LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 25th September 2007 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Declarations of Further Interest.	
2.	Opportunity for Members of the Public to ask Questions.	
3.	Minutes of the meeting held on 31st July 2007 Part 1 and synopsis of the Part II meeting held on 31st July 2007.	Enclosure 1& 2
4.	Matters arising	
5.	Chairman's remarks	Oral
6.	Report of the Chief Executive	Enclosure 3
7.	Financial Overview, Month 5 2007/08,	Enclosure 4
8.	Report of the Medical Director	Enclosure 5
9.	Receive Service Improvement Programme 2012 Progress Report	Enclosure 6
10.	Approve Management of Change Policy and Procedure	Enclosure 7
11.	Note Training & Development Plan, July 2007-April 2009	Enclosure 8
12.	Note Supplementary Equality Report	Enclosure 9
13.	Note Major Incident Plan	Enclosure 10
14.	Receive report on Managing Sickness	Enclosure 11
15.	Receive update on Emergency Operations Centre	Presentation
16.	Draft Minutes of Charitable Funds Committee, 31st July 2007	Enclosure 12
17.	Draft Minutes of Clinical Governance Committee, 13th July 2007	Enclosure 13
18.	Report from Trust Secretary on tenders opened since the last Board meeting	Enclosure 14
19.	Opportunity for members of the public to ask question	Oral
20.	Date of next meeting: 27th November 2007	

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 31st July 2007

Held in the Conference Room, LAS HQ
220 Waterloo Road, London SE1 8SD

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Ingrid Prescod	Non Executive Director (from 10.30)
	Roy Griffins	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Caroline Silver	Non Executive Director
	Barry MacDonald	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Martin Flaherty	Director of Operations
Apologies:		
	Caron Hitchen	Director of Human Resources & Organisation Development
In Attendance:		
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development
	Ann Ball	Deputy HR Director
	Ralph Morris	Head of Complaints
	Peter Thorpe	Olympic Games Planning Manager
	Jonathan Lofthouse	Member of the Public
	Laura Weatherly	Emergency Medical Technician
	Dean Weatherly	Member of the Public
	Christine McMahon	Trust Secretary (Minutes)

70/07 Declarations of Further Interest

The Chairman reported that he had been recently appointed by the Government as a Non-executive Partnership Director on the board of National Air Traffic Services Holdings Limited, the UK's leading air traffic management provider.

71/07 Opportunity for Members of the Public to ask Questions

There were no questions from members of the public.

72/07 Minutes of the Meeting held on 22nd May 2007

Agreed: The minutes of the meeting held on 22nd May 2007 with the following corrections:

Minute 56/07 (page 5): Beryl Magrath felt that the minutes did not fully convey what a positive event the Patients' Listening Event had been; there had been many positive contributions from the attendees.

Minute 63/07: CITE denotes 'Communities into training and employment' and not as stated 'Community into for and outreach work employment'.

Minute 63/7: That the following sentence be deleted: "e.g. by being advocates of the Service, helping to raise its profile amongst various ethnic communities".

73/07 Synopsis of the Trust Board's Part II minutes held on 22nd May 2007

Noted: The contents of the synopsis of the Trust Board's Part II minutes.

74/07 Matters arising from the minutes of the meeting held on 22nd May 2007

Noted: That there were no matters arising that were not addressed by the reports submitted to the Trust Board.

75/07 Chairman's remarks

The Chairman said that the Patient Care Conference, held on the 30th July 2007 at the Oval Conference Centre, had some very good speakers and was extremely well organised. There had been a good attendance from patients, other health professionals and members of staff. Professor Lord Ara Darzi's video promoting the NHS London's strategy for healthcare in London was shown. The Chairman said that copies of the video would be circulated to the Non-Executives. **ACTION: Director of Communications.**

On 23rd July 2007 the Mayor of London, Ken Livingstone and his senior policy adviser, Alex Bax, visited the LAS and met with the Chairman and the Chief Executive. As it had been six years since the Mayor had last visited the LAS the opportunity was taken to inform him of the changes that have been made, and the Service's strategic direction of travel over the next couple of years. The Chairman took the opportunity to raise the possibility of the GLA funding the Emergency Life Support Training (EMST) as advocated by the Greater London Assembly (GLA)'s Health & Public Services Committee. The Chairman said that he had mentioned the need for funding of the EMST to Joanna McCartney, Chairman of the GLA's Health & Public Services Committee, when he talked with her at the Patients Care Conference.

76/07 The Chief Executive's report

The Chief Executive referred Members of the Board to the supplementary pack of information tabled at the start of the meeting.

The Chief Executive said that Category A 8 minute performance was on track; it was 80% for July 2007. Category A 8 minute performance in July as measured in accordance with 'Call Connect' was 60.5% which was in line with the trajectory submitted to the Department of Health. The trajectory shows the 'Call Connect' Category A 8 minute performance being 58% for July, 62% for August, leading to 75% performance in April 2008. The Chief Executive said that meeting the trajectory target of 66% for September is likely to be a challenge for the Trust. In

order to improve performance as measured by 'Call Connect' work is continuing to minimise multiple despatch; to reduce the fall in performance at shift change over and reduce the fall in performance associated with rest breaks. The Senior Management Group is regularly reviewing 'Call Connect' performance to ensure the trajectory remains on target.

The Chief Executive said that Category B performance is of concern as the Trust will incur a financial penalty of £2m if the target of 90% is not achieved for the full year and a further £1m penalty if 95% is not achieved in the final quarter of 2007/08. Category B performance in July was 84% for the year to date. The Boards was reminded that the Service Development Committee in June received a report on a series of actions being undertaken to improve Category B performance.

The Board's attention was drawn to the number of events that have taken place in London since the last Trust Board meeting of 22nd May 2007; the list included the Tour de France and the foiled terrorist attack. The Chief Executive said that the LAS had been working closely with the Scottish National Ambulance and had offered support to other Ambulance Services, such as Great Western, who have been coping with the repercussions of severe weather in their area.

Emergency Planning: in March 2007 the Trust Board agreed that the LAS should take on responsibility for co-ordinating emergency planning for London. The Chief Executive said that discussions are still on-going with NHS London. If the Trust does take on this responsibility it will be with effect from October 2007.

The 'Healthcare for London – a Framework for Action' was launched in July 2007; the LAS has been heavily involved with the proposed strategy.

The Chief Executive and the Director for Service Development met with Paul Corrigan, Director of Strategy & Commissioning, NHS London and Matt Tee, the new Chief Executive of NHS Direct.

A meeting will be held with representatives of the NHS London's Provider Agency to discuss the LAS' role in implementing the strategy outlined in 'Healthcare for London'. The Chairman added that the LAS is preparing a financial analysis looking at how the Trust could positively support the proposed Primary Care Strategy by dramatically increasing the number of ECPs and creating integrated response hubs. This will hopefully see a reduction in the number of patients transported to A&E and give PCTs confidence that funding can be transferred from the Acute Hospitals to other healthcare providers.

PTS: the Chief Executive said that PTS had retained the Queen Elizabeth Hospital NHS Trust contract but lost the Camden Primary Care Trust (PCT) contract.

The Chief Executive said that the supplementary pack of information showed 999 response times in terms of Category A, B and C calls broken down according to Primary Care Trust.

The Board's attention was drawn to Graph 13 in the Chief Executive's report, 'time taken to answer calls in the Control Room', which showed improvements in performance. In April 2007, 65% of calls were answered in 5 seconds, by July, 80% of calls were being answered in 5 seconds. The improvement in performance reflected the efforts of the Deputy Director of Operations, Control Services UOC, Richard Webber, and the new operational management tier that came into effect on 2nd July. Work is being undertaken to improve performance still further.

The Chief Executive said that for the period December 2006 to March 2007 a high number of complaints were received concerning delays in the despatch of ambulances, due to an increased workload and poor staffing levels. However, since

April 2007 there has been a drop in the number of complaints received concerning delays in despatching ambulances.

In response to a question from the Chairman, the Director of Operations said that Management Information was encountering technical problems in regard to providing information concerning vehicle utilisation; every effort is being made to obtain the data in the form that the Board had requested. **Action: IM&T Director**

In response to a question from Beryl Magrath the Director of Operations said that some of the 'Call Connect' funding will be used to improve Urgent Care thereby diverting Green calls from the core fleet.

It was recognised that the Trust is facing the twin challenges of implementing initiatives to ensure that it achieves 'Call Connect' performance and implementing initiatives to improve Category B performance.

There is also the added question of whether the Trust should make a provision for the penalty of £1m to £3m should the Trust not achieve the Category B performance, or release the funds to enable Operations to implement initiatives that will help achieve the Category B performance targets. The Director of Operations said that Category B performance is generally good midweek but tends to be poorer at weekends.

Beryl Magrath asked about multiple despatches; in May the number of responses per incidents stood at 1.6 vehicles per incident. The Director of Operations confirmed that this had fallen to 1.5 vehicles per incident for Category A incidents. For the Trust overall (i.e. across all three categories) the ratio had fallen from 1.3 vehicles to 1.2 vehicles since June 2007.

In response to a comment from Barry MacDonald, the Chairman confirmed that he had written to the members of staff who had alerted the Police of the attempted terrorist attack, thanking them for the vigilance they had showed in alerting the authorities. The Board wished to express their thanks to the members of staff for their diligence.

In response to Barry MacDonald's query concerning the New Front End Model and the proposed increase in Fast Response Units, the Director of Operations said that ORH had been asked to undertake further modelling in regard to the number of Fast Response Units (FRUs) required. The Director of Operations said that for a number of reasons it was now felt that the original estimate of 210 FRUs should be revised. The review is, in part, connected to the intention to roll out the Clinical Leadership Model as outlined to the Service Development Committee in June 2007. Work is being undertaken to identify the three complexes that will trial the new Clinical Leadership Model. It is anticipated that the trial will commence during the first quarter of 2008/09. The Director of Operations said that the implementation of the Clinical Leadership Model across the Trust is likely to take from 18 to 24 months. He said that the New Front End Model has not been forgotten but that, in some respects, the Trust has moved on, and the approach being adopted reflected that the Trust has received 'Call Connect' funding four months into the new financial year.

Beryl Magrath congratulated the Human Resources Team for the improvement in the Trust's attendance management record. The figure for sick leave had remained stable at 5.73%.

The Director of Operations was unable to confirm what the actual cost of the additional staffing required by the Trust during the weekend of the Tour de France. He said that the Trust had managed extraordinarily well during the weekend of the 6th-8th July given the coincidence of the Tour de France with the Live Earth event at Wembley Stadium; a cricket match at Lords, tennis at Wimbledon and a concert by Genesis at Twickenham. The Trust had approached Transport for London for

funding as additional expenditure had been incurred due to the Tour de France but the response had been negative. The matter was also raised with the Mayor during his recent visit to the LAS subsequent to the Tour.

In response to a question from Beryl Magrath concerning Clinical Telephone Advice (CTA) the Director of Operations said that a meeting to discuss clinical support and governance in the Control Room has been arranged for the afternoon of 30th July 2007. Discussions are taking place with ECPs about undertaking a rotation through CTA. The Director of Operations said it is clear that the CTA's optimum establishment of 70 members of staff is not going to be met solely by ECPs.

In regard to the CTA function being dispersed to a number of sites across London, which might make that role more attractive and increase the number of applicants, the view of the Director of Operations and the Director of IM&T is that the CTA model needs to be demonstrably working well centrally before the function is decentralised. The Director of IM&T said that although several options were being considered as to how decentralisation could take place, it is unlikely to be technically possible to implement access from remote sites this year.

ECP: the Director of Operations said that City & Hackney PCT have agreed to fund five ECPs from October 2007. It was reported that City & Hackney PCT is really keen to work with the LAS on this initiative.

Noted: The contents of the Chief Executive's report

77/07 Month 3 finance report

The Director of Finance said that for the year to date the Trust has a surplus of £1.2m of income over expenditure. This is £600,000 less than forecasted and includes the £1m accrual set aside should the Trust not achieve the Category B performance target of 90% for the 2007/08. The Trust is forecasting to break even for 2007/08.

Income

PTS: the Director of Finance drew the Board's attention to the analysis of PTS income which showed that there had been unplanned activity arising from contracts that have been lost but where PTS has picked up more profitable ad hoc business as a result.

'Call Connect' funding has been agreed with the Primary Care Trusts and the Trust should receive £6.8m in August 2007. The Board was informed that some of this funding will be at risk should the Trust not achieve 'Call Connect' performance targets i.e. the Trust is required to achieve 72% either in January, February or March and if it falls below 68% in that time period there is a 10% penalty charge that will need to be repaid to the PCTs.

Expenditure

The Director of Finance said that the Operations budget is overspent due to increased spending on overtime in anticipation of the 'Call Connect' funding.

The Board's attention was drawn to the general expenditure trend which showed the average monthly expenditure for the year to date is £18m. The Director of Finance was confident that the average monthly expenditure will remain at £18m to £18.5m for the remainder of the year.

In response to a question from Sarah Waller concerning ECP income, the Director of Finance said that the Trust had decided to continue providing the service if PCTs were willing to fund it; in the year to date more income has been received than was forecast.

Overtime: although the amount of overtime hours rose recently, it was recognised that it was still half of what was available to Operations in 2006/07. The Board was aware, following the HR Director's report to the Service Development Committee in June 2007, that the reduction in overtime has been unpopular with some front line staff, who had worked extra shifts a regular basis and had come to rely on the additional income.

The Director of Operations said that Managers are aware of what overtime has been allocated and endeavour to use the resource in the most effective way possible. As the 'Call Connect' funding is not a one-off payment it was recognised that there is a balance to be struck between offering staff overtime to boost the take home pay of current members of staff and building the organisation by recruiting additional staff.

Under Agenda for Change, the cost of overtime is quite significant for the Trust; front line crews are paid time and half regardless of whether they work midweek or weekends and it has been difficult to recruit staff to work unpopular shifts. Members of staff are offered overtime on a priority basis and this has reduced the utilisation of Bank staff, whose numbers have consequently fallen.

Barry Macdonald queried the total expense trend. The Director of Finance said that it was in line with current budget. An updated expenditure trend will be produced in September and will include 'Call Connect' funding. **ACTION: Director of Finance**

Caroline Silver said it would be useful to see a forecast budget for September 2007 to June 2008 outlining the Senior Management Group's thinking regarding year end and the beginning of the next financial year. **ACTION: Director of Finance**

The Board was concerned that the Trust had not yet received the promised HART funding. The Department of Health had said it would fund the HART project to September 2007 if NHS London undertook to fund the project in 2008/09. As NHS London has not given this undertaking it appears that the funding will not be forthcoming from the Department of Health. The Board will make a decision at its meeting on 25th September 2007 whether the HART project will cease should additional funding not be received.

The Director of Finance said it appeared likely that the Trust will receive its requested funding for the preparatory work being undertaken in relation to the London Olympics. He also said that efforts are continuing to obtain the recurrent CBRN funding for 2007/08.

Noted:

1. **The Month 3 Finance Report.**
2. **That a forecast incorporating the 'Call Connect' funding will be presented to the Trust Board in September 2007. ACTION: Director of Finance.**
3. **That the revised budget will include a re-profiling of the pay budget. ACTION: Director of Finance.**
4. **That the balance sheet position has improved since the report was written as PTS recently received £500,000 from Bromley Hospital NHS Trust.**

78/07 <u>Auditor's report on 2006/07 accounts</u>

The Director of Finance presented the Trust's 2006/07 Accounts and the Auditor's report. At its meeting on 18th August the Audit Committee had considered the Accounts and the Auditor's report and agreed that they should be presented to the Trust Board.

Beryl Magrath asked why if the Trust scored 4 (out of possible 4) for Value for Money under 'arrangements in place for managing performance against budget', it still only scored an overall Adequate. The Director of Finance said he would investigate. **ACTION: Director of Finance.**

The Chief Executive said that the Trust expected to receive an overall ALE score of 'good' for the use of resources.

In response to a question concerning an apparent discrepancy in the report and accounts relating to the Auditor's fees the Director of Finance said the Audit Commission's fees for 2006/07 was £147,000; the reference in the Audit Commission's annual report to £125,500 did not include VAT.

Agreed: To receive the 2006/07 Accounts and the Auditor's report.

79/07 **The Medical Director's report**

The Medical Director highlighted the following from her report to the Trust Board:

Annual Health check: the rating for 2006/07 is expected to be announced on 18th October 2007. The Trust is expected to receive a rating of 'fair' for the Quality of Care component of the Annual Health Check. It is hoped that, as the majority of STEMI patients are transported for primary angioplasty and very few LAS patients receive thrombolyis, the LAS will be able to use the 'low numbers rule' and, consequently, the Trust will avoid the hit on 'Quality of Care' that occurred last year as a result of the HC using out of date clinical guidelines.

The *NHS Litigation Authority* (NHSLA) launched the pilot of the Risk Management Standards for Ambulance Trusts on the 8th May 2007. An assessor is visiting the Trust on the 8th August to assess the Trust for Level 1 under the new scheme; this will require the Trust to demonstrate that it has the relevant risk management policies, procedures and processes in place. An assessment visit in the Autumn will require evidence of the implementation of the policies etc. The Trust retains its previously obtained Level 2 under the old scheme until the pilot of the new system has been concluded.

Safety Alert Bulletins: The Safety Alert Broadcasting System (SABS) is run by the Medicines and Healthcare products Regulatory Agency (MHRA). The LAS is required to inform the MHRA through a reporting system of the actions it has taken to comply with the Regulator's instructions upon a SAB being issued. 24 alerts were received during the period of 10th May 2006 to 3rd July 2007, two were deemed to require action by the Trust. The Trust itself reported one incident to the MHRA in July 2007 in connection with MDA/2007/052, Pregnancy Test Kits, Clearview HCG.

Safety within the organisation: the Medical Director said that it appears, following the introduction of Braun Safety Cannula, that there has been a reduction in the number of needle stick injuries. The findings of a comparative evaluation of six months data, pre and post introduction of the Braun Safety Cannula, will be presented to the Trust Board in September. **ACTION: Medical Director**

High risk exposure: there were a number of examples given of incidences when front line members of staff had been inadvertently exposed to high risk illnesses. Of those reported the one that is of most concern to staff is meningococcal septicaemia.

There was a discussion around front line staff being checked for chickenpox immunity. Chickenpox can be a serious illness for adults and it presents a serious risk to patients whose immunity system has been compromised.

Clinical and cost effectiveness: the Clinical Audit & Research Unit (CARU) has recently started producing a monthly Cardiac Care Pack that contains a wide range of

clinical and operational information. The information is broken down at a Complex, Area and Service level, relating to both cardiac arrests and ST Elevation Myocardial Infarction (STEMI) patients. This pack is widely disseminated across the LAS and its findings are discussed at Area business and governance meetings, and it is used locally to measure performance against clinical targets. The disadvantage is that the numbers are currently quite small and so it is difficult to identify a trend. The Medical Director said that the recording of ethnicity is much higher than previously reported to the Board.

So as to improve the robustness of future audits CARU has identified a number of issues that need to be resolved. One issue is Team Leaders submitting g PRF and FR2 data print outs to CARU. Another is crews being encouraged to print-out a copy of the 12 Lead ECG rhythm and submit it to CARU and being reminded to document primary illness code 87 when they identify a confirmed Myocardial Infarction using a 12 Lead ECG. Crews are being encouraged to take three copies of ECG print out: one for A&E; one for the crews' own CPD folder and one for CARU in order that their diagnosis can be verified.

End of Life protocols: the Medical Director commended the efforts of the Senior Clinical Adviser to the Medical Director, David Whitmore, who has worked very hard to implement the Trust's End of Life Care Plan, liaising with Hospices, Palliative Care Teams and General Practitioners.

The Patient Specific Protocol system that was started some years ago, (and from which the Out of Hours form was developed), continues to prove a valuable method by which clinicians can inform the LAS of complex care issues surrounding their more vulnerable patients who are being cared for at home. Currently there are 137 patients in the system, with the trend in new patients showing a rise to about one new case a week.

Clinical Audit & Research Bulletin has been published and distributed throughout the Trust to publicise how the CARU department can assist front line staff to undertake research. Copies of the bulletin were circulated at the meeting.

Stroke: the Trust was recently informed that St George's NHS Acute Trust will be offering 24/7 care for patients suffering a stroke. From August 2007 the National Hospital for Neurology and Neurosurgery will be offering a 24/7 service based at UCH in this trial. The time to treatment from the onset of symptoms has been extended to six hours which may increase the number of patients suitable for thrombolysis.

In response to a question from the Chairman of the Patients' Forum, Malcolm Alexander, the Medical Director said that the results of an ECG would determine whether a patient was suitable for reperfusion by either angioplasty or thrombolysis. In recognition of the high level of interest expressed concerning this subject, it was suggested that the Clinical Practice Manager, Mark Whitbread, be asked to give a presentation on the treatment of stroke to the Service Development Committee in October 2007. **ACTION: Medical Director**

In response to a question from Beryl Magrath regarding the work undertaken with the Palliative Care Teams, the Medical Director said the Trust responds to a mixture of patients with long term conditions that occasionally require medical intervention; patients with long term illnesses where they are significantly unwell and patients with terminal illnesses.

The Medical Director said she would investigate the answer to Caroline Silver's question as to how many other Ambulance Trust have a similar palliative care/end of life procedure in place like the LAS. **ACTION: Medical Director**

Noted: The contents of the Medical Director's report.

80/07 Revised Freedom of Information (FOI) Policy

The Trust Board considered the revised FOI policy that incorporated the comments made by Members at the Trust Board in May 2007.

The Chairman of the Patients' Forum asked whether the policy should include a reference to the upcoming legislation regarding the rights of Patients Forum and LINKs organisation to information from NHS organisations. The Director of IM&T said that request for information from any organisation would be considered in line with the FOI Act.

Approved 1. The revised FOI policy
Noted: 2. The question raised by the Chairman of the Patients' Forum concerning the impending legislation giving Patients Forums and LINKs access to information.

81/07 Updated Whistleblowing Policy

The Deputy HR Director presented the policy to the Board. Although there were no substantial changes made to the Policy, it had been amended to reflect changes in legislation and highlight that, not withstanding, the difficulties regarding maintaining anonymity for the whistle blower, all reasonable steps will be taken. Following Board approval, the Policy will be re-launched to raise awareness throughout the organisation. Work will be undertaken with managers on how best to handle issues that are raised with them under the Whistleblowing Policy.

The Director of Finance said that the Policy will be extended to employees of suppliers of goods and services e.g. Make Ready contractors, who will be able to raise concerns either with their employer or with the Trust.

Approved The updated Whistleblowing Policy with the proviso that the references to appendices are corrected. ACTION: HR Director

82/07 Presentation: 2012 Olympics

Peter Thorpe, the Olympic Games Planning Manager, outlined the work being currently undertaken in preparation for the 2012 Olympics.

The underlying intention behind the preparation for the Olympics is that there will be no compromise in the healthcare services provided to Londoners during the period of the Games. The Trust's representatives are liaising with the Games' organisers to ensure that the necessary policies and procedures are in place for a seamless healthcare provision for the 10,000 athletes, and the associated non-sports personnel involved in the staging of the Games.

Although the Trust has submitted a funding application to the Department of Health for £600,000 for 2006/07 no money has yet been received. The decision was taken to proceed 'at risk' as it was recognised that the Trust needs to be involved in the early stages of planning for the Games.

Two 'Comprehensive Spending Reviews' (CSRs) are undertaken leading up to the Olympics; the LAS submitted a funding application for £7.4 to the first CSR which encompasses the lead up to the games (2008-11). Work will be undertaken to gauge

the necessary funding required by the Trust for submission to the second CSR which will encompass 2012-2014.

The Board was adamant that every effort should be made to ensure that full funding is obtained in respect of the additional expenses being incurred due to the Olympics.

Roy Griffins said he was concerned with the phrase that funding would come via the 'normal funding route' as he felt this may mean interminable delays. It was confirmed that although the Home Office has been supportive of the Trust's funding bid, it is the Department of Health who has responsibility for funding the LAS. The Director of Finance said that the liaising currently being undertaken in regard to the submitted bid for £600,000 (2006/07) is helping to forge relationships within the Department of Health.

The next steps include being more proactive, rather than reactive, to requests for information or financial bids from the Olympics' organisers and scoping a number of projects identified as part of the Trust's Olympic Programme.

The Chairman said that the Trust's funding application should fully reflect the expected expenditure incurred as a result of the Olympics. He said it was very important the Trust lay down firm markers with the Department of Health that the Service cannot underwrite the cost of the preparation for the Games.

Noted:

1. **The contents of the report.**
2. **That the Olympics Programme is being managed using the principles of Managing Successful Programmes (MSP) and is one of the SIP 2012 programmes.**
3. **That the Olympics Project team have been working closely with the ODA and the LOCOG;[1] with two members of staff being seconded to work with ODA/LOCOG (Lynn Sugg) and the OSD (Steve Waspe).**

83/07 <u>Annual report on complaints.</u>

Ralph Morris, Head of Complaints, presented the annual report on complaints received by the Trust in 2006/07. The report included details of the re-organisation of the Trust's complaints handling procedure following the closure of the Professional Standards Unit and the dispersement of investigative officers to the different operational areas so as to encourage local resolution.

557 complaints were received in 2006-07 compared to 543 in 2005-06. The Head of Complaints said that the increase should be seen in the context of the Trust's increased workload during the same period. The complaints resulted in the following actions:

19	withdrawn by complainant
82	were resolved locally following discussion and explanation
16	resulted in disciplinary investigations
165	resulted in staff receiving counselling or guidance
19	required staff to receive supplementary training
1	complaint was referred to Legal Services.

[1] *The Olympic Delivery Authority (ODA)* is the public body responsible for developing and building the new venues and infrastructure for the Games and their use post 2012. *The London Organising Committee of the Olympic Games and Paralympic Games (LOCOG)* is the organisation that will oversee the planning and development of the 2012 Summer Olympic and Paralympic Games. *OSD - Olympic Security Directorate. OSSRSC – Olympic Security Safety & Resilience Strategic Committee*.

Although no confirmation has been received by the Trust, it was thought that one complaint had been referred to the Health Services Ombudsman but as yet no details have been received from that organisation.

There was an increase in the number of complaints received by Emergency Operational Control (EOC), from 165 in 2005/06 to 225 in 2006/07. This was primarily due to delays in despatching ambulances, and reflected the availability of resources to EOC to despatch. The number of complaints received concerning the attitude and behaviour of staff fell by 3%.

It was suggested that work needs to be undertaken to educate the public that simply dialling 999 will not result in an immediate response unless it is a life threatening incident (i.e. Category A).

All complainants received a reply within the required 48 hours and 76% of complaints were resolved within the necessary timeframe (the target is 80%). Six complaints were declared to be Serious Untoward Incident with two of these later downgraded following a full investigation. Details of the above were included in the Annual Report.

Barry MacDonald said that the Trust should not be defensive regarding the number of complaints received as they should be seen as opportunities for the organisation to learn lessons and improve the service.

Beryl Magrath said that the Complaints Panel (meeting at 2pm on 31st July 2007) will be discussing the annual report. Beryl Magrath felt the format needed to be reviewed to ensure that it could be widely disseminated.

In response to a question from the Chairman of the Patients Forum, the Chief Executive said that only a small percentage of complaints would have implications for the organisation. Most complaints concerned individual members of staff which were addressed with the individuals directly. There was a consensus that the Board is interested in the implementation of recommendations that arise from complaints that had implications for the organisation as a whole. The Chairman said that the Board would like to receive a summary report advising on the outcome of those complaints and the implementation of the resulting recommendations. **ACTION: Patient Services Manager**

The Medical Director said it was important that complaints were not viewed in isolation. Both the Risk Compliance & Assurance Group (RCAG) and the Clinical Governance Committee receive the Risk Information Report; this report gathers information and highlights lessons learnt from complaints, Serious Untoward Incidents, potential claims, incident reporting, inquests and PALS enquires. Lessons learnt from complaints and SUIs were recently presented at the Senior Managers Conference and the Team Leaders Conference. The Medical Director said that there are a number of potentially high risk areas that will always be with the Trust and need to be seen in that wider context.

The Director of Communications commended the work undertaken by the Head of Complaints in drawing together the annual report and attempting to capture how the organisation has learnt from complaints. Roy Griffins said he was impressed with the general spirit of the report as it demonstrated the Trust's willingness to accept criticism.

Barry MacDonald said that amongst the examples of complaints included in the report, there were a couple of complaints that arose in part from conversation that patients had had with crews about the reason for delays in the despatch of vehicle. He suggested that as crews will not always have the full picture of what is happening

in EOC they should be discouraged from giving their views when they cannot know the wider context.

Noted: **1. The contents of the 2006/07 annual report on complaints.**
2. The efforts of the Complaints Manager in drafting the comprehensive report.

84/07 Annual report from the Audit Committee

Barry MacDonald, Chairman of the Audit Committee, presented the Committee's first annual report to the Trust Board. The report, the format of which is prescribed by the NHS Best Practice guidelines, outlined the work undertaken by the Committee during 2006/07. Beryl Magrath said she found the report very informative.

Noted: **The Annual Report of the Audit Committee**

85/07 London Ambulance Radio Project (LARP)

The Director of IM&T presented an update on the national ambulance radio programme which was established to replace analogue radio-based voice and data services with a new digital system for NHS Ambulance Trust in England and Wales. Further to the submitted report the Director of IM&T said that the financial model is expected from the National Radio Project team in August. The Trust should therefore know by September/October what the additional costs incurred due to LARP will be.

The project has been brought forward by 12 months; installations for test vehicles will take place by the end of July 2007. Installations for PTS vehicles, ambulances and response vehicles will commence in September 2007. Due to a delay in essential Airwave Control Room Software, A&E vehicles will not commence going live until at least March 2008. It is likely that the new system, within the LAS, will be 'live' by the end of September 2008.

Roy Griffins asked what would be the impact on the Trust of delays, given that the report highlighted there are a number of areas outside the organisation's control. The Director of IM&T said that the impact would primarily be felt in terms of London's Resilience and reiterated that the project had been brought forward by 12 months in response to the London bombings, July 2005. The Director of IM&T felt that the identified high level risks were manageable and the Trust is on track to deliver the project in September 2008. The Trust is working very closely with the National Implementation Team.

In response to a query from Beryl Magrath the Director of IM&T confirmed that all ambulance services will experience a shortfall between what is being provided by the national project and what they require. In the interim that the original specifications were drafted, operational demand and configuration have changed. The additional cost will not be known until the final Service Level Agreement with the Provider and associated costs have been finalised. An update will be presented to the Service Development Committee in October 2007. **ACTION: Director of IM&T**

It was recognised that there may be implications for the Trust in the training required by staff in the use of radios; there has been anecdotal evidence that the Metropolitan Police have experienced difficulties with their front line staff who have been unhappy with the system. The Director of IM&T said this dissatisfaction has occurred due to differing capacity levels in some parts of London which has resulted in uneven coverage.

The Chief Executive said he continues to be concerned that the Trust is not issuing personal radios to front line staff. This decision will be reviewed following a six

month trial whereby radios will be vehicle based equipment. There will be two radios issued per vehicle and crews will be required to wear them during the course of their shift; the major advantage of the radios is that crew members will be able to communicate directly with each other should they become separated while attending an incident.

The Director of Operations said that Richard Barnes, Chairman of the GLA's Committee that reviewed the response of the emergency services to the London bombings, July 2005, will be informed about the delay in rolling out LARP. **ACTION: the Director of Operations.**

Noted: The report

86/07 Update regarding CAD 2010

Noted:
1. **The update**
2. **That a fuller report will be considered by the Trust Board in Part II as the project has now reached a commercially sensitive phase.**

87/07 Update regarding governance arrangement for risk management

Approved
1. **The revised governance arrangements of the different groups and committees associated with risk management as outlined in the report.**

Noted:
2. **Barry MacDonald's suggestion that the Infection Control Framework be reviewed as there appeared to be some confusion as to aims, delivery and risks. ACTION: Director of Finance to review.**

88/07 Draft minutes of Remuneration Committee

Noted: The draft minutes of the Remuneration Committee of 27th March 2007.

89/07 Draft minutes of Clinical Governance Committee – 11th June 2007

Beryl Magrath, Chairman of the Clinical Governance Committee, highlighted the following from the minutes:

- Lost property bags will be trialled from July 2007 on a Trust wide basis.
- A review of the manual system to identify skill mix on ambulance and FRUs is being undertaken by the Deputy Director of Operations to ascertain whether the current process could be more robust
- The Clinical Governance meeting discussed how information is communicated to front line staff; it was recognised that there are a number of fora (Chief Executive's annual consultation meetings; the LAS News and the Pulse) for communications within the organisation. It was also recognised that, to date, not all Team Leaders have managed to meet with members of staff on an individual basis.
- Although the recording of ethnicity has improved for STEMI patients, it was considered to be an ongoing-issue for general PRF documentation. The Deputy Director of Operations is revising the wording that will be given to front line crews to assist them when they are talking to patients about the recording of ethnicity and the medical reasons for the information. It has been suggested that the Trust might wish to use flash cards which have been trialled successfully by

the Police and some acute hospitals. The Committee will consider this suggestion when it meets on 13th August 2007.

Noted: The draft minutes of the Clinical Governance Committee, 11th June 2007

90/07 Draft minutes of Audit Committee – 18th June 2007

Barry MacDonald, Chairman of the Audit Committee, highlighted the following from the minutes:

- The 2007/08 Internal Audit Plan, which will include the auditing of CAD 2010, Cost Improvement Programme (CIP), Meal breaks, Payroll and Electronic Staff Records (ESR).
- The bulk of expenditure associated with CAD 2010 will be capitalised rather than having to be treated as revenue expenditure
- RCAG was asked to review some risks that the Audit Committee were concerned about e.g. EOC staff not checking logs of Category C calls; internal communications and the sustainability of weekend rotas.

Noted: The draft minutes of the Audit Committee, 18th June 2007

91/07 Draft minutes of Service Development Committee – 26th June 2007

Noted: The draft minutes of the Service Development Committee, 26th June 2007

92/07 Report from Trust Secretary on tenders opened since the last Board meeting

Three tenders have been opened since the last Trust Board:

1. Occupational Health Tender
   Atos Origin; International SOS Assistance; Adastral Health; Heales Medical Ltd Team Prevent; Kings College Hospital NHS Trust and Nuffield
2. Reconfiguration Works, Silvertown AS
   Lakehouse Contracts Ltd; TCL Granby; Fairhurst Ward Abbott; Coniston Ltd Mitie Property Services
3. Upgrade of EOC Telephony
   Echo; Sabio

The Trust's Seal has been used twice since the last Trust Board meeting.

No. 108 Lease, Millwall Fire Station, between the London Fire Emergency Planning Authority and the LAS

No 109 Lease, Acton Fire Station, between the London Fire Emergency Planning Authority and the LAS

Following analysis of the above tenders by the appropriate department a report will be presented to the Board on the awarding of the tenders.

Noted:
1. **The report of the Trust Secretary on tenders received**
2. **The use of the seal**

93/07 Any Other Business

Laura Weatherly (EMT) asked permission of the Chairman to respond to some of the comments made by Members of the Board during the course of the meeting.

In response to Barry MacDonald's suggestion that crews should not discuss reasons for delays when they are unlikely to have 'the full picture'; Mrs Weatherly said it would be awkward for staff to refuse to discuss with patients why they have been waiting for an ambulance. If patients have been waiting for what they perceive to be a long time for an ambulance, crews are likely to receive a critical reception on their arrival. The Chairman suggested that training on this matter could be built into the de-escalation training crews receive when they join the Trust.

In response to a question from Mrs Weatherly regarding the impact of the Transport for London's proposed Low Emission Zone, the Chief Executive said that only nine A&E vehicles will be affected. The Trust is seeking exemption for those vehicles, the majority of which are the SUVs that are used to respond to specific incidents.

Mrs Weatherly said that she has found team leaders to be very supportive.

With regard to the Medical Director's recommendation that crews print three sets of ECG readings, Mrs Weatherly said in her experience data cards were often not available on station. The Medical Director said she was aware of the problem.

In respect of crews asking patients about their ethnicity, Mrs Weatherly said that she has often found patients reluctant to answer the question, even when it has been explained that the question has a medical basis i.e. the preponderance of certain diseases within certain ethnic groups.

Mrs Weatherly said that although she welcomed the introduction of rest breaks, as 12 hours is a long time to work without a break, she reported that crews often face criticism from patients who have had to wait for a response. These patients often quote stories in the media about the detrimental impact that rest breaks are having on patients. The Director of Operations said that the rest break agreement is currently being reviewed with staff side representatives. Approximately 50% of front line crews are currently receiving a rest break.

The Chairman thanked Mrs Weatherly for her contribution and invited her to attend future meetings of the Trust Board. He said that the Executive and Non Executive Directors regularly undertook ride outs with front line crews.

94/07 Opportunity for members of the public to ask questions

In response to a question from Mr Lofthouse, the Chief Executive said that the results of the ballot of Ambulance Chief Executives, that is being undertaken by the Ambulance Service Association (ASA), on the future direction of that organisation, will be published on 5th September 2007.

95/07 <u>Date of next meeting</u>

Tuesday, 25th September 2007, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 1.20 pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 31st July 2007
held in the Conference Room, LAS HQ, London SE1

Part II of the Trust Board's meeting is not open to the Public as matters of a sensitive and confidential nature are discussed. Nevertheless, as the LAS wishes to be as open an organisation as possible, the nature of the business discussed in Part II and where possible a summary of the discussions (but not the full minutes) will be published together with the minutes of Part I.

On the 31st July 2007 in Part II the Trust Board discussed the following:

CAD 2010 Project – Progress report

The Director of Information Management & Technology informed the Board that formal pre-contract reviews would take place following the receipt of the initial bids in the week ending 3rd August 2007.

When NHS London reviewed the outline business case for CAD 2010 it recommended that the Board should have additional project assurance given the importance of the project for the Trust. As none of the Board members have technology expertise it was recommended that an independent consultant be appointed to advise the Board in respect of CAD 2010. The independent consultant will liaise with Roy Griffins, who in turn will report to the Board.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board Meeting 25 September 2007

CHIEF EXECUTIVE'S REPORT

1. ACCIDENT & EMERGENCY SERVICE

1.1 999 Response Performance

The tables below set out the A&E performance against the key standards for July and August of 2007 and for the year to date. Please note that call connect is not a cumulative target and has therefore been omitted.

	CAT A8 (current)	CAT A8 (call connect)**	CAT B19
Standard	75.0%	75.0%	90.0%
July 2007	79.7%	60.9%	83.8%
August 2007	80.9%	63.7%	86.3%
YTD*	79.6%	n/a	84.2%

* Accurate as at 0900, 17th September 2007
** Applicable from April 2008

Key highlights

i. I am pleased to report that the Trust is continuing to perform well above the current Category A target of 75%. The year to date position is 79.6% and the Trust is now regularly performing at over 80% on the current measure, including for the full month of August.

ii. We are also continuing to make good progress towards the new call connect target, delivering 63.7% performance in August against a trajectory target of 62%. This will be the 5th month in a row that we have exceeded the call connect trajectory targets. The target set for September sees a significant rise to 66% and this will be particularly challenging in the context of a 5 weekend month. We still have some performance difficulties associated with maintaining call connect performance at weekends and these will need to be resolved over the coming months.

iii. Category B performance whilst improving is proving more challenging. We did not achieve our internal target of 85% for the first quarter coming in at 83.3%. There are encouraging signs however and performance on B calls is undoubtedly improving during midweek regularly reaching 89%. Ambulance staffing will need to be improved still further at weekends if the overall target of 90% for the year is to be achieved, as currently the good mid week performance is negated by poorer performance at weekends. On a positive the Trust returned 86.3% Category B performance in August, the best ever achieved.

iv. Call answering performance has improved considerably during the last three months and reached 88% in 5 secs for the month of August. September is expected to see further improvements. This is a 20% improvement over the same period last year and represents a step change in performance. Long waits for callers dialling 999 are now negligible.

v. The Trust has returned to REAP level 2 'Concern' following the brief rise to level 3 due to the terrorist threat towards the end of June, combined with major events such as the Tour de France.

1.2 Activity

- The number of incidents attended in August 07 rose 6.0% compared to the same month last year however July 07 saw a marginal fall in incidents, by 0.8%, over July 06.
- Overall workload, year to date, is up 2.5% on the same period in 2006/7
- In August the proportion of Category A workload fell again to 31% of total incidents however the Trust continues to respond to 36% as 'Red' calls.

1.3 Resourcing

- Resourcing continues to be a significant challenge for the Trust in a year with extensive cost pressures. Personal development reviews, clinical training and CBRN refreshers and re-licensing are the key abstractions currently. The main problem is with staffing ambulances and the trust produced slightly less ambulance hours in August of this year compared to last year. Ambulance staffing is expected to improve as we get into late September and October with the influx of a considerable number of university students engaged on clinical placements.

- We continue to allocate 35,000 hours of overtime a month, to cover vacancies, sickness, additional FRUs, secondments and training and development.

- Additional FRU resourcing is being provided by managers at each station, covering 11am to 2 pm each day, to reduce the performance impact of rest breaks. In addition, Team Leaders will be providing an extra FRU at each station from 2 pm to 8 pm each day from October. This is the time of day when we typically see performance drop as demand increases.

- In the medium term we will be significantly increasing the Motorcycle Response Units (MRU) and Cycle Response Unit (CRU) provision and expect this to be in place before April next year, to assist with the final 'push' towards 75% call connect performance. We will increase MRUs from three to eight, operating 16 hours a day. The CRUs will increase from two teams to five.

- The new MRUs and CRUs will be based at Waterloo and West Ham but deployed daily to serve Central and East Central sectors (and a part of West sector). The CRUs will be deployed in heavily pedestrianised areas and town centres such as Croydon and Canary Wharf. These areas have been identified as having high levels of category A calls and the greatest number of calls not reached within 8 minutes of call connect.

- As mentioned in the last report we are undertaking a review of the resourcing function. The objective of the review is to make efficiency savings in line with the Cost Improvement Plan. Following initial consultation with staff and managers, a paper has been written considering options for the future. These include: moving resourcing back to ambulance stations; reconfiguring the three resource centres so that there is one in each LAS area; reducing to two resource centres; and reducing to a single resource centre. A further round of consultation is underway, based on the report. Once submissions have been made, the Senior Management Group (SMG) will decide on the favoured option and formal consultation will begin. Trust Board will, of course, receive further reports as this process progresses.

1.4 Emergency Operations Centre (EOC)

- The EOC/UOC restructure covering the top 2 tiers of management went live on the 2nd of July. The last person appointed took up their position at the end of August and the new structure is starting to deliver in line with the intended levels. The step change in performance across several areas is described later in this report.

- The second phase of the EOC reorganisation has been delayed rather further than initially intended. This is due to a need to await the recommendations of a national group who are currently reviewing the roles and competencies across Control Services nationally. The LAS has an AOM on this group and in order to ensure that the recommendations are incorporated, this work has been delayed until October. It is believed that the benefits of awaiting best practice nationally will outweigh the benefits of implementing in the previously notified timelines.

- The Automatic Dispatching of FRUs is being expanded to Ambulances with an intended implementation date of mid November. Much work is currently being undertaken to design appropriate business rules to ensure its success and optimise the performance benefits of rapid dispatch as has been noted under the FRU electronic dispatch regime.

- The focus on all aspects of attendance management has continued. The effects of lower sickness and abstractions coupled with additional overtime from the clock-start funding has seen an overall increase in staffing levels within EOC. In July the staffing level was 102% and in August it was at 101.9 % of the existing plan which is about a 10% improvement over the same period last year.

- Call taking has seen a significant improvement over the last 2 months. In July nearly 81% of calls were answered in 5 seconds and for August the figure was just under 88%. These figures are an improvement of over 20% when compared to the same period last year.

- The rest break arrangements within EOC have been reviewed and the new system implemented at the beginning of September. This has produced greater availability of call takers already and will allow further improvements in call-taking performance to be achieved and, more importantly, sustained.

- GMT Planet, a resourcing support tool, was implemented across Control Services on the 5th of September. This will allow a more proactive stance to be taken in terms of rostering and allow a more accurate and dynamic staffing plan to be generated. When fully implemented the Employee Time Centre will be activated. This will allow staff to view their annual leave entitlement, view leave availability and book their annual leave on site and possibly remotely from home.

- The Major Incident training day previously conducted for B watch was repeated for C watch in early September. Plans are now in place for all watches to receive this training by the end of the year. The training consists of a major incident overview of about 2 hours duration, a familiarisation with the Incident Control Room and the roles associated with it and a familiarisation with the Emergency Control Vehicle.

- Following the introduction of the revised call prioritisation system for urgent calls (card 35 in AMPDS) some analysis has been undertaken by Management Information to assess the impact of this change. In essence we have found that more GP Urgent calls are now ending up as Category A patients than was envisaged and less urgent calls are falling into the 'within three hours' category than was envisaged. This has led to a better service in the round for Urgent calls but there is still some work to do to get the system working perfectly.

1.5 Urgent Operations Centre (UOC)

- The new UOC management team took up post on 3rd September. ADO John Hopson continues to take day to day responsibility, supported by AOM Sue Watkins. The introduction of the new team now gives 24 hour management cover, and improves the overall management resilience for Control Services.

- There is now a plan in place to further increase the number of A&E Support Staff, with an objective to have a further 63 employed by March next year. This will raise the establishment to 162. The response to the recent advertising campaign has been good, with over 740 expressions of interests received. Training courses are planned to accommodate the increased numbers required to reach the target.

- There has been a modest improvement in the number of hours provided by Urgent Care vehicles to 72% of plan following the posting of a small number of new A&E Support staff. It is anticipated that this will improve considerably over the next few months as new staff are recruited and trained.

- Changes to the CTA recruitment process have resulted in increased recruitment to CTA. The in post figures will rise to 45 against an establishment of 50 by end September with a further 7 applicants being assessed in October. Training courses and recruitment plans are in place to increase the in post figure to 70 by March 08.

- The number of calls being dealt with by CTA is improving with 1282 calls handled during the first week of September. It is anticipated that figures of 1400 per week will be achieved by end October .

- As A&E Support and CTA numbers improve, AOM Sue Watkins is reviewing the UOC control staff numbers and structure. This will be done in line with the general Control Services restructure to ensure uniformity of roles and functions.

- A fundamental review of the attendance management system in UOC has been undertaken. In line with the rest of Control Services, robust audit and reporting procedures have been introduced. The main focus is on long term sickness absence which has been far too high within UOC.

- PDR for this year has been started for all UOC staff. This will allow the new management team to get to know their staff, set goals clearly for this year, and ensure staff feel part of Control Services. Individual performance reviews for all staff will also be introduced this year in line with other Operational Staff.

1.6 New Operational Model Implementation

- The Board should note that progress against the Operational Model Programme of the Service Improvement Programme 2012 will no longer be reported separately in this report. A new combined report will be produced for the Board by the Service Development Directorate.

1.7 Emergency Preparedness

- Work continues to address the 205 actions that came from our experiences of the London bombings on 7 July 2005. Since the last report to Trust Board, all the ‘red’ actions (the most important) have been completed. In addition 4 ‘ambers’ and 2 ‘greens’ have also been closed. There remain 12 outstanding amber actions and 5 green actions. These include: formalising the role of the voluntary ambulance services; introducing a formalised higher level of training for Silver officers; introducing major incident ‘grab packs’ on FRUs and at hospitals (to assist officers in their roles) and increasing the number of staff able to drive the Emergency Support

vehicles. It is anticipated that these items will be resolved soon, at which point a further report will be presented to the Board listing all the changes since 7 July 2005.

- From 4 to 6 September the Trust underwent an audit by Department of Health (DH) focussed on our emergency preparedness and business continuity preparations. The audit team consisted of four members, split into two groups. The senior group were based at HQ and carried out a series of interviews across a wide spectrum of staff, Directors, commissioners and partner organisations. The second group of auditors reviewed all LAS policies and procedures and then visited various LAS sites in each Area to view CBRN and HART vehicles and to talk to staff. Early feedback from the auditors has been very positive and the LAS has been informally referred to as "way ahead". Some issues arising from the audit have included the need to exhaustively test our business continuity plan and to embed systemic emergency preparedness training. The auditors were keen to acknowledge that the LAS was already aware of its vulnerabilities and was addressing them. The final report from the auditors is awaited and will be presented to the next Trust Board meeting.

- Following the experiences of the London bombings on 7 July 2005, a complete rewrite of the LAS Major Incident Plan (MIP) was undertaken. The new plan was shortened to make it more readable and contained the key learning points from the LAS internal debrief and the recommendations from the GLA report, based on the experiences of the survivors. Significant changes to the plan include: consideration of managing a major incident without good technical communications; a new role of 'patient information officer' to keep casualties informed of what is happening; better equipment provision procedures; and pre-determined attendance of ambulances and officers to any declared major incident. The Board is asked to note the revised MIP which has already been approved by the CEO.

- Funding for the HART team has been secured from DH until the end of the calendar year. It is anticipated that funding for the final quarter will be received imminently from DH. Funding for the full 08/09 year plus any required further expansion of the team will be sought from PCT commissioners as part of this years commissioning round.

- In addition to other significant events held in London over the past two months, the annual Notting Hill Carnival took place over the August Bank Holiday weekend. An extensive LAS team was deployed to manage the event and new control arrangements were put in place in the vicinity, with partner organisations. Despite some sporadic violence including two 'shootings' and three 'stabbings', the event was predominantly peaceful. Working with St John ambulance, the LAS treated 700 patients, of which 129 were taken to hospital.

2. Patient Transport Services

Commercial

The LAS has presented its tender to a panel at Darrent Valley Hospital (new) on 8 August 2007 and we are awaiting their decision on award of contract. We continue to wait to see if we will be invited to present our bid to Kingston Hospital (existing).

We have attended an initial meeting in respect of Whipps Cross University Hospital (existing), with all providers who have passed the preliminary qualification round, following their announcement to go to tender. This tender will incorporate the day work, which we currently undertake, as well as further journeys for out of hours and taxis which is currently provided by other companies.

Our expression of interest to Richmond and Twickenham PCT has been accepted and we are currently awaiting the issue of the tender specification for us to submit a bid.

We have submitted a fresh bid to UCLH on 31 August 2007 following their re-tendering process. This process was open to all 5 companies who passed the original screening process and we are currently involved with the clarification process. UCLH intend to announce the successful bidders at some point in October this year.

Barking and Dagenham PCT have served notice on the London Ambulance PTS following the latest round of negotiations with services due to finish on 31 March 2008. This contract has been advertised in the European Journal, and Barking and Dagenham have expressed the wish that we tender afresh for this contract.

HR

4 of the 6 staff affected by the loss of Camden PCT have applied for A&E Support vacancies. There are a number of other vacancies within PTS and therefore it is not envisaged that any staff will TUPE across to the new provider OSL at the end of November 2007.

The number of applications for A&E Support vacancies from PTS staff has been low even following a number of interventions from PTS and A&E managers to stimulate interest. Activities to encourage staff to consider making applications have included PTS Bulletins, a series of open evenings and direct targeting of individuals who managers felt would be good applicants. There remain some staff in the selection process and were all to be successful all of these activities will only have produced about 20 A&E Support staff.

Performance

There were increases in arrival, departure and time on vehicles statistics to 89%, 90% and 94% respectively in August. This brings the standards back to their previous levels.

The LAS has been notified by Transport for London of changes to the definition of 'private hire vehicles'. These changes, if implemented, will impinge significantly on our ability to meet our quality standards and will incur significant financial costs in terms of licensing and financial penalties on contracts for failure to meet quality standards. We are currently looking into the full impact of these changes and are seeking to communicate with TfL on the proposed changes.

3. HUMAN RESOURCES

The following HR policies/procedures have been published since the most recent Trust Board:

- Recruitment and Selection policy – updated following review of recruitment policies, procedures and practices carried out jointly by Recruitment and Diversity Teams;
- Criteria for reimbursement of congestion charges - management guidance;
- Ante-natal care policy – review of previous policy, no changes made;
- HIV/AIDS policy - review of previous policy, minor changes made.

Other issues being presented to the Trust Board are:

- Supplementary Equalities Report
- Management of Change Policy
- Managing Sickness absence
- Training Plan

and are therefore not covered in this Report.

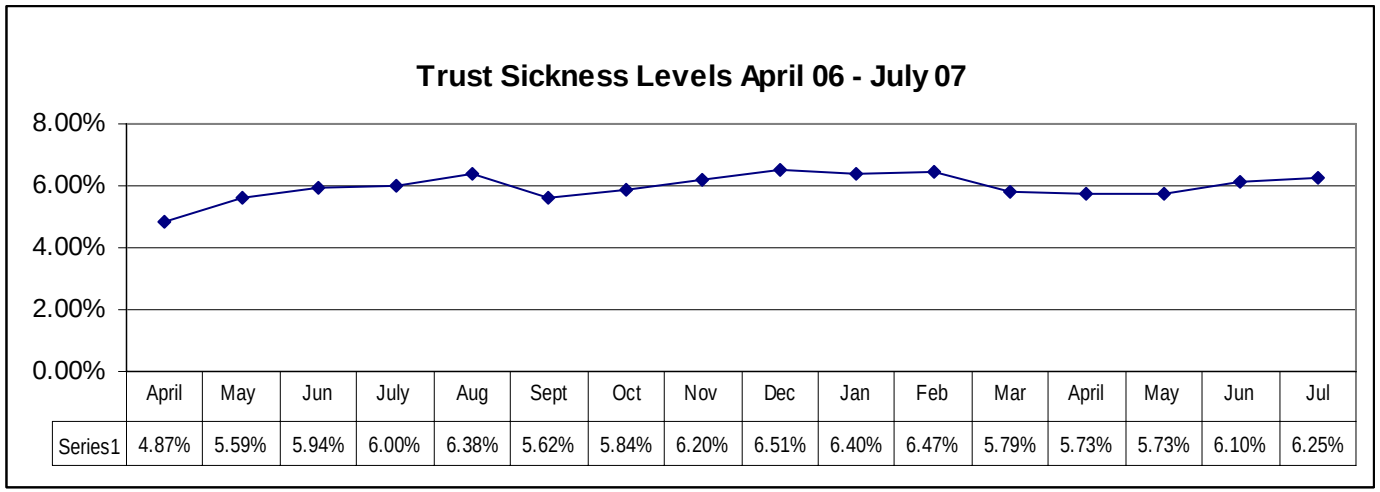
- Sickness Absence

The graph attached indicates a slight increase in absence over the last two months. A separate report on management of sickness absence is presented to this Trust Board meeting.

INTERIM WORKFORCE INFORMATION

Staff Turnover August 2006/July 2007	
Staff Group	**Turnover %**
A & C	12.85%
A & E	4.20%
CTA	0.00%
Bank Staff	5.84%
EOC Watch Staff	7.93%
Fleet	8.77%
PTS	7.61%
Resource Staff	2.00%
SMP	7.12%
Grand Total	**5.68%**

Absence 2007	**May**	**June**	**July**
A & E Ops East	5.76%	6.11%	6.43%
A&E Ops South	6.37%	6.52%	6.56%
A&E Ops West	6.27%	6.46%	6.40%
Control Services	6.16%	7.21%	6.74%
PTS	5.64%	6.35%	8.07%
Trust Total	**5.73%**	**6.10%**	**6.25%**



SUSPENSIONS as at 13.09.07		**Date of Suspension**	**Reason**	**Stage in Investigation**	**Investigating Officer**	**Hearing Date**
East	1	11.09.07	Police investigation		To be confirmed	
South	2	17.07.07	Three attitude- and behaviour- related incidents.	Interviews took place 20 August. Suspension to be reviewed.	Ruth Williams	
		26.08.07	Allegations of theft.	Complete.	Paul Woodrow	20.09.07
West	4	03.09.07	Allegation of assault	Alleged victim interviewed 05.09. Interviews continue on 18.9	Jon Knott	
		06.09.07	Patient care	Complainant Interviewed	David Court	
		09.09.07 (due to A/L)	Patient care	Complainant interviewed	David Court	
		13.09.07	Failure to provide a specimen		Paul Smith	
EOC	1	24.08.07	Under the influence of alcohol while on duty.	Preliminary investigation interview undertaken 24.08.07	Paul Tattam	Prov. 19.09.07
HQ/Fleet/Others	0					

4. COMMUNICATIONS

TV filming

'London Ambulance' on ITV London: A five-part series about the work of the Service was broadcast on ITV in the London area on Friday evenings throughout August. The programmes entitled 'London Ambulance' featured the work of staff at Islington station as well as an emergency care practitioner, the Emergency Operations Centre and the Cycle Response Unit. Each episode attracted up to 360,000 viewers, making it the second most popular programme in the time slot in the capital.

Media issues

The One Show, BBC1: Earlier this month, Emergency Medical Dispatch Allocator Andre Elbourne le Brun appeared on this topical magazine programme to talk about the issue of emergency calls. Following a film illustrating Yorkshire Police's experience of inappropriate calls, Andre took part in a studio discussion with the presenters, recounting his experience of dealing with 999 calls, and giving advice about when people should call an ambulance. He specifically encouraged people experiencing chest pain to call us. On the subject of non-urgent calls, Andre explained that the Service is looking at other ways to deal with these and described the role of clinical telephone advisors.

Community first responder scheme: Local media relations activity has been used to aid recruitment for a pilot community first responder scheme in the Borough of Haringey.

News coverage of the proposed scheme, its benefits and an up-and-coming open day received coverage in the North London Newspaper series (Tottenham and Wood Green Journal and Muswell Hill Times) and the Haringey Independent. The latter newspaper carried some negative comments about the scheme from the Chair of the Patients' Forum. A letter has since been sent to the paper from the local Ambulance Operations Manager addressing these issues.

As there is large Turkish community in Haringey the release was also shared with local Turkish media. London Turkish Radio has promoted the open day and is keen to interview the community first responder lead in the near future.

Notting Hill Carnival: Acting Assistant Director of Operations Jason Killens did a live interview with Sky News about the Service's preparations for the Carnival and the way in which patients were cared for at the event.

Camp for climate action: This recent protest attracted media attention for the Service when, in mid August, six protesters glued themselves to the outside of the Department of Transport, and two south sector crews were called in to detach them. A report by Indymedia (an independent news website) commended our staff on their positive attitudes at the scene.

Primary angioplasty: BBC Radio 4's Today programme broadcast an interview with Clinical Practice Manager Mark Whitbread as part of an item focusing on proposals to roll out primary angioplasty as a preferred treatment for the majority of heart attack patients across the country. Mark explained benefits of this kind of treatment, while former patient Kevin Jolly spoke about his recovery to lead a full and active life.

Other media stories: A statement was issued following an incident in which a five-year-old boy tragically died after becoming trapped by an electric car window. The statement highlighted the extensive efforts made by crews to resuscitate the child. Along with local press, the incident was reported in the Evening Standard, Daily Mail, Daily Mirror, the Sun, and the BBC Online.

Several enquiries from both local and national newspapers and broadcasters were received about an incident in which a building partially collapsed in Elephant and Castle, South London, injuring a worker. A statement was issued, advising that crews had been sent to the incident but that the patient was sadly declared dead at the scene.

Other local media coverage has included stories about the successful resuscitation of a man who collapsed in a street in Hampstead, and the success of a HEMS crew – including a Service paramedic – in winning the London section of the Vodafone LifeSavers Awards. On a less positive note, a delay in responding to an emergency call to an elderly lady who had fallen over in a street in Croydon was covered by a local paper.

Publications and reports

Annual Report: The Service's Annual Report 2006/07 has been published. Available in hard copy and on the website, it details another busy year for the Trust, and includes information about the new Strategic Plan, which will take the organisation up to 2013.

7/7: The London Assembly's 7 July Review Committee published its latest report on the emergency response to the London bombings. Concerns about the introduction of the Airwave digital radio system by all the emergency services were picked up on by the media, although the Committee also praised the Service for the developments and improvements already made.

Travelling times to hospital: A study about the impact of travelling times to hospital for seriously ill and injured patients received widespread coverage when it was published in August. Although the Service didn't participate in the research, the story was picked up by some local newspapers in areas where reconfigurations of hospital services are currently being proposed.

Patient and public involvement (PPI)

July and August were busy months, with the Trust being involved in a number of public events, including the London Mela, the Lambeth Show, a school fair in Newham, a cancer awareness event in Blackfriars, and an event at the Royal

London Hospital where children brought their sick teddy bears to be diagnosed and treated by doctors, nurses and members of London Ambulance Service staff!

A member of the Community Resuscitation Training Team, Jagtar Benning, went on an Asian radio station (Club Asia) to talk about the benefits of Heartstart training. He also attended a health event in Newham and worked with colleagues from the British Heart Foundation on their stand.

As plans to move Buckhurst Hill ambulance station develop, arrangements are being made to provide information in the local media and to residents in the area about the benefits of moving the station to a more appropriate location.

An open day was held at Bromley Training Centre for the residents of Biggin Hill, to raise awareness and invite applications for the community responder (or volunteer) scheme planned for the area. A similar event is planned in Edmonton in September.

The Patient Care Conference was held at the Brit Oval on 30 July and focused on strategic developments, patient and public involvement, and clinical developments. Feedback from delegates was very positive.

In August an induction meeting was held for new members of the Patients' Forum. A number of senior managers were invited to talk informally to Forum members about their areas of work. Forum members were very positive about the event, and the notes from the day will be used to develop an induction pack for future members.

The September Patients' Forum meeting focused on PTS, and patients were invited to speak about their experiences. Following the joint PTS Listening Event in May, we will continue to work with the Patients' Forum on the implementation of further developments in this area.

The PPI Manager and Events, Schools & Media Resources Manager are working with Tower Hamlets PCT on the development of a Health Education Pack, including a DVD which is being produced within the Service. The Health Education Pack will also include information about accessing local health services, contact details for a number of statutory and voluntary sector organisations, and training sessions which will be delivered by the health educators and health guides working with the community. Although the PPI Project Manager has now come to the end of her placement in the PPI team, every effort will be made to ensure that other developments within the Tower Hamlets project are also progressed. These include delivering training and feedback sessions to pregnant women and undertaking informal activities with youth groups.

It is likely that a national text messaging number will be launched in April - June 2008 to enable deaf and speech-impaired people to contact the emergency services. There is a project within the Strategic Plan focusing on this area of

development, and we are working with the deaf members of the Patients' Forum to ensure the new system meets their needs.

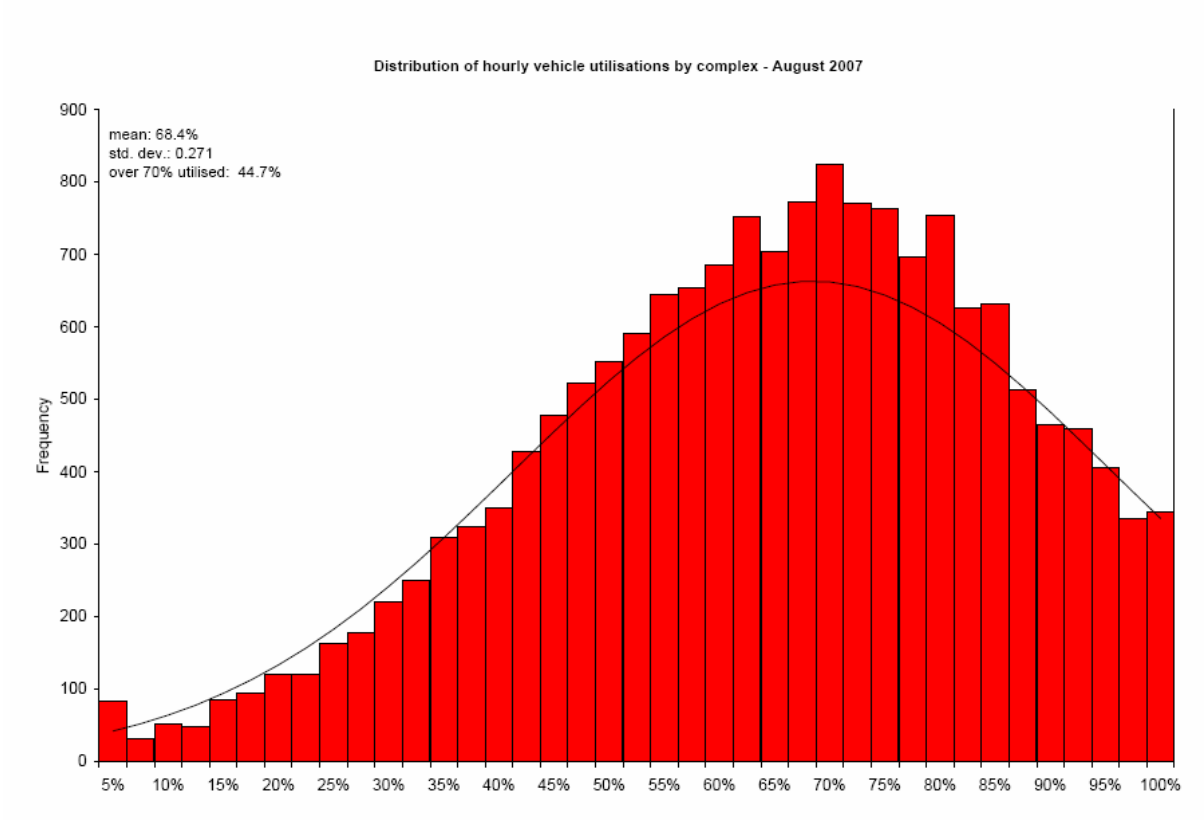
A national meeting of ambulance service PPI leads is planned for October to discuss how ambulance services will best work within the new PPI Structure of Local Involvement Networks (LINks). The PPI Manager has also been asked to address a national learning event, organised by the NHS Centre for Involvement (NCI), to talk about the Tower Hamlets project. The Chief Executive of the NCI will attend the October Service Development Committee meeting to present the findings of their report on patient and public involvement in the London Ambulance Service.

The Patient Advice and Liaison Service and the Complaints team are to merge next month to create a new department. Their responsibilities will include enquiries from patients, complaints, vulnerable adult and child protection, patient queries about the high risk register and the frequent caller initiative.

The Board is asked to NOTE this report

Peter Bradley CBE
Chief Executive Officer
25th September 2007

London Ambulance Service NHS Trust
Accident and Emergency Service
Distribution of Hourly Vehicle Utilisation by Complex – August 2007



Enclosure 4

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2007

MONTH 5 FINANCIAL OVERVIEW

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

The LAS had a surplus of £509k for the month of August. Year to date, the Trust has generated a surplus of £1,560k.

The forecast annual surplus is now £151k, up from £128k in Month 4.

The Revenue forecast includes the receipt of CatB Income (£3.0m), Olympic funding (£650k) and full CBRN funding (No top slice - £700k). Risks associated with this income are being monitored in line with A&E operating forecasts.

Forecast expense includes call connect funding of £6.8m. Total average monthly expense is forecast to increase from £18.4m (Year to Date Actual) to a monthly average of £19.5m for the rest of the year.

Total payroll expense of £13.7m was less than forecast (£14.0m). Overtime expense of £1.2m for the month was in line with the previous forecast.

Total Non-Pay expense for August of £4.9m was higher than previously forecast (£4.3m) and £100k up on Month 4. Additional expense not in previous forecast included Medical Consumables (£160k), Estates (£97k), and Additional Mapping Software (£100k). Third Party transport (£60k), Training (£60k) and accident damage (£40k).

Additional third party transport reduced PTS profitability in August. This trend is not expected to continue with a annual surplus of £420k forecast for PTS.

4. Recommendation

THAT the Trust Board note the report.

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board, 25th September 2007

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

No new Serious Untoward Incidents have been declared in the past two months.

Risk Information Report

A new development within the risk reporting arrangements to the Clinical Governance Committee is the construction of a themed report, considering the risks identified from Serious Untoward Incidents, complaints, claims and potential claims, problematic inquests, clinical incident reporting and PALS, in one specific area of care. The initial report considered obstetric incidents. Although obstetric emergencies are fortunately rare, they can result in both death and disability and be associated with very high value claims. They are also the subject of great concerns for crews and Control Room staff. Interestingly, where obstetric incidents arise they are rarely the subject of a clinical incident report, and are more likely to be identified through a complaint or potential claim. Further work to be undertaken will be deciding the action points and the dissemination of learning points from the themed reviews.

Safety Alert Broadcasting System:

The Safety Alert Broadcasting System (SABS) is run by the Medicines and Healthcare products Regulatory Agency (MHRA). When a SAB is issued the LAS is required to inform the MHRA of the actions that it has taken to comply with the alert. If no action is deemed necessary a "nil" return is still required.

Fifteen alerts were received during the period of 4th July 2007 until 10th September 2007.Those deemed to be of relevance to the Trust are detailed below. In the previous Medical Director's report details of an incident relating to Clearview HCG Pregnancy Test Kits (MDA/2007/052) were reported to the MHRA. The company responsible for manufacturing the kits has responded indicating that no fault has been found, but highlighting the need to keep both the specimen tested and the equipment used in the event of a potential fault being identified. Feedback from the Assistant Medical Director (Primary Care) suggests that these kits are generally extremely reliable but care has to be taken in reading the results and in the timing of the test.

Date issued 10/09/7 MDA/2007/071 Syringes:

This alert relates to reports of BD Medical Surgical Systems Plastipak (TM) 1ml, 2ml, 5ml and 10ml hypodermic Luer slip syringes spontaneously disconnecting from or failing to maintain a secure connection to Luer fittings of other devices.
Action: **Medical Director's Bulletin issued to all operational road staff 12th September highlighting this issue and encouraging reporting of any similar incidents.**

Date issued 06/09/07 MDA/2007/069

This alert relates to Lifepak 500 defibrillators using version 4.4 (or below) software.
Comment: Lifepak 500 defibrillators in use in the service have been upgraded and now use version 6 software. **No further action required.**

Date issued 14/08/07 MDA/2007/062

Falcon single use paediatric laryngoscope blades
According to the purchasing department LAS do not purchase these items: **No action required**

MDA/2007/043; Invacare Flamingo Mobile Patient Hoists

Confirmation received that Trust staff do not use this equipment

2. Second domain – Clinical and Cost Effectiveness

Update on Cardiac Care

Figures for survival to hospital discharge for the group of patients treated under the Defibrillators in Public Places initiative are now available for the period April 2005 – August 2007. These show 23 survivors to discharge (44.2%). The figures for the past year, 2006 – 2007 have risen to 55% (11 survivors). There are now a total of 420 defibrillators over 150 sites in London.

The LAS overall survival to hospital discharge figures should be available by the end of September.

Update on Stroke Care:

An increasing number of acute units are displaying a greater focus on Stroke Care. A recent development is the opening of the Acute Stroke Service at UCLH, which receives patients straight from the Emergency Department 24 hours a day, with the intention of providing thrombolysis to suitable patients over a 12 hour period, between 07:00 and 19:00, in the first instance. This service, which is overseen by the Neurologists from the National Hospital for Neurology and Neurosurgery Queen's Square, has replaced the RAPIDS project whereby LAS crews could take FAST positive stroke patients direct to a bed at Queen's Square, if one were available. From 13th August UCLH will accept patients from the local catchment area, and that of the Whittington Hospital.

In South London acute stroke services are provided at King's College Hospital, St Thomas's and most recently at St George's. St George's are working closely with their local District General Hospitals (Mayday, St Helier and Kingston), with the intention that all the sites provide thrombolysis to appropriate patients 'in hours' and St George's provides cover out of hours and at weekends. The LAS is working closely with representatives from the local PCTs to ensure that the necessary funding follows the patient flows.

Update on Modular Training:

The five day blocks of training comprising the Continuing Professional Development and EMT 4 courses were delivered to a total of 922 staff. (CPD: 834, EMT 4: 88). As of May 2007 the Department of Education and Development has moved to a system of modular courses, delivered over an extended day. Thus far two modules have been rolled out, with 466 staff attending the Patient Assessment module and 308 paramedics attending the Advanced Life Support module. A third module, updating staff on manual handling techniques will be rolled out shortly. Modules under development include Basic Life Support with Defibrillation and Airway management for EMTs, Obstetrics, Mental Health, Diversity, Paediatrics and 12 lead ECG interpretation.

Drugs update

Chlorphenamine has now been inserted into the paramedic drug bags.

Foam inserts have now been delivered to the Logistics Support Unit, allowing alteration of the existing General Drugs bag to allow the insertion of naloxone and hydrocortisone for use by EMTs. The timescale for this change is anticipated to be three weeks. With the additional space freed up in the paramedic pack oral morphine can be accommodated. The Logistics Store has ordered the solution and hope to include it in the drug packs within the next four weeks.

Two potential drug trials are currently being explored in conjunction with cardiologists from the London Chest Hospital and Barts and the London. The first would explore the benefits of ambulance crews administering clopidogrel to STEMI patients. The second would trial the use of adenosine in patients experiencing a narrow complex tachycardia. This drug is not currently used outside hospital in the United Kingdom, although widely used by EMS in the United States.

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

The report under Appendix 1 provides a summary of the findings from July's CPI Monthly Report and relates to the 13,924 PRFs that were audited by Team Leaders during this period. Of note is the improved completion rate, which continues to increase and the significant amount of feedback provided by Team Leaders to their staff. Of interest is the improved rate of ethnicity coding, the high compliance with

the cardiac related CPIs. Of concern is the low completion of CPIs relating to obstetric emergencies.

3. Third Domain – Governance

NHSLA update

The NHSLA have completed their first part of trialling the new risk management standards in the Trust. The feedback indicated that the Trust would already have achieved compliance with the governance and learning from experience (*incidents complaints and claims management*) standards. Further administrative processes would be needed to achieve level one compliance with the remaining three standards. A work plan has been approved by the Senior Management Group to deliver compliance with the standards. Some aspects of the level two assessment for the new system have already been complied with and a full assessment at this level will be undertaken in November, when again feedback from the Assessor will be used constructively to enhance compliance. The NHSLA will be issuing their final assessment processes incorporating feedback from all ambulance trusts next year, and the Trust will be formally assessed in the financial year 2008-9. During this year the Trust retains its current level two NHSLA status.

Annual Health Check

The Trust's performance assessment for 2006/7 will be released in mid October and initial feedback on the use of resources component from the Audit Commission has been very positive. For the quality of care component the Trust also can anticipate an improved score on last year's assessment due to meeting the thrombolysis target under the low numbers rule. As a result this component of the Annual Health Check is just based on the 3 response times targets. This is helpful, as the Trust is not penalised, as it was last year, but again fails to recognise the impact of the improved standard of care now available to a very large number of patients through the introduction of primary angioplasty.

The Standards for Better Health Group chaired by the Director of Finance has restructured its membership and is reviewing the evidence of compliance with the core standards and progress with the developmental standards for the assessment period 2007-8. The Patients Forum will be invited to contribute to the review in November.

Balanced Scorecard

As part of the performance measurement work stream of the Service Improvement Programme, the balanced scorecard has now been developed as a monthly monitoring tool to measure progress with internal and external governance requirements. These include healthcare standards and infection control criteria set out in the twelve duties of the Code of Hygiene.

4. Fourth Domain – Patient Focus

This area is covered in the Patient and Public Involvement report within the Report of the Chief Executive.

5. Fifth Domain – Accessible and Responsive Care

This area is covered in the Patient and Public Involvement report within the Report of the Chief Executive.

6. Sixth Domain – Care Environment and Amenities

Infection Control

Disposable items

A bulletin was issued by the Department of Education and Development in late July updating staff on the introduction of single use items. All these items have now been added to the EROS catalogue and complexes are able to access them. Make Ready teams are swapping over reusable for disposable items. Good progress is being made in completing the roll out.

Infection Control Coordinator post

A proposal was submitted to NHS London following a call for bids to improve infection control within health care environments. A total of £5 million has been set aside in this initiative from the Chief Nurse. A summary of the proposal submitted by the LAS is:

To fund the recruitment of **four Clinical Nurse Specialists** to co-ordinate the Trust wide infection control programme. To address the action plan identified in the recent DH Self Assessment and to further develop educational programmes for operational and other staff. To further develop monitoring processes to assess levels of bacteria and measure the presence of MRSA and Clostridium Difficile (Cdiff).

The closing date for applications was 27th August; the successful applicants should be notified by mid September.

Needlestick Injuries and Near Misses

Data is presented under Appendix 2 to highlight the potential for learning lessons from needle stick injuries. Over the 3 month period April to June 2007 a total of 14 incidents were reported, 5 from both the East and South areas, 2 from the West and 2 from unknown locations. In 12 of the incidents the risks were either low or insignificant, with only 2 incidents of medium risk. Of note 5 of the episodes involved lancets for estimating blood glucose, one involved an old style cannula still used in hospital, but no longer supplied through the LAS, and several involved either needles

used to inject patients, or needles not properly disposed of. No incidents were recorded involving the new safety cannulae.

The learning points from this snapshot audit will be incorporated into the monthly Medical Directorate update which will be available on 'The Pulse' from October 2007.

7. Seventh Domain – Public Health

Pandemic Flu

The DH document giving guidance on the ambulance response in the event of a pandemic influenza epidemic is still out for consultation. Once the advice is finalised the LAS will update its internal guidance.

Recommendation

THAT the Board note the report

Fionna Moore
Medical Director
13th September 2007

Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board

Summary of Clinical Performance Indicator (CPI) Monthly Report July 2007

Authors: Dr Rachael Donohoe & Brendan Bradley

As part of the process for ensuring that patient care is of the highest quality, the LAS measures clinical practice against seven Clinical Performance Indictors (CPIs). CPIs are a quality improvement tool that enable continual audit of clinical care as recorded on the Patient Report Form (PRF) and are undertaken by Team Leaders as part of their clinical supervisory role. The CPIs incorporate a process of structured, evidence-based feedback through which Team Leaders provide staff with constructive instruction regarding specific areas of concern and offer praise for good practice.

The LAS's Clinical Audit Facilitator monitors the collection of CPI data and produces monthly reports that draw attention to specific aspects of care and enables benchmarking and comparisons across Complexes.

This information below provides a summary of the findings from July's CPI Monthly Report and relates to the 13,924 PRFs that were audited by Team Leaders during this period.

For more detailed information and a copy of the full report please contact the Clinical Audit & Research Unit or access the common server: X:\Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2007\July 07\CPI Monthly Report July 2007.pdf

CPI Completion Rates[2]

The average CPI completion rate was 62% across the Service, with five Complexes (New Malden, Croydon, Romford, Bromley and St John's Wood) exceeding the current target of 80%. Two Complexes had completion rates that were below 25% (Whipps Cross and Islington).

In July, Team Leaders across the Service reported a total of 316 days when CPI audits could not be undertaken. This equates to an average of 12 days per Complex (ranging from 1 – 27 days). The most common reason for being unable to undertake the audits was 'office not manned'. This goes some way to explaining why the completion figures are not as high as they should be and why there is variation amongst Complexes.

Completion of the Obstetric Emergencies CPI was particularly poor across the whole Service, with only a quarter of relevant PRFs being audited.

[2] CPI completion measures, as a percentage, how many PRFs were audited compared to the expected total.

CPI Compliance Rates[3]

Overall compliance to clinical care was high across the Service for all seven CPI areas.

Greenwich Complex demonstrated excellent clinical practice by achieving at least 95% compliance for each CPI area, for the second month running.

Clinical Performance Indicator (CPI)	Average compliance (range)
1 in 20 (basic documentation check)	91% (84% – 95%)
Acute Coronary Syndrome	91% (79% – 98%)
Cardiac Arrest	91% (81% – 97%)
Difficulty in Breathing	90% (82% – 95%)
Glycaemic Emergencies	94% (84% – 97%)
Obstetric Emergencies	89% (81% – 100%)
Not-conveyed	87% (64% – 95%)

CPI compliance scores for each CPI area

Key findings for each CPI:

PRF Documentation (1 in 20)

- A valid ethnicity code (A – Z4 inclusive) was documented on 73% of PRFs.
- 91% of eligible patients had their blood glucose measured and recorded on the PRF.

Acute Coronary Syndromes (ACS)

- 88% of PRFs reported that oxygen was administered to ACS patients in accordance with the guidelines.
- A 12 lead ECG was undertaken and the interpretation recorded in 93% of cases.

Cardiac Arrest

- 86% of PRFs contained documentation indicating whether or not the arrest was witnessed.
- The patient's outcome was recorded on 87% of PRFs.

[3] CPI compliance is a percentage score used to measure the quality of PRF documentation.

Difficulty in Breathing

- An initial peak flow reading (or a valid explanation for not doing a peak flow) was reported for 65% of patients with difficulty in breathing.
- Recording of a final peak flow was slightly higher at 68%.

Obstetric Emergencies

- Documentation of the patient's gestation period was missing from over a quarter of PRFs across the Service.
- A record of the patient's obstetric history was provided for only 77% of cases.

Not-conveyed

- Almost one-fifth of PRFs relating to non-conveyed patients did not have a full, final set of basic observations (or an explanation for not undertaking them) recorded.
- Only 82% of PRFs contained evidence that advice had been given to patients who were left at home/at scene.
- A copy of the PRF was reported to have been left with only 66% of non-conveyed patients.

Staff Feedback:

Since April 2007, a total of 1,709 feedback sessions have been provided by Team Leaders across the Service as part of the CPI process. This figure represents a vast increase on the number of sessions that were undertaken in the same period last year (n = 479) and is close to meeting the overall cumulative feedback target of 1,728 sessions.

Action points:

- The LAS must ensure that the Obstetric Emergencies CPI is audited by Team Leaders, as these cases represent a huge clinical risk for the Service.
- The LAS must also ensure that a copy of the PRF is being left with non-conveyed patients and the relevant advice is being provided to these patients.
- Crews must ensure that they record initial and final peak flow readings for all patients experiencing difficulty in breathing, or document the reason for not undertaking these measures.
- The Clinical Audit Facilitator will discuss areas of low compliance with Ambulance Operations Managers at the monthly Area Business Meetings.
- The Clinical Audit & Research Unit will disseminate posters to each Complex detailing their specific areas for improvement.

Appendix 2

Needlestick Injuries and Near Misses - 1st April - 30th June 2007

Result	Ref	Incident date	Specialty	Severity	Notepad	Codes
Injury to skin / tissue (pressure sore, abrasion, sharps)	34229	01-May-2007	West Ham	Low	Received a needlestick injury from old style BM lancet post taking patient's BM.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Unintentional puncture/laceration to organ/body part	33904	07-Apr-2007	Waterloo	Insignificant	Make Ready staff started securing o2 cylinder and as sliding hand along base of bag to pick up th edebris, felt sharp pain in finger where needlestick injury occured.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34797	30-May-2007	Poplar	Insignificant	Looked through a patient's bag to find info or ID as patient unconscious. Pricked left middle finger on patinet's insulin needle.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34812	15-Jun-2007	New Malden	Insignificant	Cannulating patient and was withdrawing needle when crew felt sharp pain in right hand. Realised needle was stuck in hand and that it was a non safety hospital cannula which had been taken from the vehicle.	Counselling, Welfare and Occupational Health Services offered Investigation completed Equipment Isolated
No harm incident	34845	20-Jun-2007	Other	Medium	On opening drug pack found unsheathed needle stuck inside the pack. Needle actually protruded through to the outside of the pack.	Counselling, Welfare and Occupational Health Services offered Investigation completed Equipment Isolated

No harm incident	34951	11-Jun-2007	Other	Insignificant	On opening drug pack found an unsheathed used needle and an unsheathed drawing up needle.	Counselling, Welfare and Occupational Health Services offered Investigation completed Equipment Isolated
Injury to skin / tissue (pressure sore, abrasion, sharps)	34379	10-Apr-2007	Camden	Low	First responder administered glucagen to patient then put needle in organce glucagen box. Crew picked up bow and thumb was stuck with needle and began bleeing. Went to hospital.	Counselling, Welfare and Occupational Health Services offered
Injury to skin / tissue (pressure sore, abrasion, sharps)	34076	15-Apr-2007	Greenwich	Insignificant	Whilst reaching into oxygen bag crew received a needlestick injury to forefinger of right hand. Lancet wedged between 2 folds of material with point facing upwards.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34132	14-Apr-2007	Forest Hill	Low	Sustained a needlestick injury while pickign up used lancets.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34804	09-Jun-2007	Edmonton	Insignificant	Whislt about to do BM on patient, opened BM kit and got needlestick injury from broken lancet. Equipment: BM lancet (needle part)	Counselling, Welfare and Occupational Health Services offered Equipment Isolated
Injury to skin / tissue (pressure sore, abrasion, sharps)	34733	18-May-2007	Homerton	Low	Needlestick injury. Patient an IV drug user and laying outside when crew bent down to give O2. Patient holding a syringe which jabbed into crew's knee by mistake.	Counselling, Welfare and Occupational Health Services offered Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34910	07-Jun-2007	Waterloo	Medium	Placed a used needle into sheath and plastic covering next to tissue. On leaving scene, crew picked up tissue and needle and gave self a needlestick injury in right hand palm.	Counselling, Welfare and Occupational Health Services offered

Injury to skin / tissue (pressure sore, abrasion, sharps)	34226	28-Apr-2007	North Kensington	Insignificant	VDI vehicle checking BM kit, noticed no LAS BM lancets in kit and taking them out, stabbed right forefinger on unsheathed lancet. Then noticed BM strip (used) inside/next to lancet.	Investigation completed
Injury to skin / tissue (pressure sore, abrasion, sharps)	34166	21-Apr-2007	Whipps Cross	Low	Whilst moving patient on trolley crew aware of scratch to base of right hand. Noticed that patient had broken off end of hypodermic needle in upper arm and scratch was caused by broken end.	Counselling, Welfare and Occupational Health Services offered

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting and approval of proposed frequency of reporting to Trust Board and SDC on programme progress.

3. Summary

The report provides an update on progress in implementing the Service Improvement Programme (SIP2012) and outlines the approach to performance management of it in accordance with the principles of the Office of Government Commerce methodology "Managing Successful programmes" (MSP).

The following reporting procedure to Trust Board and SDC is proposed:

a. Trust Board – every meeting;

b. Service Development Committee – one of the five sub-programmes which make up the Service Improvement Programme will be presented to each of the five SDC meetings which take place during the year in rotation.

4. Recommendation

THAT the Trust Board:

1. Note the progress made with the Service Improvement Programme 2012 as outlined in the report.

2. Agree the proposed reporting arrangements to Trust Board and SDC described above.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 25 September 2007

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Purpose

To update the Trust Board with progress in implementing the Service Improvement Programme (SIP2012).

The Office of Government Commerce best practice approaches "Managing Successful Programmes" (MSP) and PRINCE2 project management methodologies have been adopted by the Trust to progress SIP2012. The emphasis is not just on performance managing delivery of project progress and outputs but also on clearly identifying the benefits that these outputs are intended to deliver.

Inevitably Trust Board update reports on SIP2012 will initially cover project progress only. As time progresses and projects start to deliver then the benefits realised through operational use of what the projects have produced will also be covered in Trust Board reports.

2. Approach to Performance Management of SIP 2012

The SMG agreed in January 2007 that SIP2012 should be monitored by tracking achievement of planned milestones. However, there are two basic approaches to project scheduling:

- Time driven – whatever resource is required is provided to ensure time deadlines are met at all costs, with this approach achievement of planned milestones is paramount;

- Resource driven – the availability of resources drives project duration and milestones are revised accordingly.

While a time driven approach is the more disciplined ideal, reality not infrequently requires compromise with the more pragmatic resource driven approach. This is often the case in the LAS where operational pressures compete for staff time and NHS financial constraints re-shape project scheduling. The balance between the two types of driver varies by project and the "political" or commercial context. The significance of this for planning and performance management of the five programmes within SIP2012 are:

- There is a need to be clear up front in each case whether time or resource availability drives project scheduling and performance management;

- For performance monitoring of SIP2012 as a whole there will not be 100% planned milestone achievement in any given year. Therefore upfront at the start of the year a tolerance level should be set for milestone achievement at individual programme level and overall SIP2012 level. Over time the average level of within year milestone achievement will be established. However for 2007 a best guess tolerance level will need to be set and it was agreed by SMG that this should be a target of 80% achievement against the baseline of planned milestones (i.e. a tolerance of 20% slippage). Reporting on project progress should reflect both performance against planned (baseline) milestones and against Strategic Steering Group approved changes to milestone plans.

3. Overall Progress

The overall service improvement programme to implement the Strategic Plan for the Trust in the period up to the London Olympics in 2012 is made up of five sub-programmes: "Access and Connecting (the LAS) for Health" led by the Director of Information Management and Technology); "Improving our Response" (known as the "Operational Model") led by the Director of Operations; "Organisation Development and People" led by the Director of Human Resources and Organisation Development; "Preparing for the Olympics" led by the Director of Operations; and "Corporate Processes and Governance" led by the Director of Finance. Currently there are 60 projects within these five programmes of which 27 are live. There is also a supporting Stakeholder Engagement and Communications strategy led by the Director of Communications. Work is progressing to understand the interdependencies between the projects that constitute these programmes.

The appended table gives an overview of progress against plan for the projects that are live. Project progress is summarised through a traffic light system where red indicates serious slippage against plan, amber indicates risk of significant slippage and green indicates that the project is progressing according to schedule. Currently none of the projects are indicated as being red, 5 are amber and 22 are green.

A summary of progress for each of the five programmes and the supporting Stakeholder Engagement and Communications Strategy is given below with issues for Trust Board consideration identified where appropriate. The lead directors for each programme will provide a brief oral report on their programmes at the Trust Board meeting.

4. Access and Connecting (the LAS) for Health Programme

Due to resource pressures to support other programmes in SIP2012, the Access programme has not been able to formally commence. It has therefore been decided to delay formal scoping work until the start of Financial Year 2008/09. Instead, the programme will focus on four main projects, and will report on each, in-line with the overall programme reporting structure.

- Project Progress

LARP – London Ambulance Radio Project

The overall plan is to complete installation and roll out to the operation fleet by September 2008. There has been significant progress in installing the first test vehicles, identifying the premises for installation, planning training and CTAK enhancements software and hardware to support the Airwave network. Therefore at this time, this date still appears achievable.

However there are significant concerns regarding the delivery of the software required for the control room integration, and the overall capacity of the Airwave system within LARP. Both of these issues are being closely monitored by both the project team and board and while the project is currently green it could shortly turn amber.

CTAK Enhancements

The CTAK enhancements project is focused on making changes required by Operations to the existing CAD system. In the main this is to support the current year's performance and the new clock start from April next year. A comprehensive schedule of work has been agreed that includes automating the despatch of Ambulances and the implementation of dynamic deployment software. From April next year, the project is planning to wind-down in preparation for replacement by CAD 2010.

CAD 2010

This project is focused on replacing the core CAD system and has been the subject of previous detailed reports to the Trust Board. The SHA have approved the Outline Business Case (OBC), and a formal procurement process is being undertaken. Thirteen responses were received to the Pre-Qualification Questionnaire that was released with the OJEU Notice on 27/3/07. A short list was produced and these suppliers were invited to participate in dialogue by providing an initial response to the Output Based Specification. Following evaluation, the Project Board on 22 August approved the procurement team's recommendation that all of these suppliers should continue to the next stage.

This report is deliberately vague in terms of names and numbers of suppliers. This is because procurement is at a very critical stage and any inappropriate contact, or comments could jeopardise negotiations. A full briefing was given to the Trust Board during part 2 (i.e. the confidential section) of the July meeting.

Access for Deaf People

Initial work on the Access Programme identified that members of the public who could not use a telephone to speak, cannot easily access core emergency 999 services. Following specific representation from deaf members of the

Patients Forum it was decided to progress work for patients who had either speech impediments or who were deaf.

A small project board has been established, and 2 days a week of project management time has been made available. It has already been identified that there is a national project, looking to provide a text based bureau next year. One of the first aims of the project will be to link into this work and identify how it could be used by the LAS. Compared to the other 3 projects, this project is still at a very early stage of development.

- Significant Programme Issues, Risks and Actions

There are no significant issues or risks for the programme to draw to Trust Board attention at this time over and above the comments made in relation to LARP.

5. Improving Our Response (the Operational Model) Programme

The Operational Model programme comprises two portfolios of projects, one focused on changes in Area Operations consisting of six projects and one focused on changes in Control Services also comprising six projects. Of the twelve live projects all are on track with none at risk of significant slippage at the present time, this is in accordance with the tolerance level set.

- Project Progress

The overall progress of the Operational Model remains on track with all milestones having been hit, however, it is clear that the provision of the **full** additional complex response, due to be delivered from 17 September, will not be achieved (although an increasing resource will be available on a daily basis). This missed milestone is due to ongoing training and a revised completion date of no later than 30 September has now been proposed. In project management terms this failure to achieve the milestone is disappointing as the training plan should have clearly identified the timescales necessary and therefore advance notice of any difficulties should have been apparent much earlier. This is considered to be a potential learning point for other SROs.

An invitation to tender for dynamic deployment software has now been published in the European Journal with a 52 day (statutory) window for response. Although implementation is currently scheduled for March 2007 the project team are confident that this timeframe will be reduced once a contract is awarded as the specification requires that the successful bidder provide on site technical interfacing support which will ameliorate current capacity issues in house.

Chris Hartley-Sharpe, formerly AOM for Waterloo Complex, has been appointed, initially for 12 months, to lead the First and Co-Responders Project. This is a very significant piece of work with a number of strands and a high level of complexity. Early deliverables include a potential first responder despatch desk by October 2007 and a roll-out of at least 75 additional static defibrillator sites per year for 5 years pan London. A fully worked up Project Initiation Document and bid to the British Heart Foundation are currently in preparation.

There remains some concern over the timetable for project delivery and benefit realisation and all projects are currently being reviewed to ensure that milestones are both realistic but challenging.

- Significant Programme Issues, Risks and Actions

The staff and union engagement necessary to ensure that the operational benefits of these projects are fully realised remains a significant cause for concern. Meetings have been held between the two relevant SROs and progress is now being made although initial progress remains slow.

Understanding the full interdependencies between programme strands (particularly Organisation Development & People and Access programmes) remains challenging, however, a separate interdependencies meeting has now been constituted between the relevant SROs in an attempt to address this issue.

6. Organisation Development and People Programme

The Organisation Development and People Programme has been initiated over the summer – a project portfolio manager has been appointed and taken up post; the inaugural meeting of the programme board has taken place and a project scoping workshop held. Fourteen projects have been identified to be progressed as resources permit, eight immediately. Next steps are to develop the programme documentation according to the principles of the Managing Successful Programmes approach and progress project planning and delivery. Work is progressing on some projects while scoping activity continues, progress on live projects is outlined below.

- Project Progress

Clinical Leadership Model

A significant amount of work has been done to progress the Clinical Leadership Model under the guidance of the Clinical Leadership Strategy Group:

- Vision/descriptor papers are nearing completion;
- A revised timetable has been agreed for development work/implementation;
- Two workshops were held to gain feedback on the papers and implementation plan;
- Initial station selection process/criteria drafted and proposed (this is under review);
- Work is underway to scope the work-streams/projects involved and interdependencies/ overlaps with other programmes are being mapped;
- Preparatory work has taken place to develop an over-arching summary document.

There are at least four areas of activity which will, with further scoping, disaggregate into projects focused on re-configuring the workforce profile, leadership and management, team based working and training and development for staff as individuals related to the new way of working.

Training

The structure of training provision is an essential enabler and activity is currently focused in two areas:

- The training plan 2007-09 has now been finalised and will be presented to the Trust Board in September 2007; (agenda item 12). The plan includes development of modularised training and how existing modules (and their delivery methodology) are being evaluated and reviewed as necessary;

- The restructure of the department of Education and Development has moved ahead and formal consultation is anticipated to have commenced week commencing 17 September.

Significant Programme Issues, Risks and Actions

There are no significant issues or risks for the programme to draw to Trust Board attention at this time.

7. Preparing for the Olympics Programme

The Olympics programme is at the stage of being scoped to identify the portfolio of projects which will comprise it. At the launch workshop 126 potential projects were identified with 30 flagged as having a high benefit and low barrier to initiation making them potential quick wins. These have been circulated to directorate leads for comment. The remaining projects are being reviewed to ensure they have been assessed correctly. Project scoping will commence once the project portfolio manager is in post at the beginning of October.

8. Corporate Processes and Governance Programme

The Corporate Processes and Governance Programme is well underway with an operational programme board and dedicate project portfolio manager who took up post in early July in time to cover for the programme manager who is on sick leave for several months. Five projects have been initiated and three are being started up (project briefs drafted and approved) and project plans are being developed. Two further projects are proceeding but need greater definition and two projects have been removed from the programme as after scoping they are considered to be too small to be classified as projects.

- Project Progress

Supply Chain Review projects

There are six supply chain review projects and these are proceeding at pace. Included in this cluster are the roll-out of FISC (the new procurement system) with a new module within the Trust accounting package, 'e-Series Web Basket', to streamline workflows and processes in ordering stock across the Trust. Other projects include Asset Tracking, a system for tracking equipment on vehicles and Inventory Management to develop electronic stock management.

Staff Administration

The project to review and re-design staff administration processes at complex level and realise the benefits from the implementation of the Electronic Staff Record (ESR) system has been initiated. The project board approved the Project Brief in August and workshops have been organised by Area for administrative staff to identify issues. Some analysis of technical requirements has taken place but further work is required. Next steps are to complete the analysis of the Staff Administration function and the legacy systems.

Other projects

A lot of work is being undertaken to scope and progress the other projects in the programme. Of particular note is that draft options are being considered in regard to the Workshop Review and a Payment By Results (PbR) Pilot project is being started up for the LAS to join a national pilot scheme for ambulance service income to be paid by national tariff. Initial discussions have taken place with commissioners regarding the project outline and the project brief has been approved.

- Significant Programme Issues, Risks and Actions

There are no significant issues or risks for the programme to draw to Trust Board attention at this time.

9. Stakeholder Engagement and Communications

Work is progressing to develop the Communication and Engagement Strategy to support the Strategic Plan. The strategy will focus on delivering the Service's strategic aspirations to:

- Be accessible;
- Respond appropriately;
- Engage with the public, patients and partners;
- Provide greater options for patients;
- Focus on service delivery;
- Have a culture based around the core values.

There are four communication objectives:

- To increase Londoners' understanding of our role and future plans;
- To involve the public and patients in shaping the way we deliver our service;
- To build relations with those people who are key stakeholders in our Strategic Plan;
- To develop an environment where members of staff feel valued, feel proud to work for the Service, and actively contribute to improving patient care.

The principles of the Communication and Engagement Strategy have been shared with the SMG, and following further development the strategy will be presented to the Trust Board.

10. Recommendation

THAT the Trust Board:

1. Note the progress made with the Service Improvement Programme 2012.
2. Agree the proposed reporting arrangements to the Trust Board and SDC.

Kathy Jones
Director of Service Development

SIP2012 Performance Report: Project Progress, Output Delivery and Benefits Realised

Projects by programme	Project Progress Prior to Delivery	Post Project Delivery Benefits Realisation	
	Milestone Achievement Red/ Amber/ Green	Project Outputs Delivered	Benefits Realised from operational use of project deliverables Red/Amber/Green
Access and Connecting (the LAS) for Health			
CTAK Enhancement			
CAD2010			
LARP	Could go Amber		
Access for Deaf People			
Improving our Response (Operational Model)			
Tranche 2 (Clock Start): Area Operations			
Mobile Fleet			
Increasing Solo Response Capacity			
Additional Complex Response	Milestone slippage		
First and Co-responder Schemes	Being Scoped		
Referral Pathways			
Managing Frequent Callers	Being Scoped		
Tranche 2 (Clock Start): Control Services			
Control Services Management Re-structure			
Automatic Data Reporting and Analysis			
Paperless Control Room	Scope & definition to be finalised		
Re-engineering Call Handling			
Urgent Care Workload			
Automated Ambulance Despatch (FREDA)			

Tranche 3: *"New Way of Working"* (New Front End Model Part)			
Mobile Fleet (Phase 2)	Being Scoped		
Referral pathways (Phase 2)	Being Scoped		
EBS take on Dr's Urgents	Being Scoped		
Stakeholder Engagement and Communications	Being Scoped		
Vehicle Fleet Mix	Being Scoped		
Re-configured Workshops	Being Scoped		
Real Time Assistance	Being Scoped		
Organisation Development & People			
Tranche 1: Development			
Recruitment and Induction Process Development	Being Scoped		
Develop and Implement Performance Management Framework	Being Scoped		
Leadership Development Programme	Being Scoped		
Modularised training (CPD)			
Succession Planning and Talent Management	Being Scoped		
Staff and Union Engagement	Being Scoped		
Training Re-structure			
Tranche 1: *"New Way of Working"* (Clinical Leadership Model Part)	Being Scoped overall		
Re-configured Workforce Profile (incl. Workforce Plan)			
Focus on the Individual - Training and Development	Being Scoped		
Leadership & Management Performance	Being Scoped		
Focus on the Team - Training and Development	Being Scoped		

Tranche 2:			
Training Package for Challenging	Scoping at a later date		
Leadership Newsletter	Scoping at a later date		
Leadership Scoping Exercise	Scoping at a later date		
Exploration of What Staff Involvement Means	Scoping at a later date		
Review LAS Identity	Scoping at a later date		
Introduce Team Briefing	Scoping at a later date		
Create Innovation Hub	Being Scoped		
Preparing for the Olympics			
Projects at the identification stage with detailed scoping commencing October to inform Service Plan and Budget development for 2008/09	Scoping to commence October		
Corporate Processes & Governance			
Mapping all Processes	Scoping at a later date		
Staff Administration			
Supply Chain: FISC Roll-out	Resource availability for training caused roll-out slippage		
Supply Chain: Asset Tracking	Milestone plans need development		
Supply Chain: Inventory Management	Being Scoped		
Electronic Data Capture (web based)			
Fleet Operations: Fleet Strategy and Workshop Review		Report produced for presentation to SMG in the autumn	
Fleet Operations: Flexible Fleet Management	Milestone plans need development		
Fleet Operations: Real-time Fleet Management Information	Scoping at a later date		
Re-engineer Income Collection processes			
performance Measurement (Phase 1)	Being Scoped		

Meeting Room Booking System			
Implementation of Incident Data Recording	Being Scoped		
PRF Processes	Scoping at a later date		
Scope 2008/09 CIP		Report produced, savings options identified	
The Intelligent Trust	Scoping at a later date		
Trust Development	Scoping at a later date		
Payment By Results Trial			

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 25 September 2007

MANAGEMENT OF CHANGE POLICY AND PROCEDURE

1. Sponsoring Executive Director: Caron Hitchen, Director HR-OD

2. Purpose: For approval

3. Summary :

There are circumstances that necessitate a change in both the nature and number of jobs within particular work areas of the Trust. This Policy and Procedure is aimed at ensuring that all reorganisations are carried out in a consistent and structured way and that any potential redundancies are minimised.

The purpose of this document is to ensure:

- That any reorganisation is carried out efficiently and that disruption to service delivery is avoided;
- That staff affected know how the changes are going to be managed, how it is likely to affect them personally and that they are properly supported through the change process;
- That there is a consistent approach to contractual conditions and remuneration;
- That any potential redundancies are minimised;
- That the reorganisation is fair and transparent.

The Policy has been agreed through the Joint Staff Council

4. Recommendation

THAT the Trust Board approve the Management of Change Policy and Procedure.

London Ambulance Service NHS Trust

Management of change policy and procedure

(September 2007)

1 Introduction

1.1 This document outlines the Trust's policy and procedure in circumstances of reorganisation or other organisational change.

2 Policy statement

2.1 There are circumstances that necessitate a change in both the nature and number of jobs within particular work areas of the Trust. This Policy and Procedure is aimed at ensuring that all reorganisations are carried out in a consistent and structured way and that any potential redundancies are minimised.

3 Purpose

3.1 The purpose of this document is to ensure:

- That any reorganisation is carried out efficiently and that disruption to service delivery is avoided;
- That staff affected know how the changes are going to be managed, how it is likely to affect them personally and that they are properly supported through the change process;
- That there is a consistent approach to contractual conditions and remuneration;
- That any potential redundancies are minimised;
- That the reorganisation is fair and transparent.

4 Legal Considerations

4.1 This Policy takes into account the relevant legislation including the Trade Union and Labour Relations Act 1992 and Employment Rights Act 1996, and associated ACAS guidance. It also reflects the Agenda for Change: NHS Terms and Conditions Handbook as well as the principles contained in of the document 'Human Resources Framework for SHAs and PCTs' (NHS Employers 2005).

4.2 Consultation with Trade Unions in regards to all reorganisations must take place and it is a legal requirement in circumstances of potential redundancy.

4.3 N.B. Any employer who proposes to dismiss twenty or more employees as redundant at one establishment within a period of ninety days or less has a statutory duty to notify the Secretary of State for Trade and Industry. Further information on this is available at www.dti.gov.uk

5 Responsibilities

5.1 The following responsibilities should be borne in mind when managing any reorganisation:

- All staff should be kept fully informed and supported during the change process;
- All reasonable steps should be taken to avoid redundancies;
- The process should be completed as efficiently as possible both to avoid uncertainty for members of staff and to achieve necessary financial savings;
- No employee should receive less favourable treatment on the grounds of age, gender, marital status, race, religion, creed, sexual orientation, colour, disability, working patterns or on grounds of trade union membership;
- Records must be kept in regards to decisions made during the process. These at a minimum should include details relating to gender, disability, ethnicity and age and should be used to ensure that any decisions taken are not directly or indirectly discriminatory.
- The views of individuals and trade unions should be taken into account when managing the change process.

N.B. Care should be taken to ensure that all staff affected by the reorganisation are informed and consulted appropriately. This will include those away from work such as on long-term sickness or maternity leave.

5.2 Staff have a responsibility to co-operate with the reorganisation process and to accept any reasonable job offer. Failure to do so may affect their right to a redundancy payment.

5.3 Human Resources staff have a responsibility to advise both managers and staff throughout the process. They must also attend any interviews carried out as part of the reorganisation and/or redeployment process.

6 Procedure

Prior to reorganisation

6.1 The need for a reorganisation may be brought about through a range of factors, including efficiency savings and changes to service provision.

6.2 Every effort should be made to avoid the potential for redundancies. Alternatives to redundancy should be considered, including the following:

- Restrictions on recruitment;
- Ban or limit on overtime working;
- Natural wastage;
- Termination of the employment of temporary or contract/agency staff.

6.3 Other initiatives to minimise redundancies such as re-training or redeployment are included as part of this document.

6.4 In advance of any formal consultation, informal discussions may take place with any staff who are potentially affected and will be with the aim of seeking

views on draft proposals etc. Such informal discussions must not be used as a substitute for formal consultation on the reorganisation.

6.5 A reorganisation paper should be produced. This should set out the following:

- The rationale for the change;
- The current structure;
- The proposed structure;
- Draft revised job descriptions/person specifications (if available) or proposed changes to job/role content.
- Proposals for assimilation/appointment to the new structure;
- The arrangements for consultation;
- The timetable for the reorganisation.

6.6 Details of the reorganisation should be given to all staff potentially affected by the proposed changes, as well as to their Trades Union representatives. In all cases a copy should be sent to the Chair and to the Assistant Secretary of the Staff Council. Staff and their representatives should be invited to provide comments on the detail of the proposals and should be given at least a two week period in which to do this.

6.7 The manager should consider the views of staff and their representatives put forward during the consultation period.

6.8 In circumstances when the reorganisation involves a reduction in posts, due consideration should have been given to inviting applications for voluntary redundancy. Management's decision on accepting such requests will depend upon a range of factors including cost implications, preserving necessary skills etc. and how many posts are likely to be lost as part of the reorganisation. Consideration must also be given to the redeployment opportunities for the individual, either within the Trust or locally within the NHS. Volunteering for redundancy will not necessarily mean that such requests will be approved.

6.9 In making decisions in regards voluntary redundancies, the Trust must be clear that it is cost effective. Such decisions may be subject to audit.

6.10 If voluntary redundancies are to be invited then this should be included in the reorganisation paper.

6.11 Following the consultation period a final reorganisation paper should be produced by the manager. This will be an update of the earlier paper. It will include final job descriptions and person specifications as well as the process for assimilation/appointment. It will be circulated to those affected by the reorganisation as well as their TU representatives. In all circumstances a copy should be sent to the Chair and to the Assistant Secretary of the Staff Council.

<u>Assimilation</u>

6.12 Management will, as far as possible, ensure that existing staff who are subject to reorganisation shall have an assimilation opportunity in the new structure

i.e. that these posts provide suitable alternative employment for the affected members of staff.

6.13 The new structure may not be of sufficient size to absorb all the existing staff and/or the duties contained in the jobs in the new structure may be significantly different to those contained in the previous structure.

6.14 Posts of the same banding or one banding higher or lower than employees' current pay bands may constitute suitable alternative employment.

Direct assimilation

6.15 Management will identify posts where direct assimilation ('slotting-in') may take place. This is where a job remains on the same pay banding, it is broadly unchanged and the postholder would continue to undertake the same essential duties. This is usually considered to be the case when 70% of the duties remain the same.

No direct assimilation

6.16 There is no right to direct assimilation when: the essential duties of the new and previous job do not match, or; the banding of the new post differs from the old.

Assimilation to a lower banded post

6.17 Employees affected by the reorganisation may be assimilated to an evaluated post that is one band lower than that which they previously held. The essential job duties in such circumstances will be of a lesser level but will otherwise be broadly similar.

6.18 Employees will be assimilated at a Pay Point from the range for the post's banding, equal to their current Pay Point. If the employee's current Pay Point is higher than the maximum of the range for the new job, they will be assimilated at the highest Pay Point in the range. Pay protection as set out in Section 8 applies.

Assimilation to a higher banded post

6.19 Employees affected by the reorganisation may be assimilated to an evaluated post one band up from that which they previously held. The essential job duties in such circumstances will be of a higher level but will otherwise be broadly similar.

6.20 In all cases of staff being considered for assimilation to posts of one band higher than previously held, interview/assessment will take place. The interview/assessment will be based on the job description and specification for the new post. Employees will be assimilated at either the minimum of the new pay band or, if this would result in no pay increase, the first pay point which

would deliver an increase in pay (by reference to basic pay plus any recruitment and retention premium if applicable).

Assessments

6.21 Interviews and assessments used as part of this process will help identify suitability for the post in terms of skills/knowledge etc. as well as any development needs for the employee when taking on the new role.

Competitive assimilation

6.22 In circumstances when there are more employees than posts, competitive assimilation will take place. Competition for any post shall be confined to employees of an equivalent banding in the first instance. The interview/assessment will be based on the job description and specification for the new post.

6.23 When posts remain vacant on the new structure after the assimilation process has taken place, these shall be ring-fenced to employees directly affected by the reorganisation, who will be invited to apply.

Staff who do not gain a position on the new structure

6.24 In circumstances when staff are not found a position on the revised structure then they will be placed on the Trust's Redeployment List.

Vacant posts on the new structure

6.25 Vacant posts on the new structure following reorganisation will be open to recruitment. Redeployees from throughout the Trust will be considered in advance of other applicants.

7 Redeployment

Redeployment List

7.1 Staff will be placed on the Trust's Redeployment List with immediate effect at the point that they 'fall out' of a reorganisation. The latest time that they are placed on the list will be the point that they are given notice of dismissal. The person will be put on the Redeployment List at the earliest appropriate point - this is with the aim of maximising the opportunity of identifying an alternative post. If necessary this will before the Redeployment Meeting has taken place.

Redeployment Meeting

7.2 An HR Advisor will meet with those who have not been assimilated to the new structure and will explain the redeployment process, redundancies and redundancy payments. The HR Advisor will also assist them in completing a short profile form (see appendix 1) that sets out qualifications as well as key

skills and abilities together with their employment history. The profile form will be used by the Recruitment Unit in considering any vacancies against redeployees. This form will usually be no more than two sides of typed A4.

7.3 The redeployee has the right to be accompanied at this meeting by a Trade Union representative or colleague.

Redeployment matching

7.4 As vacancies arise, and as they are submitted to the Recruitment Department, the jobs will be considered against redeployees' profiles and the Recruitment Department will contact the redeployee as appropriate. If the post is deemed suitable alternative employment i.e. a reasonable match in terms of banding and the necessary skills etc then the employee will be requested to set out in writing how they believe that they meet the person specification for the job. Employees will not be required to fill out a complete application form. The statement setting out how they meet the person specification will be given to the Recruitment Panel.

Support for redeployees

7.5 The weekly vacancy list, included with the Routine Information Bulletin (RIB), should be circulated to all redeployees.

7.6 During the redeployment period every effort will be made to support the redeployee, including providing advice/training and/or reasonable time off to attend training in order to help them gain the necessary skills to improve their employment opportunities e.g. assistance with C.V. writing or interview skills.

7.7 Reasonable time off should also be given to allow the redeployee to seek alternative work e.g. attending job interviews external to the Trust.

Job applications by redeployees

7.8 Once a post is advertised then any application received by a redeployee shall be considered, and if it is of the appropriate standard, interviewed in advance of all other candidates. Staff, in such circumstances, will receive the pay protection outlined in Section 8.

Extension to redeployment period

7.9 The redeployment period may be extended in circumstances when a job vacancy has arisen and the redeployee has actively sought the opportunity to be considered for that post.

Applying for NHS posts outside the LAS

7.10 Staff who at this point have been displaced from their substantive role and are therefore potentially redundant are permitted to state on their application forms that they have been displaced as a result of organisational change.

8 Pay protection

8.1 Staff who are redeployed to a lower banded post will be protected on their current earnings for two years from the date they start their new post ('earnings' will comprise basic salary, High Cost Area Supplement and any regularly recurrent feature such as an unsocial hours payment). This will be on a 'marked-time' basis i.e. they will not receive cost of living or incremental increases.

8.2 This will be unless or until their new pay level (basic pay, High Cost Area Supplement, On-call payments and payments for unsocial hours working) matches or exceeds their previous pay e.g. because their new job carries a shift allowance.

8.3 Following the two year period, members of staff will drop to the point on the lower banding as close as possible to their previous basic salary and HCAS. They will then receive cost of living increases and any incremental increases.

9 Termination of contract

9.1 The redeployee will receive written notice of dismissal. An employee's period of period of notice will run concurrently with their time on the redeployment list.

9.2 In considering redundancy, reference should be made to Section 16 of the AfC NHS Terms and Conditions Handbook on Redundancy Pay. In particular the paragraphs in regards Exclusion from Eligibility and Suitable Alternative Employment (paragraphs 16.16-16.19)

Appeal

9.3 The letter notifying members of staff of their redundancy will detail their right of appeal. This will be to the Director of Human Resources & Organisation Development. Any appeal should be submitted, at the latest, 14 days after leaving employment.

Redundancy payments

9.5 In circumstances when an employee opts for, and is subsequently granted voluntary redundancy or is otherwise made redundant, redundancy payments will be in line with Section 16 of the NHS Terms and Conditions Handbook.

10 Other matters

Trial Periods

10.2 All employees who have received written notice of redundancy and who start in a new post will have a four-week trial period during which both managers and the redeployee can decide their suitability to the new post.

10.3 In circumstances when written notice of redundancy has been issued there will be no effect on employees' rights to a redundancy payment should both parties decide, as a result of effective monitoring during the trial period, that the post is not suitable.

10.4 Managers have a responsibility to review and assess the performance of individuals throughout the trial period. Any deficiencies in performance need to be outlined to staff as soon as possible in order that employees have the opportunity to improve.

10.5 The trial period may be extended where a longer period is required to train the employee in their new role.

10.6 Following successful completion of the trial period the employee will be written to confirming appointment in post. In circumstances when a written notice of redundancy has been issued the employee will lose any rights to a redundancy payment at this point.

10.7 In all circumstances when an employee continues to work beyond the four week period or jointly agreed extension, any redundancy payment will be lost because the employee will be deemed to have accepted the new employment.

10.8 Employees should be informed of all of the above details of the trial period in their offer letter.

Job offers

10.10 It is essential that any job offers are put in writing to employees whether or not it is believed that they may refuse the offer.

Additional assistance

10.11 Employees should be reminded of other sources of help and assistance during this period including the Employee Assistance Programme.

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

TRAINING AND DEVELOPMENT PLAN, JULY 2007 – APRIL 2009

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

The plan contains details of the Trust's planned education, training and development activity to the end of March 2009.

The plan demonstrates an increase in planned paramedic training together with the introduction of modularised provision of CPD and EMT4 training.

This activity is aimed at supporting the workforce plan and takes account of capacity both to provide the required training and for staff to attend.

4. Recommendation

THAT the Trust Board note the training and development plan

Training & Development Plan - July 2007 April 2009

This Training & Development Plan recognises the aspirations and strategic direction of the organisation to deliver more post registration training at complex level whilst maintaining a robust programme of recruitment and pre registration courses at our training centres and providing a workforce that is skilled appropriately to satisfy the aspirations of the workforce plan.

The context within which ambulance services provide education and training for their staff is changing nationally. With greater emphasis on the merging of internally delivered training with higher education (HE)-based development, the workforce review and the emerging financial/funding pressures for all training outside medicine and nursing, there is a need for a fundamental shift in the way that ambulance service's design, plan and deliver staff training and development.

Ambulance services, in common with much of the NHS, are beginning to move toward a model of delivery for education and training that not only relies on partnerships with HE partners but that places much greater emphasis on the provision of workplace-based, practice learning that allows experiential learning to sit alongside theory based learning as equal partners, and uses the expertise of practitioners to assist staff in developing their practice.

For ease of reference the plan is described in five distinct sections:

i. Technical & Clinical
ii. University programmes
iii. Control Services
iv. Management Development
v. Staff Development (Non-clinical)

i. Clinical & Technical

Within the clinical and technical training portfolio the following courses will be available:

Pre Registration Courses.

Patient Transport Services

Ambulance Persons (AP) Course

This is a four week training package designed for new entrant staff; it includes all of the elements covered in the PTS Drivers course in addition to manual handling and the use of the manual handling small aids kit. At the conclusion of the course the student will be able to undertake the full range of operational PTS duties using all PTS vehicles. (During the period covered by this plan this training may be subsumed into the A&E Support training programme, but is maintained in its current form pending future decisions).

4 courses in total (each with 12 student places) are planned providing a total of **48** student places (to be utilised/confirmed as required by PTS).

PTS Events Course

This is a two week addition to the PTS AP training that is offered as a development opportunity to staff wishing to undertake work at large public events. The course covers items such as radio communication, personal safety and major incident/public event command structure.

2 courses (each with 12 student places) are planned providing a total of **24** places

Work Based Trainer Development Days

These are quarterly review and development days offered to PTS WBTs to assist in the cascade of the annual work based training programme.

3 days (each with 12 student places) are planned providing a total of **36** places

PTS Conversion Course

The PTS Conversion course is designed to provide a pathway for existing PTS staff to progress to A&E Support work. This course comprises of a classroom based three week theoretical & technical training. The student is then required to complete a three week driving programme prior to consolidating their skills in a four week period of operational training.

3 courses (each with 12 student places) are planned providing a total of **36** places

A & E Support Courses

The A&E Support Course is designed to equip staff with the requisite skills to staff urgent care vehicles within the Trust. This course comprises of a classroom based

four week theoretical & technical training. The student is then required to complete a three week driving programme and a further week of practical assessments prior to consolidating their skills in a four week period of operational training.

17 courses of either 6 or 12 places are planned providing **144** places.

EMT 1 to EMT 2 Bridging Courses

This course is designed to provide remaining members of staff of EMT 1 grade with the necessary skill additional skills and knowledge to progress to EMT 2 grade.

3 courses of 12 places planned providing **36** places

Driving Courses

The D1 course equips staff with the appropriate level of driving skill to drive the Trust's vehicles under normal driving circumstances. The course is one week in duration and provides a theoretical and practical base in all aspects of road craft.

The D2 course equips staff with an advanced level of driving skill to drive the Trusts vehicles and includes the legal aspects of emergency driving. The course is two weeks in duration and provides an advanced theoretical and practical base in all aspects of road craft. Practical emergency driving skills are developed under supervision during the operational training phase.

30 courses incorporating D1 & D2 are being offered providing a total of **276** places.

FRU Driving Update

This update is available to staff who are deployed on fast response units and comprises of two days theoretical & practical update as required following appraisal. This is then consolidated as required by a period of answering live calls and reviewing the driving demonstrated.

No courses are planned to at present, but this is subject to change according to service requirements.

EMT 2 End of Year Assessments

These assessments allow EMT 2 staff to qualify to EMT 3 grade.

14 2 day EOY assessment centres are planned throughout 2008 for **140** students from EMT 2 2006/2007 recruitment process. There is no requirement for these during 2009 due to no EMT courses planned in late 2007/2008.

Paramedic pre Entry Assessments

These assessments provide a robust selection process to ensure that all candidates entering the paramedic process have the requisite levels of theoretical and practical knowledge to enter the paramedic programme.

2 blocks of assessments have been planned in November 2007 and March 2008. Numbers will be dependent on accomplishment of the short listing process and success rate.

Paramedic

The paramedic course is designed to equip EMT 4 and some EMT3 members of staff to progress to paramedic status. It comprises of a six week theoretical component at Fulham Education Centre which is supported by two week period of workplace based consolidation and followed by a four week hospital placement.

Following the successful completion of the paramedic course the newly qualified paramedics are mentored for the first month of practice.

9 full time courses of 10 week duration are planned providing **200** places. Additionally two modular courses are planned providing **48** places.

The places provided within the life of this plan represent an increase in the number of paramedics trained within the service. In addition to the in-house training the university system will provide an additional 98 paramedics which could potentially be employed subject to the services need to recruit.

Post Registration Courses

Modular CPD Courses

A range of continuing professional development modules have been designed to meet the professional developmental requirements of operational clinical staff.

The modular delivery replaces the one week block previously providing Continual Professional Development and EMT 4 Courses which were previously provided to meet the developmental and risk management requirements of operational clinical staff.

636 one day modules have been planned (avoiding January, February, March and April 2008 & 2009) giving a total of **6360** places. (It should be noted that each new module provides a 10 hour training day, delivering approximately 40% more training contact time than a corresponding day in the previous model).

Currently three modules are a being delivered which cover the following topics:

- Patient Assessment
- Basic Life Support / Advanced Life Support
- Manual Handling

It should be noted that the Patient Assessment and Advanced Life Support provide significant elements of the previous EMT4 programme and these staff (EMT4) will access LMA training with associated hospital placements as previously provided.

During the period of this plan the department of Education & Development will develop further modules in:

- Diversity
- Mental Health
- 12 Lead ECG
- Obstetrics
- Major Incidents

Operational Managers' Clinical Update Days

This course is designed to provide operational managers such as AOMs and DSOs with a means of keeping their basic clinical skills updated.

15 one day modules have been planned providing **120** places.

Team Leader Courses

The Team Leader Course is a two week course which equips paramedics who have successfully completed a selection process for team leader positions and has a strong emphasis on service policy and procedures which are relevant to the role of a first line supervisor.

It is the intention of the organisation to maintain a full establishment of Team Leaders and accordingly, although plans for the Team Leader programme have not yet been finalised, 2 courses providing **12 – 15** per course have been planned for October 2007 and January 2008. A further **2** Team Leader Courses will be provided during the financial year April 2008 – March 2009.

Instructional Methods / Instructor Qualifying Courses

These courses are designed to develop operational staff into the role of ambulance aid/control instructors, and attainment of the associated IHCD award.

Each course is followed by a 4-6 week period of consolidation and mentoring.

1 three week IM and **1** three week IQ course is planned providing **12** places on each.

ii. University Programmes

Full-time BSc/Foundation Degrees

In partnership with our 3 higher education partner institutions – Universities of Hertfordshire (UoH), Greenwich (UoG) and Kingston/St.George's (SGU), the LAS contributes to the delivery of education and practice placements for students on both BSc and Foundation Degree courses. The following table details the numbers of university-based students on the various courses.

Year/Uni	Status LAS	2005 Sept	2006 Sept	2007 Sept	2008 Sept	2009 Sept
				Predicted	**Predicted**	**Predicted**
Year 1 BSc UOH	Student	28	30	30	30	30
Year 2 BSc UOH	EMT 2	23	28	29	30	30
Year 3 BSc UOH	*EMT 3*	*22*	*23*	*27*	**30**	*30*
Year 4 BSc UOH	Paramedic	0	22	20	**28**	**30**
Year 1 FD UOH	Student	11	18	18	18	18
Year 2 FD UOH	*EMT 2*	*9*	*11*	*11*	*18*	*18*
Year 3 FD UOH	*EMT3*	*3*	*9*	*10*	**18**	*18*
Year 1 FD SGU	Student	18	18	18	18	18
Year 2 FD SGU	*EMT 2*	*11*	*18*	*16*	*18*	*18*
Year 3 FD SGU	*EMT3*	*0*	*11*	*14*	**18**	*18*
Year 1 FD UOG	Student	0	18	18	18	18
Year 2 FD UOG	*EMT 2*	*0*	*0*	*17*	*18*	*18*
Year 3 FD UOG	*EMT 3*	*0*	*0*	*0*	**18**	*18*
Total	Students	125	206	228	280	282
New	Starters	21	30	48	57	54
Total LAS Employed	*EMT 2*	*20*	*29*	*44*	*54*	*54*
Total LAS Employed	*EMT 3*	*25*	*43*	*51*	*84*	*84*
Total LAS Employed	*EMT 2&3*	*45*	*72*	*95*	*138*	*138*
Paramedics BSc	Graduating		2	21	23	28
Paramedic FD	*Graduating*	*Employed*	*3*	*12*	*36*	*54*
Total Para BSc & FD	Graduating		5	33	59	82

Note: predicted figures in bold include actual student numbers plus potential additional places for students retaking the year.

Part-time Certificate, Diploma and Degree in Paramedic Science

Delivered in partnership with the University of Hertfordshire, these programmes provide a means for LAS paramedic staff to access higher education within their professional field. The following numbers are averaged out across the 18 month period of this plan. Actual figures are dependant upon application numbers and attrition during the duration of the courses.

- Certificate 12 students
- Diploma year 1 12 students
- Diploma year 2 12 students
- Degree Year 1 12 students
- Degree Year 2 12 students

iii. Control Services

Emergency Medical Dispatcher Call Taking Course

This course, which is of 4 weeks' duration, is designed to provide new members of staff the competencies and knowledge to enable them to receive and process calls into the emergency operations centre.

9 courses are planned providing a total of **112** places. This plan may be revised to reflect any changes in staff turnover or changes in recruitment associated with CAD 2010.

Emergency Medical Dispatcher Dispatch Course

This course, which is of one week duration, is designed to instruct members of staff on the policy and procedure for dispatching operational responses.

9 courses are planned providing a total of **112** places. This plan may be revised to reflect any changes in staff turnover or changes in recruitment associated with CAD 2010.

Work Based Trainer Course

This course, which is of 3 days' duration, is designed for existing members of staff to be developed into the role of Work Based Trainer, providing them with the necessary skills and knowledge to support and mentor trainees in the workplace, and to assess competence.

1 course is planned providing a total of **6** places.

Emergency Driving course

This course is delivered to identified Control Services staff to enable them to drive service vehicles under emergency conditions.

2 courses are planned providing a total of **14** places.

iv. Management Development

Exploring Leadership & Self Awareness (ELSA)

The ELSA Programme is open to junior-middle managers with line management responsibility from all parts of the organisation. A mix of recently-appointed and experienced managers is sought for each programme.

3 programmes planned, which include 5 modules in total, offering **40** places

Module 1 - 3 days (residential)
Module 2 - 3 days (residential)
Module 3 - 2 days
Module 4 - 1 day
Module 5 - 2 days

ELSA for Senior Managers

*A version of the above ELSA programme specifically for senior managers is in development, with a plan to deliver **2** programmes for a total of **20** managers during the period April 2008 – April 2009.*

Managing Disciplinaries

This course is designed to provide managers with knowledge and understanding of the disciplinary process, enabling them to conduct investigations into potential disciplinary matters confidently and competently ensuring staff are dealt with fairly and constructively.

6 one-day courses offering **72** places

Managing Attendance

This course is designed to provide managers with an understanding of the Managing Attendance Policy and the knowledge and skills to manage sickness absence effectively.

6 one day courses offering **72** places

Recruitment & Selection

This course is designed to provide managers with an understanding of the processes and procedures for job recruitment and selection and the knowledge and skills to carry out selection interviews.

5 one day courses offering **50** places

Managing Safety & Risk

This course is designed to provide managers with the knowledge required to ensure that they are able to operate successfully within the Service's Polices and Procedures.

5 one day courses offering **50** places

Display Screen Equipment

Line Managers have an obligation to ensure that Risk Assessments are carried out amongst all their staff who use DSE on a regular basis. This course is designed to assist managers in fulfilling their duties in respect of this.

5 one day courses offering **45** places

v. Staff Development (Non-Clinical)

Applying for Promotion

For all staff seeking progression in their role in the near future, preferably with a specific promotion opportunity in mind.

3 one day courses offering **42** places

Assertive Communication

This course is designed to allow participants to identify, understand and relate to assertive and other behaviours in order to boost confidence, and deal effectively with a variety of situations and people

3 one day courses offering **36** places

Presentation Skills

This course is designed to provide participants with an understanding of how to prepare and deliver effective presentations.

2 two-day courses offering **20** places

Effective Meeting Administration

This course is designed to increase confidence and provide the skills and abilities to support the meeting owner/manager/chair, organise and manage effective meetings and produce accurate minutes/notes.

2 one-day meetings providing **20** places

Return to Study

This course is designed to enable participants to make an effective return to studying, particularly those who have been away from a learning environment for some time.

2 one-day courses offering **20** places

Participating at Meetings

This course is designed to increase participant's confidence and provide the skills and abilities for effective communication when attending meetings.

2 one-day courses offering **24** places

Station Administration Development Programme

For Station Administrators to introduce new and comprehensive Station Administration guidelines and to introduce networks for the purpose of sharing best practice.

4 two-day courses offering **48** places

Excellence in Patient Care

Open to both front-line clinical and control services staff, this course is designed to support the NHS-wide drive to work with front-line staff to develop a strong customer care focus with patients. The course is suitable for perhaps a member of staff whose interactions when dealing with customers (patients/the public) have caused concern. The course gives participants the opportunity to discuss and practise some techniques to deal with a variety of situations in a more diplomatic way.

11 courses offering **110** places

Monitoring

The provision of this training plan will be monitored through the balance scorecard with a target of 85% attendance against these delivery plans.

Exclusions

Training activity currently excluded from this plan include:

- CBRN
- LARP
- CAD2010
- HART
- Ad Hoc complex based training

These have however been considered when determining the capacity to release staff for training within the period of this plan.

SUMMARY TABLE

Course/Module	Number of courses/modules	Total number of places
Ambulance Person Course	4	48
PTS Events Course	2	24
PTS WBT Development	3	36
PTS Conversion	3	36
A&E Support	17	144
EMT 1 Bridging	3	36
Driving Courses	30	276
FRU Driving	As required	As required
EMT 2 End of Year Assessments	14	140
Paramedic Pre-entry	2	Dependant on applications
Paramedic	9	200
Paramedic Modular	2	48
Modular CPD	636	6360
Managers' Clinical Update	15	120
Team Leader	4	60
Instructional Methods	1	12
Instructor Qualifying	1	12
EMD Dispatch	9	112
EMD Call Taking	9	112
Control WBT	1	6
Emergency Driving	2	14
ELSA (Senior)	2	20
ELSA	3	40
Managing Disciplinaries	6	72
Managing Attendance	6	72
Recruitment & Selection	5	50
Managing Safety & Risk	5	50
Display Screen Equipment	5	45
Assertive Communication	3	36
Presentation Skills	2	20

Effective Meeting Administration	2	20
Return To Study	2	20
Participating at Meetings	2	24
Station Administrator Development	4	48
Excellence In Patient Care	11	110

Note: For University Paramedic figures please see table on page 6

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

SUPPLEMENTARY EQUALITY REPORT

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

The Annual Equality Report was presented to the Trust Board in May 2007. However, some elements of the report were still being compiled. This supplementary report provides the outstanding data relating to recruitment activity and staff leaving the Trust

4. Recommendation

THAT the Trust Board note the contents of the supplementary report.

Supplementary Equality Report

Trust Board 25 September 2007

The Annual Equality report was presented to the Trust Board in May 2007. Some elements of the report, however, were still being compiled at that time and this supplementary report provides the outstanding data relating to recruitment activity and staff leaving the Trust.

Recruitment (Appendix 1)

During the period April 2006 and March 2007 the Trust received a total of 2846 recruitment applications. Of those 753 (26.4%) were from BME candidates.

The total number of staff appointed was 225 of which 36 (16%) were BME staff. This figure differs from that reported previously for new starters (10.1%) as it includes existing staff applying for new roles in addition to external recruitment activity.

The attached data also shows that a higher proportion of female candidates are successful in their job application with females accounting for 47% of applicants and 53% of appointees.

Of the 112 applicants who declared disability, only 1 person was successfully appointed. 75% of these candidates failed at short-listing and assessment with the remainder failing at interview.

Leavers – April 2006 to March 2007 (Appendix 2)

The attached data shows that during the reporting period a total of 273 staff left the Trust. Of these 30 (11%) were BME staff.

A higher proportion of female staff (57% of total leavers) left the Trust compared to male staff. This is likely to be due, in part, to the higher turnover in the admin and clerical roles which have a higher proportion of female staff.

Appendix 1

Diversity Breakdown of People Applying for all Posts
Within the London Ambulance Service 01/04/06 - 31/03/07

Total Number of Applicants		**2846**			
Ethnic Breakdown of Applicants		**Number applied**	**% of Total Applicants**	**Number appointed**	**% of Total Appointed**
A	British	1872	65.8%	169	75.11%
B	Irish	59	2.1%	6	2.67%
C	Other White	162	5.7%	14	6.22%
D	White & Black Carribean	24	0.8%	2	0.89%
E	White & Black African	40	1.4%	0	0.00%
F	White & Asian	30	1.1%	2	0.89%
G	Other Mixed	22	0.8%	2	0.89%
H	Indian	87	3.1%	4	1.78%
J	Pakistani	62	2.2%	0	0.00%
K	Bangladeshi	37	1.3%	2	0.89%
L	Other Asian	55	1.9%	2	0.89%
M	Carribean	136	4.8%	14	6.22%
N	African	160	5.6%	3	1.33%
P	Other Black	29	1.0%	0	0.00%
R	Chinese	10	0.4%	0	0.00%
S	Other Ethnic	38	1.3%	0	0.00%
Z	Not Disclosed	23	0.8%	5	2.22%
	Total	2846	100.0%	225	100.00%
Gender Breakdown of Applicants		**Number**	**% of Total Applicants**		
M	Male	1505	52.9%	106	47.11%
F	Female	1337	47.0%	119	52.89%
Z	Not Disclosed	4	0.1%	0	0.00%
	Total	2846	100.0%	225	100.00%
Disability Breakdown of Applicants		**Number**	**% of Total Applicants**		
Y	Disabled	112	3.9%	1	0.44%
N	Non-Disabled	2726	95.8%	222	98.67%
Z	Not Disclosed	8	0.3%	2	0.89%
	Total	2846	100.0%	225	100.00%

Appendix 2

Leavers Figs April 2006 - March 2007

Leavers by BME

BME Groups	Total	Inpost	% Ethnic Groups	% Trust
BME	30	356	8.43%	0.73%
White	243	3749	6.48%	5.89%
Not Stated	0	21	0.00%	0.00%
Grand Total	**273**	**4126**	**6.62%**	**6.62%**

Leavers by Gender

Gender	Total	Inpost	% Gender	% Trust
Male	118	2525	4.67%	2.86%
Female	155	1601	9.68%	3.76%
Grand Total	**273**	**4126**	**6.62%**	**6.62%**

Leavers by Ethnicity

Ethnic Origin	Ethnic Groups	BME	Total
A White - British	White	White	220
B White - Irish	White	White	2
C White - Any other White background	White	White	21
E Mixed - White & Black African	Mixed	BME	1
F Mixed - White & Asian	Mixed	BME	1
G Mixed - Any other mixed background	Mixed	BME	1
H Asian or Asian British - Indian	Asian or Asian British	BME	3
J Asian or Asian British - Pakistani	Asian or Asian British	BME	2
L Asian or Asian British - Any other Asian background	Asian or Asian British	BME	3
M Black or Black British - Caribbean	Black or Black British	BME	7
N Black or Black British - African	Black or Black British	BME	6
P Black or Black British - Any other Black background	Black or Black British	BME	2
S Any Other Ethnic Group	Other Ethnic Groups	BME	4
			273

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

MAJOR INCIDENT PLAN

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: For noting

3. Summary

The LAS Major Incident Plan (MIP) has been extensively updated to take into account lessons learned from the 7th July Bombings in Central London together with up to date emergency planning guidance from DH. The Chief Executive has approved the revised plan and the Trust Board is asked to note the revision.

4. Recommendation

THAT the Trust Board note the revised Major Incident Plan

London Ambulance Service NHS
NHS Trust

Major Incident Plan

Emergency Preparedness Unit

18-20 Pocock Street

London SE1 OBW

"Preparing the LAS for incident response"

CONTENTS

London Ambulance Service NHS
NHS Trust

Major Incident Plan

Introduction

This Plan outlines the operational arrangements undertaken by the London Ambulance Service NHS Trust (LAS) at the time of a major incident or emergency as defined in the Civil Contingencies Act 2004 (CCA) **This document is to be read in conjunction with the LAS Business Continuity Plan.**

It is the nature of major incidents or emergencies that they are unpredictable and each will present a unique set of challenges. The London Ambulance Service (LAS) forms part of the National Health Service (NHS) response to such incidents. It is principally geared to the immediate medical needs of those involved and their subsequent transportation to appropriate treatment centres.

All LAS staff must familiarise themselves with the contents of this plan. The plan is supported by action cards and Contingency Plans.

Aim

1. To ensure that we treat those involved as individuals and in the enormity of the situation ensure that we do not lose sight of the needs of patients.

2. To ensure an effective and co-ordinated response to an incident.

3. To ensure all staff have an understanding of their role in a major incident.

4. To describe an effective command structure.

5. To ensure that the LAS responds as part of the NHS team.

References

Civil Contingencies Act 2004
Planning for Major incidents – The NHS Guidance
Department of Health- Handling Major incidents: An Operational Doctrine, 2004
Major Incident Medical Management and Support Manual, 2nd edition
London Emergency Service Liaison Panel Major Incident Procedure Manual 7th edition
IHCD Ambulance Service Basic Training Manual
ASA Operational Arrangements for Civil Emergencies
Guide to Safety at Sports Grounds
The Event Safety Guide, second edition

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Peter Bradley CBE

Chief Ambulance Officer

1. DEFINITION & RESPONSIBILITIES

1.1 Operational Objectives

- to save life together with the other emergency services;
- to provide treatment, stabilisation and care of those injured at the scene;
- to treat those involved as individuals and respond to their needs as such;
- to provide appropriate transport, medical staff, equipment and resources;
- to establish an effective triage sieve and triage sort system to determine the priority evacuation needs of those injured and to establish a safe location for casualty clearing i.e. triage sort area;
- to provide a focal point at the incident for all National Health Service (NHS) and other medical resources;
- to provide communication facilities for NHS resources at the scene, with direct radio links to hospitals, control facilities and any other agency as required;
- to nominate and alert the receiving hospitals from the official list of hospitals to receive those injured;
- to arrange the most appropriate means of transporting those injured to the receiving and specialist hospitals;
- to maintain emergency cover throughout the LAS area and return to a state of normality at the earliest time;
- to act as a portal into the wider health services including the Health Protection Agency;

1.2 Definition of a Major incident

In health service terms, a major incident is any event whose impact cannot be handled within routine service arrangements.

In LESLP terms, a major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and will generally include the involvement, either directly or indirectly, of large numbers of people. In health service terms, a major incident is any event whose impact cannot be handled within routine service arrangements.

In Civil Contingencies Act 2004 (CCA) terms, "Emergency" is an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK or war or terrorism which threatens serious damage to the security of the UK.

1.3 Declaration of a major incident

A major incident can be declared by any member of the emergency services; however if one individual service declares a major incident which is not a major incident to the others, then the others will respond appropriately in support. In this case there is no need for the other services to declare the incident.

1.4 Responsibilities of the other Emergency Services

Procedures and arrangements for effective co-ordination at the scene of a major incident can be found in the London Emergency Services Liaison Panel (LESLP) Major Incident Procedure Manual.

It is accepted that the Police will normally undertake co-ordination at the scene of a major incident, whilst the LFB will assume responsibility for search and rescue.

2. ACTIONS BY FIRST AT THE SCENE

2.1 Major incident action cards

All LAS staff have a responsibility to ensure that they make themselves aware of the LAS procedures listed in the LAS Major incident action cards. The cards have been designed to assist all staff at the incident. These cards must be carried by staff as they have been designed to be carried in the uniform trouser pockets.

All ambulance responders who could be activated to the scene of a potential major incident should refresh themselves of the required procedures by reading through the LAS Major Incident Action cards on a regular basis.

2.2 Structured approach to major incident management

The first response will be put under a considerable amount of pressure, so it is important that staff remain focused and follow structured procedures. Staff should not deal with casualties in the first instance; they should carry out first on scene action points.

It is important to stress that incident management should remain flexible allowing local freedom to adapt and develop responses in an uncertain and complex environment.

Staff should use the 'CSCATTT' mnemonic to remind them of the structured approach to major incident management.

C – Command
Appoint an Ambulance Incident Officer (AIO), Triage Officer and Parking Officer as quickly as possible

S – Safety A, B, C
a. Ensure the safety of yourself don personal protective equipment (PPE), b. safety of the scene (using cordons/cordon tape) and c. the survivors (remove to place of safety)

C – Communications
Instigate communications including control vehicles, radios etc

A – Assessment
Carry out an assessment of the incident – requesting your required resources through a CHALET(S)/METHANE report to EOC

T – Triage
Instigate the triage system as soon as possible

T – Treatment
Commence extended treatment of patients as soon as the triage sieve is complete

T – Transportation
Consider the capability, availability and suitability of types of transport

Communications Failures

In the event of a communications failure scene commanders should plan to communicate by other means. Motorcycle Response Units and Cycle Response Units should be utilised to pass messages. These facilities should be prepared as a matter of course and good communications should be treated as a bonus.

2.3 First ambulance or response - driver

On arrival at the scene, the driver of the first ambulance or response will assume the role of Silver Control and will adopt the following procedures:

- Park as near to the scene as safety permits.
- Don high visibility clothing and safety helmet (take a short time to reflect on the situation).
- Leave blue lights on to signify control point until relieved.
- Provide EOC with an initial visual report, confirming attendance of other emergency services (see CHALETS/METHANE).
- Do not leave vehicle, and where possible maintain a communications link between your attendant and EOC.
- On arrival of additional resources, designate Bronze Parking and Bronze Triage roles.
- Hold all staff at first ambulance until briefed by Silver Medic (your attendant).
- Ensure that all arriving staff are wearing high visibility clothing, safety helmets and bring their triage packs to the control point (first ambulance).

2.4 First ambulance or response – attendant or single person response

On arrival at the scene, the attendant or single person will assume the role of the AIO (Silver Medic); they will adopt the following procedures:

- Don high visibility clothing and safety helmet.
- If incident is at a Section 12 LUL station (as per list issued to all frontline vehicles), collect hand portable radios (supplied for LAS staff in the event of an incident) from LUL Station Office for use underground.
- Carry out reconnaissance of the incident site and report back to EOC (see CHALETS/METHANE).
- Declare a ‘major incident’ based on the criteria in the definition.

PROVIDE YOUR CALLSIGN
STATE "MAJOR INCIDENT DECLARED"
AWAIT CONFIRMATION FROM EOC THAT THE MESSAGE IS RECEIVED
FULL CHALETS/METHANE REPORT SHOULD FOLLOW ASAP

- Think Command and Control - designate appropriate roles as per Major Incident Action cards "Doubling up" of some positions may be necessary in the initial stages of the incident.

- To assist personnel to provide the detailed report the following mnemonics **"CHALET(S)/METHANE"** have been devised, i.e.:

C	Casualties Approximate numbers of casualties -dead, injured and uninjured
H	Hazards Present and potential
A	Access Best access routes for emergency vehicles and suitable provisional rendezvous points (RVPs)
L	Location The exact location of the incident, using map references if possible
E	Emergency Emergency Services present and required including local authorities. Consider medical team(s). Special equipment and services i.e. Helicopter Emergency Medical Service(HEMS), British Association of Immediate Care Schemes(BASICS),Emergency Control Vehicle(ECV), Emergency Support Vehicle(ESV) Request number of LAS resources required
T	Type The type of incident with brief details of types and numbers of vehicles, trains, buildings, aircraft etc
S	Safety Safety of all personnel is paramount

M	Major Incident declared; (or hospitals to standby}
E	Exact location of the incident, with map reference if possible
T	The type of incident with brief details of types and numbers of vehicles, trains, building, aircraft etc
H	Hazards present and potential
A	Access routes and suitable provisional rendezvous points (RVPs)
N	Approximate numbers of priority 1, 2 and 3 patients, dead and uninjured
E	Emergency services present and required including local authorities, Consider Medical Team(s). Special equipment and services i.e. HEMS, Emergency Planner, BASICS, ECV, ESV Request number of LAS resources required

In liaison with the other Emergency Services identify and establish:

- Access and egress routes to and from the incident site
- Ambulance casualty clearing/triage point(s)
- Ambulance control point
- Ambulance parking point
- Ambulance loading point(s)

Consider potential hazards when designating the above.

The first crew on scene should not attempt to rescue or treat casualties until relieved of their initial "First on Scene" roles by Ambulance Officers.

2.5 Second ambulance crew or responder attendance

On arrival at the scene, the second crew will adopt the following procedures:

- Park as near to the scene as safety permits.
- Don high visibility clothing and safety helmet (take a short time to reflect on the situation).
- Switch off all blue lights.
- Keys to remain with vehicle, radio sets to be turned to low volume and driver's window left open.
- Be prepared to take a command role in the initial stages of the incident. You may be designated Bronze Parking and Bronze Triage.
- Obtain a briefing from Silver Medic.
- Do not attempt to rescue or treat casualties until relieved by Ambulance Officers.

2.6 Subsequent ambulance crew or responder attendance

On arrival at the scene, subsequent crews will adopt the following procedures:

- Be prepared to take a command role in the initial stages of the incident.
- Proceed as instructed by EOC, normally to the parking point.
- Report arrival to EOC on R/T.
- Report arrival to Bronze Parking if designated, if not report to Ambulance Control Point indicated by its blue lights flashing.
- Switch off all blue lights.
- Keys to remain with vehicle, radio sets to be turned to low volume and driver's window left open**.**
- Don high visibility jackets and safety helmets.
- Take triage pack and primary response equipment to required location.
- As directed, carry out casualty triage sieve, labelling, management and movement.
- Consider using the extra major incident dressings packs (provided at all major transport hubs).

2.7 Other considerations

In order to provide enough initial equipment for the treatment of patients prior to the arrival of an Emergency Support Vehicle (ESV) it may be appropriate for crew to strip the first and second ambulances of their equipment. Sector based training officers can be deployed to hospitals with some (limited) extra equipment to aid in the replenishment of vehicles.

Any ambulance crew that conveys a patient MUST advise Silver Control (ECV) or EOC (or Ambulance Loading officer if in position) of the following information:

- casualty numbers
- patient classification: priority 1, priority 2, priority 3
- approximate age

It should be noted that during a major incident there is no requirement for blue calls – the use of priority 1 will suffice. Bronze Loading will advise crew staff of the receiving hospital before leaving scene.

Within the assessment for required resources at the scene of the incident it may be appropriate to commandeer a coach or single decker bus. Where possible staff should request buses/coaches via EOC.

3. Emergency Operations Centre (EOC)

3.1 Introduction

EOC is an integral part of any major incident management system. The initial call will be received at the EOC who will despatch LAS resources. The early identification of serious incidents or potential major incidents is of paramount importance.

3.1(a) Pre-determined attendance (PDA)

There is a pre-determined response for explosions on the transport network, train crashes and airport incidents, or incidents where the number or type of casualties threatens to overwhelm the service.

On receipt of such a call EOC will immediately dispatch six ambulances and six officers. Consideration will also be given to the deployment of an emergency support vehicle (ESV), command unit with forward control team (FCT), and/or emergency control vehicle (ECV). This response will be deployed upon identification of the incident or incidents, without waiting for reports from the scene.

The pre-determined attendance for a declared major incident consists of 20 ambulances, 10 officers, all available ESVs, an ECV, a command unit with FCT, and a doctor. Ambulance liaison officers and hospital liaison officers should also be deployed to the appropriate hospitals.

3.1(b) Initial actions of EOC

The senior officer on duty will assume overall responsibility for the EOC response to a major incident and ensure that the following initial actions have been taken, not necessarily in the sequence detailed:

- Dispatch **pre determined attendance (**PDA) of ambulances and officers, ESVs, EPA, nearest DSOV and nearest DOV.
- Ensure that a log of all messages and actions has been commenced.
- Commence a Vehicle Movement Form to record resource movements.
- Ensure that a CHALETS/METHANE report has been requested and received from the first resource on scene and that the crew are told to carry out the procedure listed on their Major Incident Action Cards.
- Move into the Incident Control Room (ICR) as soon as possible, don tabards designating roles.
- Dispatch a Forward Control Team (FCT) to the incident with major incident radio pool.
- Commence paging instruction for all managers as appropriate.
- If the incident is on the underground then consideration should be given to dispatching resources to the next stations either side of the incident where casualties may evacuate from.
- All underground incidents will be responded to using the LUL identification codes to ensure the correct entrance is attended.
- Ensure the on-call radio engineer sets-up at least two dynamic radio channels to be used by all vehicles responding to the incident. Instruct all resources deployed to the incident to switch their radios to the designated channels.
- Check existence of relevant locality information and contingency plans for the location of the incident.
- Ensure the appropriate officer(s) proceed to the scene(s) to act as the AIO(s).
- Inform the Police service and Fire Brigade.
- In consultation with the AIO, dispatch or alert specialist resources.
- Consider dispatching the ECV if the reports received indicate that the incident will require additional communications such as leaky feeder, continue for a long period of time or it is a large scale incident.

- Notify appropriate hospital(s).
- Nominate a Medical Incident Officer and instruct him/her to report to the AIO. If Medical Emergency Response Incident Team (MERIT) is required by the AIO, notify the appropriate hospital listed to supply a team.
- Inform the on call LAS Communications Officer.
- Dispatch PTS vehicles, to the scene for early evacuation of walking casualties. Silver may wish to consider the use of TFL buses.
- Inform EBS, giving names of the receiving hospital(s).

3.1(c) Ongoing actions of EOC

- Update the Police, as appropriate, giving the names of receiving hospitals.
- Dispatch Officers if necessary to fulfil all the key roles at the scene and at the receiving hospital(s).
- Mobilise the required resources for the incident.
- Maintain liaison with Gold Command Suite.
- Notify the Resource Centres requesting them to retain personnel who volunteer their attendance. Ask Resource Centres to tell staff not to self respond.
- Update receiving hospitals and EBS of relevant scene reports, obtaining revised patient intake numbers.
- Notify appropriate fleet managers and workshop supervisors to facilitate the operation of vehicles during long term incident.
- Ensure you are in a position to give regular comprehensive briefings to the gold meetings.

3.1(d) Closure actions of EOC

- Give "scene evacuation complete" messages at the appropriate time to all participating hospitals. These messages should include known/expected number of patients still en route
- Inform other agencies of London Ambulance Service "scene evacuation complete ".
- Ensure that all EOC staff involved are available for an EOC "hot debrief" immediately after the incident.
- Re-stock ICR and grab packs to ensure room is in a state of readiness.
- Collate all documentation and incident logs.
- Prepare a report for the Head of Emergency Preparedness.

3.2 Incident Control Room (ICR)

The ICR is the dedicated management suite within EOC which supports the Silver (tactical) tier during incidents, operations and events. It is responsible for:

- Controlling deployment of resources to the incident
- Allocating ambulances their destination hospital
- Communication with hospitals and external organisations
- Primary logging duties
- Paging instruction procedures
- Facilitating requests of additional resources, equipment and personnel to scene

There is a degree of flexibility surrounding the functionality of the ICR. The concept of operations allows for an ‘Incident Island’ of seven work stations and an ‘Event’ Island of seven work stations. The configuration of the ICR also allows four ‘Sector’ desks to be created using both Islands.

The Senior EOC Officer has a responsibility to ensure that ICR is opened at the earliest opportunity once a serious incident has been identified. The ICR should be staffed with sufficient people to manage the incident, if necessary at the expense of EOC staffing.

The following staff should be deployed during an incident – suggested in the following progressive order:

Level 1 control team – for events or serious incidents

Incident Commander
Responsible for the management of the ICR team and EOC's initial actions during the incident.

Radio Officer
Responsible for dealing with all radio communications and recording vehicle movements.

Telecoms Officer (changes to Primary Telecoms Officer if required - see below)
Responsible for dealing with and logging of telecommunications throughout the duration of the incident.

Level 2 control team – serious incident or major incident declared

Primary Telecoms
Responsible for dealing with and logging of all telecommunications to the designated hospitals and EBS.

Tactical Advisor
An Emergency Planning Advisor responsible for advising the Incident Commander and the ICR team.

Critical Incident Loggist
Responsible for maintaining the critical incident log. This log is a list of critical entries taken from the overall incident log requiring urgent action.

Status Board Operator
Responsible for keeping a log of events and vehicle movements and recording them on the major incident status board maintained on the admin pc at the status board position.

Secondary Telecoms
Responsible for dealing with and logging of telecommunications to partner agencies throughout the incident.

Gold/EOC Liaison
Responsible for liaison between EOC, ICR and Gold Command Suite. This member of staff is based in EOC

Security Officer

A security officer will be posted outside of the ICR, restricting access to members of staff who are not in the ICR team. They have a responsibility to keep the room access log – noting names of staff that are given access to the ICR. Only staff wearing official major incident tabards will be given access.

Tertiary Telecoms
Responsible for dealing with and logging of telecommunications throughout the duration of the incident.

3.3 Silver Control during an extended incident

The LAS has Emergency Control Vehicles (ECV), staffed by Forward Control Team members, which may be activated for response to an incident.

Red Major

Each vehicle has radio sets programmed to ambulance frequencies, hand portables, Tetra radio sets, maps and other sources of information. They also have the facility to set up a direct line telephone link between the emergency services at the scene of an incident. Each vehicle may link into British Telecom lines, and also has a variety of mobile phones. The role of the ECV is to:

- log all communications at the site of the incident
- manage the incident in conjunction with ICR
- set up a Joint Emergency Services Control Centre (JESCC) with the other services on scene
- act as a focal point for medical, nursing and ambulance staff and other emergency services at the scene

All VHF resources will be controlled from the ICR, but an effective radio net on scene ensures that communication is maintained. The UHF or TETRA hand portables can be used for setting up this radio net.

All messages should follow the appropriate chain of command, ensuring that control is maintained. For instance, any messages for ALOs at hospitals from bronze officers at scene should pass through ICR/ECV then on to the appropriate hospital officer.

The service Command Unit will act at a conference facility for the silver team and is not designed for controlling the incident.

3.4 Paging

On receipt of a serious incident or a Major incident, EOC must ensure that the paging instruction has been instigated and followed.

Each pager message will have one of three colour coded prefixes:

GREEN:	**ALL ROUTINE / INFORMATION ONLY MESSAGES**
AMBER:	**PREPARE A STATE OF READINESS/INCIDENT MESSAGES**
RED:	**ACTIVATION REQUIRED**

3.5 Communications

Members of the command structure will have a UHF radio or a TETRA radio. When an FCT responds to the scene, they should take the pool of TETRA radios from ICR, ensuring there are sufficient for the on site command structure.

A minimum of two radio nets will be established. UHF/ TETRA will provide the command channel for Silver and Bronze officers. VHF will provide a resource channel between vehicles moving to and from scene, ICR, Silver Control, GT and ALOs and HLO's.

Silver Control will seek acknowledgement of any information/action messages passed e.g. if the AIO reports the number of remaining casualties. Silver Control will relay the message to the ICR who will then seek acknowledgement from ALOs.

The following call signs will be used at major incidents.

ICR, EOC	Redbase
1st ambulance, ECV, DSOV or DOV	Silver Control
Incident Officer	Silver Medic
Tactical Advisor (EPA)	Echo Papa (Number)
Medical Incident Officer	Mike India
Patient Liaison Officer	Bronze Patients
Parking Officer	Bronze Parking
Primary Triage Officer	Bronze Triage
Forward Incident Officer	Bronze Medic
Loading Point Officer	Bronze Loading
Casualty Clearing Station Officer	Bronze Clearing
Secondary Triage Officer	Via Casualty Clearing Station Officer
Equipment Officer	Bronze Equipment
Safety Officer	Bronze Safety
Forward Medical Incident Officer	Bronze Doctor
Ambulance Liaison Officer (ALO)	Bronze suffixed with Hospital name
Hospital Liaison Officer (HLO)	Via ALO

CBRN *call signs*

CBRN TSO	India Alpha
Decontamination Unit Officer	Bronze Decon

If the incident covers a large area it can be divided into sectors. Each sector can be identified either by a number or a point of the compass. The Officer appointed to take charge of a sector will take the Call Sign, "Bronze" suffixed with the number or point of compass/landmark (e.g. "Bronze Parking North" or "Bronze Horseguards"). If more than one major incident is being dealt with all call signs will include a suffix indicating the location of the incident e.g. Silver Medic Westminster. The important point is that all are aware of the method to be used.

3.6 Inter Service Communications

Robust communication links must be established as soon as possible. There are several technological solutions available for this, but these are no substitute for frequent Silver meetings along with well established working practices.

Technologically, there is an interoperability talkgroup available through the TETRA system. This facility should be requested via EOC who will designate the appropriate talkgroup.

4. COMMAND

4.1 Command Structure

The command structure is designed to work on three levels - Gold, Silver and Bronze.

GOLD strategic level. This is the senior tier of management usually based within the LAS Gold Suite. On occasions the Gold Commander (Gold Medic) may be based with senior officers of the other emergency services or the health authority, for example at New Scotland Yard or the designated Strategic Co- Ordination Centre (SCC).

SILVER tactical level. The first member of the LAS at the scene of the incident will become the AIO. It is usual for the role of the AIO to be handed over to a more senior ranked officer as they arrive. The AIO will not directly be involved in casualty treatment. Their role is to determine priority in allocating resources; planning and co-ordinating tasks and obtaining other resources as required.

BRONZE operational level. Those staff who are managing the operational work at the incident site. Each is responsible to SILVER MEDIC.

All staff in the command structure must wear the appropriate major incident tabards.

Silver Team Member

Silver Medic

Bronze Officer

Action Cards containing details of the roles and responsibilities have been issued and should be used by all Service personnel on scene of a major incident.

4.2 Gold Command

- **GOLD COMMANDER** (Gold Medic)

The Gold Commander is responsible for the strategic command of a major incident and will ensure that service policy is adhered to. Decisions at this level will be made in liaison with senior officers from other emergency services and communicated via the command structure for implementation by the AIO. The Gold Commander must take into account the normal workload of the Service and if necessary invoke the LAS Business Continuity Plan.

- **GOLD DOCTOR**

Gold Doctor will either be the Medical Director of the LAS or a suitably qualified member of the MIO pool. Gold Doctor will deploy to Gold Command Suite and having established that an MIO has been appointed will then be responsible for liaising with Gold Medic and designated hospitals on strategic matters.

- **GOLD STAFF**

This is a senior operational officer nominated to assist Gold Medic throughout the incident.

- **GOLD COMMAND SUITE**

Gold Command Suite is the location from which the Gold Commander and the Gold Team will manage any incident/s. There are enhanced communication facilities provided so that the Gold Commander can maintain an overview of the Service.
Gold Command Suite should be opened by an EPU/EOC Officer in preparation for the Gold Team when a major incident has been declared.

4.3 LAS Silver Command

- **Ambulance Incident Officer (Silver Medic)**

The AIO is responsible for coordinating and directing the work of the Service at the scene of a major incident. He/she will be clearly identifiable by wearing a silver high visibility tabard bearing the word "Incident Officer". On arrival he/she will assume command of all Ambulance Service/medical operations on the scene. He/she will be located at the Silver Command Point through which personnel, technical and material support will be requested as required. AIO is a tactical role and directs all ambulance resources at the scene as required.

The AIO will be assisted by an FCT from EOC. This person will act as radio operator, telephonist and loggist. They will keep a log of all communications and actions. If there is no FCT the AIO is expected to keep their own log of communications and decisions. By using a member of staff on scene.

The AIO may use Motorcycle Response Units or Cycle Response Units to convey messages if radios/mobile telephones become ineffective.

- **Ambulance Tactical Advisor**

An Emergency Planning Advisor will tactically advise the AIO of any specialist personnel or equipment that may be necessary to assist in the management of a major incident and provide advice and support on matters relating to emergency planning and other ambulance service or NHS requirements. They are also available to offer advice regarding the employment of outside agencies e.g. Local Authority and Military Aid.

- **Medical Incident Officer (MIO)**

The doctor who has overall medical responsibility at the scene. He/she will co-ordinate the work of all medical personnel on scene working directly to the AIO. He/she will be located at the Silver Command point. The MIO will ensure that all contact with designated hospitals concerning distribution of casualties is carried out through Silver Control.

- **Silver Control**

The on site control of a major incident.

4.4 LAS Bronze Command

- **Forward Incident Officer(s) – ('Bronze Medic')**

The Forward Incident Officer(s) will manage the scene under the direction of the AIO. The duties of the Forward Incident Officer include:

- Management and co-ordination of all ambulance and medical personnel forward at the actual site
- Ensuring that the liaison is ongoing with other agencies at bronze level

If the incident covers a large area it can be divided into sectors. Each sector can be identified either by a number or a point of the compass. The Officer appointed to take charge of a sector will take the Call Sign, “Bronze” suffixed with the number or point of compass/landmark (e.g. "Bronze Parking North"" or “Bronze Horseguards”)). If more than one major incident is being dealt with all call signs will include a suffix indicating the location of the incident
e.g. Bronze Medic Westminster. The important point is that all are aware of the method to be used.

- **Patient Liaison Officer - ('Bronze Patients')**

- The Patient Liaison Officer will be responsible for communicating with patients and keeping them informed as to what has occurred and how the LAS intends to deal with it. This is an ongoing task for the complete duration of the incident.

- This role should therefore be set up as soon as possible so that patients are aware and are able to assist and cooperate.

- A loud hailer is carried on all DSO vehicles for the purpose of communicating with large numbers.

- The police hold responsibility for communication with uninjured people at the scene

- **Ambulance Loading Officer - ('Bronze Loading')**

The Ambulance Loading Officer will organise the ambulance loading point(s) which should be located near to the Casualty Clearing Station. They are responsible to the AIO. The duties of the Ambulance Loading Officer include:

- Liaison with the police to ensure ingress and egress routes exist
- Ensuring liaison with the Parking Officer is commenced and is ongoing
- Ensuring that all casualties have been triaged and are labelled prior to transportation to hospital
- Instructing crew staff which hospitals to convey to

EOC will provide an FCT to support this officer.

- **Ambulance Parking Officer - ('Bronze Parking')**

The Ambulance Parking Officer will be responsible for ensuring that LAS resources are correctly parked and ready to proceed to the Loading Point as directed. The duties of the Ambulance Parking Officer include:

- Ensuring attending crews are wearing PPE
- Maintenance of records of staff and vehicles attending
- Ensuring liaison with the loading officer is commenced and is ongoing
- Management of keys and call signs of vehicles attending
- Instructing crew staff what equipment to take to the scene (e.g. triage cards etc.)
- Briefing crews on the nature of the incident

- **Ambulance Equipment Officer – ('Bronze Equipment')**

The Ambulance Equipment Officer will be responsible for the issue and recovery of all Service equipment at the scene. Other duties of the Ambulance Equipment Officer include:

- Liaison with the ALO to arrange for specialist hospital equipment to the scene as required through Silver Control/ICR
- Arranging for refreshment points to be set up at the scene for LAS staff.
- Considering the need for requesting the attendance of the NHS Major Incident pods
- Accessing major incident dressings packs provided at all major transport hubs.

- **Ambulance Safety Officer(s) – ('Bronze Safety')**

The Ambulance Safety Officer will be responsible for the overall safety of all Ambulance and NHS staff at the scene and must ensure that the environment and working practices at the scene do not place any staff at undue risk. Other duties of the Ambulance Safety Officer include:

- Identification of specific hazards
- Liaison with the multi agency safety officers
- Ensuring that correct PPE is worn
- Identification of stress/fatigue in staff
- Monitoring rest and refreshment periods

- **Primary Triage Officer - ('Bronze Triage')**

The Primary Triage Officer will co-ordinate the triage sieve of casualties at the incident site.

Other duties of the Primary Triage Officer include:

- Ensuring all casualties are sieved
- Ensuring only basic airway management is performed
- Ensuring all casualties are correctly labelled

- **Secondary Triage Officer - ('Bronze Secondary Triage')**

The Secondary Triage Officer will carry out the triage sort of casualties at the Casualty Clearing Station.

Other duties of the Secondary Triage Officer include:

- Ensuring all casualties are continually sorted
- Ensuring all casualties are correctly labelled

- **Casualty Clearing Officer - ('Bronze Clearing')**

The Casualty Clearing Officer will co-ordinate the treatment and evacuation of casualties to the receiving hospitals through the sieve and sort process.

Other duties of the Casualty Clearing Officer include:

- Arranging the siting and set up of a casualty clearing station
- Ensuring that casualties that are held at the casualty clearing station are triaged by a Secondary Triage Officer
- Ensuring that patient documentation has commenced
- Handing over patients to Bronze Loading

- **Forward Medical Incident Officer - (Bronze Doctor')**

The Forward Medical Incident Officer will assist with clinical treatment of patients as required and task any medical teams as required.

- **Ambulance Liaison Officer (ALO) – (Bronze suffix name of the receiving hospitals)**

Each hospital that has been placed on major incident alert will have an ALO appointed to it. This will normally be the local Sector Training Officer. The ALO's prime responsibility is for ambulance crew welfare and collation of patient numbers. Other main tasks and duties include:

- Providing equipment & consumables to restock vehicles
- Ensuring crew staff update their status with EOC
- Ensuring that triage tags are used
- Facilitating the quick turn around of ambulances
- Ensuring that staff welfare issues are considered for crew staff
- Maintaining a log of vehicle details and patients arriving

- **Hospital Liaison Officer (HLO)**
- The HLO is the second ambulance officer to be deployed to each hospital on major incident declaration. This will normally be the local PTS manager. The HLO's prime responsibility is to liaise with the hospital control team. Other main tasks and duties include:
  - Ensuring that liaison has commenced with the hospital control team, the police documentation team and the ALO
  - Ensuring that ambulance equipment is released from the hospital as quickly as possible
  - Ensuring that assistance is provided with the decanting of patients
  - Arranging specialist hospital equipment that is required at scene

4.5 Hazardous Area Response Team (HART)

HART is the specialised team of Service staff who have been trained to administer life saving medical care in hostile environments such as industrial accidents, natural disasters, terrorist incidents and CBRN/Hazmat incidents. They are capable of delivering this care whilst using a range of Personal Protective Equipment which is not normally available to Ambulance Personnel.

ROLE
The role of the Hazardous Area Response Team (supported by technical and scientific advice) is to provide a rapid response to;

1. Any CBRN/HAZMAT incident
2. Any Major/Catastrophic/Critical Incident (non-CBRN/HAZMAT) which requires a combined response from all three emergency services and where the assessment, incident and casualty management is within a potentially hazardous area
3. Any intelligence led operations which would, under normal circumstances, remove core resources to be deployed away form normal duties
4. Any pre-planned event requiring a tactical CBRN response to support the overall multi-agency incident plan

The role of the Hazardous Area Response Team is to provide:

- Health input to the initial assessment of the scene
- Undertake a scene assessment directly related to the needs of the ambulance and other health services
- In collaboration with partners identify the Inner Cordon and the Hot Zone
- Initial triage and immediate life saving treatment
- Hazard Identification
- Casualty confirmation
- Estimation of the resources required
- Command & Control in a CBRN/Hazmat Hot/Warm Zone overseeing
    - On going resource requirements
    - Ambulance/Health resource management
    - Casualty management
    - Evacuation

• Additional LAS CBRN command structure

- **Decontamination Unit Officer - (Bronze Decon)**

The Bronze Decontamination Officer is located in the clean area and reports to the AIO.

- Liaison with Bronze Medic and the CBRN tactical advisor
- Liaison with Police and Fire Service Commanders
- Ensuring that sufficient resources have been mobilised and arrangements made for their reception
- Inspection of all Decontamination operators that are to enter the warm zone to ensure that the CPPE is donned correctly
-
- Ensure appropriate comms/radios are available for all Ambulance Decontamination team operators
- Ensuring the health and safety of all Ambulance staff in the Warm Zone

- **CBRN Tactical Support Officer (TSO) - (Tango Sierra)**

The CBRN TSOs main function is to advise the AIO on decontamination issues. The TSO will be decontamination trained, and will have experience in managing decontamination incidents at this level.

4.6 Logistics Department

In the event of a major incident the role of the Logistics Department is to provide additional equipment, drugs, disposable blankets, medical gasses and some consumables as requested by ICR. In addition, logistics staff will liaise closely with suppliers and procurement to place emergency orders and ensure stocks are replenished.

In the event of a prolonged incident, the department will arrange refreshments for operational staff.

Initial Actions by Logistics

The on-call Logistics Manager will have overall responsibility for co-ordinating the Logistics response and if instructed will report to the Gold Command Suite. The on-call Logistics Manager will continue to have overall responsibility until the Head of Operational Support or their nominated deputy takes charge. The Officer in Charge for the Logistics Department will delegate tasks to relevant Logistics Managers as necessary.

Post Incident Activities

- Replenishment of drugs and consumable stocks.
- Recovery of equipment left at scene.
- Restocking of pod vehicles.
- Replenishment of hot cans/packs and water.

4.7 Co-ordinating meetings – overview

It is important to emphasise that it is essential that the first supervising officers on scene from each of the emergency services liaise closely with each other at the earliest opportunity.

Minutes, or a note of decisions taken must be kept of all meetings of the co-ordinating groups. It is also essential that individual LAS members of the group make their own notes of meetings.

4.8 Gold co-ordinating meetings

The Gold group will meet at a location detached from the scene with suitable communications and meeting facilities. In general the nature and difficulties of the incident will govern the frequency of Gold meetings.

The Gold co-ordinating group meetings will follow the standard template which is provided in the Gold Command Suite. The group will determine the strategic issues relevant to the incident. In addition, the group may provide liaison with central government and other bodies and ensure that sufficient support and resources are available to the incident. Gold group members will execute actions from the action cards provided.

4.9 Silver co-ordinating meetings

The Silver co-ordinating group should meet close to the scene.

The Incident Officers will call an initial meeting of the Silver co-ordinating group at the earliest reasonable opportunity.

The agenda should be based around the following:

- Safety
- situation reports
- priorities
- future developments.

The LAS should briefly describe the situation as it affects its own operations and mention those matters for which it requires the assistance or co-operation of others.

5. HOSPITALS AND THE NHS

5.1 Hospital Alerting Procedures

It is the responsibility of the Ambulance Service to select and alert the most appropriate receiving hospital(s). Where a number of listed hospitals with Accident & Emergency Departments are situated within a reasonable distance of a major incident, casualties will be distributed among them.

Receiving hospitals need a clear message that a major incident may be imminent or has been declared. For this reason, the alerting messages have been standardised. In order to avoid confusion about when to implement plans it is essential to use these standard messages.

All receiving hospitals will continue their essential function of receiving non-incident related casualties throughout the major incident.

Less severe casualties will generally be taken to hospitals further away from the incident.

5.2 Major Incident - Standby

This alerts the hospital that a major incident may need to be declared. If the incident is not upgraded to declaration, limited numbers of patients from the incident can be conveyed to a hospital on major incident standby. Where the numbers are not limited the incident must be upgraded.

When information reaching EOC indicates that a serious incident has occurred which could develop into a major incident, the appropriate receiving hospital(s) will be notified immediately.

Contact will be made through their hospital switchboard (or other major alert numbers where provided) in the following terms:-

"THIS IS THE LONDON AMBULANCE SERVICE EMERGENCY OPERATIONS CENTRE. THIS IS TO NOTIFY YOU THAT YOUR HOSPITAL IS ON MAJOR INCIDENT STANDBY, ...(NUMBER) OTHER HOSPITALS HAVE BEEN ALERTED" - followed by:-

a) Type of incident
b) Location (s)
c) Types and estimated numbers of casualties

5.3 Major Incident declared - activate plan

This alerts the hospital that they need to activate their plan and mobilise extra resources.

If a Major Incident is confirmed the standby will be upgraded and the hospital(s) will be informed that:

"THIS IS THE LONDON AMBULANCE SERVICE EMERGENCY OPERATIONS CENTRE. THIS IS TO NOTIFY YOU THAT A MAJOR INCIDENT HAS BEEN DECLARED. ACTIVATE YOUR PLAN,.....(NUMBER) OTHER HOSPITALS HAVE BEEN ALERTED" -followed by:-

a) Type of incident
b) Location (s)
c) Types and estimated numbers of casualties

NB: "Major Incident Declared" can be instigated without the "Standby" phase if circumstances dictate.

5.4 Major Incident - cancelled

This message rescinds either of the first two messages at any time.

If having instigated MAJOR INCIDENT - STANDBY or MAJOR INCIDENT - DECLARED it is found not to be required, it should be rescinded by the message:-

"THIS IS THE LONDON AMBULANCE SERVICE EMERGENCY OPERATIONS CENTRE THIS IS TO NOTIFY YOU THAT YOUR HOSPITAL IS NO LONGER REQUIRED TO STANDBY FOR THE INCIDENT AT..... THANK YOU FOR YOUR ASSISTANCE"

5.5 Major Incident - scene evacuation complete

This alerts all receiving hospitals as soon as all casualties have been removed from the site.

When confirmation is received from the scene that casualty evacuation is complete the appropriate receiving hospital(s) will be informed by:-

"THIS IS THE LONDON AMBULANCE SERVICE EMERGENCY OPERATIONS CENTRE. THIS IS TO NOTIFY YOU THAT THE SCENE EVACUATION IS COMPLETE ALTHOUGH WE STILL HAVE, ...(NUMBER OF) CASUALTIES EN ROUTE TO YOUR HOSPITAL"

Ensure that details of any known/expected casualties en route for the hospital(s) are given to the hospital(s) concerned.

5.6 Hospital Teams: Medical Emergency Response Incident Team (MERIT)

The LAS (AIO and MIO) has the responsibility within the initial stages of the incident to determine the need for a MERIT to be mobilised to a major incident. The role and function of the MERIT is to provide support to LAS staff in triage, treatment and to provide specialist interventions (for example; analgesia, amputation kits, burn assessment & treatment).

5.7 The wider NHS

Hospital and Ambulance Services Trusts are responsible for deploying the correct healthcare resources to care for casualties either at the scene or at a hospital site. Each will mobilise local resources to the maximum extent, consistent with maintaining essential care.

Primary Care Trusts will mobilise and direct healthcare resources to local hospitals at short notice to support them and to sustain patients in the community should these hospital services be reduced or compromised for a period.

The Strategic Health Authority will take strategic control of any incident that affects, or seems likely to affect, several hospitals, or have a significant impact on primary care.

The Department of Health is responsible for national oversight and monitoring of all incidents that result in activation of a major incident plan.

Health Protection Agency will provide specialist health emergency advice to the DH, SHA & NHS. They will provide both advice and capacity to deal with communicable diseases and chemical incidents and their Radiological Protection Division (RPD) will work to create similar capability for nuclear and radiological incidents.

5.8 Helicopter Emergency Medical Service (HEMS)

The helicopter must only be mobilised to a major incident following a direct request from the AIO. The aircraft may be used to transport medical personnel or equipment as well as in its primary patient treatment role.

If the helicopter conveys a patient to a hospital, ICR must be notified immediately.

5.9 The Medical Incident Officer (MIO) Pool

The LAS has established and operates a "MIO Pool' arrangement to serve Greater London. The protocol should provide for the activation of four or five doctors as follows:

(i) One doctor to be deployed as Gold Doctor (LAS HQ)
(ii) One doctor to be deployed as MIO (Silver Doctor)
(iii) One doctor to be deployed as Forward MIO (Bronze Doctor)
(iv) One or two doctors to attend the scene for tasking by the MIO

Should it become necessary to request the provision of a MIO from an acute hospital by way of 'back up', the LAS will always seek to call upon a non activated receiving hospital.

6. CASUALTY MANAGEMENT

6.1 Uninjured evacuees

People that have been involved in an incident and do not require medical intervention are categorised as "uninjured". Once these people have been removed from any hazards and processed through a triage sieve by the LAS they must be handed over to the Police for collation of details and witness statements. It would be usual for these people to be housed at a "survivor reception centre". The LAS may be requested to provide temporary medical cover at a "survivor reception centre". **These casualties must where possible be given an LAS post incident actions business card offering other NHS assistance if needed.** Post incident actions business cards are available on the DSOVs/DOVs or from the EPAs

6.2 Principles of triage

The LAS aim at any multiple casualty incident is to produce the largest number of survivors. In simple terms we need to deliver the right patient to the right place at the right time so that they receive the optimum treatment.

During an incident the LAS will use two levels of triage - these are referred as "triage sieve" and "triage sort". Both triage systems use algorithms to determine which priority group a patient falls into. The priority groups are as follows:

Priority	Description	Colour
1	Immediate	Red
2	Urgent	Yellow
3	Delayed	Green
4	Expectant	Red with Blue Corner
Dead	Deceased	White or Black

6.3 Triage sieve

The first ambulance crew or responder on scene of a multiple casualty incident must ensure that the role of "Primary Triage Officer" is allocated. Ideally this will be the second ambulance crew or responder on scene. This bronze role has the responsibility to commence a triage sieve.

This triage sieve quickly sorts out casualties into priority groups. Each LAS vehicle has a triage belt pouch pack consisting of 20 triage cards. Using the algorithm card attached to the pouch the staff member given the responsibility of triage sieve must systematically work through the patients, triaging and labelling them.

6.4 Triage sort

On the arrival of further resources, patients are moved to a place of safety, usually the casualty clearing station. At this location they can be re-triaged using a triage sort, which in essence is the Triage Revised Trauma Score (TRTS). This system is based on three parameters: respiratory rate, systolic blood pressure and the Glasgow Coma Scale.

The Secondary Triage Officer carrying out a triage sort on a patient should use the triage card that has been attached to the patient during a triage sieve, noting the findings of the TRTS on the card and then updating the triage category by refolding the card as necessary.

6.5 Expectant category

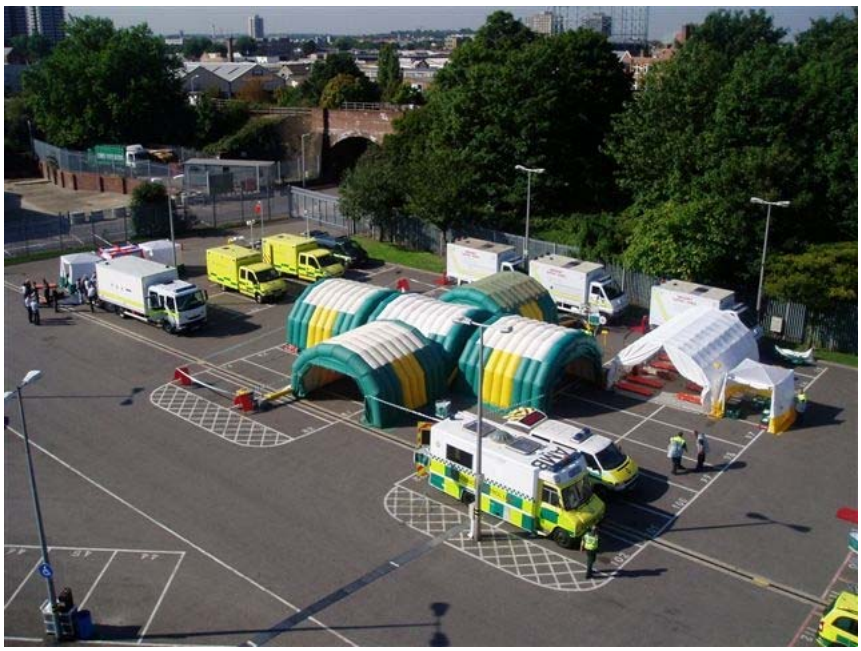
The expectant category is only used following the authority of Gold Medic. This situation arises when there are such large numbers of patients the ability of the LAS to respond to the clinical needs of every individual is compromised. Patients with potentially unsurvivable injuries will not be treated. These patients are treated the same as the dead. This allows the LAS to “do the best for the most patients”.

Expectant patients must be triage labelled as "immediate priority 1" which is red in colour but with a blue flash corner folded so that it is visible.

6.6 Casualty clearing station and ambulance loading point

The casualty clearing station is a place of relative safety to which casualties are conveyed from the incident site. Triage sort, assessment, treatment and stabilisation are carried out by LAS staff together with any mobile medical teams on scene at the station. The casualty clearing station is co-ordinated by the LAS Bronze Clearing officer, and where possible a senior doctor.

A suitable area or building between the inner and outer cordons near to the site should be identified for use as the casualty clearing station. The LAS have a number of tents held on the Emergency Support Vehicles (ESV) for this purpose. There are three coloured, single person erection tents on each ESV that should be used during initial set up. There is an inflatable tent on each ESV that if connected together can produce a "field hospital".



Once sufficient resources have arrived on scene it is vital that patient documentation starts within the casualty clearing station.

6.8 Blue calls and status reporting

All staff that convey patients to a hospital have a responsibility to ensure that EOC have been advised of the patient's triage priority, gender, and age. There is no requirement to provide blue calls due to the hospital's readiness to receive multiple casualties.

6.9 Arrival at hospital

Once the patient arrives at the hospital the patient will be re-triaged by hospital staff. The ambulance crew must ensure that they report their arrival with both EOC and the ALO at the hospital.

Where possible equipment should be retrieved and returned to the incident site. Crews may replenish some equipment through the ALO.

The ALO has a responsibility to retrieve every patient's LAS triage card. Where cards cannot be retrieved, photocopies should be made and returned to the EPU.

6.10 Labelling and documentation

Documentation of patients must start as soon as possible. Triage labels must be attached to patients in the initial stages of the incident even if there is no opportunity to collect personal details. Details of each patient should be collected as soon as they enter the casualty clearing station/area.

It may not always be possible for ambulance crews to record the usual details of patients carried on the Patient Report Forms (PRF). In this event records should be made by description, e.g. "elderly man", "teenage girl" etc. Ambulances should not be delayed at the scene in order to obtain personal details of individual casualties, which will be obtained by the police at the receiving hospitals. In all circumstances the triage label must be completed. It is particularly important that those patients who have received drugs can be readily identified on admission to hospital.

6.11 Use of buses and coaches

Within the assessment for required resources at the scene of the incident it may be appropriate to commandeer a coach or single decker bus. Where possible staff will request provision of buses or coaches via EOC. Police escorts should be considered in case of a patient deteriorating enroute to hospital. Patients should be accompanied on the bus to hospital by LAS staff. Red Cross buses should be the first option considered.

6.12 Urgent Care Service (UCS) and Patient Transport Service (PTS)

The primary role for the UCS within a major incident, is to provide support for A+E by making up for the inevitable shortfall in the rest of London, as 999 calls continue to be received for other incidents.

UCS also have a list of contact numbers for several private ambulance services.

In the Urgent Operations Centre (UOC) are Clinical Telephone Advice (CTA) staff. They may be utilised ringing back callers and advising that the LAS is dealing with a large incident and that they may need to make other arrangements.

Overview

The use of LAS PTS vehicles and resources should be considered at the earliest opportunity and a request made through the on call PTS senior Officer.

PTS operate a fleet of double and single manned vehicles including some with stretcher capability from a number of hospital sites across London. All of these vehicles have multi-occupancy capacity and a number of the stretcher vehicles also have blue light capability.

PTS will provide proportionate, scaled support to the incident as requested by the Service, this can include all or some of the following;

Command

PTS Gold (*Strategic*) – The on call Senior PTS manager who will be an integral part of the LAS Gold Co-ordinating Group within LAS HQ.

PTS Operations Officer (*Tactical*) – The on call PTS Manager who will be designated by PTS Gold on notification of the incident. They will coordinate PTS resources in support of the incident and maintain other PTS commitments.

PTS Bronze FUP (*Operational*) – A PTS manager/Team Leader responsible for the formation, equipping, briefing and dispatch of PTS vehicles at the nominated PTS Forming Up Points (FUP).

PTS Liaison Officer (*Operational*) – A PTS Manager/Team Leader who will attend the scene and act as the focal point for PTS resources, this Cell Leader can be utilised on scene to support the incident command team as required.

HLO (*Operational*) – A PTS manager/Team Leader who can attend nominated hospitals and fulfil the Bronze HLO role.

Control

PTS Central Services Control – PTS operate a central control point within UOC in addition to the various onsite local hospital controls. This will control PTS resources deployed in support of an incident.

PTS & Urgent Care Clinical Support – A suitably qualified clinician can provide advice and support to crews and control staff to assist in the dispatch of calls.

Transportation

Initial Vehicles – PTS can deploy vehicles from the Central Services fleet directly to the incident RVP, or alternative identified location to assist with the rapid removal of Priority 3 patients. Out of hours the on call Senior PTS Manager should be contacted.

Additional Vehicles – PTS can supply additional vehicles to support the incident. These would be deployed in cells of up to five vehicles. The cells would be assembled at a nominated PTS Forming Up Point (FUP) prior to deployment to the RVP or alternative agreed location.

Support

PTS Support Coordinator – A nominated PTS manager, or team led by a manager, who will coordinate support activities such as requests for staff or equipment movements.

7. MANAGEMENT OF THE MEDIA

7.1 Introduction

Within a short period of time following a report of a major incident, the media will focus in large numbers on the scene, the survivors/relatives reception centres, receiving hospitals and the mortuary.

The media response is likely to have three distinct phases:

a) An immediate response by regional communication, radio and television, followed quickly by support from their parent offices.
b) A secondary response from the major United Kingdom outlets and news agencies.
c) Substantial foreign communication interest, particularly if foreign nationals are amongst the casualties.

The most suitable response to communication requests will depend on the circumstances. Experience has shown that it is normally best to take and maintain the initiative by providing a regular flow of information rather than allow speculation to develop, which might cause public alarm or adversely affect the management of the incident. On-going situation reports and information should be made available as required. Arrange communication conferences, interviews and filming sessions and allow the LAS communication officer to bear the main burden of dealing with the media. Normally the Police Liaison Officer will be the single source for media information of general nature.

7.2 Media enquiries on scene

Where appropriate the Police set up a "Media Liaison Point" outside the outer cordon. An ambulance officer of a senior rank should be designated as a spokesperson to work in liaison with other emergency service representatives. The media liaison point will act as a point of reference for accredited communication and broadcasting representatives. The approach adopted towards the media will be particularly important and it is essential that all spokespersons avoid issuing contradictory, conflicting, incorrect or premature

statements. Under no circumstances should LAS personnel speculate on the cause of the incident or issue premature estimates of the numbers of casualties.

Any member of LAS staff approached by the media should refer them to the LAS Communication Officer.

7.3 Media enquiries in EOC

An EOC manager should be designated to deal with media enquiries received at EOC - outside office hours they are limited in the information they can give, following consultation with the on-call communications officer.

1. The time of the call to the LAS and the nature of the incident
2. The number and the sex of the people involved.
3. The hospital to which casualties have been conveyed.

7.4 Communication Officers

During the initial stages of the incident the on call Communication Officer must be paged using the red major incident paging instruction. On the receipt of this information the on call Communication Officer will respond accordingly. Dependent on the information that is on the pager message they may respond direct to the scene or to EOC.

The communication office team will ensure that at least one Communication Officer has been dispatched to the scene of the incident and where possible another Communication Officer will go to EOC/ICR. Communication officers will bring their major incident grab packs to the scene of any incident ensuring that they have their major incident tabard and relevant documentation with them.

Arrangements should be made to obtain the services of the LAS Communication Officers at the earliest possible opportunity.

7.5 Post incident

The LAS Communications department will endeavour to obtain media statements and coverage on behalf of the ambulance service. This may involve interviews with responding staff, articles in newspapers or other media. In all cases the Communication Officers will support LAS staff that are assisting with media interviews on behalf of the service.

7.6 Terrorist incidents

All media enquiries regarding terrorist incidents must be referred to the Communication Bureau at New Scotland Yard and no further comment made.

8. VOLUNTARY ORGANISATIONS

8.1 Use of resources

The LAS will maximise the use of the support offered by the Voluntary Aid Societies (VAS) during a major incident. Generally this support will fall into two areas:

- At the scene
- In support of core fleet operations

The Salvation Army and the British Association of Immediate Care Scheme (BASICS) are usually called immediately to the scene to provide assistance. The Salvation Army have a number of catering units that support LAS staff with the provision of refreshments. BASICS assist the LAS with the provision of additional doctors who provide extended care skills in support of LAS staff.

The role of St John Ambulance is to assist with core fleet duties i.e. 999 calls or urgent work back log when requested

The role of the British Red Cross is when called to the scene they will provide resources for the evacuation of P3 casualties.

Both organisations will deploy a duty officer to ICR for liaison purposes during the major incident.

All resources will be activated by ICR in consultation with the Tactical Advisor and AIO following a Gold decision.

9. POST INCIDENT ACTIVITIES

9.2 Operational activities

Post incident, the LAS has a duty to ensure that operational procedures are carried out to restock and maintain the fleet. Debriefing is a very important process in order for the LAS to gain from lessons learnt, make recommendations for change to our partners, and adapt service protocols if needed. It is therefore the EPU who have the responsibility on behalf of Gold to organise, chair and administer major incident debriefs - monitoring the progress of actions as necessary.

Post incident the LAS has a responsibility to ensure that the following procedural and administrative activities are carried out:

a. A "hot debrief" immediately after the incident chaired by the Ambulance Incident Officer and to include the circulation of welfare information
b. The re-stock of LAS resources including control rooms, NHS Pods, vehicles
c. "Stand down" time for all LAS staff involved
d. Feeding of staff where necessary
e. The collation of all paperwork and voice recordings to form a primary transcript record
f. All members of staff receive a debrief proforma
g. All operational and EOC command officers to submit a report to the EPU
h. An internal LAS ICR debrief
i. An internal LAS major incident debrief
j. Lessons learnt and debrief actions to be allocated

9.3 Debriefing

The LAS internal debriefing process should be followed at an early opportunity by a joint medical services debrief involving representatives from all the medical organisations involved in the incident The joint medical service debrief should be organised by the ambulance service who should also supply the Chair and secretarial support.

Information gathered from these debriefings can then be presented, where appropriate, to the Joint Services debriefing, usually organised by the Police Service. This will review the response overall, identify any lessons and any revision required to the existing plans.

It must be remembered that the notes taken at debriefs are subject to legal rules on disclosure and may form the basis of evidence before an inquiry.

The LAS have an obligation under the Controls Assurance process and the Civil Contingencies Act 2004 to assess their compliance with emergency planning requirements and must review, improve and test this plan on a regular basis. Lessons learnt are the basis of this process.

9.4 Post traumatic activities

Post incident the LAS have a moral and legal duty to consider staff's psychological needs after exposure to a potentially traumatic incident. The use of LINC workers is good practice and should be used for those who need support after an incident. LAS HR/welfare services will coordinate the support of staff post incident.

9.5 Recovery from Major Incident

- Consider early release of operational staff and vehicles from scene if near to “scene evacuation complete” declaration.
- Amalgamate resources if multi site incident is near to closure for the LAS on scene.
- Resource centres to view in collaboration with Gold, rota changes due to core cover Vs incident cover.
- Service Business Continuity Plan to be viewed in relation to return to normality through the whole of the LAS.
- Welfare aspects of all staff to be viewed as to what action to take over the following days/weeks.
- Hot de-brief actions to be implemented.
- Service de-brief dates to be viewed in collaboration with other supporting agencies and LESLP partners.

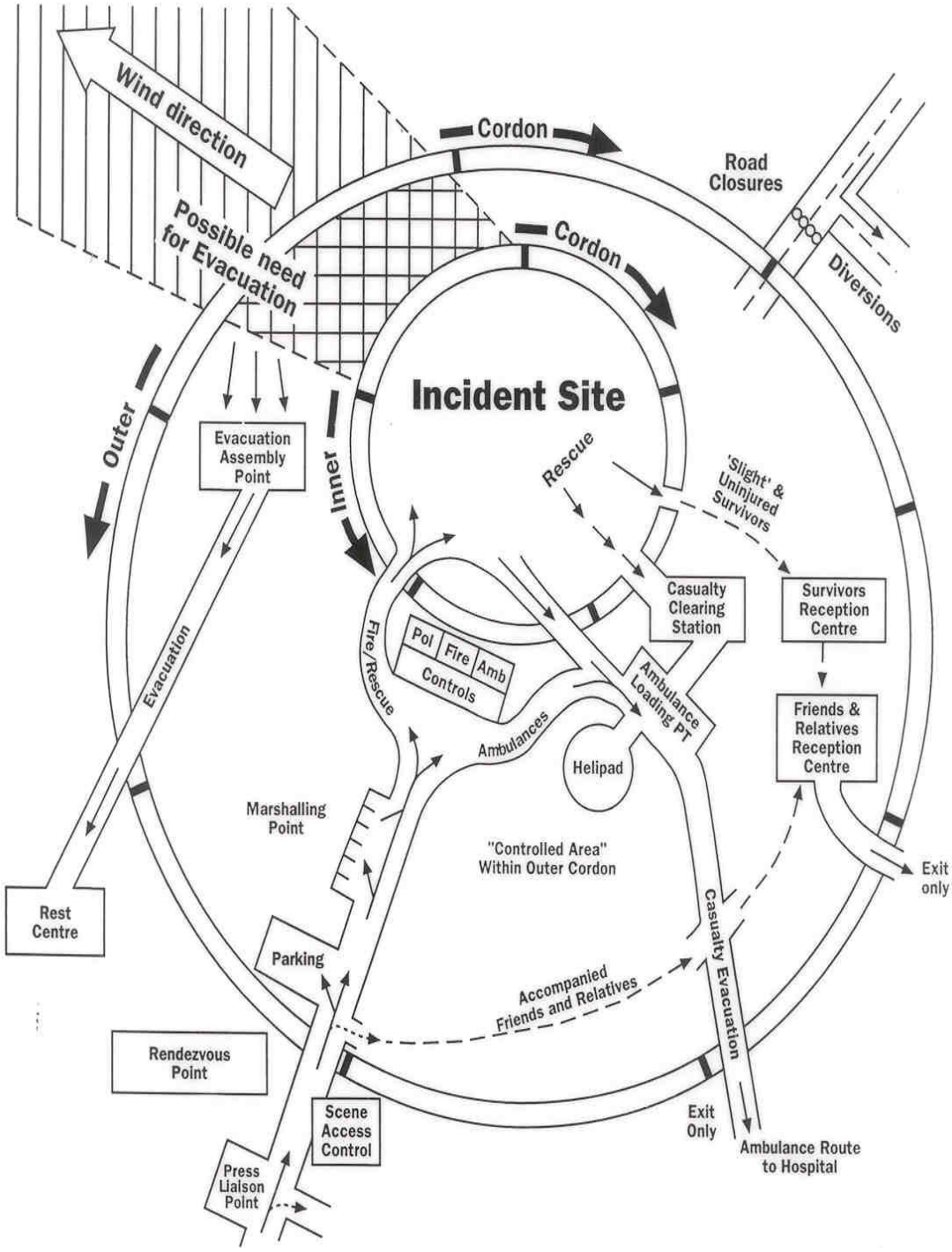
9.6 Occupational Health Service

Post incident personnel that have been referred by a LINC worker will initially be offered a professional counselling service at the Occupational Health Service.

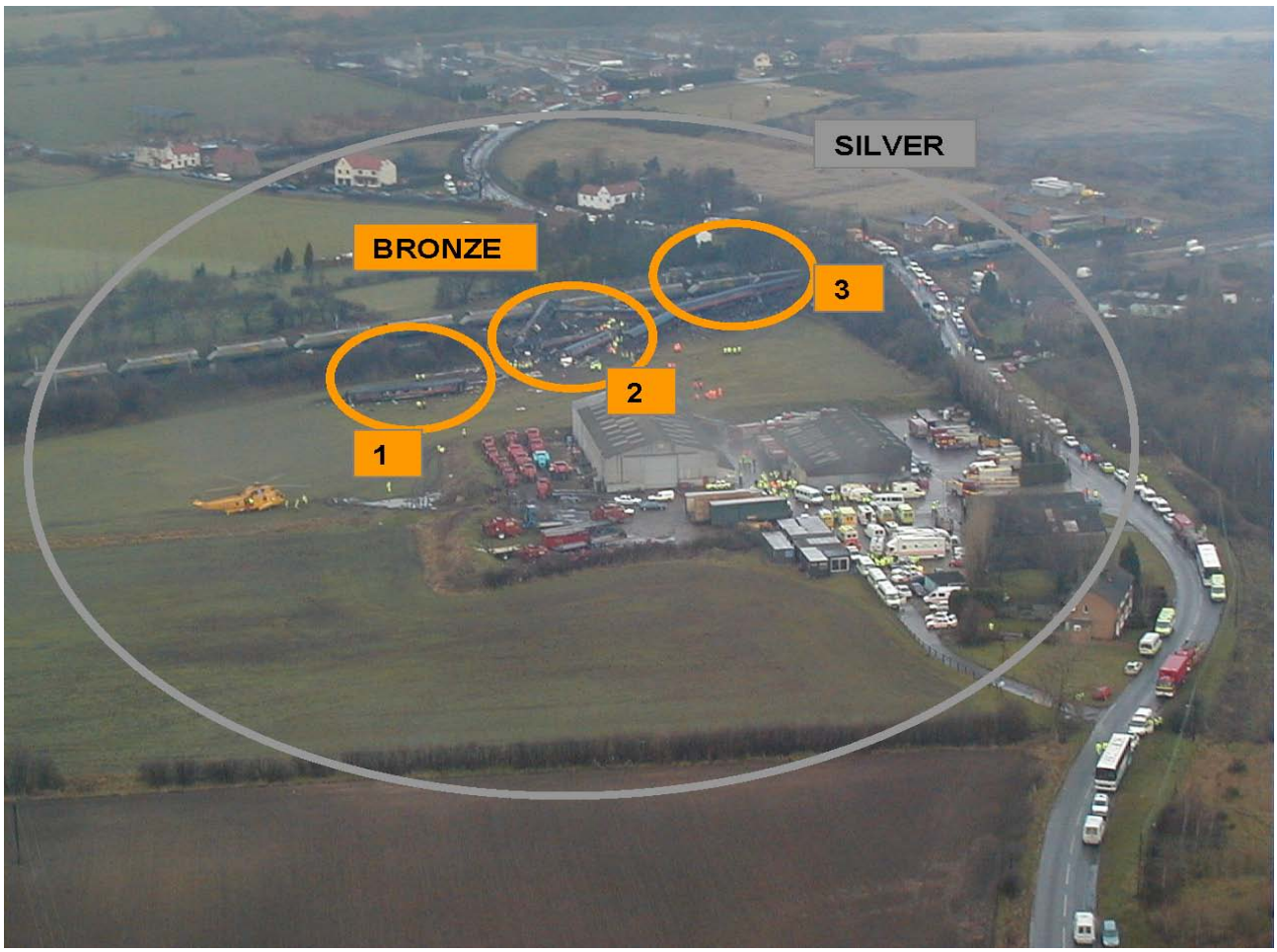
In the event that the LAS LINC worker system is saturated post incident, the Occupational Health Service will instigate a support system for the “debriefing” of staff.

Staff may self refer to the Occupational Health Department at anytime.

Appendix 1: Incident site diagram



Appendix 2 – Bronze and Silver responsibility sectors



GLOSSARY OF TERMS

AMBULANCE CONTROL POINT:
A point at which a specially equipped vehicle (ECV or CCV) is sited, at the scene of a Major Incident, to operate as an Ambulance and or Medical Control Point. It provides a reporting, co-ordinating and communications centre for ambulance, medical, nursing and voluntary aid personnel. This point will be established in close proximity to the Police and Fire Service Control vehicles subject to radio interference constraints.

AMBULANCE EQUIPMENT OFFICER:
An Officer responsible for the mustering, issue and collection of all patient care equipment on site. He/she will maintain control of the Emergency Support Vehicle's equipment and will replenish on site stocks as necessary. He/she will direct, in liaison with the AIO, the on site distribution of stretcher bearers assembled at this point.

AMBULANCE FORWARD INCIDENT OFFICER:
An Officer who, under the direction of the AIO, co-ordinates health care resources at Forward Control Point(s).

AMBULANCE INCIDENT OFFICER (AIO):
The Officer in overall control of Ambulance operations at the site.

AMBULANCE LIAISON OFFICER (ALO):
An Officer responsible for providing liaison with ambulance crews and hospital receiving staff from a Major Incident. The officer is based at the hospital.

AMBULANCE LOADING OFFICER:
An Officer responsible for the management of the Ambulance Loading Point. He/she will ensure that casualties are documented and evacuated in priority order. He/she will maintain control over vehicle access/egress and personnel operating within this area.

AMBULANCE LOADING POINT:
An area, preferably on hard standing and in close proximity to the Casualty Clearing Station, from where casualties are evacuated in order of priority.

AMBULANCE PARKING OFFICER:
An Officer responsible for the management of the Ambulance Parking point. He/she will direct vehicles and staff forward to the Ambulance Loading Point as required.

AMBULANCE PARKING POINT(s):
Point(s) designated at the scene of a Major Incident where incoming Ambulance resources report and are held in readiness for forward deployment, thus avoiding congestion at the entrance to the site or at the Ambulance Loading Point.

AMBULANCE SAFETY OFFICER:
An officer appointed to ensure the safety of all LAS & medical staff working within the incident boundary and that they are correctly dressed in PPE.

AMBULANCE TACTICAL ADVISOR:
An Emergency Planning Advisor appointed to assist and advise the AIO on Major Incident protocol.

CASUALTY EVACUATION COMPLETE:
Term used to indicate that treatment and removal of casualties from the scene is complete.

COMAH:
Control of Major Accident Hazards Regulations.

CASUALTY BUREAU:
Central information point for all records and data on casualties. Maintained by Police service.

CASUALTY CLEARING STATION:
An area set up at a Major Incident by the Ambulance Service in liaison with the Medical Incident Officer to assess, treat and triage casualties and direct their evacuation.

CASUALTY CLEARING OFFICER:
An Ambulance Officer who, in liaison with the Medical Incident Officer, supervises assessment/labelling of casualties for evacuation in accordance with triage priorities.

EMERGENCY OPERATIONS CENTRE (EOC):
Permanent Operations Room which receives, collates, and co-ordinates all demands for the A&E service in the geographical area covered by the London Ambulance Service and allocates resources accordingly.

CO-ORDINATING GROUP:
The Gold/Silver Commanders of the emergency services who convene to consider/review strategy/tactics relating to the co-ordination of activity at a Major Incident.

EMERGENCY CONTROL VEHICLE (ECV):
Specially equipped communications vehicle sighted at the scene of a Major Incident to operate as the Ambulance Control Point.

EMERGENCY SUPPORT VEHICLE (ESV):
Vehicle equipped with specialist patient care equipment, Major Incident stocks of stretchers, blankets, patient care backpacks, inflatable tents, emergency lighting etc.

EQUIPMENT/STRETCHER BEARER POINT:
Point where bulk supplies for First Aid equipment, blankets and stretchers are available. Point where able-bodied persons are assembled to assist with the on site transfer of casualties by stretcher, to the Casualty Clearing Station or the Ambulance Loading Point.

FORWARD AMBULANCE CONTROL POINT:
A selected point, near or at the scene, where the AIO/Forward Incident Officer can direct the operation. There may be a requirement for more than one Forward Control. Forward Control(s) will maintain a communications link with the Ambulance Control Point.

FORWARD CONTROL TEAM:
A radio operator trained member of EOC staff who assists the command team with radio communications and records the AIO log.

HOSPITAL LIAISON OFFICER (HLO):
An officer responsible for providing liaison with the hospital control team staff during a Major Incident. The officer is based at the hospital.

INNER CORDON:
Surrounds the immediate scene and provides security for it.

JOINT EMERGENCY SERVICES CONTROL CENTRE (JESCC):
The point from which the management of the incident is controlled and co-ordinated. All Emergency Services are represented at this location.

LESLP:
London Emergency Services Liaison Panel

LOCAL AUTHORITY EMERGENCY PLANNING OFFICER:
Co-ordinator of a local authority's response to Major Incidents etc.

MACC:
Military Aid to the Civil Community.

MAJOR INCIDENT CANCELLED:
The term used to cancel a Major Incident Alert.

MAJOR INCIDENT DECLARED - ACTIVATE PLAN:
The term used to prefix messages to confirm a Major Incident.

MAJOR INCIDENT STANDBY:
The term used to prefix messages indicating that an incident may have or has occurred which could result in a large number of casualties.

MARSHALLING AREA:
Area to which resources and personnel not immediately required at the scene, or being held for further use, can be directed to stand by.

MEDIA CENTRE:
Central contact point for media enquires, providing communication and conference facilities and staffed by spokespersons from all agencies involved.

MEDICAL INCIDENT OFFICER (MIO):
The medical officer with overall responsibility, in close liaison with the AIO, for the management of the medical resources at the scene of the Major Incident. He/she should not be a member of any mobile team.

MEDIA LIAISON POINT:
Rendezvous and initial holding area, at or near the scene, designated for use by accredited media representatives prior to establishment of a media centre.

MEDIA LIAISON OFFICER:
Officer responsible for the initial release of information from the scene of the incident and liaison with other Services at the Medical Centre.

MOBILE EMERGENCY RESPONSE INCIDENT TEAM (MERIT):
A medical team who will attend the incident site to assist the triage and treatment of casualties. The ambulance service will alert and organise transportation for the team to the incident site.

OUTER CORDON:
Seals off an extensive area to which unauthorised persons are not allowed access.

POST TRAUMATIC STRESS DISORDER (PTSD):
Stress caused as a direct result of a traumatic event causing both physical and psychological symptoms.

PRIMARY TRIAGE OFFICER:
Officer responsible for the co-ordination of the triage sieve of casualties at the incident site.

RECEIVING HOSPITAL:
Any hospital listed as having facilities to receive and treat patients who are seriously injured or critically ill resulting from a Major Incident, on a 24 hour basis. Should have facilities for provision of MIO and MERIT at request of ambulance service.

RENDEZVOUS POINT(S):
A point usually nominated by the Police, as a safe area to which all vehicles and personnel must report before proceeding to the incident site or parking points. A Rendezvous Point (RVP) will generally be identified at any high risk location for the initial mustering of Emergency Service Vehicles, (Airport, COMAH site etc.).

SECONDARY TRIAGE OFFICER:
Officer responsible for the triage sort of casualties at the Casualty Clearing Station.

SENIOR CO-ORDINATING GROUP – See Co-ordinating Group

SENIOR INVESTIGATING OFFICER (SIO):
The Senior Detective appointed to assume responsibility for all aspects of the Police Investigation.

SURVIVORS RECEPTION CENTRE (SRC):
Secure premises to which those who have been directly involved in the incident and are uninjured can be taken.

TRIAGE:
The prioritising of casualties in respect of their injuries. On this basis an effective casualty evacuation plan will be implemented.

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

REPORT ON MANAGING SICKNESS

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

Managing attendance and thereby maximising the availability of our staff continues to be a priority and a challenge for managers in the LAS.

The attached report provides context to some of those challenges and reports on current management of and subsequent impact on sickness absence within the Trust.

4. Recommendation

THAT the Trust Board note the report.

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board – 25 September 2007

MANAGING SICKNESS

1. Background

1.1 Managing attendance, and thereby maximising the availability of our staff, continues to be a priority for managers in the LAS. It is generally recognised that organisations which have shift working, work that is physically and emotionally challenging, and a dispersed workforce will tend to experience a higher rate of sickness absence than average. Although all these characteristics are common to most of the NHS, in ambulance services they apply to a greater extent and to a larger proportion of the total workforce. This results in higher levels of sickness absence in ambulance services generally than other parts of the NHS. In addition, most ambulance services have a significant number of staff working in Control Services and again the call centre environment is notorious for high sickness levels. With this in mind, however, the LAS's aim is to manage sickness absence effectively and minimise the negative impact high levels of absence can have on the organisation and its provision of service.

1.2 As well as having formal policy to manage poor attendance, the Service has introduced a number of initiatives to support staff and avoid unnecessary sickness absence. These include: the LINC programme; staff counselling; the Special Leave policy; the Employee Assistance Programme (EAP), and improved manual handling facilities.

2. Policy

2.1 The current Managing Attendance Policy (MAP) was introduced in January 2007.

2.2 Where previous policies made clear distinctions between the management of short and long term (four weeks and over) absence, the MAP focuses on managing attendance in the round. Through the MAP, managers also have guidance regarding the management of individuals who may not hit any triggers, but over time demonstrate a general attendance pattern that is not acceptable.

3. Monitoring

3.1 An audit of attendance management activity in department/Complex is conducted by the relevant HR Manager on a quarterly basis. Where the level of sickness absence is deemed a cause for concern, the audits will

take place every month, with additional support being available to the managers during the intervening periods.

3.2 The results of the audits are submitted to the next in line manager and the Senior HR Manager.

3.3 Whilst it has been observed that strict adherence to policy and timely management action will not always see an immediate reduction in levels of sickness, the reverse is almost always the case; i.e. poor adherence to policy and little management action will almost always result in higher sickness absence. This is borne out through the local audits.

3.4 At present, across the Trust as a whole, only two members of staff have been absent due to sickness for more than twelve months. Both are being monitored and managed appropriately.

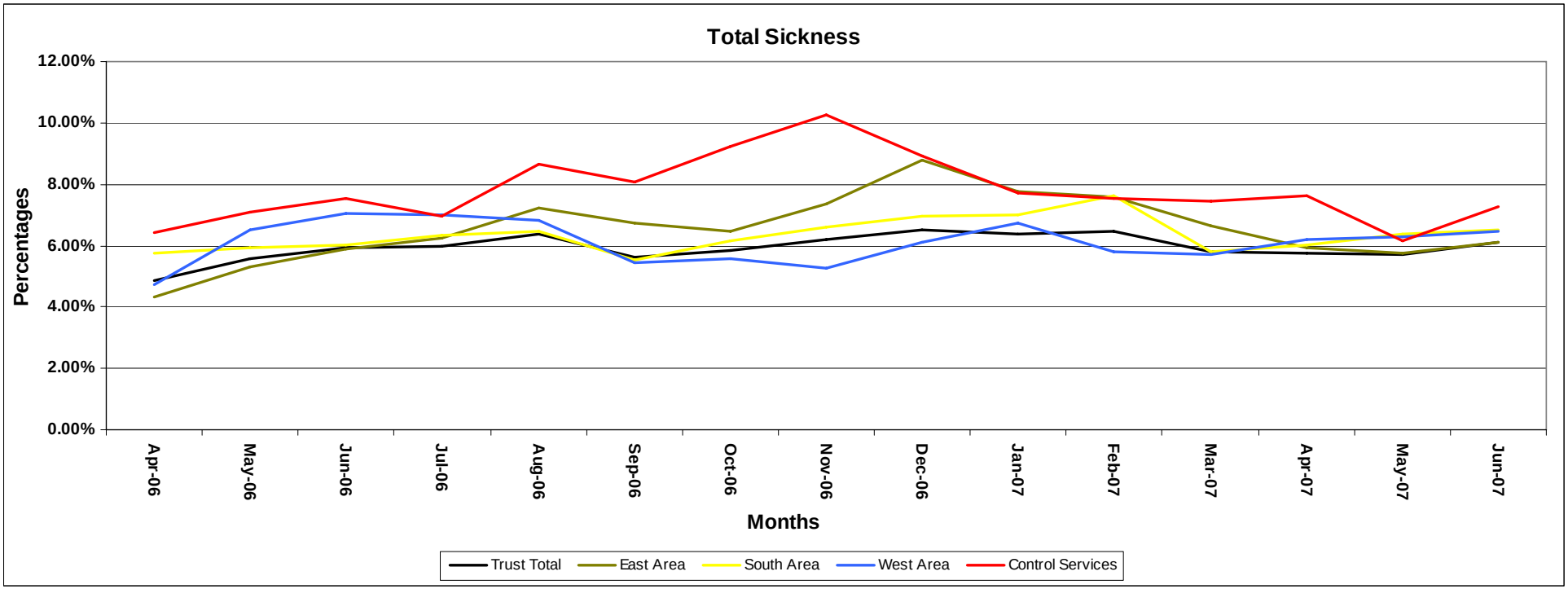
3.5 The changes in recording and reporting systems (from IPS to ESR) mean that comparable data is available from April 2006 (retrospective data prior to "go live" has now been made available to ESR). The graphs overleaf show that, for the period April 2007 to June 2007, in almost every area of the Trust there has been a slight upward trend in sickness absence. This is disappointing, particularly as audits show that there has been no discernible lapse in management attention and/or action.

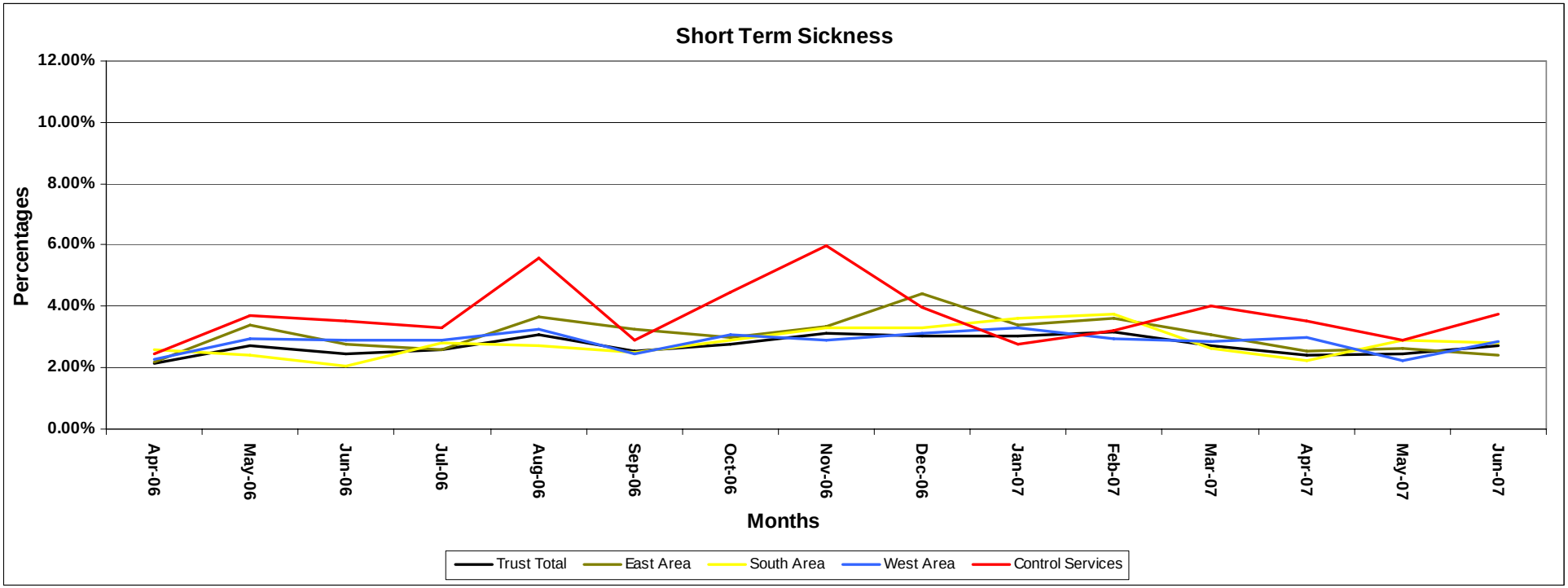
3.6 Across the board, short and long term absence typically remains largely within one per cent of an equal 50/50 split.

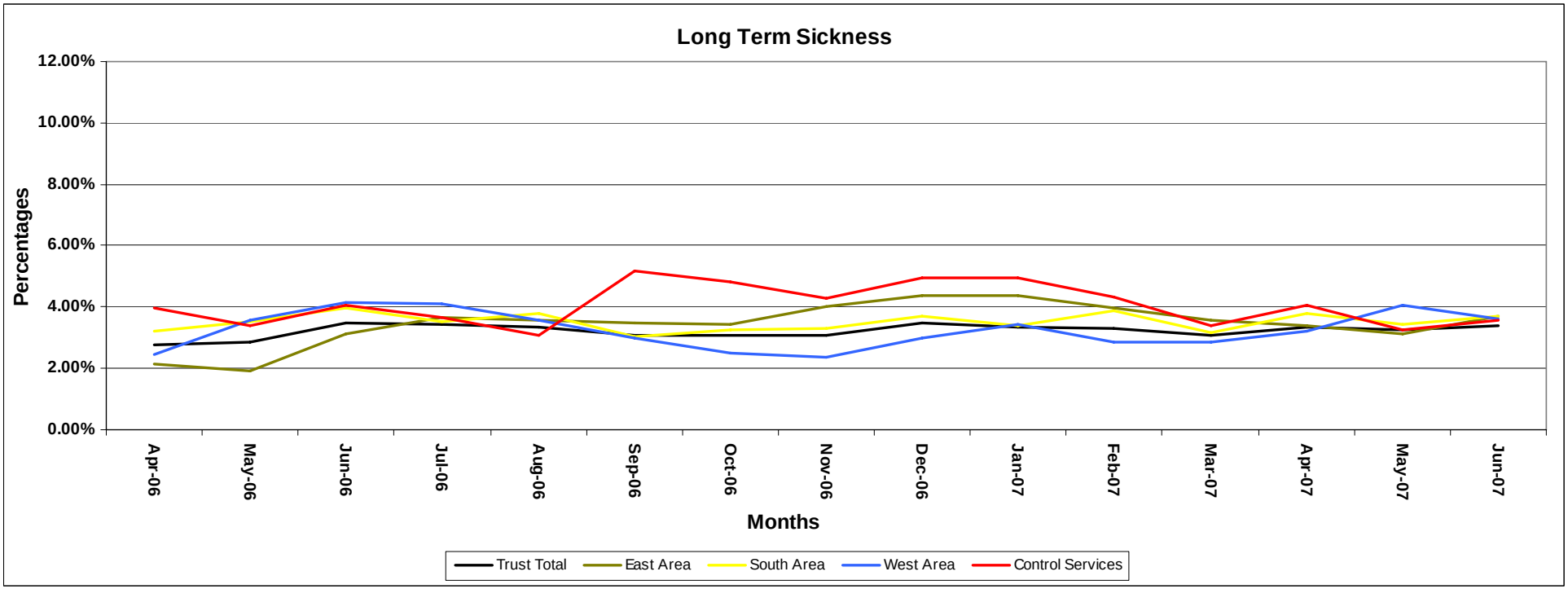
4. Further Developments

4.1 Work will shortly begin to identify particular local practices which have resulted in reduced sickness absence. From this a 'best practice' guide will be produced for all managers, providing further support to managers in the effective and consistent application of the MAP and associated management practices.

4.2 The Trust has recently completed a re-tendering process for Occupational Health Services and awarded the contract to ATOS Healthcare, who will provide services to the LAS with effect from November 2007. Occupational Health services play a crucial role in supporting the Trust in its effective management of sickness absence. It is anticipated that management of cases will be improved with the new provider and will also be assisted by the real time direct access by the Trust to case tracking. Impact and benefits will be closely monitored and the Trust will work with ATOS Healthcare to ensure that the anticipated benefits are realised.


Total Sickness
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Percentages
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Months
Trust Total
East Area
South Area
West Area
Control Services


Short Term Sickness
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Percentages
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Months
Trust Total
East Area
South Area
West Area
Control Services


Long Term Sickness
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Percentages
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Months
Trust Total
East Area
South Area
West Area
Control Services

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 25th September 2007

SUMMARY OF THE MINUTES

Charitable Funds Committee 31st July 2007

1. Chairman of the Committee **Caroline Silver**

2. Purpose: **To provide the Trust Board with a summary of the proceedings of the Charitable Funds Committee**

3. **Agreed:**

That the amenities budget for Christmas parties remain at £8.00 per person

That the average amount to be spent on televisions be raised to £400.00 in recognition that changes in technology have increased the cost of televisions.

To review the criteria for grants to retirees at a meeting of the Committee to be held on 30th October 2007.

Noted:

The contents of the Charitable Fund Accounts 2006/07,

The contents of the Annual Report of the Trustees

The contents of the internal management accounts for 2006/07

The report from Investec outlining how the fund had performed over the last 1, 3 and 5 years.

The revised Charitable Fund Procedure notes.

4. **Recommendation**

THAT the Trust Board t Board NOTE the minutes of the Charitable Funds Committee

`LONDON AMBULANCE SERVICE NHS TRUST

Draft Minutes Charitable Funds Committee

Tuesday 31st July 2007

Present:	Caroline Silver (Chair)	Non Executive Director
	Barry McDonald	Non Executive Director
In Attendance:	Caron Hitchen	Director of HR & Organisation Development
	Michael John	Financial Controller
	Eric Roberts	Staff side representative
	Christine McMahon	Trust Secretary (minutes)
Apologies:	Tony Crabtree	Head of Employee Services
	Eddie Brand	Staff side representative
	Nicholas Row	Investec

01/07 The Minutes of the last Charitable Funds Committee 27th June 2006

Agreed: **1. The minutes of the previous charitable funds committee meeting held on 27th June 2006.**

Noted: **2. Minute 02/06: the Financial Controller confirmed that the 2005/06 accounts were amended to show Transco as being restricted funds.**

3. The Financial Controller re-issued guidance to ensure that donations were correctly given to the Charitable Funds.

02/07 Charitable Fund Accounts 2006/07

Annual report of the Trustees for the year ended 31st March 2007

The Committee considered the annual report. In response to a question from Barry MacDonald the Financial Controller undertook to explain how the net gain on the revaluation on table 5.1 was derived. **ACTION: Financial Controller**

The Financial Controller will also review the Income & Expenditure report on page 8 as it appeared to be incorrectly reporting the position of the carrying value given that the Fund sold more than the reported figure to fund expenditure. **ACTION: Financial Controller**

The Chairman asked that a movement schedule be prepared to show disposal of shares and reducing cash balance within the fund to disperse funds. **ACTION: Financial Controller**

Noted: **1. The contents of the Charitable Fund Accounts 2006/07 which showed the fund's balance at 31st March 2007 being £421,000.**

2. The contents of the annual report of the Trustees for the year ended 31st March 2007.

03/07 Internal Management Accounts 2006/07

The Committee reviewed the internal management accounts 2006/07. In response to a question from Barry MacDonald the Financial Controller confirmed that less money is disbursed than the number of staff in post as not all staff participate in Christmas festivities. It was reported that Electronic Staff Records (ESR) showed 4,103 staff in post in December 2006 but the Fund received claims from Managers totalling 3,422.

A survey is being undertaken of staff to ascertain whether they wish the Trust to hold a big party at Christmas to be attended by all staff or whether staff would prefer to arrange their own departmental events (for staff based at HQ, Pocock Street and Loman Street). Complexes currently have separate events.

The Financial Controller reported that the discrepancy in the report concerning those who were estimated to be entitled and the actual number of retirement parties was due to not all staff wishing to hold retirement parties. In some cases staff that are eligible for retirement choose to continue working.

There was recognition that there have been a number of managers acting up with a lot of changes in personnel. The HR Director undertook to check that the HR Managers are aware that retirees with 20 years service are entitled to money from the Fund. **ACTION: HR Director**

Noted: 1. The internal management accounts for 2006/07
2. That the value of investment increased by £4,683 in 2006/07; at 31st March 2007 the value of investment was £415, 582.
3. That there was budgeted deficit of (£40,487); £2,423 more than was budgeted for in 2006/07.

04/07 Review of criteria for rates of payment

Agreed: 1. That the amenities budget for Christmas parties will remain £8.00 per person.
2. To increase the average sum to be expended on televisions to £400.00 in recognition of the change in technology increasing the cost of televisions.
3. To review the criteria for grants to retirees at a meeting of the Committee to be held on 30th October 2007. ACTION: HR Director to present a report at the next meeting.

05/07 Draft Budget for 2007/08

The Financial Controller presented a draft budget based on information provided by ESR system. It is estimated that 21 people with 20 years service will be eligible to retire as they will become 60 years+ but this could change as people may choose to continue working. In October the Committee will discuss the consequences of revising the 20 year rule i.e. what will the number of potential retirees be if the eligibility was changed to 15 years. It was recognised that the current criteria of 20 years potentially excludes support staff and that as a general matter it might be appropriate to reconsider whether 20 years is he right length of service. **ACTION: Financial Controller**

There was a proposal that the Committee should review its decision to run down the Fund over 10-15 years perhaps by increasing the amount spent on amenities in the short term and tapering down expenditure in the final five years.

Noted: 1. The report
2. That the Committee wished to review the terms of reference for the Charitable Funds when it meets in October. ACTION: HR Director to present a report at the next meeting.

06/07 Annual Investment Report

The Committee considered the Annual Investment report prepared by Investec. The Committee's attention was drawn to the pages 7 and 8 which presented data on how the fund had performed over the last 1, 3 and 5 years in comparison to the FTSE average. It was clear that the fund had done better the FTSE and the old CAF fund on year one basis; done reasonably well over 2-3 years period and very well over 5 year

period. The Committee had previously agreed that the funds should be held in a 75/25 split (equities/cash)

Barry MacDonald said that over a 5-10 year horizon it felt reasonable for the fund to be heavily into equities. It was recognised that although it is a small fund Investec appear to take it seriously. It was also recognised that there will come a day when the fund will be too small to be a segregated fund. The Chairman said she was comfortable with the fund and it appeared reasonable for the bulk of the fund to be held in equities.

Noted: The report

07/07 Internal Audit Recommendation

The Committee considered the recommendations of the Internal Auditors, Bentley Jennsion, who undertook the audit as part of the 2-3 annual audit cycle. The auditor's recommendations have been implemented i.e. updating of the procedure note and an example was circulated with the papers for information.

In response to a question from the HR Director concerning how do local management know of the procedures relating to the Charitable Funds i.e. handling donations etc it was suggested that an article be included in the LAS News in November setting out four key bullet points for operational staff to note. It will also be an opportunity to publish the new rates of payments. **ACTION: Trust Secretary to liaise with the Editor of the LAS News. DONE.**

Noted: The revised charitable funds procedure notes

08/07 Report from the sub-group

Agreed: 1. That the Fund would contribute 75% of the cost of garden furniture for use by staff at Bow.

Noted: 2. The report from the sub-group which reported on the sums dispersed by the Fund during 2006/07 by station and what items had been purchased.

09/07 Any Other Business

The Committee will discuss in October the merit of devolving a budget according to Area or whether it would be better to retain a central control over the use of the funds.

Noted: The report

Date of next meeting: 9.00am, 30th October 2007

The meeting concluded at 3pm

Enclosure 13

London Ambulance Service NHS TRUST

SUMMARY OF THE MINUTES

Clinical Governance Committee - 13th August 2007

1. Chairman of the Committee **Dr Beryl Magrath**

2. Purpose: **To provide the Trust Board with a summary of the proceedings of the Clinical Governance Committee (CGC).**

Presentations

NPSA: Two representatives of the National Patient Safety Agency attended the meeting; Ms Samantha Gradwell presented the findings of the last published report which covered the period April to September 2006.

ECP Clinical Performance Indicators: Dr Daryl Mohammed presented the findings of a pilot undertaken to evaluate the effectiveness of a process whereby ECP Co-ordinators carry out CPI audits over a three month period (May-July 2006).

3. Agreed:

That the use of an ethnicity 'pick list', printed on the back of the PRF form and on the hospital code cards, is an appropriate way forward to improve the recording of patients' ethnicity.

The Alternative Response Procedure, (renamed from No-Send Policy) with the proviso that the capacity section is consistent with the Trust's 'Consent Policy.**' This will be presented to the Trust Board in November.**

The amendments to the SUI Policy.

That the CGC will no longer receive the Safety Alert Bulletins as this is reviewed by the Corporate Health & Safety Group which reports to the RCAG.

That the Deputy Director of Operations will identify an Emergency Medical Dispatcher (EMD) and Emergency Medical Technician (EMT) in their first year of service to attend the full meeting of the Committee on 18th December 2007.

That two of the clinical risks on the Risk Register be proposed for deletion/regrading by the RCAG on 30th October 2007: risk 194 and 63.

Noted:

That the trial of grey Lost Property bags has been halted. The PALs Manager will estimate the cost to the Trust of seeking lost property & submit an SPPP

That it is possible for CTAK to provide information regarding how many times a Paramedic is requested and despatched to an incident. In the last two months 81 requests were received for a paramedic and 73 were despatched. An update will be included in the regular pan London report.

The Clinical Audit & Research Unit continues to receive a low number of data cards for cardiac arrests.

The Frequent Caller Initiative has been included in the Cost Improvement Programme and is now a part of the Service Improvement (SIP) 2012.

That the JRCALC Airway Management Group is to undertake a review of the evidence which will determine whether intubation continues to be a core competency for paramedics.

That the Trust was assessed under the new NHSLA pre hospital care assessment which has been specifically designed for use by the ambulance service. The purpose of the first visit was to review the Trust's policies and procedures; a second visit, in November 2007, will review the evidence of implementation of the policies and procedures.

The Public Education Strategic Group undertook a survey to identify members of staff participating in public education activities prior to holding a workshop in the Autumn.

The PALS quarterly report highlighted the work being undertaken with Frequent Callers; the high risk address register and lost property.

Risk Information Report: of the 138 complaints received April-June 2007, 11 were found not to be related to the LAS; the majority of the complaints concerned attitude and behaviour. A number of complaints were received concerning forced entry to premises and the Head of Legal Services said that the Trust's policy and procedure regarding forced entry is being reviewed. In terms of incidents, of the 183 reported April-June 2007 eight had a direct impact on patients. Of the incidents reported to the NPSA 114 were graded as insignificant and 69 were graded as low; none were reported as medium or high.

A multi-departmental approach was adopted in regard to preparing a report on Obstetrics with contributions from complaints, incidents, legal services and education and training.

The Committee considered the summary status report of clinical policies and procedures; a number of policies are overdue for review, the majority of which are concerned with the Metropolitan Police or Mental health.

4. **Minutes/oral reports received from:**

RCAG (3rd July 2007); Complaints Panel (31st July 2007); Infection Control Group (12th June 2007) and the PPI Committee (29th June 2007)

5. **Recommendation:** THAT the Trust Board NOTE the minutes of the Clinical Governance Committee, 13/08/07.

LONDON AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee
9.30am, 13th August 2007, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Ingrid Prescod	Non-Executive Director (from 10.00)
Fionna Moore (Vice chair)	Medical Director
Julian Redhead	A&E Consultant, St Marys (until 13.10)
John Wilkins	Head of Governance
Chris Vale	Head of Operational Support
John Selby	Head of Safety & Risk
Nicola Foad	Head of Legal Services
Stephen Moore	Head of Records Management (until 13.25)
Russell Smith	Deputy Director of Operations (until 13.15)
Paul Woodrow	Assistant Director of Operations, South (until 13.20)
John Hopson	Assistant Director of Operations, UOC
Paul Tattam	Ambulance Operations Manager - D Watch
Margaret Vander	PPI Manager
Tony Crabtree	Assistant Director , Employee Support Services (until 13.45)
Rachael Donohoe	Head of Clinical Audit & Research
Gary Bassett	PALS Manager (until 13.10)
Malcolm Alexander	Chairman, LAS Patients' Forum (until 13.25)
Ralph Morris	Head of Complaints
Bob Fellows	Education & Development Manager (repre. Pat Billups)
Christine McMahon	Trust Secretary (minutes)

In Attendance

Dr Daryl Mohammed	Assistant Medical Director, Primary Care
Samantha Gradwell	NPSA
Carmel Dodson-Brown	NPSA

Apologies

Sarah Waller	Non-Executive Director
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
Ricky Lawrence	Diversity Officer
Pat Billups	Educational Standards Manager

Paul Tattam, Ambulance Operations Manager - D Watch, was welcomed to the meeting. Following the recent re-organisation of EOC and UOC he has been nominated to represent Control Services on the Committee.

40/07 Minutes of the Clinical Governance meeting held on Monday 11th June 2007

Agreed The minutes of the Clinical Governance Committee meeting held on 11th June 2007.

41/07 Matters Arising

Minute 40(2): the Committee was informed that the trial of the grey Lost Property bags has been halted. The recent application to the NHS Innovation Scheme was unsuccessful as Dorset AS had received an award in 2006 for a similar project.

*Minute 40(3)***: it was confirmed that the bulletin regarding the disposal of single use equipment has been issued.**

Minute 63(1)**: The Deputy Director of Operations said that CTAK is able to provide a report that will assist in the management of the risk that 'EOC cannot guarantee to identify a Paramedic to despatch to those calls which require that specific skill level'.**

The system can provide information on how many times a Paramedic is requested and then subsequently despatched to an incident. In the last two months 81 requests were received for a paramedic (approximately ten per week) with 73 being despatched This

will be kept under review and an update included in the regular pan London report to the Committee. ACTION: The Deputy Director of Operations

Minute 05/07**: the Head of Clinical Audit & Research said that although figures have recently improved it continues to be of concern that Clinical Audit & Research Unit receives a low numbers of data cards for cardiac arrests. The Committee was informed that there are some local initiatives taking place, which if they prove successful, could potentially be rolled out across the Trust.**

NOTED: that Dr Paul Dargan (NPIS) will attend a meeting of SMG in September 2007 to speak about the Trust continuing to use the NPIS service. The Committee will receive an update in October. ACTION: Medical Director.

Minute 20/07**: the Head of Records Management confirmed that he had spoken with the Diversity Officer concerning DATIX capturing all the areas covered by discrimination legislation and records aggravating factors for biased incidents.**

Minute 21/07**: the Chairman said she was pleased that the Frequent Caller Initiative has been included in the Cost Improvement Programme and is now part of the Service Improvement Programme (SIP) 2012.**

Minute 26/07 (3): **PRFs/recording of ethnicity: The Committee agreed the wording for operational staff to ask patients regarding ethnicity. The ethnicity 'pick list' is on the rear of the PRF and also on the hospital code cards.**

The Chairman of LAS Patients Forum asked if Clinical Telephone Advisers (CTA) ask the ethnicity of their callers and was told that they do not. The Deputy Director of Operations undertook to enquire how NHS Direct acquire this information. ACTION: Deputy Director of Operations.

Minute 30/07: **Dr Mohammed confirmed that his practice is trialling the GP Handover Form discussed by the Committee in June 2007; a progress report will be presented to the Committee circa February 2008. The Head of PALS said he may be able to suggest other General Practitioners who would be willing to participate in the trial of Handover Forms. ACTION: Head of PALS/Dr Mohammed to discuss.**

Minute 32/07: **the Head of Governance said that the annual clinical governance report will be presented to the Committee in October. ACTION: Head of Governance**

Minute 34/07: **it was reported that changes introduced by the Service in response to complaints will be captured on a data base. This will enable the Trust to demonstrate it has learnt lessons from complaints and become the basis for an audit to evidence that those changes have been implemented throughout the Trust.**

42/07 **Presentation: Patient Safety Issues relevant to an ambulance service.**

Samantha Gradwell and Carmel Dodson-Brown from the NPSA gave a brief presentation to the Committee on the role of the NPSA. Ms Gradwell gave an overview of the NPSA and listed the Seven Steps to Patient Safety [4] and reminded the Committee of the themes from 'Safety First'[5].

[4] Building a safety culture; leading and supporting staff; integrating risk management activity; promoting reporting, involving and communicating with patients and the public; learn and share safety lessons and implement solutions to prevent harm.

Ms Gradwell presented the findings of the last published report which covered the period April to September 2006[6]. The report contained data on reported incidents and included medical devices/equipment 42.1% (compared to the norm for ambulance services of 17.8%); access, admission, transfers etc 25.7% (compared to norm for ambulance services of 22.6%). The NPSA has recently set up an Obstetrics Forum which is attended by healthcare professionals on a pan London basis as well by colleagues from Hertfordshire and Essex. The Medical Director said she will liaise with Ms Gradwell concerning an appropriate person to represent the LAS at the Obstetric Forum. **ACTION: Medical Director.** As the Trust has recently dealt with a number of problematical obstetric cases the Medical Director welcomed the news that the NPSA had set up this forum.

Ms Gradwell explained there had been a backlog in analysing the Trust's data due in part to a misalignment between the NPSA and the LAS data system; this had been resolved following a re-mapping exercise by the LAS. The next report will include information on the date of the incident reported.

Ms Dodson-Brown said that it was very likely that there was an under-reporting of incidents in the NHS; one estimate is that Trusts should be reporting an incident per one in ten patient contacts. This was felt to be counter to the general view that a decrease in the number of incidents/near misses was something to be welcomed as a demonstration of improvements in practice and procedures. The NPSA representatives said that staff should be strongly encouraged to report incidents and near misses in order to facilitate learning and to bring about changes which will improve patient safety.

In response to a question from the Medical Director it was confirmed that only incidents and near misses are reported to and subsequently analysed by the NPSA. The Medical Director felt that it was unfortunate that the lessons from potential claims, complaints and SUIs were not being captured at a national level so as to enable learning to be shared across the NHS. The NPSA said that there are links between the NPSA and the NHSLA at a very high level. Ms Gradwell suggested that the Trust might consider reviewing how it monitors information on incidents etc by using Datix to undertake further analysis. The Head of Safety & Risk undertook to liaise with Ms Gradwell on how this could be managed. **ACTION: The Head of Safety & Risk**

In response to a question from the Chairman of the Patients' Forum as to what are the benefits and values of the relationship to the LAS, the NPSA said that the Trust receives support and training (e.g. in the undertaking of root cause analysis) on achieving the Seven Steps; the NPSA issues the National Safety Alert Bulletins and issues feedback reports to Trusts on the reported incidents and benchmarking against the national average. When the question was asked what the LAS would like from the relationship the following comment was made: better mapping of data by the NPSA to provide a useful analysis. In response to Ms Dodson-Brown's question as to what level of training and support LAS members of staff receive concerning reporting incidents, it was confirmed by the Head of Safety & Risk that this is undertaken as part of staff induction and that staff receive feedback from Complex Training Officers regarding the outcome of reported incidents. In addition, the Trust has regularly received positive feedback from Annual Staff Surveys thereby demonstrating that staff feel confident in reporting incidents.

Noted: **The contents of the presentation.**

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[5] Moving from awareness to priority across the NHS; national co-ordinator and engagement of interested stakeholders; more effective learning from error and safety monitoring systems must have teeth.

[6] The next NPSA report (October 06 to December 07) will be published August 07.

43/07 **Pre Hospital Advanced Airway Management**

The Medical Director presented the report on Pre Hospital Advanced Airway Management.

The JRCALC Airway Management Group met on March 2nd 2007 to review the published evidence and current practice surrounding intubation in the pre hospital care field. Concern was expressed surrounding several areas: the lack of evidence of improved survival relating to endotrachael intubation, the availability of theatre placements for paramedics to consolidate learning, the skill decay experienced by practitioners who use this technique infrequently, the ability of paramedics to verify tube placement in the field and the use and availability of supraglottic airways. Further research of the evidence will determine the future of intubation in the pre hospital arena as the Group will either recommend removing intubation as a core competency for paramedics or, issue recommendations and solutions to address the areas of concern.

Following the above meeting a Medical Director's bulletin was issued to LAS crews on 27th March concerning endoctracheal tube placement and verification of position. The LA214 Airway Management Log was introduced; a document on which all advanced airway management skills must be recorded.

It was recognised that because Paramedics undertake a small number of intubations over a year it is imperative they maintain their skill level. The Medical Director said that it is unfortunate that three of the big teaching hospitals in London are not able to continue to assist the LAS by offering training placements. Fortunately, other hospitals, e.g. Kingston NHS Trust, have been able to offer training placements which has been much appreciated. The hospital placements enable Paramedics to have the opportunity to place a minimum of six Laryngeal Mask Airway (LMAs) in a hospital theatre under the supervision of senior operation department assistant or anaesthetist.

The Education Development Manager said that the Resuscitation Module currently being taught to all operational road staff incorporates the guidelines set out in the Medical Director's bulletin. The form LA214 referred to in the Bulletin enables Paramedics to record the grade of intubation encountered and why it was missed, if it was missed. The Head of Clinical Audit & Research said it would be useful for CARU to receive copies of the LA214 to assist the monitoring and reporting of intubations. **ACTION: Medical Director**

Noted:

1. **The intention of the JRCALC Airway Management Group to undertake a review of the evidence which will determine whether intubation continues to be a core competency for paramedics.**
2. **That the LAS is keen to retain intubation as a core skill of Paramedics.**
3. **That intubation or LMA placement is included in the clinical performance indicators for resuscitation.**
4. **That intubation or LMA placement is now an integral part of the resuscitation data base in the Clinical Audit and Research Unit.**
5. **That the LA214 can be viewed as part of each individual practice portfolio; it is designed to encourage staff to recognise and document difficult intubations to identify potential areas of required learning.**

44/07 **Alternative Response Procedure**

The Head of Records Management said that the 'No Send' policy which was agreed in principle by the Trust Board in November 2004, but not formally adopted, has been reviewed following the introduction of the Clinical Telephone Advice Service. As the term 'no send' conveys a negative message, the name of the procedure was changed to 'alternative response' as it is a more apt description of the revised procedure.

In response to a question from the Chairman of the Patients' Forum the Head of Legal Services confirmed that each of the points listed under Section 1.6 of the procedure must be met in order for capacity to be demonstrated. The Chairman of the Patients' Forum said that

the wording should be amended to reflect the use of interpreters (e.g. Language Line) or other third parties. In regard to section 1.10, the Medical Director said that 'GP' should be written out in full i.e. 'General Practitioner', **ACTION: Head of Records Management**

Agreed :

1. **The procedure, with the proviso that the reference to 'Capacity' is consistent with the Trust's 'Consent Policy. ACTION: Head of Records Management to check**
2. **That the Trust Board be asked to ratify the new procedure when it meets in September 2007.**

45/07 Update re. NHSLA visit 7/8th August 2007

The Head of Governance reminded the Committee that the NHSLA are trialling an assessment tool for pre hospital care designed specifically for use by the ambulance service. There are five core standards, each comprising 10 criteria.

The purpose of the visit on 7th August was to review the Trust's policies and procedures to adjust the requirements of Level 1 and provide feedback on the trust's current arrangements when measured against the criteria of the new system.. A second visit is scheduled for November, when the Assessor will review the evidence of implementation of the policies and procedures in order to meet the requirements of Level 2. The feedback received on the recent visit was that the Trust had met the requirements for two of the five standards governance and learning from experience.

A short list of 'quick wins' is being drafted for implementation over the next three months and it will be presented to SMG in September 2007. **ACTION: Head of Governance**

The Head of Governance said that clarification is being sought from the NHSLA regarding the use of the Infection Control Assurance Framework.

Noted:

1. **The progress to date and the ongoing programme of work by leading Trust senior mangers to prepare the Trust to prepare the trust for assessment by the NHSLA in 2008/09.**
2. **The efforts of the Head of Governance in co-ordinating the Trust's preparations for assessment by the NHSLA.**

46/07 Emergency Care Practitioners Clinical Performance Indicators

Dr Daryl Mohammed presented the findings of a pilot undertaken to evaluate the effectiveness of a process whereby ECP Co-ordinators carry out CPI audits over a three month period (May-July 2006). In particular, the pilot aimed to: assess the usability of the individual Emergency Care Practitioner (ECP) Clinical Performance Indicators (CPIs), Patient Report Form (PRF) viewer[7], and CPI database; assess time, resource and operational requirements for the proposed process, and inform the development of further ECP specific CPIs to be used on a rotational, ongoing basis. Dr Mohammed thanked members of CARU for the pilot and their assistance with co-ordinating the ECP CPIs.

Dr Mohammed said that the findings had provided very useful specific clinical information that can be used either on an individual basis or pan London to provide supportive feedback to ECPs. The ECP Steering Group (chaired by Assistant Director of Operations) will address training and time management issues. Discussions are taking place on how the above approach can be 'mainstreamed' i.e. making them as important as conventional CPIs and an AOM target. **ACTION: Dr Mohammed, Head of Clinical Audit & Research, the Deputy**

[7] A PRF scanner was set up by Management Information to enable the ECP Coordinators to search for and print scanned PRF images relating to ECP care delivered within their area. The Clinical Development Manager was also able to access PRFs relating to care delivered by the ECP Coordinators.

Director of Operations and the Assistant Director of Operations will meet to discuss the resource implications for co-ordinators to routinely report ECP CPIs.

Team Leaders are currently responsible for assessing all ECP PRFs that fall under any of the 6 indicators and for quality assuring PRF documentation via the 1 in 20 audit. However, given that the training and procedures for the ECP role differ from other front line staff, current CPIs are not applicable to many cases of ECP delivered care. Therefore, the following ECP-specific CPIs have developed to provide an ongoing tool with which to improve the quality of ECP delivered care:

1. Quality Assurance of basic documentation (audits of 1 PRF per ECP per day)
2. Abdominal pain
3. Back pain
4. Diarrhoea
5. Falls (patients >65 years)
6. Paediatric assessment (patients <14 years)
7. Patient Group Directives (PGDs)

The Head of Clinical Audit & Research said that the same database is being used for ECP CPI and EMT/Paramedic CPIs; it simply has a different front sheet with a different set of CPIs listed. The intention is that the work undertaken by ECPs using their paramedic (non-ECP) skills should be audited via the Team Leader CPIs, whereas calls involving the ECPs' additional skill sets will be audited through the ECP-specific CPIs. ECPs should be receiving feedback on their CPIs from their Team Leaders on their non-ECP performance. They will receive feedback for their ECP-related jobs from the ECP Co-ordinator. It was recognised that the Trust needs to be satisfied that there are proper clinical governance arrangements in place to ensure that ECPs are providing a particular level of care for patients.

The Medical Director congratulated Dr Mohammed and his team on what she said was a fantastic initiative. The Medical Director noted that under *Paediatrics,* there was only 36% compliance with social and family history documented and for *Back pain and Abdominal pain* there was low compliance in 'pain assessment recorded–final assessment'. The latter suggested that there is still work to be done in raising the profile of pain relief amongst ECPs and possibly other front line staff.

In terms of completion of the CPIs, Dr Mohammed confirmed that the completion was not undertaken on a consistent basis across the Trust. The introduction of the electronic model should encourage Co-ordinators to undertake the CPIs on a regular basis.

Dr Redhead drew attention to the *Paediatrics* CPIs, to the evidence of low compliance in a number of areas: name and relationship of historian documented; birth history taken; social and family history documented and plan considers child protection issues in relation to social and family history. The Head of Clinical Audit & Research said that the findings of the CPI audit reflected the review of the Paediatric documentation that was reported to the Trust Board in May 2007. One issue highlighted by Audit was the confusion as to what constituted 'a child'. The Medical Director said that protocols have been issued reminding crews that children over 12 are considered to be adults in regard to administering dosages of medication. However, it was noted that in terms of admittance to hospital's paediatric units the upper age is 15 and in terms of the legal system, young people over 18 are deemed to be adults. The Head of Clinical Audit & Research reported that there is some confusion amongst operational staff as to what constitutes a child and when they should document aspects that were recommended by the Victoria Climibieé Inquiry. The Head of Clinical Audit & Research said that crews need to have position clarified for them and asked whether a bulletin or LAS News article could be produced.

Dr Mohammed said that a prompt sheet could be issued to crews reminding them of child protection issues. The PPI Manager said that based on the number of referrals received by the Trust from crews there was a good level of awareness concerning child protection issues.

The crux of the matter appeared to be that crews were not documenting their concerns. The Medical Director said that an article will be written on this topic for inclusion in LAS News. **ACTION: Medical Director.**

Noted: **The contents of the report**

47/07 **Public Education Strategy Steering Group**

The PPI Manager presented the findings of a survey undertaken to identify members of staff undertaking public education activities. A workshop is to be held in the Autumn to pull together the findings of the survey and to identify best practice for the LAS when undertaking public education activities. Despite the fact that only 49 out of 126 members of staff responded to the survey the PPI Manager felt the survey provided a good snapshot of the public education work undertaken by staff, often in their own time. Of those that did respond a high level of commitment was demonstrated.

One area of concern highlighted by the survey was the continuing use of Trust vehicles that were being taken to public events despite the recent prohibition following the Ladwa SUI. When the ban on taking vehicles to public education events is lifted it is essential that crews undertake risk assessments on a routine basis in line with the new policy and the accompanying guidelines. It was also clear from the survey that there was little evaluation undertaken as to the usefulness of individual public education activities.

The PPI Manager said that at a recent community event she attended at which there were other stands staffed by the Metropolitan Police and the Fire Brigade it was disappointing to observe that the LAS had a poorer quality of 'give away items' than the other emergency services. The Public Education Strategy Group's view is that the 'give away items' should be something useful and relevant to the LAS, and this continues to be a matter under discussion.

The Deputy Director of Operations said that consideration should be given as to what events are attended by the LAS, i.e. from an educational point of view it would make more sense to undertake visits that included children in the age group of 8-12 year olds rather than a very young age group. With limited resources it would also be better to target efforts on the hard to reach communities.

The PPI Manager said that the Strategy identified the need for a Central Co-ordinator for public education events. The role would be to oversee the allocation of resources; to brief representatives on the Trust's future strategy so that they will able to answer enquiries from members of the public, and also to prioritise the events attended by LAS members of staff.

The ADO South said that he is encouraging the AOMs in the South to work closely with the local Metropolitan Police Borough Commanders as part of a multi-agency approach to PPI.

The Strategy recognises that there will be different forms of public education undertaken to reach out to different community groups. It was recognised that as a Foundation Trust the LAS will be expected to engage in PPI to a much greater degree than it is currently doing.

Noted:

1. **The findings of the Public Education Survey.**
2. **The suggestion that the Trust should consider applying for Lottery Funding to finance the public education activities. ACTION: PPI Manager to investigate the viability of an application.**
3. **That staff involved in public education events must undertake risk assessments as a matter of routine.**

48/07 **Quarterly report from PALS (April – June 2007)**

The PALS Manager presented the quarterly report. He said that he suspected there was an element of under-reporting and so the paper does not fully reflect the work undertaken by the PALS team in April-June 2007.

Frequent callers: following a recent meeting of representatives from Mental Health Teams, General Practitioner and the LAS a patient has been served with an Anti-Social Behaviour Order (ASBO). The various agencies involved had sought to work with the patient over the last 18 months to find an alternative solution and had very reluctantly sought an ASBO.

The PALS Manager felt that once network forums at complex level become established it will become easier to manage frequent callers.

High risk address register: 192 high risk addresses have been removed from the register. The details of 319 addresses were despatched to stations to be further investigated (to date 95 have been returned, with 65 addresses remaining on the Register and 30 being removed). In order to progress this project the membership of the core group panels is being reviewed and expanded.

Child Protection & Vulnerable Adult: it was noted that very few reports concerning Vulnerable Adults are received from crews.

Lost property: it was recognised that this is an area that is very time consuming for the PALS team. The PALS Manager estimated that approximately 100 enquiries were dealt with during the quarter. It was suggested that an updated SPP (including business case) should be submitted to SSG for further consideration. **ACTION: PALS Manager**

The importance of PRF documentation was highlighted as it is the only evidence available to the Trust as to what crews did/did not do when treating patient; 16 cases were referred to Pthe LAS' Complaints Department SU//ICAS for investigation when enquirers indicated that they wished to pursue matters as a formal complaint. The Head of Records Management said that an audit is to be undertaken to review the issues around PRF completion and transportation. The issues raised by the recent PRF investigation would be taken up by the Corporate Processes and Governance Programme. **ACTION: Head of Records Management to liaise with the Head of Clinical Audit & Research concerning this audit.**

The Medical Director drew the Committee's attention to the enquiries received concerning the Trust's Environment Policy. This will be raised with the Trust Board in the Autumn.

Noted:
1. **The recommendations outlined in the report.**
2. **That 196 letters of appreciation have been received from patients in April–June 2007.**

49/07 Amendment to SUI Policy for noting

Agreed:
1. **The amendments to the SUI policy that were not of a substantial nature but reflected the recent internal re-organisation in how complaints are to be managed, and the changes required by NHS London in terms of timescales for reporting incidents.**

Noted:
2. **That with effect from 1st October the PALS Manager will have responsibility for managing complaints.**
3. **That the next revision of the SUI Policy will make explicit the procedure for giving internal feedback to staff when a SUI is declared. ACTION: Head of Complaints**
4. **That the PALS Manager felt there is currently a gap in the process when a SUI is *not* declared and how that incident is subsequently managed. This is an area he will review in due course. ACTION: PALS Manager.**

50/07 Risk Information Report

Complaints: 138 complaints were received Apr-June 07; of these 11 were found not to be related to the LAS. Of the remainder, the majority of complaints concerned attitude and behaviour and non-physical abuse and delays in response. The Trust met the target of

responding to 100% of complaints within 2 days; 82% of complaints were resolved within the required 25 days. There were no SUI declared since the last meeting (13th August 2007).

The Head of Complaints said he will be undertaking a handover of the responsibility for complaints handling to the PALS Manager over the next couple of months; this will be completed on the 1st October.

Claims & Inquests: the Head of Legal Services said that the caseload and trends are broadly in line with the previous report to the Committee in April 2007. The Head of Legal Services said that although there appears to be downward trend in the number of inquests, this should not be taken as an absolute measure as an inquest can become problematic at a later time in the course of conducting an investigation for an inquest.

The Committee's attention was drawn to the summary of the output of the round table reviews of clinical negligence claims, potential claims, and contentious inquests closed between 1 April and 30th June 2007 and to the progress on implementing the actions on cases closed between 1 July and 31st December 2006. In respect of the latter all of the agreed actions had been taken with the exception of the joint agreement with the Metropolitan Police regarding the transportation of persons to hospital which was still with the Metropolitan Police. In respect of the cases closed between 1 April and 30th June 2007 further action is being taken in 10 cases and progress will be reported in the next Risk Information Report to the Committee. **ACTION: Head of Legal Services.**

The Head of Legal Services discussed with the Deputy Director of Operations whether there needed to be a risk added to the Risk Register concerning staffing at Christmas and New Year. The Deputy Director of Operations said that the risk of insufficient staffing to meet demand is already on the Risk Register[8] and this would be a duplication of that risk.

The Committee was informed that the Trust often receives notification of a claim when there had been no previous indication that an untoward incident had taken place, and consequently no investigation undertaken at the time. When such a notification is received an ADO is asked to investigate under the SUI procedure, if the incident is declared as a SUI, or under the incident reporting/accident reporting procedure.

There was also an issue identified with the number of patients who have to wait a long time for a response. The Deputy Director of Operations, Control Services said that the Trust Board is receiving a regular report concerning Category B response times. There are a number of initiatives and additional resources being deployed in an effort to reduce the length of time people have to wait for a response and increase the level of clinical support in Control.

The Chairman noted that there were a high number of complaints received concerning forced entry to premises. The Head of Legal Services said a review is being undertaken of the Trust's policy and procedure or forced entry. **ACTION: Head of Legal Services/Deputy Director of Operations.** It was suggested that crews should record on the PRF when a forced entry has been made and, if possible, state reasons.

PALS: the PALS Manager said there was nothing further to add to his submitted report.

Incident Reporting: the Head of Safety & Risk reported that of the 183 incidents reported April-June 2007 eight had a direct impact on patients. The number of incidents relating to failure of equipment fell from 73 to 62 near misses; the number of incidents relating to Lifepak 12 fell from 22 to 15. There appeared to be a downward trend in the number of incidents for Lifepak 12 and Leads compared to Quarter 3. Of the incidents reported to the NPSA, 114 were graded as insignificant and 69 were graded as low; none were reported as medium or high.

[8] Risk 265 – inability to match resources to demand. Rosters do not match current demand.

There were 104 instances investigated where equipment was reported as being defected, 58 pieces of equipment were isolated as a matter of routine and the investigation concluded that there were no significant issues identified. The Head of Safety & Risk confirmed that LA52 forms sent to his department are graded and quality checked by his team.

Obstetrics Emergencies

Complaints: The Head of Complaints said that he had reviewed the Trust's records going back to 2001. The number of complaints regarding obstetrics had been fairly stable until 2006 with approximately 8 per annum; in 2006, 13 complaints were received and in the period April-June 2007 14 complaints have been received.

The majority of complaints appear to be concerned with crews' attitude and behaviour. It is possible that this may have indirectly caused by the Trust's campaign 'only one of these is a taxi' campaign. The Committee were adamant that it was not acceptable for crews to be critical of patients; it was recognised that for many women giving birth to a first child can be a frightening experience as they don't know what is 'normal' and what is 'abnormal'.

A number of suggestions were made as to how this matter might be addressed. One suggestion was that PCTs be contacted and an information sheet regarding contacting the ambulance service at the time of delivery is included in expectant mothers' notes. This will inform women as to when it is appropriate to call an ambulance. This might be a project that the Director of Service Development's team could lead on. **ACTION: Director of Service Development.** It was recognised that crews may not have routine obstetric experience and that a prompt sheet might be a useful addition in the maternity pack given that the JRCALC guidelines are not due to be revised for another 3 years.

Claims: The Head of Legal Services reviewed the number of claims received by the Trust; there were 18 in total going back to 1991. She reviewed six files that had not been disposed of under the Retention and Disposal policy. All of the cases had been reported to the Clinical Risk Group and the opinion of the Medical Director obtained.

The purpose of the review was to ascertain how the cases were handled and what lessons could be learnt. The Medical Director's opinion was also sought on the cases.

None of the claims had been initially identified either via the Trust's complaints' or incident procedure. It was highlighted that crews need to be reminded that LA52s must be used to record all near misses and actual incidents that affect both patients and themselves. It was suggested that Team Leaders, when they are reviewing the PRF documentation should also try and identify patient incidents and ask crews to complete LA52s when necessary.

The Committee's attention was drawn in particular to the judgment by Mr Justice Roderick Evans in the case of *Grace Berry vs NHS Litigation Authority*, February 2002.

Incidents: The Head of Safety & Risk reported that the review of incident reporting showed that of the 35 incidents 20% related to delay in treatment; six of the incidents occurred at hospital when crews had concern regarding poor communication or no support whilst on scene at hospital. One incident concerned the availability of drugs.

Training & education: All new staff attending an EMT2 training course receive a formal one day training session on the topic of Obstetric and Gynaecological emergencies. The training session is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. Further reinforcement and support is then provided by the course tutors throughout the remainder of the programme. The subject of Obstetrics is a mandatory element of the course. As a consequence, all training objectives and assessments are developed on a national basis by the Institute of Health Care & Development (IHCD). Trainee Paramedic staff undertake IHCD training relevant to their role which once again is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. The duration of this training is two days. The traditional three

yearly Paramedic Recertification courses (which in the past included an obstetrics update session) is to be replaced by a series of new 'Modular' Continuous Professional Development (CPD) days, which will include a specific Obstetrics module.

It was recognised that there is a danger of skill decay for crews as they respond to obstetric cases on an infrequent basis; crews need to be reminded that they can access assistance from AMPDS.

Noted:
1. **The progress outlined in Risk Information report.**
2. **The PALS manager would submit a report on obstetric cases reported to PALS. <u>ACTION: PALS Manager</u>**
3. **That following the above discussion on obstetric cases an action plan will be drawn up as to how the Trust will manage the issues identified in the Obstetrics report. <u>ACTION: Head of Governance and Head of Legal Services</u>**
4. **The Head of Clinical Audit & Research said that there is an obstetrics audit is about to commence involving London hospitals. The findings of the audit will be shared with the Committee in due course. <u>ACTION: Head of Clinical Audit & Research</u>**

51/07 <u>Clinical risks on the Risk Register</u>

The Committee considered the clinical risks on the Trust's Risk Register.

269 At shift changeover times, LAS performance falls as we take longer to reach patients.

There was no further update to that contained in the report. The Deputy Director of Employee Services said that the fall in performance at shift change over is not necessarily due to rest breaks. There is a bigger issue around complex rosters.

138 Failing to appreciate the significance and urgency of psychiatric illnesses.

There will be a modular course introduced as part of the new CPD process that will be designed around Mental Health awareness.

31 Adverse outcome in maternity cases

It is recognised that the recruitment of a Mid-Wwife is a high priority for the Trust. The Medical Director to appoint representative to attend NPSA's Obstetrics pan London forum.
<u>ACTION: Medical Director</u>

207 Risk of not being able to download information from Defibrillators

It was reported that approximately 12% of the downloaded information from FR2 and 12 Lead ECG defibrillators is being received by CARU. The Head of Clinical Audit & Research said that some complexes are trialling different approaches and the successful one will be rolled out across the Trust. **<u>ACTION: Head of Clinical Audit & Research and not Deputy Director of Operations to be the identified lead for this risk.</u>** This issue will be raised at the Area Governance meetings.

22 Failure to under take comprehensive clinical assessments which may result in the inappropriate non-conveyance or treatment of patients

A/Head of Education & Development to update the Governance Manager on this risk for consideration by the CGC in October 2007. **<u>ACTION: A/Head of Education & Development</u>**

20 Failure to fully complete the Patient Report Form.

It was reported that the inclusion of data regarding ethnicity is better than previously reported. *74%* of PRFs are recording the ethnicity of patients.

The Head of Clinical Audit & Research reported that the possible discrepancy between the CPI figures and those reported to the committee previously by the Head of Diversity may due to the source of the data used by the Head of Diversity. The Head of Clinical Audit & Research recommended that in future the ethnicity figures should be derived only from the CPI database.

194 *Risk to patients after handover and to the viability of research projects with financial ethical and reputational impacts.*

Head of Clinical Audit & Research proposed that this risk be deleted from the Register as there are good mitigating processes in place. This will be proposed to RCAG on 30th October. **ACTION: Head of CARU**

188 Paramedics fail to re-certify on time and have to revert to Technician Status.

This risk will be reviewed in October when the number of Paramedics who have recertified will be known. A decision will be taken then as to whether the risk can be downgraded/deleted. **ACTION: Deputy Director of Operations.**

179 Trust failing to meet responsibilities under the Race Relations Act

It was confirmed that ethnicity codes have been included on DATIX.

165 Delivery of sub-optimal care for patients with age-related needs and failure to meet meet NSF Milestones

It was felt that there is a good awareness amongst crews on how to raise any concerns they might have regarding elderly patients. There was however less confidence in the standard of documentation relating to this risk.

46 *Risk of infection to staff due to needle-stick injury*

A report will be presented to CGC in October outlining the progress made in mitigating this risk e.g. the introduction of the Braun Safety Cannula. **ACTION: Head of Operational Support.**

63 *The risk of incurring liability through the re-use of single use devices*

It was proposed that this risk be deleted from the Register given the introduction of single use equipment. **ACTION: Head of Operational Support to propose deletion to the RCAG, 30th October 2007.**

52/07 Summary Status Report of Clinical Policies & Procedures

The Head of Records Management presented the report and highlighted the number of policies and procedures that were overdue for review (these were reported as having red status). The majority of the overdue policies and procedures were either linked to the Metropolitan Police or concerned Mental Health. The Assistant Director of Employee Services said that some of the delay would be due to the need to consult with Staff Side.

Noted: The contents of the report, in particular those policies and procedures whose review is overdue.

53/07 Operation's pan London Governance Report

The Deputy Director of Operations presented the pan London governance report to the Committee and highlighted the following:

Incidents: Non-clinical incidents have fallen during the second quarter of the year across all Areas and are now at their lowest levels for 12 months. Clinical incidents remain rare and statistical changes have not been significant over the period.

CPI: 60% of PRFs were reviewed in July against a target of 80%. Although there has been no sustained progress on a pan London basis in regard to PRF documentation being reviewed, there have been pockets of excellence across the Trust. Recruitment is underway to fill the current 25 team leader vacancies. In terms of feedback, 1213 out of 1296 members of staff have received feedback concerning their PRF documentation. The Deputy Director of Operations said there is evidence that undertaking CPI checks and giving feedback have brought about changes in behaviour.

Ethnicity: 74% of PRFs contain information regarding ethnicity. The previous report that stated that 94% of PRF did not contain information regarding ethnicity was mistaken.

Cardiac calls: The analyses of CPIs show that all aspects of care data regarding Acute Coronary Syndrome (ACS), & Cardiac Arrest continue to exceed 70%. Concern was expressed regarding the following areas: the recording of initial and final peak flow readings in patients complaining of difficulty in breathing; the recording of previous births in obstetric patients and documenting of leaving a copy PRF on scene.

Complaints: the management of complaints is broadly on target with 82% being resolved within 25 days. The majority of complaints continue to be about attitude and behaviour of staff.

The Committee's attention was drawn to work being undertaken in regard to clinical developments throughout the Trust. At Wimbledon complex, for example, the following have been undertaken: weekend resuscitation training weekend and weekend refresher training for DSOs. As managers are being deployed 11.00-14.00 hours to cover rest break, they are receiving additional training to ensure they can safely respond to calls. A two day event was held whereby managers were given refresher training in advanced skills

Fast Response Units: A new rota has been drawn up which includes 1 day for PDR training.

Rest break: 53% of crews are receiving uninterrupted rest breaks with 8% finishing their shift 30 minutes early. The low rate of allocation has meant the Trust is £0.5m over-budget on rest breaks. The Rest Break Agreement is being reviewed, one of the areas for discussion is the type of calls that breaks can be interrupted for.

PDR: this process is being undertaken by Team Leaders this year and it is expected to be completed by 31st October 07. IOne complex, New Malden, has already undertaken all PDRs for 2007.

Chief Executive's annual consultation: work is being undertaken to respond to the issues raised by staff at the Chief Executive's recent consultation meeting.

The strategic decision has been taken to increase the capacity of the motor bike and cycle response units; the additional resource will be deployed in Central and East and other areas of high density demand. The proposal will be considered by the SMG in September 2007.

The crew that alerted the police to the car filled with explosives have rejected publicity; their vigilance has received praise from the Home Secretary and the Mayor of London.

South Area The Assistant Director of Operations, South, highlighted the following:

CPIs: the percentage of CPIs undertaken in June was 70%. Three complexes were on target scoring 80% and above. The ADO South thanked colleagues in CARU for the work undertaken in respect of the updated database which has been a significant piece of work as it allows management to identify the outliers and those members of staff who are performing really well.

Complaints: focus is being placed on clearing the backlog of complaints by 1st July so that AOMs can simply focus on 'live' complaints.

PDR: all front line staff should have PDRS in place by 31st October. Driving licence checks are being undertaken as part of the PDR process in particular,. Tthis is in line with the financial implications for the Trust of repeated accidents.

The first clinical governance area meeting was held on the 3rd August and was attended by the Head of Governance and the Head of Legal Services.

The rosters of the motor bike unit based at Waterloo are being reviewed with the aim of improving the availability of the motor bike service and consequently improving the cardiac arrest survival figures. In addition, the Motor Bike Unit will be tasked differently and respond to more Red calls than it is currently doing.

Operation Whitgift (Croydon). Although there were some governance issues surrounding PRFs, the trial was deemed to be successful. Work is being undertaken to identify a suitable location for a walk in centre that will help reduce the number of non-emergency, alcohol related injuries that the Croydon Ambulance crews are called to over the Christmas period.

The Chairman said that the report was very helpful in giving the Committee insight to what governance arrangements are in place for Operations. She congratulated New Malden on completing the PDRs and in having such a high rate of completion of CPIs.

Control Services: the Ambulance Operations Manager, D Watch, highlighted the following developments in Control Services:

Following a relaunch in April 2007 there have been improvements in the participation of Dispatcher Assisted Resuscitation Trial (DART) and the trial will probably be extended into 2008.

AMPDS compliance: tThere continues to be problem with Cable & Wireless in respect of Caller Line Identification. The expected delivery date is later this year.

CTA compliance: the figures for the end of July were 92-93%. There was some down-turn in performance due to software upgrade and staff training. The indications are that the performance is improving.

Complaints: there is little data available for April-June; a fuller report will be presented in October.

AMPDS: quality control is being undertaken for 1% of the total call volume which involves reviewing compliance and other governance issues. The code of the month is obstetrics and quality assurance feedback is being undertaken on all those calls.

Noted: **The contents of the report.**

54/07 **Update re. Safety Alert Bulletins & NICE**

The Head of Safety & Risk presented the update on Safety Alert Bulletins to the Committee. A number of Alerts are being assessed for relevance to the LAS. These are:

- MDA/2007/059: point of care blood glucose measurement systems: hemocue glucose 201+ and hemocue glucose 201 RT.
- DH (2007) 07: TK Control potentiometer (lighting dimmer)
- DH (2007) 06: Electrical extension lead (multiple socket outlets)
- MDA/2007/043: Invacare flamingo mobile patient hoists
- DH (2007) 05: medical gas outlet Mark IV Valve Plate

Agreed: **1. That as Safety Alert Bulletins are reported to the Corporate Health & Safety Group, which in turn reports to the RCAG, it is no longer necessary for the CGC to continue to receive the report.**

Noted: **2. That that were no new NICE bulletins at present relevant to the Trust. The LAS has registered interest in the review of the Head Injury Guidelines and the Acute Coronary Syndrome once they are published.**

55/07 **Reports from Groups/Committees**

1 *Risk Compliance & Assurance Group – 3rd July 07*

The Head of Governance said that work is being undertaken to ensure that the Trust meets the requirements of the NHSLA's new ambulance standards. The first visit took place on 7th August (Level 1) and the second visit will take place in November (Level 2).

Noted: **The minutes of the RCAG, 3rd July 2007**

2 *Complaints Panel – 31st July 07*

The Panel was informed that the PALS Manager will take responsibility for the management of complaints with effect from 1st October. The Panel considered the paper 'developments in the handling of complaints within the NHS and Social Care Arena – *Making Experiences Count*' which set out the proposed changes announced in the consultation event chaired by the Parliamentary Health Ombudsman. The Panel also received the Annual Complaints report for 2006/07.

Noted: **The minutes of the Complaints Panel, 31st July 2007.**

3 *Standards for Better Health – 27th July 2007*

Noted:
1. **That the Standards for Better Health group has met and will be focussing on how the Trust can demonstrate its compliance with the developmental standards together with the core standards when completing the Annual Declaration for 2007/08 in April 2008.**
2. **The minutes of the Standards for Better Health Group – 27th July 2007**

4 *Infection Control Group – 12th June 2007*

The Head of Operational Support highlighted the following from the minutes:
- The Infection Control action plan is being implemented.
- That in respect of the workplace inspection process, infection control audit criteria have now been included and will be undertaken by Health & Safety representatives.
- An issue has been raised concerning clinical waste being inappropriately disposed of at some complexes. This has been discussed with complex management and a Health & Safety Bulletin is to be issued.

Noted: **The minutes of the Infection Control Group, 12th June 2007.**

5 *PPI Committee – 29th June 2007*

The PPI Committee discussed how the NHS Centre for Involvement's recommendations would be progressed. The plan will be considered by the Service Development Committee in October.

The PPI Manager said that there will be progress made in enabling Deaf people to access the 999 Services via SMS messaging with effect from April-June 2008. No new equipment or training will be required as access will be provided via Typetalk. Deaf people will be able to access the service by pre-registering and being able to text 999 to access the Service.

Work is being undertaken with the Bangladeshi community in Tower Hamlets with a number of partners including the PCT, the Royal London Hospital, and voluntary sector agencies such as Social Action for Health. Members of the Bangladeshi community have reported to Social Action for Health that they are concerned about the questioning required

using the AMPDS system leading to delays, and are uncertain whether they are 'allowed' to call an ambulance when they are in labour. Communication needs to be undertaken to reassure the public about these points.

Noted:

1. **The minutes of the PPI Committee – 29th June 2007.**
2. **That the following groups have not met since the last CGC meeting: Clinical Audit & Research Steering Group; Race Equality & Diversity Strategic Group, the Clinical Steering Group and the Training Services Group.**

56/07 **Any Other Business**

Agreed: **That the Deputy Director of Operations will identify an Emergency Medical Dispatcher (EMD) and Emergency Medical Technician (EMT), in their first year of service, to attend the full meeting of the Committee on 18th December 2007. Expressions of interest will be called for via the weekly Routine Information Bulletin. ACTION: Deputy Director of Operations.**

57/07 **Dates of next meeting:**

Core: Monday, 15th October 2007 at 9.30 in the Conference Room, HQ
Full: Tuesday, 18th December 2007 at 2.00pm in the Conference Room, HQ

Meeting concluded at 13.50

Enclosure 14

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 25th September 2007

Report of the Trust Secretary
Tenders Received

1. Purpose of Report

i. The Trust's Standing Orders require that tenders received be reported to the Board. Set out below are those tenders received since the last Board meeting.

ii. It is a requirement of Standing Order 32 that all sealings entered into the Sealing Register are reported at the next meeting of the Trust board. Board Members may inspect the register after this meeting should they wish.

2. Tenders Received

There have been 3 tenders received since the last Trust Board meeting.

Window and roof replacement, Kenton AS	Fairhurst Ward Abbot Expert Property Solutions Coniston Ltd Diamond Build W. C. Evans & Son
CAD 2010 (company appraisal)	Integraph Fortek Northrop Grummon EADS (including Integraph) BAE Systems (including Asset Co Team) BAE Systems (including Fortek)
Tolworth AS	Kilby & Gayford Russell Crawberry GB Group Eugena Ltd.

3. Recommendations

THAT the Board note this report regarding the receipt of tenders.

Christine McMahon
Trust Secretary