London Ambulance Service
NHS Trust

Strategic Plan

2006/07- 2012/13

A World Class Ambulance Service

That Responds Appropriately to All Our Patients

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Strategic Plan 2006/07-2012/13

1. Introduction

1.1 Background

This Strategic Plan sets the direction for the London Ambulance Service NHS Trust (LAS) and outlines how it will be implemented in the wider context of developments in the NHS in the fields of emergency, urgent and out of hours care. It describes what the LAS will strive to deliver for its patients, the public of London and other key stakeholders for the period 2006/07 to 2012/13, culminating when the Olympics come to London.

In order to drive forward service improvement and modernisation in the future the plan builds on the achievements of the Service Improvement Programme 2000/01-2005/06 which turned the organisation into a two star Trust achieving national targets in the face of increasing demand. As such it maps the route to achieving the LAS Vision, Purpose and 'CRITICAL' Values (Appendix 1), translating these into tangible outcomes and programmes of work to deliver them:

Vision: *A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.*

Purpose: *The purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement.*

We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London.

The development of this seven year strategic plan is founded on carrying forward Government policy for the provision of emergency, urgent and out of hours care, specifically building on the NHS core principles documented in the Government's 10 year *NHS Plan* published in 2000, the NHS planning and governance framework "*Standards for Better Health"* published in July 2004, the Department of Health's National Ambulance Review "*Taking Healthcare to the Patient: Transforming NHS Ambulance Services*" published in June 2005, the Health White Paper *"Our Health, Our Care, Our Say"* published in February 2006 and publications in late 2006 on the development of urgent care and accessing emergency care.

The plan is also based on:

- Extensive consultation with eight key stakeholder groups during 2005: patients and public; Primary Care Trusts; NHS partners; police and fire services; LAS staff; Department of Health and Strategic Health Authorities; the Greater London Authority and London Boroughs; and key suppliers. Discussions with patients, unions, commissioners and other stakeholders are ongoing;

- Identification of a number of strategic choices about long-term direction regarding the scope and scale of future LAS activity given developments in the wider NHS and London and what the

implications for the organisation are likely to be. The strategic choice of direction will remain relatively constant over the period of the plan but the tactical plans to realise the ambition will of necessity need to be flexible to respond to internal developments and external drivers for change.

The consultation undertaken and strategic choice made has helped the Trust Board identify the way forward to be:

"A world Class Ambulance Service that Responds Appropriately to All Our patients"

2. Strategic Context

2.1 Baseline: current services and performance

The London Ambulance Service operates in two areas, firstly Accident and Emergency (A&E) care commissioned by the Primary Care Trusts in London for the populations they serve. The second operational area is Patient Transport Services (PTS) where the LAS wins contracts through competitive tendering. These contracts are for the transport of patients to and from locations for medical attention or to hospices when Paramedic or Emergency Medical Technician attendance during transit is not required.

Service Improvement Programme 2000/01- 2005/06

Since the year 2000 the focus for development of both Accident and Emergency and Patient Transport Services has been the Service Improvement Programme. Substantial, quantified progress over the period has been made as follows:

People:

- A substantial shift in staff attitudes and morale (e.g. 60% of respondents in the autumn 2005 feel positive about working for the LAS compared to 42% in autumn 2000);
- Reductions in assaults on staff (153 reported assaults on staff per 1000 staff in 2000 reduced to 87 reported assaults per 1000 staff 2005/06);
- Reductions in staff sickness (reduced from 8% in 2000 to 6.69% in 2005/06).

Patients:

- Cardiac arrest survival rate increased from 2.5% in 1998 and 1999 to 10.9% in 2005/06;
- Increasing proportion of demand diverted to more appropriate care, increasing from 0% in November 2000 to 23.6% in March 2006 and 33% in December 2006;
- A comprehensive cleaning and equipping system (the Make Ready scheme) in place in all complexes by end of March 2006;
- Clinical supervision in place across the Service with the introduction of Team Leaders and Sector Trainers;
- Reductions in complaints in A&E and PTS (e.g. from 5.2 complaints per 10,000 journeys per month in A&E in November 2000 to 1.507 in 2006);
- The development of a PPI strategy and appointment of a PPI manager;
- The roll-out of a drugs management system across the Service.

Performance:

- Category A performance improvement from 40% in 8 minutes in 2000 to 75.1% for the year 2005/06 with a higher absolute number of such calls being responded to in 8 minutes at the end of the period as a consequence of substantial growth in call volume;
- Category A14 up from 83% in 2000 to 95.08% in 2005/06;
- Category A activation time within 2 minutes up from 68% to 86.33%;
- Reductions in vehicle accident rates for both A&E and PTS vehicles (e.g. 5.53 RTAs per 10000 activations in 2005/06 down from 16.16 in 2000 for A&E vehicles) ;
- Internal efficiency savings of £3m pa realised to help fund development activity.

What follows is a review of current services and their performance baseline for this strategic plan, founded on the achievements of the Service Improvement Programme.

Accident and Emergency

Current A&E services can be categorised either in terms of Access or Response with service performance measured primarily but not exclusively in terms of speed in line with national targets, or in the case of Category C calls (see below) local arrangement with Primary Care Trust commissioners .

Access

The only way of accessing LAS services is by telephone. Calls are assessed as either immediately life threatening (Category A), not immediately life threatening but requiring an emergency response because of their seriousness and potential to become life threatening (Category B) or requiring an urgent clinical response but not conditions of sufficient acute seriousness to warrant an immediate emergency response (Category C). Calls are initially handled by the Emergency Operations Centre (EOC) and if assessed as Category C passed to the urgent Operations Centre (UOC). Service performance in relation to these call categorisations is measured against the following targets:

- 95% of 999 calls answered within 5 seconds
- 95% of doctors' "Urgent" calls answered in 30 seconds
- Activation time for a response vehicle for 95% of calls within 2 minutes for Category A and Category B calls;
- A call back by a Clinical Telephone Advisor for Category C (Green) calls within 30 minutes in 100% of cases, (with 60 minutes response if a vehicle is found to be required following CTA).

The achievements arising from *Service Improvement Programme* launched in 2000/01 and performance in 2005/06 outlined in the table below provide the baseline for this strategic plan.

Performance Target	2005/06 Actual
95% of 999 calls answered within 5 seconds	74.1%
95% of doctors calls answered in 30 seconds	66.8%
Activation time for a response vehicle for 95% of calls within 2 minutes for Category A calls	86.33%
Activation times for a response vehicle for 95% of calls within 2 minutes for Category B calls	53.71%
A call back by a Clinical Telephone Advisor for Category C (Green) calls within 30 minutes in 100% of cases. Extended to 60 minutes if a 30 minute ring-back is performed and a second call is warranted	Data not available as calls exceeding this time limit automatically returned to the Emergency Operations Centre but the system is not capable in 2005/06 of separating this group of calls

Response

Once the service has been accessed by telephone a variety of responses may be made depending on the categorisation of the call. Service performance is measured against the following targets:

- Arrival on scene within 8 minutes in 75% of cases for Category A calls (from call connect to the control room as from April 2008 – see below);
- Arrival on scene within 19 minutes in 95% of cases for Category A calls;
- Arrival on scene within 14 minutes (19 minutes from April 06) in 95% of cases for Category B calls;
- Arrival in hospital within 15 minutes of the Stated Time of Arrival in 95% of GP Urgent calls (clock stops on arrival of the ambulance clinician from April 2006 – see below);
- Arrival on scene within 60 minutes of the original call in 100% of appropriate cases for Category C (Green) calls if the Clinical Telephone Advisor decides that attendance by LAS personnel is warranted. These may be Paramedics, Emergency Medical Technicians (EMTs) or Emergency Care Practioners (ECPs).

The achievements arising from the *Service Improvement Programme* 2000 and performance for 2005/06 outlined in the table below forms the baseline for this strategic plan.

Performance Target	2005/06 Actual
Arrival on scene within 8 minutes in 75% of cases for Category A calls	75.1%
Arrival on scene within 14 minutes in 95% of cases for Category A calls	95.08%
Arrival on scene within in 95% of cases for Category B calls in 14 minutes	75.02%
Arrival on scene within 60 minutes of the original call in 100% of appropriate cases for Category C (Green) calls when the Clinical Telephone Advisor decides that attendance by LAS personnel is warranted.	Data not available as calls exceeding this time limit automatically returned to the Emergency Operations Centre but the system is not capable in 2005/06 of separating this group of calls

As a consequence of the National Ambulance Review it has been decided by Government that:

- as from April 2008, for the purposes of measuring 999 Category A and Category B response times the clock should start when the call is connected to the ambulance control room to more closely match the patients' experience and to ensure consistency across the country;
- by April 2009 national performance requirements for Category B response times should be replaced by clinical and outcome indicators against which performance should be managed locally;
- as from April 2007 the performance requirements for responding to patients whose GP calls an ambulance on their behalf (GP Urgents) should be the same as for 999 calls, and as from April 2006, as an interim measure, the clock should stop for this group of patients when an ambulance clinician arrives at the scene.

These changes, on top of the existing national targets, present challenges for the LAS to achieve. It is accepted that the change in clock start time will reduce current reported 8 minute performance by 25-30% (ORH Modelling November 2005).

Workload profile

Like other ambulance services the LAS has traditionally been perceived as an emergency service responding to 999 calls (over 75% of respondents in the 2005 Mori survey gave answers to this effect when asked about what they thought was the most important role of the Service). The Trust has traditionally focused on this activity with a 'Blue Light' response being provided to get patients taken ill or suffering trauma to hospital Emergency Departments (A&E) as quickly as possible:

> *"Training and service provision has been organised around the needs of patients with life threatening emergencies, with severe breathing difficulties, acute coronary syndrome or suffering major trauma. The emphasis has been on life support – stabilising the patient's condition sufficiently for rapid transport to hospital for definitive care. Ambulance technician and paramedic training has focused on trauma, with double – crewed ambulances being the primary method of service delivery."* (Taking Healthcare to the Patient: Transforming NHS Ambulance Services", Department of Health, June 2005)

However only around 10% of the Service's patients are in immediate danger of dying and around another 10% also require an immediate response because, unless attended to quickly, their condition may deteriorate seriously.

Around another 20% of patients are in no danger of dying but nevertheless need the LAS to be there quickly, often because of the pain they are experiencing or complications which might develop if help does not arrive within half an hour. Many of these patients require two people to assist them or they will need to lie down as they are taken to hospital or an urgent care centre, so a double crewed ambulance is required.

The remaining approximate 60% of patients do not need a double crewed ambulance and a variety of responses are possible depending on the assessment in the Urgent Operations Centre as to whether attendance by LAS personnel is appropriate or whether Clinical Telephone Advice is sufficient. The planned development of the Emergency Care Practioner (ECP) programme is a direct response to this.

Patient Transport Service

In PTS operations service provided is defined according to the requirements of each contract won. However there are some generic measures of service performance against the following targets:

- Percentage of PTS patients arriving at destination +/- 45 minutes of agreed time;
- Departure time: Percentage of patients on vehicle within I hour of notification of transport need;
- Patient Survey Results.

The baseline for this strategic plan arising from the *Service Improvement Programme* 2000 and performance in 2005/06 is given in the table below.

Performance Target	2005/06 Actual
Percentage of PTS patients arriving +/- 45 minutes	82.12%
Departure time: Percentage of patients on vehicle within I hour	87.58%
Patient Survey Results (average 2005/06) 95% scoring 5 or 6	90%

2.2 Drivers for change 1: NHS Plan, Standards for Better Health/Clinical Governance, the National Ambulance Review and the Health White Paper

The starting point for framing the Strategic Plan is the need for the Trust to make a demonstrably greater contribution to meeting NHS system-wide objectives in accordance with the Government's 10 year *NHS Plan* published in 2000, the NHS planning and governance framework "*Standards for Better Health"* published in July 2004, the Department of Health's National Ambulance Review "*Taking Healthcare to the Patient: Transforming NHS Ambulance Services*" published in June 2005 and the Health White Paper *"Our Health, Our Care, Our Say"* published in February 2006.

For the NHS as a whole up to 2008 the primary delivery vehicle for these are the three year Strategic Health Authority (SHA) and Primary Care Trust (PCT) Local Delivery Plans, detailing how the NHS targets set out in the NHS planning framework will be achieved. The LAS has a key role to play in supporting the NHS in achieving these targets, many of which depend on taking a whole system approach, with each organisation - including the LAS - playing its part in delivery, with local sharing of performance and financial data and involving front-line staff.

As an NHS Trust, the LAS sees itself as an active contributor to principles such as designing services around the people who use them, involving patients and the public, meeting national priorities and achieving cultural change. The emphasis is on:

- making measurable progress in high priority areas;
- developing capacity by increasing staff efficiency and levels where necessary, facilities and equipment;
- changing the way the whole system works, particularly ensuring greater choice for patients and users.

Every organisation needs to:

- ensure the safety of service users, including developing clinical governance arrangements;
- ensure people are fully informed and involved;
- take into account the working time directive;
- take part in emergency planning;
- continue to modernise service delivery (including sharing good practice);
- provide new skills and competencies;
- introduce new information and communication systems.

The health and social care priorities are:

- improving access to all services through better emergency care, reduced waiting and more choice for patients;
- focusing on improving services and outcomes in cancer, coronary heart disease and stroke, mental health, older people and improving life chances for children;
- improving the overall experience of patients;
- reducing health inequalities;
- contributing to the cross-government drive to reduce drug misuse.

The key national target for LAS remains maintaining response time performance of reaching 75% of patients with conditions prioritised as Category A in eight minutes. Having reached the Category A target, the LAS must concentrate on other national targets (specifically Category B, 19 minutes) and GP Urgent calls as well as improve performance against clinically focused indicators.

The new service improvement programme, and many core activities, need to link to these targets and principles. This plan is designed not only to maintain performance against the Core Standards documented in *Standards for Better Health* but also to make demonstrable progress against the Developmental Standards. These will be used by the Healthcare Commission to determine the Trust's annual performance rating and as such are essential if Ambulance Trusts in due course are expected to move towards Foundation status.

As an ambulance trust the National Ambulance Review is of particular importance as it envisages a reduction of one million in the number of patients taken by ambulance to hospital annually. While the LAS is not affected by the recent consolidation of the thirty one such trusts into twelve larger ones the outcome of the review maps out the future direction of travel. Over the next five years ambulance trusts, working with patients and the public are required to achieve not only operational but also cultural change becoming services which respond appropriately to all patients and which look, feel, behave and deliver differently, building on the principles that there should be:

- High case completion at point of both telephone contact and physical contact;
- Reduced duplication;
- Localisation - embedded with primary care and community services;
- Flexible and highly empowered workforce as the key to cost efficiency.

In developing this Strategic Plan the LAS has built on these principles in order to :

- Improve the speed and quality of call handling;
- Provide significantly more clinical advice to callers (hear and treat), and work in a more integrated way with partner organisations to ensure consistent telephone services for patients who need urgent care;
- Provide and co-ordinate an increasing range of mobile healthcare for patients who need urgent care (see and treat);
- Provide an increasing range of other services, e.g. in primary care and diagnostics;
- Continue to improve the speed and quality of service provided to patients with emergency care needs.

The implications for the LAS in doing this is that approximately 200,000 fewer patients per annum will be taken to hospital Accident and Emergency departments. A new approach to patients, callers and the public is necessary, requiring changes in vehicle, skill and workforce mix, training and education, roles, responsibilities and relationships, information management and technology as well as structure and operating arrangements. This Plan identifies the approach the LAS is taking to these challenges in order to realise in London the benefits defined by the National Ambulance Review:

- Patients receive improved care, consistently receiving the right response, first time, in time;
- More patients treated in the community, and fewer unnecessary A&E attendances;
- Greater job satisfaction for staff as they use additional knowledge and skills to care for patients;
- More effective and efficient use of NHS resources;
- Improvements in self care and health promotion.

The February 2006 Government White paper *"Our Health, Our Care, Our Say"* signalled a fundamental shift in the running of the NHS which will impact on the development of care pathways. The operational implications for ambulance services as players in a "whole systems" approach to care will need to be worked through.

Significant aspects of the White paper potentially are:

- a requirement for Primary Care Trusts to move 5% of acute hospital activity into primary care over the next 10 years;
- a re-think on the closure of community hospitals;
- turnaround teams will become service re-configuration teams in areas with persistent financial deficits;
- a possible duty on local authorities and the NHS to work together to improve the health and well-being of older people to mirror the one improving services for children.

However NHS policy and governance imperatives associated with the Trust making a greater contribution to meeting NHS system-wide objectives only provide some, all be it key, drivers for change. The Strategic Plan has been developed also with cognisance of other developments.

2.3 Drivers for change 2: Environmental scan

In addition to those drivers for change which arise from NHS and Government health policy (section 2.2) a number of emerging themes have been identified from the wider operating environment, some but not all of which are specific to London and to its ambulance service:

1. Stakeholder feedback to the Trust on what they want it to deliver to them over the forthcoming years expressed through Stakeholder Goals and targets. Collectively stakeholders want the LAS to be an accessible service that responds appropriately to patient needs while remaining focussed on delivery. They also want the Trust to more effectively engage with its patients and partners, provide greater options for patients, and have a culture built on the stated CRITICAL values (Appendix 1). This is explored further in section 3.

2. The requirements of Primary Care Trust commissioners that the LAS assist them in preventing unnecessary hospital attendances and admissions through alternative methods of responding to 999 calls and assisting in the management of chronic diseases outside of hospital in a way that is not only clinically safe but demonstrably so. This will help meet the national target that no patient should wait longer than 4 hours in hospital Emergency Departments. Commissioners also want the Service to meet existing and new response time targets in an environment of zero growth in funding through greater efficiency and provide equitable performance across London. They are also keen for the LAS to more effectively integrate with the wider health economy and play a full part in local emergency care networks.

3. The consequences of demand growth, the workload profile mentioned in section 2.1 and the impact of developments in *Out of Hours (OOH)* provision as a consequence of GPs no longer being required to provide OOH cover. The default for the public if they are unable to access healthcare out of hours (or are uncertain how to do so) is to contact the ambulance service even if their need is not an emergency. During 2004/05 call volumes rose at a rate of 7.5% and 2005/06 ended at 3.8% above the level of overall demand for 2004/05 which is in line with the long-term annual growth rate of 3%-4% per annum. Changes in OOH provision will provide a stimulus to organic demand unless carefully managed and further alter the balance between urgent and emergency calls in the workload profile. This will not only stretch the Service but also put pressure on hospital Accident and Emergency departments unless demand can be managed more effectively through alternative responses, for example deployment of Emergency Care Practioners specialised in the management of chronic conditions to treat patients in their homes and thereby reducing hospital attendance.

4. The need to respond to population and visitor growth, particularly in the Thames Gateway area, will have a further impact on demand. The affected boroughs are mainly in NE London – The City, Hackney, Tower Hamlets, Newham, Havering, Redbridge, Barking & Dagenham and Waltham Forest – but almost a third of the developments will be in the boroughs of Lewisham and Greenwich in south east London. Based on the rule of thumb that the 999 ambulance service treats 1 patient per year per 10 people in the population, a further 30,000 calls could be expected in the Thames Gateway area in 2016, compared with 2003/04. Three main issues arise from this:

I. *The impact on relative PCT contributions to the LAS* - as a consequence of the move to Payment By Results (PBR) where PCT contributions are related to actual activity rather than weighted capitation which has been the basis hitherto for the service level agreement which was last re-based in 1991. The last time this was reviewed, in 1999, it became clear that the consequences would have been considerable for PCT allocations, and for this reason, commissioners chose not to pursue it. However, differential population increases of the nature proposed for the Thames Gateway area in the context of PBR make a re-structuring of PCT funding unavoidable;

II. *Resource requirements (with revenue and capital consequences)* - an extra 30,000 calls represents the average yearly workload of three ambulance stations. The costs of this are considerable in capital and revenue terms. Primary Care Trusts in the Thames Gateway area need to be aware of this now and to work with the LAS on modelling the consequences. They should also be considering the LAS when planning any new build (health centres etc.) since costs to the whole health economy may be reduced by including ambulance stand by points, or even stations, within plans (see 5 below);

III. *The potential to develop new models of care* - the LAS worked with the old North East London Strategic Health Authority to develop thinking on how the ambulance service contribution to emergency care should be included in the vision for the Thames Gateway area. As there will be no new hospital for the area, the emphasis will clearly need to be on avoiding A&E attendance if at all possible. This points towards a skewing of investment towards Emergency Care Practitioners (ECPs) over Emergency Medical Technicians (EMTs) or Paramedics.

The opening of Heathrow Terminal 5 will have the effect when working to full capacity of doubling the number of people passing through the airport. This will present additional challenges to service provision in that location.

5. <u>Opportunities for co-location with PCT facilities</u> when they consider new builds. There are considerable service benefits associated with co-location, with the potential for new models of care. There may also be cost benefits. However, the LAS needs ideally to locate its vehicles in areas with easy access to main roads and as close as possible to areas of high demand. Therefore the LAS needs to work more closely with PCTs so they consider the LAS at the earliest possible stage when any new builds are planned, even before decisions have been made about where to locate facilities.

6. <u>The need to further develop and deliver new local Category C measures</u> as an agreed response with PCT commissioners and patient groups to the Government announcement that there is no longer a national response time target for Category C patients, particularly a new focus on outcome measures for specific disease groups. Ambulance services are expected to develop appropriate performance measures and PCTs/SHAs are expected to monitor ambulance services against these targets. Once developed, some of these measures may have investment implications, including, potentially, implications for investment elsewhere in the health economy.

   While some Category C measures may be generic and simple (e.g. the proportion of patients receiving telephone advice within appropriate timescales), others may need to be more sensitive to the needs of specific patient groups. Older people who fall are a good example. The Older People's NSF places an obligation on ambulance services to refer uninjured fallers to falls teams. A measure could be developed for this (numbers, timeliness etc.).This approach should not be confined to Category C patients, however.

There is scope for the development of an appropriate measure in any disease area where there is evidence or guidance for what care is appropriate. Disease/condition groups for whom such an approach could be adopted include: Epileptic patients; Diabetic patients; Asthmatic patients; Patients with Chronic Obstructive Pulmonary Disease (COPD);Mentally ill patients; Older people who fall; Cardiac patients; and Stroke patients.

For seriously ill and injured patients (e.g. myocardial infarctions, stroke and trauma) the most appropriate place of care maybe a specialist unit more distant than the nearest district general hospital. This approach to care is consistent with discussions about how hospital services should be re-configured. However longer distances travelled have resource implications for the ambulance service which need to be factored into discussions.

It is likely that securing appropriate pathways for these patients will require significant investment in additional knowledge and skills for LAS frontline staff including expanding the Emergency Care Practioner (ECP) programme – see section 4.1. ECPs convey around half the patients they attend, whereas normal ambulance crews convey 75 – 80%. The impact on numbers of hospital admissions and lengths of stay is not clear as yet. However, the same principles apply as do within the A&E department: if you increase the skill level at the "front door", you can reduce escalation, hand-offs and delays. All frontline staff will need to be given increased diagnostic and treatment skills as solo responders become a greater percentage of the workforce.

The impact of these investments is highly dependent on the appropriate alternatives to A&E being in place, accessible to frontline staff and resourced to meet the presenting need. This means that, for the full benefits to be achieved of a workforce with higher skill levels, there will need to be investment in the downstream pathways in health and social care.

7. Any possible future requirement by Government for PCTs to divest themselves of their provider functions would present a potential opportunity for the LAS to form closer association with other healthcare professionals such as District Nurses, Community Matrons, GPs and Health Visitors who like ambulance staff and ECPs bring the NHS into people's homes. Greater numbers of autonomous professionals working closely with colleagues in other health and care organisations would have different expectations from their employer. The LAS would need to respond to this, as well as embedding the successful change that has taken place so far. Results of successive staff surveys show that improving delivery has improved the climate at the LAS so that morale is higher than before and people are proud to work for the service. The LAS Organisation Development programme is aimed at making the change sustainable by addressing the organisation's culture. PCT support for this activity will add to the internal drive for change.

8. Demographic changes in the population will present particular challenges to service provision in the future. Not only is the population hyper-diverse with 28.8% of the population classified as being of Black and Minority Ethnic (BME) but also 25% of people were born outside the United Kingdom and no less than 300 languages are spoken in the Capital. Over the next ten years people from BME backgrounds will make up over 80% of the increase in London's working age population. Additionally there will be fewer young people in the population, reducing the pool for recruitment and increasing competition between employers in the labour market. In common with other employers the Trust will have to consider carefully its proposition to the labour market within the parameters set by the NHS pay and conditions framework "*Agenda For Change"*.

9. Emergency preparedness for and response to terrorist threats and conventional major incidents must remain a priority issue in the wake of events on 7 July 2005. The LAS has received additional support from central sources in order to enhance its ability to respond to potential acts of terrorism. Some of this support has been non-recurrent, which needs to be addressed.

10. The Olympic and Paralympic Games coming to London in 2012 present particular challenges to the Service with the influx of an exceptionally large numbers of people into the capital and the need to provide dedicated cover at sporting venues. Resources will need to be allocated to both planning for the Olympics and to provide the additional operational cover required. The impact of the legacy of population growth must also be taken into account alongside the planning for Thames Gateway growth already discussed.

11. NHS funding constraints in the context of the amalgamation of the previous five Strategic Health Authorities in London into one (as from April 2006) may bring about structural change in the pattern of service provision in acute trusts in the Capital. This could have operational implications for the LAS in terms of where it takes patients when they have particular conditions and consequently impact on the achievement of performance targets.

12. Re-configuration of Acute Trust services in London with not all Emergency Departments offering the full range of specialist services will present new challenges to meeting performance targets as ambulances will have longer distances to travel, for example the further development of Cardiac Care and specialist Stroke and Trauma Centres.

3. Strategic Direction and Objectives

3.1 Approach and methodology

This document brings together two strands of work that have been undertaken during 2005 to define the strategic direction of the London Ambulance service from 2006/07 to 2012/13. This section explains how this direction of travel is defined and a graphical representation of the approach is given overleaf.

The core concept behind the approach to development of this Strategic Plan was to base it on delivery of the "*Vision"* for the London Ambulance Service as a "World Class Ambulance Service" as seen from the perspective of eight key groups of stakeholders. This is based on consultation with them.

As a consequence of the stakeholder consultation a short description was developed for each group as to what the Trust would deliver to them by the end of the plan period which would define their experience of interacting with it. This description has been termed a *"Stakeholder Goal"*.

Common underlying themes from these Goals have been identified and termed *"Stakeholder Aspirations"* which have been expressed in tangible terms through measures and targets. This enables progress towards achieving what stakeholders want from the LAS to be tracked, progress managed over time and achievement demonstrated at the end of the plan period. These are "*Lagging (outcome) Measures"* which report outturn performance historically over previous months at year end.

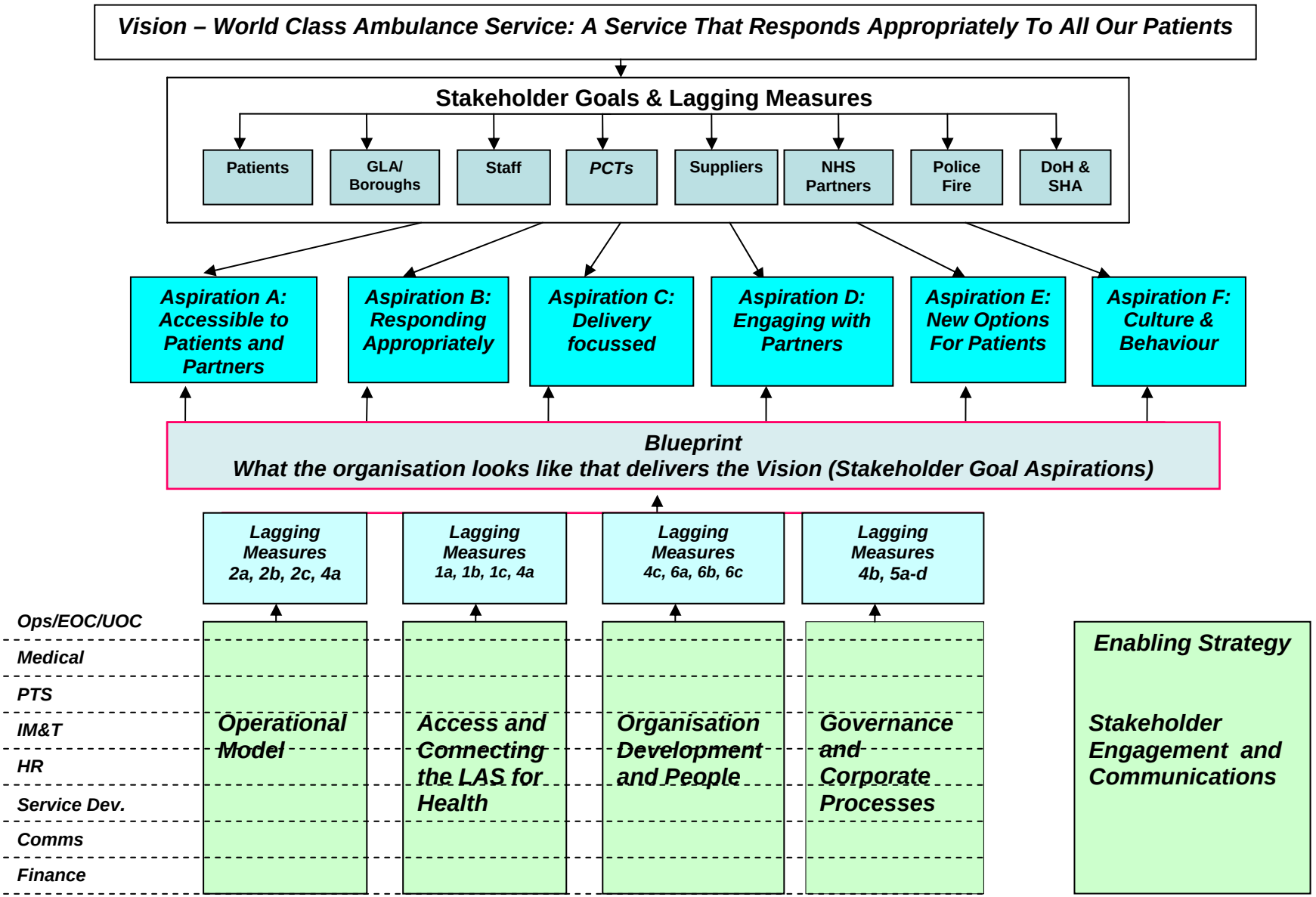
However, given that the organisation does not exist in a vacuum, delivery of the identified *Stakeholder Aspirations* has to take place with cognisance of the drivers for change identified in section 2 of this plan. Concurrently work has been undertaken to envision the scope of LAS activity in the future given developments in the wider NHS and London and what the implications for the organisation are likely to be. This gives rise to a number of strategic choices as to future direction.

These two strands of work, the Stakeholder Goals/Aspirations and the envisioned scope of future operations have been brought together to define a "*Blueprint*" of what the organisation needs to look like in the future.

The delivery mechanism to achieve the Blueprint and Vision is a programme of service improvement and modernisation comprising four cross-functional "*Vital Few Strategic Programmes"* for transformational change and an enabling *Stakeholder Engagement and Communication Strategy*. These have been developed for implementation over the next seven years so that at the end of the period the LAS will "look, feel and behave differently" as described by the Blueprint.

Each strategy has forward looking *"Leading Measures"* associated with it which enable ongoing performance management on a monthly basis. These relate to the activities which determine achievement of the targets set against the lagging (outcome) measures. The new LAS approach to performance management which comprises both the lagging and leading measures brought together in a Balance Scorecard is described in section 7 of this document.

The LAS has had a focus on "*Organisation Development*" (OD) for several years. The required changes to service delivery will not be achieved if the Trust does not pay equal attention to the organisation's structures, capacity and capability, culture, attitudes and behaviour.


Vision – World Class Ambulance Service: A Service That Responds Appropriately To All Our Patients
Stakeholder Goals & Lagging Measures
Patients
GLA/ Boroughs
Staff
PCTs
Suppliers
NHS Partners
Police Fire
DoH & SHA
Aspiration A: Accessible to Patients and Partners
Aspiration B: Responding Appropriately
Aspiration C: Delivery focussed
Aspiration D: Engaging with Partners
Aspiration E: New Options For Patients
Aspiration F: Culture & Behaviour
Blueprint
What the organisation looks like that delivers the Vision (Stakeholder Goal Aspirations)
Lagging Measures 2a, 2b, 2c, 4a
Lagging Measures 1a, 1b, 1c, 4a
Lagging Measures 4c, 6a, 6b, 6c
Lagging Measures 4b, 5a-d
Ops/EOC/UOC
Medical
PTS
IM&T
HR
Service Dev.
Comms
Finance
Operational Model
Access and Connecting the LAS for Health
Organisation Development and People
Governance and Corporate Processes
Enabling Strategy
Stakeholder Engagement and Communications

3.2 Organisation Development

The changes described throughout this plan will make Trust services quite different. This means the organisation will need to be different in many ways too.

An organisation built around the idea that every patient is in immediate danger of losing their life has to respond and provide technically expert care quickly. When a patient's life depends on getting things right promptly, tight discipline is needed, and in this context a "command and control" style of management is sometimes necessary too.

But most LAS patients need a caring response more than they need a quick one. They need staff to spend time with them – understanding their situations and resolving their problems. The skills needed are less "technical" – involving skilled communication based on education in assessment and understanding of underlying causes and chronic illnesses and the ability to work with other health professionals in the community to secure the right next step for the patient.

The ambulance professional of the future will have far more independence in decision-making and they will follow guidelines, rather than rules. The emphasis will be on clinical leadership. A command-based or protocol-driven approach will only be right for these professionals on the rare occasions when saving life depends on giving and following instructions.

The above is also reflected in the way the organisation is led and managed. Whilst a transactional, managerial approach is sometimes necessary, and is an important part of the leader's toolkit, it can no longer remain the prevalent or default style. The leadership of the organisation must be approached in the same way that patient care must be approached, with a view to engaging and communicating with individuals to better understand and meet their needs, and motivate and inspire them to develop both themselves and the organisation to enable continual growth, effectiveness and success.

This is what is meant by "an organisation that looks, feels and behaves differently".

To some extent this "cultural change" will just happen by virtue of the fact that the LAS changes its' response regime and increases workforce skills. However, there will need to be an integrated approach across the organisation to changing not only systems, processes and structures, but also how things are done and the way in which staff are engaged and the organisation led if the Service are to be successful in reaching this goal.

To this end the Organisation Development & People programme includes:

- Implementing a workforce plan that supports the operational model and aims for a staff profile that better represents the population of London;

- Establishing a workforce whose personal values, attitudes and behaviours mirror those espoused and promoted by the organisation;

- Providing the workforce with the appropriate skills and resources to enable them to feel confident in delivering optimum patient care;

- Introducing meaningful, ongoing personal development and review whereby all members of staff will have a chance to discuss their progress and their aspirations with their manager;

- Safeguarding the time for training, education and development that is allowed for in our resourcing plans and holding managers to account for releasing staff for training, and staff to account for engaging in it;

- Introduce a process for succession planning, and a programme of talent management, to allow staff the opportunity for further development and career progression;

- Establishing the prevalence of a management style that is supportive of staff, promotes staff involvement and development, and enables the emergence of leadership at all levels;

- Providing development opportunities for managers and teams throughout the organisation by means of an integrated leadership and management development programme;

- Becoming a 'Learning Organisation' that works cross-functionally and in a customer-focused and team-based way with all colleagues and partners, both internally and externally;

- Ensuring systems are in place to make staff able, and feel able, to participate, be heard, and thereby influence organisational decision making;

- Embracing a culture of mutual challenge and personal accountability for behaviour and performance;

- Developing resilient face-to-face, two-way communication processes throughout the organisation and ensuring that information gained and shared enable further organisational improvement;

- Using "service improvement" techniques to involve staff in improving systems and increasing efficiency so that we work smarter instead of just harder and make the working day smoother and less frustrating for everyone.

3.3 Vision: Stakeholder Goals, Aspirations and Outcome Objectives – "A world class ambulance service….."

Vision

The London Ambulance Services aspires as its *Vision* to be "A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care", with the stated purpose "to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement. We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London".

In reality "World Class" looks like different things to different people depending on the nature of their inter-action with the Service and as such is subjective. To be "World Class" requires the organisation to meet the differing stakeholder needs and provide them with an experience of it which at least meets if not exceeds their expectations and leaves them feeling satisfied. Understanding what it is that key stakeholders want is therefore crucial.

LAS Stakeholder Goals, Aspirations and Outcome Objectives

There are eight groups who have been identified as key stakeholders in the London Ambulance Service NHS Trust:

- Patients and the Public, particularly BME groups (including the Patients' Forum);
- Primary Care Trusts;
- Department of Health/ London Strategic Health Authorities.
- LAS staff;
- NHS Partners (General Practioners and other London NHS Trusts);
- Greater London Authority/London Boroughs (particularly Social service Departments);
- Blue Light Emergency Services (Metropolitan Police and London Fire Brigade);
- Strategic Suppliers (mission critical supplies).

Following extensive consultation with them during 2005 and research by Mori in 2006 into public perceptions of the LAS a short description was developed for each group as to what they wanted the Trust to deliver to them by the end of the plan period which would define their experience of interacting with it. These descriptions, the "*Stakeholder Goals*", have been used as one of the key foci in planning for 2006/07-2012/13. These *Stakeholder Goals* are given in the diagram overleaf.

There is commonality of requirements and overlap between the Goals and the underlying themes have been identified and a consolidated list of *"Stakeholder Aspirations"*, things that they collectively are looking for LAS to deliver, has been distilled. It is these core deliverables expressed in the Goals that the organisation has to deliver over the seven years of the Strategic Plan period to achieve its Vision. The organisation needs to develop so it is configured to perform in the desired way.

Vision

A world-class ambulance service for London Staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.

Values

C*linical Excellence* ***R****espect and courtesy* ***I****ntegrity* ***T****eamwork* ***I****nnovation and flexibility* ***C****ommunication* ***A****ccept responsibility* ***L****eadership and direction*

Stakeholder Goals

Patients &Public

An organisation which provides the right response, in the right place, at the right time to satisfy patient's needs, balancing response time targets with what patients really want and need. This requires:
1.The LAS to work collaboratively in partnership with other providers across the health and social care system, thereby creating a shared responsibility for the health and wellbeing of our citizens;
2.Easy and patient centred access routes, responses (be that treatment, conveyance, referral etc.) in and outside of the home based on their diverse needs, conditions and cultural characteristics;
3.Continuous engagement, two way communication and feedback from the many communities of London to ensure that patients and their carers drive continuous service improvement;
4.Staff treating all patients and public according to the LAS Values, sensitively and with awareness of diversity in cultural norms.

GLA/London Boroughs

The LAS will deliver an integrated, responsive and person-centred health and social care system based on frameworks developed with other partners, meeting the varied and diverse needs of individuals, communities and local authorities. This is done through:
(a) Information
-Vulnerable people
-Epidemiology
-Ethnicity
(b) Contributing to each other's planning activities
(c) Identifying gaps in service provision

Staff

'I will make a positive contribution to everyone's well being whilst delivering excellence, supporting and challenging others and myself in the provision of a world leading service'

PCTs

Jointly ensure points of access to pathways that deliver appropriate care relevant to patient needs, through integration with local health and social care providers in the community. A flexible, skilled, confident, empowered and proactive partner service which inspires patient confidence and provides them with high quality outcomes, using shared information and resources to manage demand effectively across the system.

Strategic Suppliers

To achieve world class status as a customer the LAS will be a streamlined, forward thinking, flexible organisation that delivers a quality service through planning ahead, engaging in shared innovation and continuous, long-term collaboration. A partner that engages in trusting relationships focussed on achieving realistic shared objectives with the end goal of improved clinical effectiveness. Providing a consistent network of knowledgeable people to work with and communicating in an open, positive, timely fasion with supply partners. LAS will be clear and unambiguous with requirements, empathise with supplier needs and listen to reason. Not driven by price alone but rather looking for best value and continuous improvement over time.

NHS Partners

A prompt service that we can rely on to be there for our patients when we need it, staffed by skilled professionals who can secure the right care in both emergency and urgent situations. This may include taking fewer patients to hospital and utilising the full range of primary and community health services that are available.

Blue Light Emergency Services

An ambulance service that will prioritise requests from 'Blue light' services. A trusted partner in intelligence led operations. Driven by the overarching need to deliver an effective and timely response to the Capital, recognising local needs and diversity. By:
Joint learning/ training/ risk assessment;
Sharing skills, resources, information;
Jointly supporting public education programme;
Delivering a speedy fast response;
Supporting the overall objectives of the emergency services;
Developing a memorandum of understanding

DoH & SHA

A three star Service which meets national targets for performance and cost efficiency, delivering its part of the NHS Plan, deploying national NHS strategies and achieving high satisfaction scores from patient, public, governmental and NHS partner stakeholders

Stakeholders told the LAS that they wanted it to be an accessible service that responds appropriately, engages the public, its patients and partners, provides greater options for patients, continues to focus on delivery and has a culture built around its CRITICAL values (see appendix 1). The six Aspirations which define the specifics to be delivered over the plan period expressed in both words and tangible, quantified outcome objectives (*Lagging Measures and Targets*) are:

Stakeholder Goal Aspirations	Outcome Objectives	
	Measure	**Target**
1. An accessible service… – ***Accessible to Patients and Partners:*** *E*asy to contact; recognising diversity; responding to partners with right level of authority given to Ambulance Operations Managers	1a **Community engagement and meeting the needs of the population** Systems are in place to ensure that anyone can access our service, regardless of language, disability, age etc.	90% of the population by 2012 (measure to be defined)
	1b **Sharing information externally and promoting best practice** Systems are in place to share data with our partners and stakeholders e.g. Extranet for partners to access	By 2008
	1c **Improved information sharing within the LAS** Provide up to date and accurate information to all staff who need it from a single source, which is re-usable and accessible: input at the most appropriate level to ensure timeliness	By 2008
2. …that responds appropriately… ***- Responding Appropriately:*** *Right response, right place, right time; timely, reliable (for patients and professionals); measured in terms that mean something to patients; appropriate priority to blue light colleagues; responding to major emergencies.*	2a **Appropriate response to advice-suitable calls** Advice-suitable calls are assessed appropriately and effectively	All advice suitable calls CTA assessed at 98% compliance with Quality Assurance systems
	2b **Workforce skilled to match patient need** Workforce skill/type mix re-configured to match demand and provide appropriate patient care to workload profile (Emergency v Urgent)	To be determined following full analysis
	2c **Appropriate referrals to alternative providers** Appropriate referral of patients following face to face assessment	98% of patients referred to appropriate destination by 2013

Stakeholder Goal Aspirations	Outcome Objectives	
	Measure	**Target**
3. … engages the public, its patients and partners… ***– Engaging Patients, Partners and the Public:*** *Collaborative – use of pathways; health & social care (shared information, responsibility, & facilities; joint planning [identifying gaps in provision]; demand management); listens & responds; informed, forward thinking customers.*	3a **Patient, public and partner involvement in all service developments** Service developments are made with the involvement of patients, partners and the Public	100% of service development initiatives
	3b **High patient satisfaction with the service received** Patient satisfaction scores in relation to the service they received from the LAS	95% of patients are satisfied or very satisfied
	3c **Partners satisfied with "how we do business"** Healthcare and other partners (suppliers, emergency services, social services) are satisfied with the experience they have in dealing with the LAS	90% pf partners satisfied or very satisfied
4. … provides greater options for patients… ***– New Outcomes for Patients:*** *Fewer go to A&E; staff skilled & confident to use alternative care pathways; career pathways in place*	4a **Increased number of patients given access to appropriate definitive care first time** Reduction in number of patients transferred or referred on	Target to be determined following further research
	4b **Consistent audit of appropriateness** Develop a suite of measures to monitor this consistently, including CPI checks, clinical audit, clinician feedback and patient surveys	Target to be determined following further research
	4c **Increase and develop staff skills and their confidence in their skills** Embed a robust PDP/PDR process, including use of case reviews, professional portfolios, reflective practice and patient outcome data	All staff have a PDP and appraisals conducted twice a year and carry out their development plans fully

5. …continues to focus on delivery… **– *Delivery Focused:*** *National targets; Government frameworks; Standards & guidance; cost effectiveness.*	5 a-d **Measure what matters** Develop a comprehensive set of indicators to measure performance for: a. Patients, b. People, c. Processes, d. Performance	(see section 7 of this plan)
6. …and has a culture built around our CRITICAL values **– *Culture & Behaviour:*** *Consistent with the values; respecting diversity; taking accountability, challenging each other; empowering; good management; skilled people (technical & inter-personal); consistent.*	6a **Attitude and behaviour** Measurable high standards of attitude and behaviour. All staff behave in ways that reflect the values of the LAS	Target to be determined following further research
	6b **A learning organisation** Evidence of a learning organisation as measured by an validated tool	Target to be determined following further research
	6c **Leadership at all levels** Visible leadership at all levels through identifying the leadership qualities required in all roles and providing a robust structure for supporting the development of leadership skills as part of Continuing Professional Development	Target to be determined following further research

3.4 Scope and scale of future operations – "…….that responds appropriately for all our patients": Strategic Choice

In addition to understanding what stakeholders want from the organisation, a second consideration is the scope and scale of future operations. Given that the organisation does not exist in a vacuum, delivery of the identified *<u>Stakeholder Aspirations</u>* has to take place with cognisance of the drivers for change identified in section 2 of this plan. Therefore work has been undertaken concurrently to envision the scope of LAS activity in the future given developments in the wider NHS and London and what the implications for the organisation are considered likely to be. This gives rise to a number of strategic choices as to future direction.

Five options have been identified as to the potential scope and scale of future LAS operations. These range from scaling back to handling only the minority of calls received which are real emergencies requiring an immediate "Blue Light" response (Category A and B), to seeking to expand to become <u>the</u> *<u>Out of Hours</u>* contact point for the public wanting to access the NHS in

London when not going directly to hospital A&E departments themselves (Category C). The strategic choice as to the direction of travel for the LAS over the plan period is to follow the mid way between these two extremes with the organisation seeking to keep its' current 'market share' of calls to the NHS in London but consolidating the Trust's position, service provision and performance by embracing, promoting and integrating the majority of non-life threatening but urgent calls (Category C) as core LAS work.

The approach of focusing on urgent care while maintaining emergency service provision implies significant changes to Service support, provision and culture and positions the organisation to move, if required, to:

- co-ordinate response to additional *Out of Hours* demand (that is undertake a wider call taking and tasking role for other healthcare providers) and/or;
- manage services currently provided directly by Primary Care Trusts which have synergies with the current service portfolio should the latter decide or be required to relinquish management of such provision;
- be in a position to apply for Foundation Trust status if and when required to do so.

Over the years 2006/07 to 2012/13 the London Ambulance Service has as "*prime objectives"* to:

- re-define itself as a provider of urgent care in London as much as it is a provider of emergency care, and demonstrate to partners and the public that it is of equal significance to the health service in this respect;
- develop an organisation which "responds appropriately to all our patients" whether their need is of an emergency or urgent nature.

The tactical specifics of the plan to realise the strategic choices made will change over time but this Plan framework is intended to give effect to these objectives over the long–term.

3.5 The Blueprint – "what we want the LAS to be"

To better define "what the LAS wants to be" a *Blueprint* has been developed which describes the organisation which is necessary in order to deliver the *Vision* as expressed through the *Stakeholder Goals*, *Aspirations* and *outcome objectives* detailed in section 3 and the *prime objective* of being and perceived to be as much a provider of urgent care as of emergency care (section 3.4).

The *Blueprint* provides a picture of what the LAS looks like, fells like and how it behaves in 2015, two years after the end of this plan period once the programme of change contained within it has been implemented and bedded down. It is structured around the *Stakeholder Aspirations* explaining in detail what the change requirement is and how this is responded to by the LAS.

The Blueprint has been used to identify what process and other changes are required to move the Trust from where it is in 2006 to where it wants to be in 2015 and to define corporate strategy, change programme benefits, objectives and projects (detailed in section 4).

The Blueprint can be found in appendix 2.

4. Managing Transformational Change – The Implementation Programme *(Part 3)*

4.1 Vital Few Strategic Programmes - what needs to change

The purpose of the corporate *Vital Few Strategic Programmes* and the enabling *Stakeholder Engagement and Communications Strategy* is to implement the *Blueprint* and deliver the targets set against the *Lagging Outcome Measures* identified in section 3.3. These provide the structure for the new service improvement and modernisation change programme to transform the organisation from the way it is in 2006 to the way it aspires to be in 2013. The table below details the *Vital Few Strategic Programmes* and their rationale while the implementation programme structure and initial project portfolio is described in section 4.2. It also outlines the *Stakeholder Engagement and Communications Strategy*.

Description and Scope	Outcome Objective Supported	Rationale
1. Access and Connecting (the LAS) For Health Scope: Covers not only access to LAS services by patients and the public but also Connecting for Health and access/connectivity within the LAS and between it and partners: • Development of an access strategy • Access for disabled people (e.g. deaf) • Connecting for Health • CAD2010 • *Internal IT strategy* • Records and Information Strategy • High Impact changes to EOC/UOC	1a **Community engagement and meeting the needs of the population** 1b **Sharing information externally and promoting best practice** 1c **Improved information sharing within the LAS** 4a (i) **Increased number of patients given access to appropriate definitive care first time**	Patients have told the LAS they want to be able to access the Service quickly and easily. They want it to be equally accessible to disabled people who face communication barriers and to those who do not speak English. Overall they want simplicity: to speak to a helpful human. Others, like General Practioners who ring the Service because they need help in finding beds or providing transport and the Metropolitan Police who need assistance at the scene of incidents, also want quick and easy access to the Service. Partners like Primary Care Trusts (PCTs) and suppliers have said they want to be very clear who to contact to get information, or seek help in making service improvements, and they want local LAS managers to have authority to make decisions about local developments. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients which requires appropriate infrastructure.

Description and Scope	Outcome Objective Supported	Rationale
2. Improving our Response (Operational Model) Scope: Covers service portfolio and the ways of delivering provided to patients/healthcare professionals/public once they have made contact with the LAS: • Develop and operational model for tasking • Develop implementation plan for new ops. model • Implement new operational model • CTA projects • Care pathway development projects • New clock start operational performance – High Impact (excl. EOC/UOC) • Olympic and Para Olympic Games 2012	2a **Appropriate response to advice-suitable calls** 2b **Workforce skilled to match patient need** 2c **Appropriate referrals to alternative providers** 4a.(ii) **Increased number of patients given access to appropriate definitive care first time**	The LAS has previously provided a "one-size-fits-all" service. Stakeholders have said they want the Service to provide the right response, in the right place, at the right time. They want the Service to be timely and reliable, for patients and professionals. Although they recognise that the major challenge for the Trust is to start to provide appropriate care for patients with lesser emergencies, they also want it to give priority to blue light colleagues and be able to respond even better to major emergencies. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients which requires development of these pathways and appropriate operational models, methods, processes and protocols.
3. Organisation Development And People Scope: Covers Organisation development (section 3.2), culture, HR strategy, education and training (clinical and non-clinical), Diversity and workforce skill mix including. recruitment and retention and IR: • Education and training • Attitude and behaviour/cultural interventions • Organisation Development • Implementation of Diversity Plan • High Impact changes (workforce) • Staff engagement	4c **Increase and develop staff skills and their confidence in their skills** 6a **Attitude and behaviour** 6b **A learning organisation** 6c **Leadership at all levels**	All stakeholders said that they wanted to see the Service's CRITICAL values (Appendix 1) consistently applied across the Service. Staff and managers are committed to challenge themselves and each other to be accountable for their behaviour as ambassadors for the LAS in everything they do. There is a call for new styles of management – supportive of staff and promoting staff involvement and development. It is clear that most people see this as underpinned by skills – clinical, managerial, leadership and communications. People want to be held accountable, and to hold each other to account, for the highest standards of behaviour and performance. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients. Staff are clear they want access to extra skills so that they contribute to the well being of all patients.

Description and Scope	Outcome Objective Supported	Rationale
4. ***Governance and Corporate Processes*** <u>Scope</u>: Covers Corporate and Clinical Governance and development of all corporate management processes a. Audit and quality assurance of clinical care b. Corporate processes c. Standards for Better Health and NHSLA d. Productivity and efficiency e. Foundation Trust review f. Managing Successful Programmes	4b. **Consistent audit of appropriateness** 5 a-d **Measure what matters**	The Strategic Health Authorities and Primary Care Trusts are clear that they want the Service to continue to focus on national targets, on Government frameworks such as National Service Frameworks and to meet externally set standards. They want the LAS to be cost effective too. Patients want our service to be measured in terms that mean something to them. LAS work with the early patients of Emergency Care Practioners has clarified this. It isn't just about clinical care. It is also about courtesy and respect, about being informed and being reassured. It is about having patients' problem solved. These patients are clear that they do not want to be taken to A&E if they don't need to be there. The Trust itself wants to ensure that internal performance management systems ensure that it delivers on all of its obligations: financial, performance and governance.
Stakeholder Engagement and Communications Strategy <u>Scope</u>: Covers engagement and communications with internal and external stakeholders especially Patients and the Public but also other healthcare professionals, emergency services, social services, key suppliers etc., most particularly PPI: Stakeholder Engagement and Communications projects including: a. patients; b. public; c. NHS partners d. social services e. other emergency services	3a **Patient, public and partner involvement in all service developments** 3b **High patient satisfaction with the service received** 3c **Partners satisfied with "how we do business"**	Government policy places primacy of place on a patient centred NHS with Public and Patient Involvement at all levels from setting strategic direction to the individual patient experience in the care they receive through listening to them, providing information about their treatment etc. All the partner organisations consulted asked the LAS to be collaborative. This means working with them to develop and use different pathways for patients, and work with them in planning, for example, jointly identifying gaps in other services that might be leading people to ring 999 and working with them to set up alternatives. Partner organisations also want us to share more: information about patients in order to ensure they received seamless care; responsibility for the whole package of care received by patients; and also to share premises so that the local health team will be better integrated.

4.2 Programme approach, structure and organisation

Benefits Realisation

The approach being taken to implementation of the new service improvement and modernisation programme is to use the *Managing Successful Programmes* methodology sponsored by the Office of Government Commerce which overarches the PRINCE 2 project management methodology. This approach emphasises clarity and consistency of vision for the programme and a benefits focus, that is realising change benefits for the organisation necessary for achievement of its strategic direction and objectives as the primary focus of the improvement programme rather than just the production of new capability through projects. It emphasises managing benefits from identification through to realisation with frequent review of the intended benefits of the programme so that it remains aligned with its desired outcome.

The following table gives a high level outline of the *initial programme plan*, however this will develop within the overall framework over the plan period as scoping is completed, in response to developments in the environment within which the LAS operates and depending on resource availability and project inter-dependencies.

Programme	Project Portfolio
1. Access and Connecting (the LAS) For Health	**1. Provide access for all Londoners and visitors to London to the services of the LAS regardless of disability or language** - Investigate other (non-telephone) access channels, particularly those that are more user friendly to disabled people and those who don't speak English - Explore possible technological and other solutions to improve translation - Exploit solutions to aid access addressing information barriers, physical barriers, policy and procedural barriers
	2. Maximise the benefits of the national Connecting for Health programme with regard to connecting the LAS with the rest of the NHS (Patient Records and Acute Trusts) for enhanced care pathways, capitalising early on the opportunities presented - progress the evaluation and deployment of electronic patient records in partnership with the London cluster and Connecting for Health local provider - establish access to the NHS data Spine - Develop expertise in using the data and maximising the value of the information for the Trust
	3. Provide better integration and management information sharing with our partners and stakeholders (e.g. PCTs, SHA, emergency services, suppliers) - Identify scope for access to LAS data with NHS partners and commence pilot - Develop Extranet and connectivity with stakeholder Extranets - Develop information sharing protocols - Develop information data warehouse
	4. Fit for purpose infrastructure to support operations (call taking, despatch, response control and CTA) - Support High Impact Changes developed under Portfolio 2 (Improving our Response [Operational Model]) – continue existing CTAK enhancements - Progress CAD 2010 project for future CAD system - Progress implementation of Airwave and begin exploitation of the Airwave network for additional benefits - Review MDT infrastructure and commence upgrade where appropriate - Review the need for improvements to PSIAM in line with the Operational Model - Move towards office automation in accordance with best practice - Implement Internet Protocol Telephony (single network for voice and data convergence) - 24/7 infrastructure monitoring and back-up servers

	5. Provide direct benefit (e.g. reduced risk) for patient care through provision of front-line information and tools - Exploit opportunities presented by Electronic Patient Record and CAD2010 - Investigate distributed call management - Investigate Automatic Estimated Time of Arrival update to callers - Investigate "MDT Lite" – a reduced mobile data facility in a hand-portable format
	6. Realise real-time management information reporting and communication for staff, providing up to date data and accurate information to all who need it from a single source. - Identify and scope projects to implement Records and Information Management Strategy - Implement projects to give effect to Records and Information Management Strategy - Develop policy and implement procedures for minimising use of paper and maximising use of electronic media

Programme	Project Portfolio
2. Improving our Response (Operational Model)	**1. Develop an operational model for tasking the right resources to the right jobs which describes what resources will be deployed, and how, in order to meet patient need, and how this will be managed - includes:** - identify nature of patient need - identify skills required to meet patient need (inc. phone assessment [possible GP involvement] and face to face) - identify qualifications/job roles required to meet patient need - identify vehicle types and equipment required - identify staff numbers required to meet patient need and meet performance targets - identify vehicle numbers required
	2. Develop implementation plan for new operational model - cost the implementation of the model - create implementation plan for the model (including identifying practical constraints [such as availability of training places or the skill types required] and alternatives) and taking into account the outcome of the access strategy project(s) - decide (on basis of affordability) the timescales for roll-out of the new model - develop education and development strategy to support operational model (covering all staff)
	3. Implement new operational model (as per implementation plan)
	4. CTA Projects - pilot CTA on remote sites - implement remote-site CTA if pilot successful
	5. Care Pathway development projects - develop full possible range of referral pathways - secure access to all pathways from CTA
	6. New Clock Start Operational Performance – High Impact Changes not covered by 1-5 above (supported by Portfolio 1 and Portfolio 3): - Develop and implement an operational plan to successfully achieve new targets with effect from new clock start - Develop and implement IM&T support plan to deliver the operational plan to successfully achieve new targets with effect from new clock start (NB. Identifies requirements for changes in Emergency Operations Centre and Urgent Control Centre but these are implemented through Programme 1 (Access Strategy and Connecting (the LAS) for Health) and requirements for Workforce but these are implemented through Portfolio 3 (Organisation Development and People).
	7 . Olympic and Paraolympic Games - Operational planning to manage additional demand arising and provide coverage at sporting venues
	8. Development of the Thames gateway - Operational planning for the increase in population in the Thames gateway area
	9. Major incident resilience - planning and implementation of major incident resilience preparedness

Programme	Project Portfolio
3. Organisation Development And People	**1. Establish a workforce profile as described in the Workforce Plan supporting the Operational Model and which is more representative of the population of London** - Analyse how the public and staff see the service as an employer - Consult with stakeholders - Review and re-design recruitment strategy - Progress the recruitment dimension of Workforce Plan Phase 1 (response staff) - Create, consult on and implement Workforce Plan Phase 2 (call taking and support functions)
	2. Establish an appropriately skilled workforce, confident to use their skills and a much wider range of care pathways - Progress the induction, training and education requirement aspects of the Workforce Plan Phase 1 (e.g. Enhance trainer development) - Workforce modernisation and skill mix delivery - Individual performance management and progressing effective use of Personal Development Reviews (PDR) and Personal Development Plans (PDP) - Prepare increased numbers of staff for lone working on Fast Response Units
	3. Establish a workforce that lives the CRITICAL values, treating everyone as they would wish to be treated - Review Operational Model roles and link all roles to the strategic direction - Appropriate training given to staff roles that support how to challenge (including clinical practice) - Values aspect of recruitment - Leadership Development programme
	4. Establish a learning organisation that works cross-functionally in a customer-focused and team based way (internally and externally with partners) - Protected learning time and time out for e.g. PDR/PDP - Training needs analysis and development of a robust training programme - Adopt new ways of working to deliver the training programme - Personal awareness training - Staff engagement (e.g. staff led projects)
	5. Embed a culture of mutual challenge and accountability for personal behaviour and performance - Process for clinical supervision - Staff briefings - Reward and Recognition - Devolve Board/SMG decision making - Formal process and training for performance management with a Performance Management Framework in place for all staff (encompassing appropriate consequences e.g. reward and recognition)
	6. Establish new styles of management (supportive of staff and promoting staff involvement and development) with leadership at all levels underpinned by skills (clinical, managerial, leadership and communications) - Agreed performance objectives for all staff and implementation of performance management system for all staff - Recognising and celebrating achievements - Leadership and management development for all managers - Design and implement a succession planning system - Coaching and mentoring - Development time built into all rotas - Union partnership agreement

Programme	Project Portfolio
4. Governance and Corporate Processes	**1. Improve process efficiency** - Process improvement for reduction of LAS costs to closer align with national reference costs for ambulance trusts - Fleet strategy and workshop review - Flexible fleet management - Real-time fleet management information - Development of local Key Performance Indicators to support performance management - Implement other process improvements following process mapping to increase efficiency
	2. Ensure corporate processes contribute to patient experience and outcomes by supporting the front line (this includes response time performance) - Mapping all processes and identify improvements - Implement process improvements as appropriate to optimise contribution to patient experience and outcomes
	3. Provide better integration with the whole system (LAS, NHS and London-wide) - Development of the Intelligent Trust (stakeholder intelligence) - Trust development (Foundation Trust status evaluation if Ambulance Trusts are required to do so, evaluation of other development opportunities) - Agreed delegation of authorisation for improved partner interface
	4. Reduce operational and clinical risk (e.g. ability to deal with all types of patient) - Review fitness for purpose of abstraction management - Software system to facilitate risk management and the risk register - Map processes to ensure optimisation of risk management opportunities presented by Electronic Patient Record - Enhance Quality Assurance of clinical practice - Optimise use of individual performance management tools and their availability to operational managers
	5. Improve process quality/effectiveness - Electronic Staff Record Phase 2 - Supply Chain Review: • Inventory management • Asset tracking for equipment - Electronic data capture (web based) - Enhance management of confidential information
	6. Reduce process cycle time - New ordering/financial system - procurement (FISC) to replace EROS - Regular supplier reviews - Development of faster establishment control and recruitment process - Improve information reporting time (e.g. Resource Centre to get information on staff availability)
Enabling Strategy	
Stakeholder Engagement and Communications	**1. Communications projects, including patient, public and partner involvement** - Develop a stakeholder engagement and communications strategy for the programme and each portfolio - Build on experience of Patient Care Conferences to create year-round programme designed to cement ongoing patient involvement and public education - Expand community involvement opportunities (LAS attendance and involvement at events) - Build partner relationships (NHS, social services etc.) - Devise and conduct regular surveys of our partners and act on outcomes - Devise and conduct patient surveys and act on outcomes - Specifically address issues identified with black and ethnic minority patient satisfaction - Carry out baseline assessments of current partnership projects - Identify all service developments (in order to then ensure patient involvement) - Develop systems to record patient involvement - Identify benefits to patient / public of getting involved in LAS (in order to maximise involvement) - Communicate PPI strategy to staff / training and education - Give patients choices about involvement and build relationships with them - Ask for participant feedback on whether they felt involvement was genuine - Identify staff with partnership working interest and skills

4.3 Delivery of Core and Developmental Standards and the Diversity Agenda

A key requirement of the service improvement and modernisation programme described in this plan is to support the Trust in meeting the requirements of the NHS planning and governance framework "*Standards for Better Health"* published in July 2004. This plan is designed not only to maintain performance against the *Core Standards* but also to make demonstrable progress year on year within resource constraints against the *Developmental Standards* . These will be used by the HealthCare Commission to determine the Trust's annual performance rating, along with delivery against national targets, the Information Governance Toolkit and achieving financial balance. As such achievement against the Standards is essential to move towards Foundation status. Compliance with national targets and performance criteria although supported by development activity remains part of routine operational work and not a separate work stream however.

It is also a legal obligation, as well as a requirement of *Standards For Better Health*, for the Trust to comply with various pieces of legislation concerned with equality of treatment for both patients/the public and staff which forms the framework for the Race Equality and Diversity Implementation Plan. There are six strands of diversity for which legislation exists: race/ethnicity, disability, sex/gender, religion and belief, sexual orientation and age.

The Trust has an established Race Equality and Diversity Implementation Team and in accordance with legislation undertakes *Equality and Diversity Impact Assessment* of relevant functions, policies, procedures and practices to identify actions arising from the assessments for incorporation into the Trust's *Race Equality and Diversity Implementation Plan* and *Race Equality Scheme Action Plan*. While responsibility exists and implementation takes place across the Trust, through all directorates and programmes, responsibility for oversight and driving development and implementation forward rests with the Senior Responsible Owner for *Programme 3, Organisation Development and People* with implementation of the diversity agenda a clearly identified strand of the Programme (project area 15 – see section 4.2).

The Trust is confident that implementation of the change programme will progress the diversity agenda in a way which not only meets legal requirements but positions it to better serve the needs of the hyper-diverse population of London (see section 2.3).

To achieve compliance and keep abreast of changing inspection system requirements year on year the Service will need to adapt and grow resources to serve the increasing inspection criteria from the NHS, Healthcare Commission and NHS Litigation Authority. It will be necessary to maintain flexibility to adapt and adjust so the Service can continue to comply with and act to improve where necessary performance against the assessment criteria defined by the various accreditation bodies. To achieve Foundation Trust status performance will need to be reported with information that secures the highest ratings from these systems of accreditation.

5. Critical Success Factors

5.1 Management of strategic plan delivery

Achievement of the ambitions outlined in this strategic plan will only be possible with the complete buy-in and commitment from all areas of the Service, support from key external players and robust implementation management. In particular there are three areas which will require specific attention which cut across the whole strategic programme:

- Identification and management of Critical Success Factors for plan delivery and benefits realisation;
- Risk management at the plan level;
- Stakeholder engagement in achievement of, and on-going support for, the long-term direction and objectives for the organisation identified in section 3 of this plan.

Each of these is considered in turn.

5.2 Critical success factors

An overarching set of *Critical Success Factors* (*CSFs*) has been produced for the implementation of this plan which capture the assumptions made and the commitment required from all involved. A key *Critical Success Factor* is to robustly manage the *Leading Measures* identified for management control purposes which if correctly identified and performance managed will determine target achievement on the *Lagging (Outcome) Measures*.

Critical Success Factors are categorised into either those which relate specifically to the early part of the plan period when it is necessary to ensure a sound operational model for sustained Service performance or those that relate to longer-term transformational change:

(i) *Shorter term 'High Impact Changes' for sustained performance improvement*: There are a number of critical success factors that apply to all the *High Impact Changes* within project area 18. (New Clock Start Operational Performance – High Impact Changes). This is designed to position the LAS for the challenges presented in maintaining operational performance in the first two years of the plan period (e.g. the change to clock start timing in April 2007 - see section 6.1) so as to provide a sound foundation for the rest of the plan period. These Critical Success Factors for ensuring that the performance improvements intended are fully realised are:

1. Creating a service wide multi-disciplinary approach to performance improvement. This must be driven at Senior Management Group (SMG) level with complete buy-in from all parties and must be firmly rooted in all SMG objectives;

2. Providing capacity for high level professional analysis of current performance together with the formulation of strategic but practical interventions which address the root causes of poor operational performance;

3. Creating a culture of sustained performance improvement which ensures that the initiatives introduced or changes made are the correct ones and that they will be sustainable;

4. Creating absolute clarity on roles and responsibilities both centrally and locally for driving through performance improvement strategies;

5. Developing a comprehensive communications plan for the whole Trust and wider NHS which communicates what we are striving to achieve, why it is important and how we are going to achieve it;

6. Creating a climate in which further change/modernisation can realistically be achieved;

7. Moving the 'emergency service culture' of the organisation to one in which all change which improves patient care is embraced;

8. Achieving a new 'Partnership Agreement' with the Trade Unions to ensure that working practices are modernised quickly and much greater flexibility is secured and utilised to improve patient care;

9. Achieving absolute agreement from all to move progressively towards the response model described in the Department of Health review '*<u>Taking Care to the Patient'</u>*. In this model high level assessment of incoming demand leads to fewer overall responses. When a response is needed it is increasingly a single responder with ambulances reserved in the main for transporting patients with a confirmed need;

10. Acceptance and support from our commissioners that such a radical change in response regimes is the right way to go and acceptance that the scale of change is such that it will take several years to fully achieve.

(ii) *<u>Longer term Benefits Realisation from the four programme areas and supporting stakeholder engagement strategy:</u>* There are a number of critical success factors that apply to realising the benefits intended to be achieved at the end of the seven year Strategic Plan period, these are:

	Critical Success Factor	Managed By Programme/ Strategy
Patients		
	Excellent clinical governance	4
	Audit of non-conveyed calls	4
	Better clinical support/advice/mentorship	3
	Development of relationships with social service departments of the London Boroughs and new care pathways to their services	2
	Valuing diversity	3
	More effective, appropriate patient contact	2
	Convincing staff that the LAS supports them and that they are not automatically in the wrong	3
	A comprehensive public education/ PPI programme with dedicated local teams (three people per complex)	Stakeholder Engagement
	All staff trained and educated to meet the case mix the LAS is attending (i.e. 200,000 fewer A&E attendances)	3
	Employment of 70 full time equivalent CTA staff plus General Practioners to provide clinical oversight.	1
	Employment of up to 300 Emergency Care Practioners	2
	Culture change to a position where continuing patient care improvement is everyone's reason for coming to work	3
	Focus on patient care performance as part of Personal Development Reviews	3
Performance		
	High performing management teams committed to sustained performance Improvement.	3
	Staff and public acceptance of a 'New Front End Model' predicated on a predominantly solo initial response. Staff acceptability of the need for 'Individual Performance Review' linked to PDR which holds them to account for both operational and clinical performance. Staff acceptance of the need for the introduction of a comprehensive 'Distribution Plan' which provides much more flexible resources which are then always placed in the right geographical area to optimise performance across hour of day and day of week. Obsessive commitment to optimising the production of available Ambulance and FRU hours to ensure it is line with anticipated demand.	2/ Stakeholder Engagement 2/3 2 2
	Transformational change with both EOC and UOC including management re-structuring.	2
	Willingness to cause conflict in order to achieve high levels of performance, attitude, behaviour and patient care.	3
	Acceptance that staff need to be more efficient and work smarter and not harder to improve patient care.	2
	Weekly performance management which is balanced and focused and covers all functions	2/4

	Critical Success Factor	Managed By Programme
People		
	Recognition of the significance of key roles that are currently under-rewarded e.g. sector dispatchers	3
	Individual accountability – Personal Development Reviews and valuing, empowering and supporting staff	3
	Provision of training as required in resource planning	3
	24 hour, visible, consistent management support	2
	Development of a more flexible working culture	3
	Effective talent management and use of knowledge in the organisation	3
	Ring fencing of training time for front-line staff	3
	Moving away from the concept of the permanent two man crew with a change to a larger team of ten-fifteen people	2
	Development of greater staff engagement at local level as part of a comprehensive, effective communications strategy	Stakeholder Engagement
Processes		
	Fully automated business processes to support operational/business priorities	4
	Redesign governance structure to ensure agile and speedy decision making and integrate activity	4
	Embed programme and project management methods/processes in departments and ensure all Plan projects are managed appropriately	4
	Maximise resource utilisation to eliminate waste	4
	Involve staff in making improvements	Stakeholder Engagement
	Remove all paper and need for processing from stations	4

Risk management and *Stakeholder engagement* are also *Critical Success Factors* but these are considered separately in sections 5.3 and 5.4 below.

5.3 Risk management (Strategic Plan level)

There are very significant *risks* reflecting the size and scope of the London Ambulance Service (LAS) NHS Trust and the scale of improvement planned. At the same time, NHS organisations have made significant progress over recent years, through the work of *clinical governance*, the implementation of *controls assurance* and the development of governance roles of boards to address risks at an appropriate level and this approach is used in the London Ambulance Service.

Regulatory and inspectorial roles with regard to risk management are carried out by a range of legislative and advisory bodies, including the Healthcare Commission and the NHS Litigation Authority (NHSLA). In addition, independent inspection of controls assurance and finance is provided by internal auditors.

The LAS is accountable for its performance and must create a coherent strategic framework within which service improvement can be delivered. The Assurance Framework brings together strategic

objectives, risks and performance measurement and is used to keep the Board informed of these issues.

It undertakes its performance role through identifying risks which may threaten the achievement of strategic objectives, for example the risk information provided by Datix (the integrated risk management system) or in Trust-wide risk assessment workshops.

Once a risk is identified it is entered onto the Trust-wide Risk Register where it becomes part of the risk reporting structure. Action plans are then put in place to reduce or eliminate these risks.

The following high level risks to the successful implementation of the seven year Strategic Plan have been identified, these will be owned for risk management and monitoring purposes by either the Senior Management Group or by one of the five implementation programmes:

High Level Risks to Successful Implementation of the Strategic Plan	**Managed/ Monitored By Strategy Steering Group (SSG), Programme No. or Stakeholder Engagement Strategy**
Incorrect balance struck between focus on current performance and development for the future – diary pressures prevent SMG devoting sufficient time to personal involvement in managing the development programmes and conveying their importance	SSG
Potential for blame and tension between Operations, Emergency Operations Centre and support departments	SSG
Change of Government policy towards the NHS, particularly as a consequence of any general elections during the Plan period or lack of appetite to see through current policies	SSG
Impact of likely Pandemic Influenza	SSG
Technological fragility – Emergency Operations Centre or Urgent Operations Centre infrastructure failure	1
Failure to learn from major incidents	2
Management and staff capacity and capability/resources insufficient to deliver the Plan	3
Insufficient senior manger training, particularly in the general management training they receive	3
Failure to harness potential of particularly talented staff	3
Failure to manage the "old hands" with consequent negative impact on culture change / modernisation required	3
Failure to challenge inappropriate behaviour and address conflict avoidance	3
Availability of suitable recruits due to demographic change	3
Industrial Relations – a lot of change/modernisation is required early on in the Plan and will make demands on union representatives	3
Risk of fatigue at the second and third tiers of management due to workload pressures	3
Insufficient succession planning to maintain the strength of the Senior Management Group and lack of structure and support for this	3
Insufficient performance management of staff and focus on development of teams including the Senior Management Group	3

High Level Risks to Successful Implementation of the Strategic Plan	**Managed/ Monitored By Strategy Steering Group (SSG), Programme No. or Stakeholder Engagement Strategy**
Risk to reputation from being perceived as arrogant and not sharing information/ consulting i.e. perception of telling people about service provision giving the impression that their views are not really wanted. Stakeholder engagement, pro-active management and more partnership working required rather than a re-active approach.	Stakeholder Engagement
Potential risk to LAS reputation arising from incidents	Stakeholder Engagement
Incorrect balance struck between the centre and local parts of the organisation i.e. level of empowerment and stakeholder engagement	Stakeholder Engagement
Financial losses arising from the activities of Patient Transport Services draining Trust resource	4
Failure to maintain 75% Category A performance necessary to retain "licence to practice"	4
Risk to potential growth arising from financial pressures e.g. reduced annual uplift and increased capital scarcity	4
Cost inefficiency within the Trust in the context of Payment By Results resulting in an imbalance between the costs incurred in service delivery and the income received for it	4
Inability to meet the requirements to become a Foundation Trust	4
Changes as a consequence of "Creating a Patient-Led NHS" and consequent change in the strength of the Trusts' position to argue its position	4
Insufficient productivity in the Urgent Operations Centre (cost per call)	4
More complex and onerous targets and inspection regime	4
Lack of effective project management resource	4
Advent and impact of any litigation against the Trust, particularly in financial terms	4
Financial risk arising for non-recurrent resources for activities the Trust is required to be involved in such as aspects of emergency preparedness	4
Unpredictability of demand increase	4

In order to reduce the level of risk, the LAS prioritises its actions by:

- Being clear about what the risks are, and the ones the LAS can actually do something meaningful about;
- Gaining a focus from staff on the things that really make a difference so that people's efforts are maximised not diffused;
- Making sure that decision making and action is taking place in the specialist risk management groups so that risks are being focussed on by the right people so that progress can be made and reported up to the Board;
- Using the Risk Register to help prioritise the allocation of requests for funding. All Strategic Programme Project Profiles (SPPPs) should reference risk and therefore will form one of the elements of how a decision will be made;

- Getting good quality data and information across the Trust and maintaining an informed view of what is actually happening;
- Actively and appropriately intervening where issues are escalating outside the control of a single group or identified lead;
- Working with other agencies and Trusts where we can to manage risks which cross the boundaries of our organisation;
- Learning from risks and focusing on achieving outcomes that support the improvement of patient care to inform Governance and Corporate Processes strategy.

The risks identified are challenging but the LAS is confident that they are manageable on the basis of its risk management process, allowing the prioritisation of work necessary to manage the risks identified.

5.4 Stakeholder engagement (Strategic Plan level)

The active engagement of all stakeholders in supporting the implementation of the change programme is essential for success and realisation of the intended benefits, especially the eight key groups (see section 3.3):

- Patients and the Public, in particular BME groups (including the Patients' Forum);
- Primary Care Trusts;
- Department of Health/ London Strategic Health Authorities.
- LAS staff;
- NHS Partners (General Practioners and other London NHS Trusts);
- Greater London Authority/London Boroughs (particularly Social service Departments);
- Blue Light Emergency Services (Metropolitan Police and London Fire Brigade);
- Strategic Suppliers (mission critical supplies).

Stakeholder engagement will happen across the Trust at all levels but for the plan as a whole will be overseen by the Senior Responsible Owner for the enabling *Stakeholder Engagement and Communications strategy.* Additionally, in accordance with the *Managing Successful Programmes* approach (see section 4.2) each of the four Programme areas will have its own stakeholder engagement strategy describing how the programme will engage with all stakeholders. These engagement strategies will including mechanisms for encouraging, receiving and responding to feedback from stakeholders, and contain measures to determine how well the communication process is engaging with them.

6. Managing Demand

6.1 Managing Demand and High Impact Change

Primary Care Trust commissioners require the that the LAS assist them in meeting the national target that no patient should wait longer than 4 hours in hospital Accident and Emergency departments through alternative methods of responding to 999 calls, meet existing and new response time targets in an environment of zero growth in funding and hence staff numbers

through greater efficiency and provide equitable performance across London, all in a way that is not only clinically safe but demonstrably so.

In short the LAS is required to manage a growing number of 999 calls in a different way to just attending the patient quickly and transporting them to hospital A&E departments. During 2004/05 call volumes rose at a rate of 7.5% and 2005/06 ended at circa 3.8% above the level of overall demand for 2004/05 which is in line with the long-term annual growth rate of 3%-4% per annum. Only by developing alternative responses can the A&E waiting time target for patients be achieved and LAS response time performance be maintained without significant extra resource at a time when the growth in NHS funding is slowing and Commissioners have zero rated Acute Trust with large deficits to deal with.

The LAS has worked on a number of initiatives to manage demand in a different way such as:

- Development of Clinical Telephone Advice as an alternative to sending a vehicle to suitable Category C calls;
- Implementation of the 'No Send' policy whereby for non-life threatening Category C calls deemed suitable for Clinical Telephone Advice and where deemed clinically safe the Service have and use the power to refuse to send a vehicle even if insisted upon by the caller;
- Development of the Emergency Care Practioner (ECP) programme, with several pilots in London, whereby ECPs treat patients out of hospital rather than convey them unless there is a genuine need.

However in the context of challenges such at capacity constraint in the face of ever increasing demand and changes to clock start timings in April 2007 the Trust has decided that a new operational model is required, both in the short to medium term through making some *High Impact Changes* and in the longer term in the way it responds to the majority of urgent non-emergency Category C calls. Both of these strands are managed through Programme 2 described in section 4.1 and 4.2 however project 18 - New Clock Start Operational Performance - *High Impact Change* is so fundamental to managing and responding to organic demand in the near term that its implementation underlies planning assumptions about operational activity going forward and hence the resource headroom and consequent scheduling for the rest of the service improvement and modernisation programme.

High Impact Change Philosophy

For most NHS organisations the system up to now has been designed to prevent performance failure; to avoid breeches of performance standards or targets and to achieve key targets. The basic aim has been to achieve the performance or quality standard. The current systems tend to focus on particular departments rather than seeking to transform the whole system. Targets are often only achieved by staff working more hours or to a higher level of intensity. The typical performance improvement strategy might have the following components:

- Design the system to prevent performance failure
- Create awareness of targets and performance requirements and raise leadership intent to deliver them.
- Seek to improve the performance of specific departments or areas.
- Make everyone work harder
- Implement measurement systems which monitor compliance with the required performance.

The LAS is currently very much aligned to the above model and has reached a point where following the rationale described previously will fail to deliver the improvements required. The improvement philosophy underpinning the concept of *High Impact Changes* starts from a different mindset. The system needs to be designed not just to avoid performance failure, but also to enable continuous improvement across the whole organisation. Typical components of this type of performance improvement strategy could include:

- Designing the system to continually improve
- Taking a detailed process view of the flow of calls and patients across departmental/organisational boundaries .
- Working smarter not harder
- Focusing on bottlenecks in the system
- Managing and reducing causes of variation in performance
- Segmenting patients according to their specific needs
- Implementing measurement systems for improvement that reveal the true performance of the system and the impact of any changes made in real time.

Performance is improved by mapping patients through the system and removing activities that do not add value or create delays and bottlenecks. Processes must be simplified and speeded up. This often involves both process re-design and role re-design and the two have to be considered in parallel.

The *High Impact Changes* which will be implemented under Programme 2 (and see Appendix 3) are designed to deliver fundamental change across the service in terms of how the LAS organises its processes to deliver on both the challenging new performance targets and high quality patient care. They have been developed by thinking carefully about what needs to be different in A&E Sectors, the Emergency Operations Centre , the Urgent Operations Centre and within Patient Transport Services. In doing so the Service has considered the whole system and have worked to ensure that the changes are complimentary and improve the whole system rather than individual departments.

There will be a need for dedicated high level data analysis support to the A&E Senior Team in order to drive through the changes required and evaluate the impact of these changes in real time. In addition to data analysis there will be a need for significant skills in the whole area of performance improvement across whole systems and additional resource will need to be brought in to assist with this function.

There will need to be stringent performance management arrangements at both local and central levels and the whole process requires complete buy in and commitment from all areas of the service to achieve success.

6.2 Operational activity and resource model of the London Ambulance Service

An operational activity model of the London Ambulance Service has been developed which links call volumes with consequent resource requirements (finance, workforce and assets such as fleet size) to handle a given level of demand based on an understanding of cost drivers in the organisation. The activity model enables scenarios to be developed to inform planning assumptions and for a given level of income an estimate to be made of the level of funding likely to be available for development work each year after providing to meet the expected scenario as to the level of call volumes received. The planned level of development expenditure, along with

project inter-dependencies, is a key determinant of project scheduling within each of the four change programmes described in section 4.2. This plan is based on and informs the planning assumptions made using this model which has been used in developing Sections 8.1 (*Workforce Planning*) and 8.2 (*Financial Planning*) of this Strategic Plan.

6.3 Capacity and Business Continuity Plans

Capacity Plan

For many years the London Ambulance Service has worked at, or near, capacity. There have been occasions, e.g. Winter Pressures, when the LAS has produced a specific plan to deal with anticipated capacity issues. The NHS now accepts that 'over capacity' can occur at any time of the year and has introduced the philosophy of 'Whole System Capacity Planning'. The response by the LAS has been to produce a new *Capacity Plan* which triggers specific measures when the Service is operating at 'over capacity'.

It is the intention of the LAS to maintain a high level of patient care service to the communities of London when experiencing capacity pressures. This is critical to maintain public confidence in the Service and the good reputation of the LAS. During periods of high pressure, the LAS will consider a variety of tactical options that are considered most suitable to deal with the over-capacity situation. The tactical options that may be considered are identified in the *Resourcing Escalatory Action Plan* (REAP) which is designed to increase operational resourcing in line with demand, to cope with periods of high pressure and maintain the quality of patient care.

The REAP plan is in operation at all times. In general it will operate at REAP level one, when the Service is at a steady state. There are varying levels reflecting increasing pressure on the Service, up to level five, where there is the potential of Service failure. Each level is triggered by intelligence from inside the Service or from the external environment. The triggers are detailed in the LAS *Capacity Plan*.

The REAP plan and the REAP levels apply to the whole organisation. The current level will be widely publicised. Every manager has a responsibility to know the current level. Each operational manager and head of department has a responsibility to understand the plan and to have a corresponding implementation plan for their area of operation. All areas of the Service are required to take meaningful action, with the appropriate urgency, as the plan escalates.

There are key triggers which will apply. Each trigger has several parts. Judgement is required to consider whether enough parts have been met to activate the trigger. Each trigger causes an escalating level of the REAP to be activated. Some of the triggers depend on statistical data. The trigger is activated when the data differs considerably from a 'normal' accepted value. As these values are dynamic, the current 'normal' values will vary. In addition to the key triggers, failure of the mission-critical or vital support departments, may trigger any of the REAP levels.

The Deputy Director of Operations will hold responsibility for assessing the key triggers and advising the Director of Operations and the on duty *Gold* officer which trigger has been reached. A weekly return will advise the Director that this task has been carried out. The Director of Operations will declare changes to the REAP level, which will then be advertised widely across the Service, to all departments. Having been made aware of the developing/deteriorating situation,

Gold Control will call an 'over-capacity' meeting at the necessary level, to take action and lead the recovery effort. supported by all departments.

Business Continuity Plan

The Civil Contingencies Act 2004 requires the LAS to have a *Business Continuity Plan* (BCP) to maintain critical services (A & E (Call handling & response) – Emergency Bed Service (EBS) – Patient Transport Service (PTS)) and vital support (elements from – Office of CEO - Finance – Human Resources – Operational Support – Emergency Planning Unit – Information Management and Technology – Communications – Service Development) during an 'Emergency' (Major Incident). The LAS's *Business Continuity Plan* is intended to anticipate, prepare, prevent, respond and recover from an 'Emergency' and maintain patient care as far as is reasonably practicable.

The sources of an 'Emergency' are almost limitless and could be internal (e.g. loss of Trust infrastructure) or external and of a spontaneous nature (e.g. a transportation accident) or slow burn (e.g. influenza pandemic). Sources of an 'Emergency' are, in summary, 'the denial or loss of services or facilities that affects the LAS response to the public of London in terms of A & E, PTS & EBS'.

Plans for some aspects of Business Continuity to support 'call handling & response' exist separately (e.g. the LAS *Capacity Plan* is a specific plan designed to cater with 'pressure & continuity'). In broad terms, these plans deal with the day to day pressures that are placed on the Service and all aspects are practised/invoked on a regular basis. The *Business Continuity Plan* does not supersede those arrangements, but in effect takes the Service into the next stage of Continuity/Recovery on the basis that the incident/event causing concern has passed through the usual and/or anticipated stages into the extraordinary or emanates from another unique, rare or unusual set of circumstances.

The LAS *Business Continuity Plan* is a generic plan that may be implemented totally or, as necessary, in part whilst continuing, as far as is reasonably practicable, to continue to perform its Critical Functions: A & E (call handling and response), PTS & EBS.

The *Business Continuity Plan* will be led by the Director of Finance, but Departments are responsible for maintaining their Business Continuity plans. Once alerted that the Plan is being invoked each of the Directorates will refer to relevant parts of their own Business Continuity plan to provide the required level of support to the LAS in the maintenance of Critical Services.

The decision to invoke the *Business Continuity Plan* rests with the on duty *Gold Control* officer and will be based on any, some, or all of the circumstances described in the *Business Continuity Plan* or as advised by the Chair of the Emergency Business Continuity Group (Director of Finance/Deputy Director of Finance) or nominee. The decision will be confirmed by the *Gold Control* officer declaring an 'Internal Major Incident' and a Gold Group convened supported by the Emergency Business Continuity Group (EBCG).

Once the BCP is invoked the Emergency Business Continuity Group (EBCG) will be convened with appropriate representatives drawn from relevant departments to identify the threat/risk and suggest remedial actions to *Gold Control* for the short, medium and long term. The nature of the continuity/recovery will depend on the nature of the challenge and the EBCG will, in its make-up, reflect the nature of the threat and the departments/personnel required to remediate and return to normality.

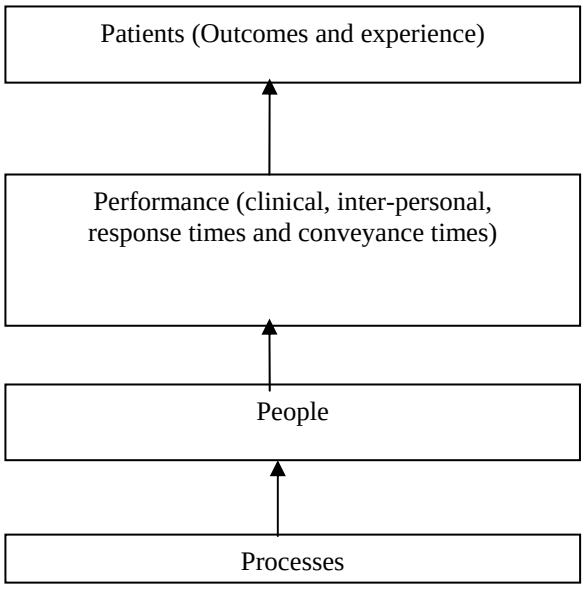
7. Performance Management

7.1 Balanced Scorecard – how the organisation works

Performance management in the LAS has traditionally focused on targets set against '*Lagging Measures'* (or *Outcome Measures*) which define in tangible terms past achievement. These are of restricted use as forward looking control instruments as they detail what has happened and is now beyond influence – the degree to which the organisation has been successful over the previous time period.

Forward looking '*Leading Measures'* which enable ongoing performance management on a monthly basis are the really important control leavers. These relate to the activities which determine achievement of the targets set against the *Lagging (Outcome) Measures*. A *Balanced Scorecard* takes account of both *Leading and Lagging Measures* and this methodology has been adopted by the LAS for future performance management as a smarter, best practice, approach.

The scorecard under development for the Trust is not just a list of separate measures each with a target but rather has coherence as a *theory of how the LAS works*, the same theory that underlies the operational model. In accordance with the scorecard structure used in the wider NHS, the London Ambulance Services is developing a *Balanced Scorecard* using the same four *quadrants or perspectives*: *Patients, Performance, People* and *Processes*. The *theory of how the LAS works* is about the cause and effect relationship between these quadrants as illustrated in the diagram below:



This *theory of how the London Ambulance Service works* which underlies the *Balanced Scorecard* has the rationale that the ultimate objective of optimum patient outcomes and experience is delivered by performance across the board in terms of clinical standards, inter-personal behaviour, speed of response and conveyance to the appropriate location. Performance is determined by front-line people with necessary support service people behind the scenes enabling them to do their job and organisational processes providing the framework with in which both groups operate.

7.2 Balanced Scorecard for the London Ambulance Service NHS Trust

An overview of the long-term Balanced Scorecard under development for used by the London Ambulance Service for performance managing implementation of the strategic plan, both in terms of transformational change and also day to day operations, is given below. The approach is to relate the *Outcome Objectives* for the Strategic Plan identified in sections 3.3 and 4.1 (which if achieved will mean that the Trust has delivered its *Stakeholder Goals)* to the objectives of and benefits arising from the four programmes of work which will deliver these Outcomes.

A Benefits Realisation approach has been taken in defining the programmes. This approach starts with identification of the end objectives of each programme and decomposes these into a series of tangible, measurable benefits from which the required enabling projects and business changes are identified. Tracking delivery of these projects, business changes and the benefits they deliver provide the leading measures to realise the lagging Strategic Plan *Outcome Objectives*. Work to define the benefits in measurable terms is underway.

Balanced Scorecard for the London Ambulance service NHS Trust

For definition of the Lagging Outcome Objectives see section 3.3

Patients (Outcome and Experience**)**

Lagging
1a Community engagement and meeting the needs of the population
3b High patient satisfaction with the service received
4a Increased number of patients given access to appropriate definitive care first time
4b Consistent audit of appropriateness

Leading
- *Access:*
  1. To provide access for all Londoners and visitors to London to the services of the LAS regardless of disability or language (*this must focus on real [evidence backed] not perceived difficulties*).
  2. To provide direct benefit *(e.g. reduced risk)* for patient care through provision of front-line information and tools

- *Corporate Processes and Governance*
  1. Reduced operational and clinical risk (e.g. ability to deal with all types of patient)

- *Operational Model*

Performance

Lagging
2a Appropriate response to advice-suitable calls
2c Appropriate referrals to alternative providers

Plus:
- Access and Response performance targets as per section 2.1 (Call answering, A8, A19, B19, Doctors' Urgents etc.)
- Financial Balance

Leading
- *Access:*
  3. To have a fit for purpose infrastructure to support operations *(call taking, despatch, response control [e.g. MDT] and CTA)*

- *Corporate Processes and Governance*
  2. Maximise the contribution of corporate processes to patient experience and outcomes by supporting the front line (*this includes response time performance*)

- *Operational Model*

People

Lagging
2b Workforce skilled to match patient need
4c Increase and develop staff skills and their confidence in their skills
6a Attitude and behaviour
6b A learning organisation
6c Leadership at all levels

Leading
- *Organisation Development & People:*
  1. Establishment of a workforce profile as described in the Workforce Plan supporting the Operational Model and which is more representative of the population of London
  2. Establishment of an appropriately skilled workforce, confident to use their skills and a much wider range of care pathways
  3. To establish a workforce that lives the CRITICAL values, treating everyone as they would wish to be treated
  4. Establishment of a learning organisation that works cross-functionally in a customer-focused and team based way *(internally and with external partners)*
  5. Embedded culture of mutual challenge and accountability for personal behaviour & performance
  6. Establishment of new styles of management *(supportive of staff & promoting staff involvement & development)* with leadership at all levels underpinned by Skills *(clinical, managerial, leadership & communications)*

Process

Lagging
1b Sharing information externally and promoting best practice
1c Improved information sharing within the LAS
3a Patient, public and partner involvement in all service developments
3c Partners satisfied with "how we do business"
5 a-d Measure what matters

Leading
- *Corporate Processes and Governance:*
  1. Improved process efficiency
  3. Better integration with the whole system (LAS, NHS and London-wide services)
  5. Improved process quality/effectiveness
  6. Reduced process cycle time

- *Access:*
  4. Provision of better integration and management information sharing with our partners and stakeholders *(e.g. PCTs, SHA, emergency services, suppliers)*
  5. Maximisation of the benefits of the national Connecting for Health programme with regard to connecting the LAS with the rest of the NHS (Patient Records and Acutes) for enhanced care pathways, capitalising early on the opportunities presented.
  6. Realisation of real-time management information reporting and communication for staff , providing up to date data and accurate information to all who need it from a single source

- *Operational Model*

8. Resource Plan

8.1 Workforce planning

A skilled, professional workforce configured to future needs and committed to patient care and the Values of the London Ambulance Service are a pre-requisite to achieving the objectives of the Trust. Detailed work has been undertaken to identify the likely front-line clinical workforce requirements based on modelling and planning assumptions made for the plan period, in particular:

- Analysis of anticipated future demand and the categorisation of calls -
  - the number of incidents (all categories) will increase by 3% per annum;
  - the number of emergency transfers will increase by 6% per annum;
  - there will be an additional 30,000 incidents per annum after 2010 resulting from the Thames Gateway developments;
  - the number of Category A calls will reduce to 25% - 30% of all calls by 2010, the balance will be down graded to Category B calls;
  - Olympics impact is ignored as special planning will take place for this one-off event.

- The planned response regime –
  - all Category A and Category B patients will initially receive a response from a Fast Response Unit with a solo responder except for cardiac arrest cases (3% of category A) and other patients who clearly require transport to hospital and will automatically get an ambulance;
  - 10% of Category B calls will be transferred directly to Clinical Telephone Advice (CTA);
  - 85% of Category C calls will be transferred to CTA, the remaining 15% will be responded to by Emergency Care Practitioners (ECPs) to make an assessment of the patient and possible treatment on scene;
  - all emergency transfers and Urgent patient journeys will be undertaken by an ambulance;
  - reduction in patients conveyed to A&E of 200,000 per annum;
  - 50% utilisation;
  - represents c. 2% annual growth in overall productivity

- skill mix – analysis has been undertaken as to the skill mix requirements for each type of response. There will in future be a larger number of single first responders who will require an enhanced level of assessment skills and form a greater proportion of the workforce. We will also move progressively towards a two tier system of ambulance transport with Advanced Life support (ALS) ambulances and Basic Life Support (BLS) ambulances with an appropriate skill mix. Category C patients who cannot be managed appropriately through CTA will receive an assessment visit from an ECP and an increased number of staff trained to this level will also be required.

Overall crew staff numbers are planned to increase over the period from 2,700 in 2006/07 to 3,150 in 2012/13. It is envisaged that there will be a three tier frontline workforce:

Emergency Care Practitioners; Registered Paramedics; and Emergency Care Assistants. This will create a front-line clinical workforce with almost 80% of staff providing direct care to patients being professionally trained together with an increase in those with basic training. Existing Emergency Care Technicians will be up-skilled through professional training to Paramedic status complemented by the recruitment of university trained Paramedics. There will also be growth in the number of CTA staff from 50 in 2006/07 to 120 in 2012/13.

Further work is to be undertaken to identify future requirements for call-taking and despatch staff, Patient Transport Service staff and support department staff.

Consultation with staff side is underway and a full partnership approach will be taken to progressing the workforce plan.

A workforce strategy will be developed ***in partnership*** to support the achievement of this workforce plan. This will include, amongst other things, the approach to training and development, recruitment, retention, career progression and modernisation of working practices.

This workforce plan will be reviewed annually and will take account of any future changes to national or local policy or any new service developments such as provision and expansion of Out of Hours services.

8.2 Financial planning

Assumptions

Outlined below are the financial assumptions for income, costs and assets over the plan period based on implementation of the direction for the Trust outlined in this Strategic Plan and in particular estimated growth in activity and the Workforce Plan:

1. Income Assumptions

    - Over the planning period, average daily activity is forecast to increase by 3.5% p.a. A&E income is assumed to increase by 3.4% p.a. in the same period. This would represent a £38m increase in annual income by 2013;
    - Commercial Income is forecast to grow by 10% p.a.;
    - Income for specific activities such as the Olympics has not been specifically planned at this stage.

2. Cost Assumptions

    - As demand increases by 3.6% p.a., total cost (excluding depreciation) is forecast to grow by 3.3%. A key driver is an increase in overall productivity of 1.9% p.a. to 0.7 incidents per total WTE by 2013;
    - Total Pay is forecast to grow by 4.75% p.a. This is a combination of an increase in staff (1.5%p.a.), pay inflation (2% p.a.) and increasing the skill level of the existing front line workforce;

- Non-Pay excluding depreciation is forecast to decrease by 2.9% p.a. over the period;
- Financial, Depreciation and Other Costs are broadly constant during the planning period.

3. Financial Resource Assumptions

- Total Assets employed grows from a base of £104m to £111m in the planning period. This equates to a 1% annual growth rate;
- Fixed Assets are generally fixed as income grows by 3% as greater efficiencies are achieved from the capital base;
- Likewise, working capital decreases slightly over the period as overall economic activity increases.

Financial Plan

On the basis of the assumptions made the following characterises the Financial Plan for the Trust over the plan period:

- Income increases by 3.2% to £258m in 2013, an increase of £44m in annual income;
- Expenses excluding Financial, Depreciation and Other costs grows by 3.3% p.a. to £248m;
- Earnings before Interest, Taxes, Depreciation and Amortisation (EBITDA) is maintained circa £9.5m on an annual basis in the planning period;
- Financial, depreciation and other costs are broadly constant in the planning period;
- The forecast assumes an annual breakeven position;
- Total cost per A&E incident is forecast to decrease from £221 to £210, a 1% reduction p.a.;
- Total Assets employed grows from a base of £104m to £111m in the planning period. This equates to a 1% annual growth rate.

Appendix 1

London Ambulance Service Values

Clinical excellence

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

Respect and courtesy

We will value all colleagues and the public, treating 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 a 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.

Appendix 2

Scenario 2015: Blueprint for a service that responds appropriately to all our patients

It is 2015, two years after the end of the 2006/07-2012/13 plan period when the changes made during that time have become embedded. The ambulance service has changed a great deal in the last ten years.

We have responded to the six aspirations that came from our stakeholder consultations in 2005 Our stakeholders said they wanted us to be:

- An accessible service,
- That responds appropriately,
- Is focussed on delivery,
- Engages its patients and partners,
- Provides greater options for patients, and
- Has a culture built on our CRITICAL values

This blueprint describes what that means in more detail.

Accessible to patients and partners

What this meant:

Patients told us they wanted to be able to access us quickly and easily. They wanted us to be equally accessible to disabled people who face communication barriers and to those who did not speak English. Overall they wanted simplicity: to speak to a helpful human.

Others, like GPs who ring us because they need our help in finding beds or providing transport and the Metropolitan Police who need our assistance at the scene of incidents, also wanted quick and easy access to our service.

Partners like Primary Care Trusts (PCTs) and our suppliers said they wanted to be very clear who to contact to get information, or seek our help in making service improvements, and they wanted our local managers to have authority to make decisions about local developments.

How we responded:

Ten years ago pretty much the only way of accessing our service was by telephone.

But the public's use of technology in their everyday lives has continued to change as it did in the previous 10 year period (1995 – 2005). This was the time when mobile phones and the Internet revolutionised the way in which society behaved and set benchmarks in terms of expectations.

In the world of 2015, 2-way data and video communication are now as commonly used as the traditional voice communication by telephone. Indeed, these 3 technologies (voice, data & video) are fully integrated, with on-line video conferencing via mobile communicators (the successors to

mobiles phones) considered as 'normal'. There has also been a convergence of traditional telephone numbers with mobile communicators that means people have a single contact number that is transportable between devices. Improvements in security and satellite technology now enable the identity and location of a caller to be validated to a high degree of accuracy.

Building upon these advances, we have implemented an additional range of options to access our services

1: Direct emergency response: Given the advances in identity validation, members of the public are now able to request the direct sending of an ambulance in an emergency situation. This can be done by direct data input, voice recognition software or the sending of a pre-determined code from a hot key on the mobile communicator. The technology advances automatically locates the location of the caller (and their identity).

2: Self Service: A range of options are available for members of the public to access databases remotely in order to carry out self diagnosis and book appointments. There is also the facility to seek help and interact on-line with a response hub operative.

3: Pooled Resources: The Ambulance services across the country have 'pooled resources in order to meet periods of high demand. While they remain individual services, response hubs are dynamically linked allowing demand to be managed and shared across the county.

4: Single non emergency numbers: 991, 992 & 993 have been nationally implemented as non emergency numbers for the Police, Fire and Ambulance Services. There is full voice & data integration between the 3 services in order that when a multi-agency response is required the first agency taking the call can dynamically request assistance, passing full details of the requirement to the others without the need to re-key data.

Importantly the Ambulance Service has recognised the change in technologies and has adapted its business and working practices to ensure maximum benefit in providing services to members of the public. All of these methods have increased the ability of people to contact us if they have difficulty hearing or speaking and if they do not speak English.

Providing appropriate responses

What this meant:

We were providing a "one-size-fits-all" service. Our stakeholders said they wanted us to provide the right response, in the right place, at the right time. They wanted the service to be timely and reliable, for patients and professionals.

Although they recognised that the major challenge for us was to start to provide appropriate care for patients with lesser emergencies, they also wanted us to give priority to blue light colleagues and be able to respond even better to major emergencies.

How we responded:

When someone contacts us for help we very quickly establish whether the patient needs an immediate response.

Only one in ten 999 patients are in immediate danger of dying. We identify all of them within seconds through our questioning process. But we send an immediate response to another ten percent because we know that if we are not there quickly, their condition may deteriorate seriously.[1]

We send a car **and** an ambulance to this twenty per cent because we know that a patient in cardiac arrest will need the help of three people, and a vehicle that can take them quickly to hospital. One of the three people will have all the extra skills a life-threatened patient may need for their care[2]. The first response will be on scene within five minutes, and the second one will arrive no more than three minutes later. The information gained in the control room is sent electronically to the attending vehicles, so that the staff who attend them have all the information we have about the patient's previous medical history and present circumstances that will help them provide the correct care.

These three people will provide on-scene care that stabilises the patient and diagnoses their condition well enough that we can give the hospital to which we are taking the patient detailed information that will help them prepare for the patient's arrival. Once on the ambulance we will send the information electronically, which avoids the time delays and danger of mis-heard messages that sometimes happened in the past when crews had to ring the control room to ask for the information to be passed on to the hospital.

About another twenty per cent of our patients are in no danger of dying, but nonetheless need us to be there quickly, often because of the pain they are experiencing or complications that might develop if we do not arrive within half an hour. These patients may have experienced a fracture, they may have recovered from a fit or they may be a very elderly person who has fallen and who is in danger of developing pressure sores if left on the floor for too long. We will arrive with these patients within twenty minutes of receiving the 999 call.

Many of these patients will need two people to help them (e.g. to lift them from the floor) or they will need to lie down as we take them to hospital or an urgent care centre, so we will send a double crewed ambulance to these patients. The skills these patients need are excellent assessment of their need, immediate aid for their problem, empathy and an explanation of what is happening. Patients in this group will not need paramedical skills.

The Emergency Medical Technicians who respond will complete an electronic record of the call, which will be added to the patient's electronic record and transmitted back to the ambulance operations centre so that we will be able to review our success.

A lot of what happens for the remaining 60% of patients depends on what happens in the control room, or response hub, as we call it now. Once we know that the patient does not need us there within twenty minutes we switch to a different line of questioning.

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[1] NB – these figures (10% plus 10%) need verifying

[2] In the past these skills were the preserve of the paramedic, who had some extra skills over and above those of an emergency medical technician (EMT). They could intubate patients (place a tube down the throat to help breathing), they could cannulate (insert a needle through which drugs or fluids can be administered) and they were permitted to administer a number of "prescription only" drugs that had been authorised by the Medical Director. But EMTs could always carry out the vast majority of interventions that could save life in the first few crucial minutes. Paramedic skills come into play a few minutes later into the care and, in London, are only used in five per cent of cases. So we had to consider whether the paramedic role was the right one. These days the vast majority of people with paramedic skills are Emergency care Practitioners (see later) and therefore able to provide definitive care for a far greater number of patients.

We have a large team of people, supervised by a doctor, who can spend the time with the caller that is needed to establish exactly what the patient needs next. We started this in the year 2000, after researching it thoroughly, but now we have a much larger team doing it. They have all worked as front-line ambulance people.[3] They can imagine the home circumstances of the patient. They can convey empathy, and understand the combination of clinical and personal circumstances that lead a person to ring 999.

They have received extra training in assessing patients over the telephone, and in the chronic conditions that may have led to them making the call. They have the support of a computer aided diagnostic tool to back up their knowledge. They have access to the patient's prior medical history through the *Connecting for Health* data spine and therefore know the name and contact details of the patient's GP and any others who are involved in the patient's care.

They also understand the limits of the education they have received. The doctors who supervise that service, most of whom are General Practitioners (GPs), are available to advise our clinical telephone advisers (CTAs), or to take over when callers have problems that the CTAs are not qualified to deal with. These GPs also constantly review the decisions being made and every week they run a clinical review session with the CTAs where practice is discussed and CTAs can learn from the GPs' expertise.

As a result of this, we have a robust and safe system that nonetheless means that far fewer ambulances are sent as a matter of course.

In fact we never send an expensive ambulance crewed by paramedics or EMTs if we know we don't need to. Our Patient Transport Service provides cars and larger vehicles to transport patients who will not need care en-route but have no access to transport of their own. Our Urgent Care vehicles are also available for patients who may need a little more in the way of oversight or care when they travel. These vehicles are also controlled by the response hub.

As a result of all these arrangements, we now only send responses to half of the 60% of patients who have a less serious need. In other words only 70% of our 999 patients receive a physical ambulance service response and only 40% receive a traditional double-crewed ambulance response.

But when patients do need a face to face assessment our emergency care practitioners (ECPs) really come into their own. They are trained to paramedic level but they have extra education in patient assessment, physical examination, chronic conditions, care of children and older people, pharmacology and a number of other areas that mean that they can provide a thorough service for this group of patients. However, they can and do attend all types of calls.

Generally they operate singly, in "people carrier" vehicles which are cheaper to buy and equip than a traditional front line ambulance but have all the equipment required for patients and can be used to transport patients who can travel sitting down.

We know from our evaluation of the role as it was being developed more than ten years ago that ECPs are confident to leave more patients at home or refer them elsewhere. Only 30% of the patients they see end up in an A&E department. ECPs can take patients to urgent care centres all over London or they can call on PTS colleagues to provide that transport. They can also refer patients to GPs and other care providers. ECPs can contact their EBS colleagues at the response hub and get information about service availability at the time. At times the ECPs will make

[3] NB – An issue for resolution - should the telephone advisers be separate from the call takers, or should it instead be an all-in-one role, so that patients do not get passed from one person to another.

whatever arrangements are required themselves. At times the EBS team will take over the case, so that the ECP can go on to another call. The case notes that the ECP has taken are added electronically to the patient's care record on the *Connecting for Health* data spine, which means that EBS colleagues can pass full case notes to the next care provider.

As our most skilled staff, ECPs provide clinical supervision and support for EMTs and paramedics. The more experienced of them mentor those still going through their ECP training. At these times they work as part of a double crewed ambulance team and of course this means that they can maintain their skills in the more acute part of ambulance care.

However, ECPs are seen as part of primary care team in their local health area. Urgent Care Networks commission ECP cover so that ECPs work in walk in centres, minor injuries units, urgent care centres and primary care practices as well as ambulance services. They rotate between these centres so that they have the opportunity to gain experience and mentorship in those settings. They also work closely with GPs in delivering out of hours services. As a result, they are fully integrated into the NHS workforce and all professionals involved in urgent care understand each other's role and contribution as never before.

The service has always given access to GPs who wish to arrange transport for their patients and EBS First, begun in 2005, enhanced this service so that GPs only had to make one phone call in order to arrange both a bed and transport. This service is now extended to any health or care professional in the community who needs it, including NHS Direct nurses, mental health professionals and others.

In addition, the response hub can share its detailed, up-to-date information about bed and care availability with any health professional who is registered with the service. These care professionals can access this information electronically, through the *Connecting for Health* data spine. But EBS staff in the response hub are also available when a hard-pressed health worker needs to make complex arrangements for the patient in their care. For example a district nurse who needs to arrange for a patient to be taken into hospital, can ask EBS to arrange that as well as secure a sitting service to look after the patient's housebound spouse and inform all the patient's other support services such as social worker, GP, meals on wheels etc. that they are being admitted to hospital so that arrangements can be made for the patient's return home.

The expansion of the clinical telephone advice service was the main response to the increase. As a result of the reduced rate of dispatch it has been possible to respond to increased demand without increasing the ambulance fleet exponentially.

The LAS intervenes actively for patients who ring regularly, of whom there are around 25 in London at any one time. The service's patient advice and liaison service coordinates case conferences for these patients involving all the relevant care professionals. This results in social service support, re-housing for patients who can no longer manage on their own and referral, for example, to alcohol services.

When patients call for a problem that is likely to recur, the service refers them to appropriate services that can prevent the problem arising again. These include falls prevention teams, specialist chronic conditions nurses and GPs.

But in addition, the service now has a role in preventing emergencies arising in the first place. The service monitors weather patterns that lead to an increase in emergency calls from patients with chronic conditions and ECPs phone or visit these patients to offer advice on how to avoid those

happening. The ECPs work closely with primary care trusts in this work, which hold lists of those patients most likely to be admitted to hospital.

New threats emerged late in the last century and early in the new millennium. Events such as the foot and mouth epidemic and fuel protest of 2001 plus flooding of 2002, heightened our awareness of the need to have robust business continuity arrangements and plans to deal with slowly developing emergencies (known as rising tide incidents). The sarin gas attacks on the Tokyo underground and the terrorist attack on the World Trade Centre in 2001 also introduced a new scale of terrorist threat to prepare for.

10 years ago we were already recognised for our ability both to plan for and to manage typical "big bang" major incidents such as terrorist bombings and rail crashes and we got our first experience of responding to multiple terrorist attacks on July 7th, 2005.

Learning from all of these events we now:

- Not only train, but re-train front-line staff as part of CPD
- Have genuinely seamless arrangements in place with other agencies to deal with CBRN incidents business continuity and major incident plans now equip us to deal with anything from relatively minor disruptions in our 999 service through to truly Catastrophic incidents
- We can implement our plans in a graduated and measured way meaning that the 999 service we offer to the public suffers hardly any disruption
- with the enhanced skills of our staff we are able to discharge some patients at the scene, which reduces our need to take ambulances from 999 services and reduces the number of minor casualties being transported to A&E departments. (With fewer casualties being transported to hospitals and with better information available to them, hospitals now cancel fewer elective procedures and clear fewer beds to deal with incidents than they used to, meaning that other NHS patients do not lose out.)
- are able to transmit casualty data electronically from the scene, which means the hospital has a much better idea of what to expect when casualties arrive
- have formal arrangements to scale down the response to less urgent calls in order to create the capacity to deal with sustained large scale incidents on a national level.

All this is made much easier as we're now using a common, national digital radio system and we have standardised vehicles and equipment. We've also got arrangements with our key suppliers in place so that we can access vast stocks of clinical supplies and equipment if we need it.

Focussed on delivery

What this meant:

The Strategic Health Authorities and PCTs were clear that they wanted the service to continue to focus on national targets, on Government frameworks such as National Service Frameworks and to meet externally set standards. They wanted us to be cost effective too.

Patients wanted our service to be measured in terms that meant something to them. Our work with the early patients of ECPs clarified this for us. It wasn't just about clinical care. It was about courtesy and respect, about being informed and being reassured. It was about having their problem solved. These patients were clear that they did not want to be taken to A&E if they didn't need to be there.

We ourselves identified that we wanted to ensure that our internal performance management systems ensured that we delivered on all of our obligations: financial, performance and governance.

How we responded:

Ten years ago there were few ways of measuring performance except how quickly we got to the patient. This was a fair proxy for outcome, but as many people said, it meant that we could get to a patient within eight minutes and fail to save them and it would go down as a success, yet we could get there in nine minutes and provide excellent care that saved their life, yet it was recorded as a performance failure. Over the years we have added measures of performance that are about the care provided and the outcomes for patients, including the majority of patients for whom the time we take to reach them is completely irrelevant.

The old direct performance measures focused on speed to patient and financial balance with some indirect measures covering clinical outcomes and governance. These measures reflected the emergency nature of essentially an ambulance service. Today, the service is providing a wider range of urgent care services. The service organisation has evolved into a more complex, flexible organisation which is designed to adapt to the changing needs of the Urgent Care Sector while maintaining a relentless focus on basic operating, clinical and financial performance. The service is now funded by a variety of stakeholders, both local and national, using activity & quality based measures. The Performance Measurement system has evolved into a balanced series of metrics that focus on Patients, People, Processes and Performance linked into both national and local Healthcare measurement systems.

The current measures are delivered using credible, transparent information systems that deliver meaningful analysis tools to stakeholders.

Engaging with the public and our partners

What this meant:

All the partner organisations we spoke to asked us to be collaborative. This meant working with them to develop and use different pathways for patients, and work with them in planning. This meant, for example, jointly identifying gaps in other services that might be leading people to ring 999 and working with them to set up alternatives. They also wanted us to share more: information about patients in order to ensure they received seamless care; responsibility for the whole package of care received by patients; and also to share premises so that the local health team would be better integrated.

How we responded:

We pride ourselves on our responsiveness and the quality of that response. We know that our actions can make a very big difference to how the rest of the NHS performs, as well as to outcomes for patients. We meet with colleagues in the NHS on a regular basis so that we understand their objectives. We offer solutions to their problems where we can and cooperate to improve patient care. That is why PCTs see us as their supplier of choice in all emergency and non-emergency care and transport.

Engaging with London's public has never been easy.

What has not changed is:

- **Ethnic diversity:** For example there are people of almost 100 nationalities living in London and over 300 languages are spoken. We need to be constantly adapting to circumstances as new language and ethnic groups join our population mix and as others grow older.
- **Mobility:** A third of Londoners move house every year. It is not surprising that many do not grow roots into the local health and social care networks that could support them instead of the 999 service
- **Tourists and commuters:** the population of London still swells daily by around a million. 2012 was the year of the Olympic and Paralympic games, which saw record tourist numbers
- **Health issues:** London still has high health needs associated with deprivation, higher than national average levels of mental illness and disproportionately high levels of HIV and TB, drug and alcohol dependence and sexually transmitted infections

But some things have changed:

- the population is, on average, older than it was
- New build, particularly in the Thames Gateway area, has increased the population by 11% (800,000) since 2001 – the equivalent of a city the size of Leeds
- By 2016 London's population has grown by around a further 800,000
- There are no more beds in London hospitals than there were a decade ago. Instead there has been massive investment in primary and community health care services, with the emphasis being on treating patients as near as possible to their own homes
- Patient and public expectations have continued to grow, as a consequence both of Government policy and of the fact that people expect more, and more choice, in all aspects of their lives

All of these factors, whether old or new, pose particular challenges to providers of healthcare in London. Communication, information and mutual consultation are key.

Providing greater options for patients

What this meant:

All our stakeholders told us they wanted us to take fewer patients to A&E. They wanted our staff to be skilled and confident in using a much wider range of alternative pathways for patients.

Staff were clear they wanted access to extra skills so that they contribute to the well being of all our patients.

How we responded:

If patients do need to go to a hospital we choose where to take them on the basis of their condition. For example, patients with a Myocardial Infarction (MI) (heart attack) will be taken directly to the unit that can provide the right intervention. We were already starting this ten years ago, but now we can do it for any patient who needs specialist care: for example people who have had strokes and people with complicated traumatic injuries. This will sometimes mean passing a hospital that does not have these facilities, but we will do this when we know that it will improve the patient's

chance of survival and avoid the clinical risk involved in transferring a patient from one unit to another.

When we arrive at the hospital our staff assist the medical team there and as soon as they can they add their notes on the case to the patient's electronic record. They also transmit them back to the operations centre once they return to their vehicles so that the full record can be used to review our success in treating patients.

But if a CTA has concluded that a patient does not need an ambulance response but instead needs to attend a Minor Injuries Unit or Walk in Centre, or see their GP, or be visited by another care provider like a district nurse, mental health specialist, health visitor or social worker for example, they can secure that care for the patient. If the patient needs transport, they can call up an LAS Patient Transport Service vehicle to provide that.

GP practices reserve a number of emergency appointments for patients who have rung 999 and our CTAs can secure those appointments on-line so that the patient knows what slot they have before the phone call ends. They can also make GP appointments for the following day.

Many other health and social care professionals are also available to CTAs. Our Emergency Bed Service (EBS) has extended the services it provides and is now an integrated and crucial part of the response hub. They have real time information, constantly updated, about the availability of emergency and urgent services, ranging from specialist intensive care beds, through emergency hospital beds, to outpatient and rapid access clinic appointments, intermediate care beds and slots in urgent care centres all over London. They have access to health and care workers who can visit patients and they know who is available when. They can also access voluntary sector services such as Red Cross "sitting services", care lines and advice services of various types, such as welfare advice or mental health support.

If the arrangements cannot be made for the patient while the advice call is still going on, our EBS team take over the responsibility for the call. They work to secure the care that is needed and they ring the patient back once they have succeeded so that the patient knows what to expect. As they always did with emergency beds, they maintain oversight of the patient's case until they know that the patient has arrived at the destination or the care provider has visited the patient. The patient's case records are transmitted electronically to the next carer through the NHS's *Connecting for Health* data spine.

We encourage patients to make their own way to their appointment or urgent care centre if they are able to do so. But sometimes, even when we know the patient does not need an ambulance, we nonetheless arrange transport for them. This is because we understand the "social contract" between the public and the NHS, and our role as the last port of call for people who need help, many of whom lack access to transport.

Culture, attitude and behaviour

What this meant:

Everyone said that they wanted to see the service's CRITICAL values consistently applied across the service. Staff and managers were committed to challenge themselves and each other to be accountable for their behaviour as ambassadors for the LAS in everything they did.

There was a call for new styles of management – supportive of staff and promoting staff involvement and development.

It was clear that most people saw this as underpinned by skills – clinical, managerial, leadership, communications. People wanted to be held accountable, and to hold each other to account, for the highest standards of behaviour and performance.

How we responded:

As members of LAS staff, whether we work at the front-line or support those who do, we understand that there is a contract between us and the LAS that goes beyond the simple statement of terms and conditions that we signed when we joined the service.

When we came for interview we needed to demonstrate good communication skills, a caring attitude and a strong motivation to learn and improve. Emotional maturity was also very important. It can be a tough and stressful job, both in the response hub and "on the road". The LAS needs people who have good coping mechanisms and are also able to seek support when things are difficult.

That was the same if we were applying for a job in support services, as an administrator or a professional in finance, human resources, communications, logistics, information technology, research or statistics. The LAS offers excellent training opportunities to all these staff too and, in return, expects them to commit to their personal development and, crucially, a customer service ethic. In the LAS we never hear the words "it's not in my job description". "Yes" is the most common answer to a request for help.

We have always been very lucky in being a part of the NHS that finds it easy to recruit and retain staff. We have not changed our initial entry requirements. It is still possible to join the service after successfully completing post-16 education at A/vocational diploma level. We have not made it necessary to gain a degree in order to join, because we know that there are many intelligent, resourceful and caring people who, for one reason or another, do not go onto higher education straight from school. We also recognise the reduction in the numbers of young people entering the workforce and the need to maintain healthy access routes to professional ambulance careers.

However, you can gain a degree in paramedic science and join the service through that route. Or, having joined with the basic entry requirements, you can go on to gain higher education qualifications at diploma, degree or post-degree level, dependent on your ability and ambitions supported by the service to do so.

Being able to speak a language other than English will increase your chances of getting an interview and we will not employ anyone who is intolerant of the diversity of our community in London. It is very important to us that our staff profile reflects as far as possible the diversity of the Capital city.

The LAS provides the training and experience to do a good job and to progress as far as our ability will take us. In return we are expected to be committed to our learning and development, to take a

self-critical approach to our practice, to seek feedback from our colleagues and managers and take our own opportunities to learn rather than simply wait for the LAS to provide us with learning opportunities.

In the past we were known for a traditional, hierarchical management style that did not always site well with how things were done in the rest of the NHS. We still need that on occasion. For example, at a major incident, our staff will need to carry out orders – for their own safety and for the sake of patient care.

There are also occasional times when staff act negligently. We do not tolerate that. But we do not blame people for mistakes that could not have been avoided. Instead we investigate the faults in the system that led to the mistake, and do whatever we can to stop that occurring again. We expect people to take personal responsibility for their actions, admit to uncertainty and ask for help when they need it.

So, instead of telling people what to do, and asking for compliance based on seniority, managers lead by example and provide leadership and direction and, crucially, support. We encourage staff to question our systems and suggest improvements. We involve them in making these improvements and they get credit for being innovators. Everyone respects each other for the skills and attitudes they bring to the job, regardless of where they are in the organisation.

We expect to work hard, to be efficient, productive and motivated to perform to the highest professional and personal standards. We expect all those things from our colleagues. The LAS is an organisation we are proud to work for.

Appendix 3

Managing Demand –High Impact Changes

High Impact Changes – A &E Service

1. Progressively implement the New Front End Model in ORH LO77 to provide sufficient FRU resources to ensure that main response time targets are achieved by a single responder whilst ambulance resources are held back to provide transport only when it is required. Excludes situations where clearly an ambulance is required as part of the initial response eg. Cardiac arrest.
2. Achieve consistent 97% hour by hour staffing on FRUs and Ambulances against the ideal cover from the ORH LO77 modelling.
3. Eliminate the telephone handshake on station and mobilise crews by alert message to call waiting on MDT
4. Eliminate unnecessary multiple initial tasking to single incidents.
5. Introduce a system to allow available managers to be efficiently tasked to emergency calls .
6. Further modernise working practices to achieve an acceptance that all ambulances and FRUs need to be dynamically deployed in line with the EOC distribution regime. This will include mobilisation from ambulance stations and fixed deployment sites together with the need to actively move around the service to achieve optimum cover.
7. Improve overall ambulance availability by 300hrs per day by actively managing down overall job cycle times . (Reducing from 62minutes on average to 52 minutes).
8. Review and improve the overall attendance management systems within A&E to consistently achieve overall A&E sickness levels of 5.5% or below.

High Impact Changes – Emergency Operations Centre

1. Achieve consistent 97% hour by hour staffing against a revised ideal modelled by ORH
2. Introduce a revised EOC management structure to ensure high levels of visible leadership and personal accountability. Review and refine the EOC Sector controllers role to ensure that only the highest quality individuals are allowed to dispatch vehicles and that they are held to account for their personal performance.
3. Progressively move FRUs back to sector desks to ensure that geographical sectors have all available resources visible to the dispatcher.
4. Introduce Automated dispatch for FRUs ensuring that activation times are then reduced to under one minute.

5. Eliminate unnecessary multiple tasking to single incidents and hold ambulance dispatch until a definite need for transport at that level is identified.

6. As FRU numbers increase against the LO77 New Front End Model plan progressively extend the tasking of FRUs to both Red and Amber Calls.

7. Restrict Urgent workload on the core emergency fleet to those calls which have an STA of 60 minutes or under.

8. As the UOC takes on more of the green workload progressively restrict the dispatch of core emergency resources to only those Green calls which have been upgraded and/or referred back by UOC.

9. Implement and maintain a comprehensive Distribution Regime for both FRUs and Ambulances against a sophisticated plan based on actual and predicted workload.

High Impact Changes – Urgent Operations Centre

1. Introduce a revised and unified UOC management structure to ensure high levels of visible leadership and personal accountability

2. Implement the full technical functionality for UOC to allow the optimal use of all UOC resources.

3. Achieve consistent 97% hour by hour staffing for all Urgent Care Resources against a revised ideal modelled by ORH

4. Progressively increase the numbers of calls being handled by UOC until they are dealing with 80% of all suitable Green Calls and all Doctors Urgents which have an STA of over 60 minutes.

5. Introduce physician support for CTA and ECPs which allows high levels of call resolution over the telephone.

6. Introduce a system whereby large volumes of Green Calls can be handled by an external provider at times when overall demand on available LAS resources causes severe capacity issues.

7. Review the role of EMT1 within the context of overall workforce planning for Urgent care. Introduce revised roles and skill mix arrangements which accurately reflect the patient care needs as defined by the workload.

8. Embed the current PTS central Services function into the UOC operation and optimise the use of PTS staff in management of appropriate A&E workload.

9. Continue to develop and grow the ECP programme in collaboration with local PCTs and Urgent Care Networks. Increase the utilisation of ECPs to achieve maximum impact on both Urgent Care workload and Emergency workload.

High Impact Changes – Patient Transport Service

1. Matching Operational Resources to meet varying demand - this will include looking at Rotas which take operational hours and unusual demand patterns into account making sure that sufficient resources are available to meet demand without recourse to excessive third party involvement.

2. Achieving Excellence in Planning - this will include giving planners the tools to do their job , always planning against appointment time rather than by geographical area and maximising the number of patients conveyed on each trip.

3. Improving the accuracy of recorded journey data - this will include recording appointment times correctly, defining exactly what we mean by arrival and departure times etc.

4. Reducing block bookings at inappropriate times - this will include convincing hospitals not to block–book high numbers of patients at set morning and afternoon times, cooperating with hospitals to help them book long-distance journeys at suitable times etc.

5. Measuring, reporting and monitoring individual productivity - this will include making sure that call-signs are understood and used for all journeys, especially when changing from single crew work to double crew work.

6. Achieving the full staffing of PTS Central Services in line with the ideal modelling work completed by ORH

7. Reviewing how we survey our patients - this will include reviewing the current survey form, how and when patients fill them in, or introducing other methods to gain feedback.