London Ambulance Service NHS Trust Service Plan 2006/07

(Strategic Plan 2006/07-2012/13): Year 1 Towards

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

London Ambulance Service NHS TRUST

Enclosure 6

TRUST BOARD 28th March 2006

SERVICE PLAN 2006-07

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: *For agreement*

3. Summary

The Service Plan 2006-07, Budget and Workforce Plan are an integrated whole. The Service Plan wording is attached with gaps where decisions are yet to be made or where components are reported elsewhere on the meeting agenda - the Budget and Workforce Plan follow.

The Service Plan 2006-07 is Year 1 of the Strategic Plan 2006/07-2012/13 which will be presented to the Trust Board in its entirety in May as previously agreed.

Included in the Service Plan is a review of achievement against objectives for 2005/06.

4. Recommendation
   - *That the Trust Board agree the wording of the Service Plan 2006/07*

London Ambulance Service
NHS Trust

Service Plan and Budget 2006-07

Year 1 Towards A World Class Ambulance Service

That Responds Appropriately to All Our Patients

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Contents

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1. Introduction

The year 2005-06 was an extraordinary one for the London Ambulance Service NHS Trust (LAS). The Service showed its resilience by its response to the terrorist attacks on 7 July 2005 and completed the sixth and final year of its Service Improvement Programme (SIP), at the same time as struggling to meet performance targets.

This Service Plan identifies what the LAS will strive to deliver for its patients and the public of London in 2006/07. Alongside immediate performance challenges this is the first year of the new seven year Strategic Plan for the organisation. The Strategic Plan sets direction in the wider context of developments in the NHS in the fields of emergency, urgent and out of hours care. It outlines what the LAS will strive to deliver for its key stakeholder groups, following extensive consultation with them, 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 Strategic Plan builds on the achievements of the SIP which turned the organisation into a two star Trust achieving national targets in the face of increasing demand. As such the Strategic Plan maps the route to achieving the LAS Vision, Purpose and 'CRITICAL' Values (Appendix A), 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.

This Service Plan builds on performance in 2005/06 in the context of difficult operating conditions, particularly an increase in damand of 47% in Category A calls and the demands placed on the Service arising from terrorist attacks on the Capital. The Service Plan aims to carry 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 and the Health White Paper *"Our Health, Our Care, Our Say"* published in February 2006.

The key stakeholder groups who have been consulted are: 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 while the feedback received during the Chief Executive's consultation meetings with staff is influential in planning for the forthcoming year. This broad consultation has helped the Board identify early priorities for the way forward for the Trust to become:
"A world Class Ambulance Service the Response Appropriately to All Our patients".

2. Review of 2005/06 - achievement against the Service Plan

2.1 London Ambulance Service aspirations for 2005/06

The 2005/06 Service Plan was focused on delivery of two aspirations for the London Ambulance Service:

- To improve the delivery and outcomes of services for our patients and the public;
- To ensure that change is sustainable through investment in organisational Development.

These aspirations informed the key objectives for the Senior Management Group and reflected requirements to complete the final year of the Service Improvement Programme 2000/01-2004/05. The remainder of this section reviews performance during 2005/06 towards achievement of these aspirations and the associated specific objectives for the organisation.

2.2 Action to achieve aspirations for 2005/06 – performance review

Performance

High levels of demand continued throughout 2005/06 ending at circa 3.8% above the overall demand for 2004/05 which itself was 7.5% above 2003/04. Due to organic growth and changes in the AMPDS coding of calls (resulting in re-categorisation of previously Category B calls to Category A) overall growth in Category A demand was 47% over the year equating to 88,000 additional calls. This, coupled with a particularly high level of front line vacancies threatened achievement of the targets to: respond to 75% of category A calls within 8 minutes across London; ensure that performance against this target did not fall below 70% for any PCT area while aiming for 72%.

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 response by the LAS during 2005/06 to the threat to performance levels was to produce a new Capacity Plan which triggers specific measures when the Service is operating at 'over capacity' with 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 the organisation will operate at REAP level one, when the Service is at a steady state.

There are varying REAP 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 prevailing level is widely publicised.

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. In December 2005 to address the threat to performance a REAP Level 3 was declared remaining in force until March 2006.

Despite the significant increases in demand and as a consequence of implementing the Capacity Plan the Service expects performance against the 8 minute Category A response target for the full year to be 75%. The Category A14 minute target is anticipated to be achieved with a full year figure of 96% overall.

Supplementary targets for Category A 8 minute performance by PCT area are expected to be partially achieved in that 30 out of 31 PCTs will be above their 70% Category A 8 minute performance floor for 2005/06. The remaining 4 PCT areas will be only 1-2% off target and work will continue in 2006/07 to improve performance in these areas.

The Category B14 and Urgent targets remain very challenging and inevitably progress against these has been hampered by the need to maintain Category A performance in the face of significant demand growth.

The performance achievements above have been obtained simultaneously with an exceptionally high level of operational distractions and challenges. The most significant of these are:

- the terrorist attack on the London transport system in July 2005 where the service had to respond to four major incidents simultaneously and the heightened state of security in the aftermath. The role the Service and its staff played in responding to the terrorist attacks in July 2005 has been widely recognised, not least through the New Year Honours list;

- working through the impact of changes to employment terms and conditions arising from the NHS Agenda for Change programme with the uncertainty and discontent generated which fed through as a negative impact on morale. This was followed by staff reluctance to work overtime upon receipt of lump-sum back pay;

- preparing for the 2012 Olympic bid culminating in addressing the International Olympic Committee;

- unexpectedly large number of front-line staff vacancies during 2005/06 which is being addressed.

Service Improvement programme 2000/01-2005/06

Since the year 2000 the focus for development of all areas of the Trust has been the Service Improvement Programme (SIP). 2005/06 saw the conclusion of the SIP and substantial, quantified progress over the life of the programme period has been made as follows:

People:

- A substantial shift in staff attitudes and morale;
- Reductions in staff incidents and assaults on staff;
- Reductions in staff sickness.

Patients:

- Improved cardiac arrest survival rates from 2.5% in 1998 and 1999 to 8.1%.
- Increasing proportion of demand diverted to more appropriate care;
- 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 advent of Team Leaders and Sector Trainers;
- Reductions in complaints in A&E and PTS;
- 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 76.5% for the year 2004/05 and every effort made to maintain this level of performance during 2005/06 in the face of a quantum change in the level of Category A calls as a result of both changes in AMPDS coding in April 2005 and organic demand growth with the result that a higher absolute number of such calls are being responded to in 8 minutes now (February 2006) compared to a year ago;
- Category A14 up from 83% in 2000 to 95%;
- Resource/demand match compliance significantly improved in CAC, 97% compared to the 85% baseline;
- Category A activation time within 2 minutes up from 68% to 89%;
- Reductions in vehicle accident rates for both A&E and PTS vehicles;
- Internal efficiency savings realised to help fund development activity.

A summary of significant achievements and review against the key objectives of the Service Plan 2004/2005 follows.

Aspiration: *To improve the delivery and outcomes of services for our patients and the public.*

Achievement against key objectives in 2005/06 for this aspiration:

Achievement	Objective
Partially achieved	1. Ensure the Urgent Care Service is designed and developed as an integral part of the LAS delivery of appropriate patient care
Achieved Achieved Partially achieved Not achieved Not achieved Achieved	7. Achieve performance targets listed below: • 75% Category A8 performance for the year as a whole • 95% Category A14 performance for the year as a whole • Category A8 performance of 72% by Quarter 4 for each PCT • Improve Doctors urgent performance on 2004/05 results • Improve Category B14 performance on 2004/05 results • Financial Balance

Achievement	Objective
Partially achieved	8. Achieve the agreed trajectory targets for PTS, EOC and Urgent Care
Achieved	9. Successfully complete the final year of the Service Improvement Programme (SIP) initiatives
Partially achieved	10. Successfully achieve all Service Improvement Programme outcomes (in addition to those set out in objectives 6 and 7)
Achieved	11. Ensure the savings programme delivers £3 million worth of savings by allocating sufficient management time and effort to it
Achieved	12. Introduce patient care outcomes and clinical indicators
Achieved	13. Implement the PPI strategy and ensure support for the process from local management
Achieved	14. Rollout Make Ready to 10 complexes
Achieved	15. Use the Intranet to automate at least 5 Business processes
Achieved	17. Agree and successfully deliver the operational workforce plan

Aspiration: *To ensure that change is sustainable through investment in organisational development.*

Achievement against key objectives in 2005/06 for this aspiration:

Achievement	Objective
Partially achieved	2. Successfully implement Agenda for Change;
Not achieved	3. Agree a two year Organisation Development work programme and ensure appropriate resources are in place to give it the best chance of success
Achieved	4. Prepare and obtain Board approval for the LAS seven year Strategic Plan (2006-2013)
Partially achieved	5. Roll-out Personal Development and Review process;
Achieved	6. Implement the diversity plan
Not achieved	6a. Demonstrate significant progress in the recruitment of BME staff
Achieved	16. In response to the most recent staff survey, work together to develop effective internal communications at local level in all sections of the Service

3. Context for 2007/08 Service Plan

3.1 Drivers for Change

There are three different types of drivers for change which the LAS has to take account of: those arising from Government policy for the NHS; those identified from the wider operating environment; and those arising from within the LAS itself. The new Service Improvement Programme 2012, and many core activities, link to these drivers for change.

Policy drivers

The LAS has a key role to play in supporting the NHS in achieving the Government objectives and targets identified in the various published policy documents (see section1). Many of these 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, achieving cultural change.

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. The LAS must concentrate on other national targets (Category B, 19 minutes and GP Urgent calls) as well as improve performance against clinically focused indicators. However as a consequence of the National Ambulance Review it has been decided by Government that:

- as from April 2007 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 20% (ORH Modelling November 2005). A number of high impact changes will need to be embedded during 2006/07 to counteract this (see section 4.2).

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. 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.

The implications for the LAS 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 (with increasing focus on Emergency Care Practioners [ECPs]), training and education, roles, responsibilities and relationships, information management and technology as well as structure and operating arrangements. This Service Plan for 2006/07 progresses the approach the LAS is taking to these challenges in order to realise in London the benefits defined by the National Ambulance Review.

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.

This Service Plan, and many core activities, link to these principles, policy objectives and targets. It is designed not only to maintain performance against the Core Standards documented in "Standards for Better Health" (see sections1 and 4.3) 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 to move towards Foundation status.

Operating environment drivers

In addition to drivers for change which arise from health policy a number of emerging themes have been identified from the wider operating environment:

1. *Stakeholder feedback to the Trust* on what they want it to deliver to them over the forthcoming years (see section 3.2);

2. *The consequences of demand growth* and the impact of developments in Out of Hours *(OOH)* provision as a consequence of GPs withdrawal from providing OOH cover following on from new GP contracts;

3. *The requirements of Primary Care Trust commissioners* that the LAS:

   - Assist them in preventing unnecessary hospital attendances through alternative methods of responding to 999 calls,
   - Assist in the management of chronic diseases outside of hospital and meet response time targets in an environment of zero growth in funding;
   - Provide equitable performance across London;
   - More effectively integrate with the wider health economy and play a full part in local emergency care networks.

4. *The need to respond to population growth*, particularly in the Thames Gateway area. Three main issues arise from this: the impact on relative PCT contributions to the LAS; resource requirements; and the potential to develop new models of care;

5. *Opportunities for co-location with PCT facilities* when they consider new builds to realise service and cost benefits and the potential for new models of care;

6. *The need to further develop and deliver new locally agreed Category C outcome measures* for specific disease groups in response to abolition of the national response time target for Category C patients;

7. *The possible requirement for PCTs to divest themselves of their provider functions* presents a potential opportunity to form closer association with other healthcare professionals such as District Nurses who bring the NHS into peoples homes;

8. *Demographic changes* with fewer young people reducing the recruitment pool and hyper-diversity (28.8% of the population Black and Minority Ethnic (BME), 25% of born outside the UK and 300 languages are spoken in the Capital.

9. *Emergency preparedness for and response to terrorist threats* a priority issue in the wake of events on 7 July 2005 with the need to secure recurrent central funding;

10. *The 2012 London Olympic and Paraolympic Games bringing an* influx of people to the capital and the need to provide dedicated cover at sporting venues;

11. *NHS funding constraints*, the amalgamation of five Strategic Health Authorities into one may bring about structural change in the pattern of acute trust service provision.

Internal LAS driver

The LAS has traditionally been perceived as an emergency service responding to 999 calls with a 'Blue Light' response to get patients to hospital Accident and Emergency (A&E) departments as quickly as possible. 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. Another 20% of patients are in no danger of dying but nevertheless need the LAS to be there quickly (for example they maybe in pain). The remaining approximate 60% of patients do not need a double crewed ambulance arriving at speed and a variety of responses are possible.

The challenge for the Trust is to move to a position as quickly as possible whereby it manages demand differently. The Strategic Plan 2006/07-2012/13 maps the long-term route, the Service Plan maps the steps in 2006/07 along this route.

3.2 London Ambulance Service Strategic Direction and Objectives 2006/07-2012/13

The London Ambulance Services aspires as its Vision to be "A world-class ambulance service for London, In reality "World Class" looks like different things to different people and requires the organisation to meet differing stakeholder needs.

The eight stakeholder groups consulted (see section 1) 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 A).

The six "Aspirations" which define the specifics to be delivered over the next seven years expressed in both words and tangible, quantified outcome objectives are given in Appendix B.

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 "Stakeholder Aspirations" has to take place with cognisance of the drivers for change identified in section 2 of this Service Plan.

The direction of travel over forthcoming years for the LAS is to seek to keep the organisation's current 'market share' of calls to the NHS in London but consolidate the Trust's position, service provision and performance by embracing, promoting and integrating the majority of non-life threatening but often complex 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.

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.

This Service Plan is intended to progress these objectives in 2006/07.

4. Objectives and Actions for 2006/07

4.1 Transformational Change - implementation programme 2006/07

The implementation programme to achieve the long-term objectives of the LAS comprises five strands:

1. *Access and Connecting (the LAS) for Health* - 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, led by the Director of Information Management and Technology;

2. *Operational Model: Strategy For Responding* - covers service portfolio and the ways of delivering provided to patients/healthcare professionals/public once they have made contact with the LAS, led by the Director of Operations;

3. *Organisation Development And People* - covers Organisation Development, culture, HR strategy, education and training (clinical and non-clinical), Diversity and workforce skill mix (including recruitment and retention) and IR, led by the Human Resources Director,

4. *Partnership and Communication* - covers relationships with external stakeholders and their involvement with the LAS especially Patients and the Public (PPI) but also other healthcare professionals, emergency services, social services, key suppliers etc., led by the Director of Communications;

5. *Governance and Corporate Processes* - covers Corporate and Clinical Governance and development of all corporate management processes, led by the Director of Finance.

These five programmes provide the structure for all development activity in the Trust. Detail of the projects funded in 2006/07 within each of these is given at Appendix C, cross-referenced to contributing departments who include their contributions to the programmes in their departmental plans for the year.

Key Objectives and Actions for 2006/07 (1): Implementation Programme and Governance

The items that follow are the key objectives to achieve and actions to undertake during 2006/07 in relation to the implementation programme and Governance of the Trust.

Key objectives and actions relating to operational performance and management of demand during 2006/07 and those addressing changes to clock start times in April 2007 are given in section 4.2.

NB. This section to be completed once SMG have decided what is to be funded in 2006/07 and the Chief Executive has set SMG objectives

	Objective/Action	**Lead Programme or Directorate**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

4.2 Managing Demand - high Impact changes and trajectories 2006/07

During 2004/05 call volumes rose at a rate of 7.5% and as at quarter three of 2005/06 growth in the number of 999 calls is running at 3-4% in line with the long-term rate of annual growth. The planning assumption is that demand will grow at a similar percentage during 2006/07. Only by developing alternative responses can the LAS manage a growing number of 999 calls, meet commissioners' requirements and existing and new response time targets in an environment of zero growth in funding and hence staff numbers.

In the context of capacity constraint, increasing demand and the immediate 20% drop in reported performance as a consequence of changes to clock start timings in April 2007, the Trust has decided that a new operational model is required. It is necessary to make some

"High Impact Changes" during 2006/07 which will be managed through the Operational Model Programme described in section 4.1. The "New Clock Start Operational Performance - High Impact Change" project is fundamental to managing demand in the near term. Its implementation underlies planning assumptions about operational activity going forward, hence the resource headroom and scheduling for the rest of the service improvement and modernisation programme.

The "High Impact Changes" 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 has worked to ensure that the changes are complimentary and improve the whole system rather than individual departments.

The performance trajectories for 2006/07 can be found at Appendix D

Key Actions and Objectives for 2006/07 (2): Operational performance and management of demand

This section to be completed once SMG have decided what is to be funded in 2006/07 and Chief Executive has set SMG objectives

	Objective/Action	**Lead Programme or Directorate**
1.		
2.		
3.		

4.3 Delivery of Core and Developmental Standards and the Diversity agenda

A key requirement for the Trust is to meet the requirements of the NHS planning and governance framework "Standards for Better Health" published in July 2004. This Service Plan is designed not only to maintain performance against the Core Standards but also to make demonstrable progress over 2006/07 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.

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. Work under Project 16 in the Governance and Corporate Processes Programme will drive forward LAS activity to ensure compliance.

The Trust has established a 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 to progress equality and diversity, through all directorates and programmes, oversight and driving development and implementation forward will take place through the Organisation Development and People Programme.

5. Critical Success Factors, Risk and Stakeholder Engagement

5.1 Critical Success Factors

A set of Critical Success Factors (CSFs) has been produced for the implementation of the High Impact Changes and the five programmes for service improvement which capture the assumptions made and the commitment required from all involved. These can be found in the Strategic Plan.

5.2 Risk Management

There are very significant risks reflecting the size and scope of the LAS and the scale of improvement planned. However 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. Regulatory and inspectorial roles with regard to risk management are carried out by a range of legislative and advisory bodies. In addition, independent inspection of controls assurance and finance is provided by internal auditors.

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. 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. Using this model, the following principal risks and their associated action plans which relate to the proposed development activity in 2006/07 have been identified:

1. Long-term risks to delivery of the Strategic Plan particularly relevant in 2006/07

Principal Risks	Owned By Strategy Steering Group (SSG) or Programme
Impact of likely Pandemic Influenza	SSG
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
Technological fragility – Emergency Operations Centre or Urgent Operations Centre infrastructure failure	Access & Connecting (the LAS) for Health
Failure to learn from major incidents	Operational Model: Responding
Industrial Relations – a lot of change/modernisation is required early on in the Plan and will make demands on union representatives	OD & People
Risk of fatigue at the second and third tiers of management due to workload pressures	OD & People
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.	Partnership and Communications
Uncertainties in Trust finances arising from the competitive position of Patient Transport Services	Governance & Corporate Processes
Failure to maintain 75% Category A performance necessary to retain "licence to practice"	Governance & Corporate Processes
Risk to potential growth arising from financial pressures e.g. reduced annual uplift and increased capital scarcity	Governance & Corporate Processes
Changes as a consequence of "Creating a Patient-Led NHS" and consequent change in the strength of the Trusts' position to argue its position	Governance & Corporate Processes
Insufficient productivity in the Urgent Operations Centre (cost per call)	Governance & Corporate Processes
More complex and onerous targets and inspection regime	Governance & Corporate Processes
Lack of effective project management resource	Governance & Corporate Processes
Financial risk arising for non-recurrent resources for activities the Trust is required to be involved in such as aspects of emergency preparedness	Governance & Corporate Processes
Unpredictability of demand increase	Governance & Corporate Processes

2005/06 risks below to be determined by Risk Management

1. Short term risks for the Trust for 2006/07

Principal Risks	Development Activity
High Risks	

Principal Risks	Development Activity
High Risks (continued)	
Medium Risks	

Principal Risks	Development Activity
Low Risks	

These risks 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.

5.3 Staff Engagement

Communicating with staff and involving them in Service initiatives and changes is a vital ingredient in our plans to continue developing the organisation.

The LAS believes that its success depends on staff feeling informed, listened to, involved and valued. A number of communication tools have been enhanced – intranet, internal magazine, routine bulletins – and much attention has been given to face to face communication although this is a vital area which needs constant attention and development.

The sixth annual series of Chief Executive meetings were attended by about 1,500 staff and provided a huge amount of feedback from the 35 events held across the LAS. Key issues raised were around:

- Agenda for Change – the new NHS pay system;
- Development of the new Urgent Care Service to provide a service that better meets the needs of all our patients and to relieve the pressure on 999 crews dealing with life-threatening calls;
- Changes to the system used to prioritise 999 calls;
- The need for more staff on the 'front line'.

Other issues raised included:

- The desire for more training and development throughout the Service;
- A better understanding by police of how to use the ambulance service;
- A better understanding by other health professionals of how to use the ambulance service;
- More support for front line staff by managers, especially out of normal hours.

Regular internal conferences for managers and team leaders continue to be used to share key messages and information and to reiterate the importance of the LAS values.

Much attention is being given to improving local management communication and this will be assisted by the creation of stronger management teams following a further A&E service restructure which saw the introduction of assistant directors of operation to take responsibility for the three geographical areas of the Service, the Urgent Operations Centre and the Emergency Operations Centre (formerly Central Ambulance Control).

It is accepted that developing effective communications throughout the Service is key to the organisation's success and considerable focus will always be placed on ensuring that we continue to develop and improve the methods we use to inform staff, listen to them, act on what we hear and engage them in the development of the service.

6. Performance Management – Balanced Scorecard for 2006/07

The Balanced Scorecard which will be used by the London Ambulance Service during 2006/07 for performance managing implementation of the Service Plan, both in terms of transformational change and also day to day operations is given below.

2006/07 Balance Scorecard to be inserted here when developed by Finance

Appendix A

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 B

Strategic Direction of the London Ambulance Service

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 AOMs	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
	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)	60% of workforce ECPs by 2013 (to be confirmed as part of the seven year workforce plan).
	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

Appendix C

Projects Funded in 2006/07

NB. To be determined by SMG during budget setting process

Programme	Project Funded in 2006/07	Contributing Departments *(Included in functional plans)*
1. Access and Connecting (the LAS) For Health Strategy	**12. Develop an access strategy** - -	
	11. Connecting for Health projects and those that are related to it - -	
	14. Records and Information Strategy - -	
	18. New Clock Start Operational Performance – High Impact Changes (Strand 2) - -	
	26. CAD 2010 - Implementation of the CAD replacement strategy	
2. Operational Model: Strategy For Responding	**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:** - -	
	2. Develop implementation plan for new operational model - -	
	3. Implement new operational model - -	
	6. CTA Projects - -	
	7. Care Pathway development projects - -	
	18. New Clock Start Operational Performance – High Impact Changes (Strand 1) [supported by Programme 1(Strand 2) and Programme 3 (Strand 3)]: - -	
	21 . Olympic and Paraolympic Games - -	
	22. Development of the Thames gateway - -	
	24. Major incident resilience - -	

Programme	Project Funded in 2006/07	Contributing Departments *(Included in functional plans)*
3. Organisation Development And People Strategy	**4. Education and training projects** - -	
	5. Attitude and behaviour/culture interventions - -	
	13. Organisation Development - -	
	15. Implement Diversity Plan - Implement Race Equality Scheme Action Plan and Race Equality and Diversity Implementation Plan	
	18. New Clock Start Operational Performance – High Impact Changes - -	
	23. Implementation of the Sector Operating Model Review - -	
	25. Union engagement - -	
4. Partnership and Communication Strategy	**9. Communications projects, including patient, public and partner involvement** - -	
5. Governance and Corporate Processes Strategy	**8. Audit and quality assurance of clinical care** - -	
	10. Corporate processes - -	
	16. Standards for Better Health and NHSLA - -	
	17. Managing Successful Programmes - -	
	19. Foundation Trust Status Application - -	
	20. Productivity and efficiency - -	
	27. Development of new Governance processes - -	

Appendix D

Performance Trajectories for 2006/07

NB. 2006/07 Trajectories to be associated here once decided by Trust Board

Resource Plan and Budget for 2006/07

NB. 2006/07 Workforce Plan and Budget to be associated here once decided by Trust Board