion was a key part of the Board's plan for the year. This subgroup

developed an awareness raising plan on compassionate care, which targets both the general public and professionals. Information was shared with professionals on when and how to refer domestic violence concerns about adults at risk to MARAC (multi-agency risk assessment conferences).

The subgroup is also responsible for reviewing policies. To this end, we helped partner organisations to check their Care Act readiness by developing a policy checklist. With some recent serious cases in mind, we also circulated a self-audit tool to help partners check whether they have appropriate policies, procedures and practices in place on:

- non-engagement
- refusal of services
- carers
- domestic violence

Results of these self-audits were analysed and areas for improvement were identified.

Preventing abuse or neglect before it occurs is always better than addressing the harm after it has happened. That's why the government has suggested that Safeguarding Adults Boards develop Prevention Strategies setting out what they intend to do to prevent abuse. Our Communications and Policy subgroup held a Prevention Strategy workshop with a range of organisations in Islington. Using ideas generated from this workshop, a prevention strategy will be drafted and consulted on next year.

Simon Galczynski
Interim Chair
Communications & Policy Subgroup

3. Learning & Development

This subgroup focuses on people, particularly staff and volunteers, knowing what to do if abuse happens. It also is responsible for making sure skilled staff and volunteers spot abuse and take timely and proportionate protection.

A more diverse range of safeguarding adults courses is now being offered to staff and volunteers across the partnership. This includes drama sessions, which are an effective and accessible way of training large groups. An e-learning resource has been developed and is now available. This has opened up learning to a wider audience than before. The total number of people trained during the year was 1876 (an 18% increase on the previous year).

Much has been done to support the implementation of the Care Act through workshops, courses, briefings and the e-learning module.

'…..it was a pleasure receiving such good feedback from my staff team, on a trainer from Islington. The guys felt that you understood the dynamics perfectly and conveyed the information in a relevant and appropriate way. Thanks again…'

Feedback from a training course delivered to a provider of housing for lesbian, gay, bisexual and transgender people

Training courses continue to be well-received and feedback is generally very positive. The subgroup has assisted with quality assuring some of the safeguarding adults training courses offered by Islington Council. Innovative ways of providing learning, such as bite-size learning, out-of-hours learning and social networking websites continue to be explored.

We have reviewed the University of Bournemouth competency framework, which has been adopted by this partnership. This helped our understanding of how the competency framework is being used by employees and managers in Islington.

Neil Chick
Chair
Learning & Development Subgroup

4. Serious Case Reviews

The Serious Case Review subgroup has a role in making sure that serious cases are properly reviewed and any learning from them shared with partner agencies to avoid the same happening again in the future. Effective partnership is the focus of this subgroup in the partnership strategy.

During the year, there has been one Serious Case Review held in Islington. The findings have been shared with the Islington Safeguarding Adults Partnership Board and this subgroup has reviewed the recommendations. An action plan has been produced to address learning from this case. The Serious Case Review report has been published, and is available on the Islington Safeguarding Adults Board's webpages.

From the above review, various procedural issues were identified. Learning from this will inform the way future Safeguarding Adults Reviews will be carried out in Islington. Both the Mental Capacity Act and the Care Act will have significant implications for the way Reviews are carried out in the future. Shared learning from across the country is being reviewed to achieve practice in Islington in future reviews.

A Serious Case Review relating to an Islington resident was held in Haringey in 2013-14. The findings of the Haringey Serious Case Review were shared with the Islington Safeguarding Adults Partnership and this subgroup oversaw the actions required from the action plan during 2014-15.

A Domestic Homicide Review has been underway in Islington. The Serious Case Review subgroup is represented on the review panel. The case remains at an early stage due to judicial matters outstanding on the case.

We identified a need to amend the existing serious case review guidance. This was done and now Domestic Homicides are referenced and included in local arrangements.

Awareness-raising of MARAC (multi-agency meeting to discuss high risk cases of domestic violence) has continued amongst care managers and teams across health and social care. Members of the Serious Case Review subgroup contribute to the MARAC steering group, which ensures effective communication between the groups.

The subgroup has continued to be open to requests for Serious Case Reviews. At least two recent cases are likely to be put forward for review after the judicial processes have finished.

Paul Cheadle
Chair
Serious Case Review Subgroup

Experiences and Statistics

Statistics are very useful. They help us to understand how we are doing and compare our performance over several years. Statistics also highlight areas we need to work on. But statistics can hide the real people and situations. So, it is important to understand people's experiences, not just the statistics.

This section looks at both people's experiences and the statistics behind the work we do.

1. Experiences

No two safeguarding cases are exactly the same. Every person is different.

The only way we can truly personalise safeguarding is to find out about people's experiences of safeguarding. We do this in a variety of ways.

Auditing cases is one such way. Each month we carry out a small sample of cases to get a better understanding of what happened in the case. We also check that wherever possible people who were at risk of harm or abuse, got the outcome they wanted. Any learning or good practice is shared with professionals to help them develop their skills and improve service user experiences.

Service users and carers feedback is another rich source of information for us. We engage with them through various ways such as our community conference. People's feelings of safety are checked through surveys. Engaging with carers and service users and public is an area of work we want to develop further.

Our Quality, Audit and Assurance subgroup also reviews patient and service user compliments and complaints alongside data to get a more rounded picture of people's experiences.

2. Statistics

Alerts

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a 'safeguarding alert'.

In April-March 2013/14 we had **1165 alerts** about possible abuse.

In April-March 2014/15 we also had **1165 alerts** concerning a total of **913 individual people**. There has been no change in the number of alerts we have received. Although we have continued to raise awareness locally about abuse and neglect, there has been less national media attention recently and this may explain why the number of alerts we have received has not changed.

Case Study: Learning from feedback

Mrs A is the main carer for her husband, who has Parkinson's disease. Mrs A has an anxiety disorder, but it is generally very well managed. She gets short respite breaks from caring for her husband from a home care agency. Safeguarding concerns were raised about the standard of care given by the home care agency supporting Mr A.

A safeguarding case conference was held about the home care agency. Mr A was assessed as not having the mental capacity to take part in the safeguarding meeting. In line with best practice, Mrs A, as his next of kin was invited to attend. Mrs A appeared to agree with the decision in the meeting to place her husband in a care home. However, after the meeting, she told the social worker that the stress of the safeguarding process had triggered her anxiety symptoms again. She said she had been so anxious during the meeting, she hadn't been able to focus on the discussion and couldn't even remember what she had agreed to.

The professionals involved in the meeting reflected on this feedback from Mrs A. They agreed that Mrs A's own support needs in the safeguarding process had been underestimated. Mrs A was then offered advocacy to support and empower her in the safeguarding process.

Learning from this case has been shared with practitioners to ensure the support needs of relatives are fully considered in future. Learning from feedback is just one of the ways that we use to constantly refine and improve the safeguarding experience. The wellbeing of those we safeguard, and their carers, through the safeguarding process is important to us.

*Names and details have been changed to protect identities in all the case studies in this report.

Referrals

After an alert has been received, we then gather more information about the person and the concern. Once this has been done, we decide whether the case needs to be referred for investigation. A case that went on to be investigated is known as a 'referral'.

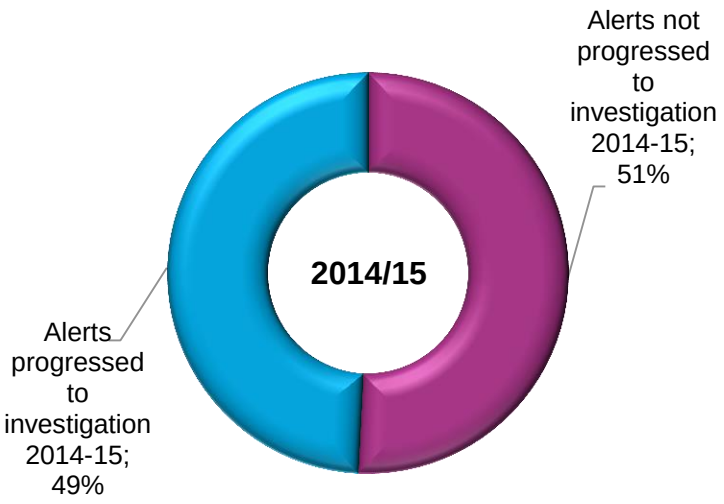
In 2013/14 we had **511 investigations (44% of the total alerts raised)** about suspected abuse.

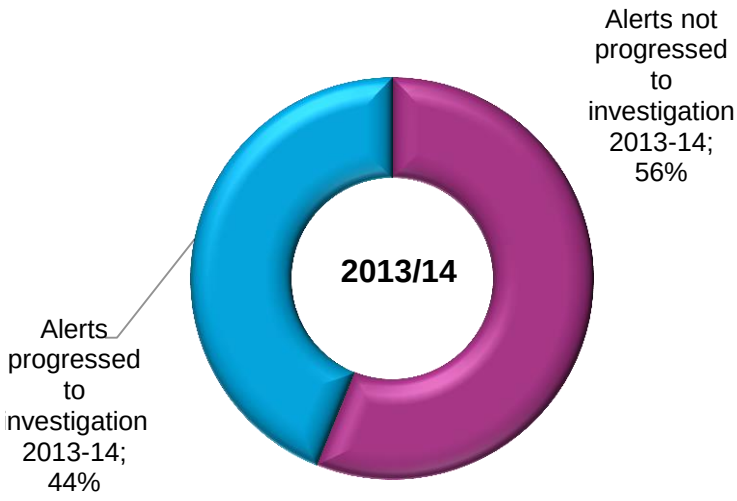
In 2014/15 we had **573 investigations (49% of the total alerts raised)**. This is an increase of 12% on last year.

Update

From April 2015 onwards, some of the terms we use, such as 'referral; will be changing. This is because the Care Act has introduced new terms for us to use. The term 'safeguarding referral' will be replaced with the term 'safeguarding concern'. 'Safeguarding investigations' will be known as 'safeguarding enquiries'.

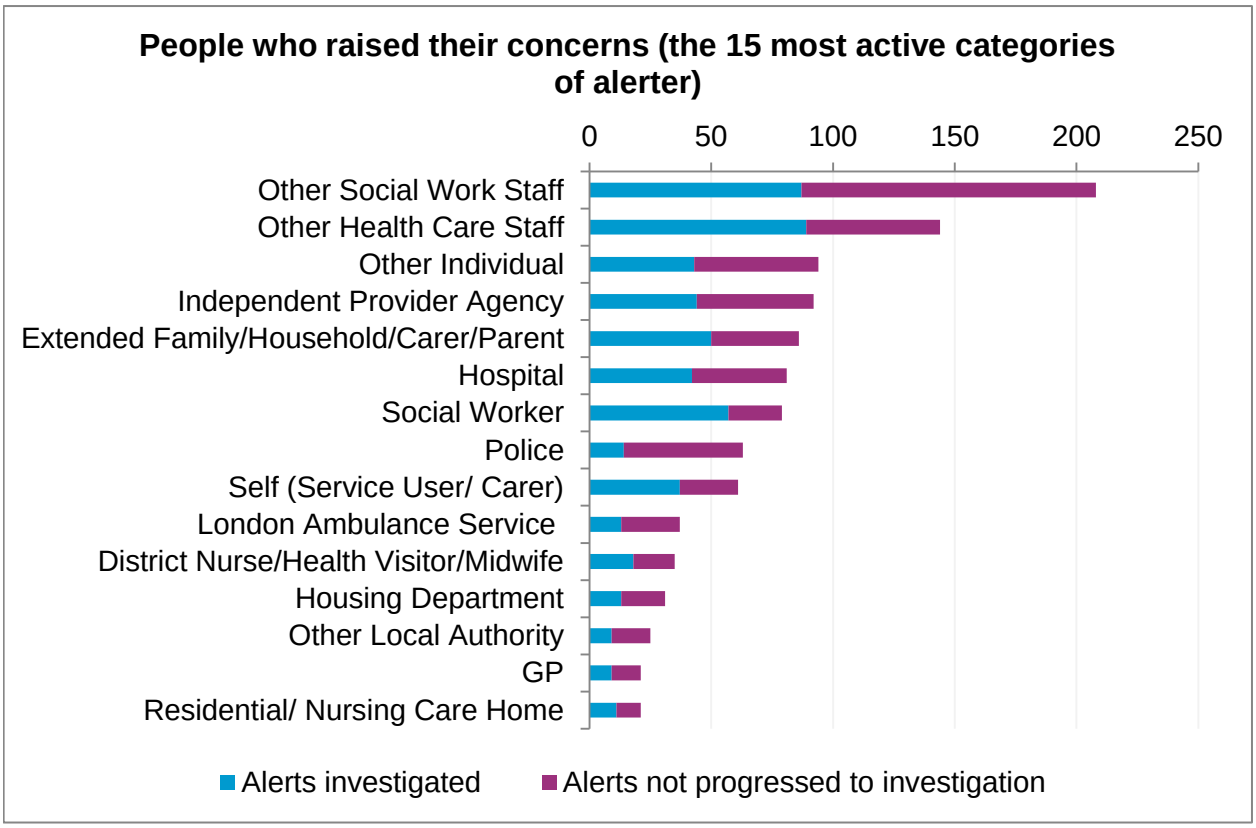
Safeguarding Adults 2014/15 & 2013/14: Alerts Proceeding to Investigations





This trend shows that people are getting slightly better at knowing when to report concerns about neglect and abuse. Sometimes, people are worried about an adult but when we look into it, it turns out not to be a safeguarding issue. In this situation, the Access and Advice team of social services will signpost the adult to appropriate services or give general advice and support.

3. People who raised their concerns

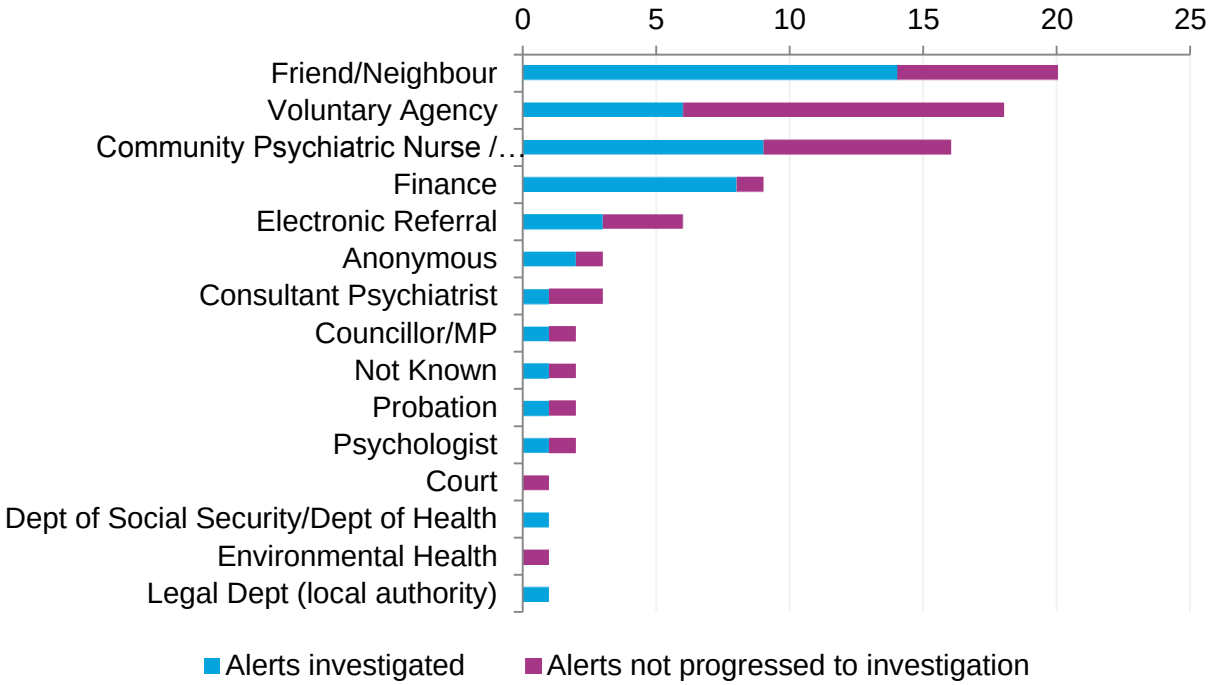


This chart refers to the 1165 alerts which were begun during the year

The people who are most likely to report concerns about abuse and neglect are health and social care staff. This is not surprising because health and social care staff get a lot of training and advice on spotting abuse and neglect. Also, adults with care and support needs are likely to be visited or monitored regularly by health and social care staff.

As abuse and neglect often take place in people's own homes, extended family and friends are in a good position to spot abuse too. We continue to raise awareness among unpaid carers and the general public about how to spot abuse and neglect and how to report concerns.

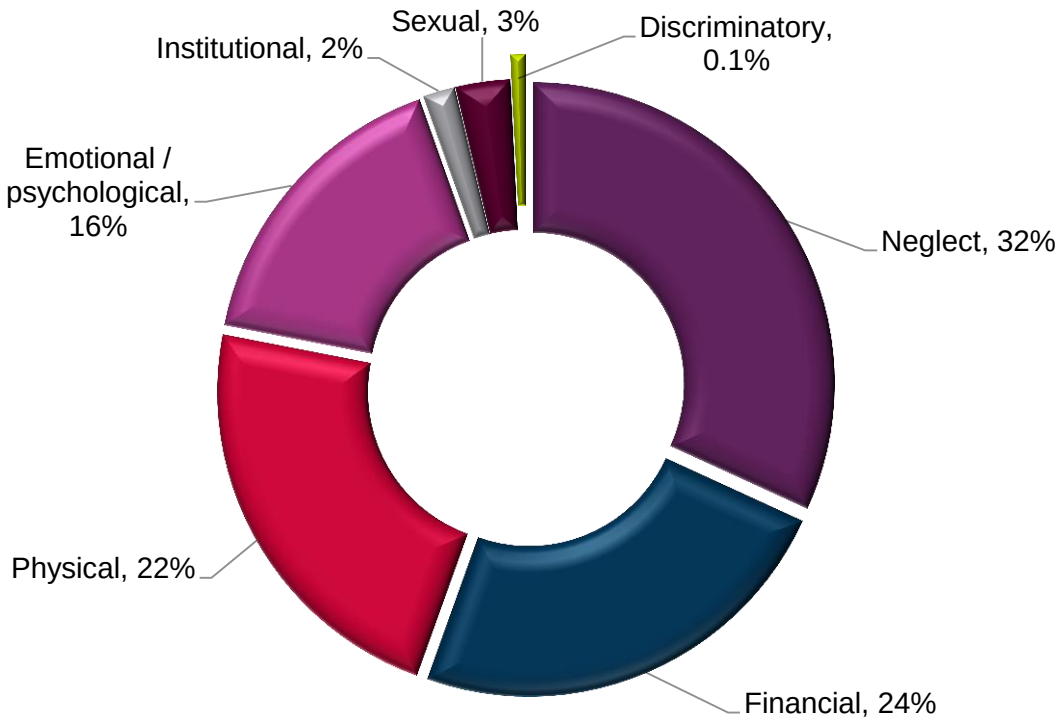
People who raised their concerns (the 15 least active categories of alerter)



This chart refers to the 1165 alerts which were initiated during the year

4. Types of abuse investigated

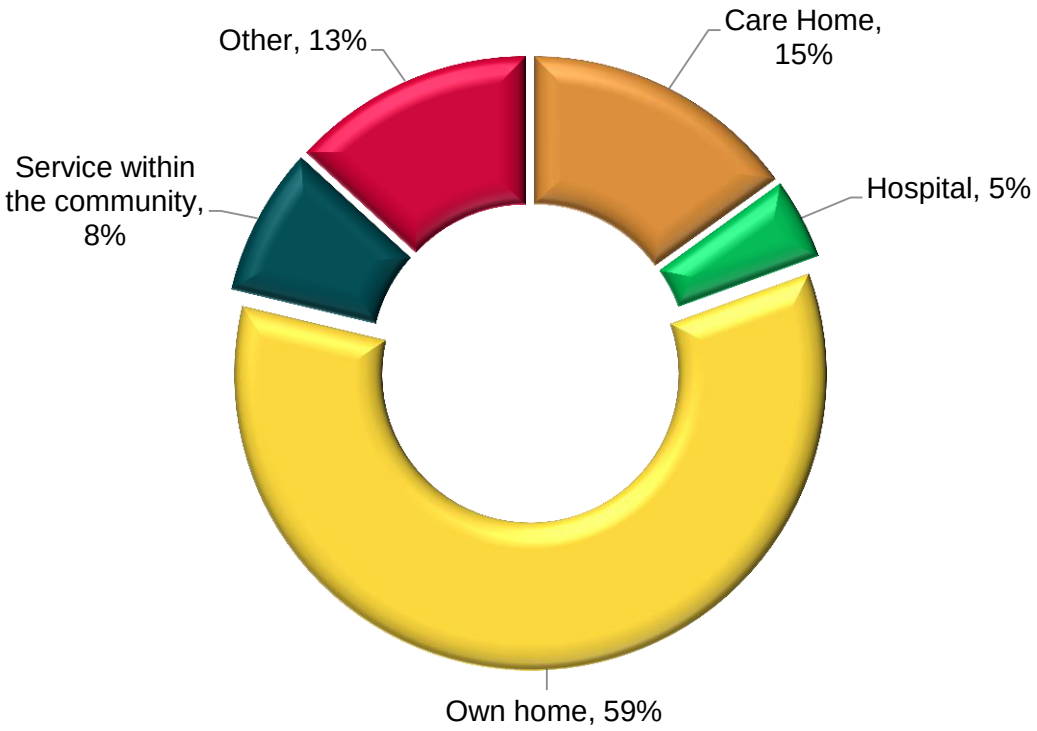
The different types of abuse that were investigated are shown in the chart below:



This chart refers to 545 investigations which were completed during the year
Some cases involved more than one type of abuse.

This chart shows that over the course of 2014/15, the most common types of abuse we investigated were neglect and financial. This is a broadly similar picture to previous years. With the introduction of the Care Act in April 2015, we will have a duty to investigate additional types of abuse: domestic violence, modern slavery and self-neglect in future.

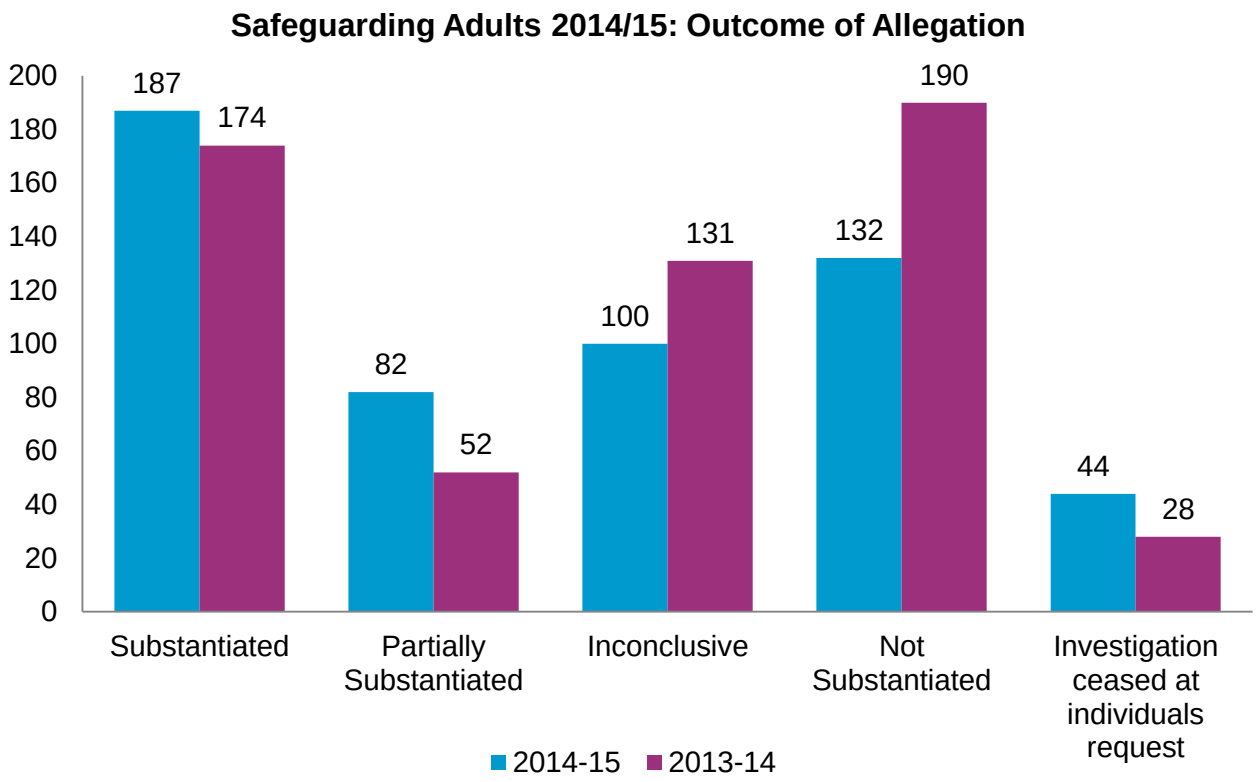
5. Location of abuse investigated



This chart refers to 545 investigations which were completed during the year. Some cases involved more than one location of abuse.

Abuse and neglect in care homes and hospital often make media headlines. The abuse at Winterbourne View Care Home and the neglect at Mid-Staffordshire NHS Trust got a lot of media coverage. But this chart shows the real story – that more than half of all cases of abuse and neglect take place in the adult's own home.

6. Decisions taken



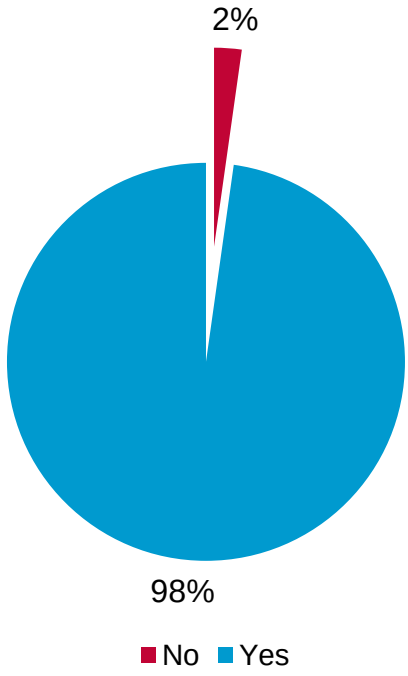
This chart refers to 545 investigations which were completed during the year. These include some cases which were started in the 2013-14 year, but completed in 2014-15. They exclude cases which had not been completed because the outcome had not been decided yet.

The number of cases where we decide abuse took place (substantiated and partially substantiated) has risen slightly in the last year. In 44 cases we stopped the investigation because the adult asked us to. We always try to follow the adult's wishes. Only where there are serious risks to other adults or children will we carry on investigating. In roughly two-thirds of cases, the adult at risk has been assessed as lacking mental capacity to make an informed decision about the safeguarding concerns. In these cases, we take into account the views of the adult's representative, family or friends. Where the adult has no one to represent their views, we appoint an independent mental capacity advocate (IMCA).

We are pleased that there are fewer cases where the outcome was inconclusive. Making a decision about safeguarding concerns isn't always easy. It takes great skill and care to investigate concerns thoroughly. We always try to work out whether abuse has taken place or not but sometimes there is not enough evidence to say with certainty. Even when it is not possible to say whether abuse took place, we always try to manage the risks with the person concerned.

7. Action to help the adult at risk

Was any safeguarding action taken where the allegation was substantiated / partly substantiated?

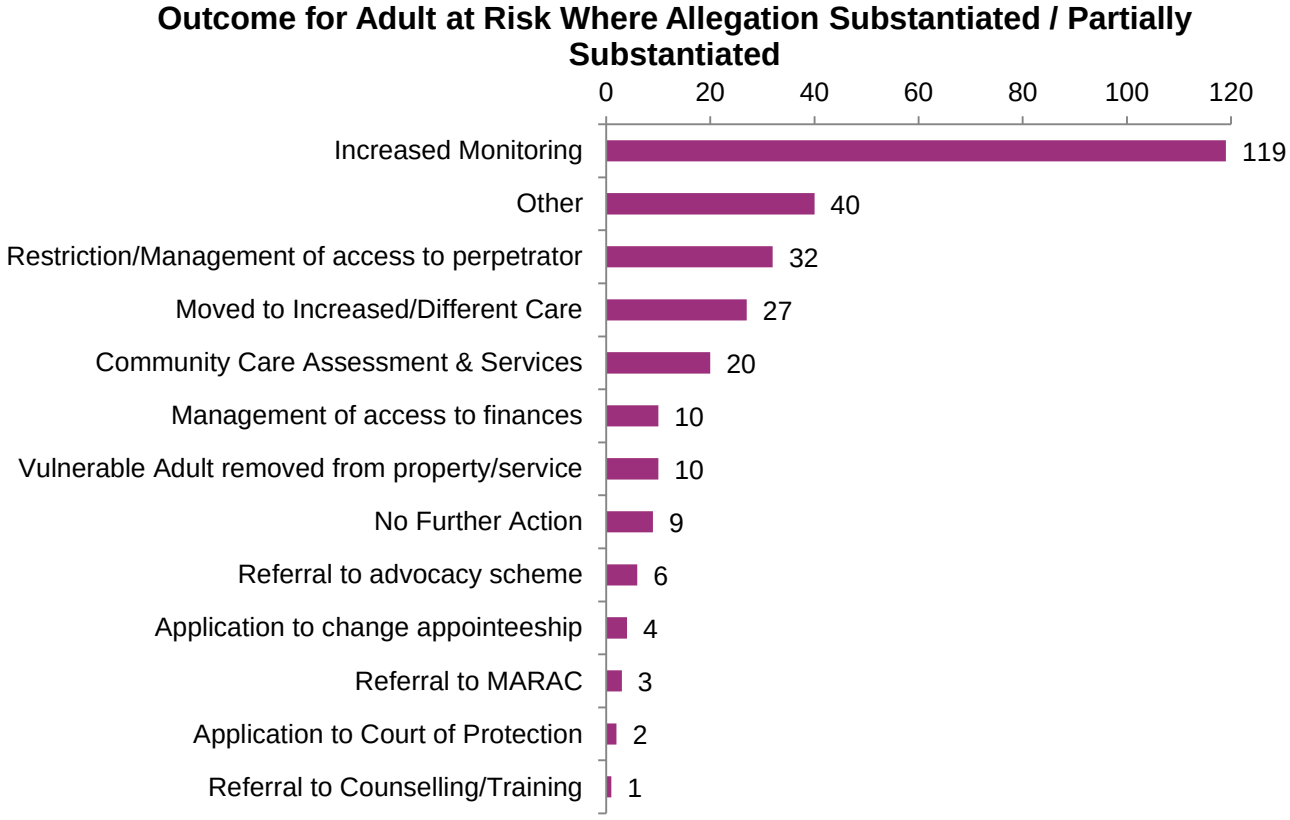


This chart refers to 269 completed investigations where abuse was substantiated (187) or partly substantiated (82)

In 98% of cases where we agreed some level of abuse or neglect had taken place, we took action to safeguard or support the adult involved. In the 2% of cases where we did not take action, this would have likely been because the adult did not want us to do anything.

These figures suggest that our safeguarding involvement is worthwhile because it nearly always resulted in action. For further detail on the kinds of actions we took, see the graph on the next page.

8. Outcome for adult at risk



***** *MARAC is an acronym for Multi Agency Risk Assessment Conference.*

This chart refers to 269 completed investigations where abuse was substantiated (187) or partly substantiated (82) *There may have been more than one outcome for each adult at risk.

Increased monitoring is the most common action taken to protect an adult. Increased monitoring could include family and friends agreeing to visit an isolated adult more often or a community nurse visiting a patient at home regularly to check for pressure sores and give regular advice and support.

There were 276 cases where we decided the abuse or neglect did not happen, we could not say whether abuse took place or an adult asked us to stop investigating. For those 276 cases, we made the most of the opportunity and took action to prevent the possibility of harm in the future where possible.

Mr B is 90 years old. He lives in a small flat on his own. In recent years, his hearing and vision have got worse and he has been diagnosed with dementia. Because his only daughter lives in Spain, Mr B became more reliant on his nephew for general help and support and some years ago signed a Lasting Power of Attorney (LPA) appointing his nephew to look after his property and affairs.

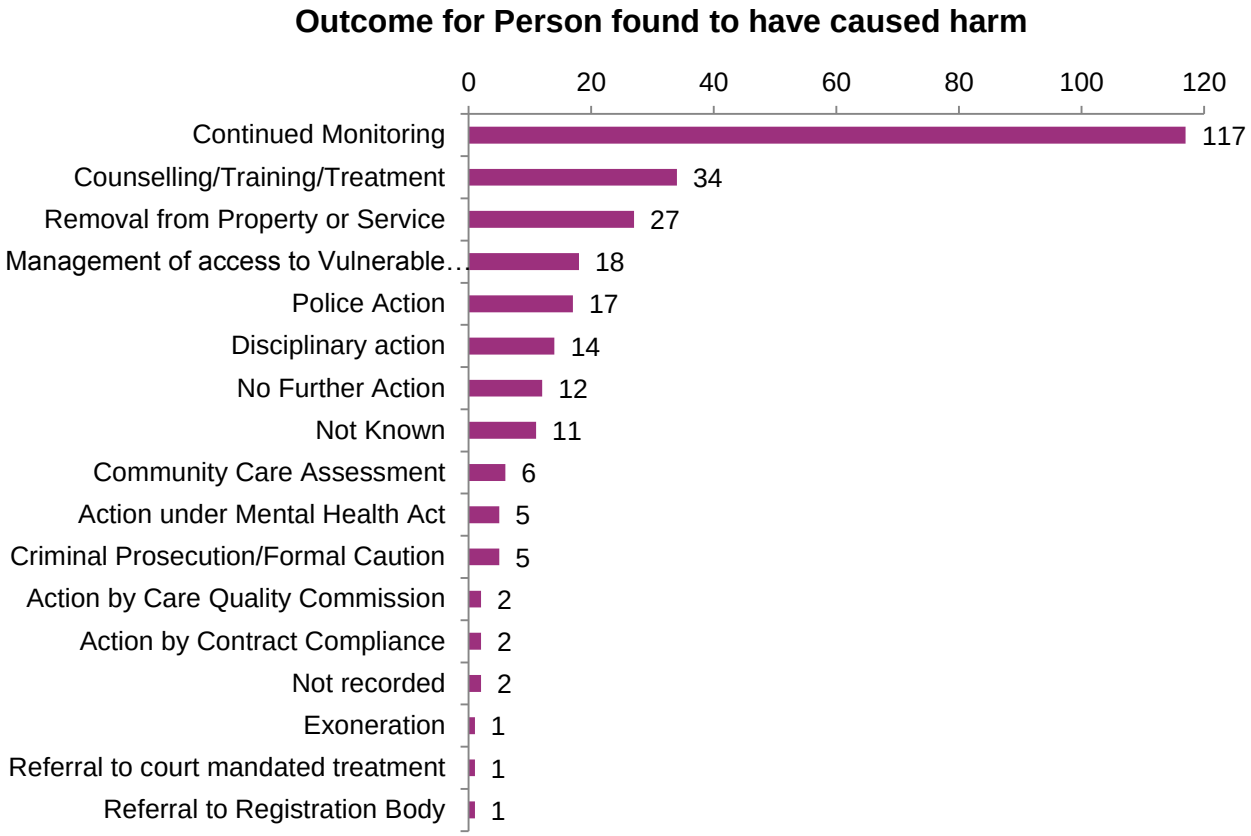
Mr B's daughter came to visit her father recently and was shocked to see how thin and neglected her father was looking. Mr B's daughter contacted Social Services for advice.
When the social worker visited Mr B, she discussed his care and support needs. After talking to Mr B and his daughter, it became clear that Mr B was no longer able to read his own bank statement and mail. Mr B was distressed to discover he was in significant arrears on his rent and utility bills.

The social worker became suspicious of the way Mr B's nephew had been managing the finances. A safeguarding concern was raised and an investigation opened. Mr B's nephew tried to block the investigation and refused to share any of Mr B's financial documents with social services or the police.

Working together with the police and the Office of the Public Guardian, legal steps were taken to force Mr B's nephew to account for the way he had spent Mr B's money and to share the financial records with the authorities. It then became clear that Mr B had not been managing his finances properly. The Court then revoked the LPA meaning that Mr B's nephew was no longer allowed to manage Mr B's finances. The Council has been appointed to manage Mr B's finances instead. The Crown Prosecution Service and the police are looking at whether there is enough evidence to prosecute Mr B's nephew for fraud and false accounting.

Mr B's daughter has since moved back to Islington and is caring for him. Although Mr B's health continues to worsen, he now has enough food to eat, his home is well-heated and he seems much happier.

9. Action taken against people alleged to have caused harm



This chart refers to 269 completed investigations where abuse was substantiated (187) or partly substantiated (82)
*There may have been more than one outcome for each person alleged to have caused harm.

This chart shows that in almost half of cases, continued monitoring was the action taken against the person found to have caused harm. An example of this is where a care worker was found to have caused a patient to develop a pressure sore because they had not turned the bedbound patient frequently enough. In this case, the care worker may be monitored and supervised more closely by managers as part of the protection plan.

In some cases, the concerns are serious enough for the Police to take action. The action that the Police take ranges from giving cautions, pressing criminal charges against the person alleged to have caused harm or working to achieve a community resolution.

The Community Risk Multi Agency Risk Assessment Conference (CRMARAC) has proved to be an effective way of dealing with some people alleged to have caused harm. The CRMARAC has secured funding for a dedicated mental health practitioner to work on some long standing cases. In the last 12 months, 75 cases have been referred to the CRMARAC and repeat calls, particularly about anti-social behaviour to Police have fallen as a result.

C has a mental health diagnosis. She had been seriously physically and emotionally abused by her partner for many years. Her mental health support worker encouraged her to report the abuse to the Police. The Police arrested and charged C's partner with unlawful possession of an offensive weapon.

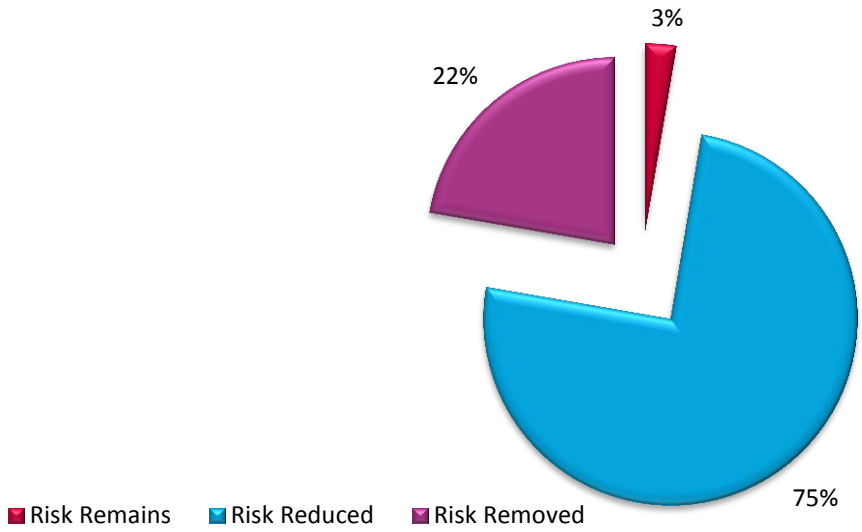
However, after the charges had been made, C's mental health worsened. She became hostile to the professionals and said she did not wish to attend court. Specialist officers from the Police's Domestic Abuse Unit (DPAU) visited C at home and spent time forming a rapport with her. The police worked sensitively with C to help her overcome her fear of going to Court. Special measures were arranged for the Court trial and C was taken to and from Court by the DPAU. The Court trial found C's partner was found guilty.

Despite C having endured domestic abuse for many years, this was the first time that she had taken a case all the way through the court process. It is likely that the case would have failed had it not been for the specialist care and support given to C.

*Details have been changed to protect to identities.

10. The impact of safeguarding

Impact of safeguarding actions where allegation was substantiated / partly substantiated



This chart refers to 269 completed investigations where abuse was substantiated (187) or partly substantiated (82).

The purpose of safeguarding is to help people feel safer. One of the ways we measure this is by looking at whether our safeguarding actions have reduced the risk of future abuse or neglect happening. The above chart shows that in 97% of the cases, our actions have either removed or reduced the risk of harm.

In only a very few cases, the risk remains. Usually, this is the adult's choice. We always check first that the adult has the mental capacity to make that decision, is comfortable with the risk and understands the possible consequences of not taking steps to reduce the risk.

11. Serious Case Reviews

Islington has had its first serious case review for a number of years.

The purpose of a serious case review is to learn lessons from a serious injury or the death of an 'adult at risk'. The learning is shared widely and looks at what needs to change to reduce the risk of further such incidents.

The serious case review involved a man (Mr AA) who died aged 86 in June 2013. From 2008 until shortly before his death, he had lived in a residential care home. Because Mr AA had dementia and needed help with this care, he had moved into a care home.

His health worsened in 2013 and this led to three hospital admissions. Following the third admission, Mr AA was discharged to a registered nursing home where he died 15 days later in June 2013.

A decision was made to undertake a Serious Case Review in this case. This was because safeguarding concerns had been raised before and following Mr AA's death. It was identified that organisations should look closely at the care Mr AA received and review the way in which different organisations worked together in meeting his health and social care needs. The review set out to learn lessons to consider if the care Mr AA received could have been better, and identify whether improvements could be made for the future.

The full report has been published and is available on our webpages.

The report concludes that:

- on two occasions when Mr AA was discharged from hospital there was poor discharge planning
- his increasing care needs were not responded to by a number of professionals involved
- there were concerns around how professionals communicated with each other around his care needs
- he was not shown the dignity and care at the end of his life or in his death that most would want for their friends and family.

These are serious findings which have been shared with the organisations involved. All the recommendations in the report have been accepted by the relevant organisations. Each organisation has developed an action plan to ensure that the recommendations from the report are implemented. The Safeguarding Adults Partnership Board is monitoring the progress of organisations against their action plans.

Our progress in implementing the serious case review action plans will be shared with you in our next annual report.

12. Deprivation of Liberty Safeguards

Every adult should be free to do the things they want to do and live the life they want to live.

If someone's freedom is taken away in a hospital or care home, there are laws and rules in place to make sure that it is in that person's best interests. The rules are called the Deprivation of Liberty Safeguards (DoLS).

We monitor how these safeguards are used in Islington.

DoLS legislation has been in force since 2009. Initially, there were relatively few DoLS applications. For the years 2009-2014, the number of applications in Islington never went above 50 applications in a year.

However, since the so-called Cheshire-West Judgement last year, the number of applications in Islington has risen dramatically from fewer than 45 in 2013/14 to nearly 450 in 2014/15. (See graph on next page) This equates to a roughly 1100% increase.

The effect of the Court ruling has been that far more people in residential care and hospitals are now entitled to the DoL Safeguards. The judgement also means that many people who get community care, such as people in supported living housing, who may lack the mental capacity to consent to their care are also now entitled to the DoL safeguards.

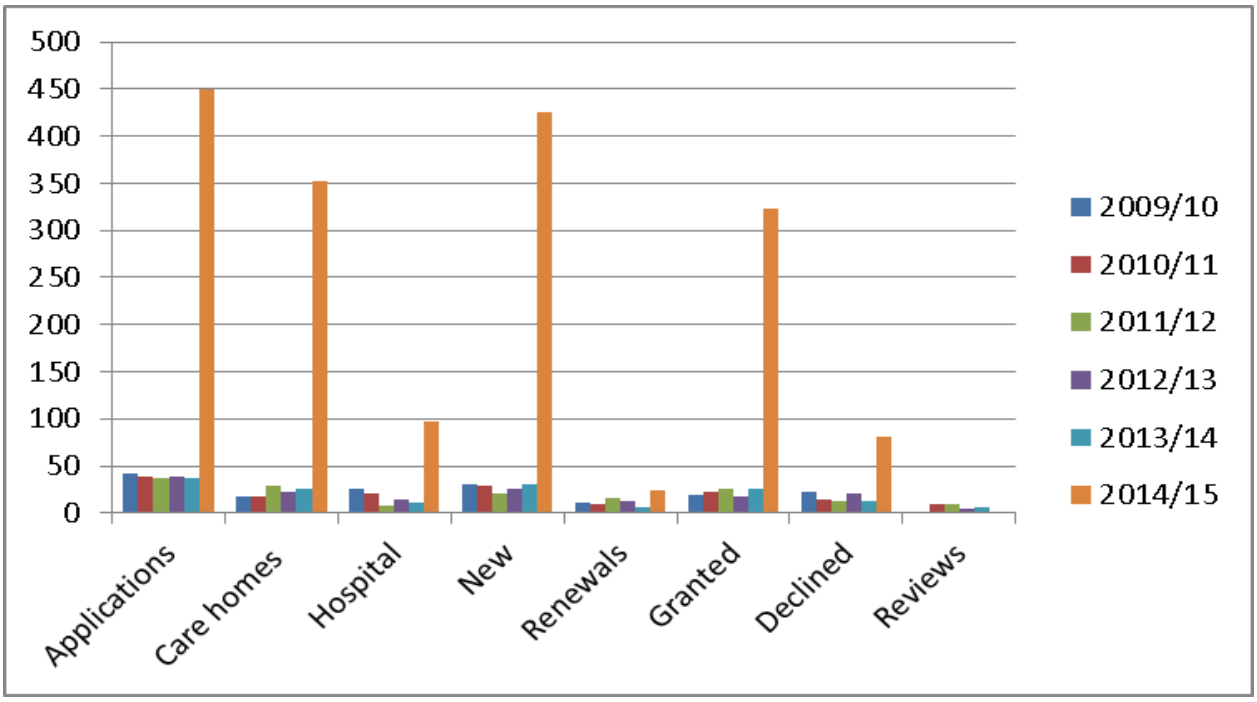
Islington is not alone in having to process many more DoLS applications than last year. The picture is broadly similar across the country. We have risen to the scale of the challenge and are now managing to turn around most applications within timescales. To cope with the huge increase in DoLS applications, Islington Council's DoLS service has implemented a plan to manage the pressures and taken on extra staff.

What is the 'Cheshire West' judgement?

In March 2014, the Supreme Court made a long awaited decision in a case about three people who lacked the mental capacity to make decisions about their living arrangements. The Court decided that all three were subject to a deprivation of their liberty. The judgement was important because it made the law on DoLS clearer and brought in an 'acid test' to work out whether or not a deprivation of someone's liberty was taking place.

Applications and authorisations

Deprivation of Liberty Safeguards applications 2009 - 2015



In Islington, most DoLS applications in 2014-15 resulted in an authorisation (82% of applications).

There are currently 342 people in Islington who have a Deprivation of Liberty authorisation in place. However, according to our calculations, we anticipate a further increase in DoLS applications and authorisations next year. This chimes with the view of some legal experts who believe that a large number of people are currently being deprived of their liberty without proper legal authorisation.

In large part, this may be due to staff in hospitals, care homes and supported living placements not being fully aware of the law on DoLS. For this reason, we continue to offer a range of training courses on the Mental Capacity Act and the Deprivation of Liberty Safeguards. We have also produced information leaflets for the public and for staff to explain how the safeguards work.

Opportunities to raise awareness among the public, patients and carers have also been used, for example at the Chapel Market and Whittington information stalls.

What does a deprivation of someone's liberty look like?

There are many ways that someone's liberty or freedom can be restricted. Some of the things we check are:

- Is the patient or care resident allowed to make their own decisions?
- Is the person being made to stay in the care home or hospital against their wishes and not allowed to leave?
- Is the person allowed to see friends or family when they want?

There may be good reasons why someone's liberty is being restricted, but it is only lawful if a DoLS application has been made and two different specialist assessors agree that it is necessary.

Approximately 3 out of every 5 DoLS applications were made for someone with dementia and 1 in 5 were made for someone with a learning disability.

Carrying out a DoLS assessment and authorisation makes sure that the human rights of some of the most vulnerable people in our care homes, hospitals and the community are protected. But the DoLS process also has the advantage of highlighting other issues in a person's life and can lead to significant improvements in both the person's care and the way the care home or hospital runs. An example of this is explained in the following case study. To protect identities, some details have been changed.

Case Study

Ms D is a 50 year old woman with complex mental health and other care needs. She has lived in a care home for several years. Recently, Ms D had tried to leave the care home. So, the care home made an application for a Deprivation of Liberty Safeguards to ensure that their preventing her from leaving the care home was lawful.

As part of the DoLS assessment process, an independent psychiatrist visited Ms D. Having talked to Ms D, her family and the staff at the care home, the psychiatrist noticed that Ms D was on a high dose of one particular medication. The psychiatrist felt that Ms D was being over-medicated.

These concerns were raised with Ms D's social worker. Another psychiatrist then reviewed Ms D's medications and a better medications care plan was agreed for Ms D.

Had it not been for the DoLS assessment, it may not have come to light that Ms D was not on the right dose of medication for her condition.

Next steps for the partnership

As we look ahead, there is still much more to be done.

We want the person we safeguard to be at the heart of everything we do. Their wellbeing must be uppermost in our work. Every person is an individual and their differing needs and priorities must be recognised. Wherever possible we must involve them and their family or friend carers fully in decisions about safeguarding them.

This is a priority not only because the Care Act requires it, but because it is the right thing to do. A personalised safeguarding response is the only way we can ensure that people's rights and freedoms are protected. Making sure this happens is one part of the work we're planning to do.

Our strategy

We have joined forces with Camden Safeguarding Adults Board and agreed a joint strategy across the two boroughs for the next 3 years. Because we are neighbouring boroughs, we share many challenges that need to be tackled. Working alongside each other focusing on the same issues makes sense. We consulted widely across the public, partner organisations, service users and carers to make sure that our new 3-year strategy is on the mark and reflects what local people want.

Both boards have a vision to improve how safe people feel and how safe they are from abuse. Both boards are committed to helping adults, their carers, the public and professionals to work together to make Camden and Islington places where adults can enjoy their right to live free from neglect and exploitation. This strategy will help us turn these ambitions into a reality.

> *"Alone is helpless, together is action"*
>
> Response from public consultation on our joint 3 year strategy with Camden Council.

Our key strategic themes mirror the government's aims for safeguarding adults:

1. Empowerment
2. Prevention
3. Proportionality
4. Protection
5. Partnership
6. Accountability

We look forward to delivering on our key strategic themes together.

Our prevention strategy

Prevention is better than cure, so the saying goes. And it's never been more apt for safeguarding adults. If there's a way of preventing abuse or neglect before it happens, we should invest time, energy and resources in doing so. We should work together to prevent harm.

Much abuse and neglect can be avoided (or at the very least, the impact lessened) by taking preventative steps in the first place. Take for example, pressure sores. Sometimes they are completely unavoidable, but often they happen because someone's care wasn't good enough and

simple steps such as using turning charts could have prevented a pressure sore developing.

Preventing abuse of adults at risk in the community is an important part of the work of the Islington Safeguarding Adults Partnership Board. This prevention work fits in with the vision of the recently legislated Care Act 2014. The Care Act sets out the general principles of promoting wellbeing and preventing or delaying the development of needs. The Care Act also says we have to have a prevention strategy.

We are developing a separate prevention strategy to sit alongside our joint strategy with Camden. Consulting with the public on this prevention strategy will be the next step to make sure we are planning our work along the right lines. Once we have finalised our prevention strategy, all the organisations involved in the partnership will work together to make the strategy happen.

Progress on both our prevention strategy and our joint strategy with Camden will be shared with you in our next annual report.

Appendix A

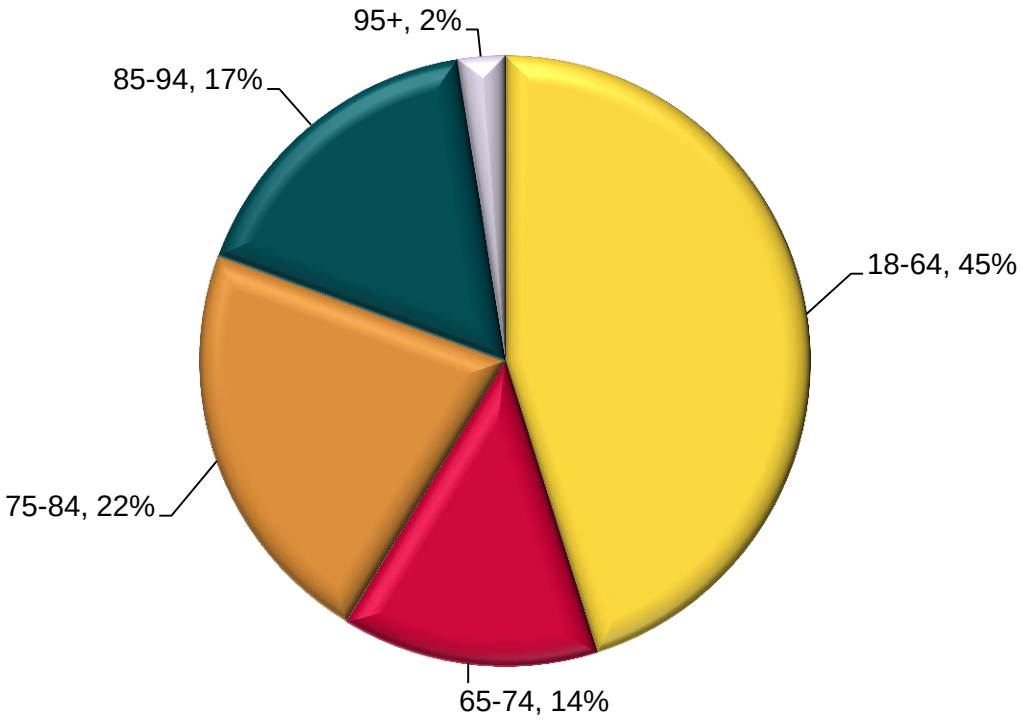
Making sure we safeguard everyone

Equality and Diversity matter to us. We want to make sure that all groups in Islington are part of our safeguarding work, when they need to be.

In this part of our review, we look at how the Islington population is represented by the people who had safeguarding concerns raised about them.

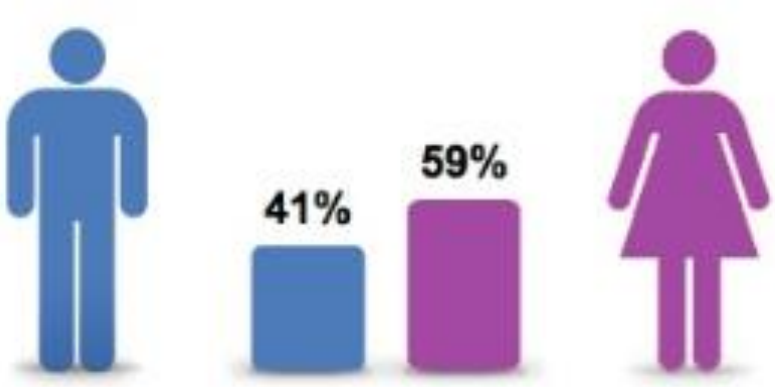
With their consent, we capture information about the age, sex, ethnicity, sexuality, mental capacity and service user category of the people we safeguard. Having a clear picture of who we are safeguarding and where there are gaps, helps us decide where to focus our attention in the future.

Chart showing recorded age of the adult



The chart above shows that over the course of 2014-15 there was a large proportion of older people represented in safeguarding alerts. This is consistent with national and international research, which shows that the older an adult is, the more at risk of abuse they are. Therefore, it appears we are continuing to do well in encouraging people to come forward and report suspected abuse of older people.

Chart showing recorded sex of the adult



The above two charts both refer to the 913 adults who have had alerts raised concerning them.

This chart shows a broadly similar trend to previous years in that more concerns were reported about women than about men. It is difficult to know whether this is because women experience more abuse, or whether abuse of women is more commonly reported than abuse of men. National research (Scholes et al, 2007) shows that women are more likely than men to tell other people if they are harmed by someone. It is also widely accepted that women are more likely to experience domestic abuse than men.

Table showing recorded Ethnicity of Service Users April 2014- March 2015

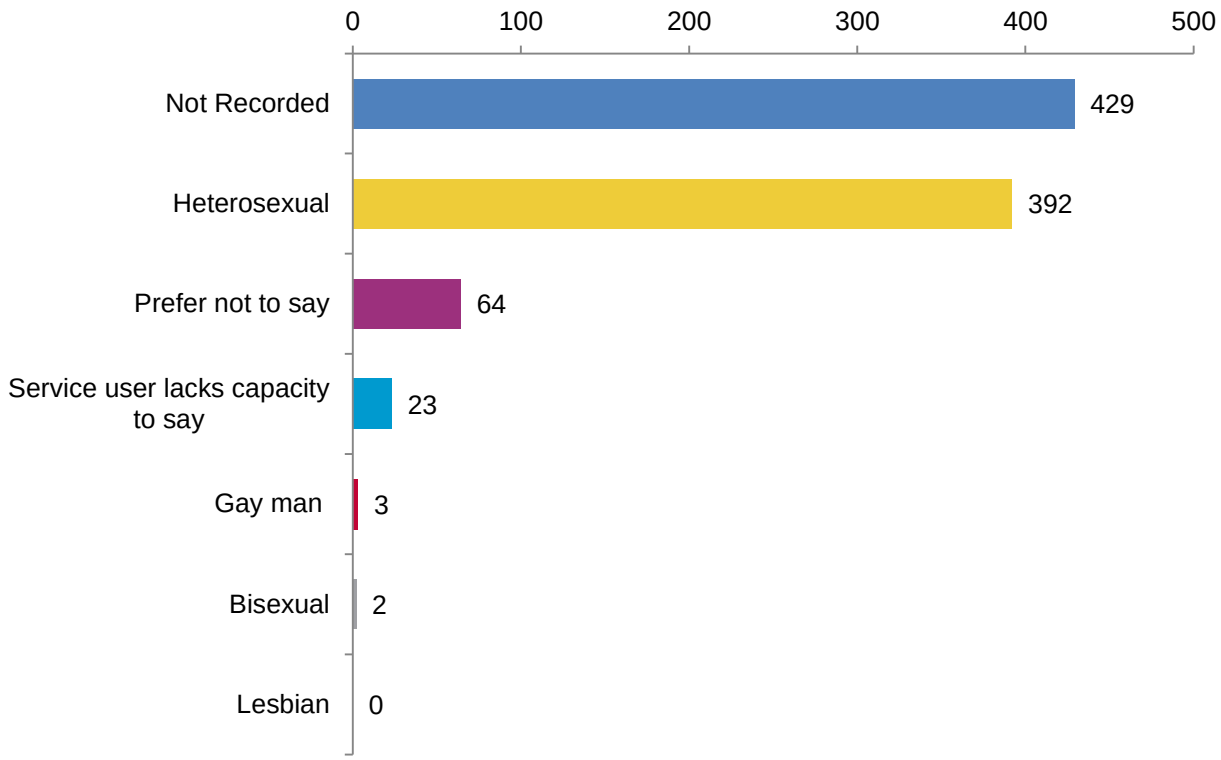
Ethnicity	Alerts	Islington adult population*	%
White British	437	98,322	0.44%
White Irish	84	8,140	1.03%
Other White (includes traveller of Irish heritage, gypsy/Roma and any other white)	90	34,053	0.26%
Black Caribbean	77	7,943	0.97%
Black African	37	12,622	0.29%
Any other Black background	15	5,729	0.26%
Asian Indian	12	3,534	0.34%
Asian Chinese	5	4,457	0.11%
Asian Pakistani	6	951	0.63%
Asian Bangladeshi	6	4,662	0.13%
Any other Asian background	15	5,430	0.28%
Mixed/multiple ethnic groups	21	13,339	0.16%
Other (includes any other ethnic group, information not yet obtained, refused to say,	108	6,943	1.56%
Totals	913	206,125	0.44%

This table refers to the 913 adults who have had alerts raised about them. The population data was released from the 2011 Census during the second, third and fourth data releases, which took place during 2013. Data was downloaded from http://www.nomisweb.co.uk/

The table shows that alerts were raised for people from a range of ethnicities in 2014/15. From our data, it seemed that safeguarding concerns about people who described themselves as being of Chinese ethnicity were least likely to be reported to us. We have taken action to address this. Our general leaflet on safeguarding is now available in Chinese and we have made links with the local Chinese community through the Islington Chinese Association.

Different ethnic groups may have different proportions of adults at risk. For example, the average age varies across ethnic groups in Islington. Where there are more older people in an ethnic group, we would expect to see more safeguarding alerts for that group.

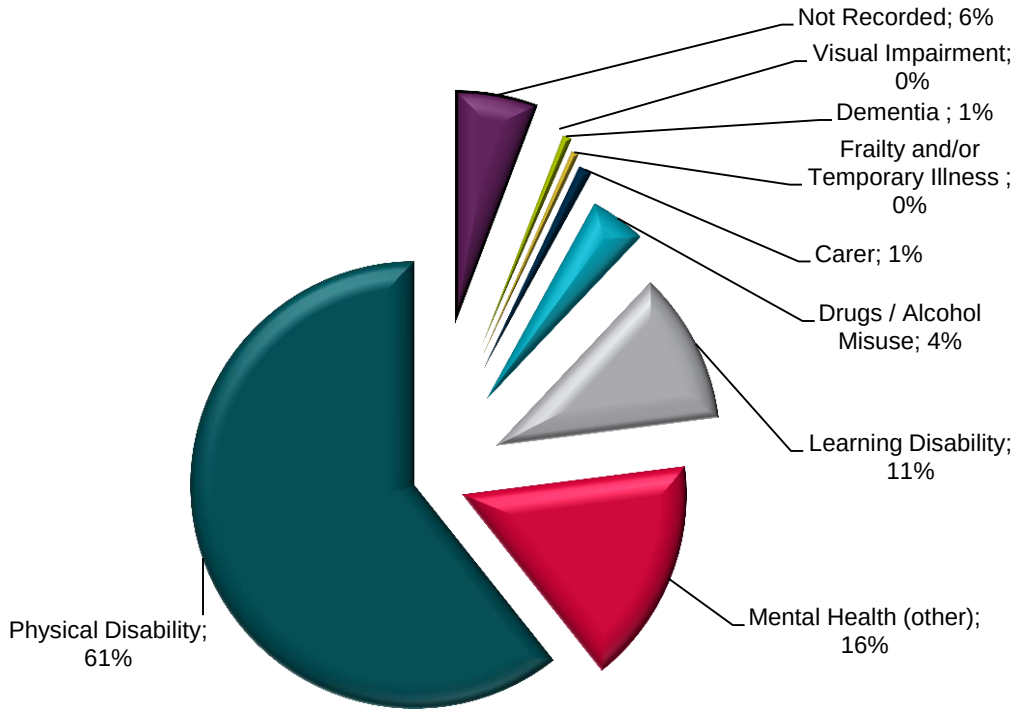
Chart showing recorded Sexual Orientation of Service Users April 2014- March 2015



We have recently started asking some of the adults we safeguard about their sexual orientation. Therefore the above chart is not complete and in almost half of cases, we did not record the sexual orientation of the adults concerned. We will work towards creating an environment where staff feel confident asking questions about sexual orientation and the adults concerned feel safe disclosing their sexual orientation.

The government estimates that roughly 6% of the UK population is lesbian or gay. Although our data is not complete, there may be enough data to suggest that lesbian and gay people are under-represented in safeguarding alerts. That's why we've taken action. We delivered a bespoke safeguarding adults training course to an organisation which provides housing to lesbian, gay, bisexual and transgender (LGBT) people in Islington.

Chart showing recorded Service user's main need April 2014 – March 2015



These charts both refer to the 913 adults who have had alerts raised concerning them.

We look at the care needs of the people who had a safeguarding alert raised about them. This is to make sure that there are no particular groups that are not getting the safeguarding support they might need.

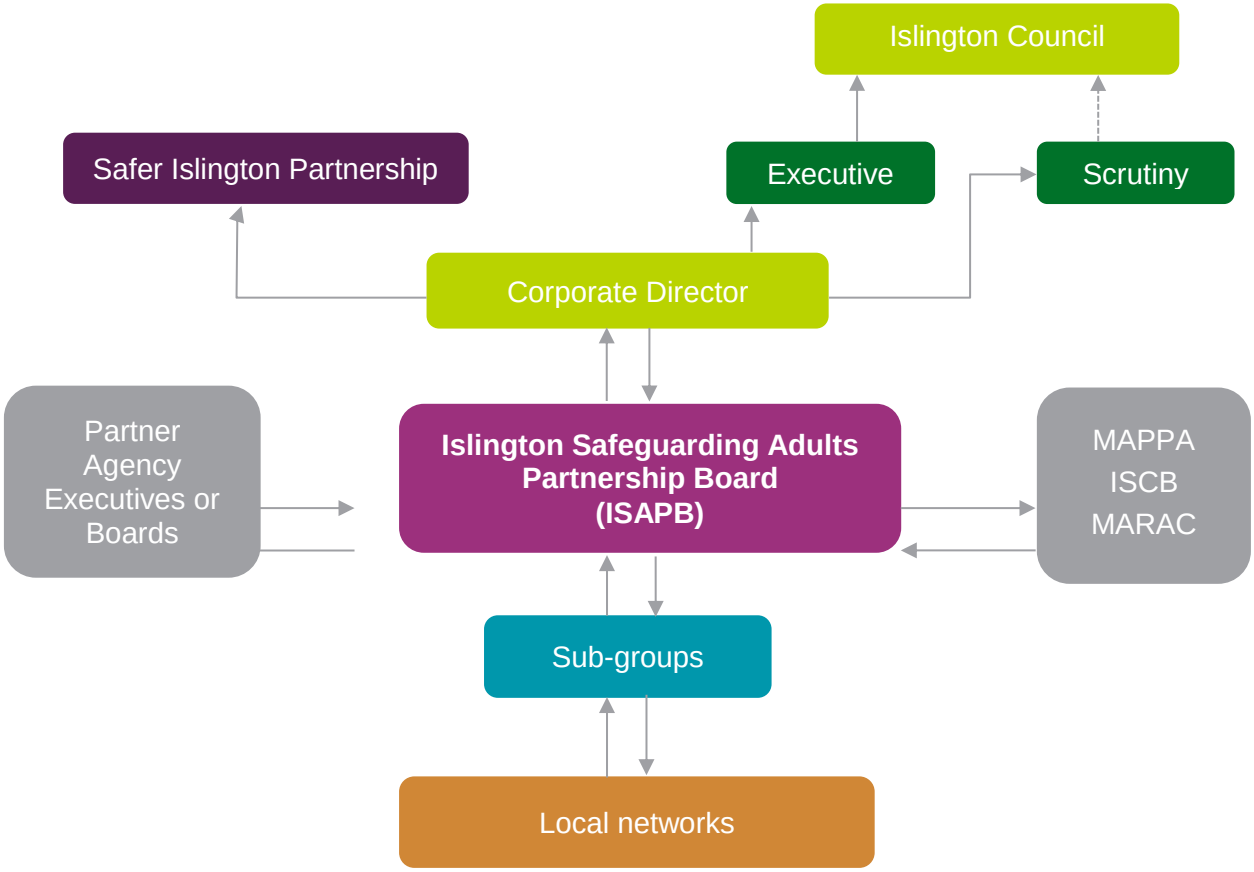
As in previous years, there continue to be more alerts raised about people with physical disability than any other care need group. This is also consistent with other boroughs in London and across England.

The chart shows that very few alerts were raised for people whose main need is that they care for someone else. Although this is an improvement on previous years, it suggests that we may need to do more to make sure carers are receiving all the help they need, including safeguarding support.

Appendix B

How the partnership board fits in

The picture below shows how the Islington Safeguarding Partnership Board fits in with other organisations and partnerships. The arrows and lines show who reports to whom.



Council – All elected councillors. It is the lead body for the local authority.

Executive – Eight councillors who are responsible to the council for running the local authority.

Scrutiny – This is a group of 'back bench' councillors who look very closely at what the council does.

Safer Islington Partnership – This is a group which looks at crime and community safety. It involves the council, police, fire service, voluntary sector and others.

Corporate Director (for Housing and Adult Social Services) – Is responsible for setting up and overseeing the ISAPB.

ISAPB – This has an independent chair who does not work anywhere else in the council or partner organisations.

MAPPA – Multi-Agency Public Protection Arrangements is a group which oversees management of offenders who pose a serious risk to the public.

ISCB – Islington Safeguarding Children's Board works to safeguard children in the borough.

MARAC – Multi-Agency Risk Assessment Conference. This group responds to high risk domestic abuse.

Appendix C

Who attended our board meetings?

Engagement from our partners in the work we do is important. Although much of the work goes on behind the scenes, it is also important for our partners to take part in the meetings.

Four times a year we hold Board meetings. We also invite our partners to attend an away-day and a challenge event with the Camden Safeguarding Adults Board. The table below sets out which organisations were represented at these meetings.

Partner Organisation	Board Meeting 07-May-14	Board meeting 23-Jul-14	Board meeting 04-Oct-14	Away Day 20-Nov-14	Board meeting 28-Jan-15	Challenge Event 16-Mar-15
Independent Chair	P	P	P	P	P	P
Islington Council	P	P	P	P	P	P
Islington Safeguarding Children's Board	P	P	P	P	P	A
Safer Islington Partnership	A	P	A	N	A	A
Islington Clinical Commissioning Group	P	P	P	P	P	S
Moorfields Eye Hospital NHS Foundation Trust	P	A	P	N	P	P
London Fire Brigade	A	P	P	P	P	P
Camden & Islington Foundation Trust	P	P	P	P	N	P
Whittington Health	P	S	P	P	A	P
Police	P	P	P	P	P	P
CPS	~	~	~	~	~	~
Probation	P	A	P	P	P	A
London Ambulance Service	A	A	P	P	P	P
Co-Opted Organisation						
Age UK Islington	P	P	P	P	A	P
Notting Hill Housing Group (Home Support)	P	A	P	P	P	P
Islington LINK/Healthwatch Islington	P	P	P	P	P	P
Single Homeless Project	S	P	P	P	P	P
Attendees						
CQC	C	C	A	C	C	C
NHS England	~	A	A	P	N	A
LBI Councillor	A	P	A	P	P	P

Key

P = Present
A = Apologies no substitute
S = Substituted
N = no apology or substitute recorded

C = Does not attend; receives papers only

Appendix D

Our impact on the environment

The work of the Safeguarding Adults Partnership Board has a low impact on the environment in Islington. Environmental impacts include fuel use for vehicles visiting service users, carers and their family and other general office impacts such as paper and energy use. Wherever possible, we manage the impact on the environment. For example, wherever we can we avoid printing documents and send out electronic versions instead to reduce paper and energy use. From time to time we hold 'virtual' meetings on line to cut our travel impact.

Sometimes our work also highlights opportunities to reduce household environmental impacts. For example, we might refer adults at risk to the Seasonal Health Intervention Network (SHINE). SHINE gives energy saving advice to residents. Not only does this help the environment, but it also reduces fuel poverty and improves the health and wellbeing of residents in Islington.

For more information about SHINE, see http://www.islington.gov.uk/services/parks-environment/sustainability/sus_awarmth/Pages/shine.aspx

Appendix E

What should I do if I suspect abuse?

Everybody can help adults to live free from harm. You play an important part in preventing and identifying neglect and abuse.

If you suspect abuse or neglect, it is always safer to speak up!

If you suspect abuse of a vulnerable adult, please contact:

Adult Social Services Access and Advice Team
Tel: 020 7527 2299
Email: access.service@islington.gov.uk
Fax: 020 7527 5114

You can also contact the **Community Safety Unit** which is part of the police:

Tel: 020 7421 0174

In an emergency, please call 999.

For more information please see:

www.islington.gov.uk/safeguardingadults

For advice on **Mental Capacity Act and Deprivation of Liberty Safeguards** you can contact the Islington DoLS office on:

Tel: 0207 527 3828
Email: dolsoffice@islington.gov.uk

All the people whose faces you can see in the photographs in this review have agreed for their images to be used.
We hope you enjoyed reading this review. If you would like to let us know your thoughts, please email: **safeguardingadults@islington.gov.uk** or write to us at:

Safeguarding Adults Unit, Islington Council, 3rd Floor, Newington Barrow Way, Islington, London, N7 7EP

HEALTH SCRUTINY COMMITTEE
WORK PROGRAMME 2015/16

19 MAY 2015

1. Membership, Terms of Reference and Dates of Meetings
2. Work Programme 2015/16 and prioritisation of scrutiny topics
3. 11/Out of Hours service specification
4. Islington CCG Annual report
5. Scrutiny Review – Patient Feedback – Draft recommendations
6. Health and Wellbeing Board - update

02 JULY 2015

1. Drug and alcohol misuse – Annual Update
2. Camden and Islington Mental Health Trust Quality Account
3. Whittington Hospital defecit
4. Islington Healthwatch Annual Report
5. Scrutiny Review – Health Implications of Damp Properties – Approval of SID
6. Work Programme 2015/16
7. Health and Wellbeing Board – update

14 SEPTEMBER 2015

1. NHS Trust – Whittington Hospital – Performance update
2. Scrutiny Review – Health Implications of Damp Properties - Presentation
3. 111/Out of Hours service
4. Work Programme 2015/16
5. Hospital Discharges
6. Health and Wellbeing Board – update

19 OCTOBER 2015

1. London Ambulance Service – Performance update
2. Scrutiny Review – witness evidence
3. Annual Adults Safeguarding report
4. Work Programme 2015/16
5. Procurement of GP premises
6. Health and Wellbeing Board - update

23 NOVEMBER 2015

1. Scrutiny Review – witness evidence
2. Work Programme 2015/16
3. Presentation Executive Member Health and Wellbeing
4. 111/Out of Hours service – Draft service specification and consultation responses
5. Health and Wellbeing update
6. Value Based Commissioning

07 JANUARY 2016

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – witness evidence
3. Work Programme 2015/16
4. Health and Wellbeing Board - update

08 FEBRUARY 2016

1. Child Protection in Islington – Annual Update
2. Scrutiny Review – Draft recommendations
3. NHS Trust – Moorfields – Performance update
4. Work Programme 2015/16
5. Health and Wellbeing Board - update

11 APRIL 2016

1. Scrutiny Review – Final report
2. Scrutiny Review – GP Appointments – 12 month report back
3. Work Programme 2015/16
4. Health and Wellbeing Board – update

16 MAY 2016

To be determined

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