LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
29 SEPTEMBER 2009

London Ambulance Service NHS
NHS Trust

Meeting to be held at 10.00am on Tuesday 29th September 2009
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

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1.	**Welcome & Apologies**		
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	4.1 Minute 67/09 (57/09) Board effectiveness review	PB	Oral report
	4.2 Minute 77/09 Balanced scorecard report	MD	Presentation
	To receive a presentation on the balanced scorecard report.		
5.	**Formal reports from sub-committees**		
	5.1 Audit Committee		
	To receive the minutes of the meeting held on 8th June 2009 and to note the oral report of the meeting held on 15th September 2009	CS	4
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10.	**Winter Planning and Flu Preparedness**	MF	9
	10.1 To note the arrangements for Winter Planning;		

10.2 To receive a summary statement concerning Pandemic Flu management and to approve the declaration of readiness.

11. Declaration on safeguarding Vulnerable Children FM 10

To receive a progress report and to approve the declaration on safeguarding arrangements.

12. CQC Inspection on the prevention and control of infections FM 11

To note the CQC inspection report and the action plan.

13. Finance and governance declarations 2009/10 – NHS London MD/SA 12

To note the governance declaration for 1st quarter 2009/10 and to approve the declarations for 2nd quarter

14. Freedom Of Information Act Policy PS 13

To approve the updated policy.

15. Policy on the development of procedural documents SA 14

To approve the updated policy.

16. Service Improvement Programme:

Programme Update KJ 15

CAD 2010 PS 16

17. Application process for becoming an NHS Foundation Trust

17.1 To receive the final report on feedback from the consultation process AP 17

17.2 To receive a progress report on the application process and the next steps, including: SA 18

- Long term financial model & financial assumptions MD Presentation
- Membership Strategy – for approval SA 19
- Constitution SA 20
- Governance Arrangements SA 21

18. Training Plan CH 22

To note the training plan.

19. Business Cases for approval MD To follow

19.1 Lease of Ambulances

19.2 Silvertown Olympic Site

20. Report of Trust Secretary SA 23

20.1 To note the 2009/10 Register of Interests for Directors

20.2 To note the committee programme for 2010

20.3 To note the plans to review the format and level of papers for meetings of the Trust Board and Service Development Committee Oral report

20.4 To note the Trust Board and Service Development Committee forward planner from September 2009 to December 2010

21. Questions from Members of the Public

22. Any Other Business

23. Date of next meeting

The next Trust Board meeting will be held on Tuesday 24th November 2009 at 10.00am at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.

There will be a meeting of the Service Development Committee on Tuesday 27th October 2009.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 28 July 2009 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	Richard Hunt	Chairman
	Sarah Waller	Vice Chairman
	Peter Bradley	Chief Executive Officer
	Martin Flaherty	Deputy Chief Executive Officer
	Mike Dinan	Executive - Director of Finance
	Roy Griffins	Non Executive Director
	Caron Hitchen	Executive - Director of Human Resources & Organisation Development
	Beryl Magrath	Non Executive Director
	Fionna Moore	Executive - Medical Director
	Caroline Silver *	Non Executive Director *(until 12:50 p.m.)*
Apologies:	Brian Huckett	Non Executive Director
In attendance:	Kathy Jones	Director of Service Development
	Sandra Adams	Director of Corporate Services
	Peter Suter	Director of Information Management & Technology
	Angie Patton	Head of Communications
	Richard Webber	Director of Operations
	Asif Islam	Deputy Director of Finance
	Nick Daw	Head of Patient Transport Services
	Martin Salter	Corporate Processes Programme Manager
	Malcolm Alexander	Patients Forum
	John Ellman-Brown	Capita Company Secretarial Services

**** by telephone***

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66/09 Welcome and Apologies

The Chairman welcomed everyone to the meeting noting that apologies had been received from Brian Huckett. In particular, he welcomed Sandra Adams to the Trust and to her first Trust Board meeting.

67/09 Minutes

After review and due consideration:

IT WAS RESOLVED THAT the minutes of the Trust Board meeting held on 19 May 2009 be and are hereby approved as a true record of the meeting, and that they be signed by the Chairman.

66/09 **Trust Board Meeting 19 May 2009: Part II Synopsis**

The synopsis of the minutes from the Trust Board Part II meeting held on 19 May 2009 was noted.

67/09 **Matters Arising**

Minute 59/09: Board Effectiveness Review: It was confirmed that no action had yet been taken in terms of circulating the "freehand" comments and scores to all Directors, or on the review of Board Committees. The CEO would follow up on this.
Action: CEO

Minute 61/09: CGC Meetings Draft Minutes: Dr. Moore reported the manufacturers of Glucose and Sodium Chloride had proven unwilling to re-package the drugs, despite the similarity in the packaging that could easily lead to the administration of the incorrect drug. However, changes were being considered within LAS in terms of the packaging of the fluids, to ensure confusion was minimised. She would report further at the next meeting.
Action: Medical Director

68/09 **Chairman's Update**

The Chairman reported his first impressions since joining the organisation.

- This was his first foray into the public sector and the NHS, so resolving who does what will take some time. However, to date, the quality of the LAS staff he had met had all exceeded his expectations;
- His background was in logistics delivery, which had a strong resonance with the LAS;
- Headline items he had identified were as follows:

    - **Clinical Agenda**
    - **People Agenda**
    - **Performance**
    - **FT Status**

each of which required attention at a time of increasing demand on the Service and a tighter financial framework in which to operate.

69/09 **Chief Executive's Report**

The Board considered the report of the Chief Executive.

The post of "Director of Health Promotion" was being advertised externally, and the CEO would advise progress to the Board when he had something further to report.
Action: CEO

It was noted that, in mid-June Cat A had been 74.6% and Cat B 86% however, since then, performance had dropped off dramatically, for which the primary reasons were increased workload and decrease in overtime uptake. As a result of this drop in performance, a recovery plan had been developed by the Director of Operations and it was hoped to have Cat A recovered by August and Cat B as soon as possible thereafter.
Action: Director of Operations

After further discussion:

IT WAS RESOLVED THAT the report of the Chief Executive be and is hereby received.

70/09 Final 2008/09 Audited Accounts

The Board considered the audited Annual Accounts of the Trust for the year ended 31 March 2009.
Directors noted that the Audit Committee had recommended the accounts for Board approval at its meeting on 8 June 2009, and that the Audit Commission (the Trust's external auditor) had given the accounts an unqualified opinion. In addition, the accounts had been completed by the target date of 23 April 2009 and subsequently submitted to the NHSE, Audit Commission and NHS London.

After further discussion and due consideration:

IT WAS RESOLVED THAT the audited annual accounts of the Trust for the financial year ended 31 March 2009 be and are hereby approved.

71/09 Report of Finance Director: Month 3

The Report of the Finance Director for June 2009 (month 3) was reviewed.

Directors noted a month end deficit of £208,000 and a year to date surplus of £314,000. A full year surplus of £1.69 million was being forecast. Mr. Dinan reported that the forecast profile had been changed so as to reflect the activity undertaken to support performance. Despite this, the full year forecast had been maintained.

Mr. Dinan would provide the following update reports to the next meetings of the Trust Board and SDC:

- Trust Board 29 September 2009: A&E Services Contract; and
- SDC 27 October 2009: Accident Damage

Action: Director of Finance

After further discussion:

IT WAS RESOLVED THAT the Finance Report for June 2009 (month 3), as presented by the Director of Finance, be and is hereby received and noted.

72/09 Report of Medical Director

The Report of the Medical Director was reviewed and discussed.

After due consideration:

IT WAS RESOLVED THAT the Report of the Medical Director, with the exception of the Fourth Domain trial, be and is hereby received and noted.

The Board discussed at length the Fourth Domain proposed trial 'Selecting the Right Care Pathway for every Call', noting the various elements to be trialled. The

Board generally supported the proposal but that it was a step-change in the way the Trust operated. Dr. Moore agreed to provide an update on outstanding issues at the Trust Board meeting on 29 September 2009, prior to the Board giving its approval to the trial.
Action: Medical Director

73/09 Service Improvement Programme ("SIP") 2012 Update

The Board considered the SIP 2012 Update report, presented by the Director of Service Development.

Directors noted the new format of the SIP which had consolidated 7 sub-programmes and a supporting Stakeholder Engagement and Communications Strategy into 3 programmes as follows:

- Clinical Development, Leadership and Workforce Programme;
- Performance and Service Delivery Programme;
- Preparing for the Olympics Programme.

After due consideration:

IT WAS RESOLVED THAT the SIP 2012 Update report, as presented, be and is hereby received and noted.

74/09 Business Cases

- **Acquisition of Ambulances**

The business case for the acquisition of 65 new ambulances as part of the strategic fleet plan and the 2009/10 Trust business plan was presented by the Director of Finance.

The Board noted that the acquisition would allow an additional 40 ambulances to be procured as part of the agreed 2009/10 commissioning agreement and 25 would complete the replacement of the LDV fleet. The total purchase cost was £7.1m and was affordable.

After due consideration:

IT WAS RESOLVED THAT the business case for the purchase of 65 new ambulances, as presented by the Director of Finance, be and is hereby approved.

- **Replacement of Defibrillators**

The business case for the replacement of 140 defibrillators with updated versions was presented by the Director of Finance.

The Board noted the capital cost in year 1 amounted to £1.7m and was affordable in each of the 5 years of the useful life of the assets. The capital and associated revenue costs were within the 2009/10 BP.

After due consideration:

IT WAS RESOLVED THAT the business case for the purchase of 140 replacement defibrillators, as presented by the Director of Finance, be and is hereby approved.

75/09 KA34 Compliance Statement

Directors considered the annual KA34 compliance statement, presented by the Director of IM&T, noting that it was a compliance statement that followed national guidelines, and contained important governance confirmations.

After due consideration:

IT WAS RESOLVED THAT the KA34 Compliance Statement, as presented by the Director of IM&T, be and is hereby received and noted.

76/09 CAD 2010 £10m Loan

The Board considered the CAD 2010 £10m loan application which had been brought back to it for formal approval. This was due to the fact that, despite it having been included within the FBC approved by the Board in July 2008, NHS London had changed the approval process and now required formal and specific approval of the loan application from the Trust Board.

Accordingly:

IT WAS RESOLVED THAT the CAD 2010 £10m loan application be and is hereby approved.

77/09 Balanced Scorecard Report

The Board received an update briefing and presentation on the current status of the Trust's Balanced Scorecard from the Director of Finance and Martin Salter.

The Board considered that the Scorecard contained too much information; initial detail should consist of a high level summary with the ability to 'drill down' for further information if so desired. It was agreed therefore that draft summary items would be presented to the Board meeting on 29 September for discussion, along with a presentation on how to 'drill down' into the system for further details.
Action: Director of Finance/Martin Salter

Mrs. Silver left the meeting at 12:50 p.m.

78/09 Report of the Trust Secretary: Tenders received and Use of the Trust Seal

Tenders Received
Directors noted that there had been 2 tenders received since the previous Board meeting as follows:

Coaching, Mentoring and Work/Life Balance Programme

Coaching on Call	Tavistock & Portman NHS Foundation Trust
Davidson Nicklen & Associates	The Performance Coach
Lane 4 Management Group	

Refurbishment of Bounds Green

Sibmar	Lakehouse Contracts
Caniston	TCL Granby

Use of Seal
The Seal had not been used since the last Trust Board meeting.

79/09 **Next Meeting**
It was noted that the next Trust Board meeting would be held at 10:00 am on Tuesday, 29 September 2009 in the Conference Room at LAS HQ.

80/09 **Any Other Business**

The Chairman requested that within Reports and Presentations made to the Board in future all pages be numbered.
Action: All

There being no further business, the Chairman declared the meeting closed at 12:55.

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Chairman
29 September 2009

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 28 July, 2009
in the Conference Room, LAS HQ,
Waterloo, London

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.

Update on Serious Untoward Incidents ("SUIs")

- **Child N:**

The Medical Director briefed the Board on the current status of the Child N serious case review. Due to court reporting restrictions, further details cannot be published at this time.

Further SUIs

The Deputy CEO advised that no further SUIs had been identified although a recent incident reported in the media was under consideration for SUI classification.

As a result of this incident, the Chairman had received two letters from MPs that required responses. The deputy CEO agreed to draft suitable responses following the meeting.

MATTERS ARISING

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 28 July 2009

MINUTE NO.	PART I MEETING	RESPONSIBILITY	DATE
67/09	**MATTERS ARISING** ▪ **Minute 59/09: Board Effectiveness Review** 1. Freehand comments and scores to be circulated to all Directors 2. Review of Board Committees to be commenced ▪ **Minute 61/09: CGC Meetings Draft Minutes** Update on LAS proposals for packing of Glucose and Sodium Chloride	**CEO** **Director of Corporate Services** **Medical Director**	**September 09** **SDC: 27 October 09** **TB: 29 September 2009 (Medical Director's report)**
69/09	**Chief Executive's Report** 1. Update on appointment of "Director of Health Promotion" 2. Update on performance recovery plan	**CEO** **Operations Director**	**TB: 29 September 2009 (CEO report)** **TB: 29 September 2009 (CEO report)**
71/09	**Report of Finance Director** 1. A&E Services Contract update 2. Accident Damage update	**Finance Director** **Finance Director**	**TB: 29 September 2009 (FD report)** **SDC: 27 October 2009**
72/09	**Report of Medical Director** Update on outstanding issues re Fourth Domain trial 'Selecting the Right Care Pathway for every Call'	**Medical Director**	**TB: 29 September 2009 (Medical Director's report)**
77/09	**Balanced Scorecard Report** Draft summary items and presentation explaining how to 'drill down' for further detail	**Finance Director**	**TB: 29 September 2009 (Finance Director's report)**

80/09	**<u>Any Other Business</u>** All report and presentation pages to be numbered.	**All**	**All future meetings**

LONDON AMBULANCE SERVICE NHS TRUST

AUDIT COMMITTEE

Minutes of the meeting held on Monday 8 June, 2009
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

Present:	Caroline Silver	Non-Executive Director (Chair)
	Brian Huckett	Non-Executive Director
	Roy Griffins	Non-Executive Director
In Attendance:	Dr Beryl Magrath	Non-Executive Director
	Peter Bradley	Chief Executive Officer
	Laila Abraham	Interim Head of Governance
	Asif Islam	Head of Finance
	Michael John	Financial Controller
	Phil Johnstone	District Auditor - Audit Commission
	Dominic Bradley	Audit Manager - Audit Commission
	Chris Rising	Senior Manager - RSM Bentley Jennison
	David Foley	Senior Manager - RSM Bentley Jennison
	Gary Douglas	Local Counter Fraud Specialist – RSM Bentley Jennison
	Clive Parker-Wood	Interim Trust Secretary

01 Welcome & Apologies

The Chairman welcomed everybody present at the meeting and it was noted that apologies had been received from Mike Dinan and Sarah Waller.

02 Minutes

After review and due consideration, the following amendments were noted for correction to the minutes of the Audit Committee meeting held on 9 March 2009:

Minute 04/09: "IFRS": The two main outstanding areas of work were:
a) Accounting for the holiday pay liability;
b) Establishing whether ambulances are to be classified as operating or finance leases.

Minute 10/09: "Subsistence": Mr John reported that "Back-to-Back" arrangements would be decreased before 31 March 2009 and that the liability would be reduced from £7 million to £1 million.

It was resolved that following the amendments to the minutes of the Audit Committee meeting held on 9 March 2009, they be and are hereby approved as a true record of the meeting, and that they be signed by the Chairman.

03 Matters Arising

Minute 14/09: "Risk Management": Mrs Abraham advised the committee that all preparations for the Risk Management workshop had been completed. It was noted that the workshop had been postponed until after the new Chairman of the Board and Director of Corporate Services had commenced their new roles at the Trust. It was further noted that a date for the workshop would be decided on in due course.

04 Risk Register

Mrs Silver informed the committee that the Risk Register would be discussed earlier on in the meeting to indicate its importance and allow members more time to debate and resolve any issues contained within the register.

Mrs Abraham updated the committee regarding the new format of the Trust's Risk Register. The new version of the Trust Wide Risk Register had previously been agreed at the RCAG

meeting in February and comments from that meeting had been incorporated in the register presented to the committee. It was noted that the Risk Register recorded all "High Risks" and was still a work-in- progress document.

Mrs Abraham stated that the "Key Controls" and "Further Action Required" sections within the Register would be constantly updated and monitored and that the whole register should be seen as a live document used to assist in the mitigation of risks.

A discussion took place regarding the number of high level risks being included in the risk register. After some debate, the committee agreed that there were fewer risks being included within the new format risk register and it was noted that this was due to the fact that the register now only contained "High Level" risks. It was agreed that it would be in the best interests of the committee to establish what risks the RCAG and Clinical Management Committee managed.
Action: Laila Abraham

Mrs Abraham reported that the process for the risk register would move into Performance Accelerator to enhance and streamline reporting.

After a long discussion, It was agreed that the high level risks register should contain full details of risks and that there should be a mechanism in place to allow summaries of all risks to link up with the "High Level" Trust Wide Risk Register and be presented to the Audit Committee.
Action: Laila Abraham

05 **Audit Commission: Annual Governance Report – Audit 2008/09**

Mr Bradley presented to the committee the final report containing the results of the work undertaken by External Audit for 2008/09.

Mr Bradley informed the committee that, subject to satisfactory clearance of outstanding matters, he planned to issue an audit report including an unqualified opinion on the financial statements.

Mr Bradley reported that the financial statements were submitted to audit a day before the deadline and did not contain any material or significant errors. It was noted that three non-trivial errors were identified, which the officers had amended and one non-trivial error that had not been amended.

Mr Bradley informed the committee that the Trust had overprovided the provision against the HMRC subsistence claim, which Price Waterhouse Coopers ("PWC") had estimated at £590K. The Trust did not wish to amend to this figure and had kept a provision in the accounts for £1 million. It was noted that this was because the Trust considered that it would be left with additional costs if the final figure should prove to be more than the figure stated by PWC.

Mr Bradley reported that the audit had not identified any weakness in the design or operation of an internal control that might have resulted in a material error in the Trust's financial statements.

Mr Bradley stated that during the stock take process, it was noted that the controls around non-drug items were weak and that the following errors and control issues were found:

- Not all paperwork could be found to verify that individual items had been issued.
- Where an ambulance was sent out with a "complete kit", a number of lines within the stock sheets were not annotated as being "taken" despite logistic officers being certain that they would not have been issued without these key items.
- There were three "stock counting errors" from the year end exercise, which had been undercounted / over-counted, where there was no movement of stock either in or out to explain the difference.

- There was a mis-categorisation between two items that looked similar in the store room.
- One example of double counting of an item, where it appeared on the stock sheets in two different places.

It was noted that the controls around stored drugs were adequate, and that no errors were found during the stock count of drugs.

Mr Bradley reported that following the review of the register of interests, it was found that the register was not being used in a robust way. Mr Bradley stated that the Trust had met all the "Value for Money" criteria and that it had adequate arrangements to secure economy, efficiency and effectiveness of resources.

After due consideration, the Committee:-

1. Took note of the adjustments to the financial statements which were set out in the report;
2. Agreed not to adjust the errors in the financial statements which management had declined to amend;
3. Approved the letter of representation on behalf of the Trust; and
4. Agreed to the proposed action plan.

06 Audit Commission: Audit Commission Progress Report against 2008/09 Audit Plan

Mr Johnstone stated that the Audit Commission had completed their triennial review of the Internal Audit function and that it was in their view that the role of Internal Audit was meeting the required NHS internal audit standards.

Mr Johnstone reported that the Audit Commission had concluded the first part of the 2009 Auditor Local Evaluation ("ALE") assessment for the sections on internal control, financial management and value for money and this had recently been through their regional and national quality control process.

Mr Johnstone advised the Committee that the Trust had provided a good standard of evidence for each area and two good Financial Management Notable Practice examples that would increase the score of financial management to a level 4. It was noted that Internal Control and Value for Money remained unchanged at level 3. However, it was further noted that, these scores were not final at this stage and a full update on the final scores achieved by the Trust would be presented at the next meeting.
Action: Mr Johnstone.

On the basis that thr level 4 ALE score would indeed be achieved, Mrs Silver commended the efforts of all the individuals involved in attaining a level 4 score rating.

07 Audit Commission: Audit and Inspection Plan – 2009/10

Mr Johnstone advised the committee that the Audit Commission's fee for the audit work they proposed to undertake for the 2009/10 financial year was based on the risk-based approach to audit planning as set out in the Code of Audit Practice and work mandated by the Audit Commission for 2009/10.

Mr Johnstone stated that the total indicative fee for the audit for 2009/10 was £136k (excluding VAT), which compared to the planned fee of £131,325 for 2008/09.

It was noted that the Audit Commission had published its work programme and scales of fees for 2009/10 and that the Audit Commission scale fee for the Trust was £193,325. It was further noted that the fee proposed for 2009/10 had been set at 29.7% below the scale fee and would be billed in monthly instalments.

The Committee approved the Audit Commission's proposed fee for audit work for the 2009/10 financial year.

08 Internal Auditors' Report – Internal Audit Progress Report

Mr Rising stated that the report contained four final Internal Audit reports and that of these four, two were limited assurance reports on Policies & Procedures and Drug Controls.

Policies & Procedures:
Mr Rising stated that ten policies and procedures across four categories had been sampled to verify that not only had they been updated, reviewed and approved but that they had been communicated appropriately and were workable and understandable.

It was noted that the Trust had made a concerted effort to ensure that all polices and procedures were added to the intranet in a timely fashion so as to allow staff to refer to them when they wished. Mr Rising stressed that the main issue revolved around operational staff not having electronic access to these policies and procedures due to the nature of their roles.

The recommendations in the Action Plan were all agreed by the committee and assurance was given that all 7 recommendations would be managed by the Head of Records and Business Continuity. It was noted that all the recommendations contained within the report were understood by the committee and full implementation of all the recommendations would be complete by mid-September 2009.
Action: Head of Records and Business Continuity.

Drugs Controls:
Mr Rising stressed that the committee should pay particular attention to the drugs report as this had highlighted a number of significant weaknesses regarding the management of drug packs within the Trust.

Mr Rising highlighted the key findings from the Drug Controls review and the following points were noted:

- Testing undertaken as part of the audit identified fundamental weaknesses in the control over drug packs, particularly in respect to the management of out of date drug packs;
- Testing identified that packs were not being returned on a timely basis;
- Testing identified that return drug pack lockers at two stations had been opened to enable access to used packs to address shortages at individual stations;
- Finally, testing identified at least six drugs packs returned to Logistics in January 09 were over a year out of date.

Mr Rising informed the committee that serious untoward incidents in respect of drug errors were not formally reported to the Board via the report of the Medical Director. It was suggested that the introduction of reporting this would ensure that the Board were made aware of any trends in the numbers of drug errors and could ensure that suitable actions were taken in respect of this.
Action: Fionna Moore/Richard Webber

The Committee discussed the findings and the 7 recommendations contained within the report. It was noted that out of these seven recommendations, 5 were Fundamental Recommendations (action was imperative) and 2 were significant (required action to avoid exposure to significant risk).

It was noted that all recommendations contained within the report had been understood by all committee members and it was agreed that implementation of six of the necessary actions had been completed and the other three were being implemented:

Mrs Abraham informed the committee that an internal audit manager had been recruited to investigate and begin the process of implementing the actions from all internal audits.

After due consideration it was agreed that overall responsibility for implementing the recommendations from the Drug audit would remain with Richard Webber and that a verbal update on the progress of the implementation of the rest of the recommendations contained within the report would be given at the next audit committee meeting in September 2009.
Action: Richard Webber.

09 Internal Auditors' Report

The report was taken as read. Mr Rising stated that based on the work undertaken in 2008/09, significant assurance could be give that there was a sound system of internal control, designed to meet the Trust's objectives, and that controls were generally being applied consistently.

Mr Rising assured the committee that the Trust had taken immediate action following the issue of the report to address the weaknesses identified from the audit. It was noted that a detailed action plan had been developed which included actions address both the issues identified and to ensure ongoing compliance within the Trust.

10 Ratification of Final 2008/09 Audited Accounts

The accounts for the year ended 31 March 2009 were taken as read. Mr John reported that the Trust had completed the accounts on 23 April 2009 and that it had retained a surplus of £725k for the financial year.

Mr John reported that the Trust was required to make a 3.5% financial return on average net relevant assets. The actual rate of return in 2008/09 was 4.2% which was above the permitted range of 3.0% to 4.0%. The variance from 3.5% was due to a fall in value of land & buildings attributable to the current economic downturn.

Mr John stated that the Trust had achieved it External Financial Limit (EFL) target of £7,267k for the year.

Mr John reminded the committee that the Trust was given a Capital Resource Limited (CRL) which it was not permitted to overspend. It was reported that the CRL was under spent by £1,247k against the limit agreed with the London Strategic Health Authority of £15,865k.

Mr John advised that the Public Sector Payment Policy (PSPP) performance for Non-NHS trade policies was 85% and for NHS invoices 89% (in numbers of invoices); the target set by the Strategic Health Authority was 95%.

It was noted that the Trust was required to submit its audited accounts to the Department of Health on or before 12 June 2009.

After due consideration, the committee ratified the final 2008/09 audited accounts for the financial year ending 31 March 2009.

11 Audit Recommendations Database

Mrs Abraham stated that the report outlined the current status of all fundamental Internal Audit Recommendations which had not previously been reported as implemented to the audit committee.

Mrs Abraham informed the committee that managers were required to establish action plans for the implementation of accepted recommendations within a reasonable timeframe with the aim of making the whole process regarding internal audit recommendations more efficient and streamlined.

It was noted that there were two New Reports (Drug Controls & Standards for Better Health), five Fundamental Recommendations and two Significant Recommendations.

Mrs Abraham stated that the whole implementation of recommendations would be uploaded onto Performance Accelerator shortly.
Action: Laila Abraham

The committee noted the progress of all the reports and recommendations.

12 Report of the Local Counter Fraud Specialist (LCFS) – Annual Report 2008/09

The report was taken as read. Mr Foley stated that the annual report provided details of work conducted by the LCFS during the work plan year of 2008/09 across the generic areas of the counter fraud strategy, and in line with the agreed work plan for the period.

Mr Foley advised the committee that the development of a real anti-fraud culture across the Trust was a key area of work, which had increased significantly as a result of the increase in resources to the Trust counter fraud work plan.

Mr Foley reported that were a total of 13 cases of fraud investigations and referrals and out of these, 7 had been completed whilst 6 were ongoing.

13 Report of the Local Counter Fraud Specialist (LCFS) – Annual Draft Work Plan 2009/10

Mr Foley advised the committee that the draft LCFS work plan for 2009/10 outlined areas of work across 7 generic areas of the national Counter Fraud Strategy. It was noted that it was a statutory requirement to have an agreed work plan in place.

Mrs Silver enquired about what the Trust could do to improve its current rating awarded by the LCFS to a rating of 4. Mr Foley informed the committee that in order for the Trust to improve its current rating, it would require all fraud cases being identified and reported with as much information as possible. Furthermore, any internal systems with “loop-holes” within them that allowed individuals to commit fraud would also need to be discovered, reported and dealt with in a timely manner. The committee accepted and noted the contents of the report.

14 Audit Committee Annual Report

Mrs Abrahams informed members that the report was not a statutory requirement however, it did provide recommendations for improvement based on self assessment and best practices.

It was noted that the report confirmed that the audit committee was compliant with all the duties specified in the Terms of Reference, that internal and external control processes and assurance on controls were effective and lastly, that the self assessment exercise had identified some areas of improvement.

A discussion took place amongst the members of the committee and the following points were noted:

- It was felt by the majority of the members that the report was very similar in content to last years report;
- The Terms of Reference of the Audit Committee required updating;
- It was agreed that each member (4 in total) would review the report and submit any comments to Mrs Abraham before the next audit committee meeting.
- Once all comments had been received, the report would be brought back to the next audit committee in September 2009 for ratification and recommendation for presentation to the Board. **Action: All members / Laila Abraham**

Mrs Silver recommended that all the members of the audit committee arrange to meet (via conference call) to discuss the current Terms of Reference and the self assessment. All the members agreed.
Action: Caroline Silver

It was resolved that the annual report of the audit committee would be presented to the Board when the Terms of Reference had been reviewed and updated.

15 Financial Risk Review

Mr Islam explained that the Trust's total estimated financial risk for 2009/10 amounted to £8 million against a total turnover of £282 million.

Mr Islam stated that in order for the Trust to implement a cost improvement plan all training schemes would need to be completed on time.

After a lengthily debate about whether or not the financial risks should be included on the Trust's risk register, it was agreed that a workshop would be held on risk and risk management framework in the context of the Board training overall, the arrival of the new Chairman, and the LAS's govermance framework.

16 HCC / NHSLA Update

Mrs Abraham reported that as it stands, the Trust needed a re-assessment of its current level 1 rating in October 2010. It was reported that the Trust would be aiming to achieve a level 2 rating by May 2010 and that this could be achieved by ensuring that every risk management policy & procedure was implemented.

It was noted that from April 2010 all health and adult social care services in England needed to be registered with the Care Quality Commission based on a single set of common quality standards and guidance, which all providers of regulated activities will have to meet. The guidance would be focused on what constitutes a quality experience for people who use services and is built around the quality of outcomes that people should experience rather than the policies, systems and processes used to deliver care.

17 Standing Committee Items

The 7 entries in the Directors' Hospitality Register were noted by the committee.

18 Minutes of the of the Clinical Governance Committee - February 2009 & April 2009

The minutes were taken as read and noted by the committee.

19 Work-Plan & timetable of Audit Committee meetings for 2009/10

The committee reviewed the timetable and it was agreed that the audit committee meeting taking place in November 09 would not need to discuss "The Benefits Realisation Process" as this item of business had already been resolved.
Action: Clive Parker-Wood

It was noted that the Review of the Terms of Reference of the Audit Committee would be added as an Agenda Item to the next audit committee meeting being held on 7 September 2009.

The members agreed that the proposed audit committee meeting dates for 2010 would be reviewed and finalised at a future meeting.

20 Next Meeting

The next Audit Committee meeting would be held at 2:30 pm on Monday, 7 September 2009 in the Conference Room at the Trust's headquarters.

21 **Any Other Business**

Mrs Silver requested that a review of the stock control systems within the Trust be undertaken.
Action: Chris Rising

There being no further business, the Chairman declared the meeting closed at 5:30 pm.

…….
Chairman

LONDON AMBULANCE SERVICE NHS TRUST

CLINICAL GOVERNANCE COMMITTEE
(Full meeting)

Minutes of the meeting held on Monday 27 July, 2009 at 2:00 p.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	Beryl Magrath	Chair
	Fionna Moore	Medical Director: Vice-Chair
	Sandra Adams	Director of Corporate Services
	Nicola Foad	Head of Legal Services
	Stephen Moore	Head of Records Management & Business Continuity
	Fenella Wrigley	Assistant Medical Director, Control Services
	Gary Bassett	Head of Patient Experiences
	Chris Vale	Head of Operational Support
	Laila Abraham	Head of Governance (Interim)
	Andrew Stainthorpe	Head of Clinical Audit and Research (Interim)
	Paul Gates	PIM East
	Phil Flower	AOM Control Services
	Jon Knott	Performance Improvement Manager (on behalf of Peter McKenna)
	John Selby	Senior Health and Safety Adviser
	Jason Killens	Deputy Director of Operations
	Bill O'Neill	Assistant Director, Organisation Development
	Dr Julian Redhead	Emergency Medical Consultant – St Mary's Paddington
In Attendance:	Len Bamber	St John Ambulance
	Clive Parker-Wood	Capita Company Secretarial Services (Minutes)

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1. Welcome & Apologies:

The Chairman welcomed everybody present at the meeting and it was noted that apologies had been received from Kathy Jones, Margaret Vander, Angie Patton, Sarah Waller, Tony Crabtree, Paul Woodrow, Lizzy Bovill, Peter McKenna and Malcolm Alexander.

2. Minutes from the previous meeting:

After review and due consideration by the Committee, it was resolved that the minutes of the Clinical Governance Committee meeting held on 27 April 2009 be and are hereby confirmed as a true record of the meeting, and that they be signed by the Chair.

3. Matters Arising:

1. ***Minute 24//09:*** It was reported that there had been an improvement in the number of staff admitting that they had made an error rather than blaming their equipment. The integration of a "no blame" culture would take a long time but it was noted that it would be very beneficial to the Trust's performance in the long-term.

2. ***Minute 26//09:*** Mrs Abraham confirmed that she had circulated the HCC 2008/09 Final Declaration to all members of the CGC.

3. ***Minute 27/09:*** Mrs Abraham reported that an assessor from the NHSLA had visited the Trust in May. It was noted that the Trust was on track for progress towards Level 2 by 2010.

4. ***Minute 30/09:*** Dr. Moore reported that the wording on the packs of Glucose and Sodium Chloride was clear enough for ambulance staff to easily identify which was which. The manufacturer had expressed reluctance to change the labelling. The need to check the label before fluid administration had been emphasised and it was suggested that ambulance staff pack the two different fluids into different parts of their paramedic bags. It was agreed that the costs to re-brand the two packs would be too expensive.

4. **Area Governance Reports:**

The Committee received the following Area Governance Reports. The CGC noted that REAP level 4 had prevented any Area Governance meetings in the last month. This had also had an impact on CPI audits and PDRs. However, the Areas had been able to accomplish some good work at different complexes:

- **Control Services**

Phil Flower presented the report on behalf of Control Services. It was noted that:

- Target overall compliance level was 90%;
- Call volumes up 25% - huge burden on service;
- Too many incidences of not verifying locations and too many freelance questions;
- Implementation of MPDS Clinical Performance Indicators version 12 already updated twice with no adverse outcomes;
- No outstanding governance issues for Clinical Telephone Advice (CTA);
- About half the CTA staff have been trained in the use & application of the updated No-Send policy;
- Significant increase in total number of calls QA'd in the current quarter due to additional staff under development;
- Around a third of HCP calls received deemed to be suitable for PTS carriage via CTAK onto a dedicated PT sector were not suitable – there would be enough data by the end of July to compile a report to make recommendations for change;
- Thames Ambulance Service and ATS were currently being utilised for the conveyance of bariatric patients;
- CTA Quality Assurance had a further two staff seconded to the department and had significantly increased the amount of feedback given to advisors
- Urgent Care had a set of codes introduced to signify why a call has been sent to EOC plus a code to signify that they were holding a call purposely for a specific crew and also one that was used when retrieving a call from EOC;
- The Clinical Support Desk had seen a steady rise in the number of calls in the last three months;
- There had been an increase from 998 calls in April to 1254 in June. Ambulance saves were 187 in April and 253 in June;
- The workload for urgent care had dropped slightly in June;
- Staffing remained a concern – the recruitment of another 50% equivalent would leave just one person short. Looking to the future, 3 more staff needed to be recruited in the current round of recruitment;
- The fall in GP medical referee referrals was of concern. EBS had been asked to improve uptake in this service by 15% over the whole year (risk register?) **Action: Lizzy Bovil.**

- **South Area**

The report from ADO South was presented: **It was noted that:**

- Various Alternative Care Pathways projects were ongoing, including -he Urgent Care Centre (UCC) at Queen Mary's Sidcup which is a nurse and GP led unit open between 9:00 to 23:00 ,365 days a year which accepts patients presenting minor injuries and offers x-ray facilities; and
- The Soho Walk in Centre (WIC) is staffed by a primary care nurse practitioner with limited support form GPs and is used by CS47 & the CRU desk for calls in the Soho area to deal with minor injuries.
- There had been a 10% increase in drug audit compliance since May 2009, with 40% of complexes in the South area achieving 100% drug audit compliance in June Three

complexes were currently showing non-compliance to drug audits and these were being challenged weekly by the PIM;
- Various schemes to improve communication are being tested throughout the area. Once these schemes have been trialled, and if successful, they could be adopted as best practice across the area;
- Current Individual Performance Monitoring (IPM) focused on crew mobilisation, job cycle time and time at hospital. Each complex reviews the IPM on a monthly basis and sends letters to the top and bottom performers in each category. If no improvement is made within the month, staff are interviewed by their management team;
- 69% of motor accidents in the South are reported verbally to Legal Services within 2 days;
- 31% of Road Traffic Collision (RTC) reports are now received by Legal Services within 2 days;
- The average no. of days taken for the report to be received by Legal Services has improved;
- The South has seen a 9% increase on Clinical Performance Indicators compliance since April to 41%;
- There had been a 25% reduction in staff working overtime – one of the reasons given for this was due to the fact that staff were tired;
- In September, 270 new student paramedics would be posted to areas of greatest need – with supervised training in the workplace for 4 weeks as part of ongoing 3 year training package;
- The South currently had 13 complaints and 11 PALS concerns. There was one case being considered for Serious Untoward Incidents (SUI). The possible SUI case would be discussed outside the meeting. **Action: Fionna Moore**

- **East Area**

Paul Gates presented the report from ADO East. It was noted that:
- The East Area Clinical Governance meeting did not take place on 23 July 2009;
- The East area had seen an improvement of 13% to 27% CPI completion;
- All complexes apart from two have seen CPI activity, compared to four complexes not delivering anything reported in April;
- The improvement in completion rates had been achieved by the increased use of staff on alternative duties to deliver the CPI and team leaders had been given some time to carry this out despite the operational demand issues. This was to mitigate the risk the area has on its risk register to clinical care delivery and providing feedback to staff;
- Whipps Cross complex would shortly be doing a piece of work with Transport for London (TFL) and the Metropolitan Police Service (MPS) to look at a way to manage people that are asleep on night buses that end up at Ilford terminus. These calls come in as patient unconscious to the Trust. The project could see ambulance and police staff managing this demand differently & thus preventing inappropriate calls to the Trust;
- Work in Romford was ongoing to deliver a trial of a Police Officer and member of LAS staff working on the same vehicle to manage domestic violence. As the MPS were the Trust's biggest user, a vehicle to go to calls from alcohol or domestic issues would potentially reduce the no. of calls to the Trust. An operating model exists in Yorkshire and has proven beneficial to that Trust;
- Work was ongoing with the Head of Patient Experiences to identify trends and individuals regarding attitude & behaviour complaints received by the Trust from patients who have called the Trust. Where persistent issues are raised against staff on multiple occasions, local managers would be tasked with managing these staff to improve their behaviour.

- **West Area**

Peter McKenna presented the ADO West report. It was noted that:
- In the period April 2009 to present the West had received 8 complaints. 4 were still outstanding and currently being dealt with;
- The area had no SUIs on which to report;

- The are maintained a 36% CPI completion rate, this was consistent with the Trust average of 36%;
- Initial driving license details and routine checks were being recorded across the area using ProMis. The local process used by Fulham had previously been identified as an ideal model, and several complexes had used the template to manage their own checks;
- The area is proactively managing drugs management. Complex Management are challenging non-compliant staff with positive results;
- The Camden Alternative Response Vehicle had now been re-activated and was working Friday and Saturday nights within the Borough;
- The ECP programme Lead had been approached regarding the utilisation of ECPs in the West and the deployment process. Work was ongoing to identify if the activation list held in MPDS needed updating to ensure maximum benefit of the skill set ECPs brings to the Trust;
- The PTS Mental Health Bus trial – currently being undertaken out of Camden - was a dedicated vehicle that works in conjunction with the local Police and Approved Mental Health Professionals. Initial reviews show an estimate of over 100 hours of Emergency work has been freed up by the utilisation of this vehicle (The communication flow chart is attached);
- Brent complex had instigated an electronic rolling notice board sited at the signing on desk on station. This method of communication was now being considered at Trust level;
- St John's Wood station were currently trialling an in-cab briefing sheet which allows staff to familiarise themselves with current issue when not starting shift at the main station for the complex.

The Committee thanked all presenters for their reports, which provided detailed and very useful information.

Mr. O'Neill noted that there had been no reference to New Ways of Working in the reports from South and East, and asked whether the committee felt this was something that should be included in the area reports, or presented as a separate update, to enable the progress of NWOW to be visible to the committee. The consensus was that this would be a useful additional update which Mr. O'Neill undertook to provide. **Action: Bill O'Neill**

5. <u>Medical Directorate Update:</u>

By way of introduction Dr Moore provided an update on the expansion of the Medical Directorate. It was noted that 2 new AMDs had been appointed - Ms Peta Longstaff joined the West team and Dr Neil Thomson joined the East team. Both AMDs would be in post by mid September.

The Medical Director stated that no new guidance had been received from NICE.
It was reported that JRCALC had issued updated guidelines on oxygen therapy and sickle disease and a new guideline on pelvic fractures. These were available on the Pulse and were introduced to the Team Leaders at their conferences at the end of June, for dissemination to their teams.

Dr Moore updated the committee regarding the appointment of a Flu Director (herself) at executive level. The flu director would issue regular guidance to staff covering identification of swine flu, actions on scene and during transport to hospital. Hand and respiratory hygiene issues highlighted. It was noted that all children under the age of 1 would require assessment by a GP.

Dr Moore reported that a decision of JCPCT was announced on 20 July. It was noted that there would be a trauma system with 4 networks, 3 going live in April 2010. It was further noted that 8 HASUs had been agreed which was a more complicated arrangement and would not all be ready by April 2010. LAS would be closely involved in the implementation.

Dr Moore informed the members that the LAS consultant midwife advisor regularly met with the HOMs, attended by NHS lead on midwifery issues. The meetings focused on highlighting issue around difficulties in accessing community midwives, the lack of dedicated phones in maternity units, cross boundary issues and improving communication between LAS staff and midwives.

6. Clinical Risks:

Mr Selby requested that the "Incident Reporting" paper provided in the clinical governance committee pack be withdrawn due to the fact that it contained incorrect information. The members agreed and there was nothing further to report.

6.1 Claims and inquests

Ms Foad presented the report and explained that it outlined the key issues identified from the claims and inquest files opened between 1 April and 15 July 2009 and from the current cases reported to the NHS Litigation Authority under the Clinical Negligence Scheme for Trusts. It was noted that the routine Risk Information Report would be presented to the next Clinical Governance Committee Meeting. **Action: Nicola Foad**

6.1.1 Damage to property

Ms Foad reported that this was the most common allegation in the recently opened claims. It was noted that claims had arisen when entry was forced to an address where a patient's life was believed to be at risk. The revised OP/017 had not been implemented for sufficient time to demonstrate an improvement

6.1.2 Failure to immobilise

It was noted that allegations that the patient was not immobilised correctly or at all in incidents between 2003 and 2005 were made in three of the twelve cases reported. A potential claim was currently being investigated where it was alleged that the patient was not immobilised in early 2009.

6.1.2 Not conveyed to hospital

It was noted that in order to be satisfied that the decision not to convey a patient to hospital is made appropriately and in accordance with the Capacity Tool, it was vital that Team Leaders undertook checks on 100% of Patient Report Forms where the patient was not conveyed and give feedback to staff on the assessment recorded.

6.1.3 Good Governance

It was noted that the robustness of the processes for reporting, investigating, and learning from incidents that gave rise to claims and criticism at inquests would be reviewed. In future Risk Information Reports the number of incidents reported before a claim or potential claim was notified will be reported and the Clinical Governance Committee would receive regular assurance reports on the implementation of recommendations from incident investigations.

6.2 PALS and Complaints

Patient property:

By way of introduction, Mr Basset provided the committee with some background to patient property. It was noted that since the inception of the Patient Advice and Liaison Service (PALS) in 2003, around three thousand enquiries relating to missing patient property had been received, of which less than 20% had been satisfactorily resolved.

Most disappointingly, since the inception of the SPATS (Smart Possession and Tracking System) project, which had been implemented to address the problems identified, the Trust had managed to resolve only 16% of lost property cases. It was indicated, following an analysis of comprehensive data, that some stations are more efficient than others at adhering to Trust policy. Hillingdon, who have a SPATS champion who has been closely involved in the initiative, were by far the most compliant which determined that very few patient property losses were incurred and evidenced that the procedure worked, when applied.

Considerable effort had been made to explore the issue but the conclusion was that crews simply do not adhere to the designated Trust procedure and in consequence there was no way of proving what they did or did not do with any patient items.

Mr Bassett informed the committee that under new regulations that came into force on 1 April 2009, the Trust has an obligation both to work with other health and social care agencies and that guidance from HSC stressed the obligation to put the complainant back in the position they were in, where possible, before they experienced the problems they encountered. This meant that the Trust should offer financial redress where appropriate and in accordance with the Treasury guidance without the requirement for affected persons to make a legal claim. Mr Bassett advised that such payments would need to be met from local complex budgets, where the attending staff had not complied with Trust policy (OP/17) as he had been advised that the Trust would not be establishing a dedicated fund for this purpose.

NHS Direct initiative

Mr Bassett advised that using the MEC approach across the totality of service user and stakeholder feedback mechanisms, the initiative was becoming the highest source of patient dissatisfaction. Some 37 incidents had been received as complaints, enquiries to PALS and incident reports from other agencies, including NHSD themselves. 2 cases had been referred for consideration of declaration of a SUI

A mechanism had now been established with NHSD in accordance with the new complaints legislation which requires all involved agencies to work together to provide a collective response.

Mr Bassett explained the emerging themes and gave examples of actual patient experiences. These included examples of ambulances being dispatched after referral to NHSD who in turn had contacted the patient's GP/deputising Service who had then placed a 999 call. Other examples raised a number of clinical risks which reflected possible shortcomings in the MPDS triage facility effecting inappropriate calls to be designated as suitable for referral to NHSD.

Mr Bassett thanked the Medical Director for her prompt action in seeking to ensure that patients would be advised that their 999 call was to be passed to NHSD, one of the issues that patients had raised. Mr Bassett also advised that he had asked that more information be published on the Trust website and suggested that the Trust write to GPs and social care agencies to explain the initiative across the health and social care economy.

Mr Bassett expressed his concern that research evidence suggested that the patient groups who were the likely subject of referral were similarly those patients who were least likely to raise concerns, and thus it remained a possibility that many more patients were dissatisfied with the service than the Trust were aware of.

Mr Bassett also expressed concern at the additional workload to his department at a time of significant demand, reflecting the operational pressures to the Trust, and advised that this would inevitably inhibit his department's ability to achieve a timely response to all complaints and enquiries.

6.3 Equality and Diversity

Mr O'Neill stressed that an Equality Impact Assessment (EIA) was a tool aimed at improving quality of the emergency and other services LAS provides as well as all the business functions and areas of the Trust by ensuring that individuals and teams think carefully about the likely impact of their work on different communities or groups. It was noted that an EIA consisted of an initial screening process followed by a full assessment where identified as necessary.

Mr O'Neill explained that the reasons why LAS needed to carry out an EIA was firstly because of the need to provide appropriate services to the Trust's diverse local community, so as to ensure health services were provided equitably and were generally accessible to all; secondly, all public bodies were obliged to undertake equality impact assessments of their policies and functions, as set out in the equalities legislation.

Mr O'Neill informed the committee that the Trust needed to have an easy to understand, usable EIA tool. It was agreed that the outcomes of the EIA procedure also needed to be easily accessible, taking into account the new Equalities Bill which identified new ways of improving EIA functions.

It was noted that a new equality monitoring procedure had been drafted to ensure the Trust was best placed to collect the requisite equality monitoring data on all its services, employment, training, engagement & decision-making processes. The new procedure, which encompasses all six equality strands, would, following extensive consultation, be submitted to Senior Management Group for approval and thereafter the Trust Board. In advance of the procedure being launched, clear communications with our stakeholders on the key aims and objectives of this procedure will take place and any staff undertaking the monitoring will receive appropriate training. Mr. O'Neill reminded the committee that pending the new procedure, the existing procedure should still be used.

6.4 Clinical Risk Update

Mrs Abraham stated that the purpose of the update was to provide the Clinical Governance Committee with an update on progress made with action plans that were in place to mitigate clinical risks on the Risk Register. The paper updated the CGC as follows:

(1) Swine Flu:

Risk 279 has been updated and further actions had been put in place to take account of the swine flu.

(2) Review of Risks:

All clinical risks had been reviewed with their owners resulting in updates to the controls in place and planned further action.

(3) New Risks:

Drug packs and LP12 are identified as the 2 key risk areas from the reported incidents. Detailed analysis of the investigation and action plans of these incidents would be carried out.

The Committee reviewed the format of the risk register and examined in detail all the risks on the risk register for accuracy and any progress made. It was resolved, following the review and some debate, that a number of the current risk rating scores be adjusted and that these would be updated by Mrs Abraham. **Action: Mrs Abraham.**

7. Clinical Policies and Procedures update:

By way of introduction, Mr Moore informed the members that the purpose of the report was to update the committee on progress with clinically relevant policies and procedures.

It was noted that work on the migration of OP/32, TP/03 and OP/10 to Staff Side including having their Equality Impact Assessments (EIA) completed before approval had progressed slower than planned and they were not yet ready for approval by the committee. The delays were due to the fact that the document owners had experienced difficulties with completion of the current EQIA form. An update would be provided at the next CGC meeting. **Action: Mr Moore**

After reviewing the detail for the specific documents, the Committee noted the position with the procedural documents.

8. Special Reports – VAS (St John Ambulance):

By way of introduction, Mr Bamber stated that St John Ambulance had set out to create a formal Clinical Governance Management infrastructure in 2007 following a resolution to modernise and formalise service practice and procedure under an auditable and transparent management system. It was noted that a clinical governance lead nurse officer had been recruited by National Headquarters to build a pilot organisation.

Mr Bamber updated the members on work St John Ambulance had carried out in 2008. A steering group and implementation group were established which met quarterly and reported to the Board at the same frequency. It was noted that early work focused on a small number of specific but high profile areas to establish early confidence and "quick wins" to engage staff at all levels.

Mr Bamber reported that the programme for 2009 had been built upon the outcomes of the 2008 audit and listed the next 8 tranche of areas for introduction of clinical governance policies and procedures.

It was noted that from the outset, the policy at St John Ambulance has been not just to meet the demands of audit processes to meet statutory requirements, but to introduce clinical governance as a living tool to provide for and protect the practitioner and patient.

Mr Bamber informed the committee that London District still had some way to go to reach a fully compliant clinical governance standard in all areas. This was due to the fact that the processes and procedures required conversion and modernisation to meet the demands of a more rigorous and formal auditable process and emerging requirements and to align procedures and standards with

9. Clinical Governance Committee (CGC) - 2010 work plan

The committee reviewed the Annual Clinical Governance Committee Cycle Matrix 2009-2010 and the following points were noted:

- All CGC meetings would start at 2:00pm;
- After some discussion, it was resolved to keep the number of CGC meetings to four per year;
- It was suggested that because of the long agenda, the CGC should meet at least six times per year. However this would prove difficult, as it was vital that all area reports were presented to the CGC as this gave the area managers an opportunity to present, discuss and debate all matters (positive and negative) in front of managers from other areas.
- It was agreed that only exception reports from groups/committees feeding into the CGC would be presented at future CGC meetings;
- It was suggested that the risk register including the risk report and new risks would, in future, be discussed at a separate sub-group meeting outside the CGC meeting;
- The Terms of Reference for the CGC was reviewed and it was agreed that going forward, the reference to "Full" meetings would be removed - Only "Core" CGC meetings would be held and membership for these meetings would include all members from "Core" membership as well as "Full" membership.
- Mrs Abraham to update the CGC Terms of Reference. **Action: Mrs Abraham**

10. Annual Heath Check 2009/10:

Mrs Abraham informed the Committee that the Trust needs to submit declaration on their performance on 2009/10 core standards for the first 7months in November 2009. In January 2010 the Trust will have to submit applications for 2010 registration, the registration requirements are outcome based and have a greater clinical focus.

11. NHSLA:

Mrs Abraham reported that the new proposed Policy and Procedure for the Development and
Management of Procedural Documents would replace the existing separate Policy (TP/001) and Procedure (TP/002).

It was noted that the new documents had been produced following feedback from the NHSLA Assessment which was carried out in October 2008 and a subsequent visit on 20 May 2009. It was noted that the main changes made within the policy are

- An expansion of the consistent approach to the development and management of all corporate procedural documents to include protocols, strategies, plans and guidance in addition to policies and procedures and forms;
- Approval of the relevant director or senior manager to be obtained prior to the development of the document;
- A new checklist for document developers; and
- Greater emphasis on implementation, in particular the need for document owners to provide auditable detail on the training provided and the ways in which the effectiveness of a document would be monitored over its lifespan.

12. Reports from Groups/Committees:

The Committee noted the minutes and reports from the following Groups and Committees:

- Infection Control Steering Group: 5 June 2009; The CGC noted the problems associated with sluices
- Risk Compliance & Assurance Group: 18 May 2009;
- Clinical Steering Committee: 29 May 2009; The CGC were pleased to note that all Team Leaders were to be allocated to clinical update courses in the autumn, whatever REAP level was in place at the time Feedback, Learning & Improvement Group: 11 May 2009 (inaugural meeting).

13. CGC Self Assessment:

The CGC Self Assessment was completed by the Chair and the remaining members of the committee. It was noted that all of the questions were answered in the affirmative except for the question regarding members' training needs, which received a negative response**.**

14. Next Meeting:

The next CGC meeting would be held on Monday 19 October, 2009 at 2.00 pm.

15. Any Other Business:

There being no further business, the Chair declared the meeting closed at 5:35 pm.

…….
Chair

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 29th SEPTEMBER 2009
CHIEF EXECUTIVES REPORT

1. SERVICE DEVELOPMENT

An internal board has been established with oversight of the Healthcare for London workstream. The workstream board will have a specific focus on the establishment of the constituent projects, their management and control, and their successful delivery into the service.

Current position:

Stroke & Major Trauma

Operational Research in Health (ORH) has been commissioned to model the impact of implementing these new pathways. A draft proposal has been submitted suggesting an 11 week schedule of work commencing end of September 2009. LAS are evaluating this proposal.

Stroke

LAS continue to work closely with Healthcare for London to implement a two stage transition to the full stroke model. From February 2010 all Face/Arms/Speech test positive (FAST+) patients who can be conveyed to a Hyper Acute Stroke Unit (HASU) within 3 hours will be conveyed in this manner. This will be expanded to include all FAST+ patients from April 2010.

These transition plans will be complemented by a trial in South East London where all FAST+ patients who can be conveyed to the permanent HASU at King's College Hospital or the temporary HASU at St Thomas's to arrive within 3 hours of onset of symptoms will be conveyed in this manner. As HASU beds come on line at Princess Royal University Hospital (PRUH) in Bromley from autumn 2010 capacity at St Thomas's will be reduced until it closes.

With this in mind LAS have ensured that a single pan-London protocol for admitting patients to all HASUs is due to be signed off at the HfL Stroke Clinical Expert Panel on Tuesday 15th September. This is set to include the assertion that HASUs will not close to LAS-borne patients who can arrive at a HASU within three hours of onset of symptoms.

Once this protocol is agreed LAS will communicate the change to staff likely to encounter FAST+ patients in South East London.

In order to support the "no closure" approach, the Emergency Bed Service (EBS) (with commissioners' support) have offered to manage capacity within the system and support crews in deciding which is the best destination for an individual patient. This will be discussed at the stroke project's Clinical Expert Panel on 15th September.

Trauma

The LAS is working closely with the London Trauma Office and trauma networks across London to develop robust implementation plans. Training plans are in place to ensure that all frontline staff are aware of the changes to trauma care, and can effectively triage patients within the new trauma system. Clinical leads will also receive a clinical update addressing issues relating to implementation of the HfL programme in addition to a number of other clinical initiatives.

A communications plan has been developed to ensure all staff are aware of the impact the changes in trauma care will have on the LAS. Major trauma centres based at The Royal London Hospital, Kings College Hospital and St Georges Hospital will go live in April 2010, with a fourth centre at St Mary's Paddington scheduled to go live in October 2010. The LAS is confident we will be able to respond to this effectively.

Unscheduled Care

No activity since last report.

Children & Young People

LAS were contacted by the Children and Young People (CYP) project with regard to their Acute Paediatric Workstream. The intention is to implement a system similar to that operated in Manchester where Paediatric Assessment Units (PAUs) based at the front of A&E will admit patients directly to A&E/Paediatric Intensive Care Unit (PICU)or (more frequently) treat and, where appropriate, refer.

Not all PAUs will have a PICU on the same site so there will be some element of networking.

This work stream will not oversee implementation. Instead, commissioning guidance will be written covering minimum standards (eg PAUs to cover 0800-2000) and it will be up to sectors to develop plans which focus on the minimum requirements as set out by HfL and any extra local needs.

Therefore the challenges for LAS are to link with a pan-London plan without any pan-London coordination and ensure crews are clear on protocols at individual sites. LAS will continue to push for better pan London coordination ahead of the publication of the "Case for Change" in the early autumn.

The work stream is also developing proposals for Paediatric Major Trauma Centres. LAS were led to believe that GOSH and Evelina (at St Thomas's) would be front runners for two of the possible three designated centres. This would only leave the third as possibly being linked to a Major Trauma centre, which would therefore be the default destination for LAS.

2. SERVICE DELIVERY

A&E Operations (Graphs 1 – 10)

Operational performance for Category A calls up until mid June had been broadly on track and was at 74.5% for the year. In my last report I noted that we had had a period of sustained and unprecedented demand during June and July which had seen the year to date Cat A performance fall to 72.7% by mid July. I am pleased to report that following some direct intervention Category A performance has shown

improvement through August and early September and as a result the year to date position is now back over 74% and we expect to be at 75% for the year by mid October.
Category B performance has started to improve and for the month of August we delivered performance of 86.8%, which compares favourably with the agreed trajectory of 86.5% and the performance delivered for the same month last year, which was 81.1%.

I am pleased to also be able to report that the Category C incidents attended within an hour has continued to improve and attained in excess of 88% for the month of August. We continue to use NHS Direct to resolve some of our Green call demand and have seen a significant increase in activity with 306 calls per day being passed to NHSD and 262 per day being resolved by them in July without the need to dispatch an Ambulance.

The increased demand, driven by the heatwave and swine flu in early July, abated somewhat in the last week of July and as a result the Category A volume saw an overall increase of 10% and Category B volume of 14% when compared with July 08. The workload in August continued to fall back to more normal levels resulting in an overall increase in activity of 2.9% on Category A call volume and 8.3% on Category B volume when compared to last year. The continued referral of a number of Category C calls to NHS Direct resulted in a significant fall in Category C calls responded to, and so the overall increase in demand for August was 3.2%.

As a result of the Trust not meeting the National Performance Standards for the first quarter of 2009/10, we have continued to meet regularly with the Strategic Health Authority and the Commissioners to monitor our performance.

In addition the LAS has been classified as “Performance under review” by the Department of Health (one of four ambulance trusts) under its new quarterly performance management system. Given our performance for the second quarter of this year we expect to be removed from this grouping in October.

Our activities have been focussed on an agreed performance recovery plan which currently incorporates 8 Key Focus Items (KFI) and a further supporting 60 items. The 8 KFIs are:

1. Increase usage of Active Area Cover and Temporary Area Cover deployments in line with trajectories set. Over the last 3 months there has been a sustained improvement and the trajectories have been achieved for most of the day with poor compliance noted at times of high utilisation

2. Reduce the time between patient handover and green at hospital.
and robustly manage handover delays in excess of 1 hour. To date a one minute improvement has been achieved over the last quarter and whilst lengthy delays are less frequent, there has been little progress on the hospital handover delays which have been escalated to the SHA.

3. Reduce mobilisation time by 30 seconds for Ambulances and 15 seconds for Fast Response Units. This was a specific recommendation from the ORH report and some improvements have been achieved which coincided with the utilisation decreasing,

4. Increase ambulance hours produced in line with trajectory. As can be seen by the attached graphs some improvements have been attained and there is

5. Increase rest break allocation in line with trajectory. Whilst there have been some improvements the intention to achieve 80% still remains the focus.

6. Activate on all calls immediately and do not hold calls unless there are no resources within a reasonable running distance. This has been implemented and has contributed to the improved Category B performance noted.

7. Demand reduction through managing additional green and amber calls through clinical telephone advice. This work is in hand and will be delivered by November and build on the progress already achieved.

8. Review rosters to ensure that hours produced meet the demands on the service across all hours of the day and week. A significant workstream is already underway to deliver this and is anticipated to be concluded by April 2010.

To date 17 of the supporting activities have been delivered, 12 discounted and a further 31 are at various stages of implementation.

The Airwave Radio rollout has continued to be successfully implemented across London. To date the entire of East and West areas have been brought 'live'. At the time of writing half of the South area, South East area, has been implemented and by the time of Trust Board all operational areas will be utilising Airwave. The last aspects are to implement Airwave across PTS and Urgent Care.

During the period since the last Board report the Trust has twice reduced its Resource Escalatory Action Plan (REAP) level, reducing from level 4 'Critical' to level 2 'Concern'. The latest reduction occurred on 1st September and followed the sustained reduction in demand. This continues to remain under weekly review by the Director of Operations and should the incoming demand start to increase, consideration will be given to raising the REAP level.

The delivery of the new Mercedes ambulances has continued to be behind plan. Currently we have had 43 ambulances delivered with 5 at various stages of completion and due for delivery within the next 2 weeks. Further work is underway with the suppliers to improve the rate of delivery.
The application we submitted under the 'extenuating circumstances' provisions to the Healthcare Commission/CQC in relation to Category B performance during the winter period of 2008/09 where performance was adversely affected by significant hospital delays is still under consideration and we anticipate hearing the outcome in early October.

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for the year to date (2009/10), the complete validated performance for July and August and the un-validated performance for the first 14 days of September.

	CAT A8	CAT A19	CAT B19
Standard	**75%**	**95%**	**95%**

2009/10 YTD	74.1%	98.4%	85.0%
July 2009	72.8%	98.4%	81.3%
August 2009	75.8%	98.9%	86.8 %
September 2009 (to 14th)*	79.2%	99.2%	89.5%

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

Overall activity rose by 4.5% in June, 7.7% in July and 3.2% in August as compared to the previous year. The point of greatest concern is that the YTD shows an increase of Category A8 activity of 2.2% and Category B activity of 8.2%. Resource utilisation continues to be an area of further concern with utilisation hitting 75% in June, 75% in July, and fell back to 70% in August which is someway off the ideal of 55%.

Call answering performance saw a slight reduction to 92% in July, largely attributable to the increased workload, however in August has seen an improvement back up to 95%.

We produced circa 246,430hrs Ambulance Hours resourcing for July and August this year which was circa 5,000 hrs per month more than for the same period last year, a 4.5% increase. FRU hours produced for July/Aug 09 increased by circa 1.4% to 116,349hrs compared to 114,751hrs for the same period as last year. Whilst both Ambulance and FRU hours have increased year on year the overtime spend for this period has decreased by 12% to 105,330hrs.

2008/2009 CQC ratings

The LAS expects to be advised of its Care Quality Commission ratings for 2008/2009 in October. Our expectations are that we will receive an excellent rating for use of resources and either a fair or good rating for quality of services.

2.1 PATIENT TRANSPORT SERVICE

Commercial

PASA and the London Procurement Programme have issued notification of those contracts being placed out to tender during phase 2 of the programme. The contracts available are:

- Barnet & Chase Farm NHS Trust (Caring for You)
- Bexley PCT (Unknown)
- Bromley PCT (LAS)
- City & Hackney PCT (Medical Services)
- Ealing PCT (Unknown)
- East London Foundation Trust (Medical Services)
- Great Ormond Street NHS Trust (DHL)
- Greenwich Teaching PCT (Unknown)
- Hillingdon PCT (LAS), includes Hillingdon Hospital NHS Trust (Door to Door)
- Newham PCT (M&L)

- Newham University Hospital NHS Trust (M&L)
- North Middlesex University Hospital NHS Trust (M&L)
- North West London NHS Trust (DHL)
- South London NHS Trust (An amalgamation of Queen Elizabeth, Queen Mary's and Bromley Hospitals contracts which are all held by LAS).

This process is being conducted outside of the framework agreement which was set up last year and will consequently be open to anyone caring to bid for the work on offer.

Pre-qualification questionnaires are due for return by 12 noon on 16 September 2009. The process is timetabled to be completed with commencement of new contracts between 1 April to 1 May 2010.

A decision on what contracts the LAS will bid on will be made once the contract specifications have been issued, following the pre-qualification stage.

Operations

The new PTS middle management structure will come into operation with effect from 1 October 2009. Some vacancies remain for the posts of Transport Operations Centre and PTS Operations managers which have been advertised both within the LAS and externally. Interim placements have been made to allow the new structure to proceed.

The new grades will ensure that PTS staff have a more visible management presencethroughout their working day; with a greater focus on achieving effective and efficient operations.

Staff are being advised of the changes through a series of station meetings and this will be reinforced by a PTS bulletin issued the final week of September.

The 10 staff associated with the loss of the Barts contract have been reassigned to vacancies elsewhere within PTS. PTS now has a full complement of staff at the Ambulance Person grade for the remaining contracts. Work is now underway to realign rotas to ensure that staff availability meets with changing operational needs brought about by the loss of Barts.

Performance

Quality continues to improve against our three main indicators, with Departure time and Time on Vehicle now hitting the KPI target of 95%. Performance for August was:

- Arrival time: 94%
- Departure time: 95%
- Time on Vehicle: 96%

3 HUMAN RESOURCES

Workforce Plan implementation

The vacancy level for A&E staff as at 31.8.09 is reported as 290 wte. with recruitment activity on track to meet full establishment by early 2010 and the increased HART establishment before the end of March 2010.

As at the end of August, 170 Student Paramedics have begun training (out of a possible 192 places) and 50 A&E Support (out of a possible 72 places).

Currently all Student Paramedic training courses are fully allocated up to and including the course commencing on 30 November (130 students) with 65 out of 68 A&E Support places filled for the same period.

From the 1 April to 31 August 2009, 222 staff have successfully completed their initial training and transferred to operations.

In addition 46 graduate Paramedics have been selected for employment (4 more under consideration) with 11 confirmed start dates by 1 October 2009 and other start dates to be confirmed on receipt of HPC registration.

64 staff in total are therefore currently confirmed as expected to become operational in the month of September.

Recruitment to Emergency Operations Centre staff continues to be on track to deliver the increased establishment for 2009/10 in preparation for the implementation of the CAD 2010 project.

All other general recruitment is also continuing as required.

Workforce information

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

Trust sickness levels for July show an increase to 4.66%, the highest level since February 2009 (4.87%). Whilst this remains within the target tolerance, firm management of sickness absence will be required as we approach winter and the overtime incentive bonus (linked to attendance) is withdrawn.

Staff turnover has stabilised at 5.78% indicating a halt to the downward trend experienced continuously since October 2008.

Development of the MPET funding SLA

Whilst agreement has been reached with NHS London to support the activity of training for 377 Student Paramedics and 121 A& Support staff, we still await the formal contract details currently being finalised by the SHA. The Trust will however commence formal invoicing for activity to date pending completion of the contract.

Partnership working, staff engagement and joint consultative arrangements

The Staff Survey Steering Group has met twice and terms of reference have been agreed. Membership is drawn from all area of the Trust, and includes staff side representation. This year's national NHS staff survey will be received for distribution in week commencing 28 September. Managers will receive a briefing pack to advise them of the schedule and requirements, and asking them to take steps locally to encourage staff to complete and return the survey questionnaires. Particular emphasis will be placed in all supporting communications on trying to reassure staff that their responses are confidential and cannot be accessed by any trust employee.

Preliminary work has been conducted by the newly appointed Staff Engagement Manager and the Strategic Steering Group has endorsed the staff engagement approach presented at its September meeting. A full Staff Engagement Strategy will now be developed building on the positive work done to date and which has been recognised nationally within the McLeod report published earlier this year.

Health and Safety

Reported levels of adverse incidents for the calendar year to date against the key categories of clinical incidents, manual handling incidents, and physical and non-physical assault are included in the table below.

Incidents by Incident date and Category (Month)

	Lifting/Handling/Carrying	Clinical Incident	Non Physical Abuse	Physical Violence	Total
Jan - 2009	46	74	67	33	220
Feb	42	47	83	23	195
Mar	40	56	85	29	210
Apr	48	79	101	21	249
May	60	96	88	23	267
Jun	32	89	61	29	211
Jul	26	80	86	22	214
Totals:	294	521	571	180	1566

These do not show clear trends. It is believed, however, that some reporting may have been delayed and that the lengthy period spent at REAP Level 4 may be a contributory factor. The Health and Safety team is undertaking briefings to raise awareness and stress the priority to be attached to timely incident reporting and investigation, and also offering refresher guidance to managers in incident investigation.

Membership and terms of reference for the corporate health and safety group is currently under review. The trust has been notified that the Health and Safety Executive intends to undertake an inspection as part of its general employer scrutiny responsibilities. This is currently scheduled for February 2010, and the Health and Safety Advisors are co-operating with the Inspectors and will facilitate the arrangements as necessary when further details are known.

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Disciplinary Appeals and Employment Tribunals

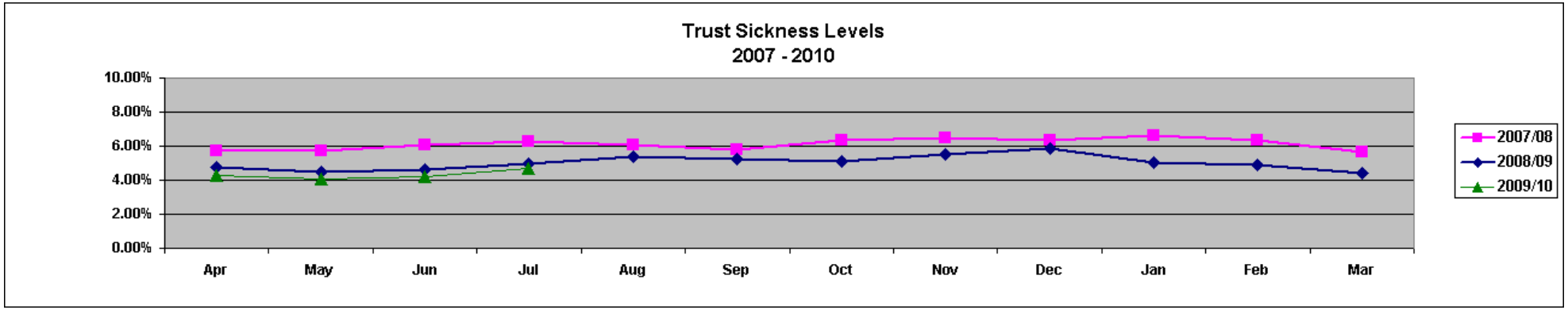
Since the last Trust Board meeting, 1 appeal against dismissal has been heard with the following timescales:

Case No.	Date of appeal letter	Hearing date	Further comments
1	21.7 09	23`.9.09	

The Trust has had one Employment Tribunal case heard in the period since the last Trust Board which was successful for the Trust.

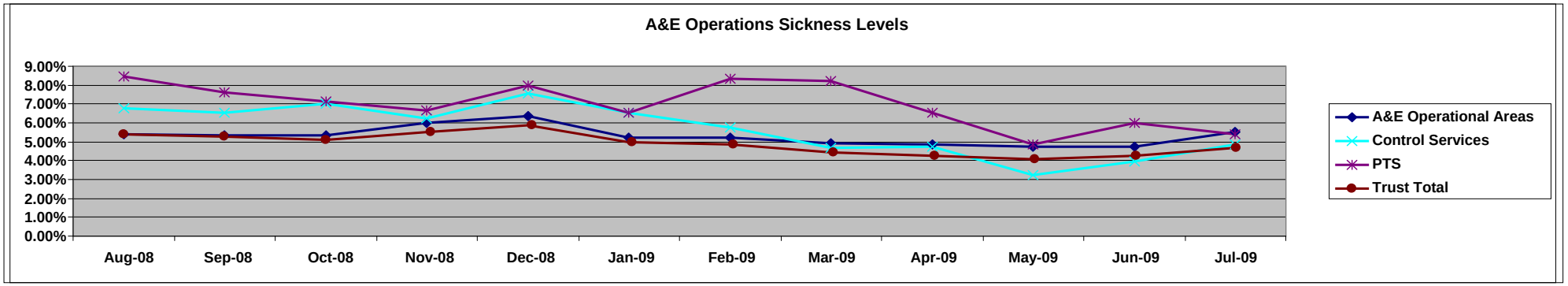
Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%
2009/10	4.27%	4.07%	4.24%	4.66%								



A&E Ops Sickness Levels

	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09
A&E Operational Areas	5.40%	5.34%	5.37%	6.02%	6.35%	5.23%	5.21%	4.91%	4.84%	4.76%	4.72%	5.51%
Control Services	6.78%	6.52%	7.04%	6.23%	7.55%	6.52%	5.76%	4.70%	4.71%	3.25%	3.95%	4.84%
PTS	8.47%	7.65%	7.16%	6.69%	7.98%	6.57%	8.35%	8.23%	6.51%	4.84%	6.02%	5.39%
Trust Total	**5.41%**	**5.26%**	**5.12%**	**5.50%**	**5.89%**	**5.01%**	**4.87%**	**4.44%**	**4.27%**	**4.07%**	**4.24%**	**4.66%**



Staff Turnover

Staff Groups	Oct-07/Sep-08	Nov-07/Oct-08	Dec-07/Nov-08	Jan-08/Dec-08	Feb-08/Jan-09	Mar-08/Feb-09	Apr-08/Mar-09	May-08/Apr-09	Jun-08/May-09	Jul-08/Jun-09	Aug-08/Jul-09
A & C	14.59%	15.38%	15.27%	15.76%	15.14%	14.51%	14.06%	12.62%	12.30%	11.56%	10.03%
A & E	5.44%	5.64%	5.60%	5.58%	5.51%	5.45%	5.10%	4.99%	4.86%	4.50%	4.34%
CTA	8.51%	9.09%	9.52%	7.14%	6.97%	7.32%	7.69%	2.50%	2.56%	2.44%	4.88%
EOC Watch Staff	12.87%	13.31%	13.55%	11.70%	11.52%	11.47%	10.76%	9.97%	10.00%	9.55%	10.54%
Fleet	5.66%	11.32%	14.00%	14.00%	14.00%	13.46%	13.21%	10.53%	8.62%	8.47%	8.47%
PTS	12.61%	12.55%	11.86%	12.45%	12.98%	12.13%	10.92%	9.27%	9.39%	9.05%	8.64%
Resource Staff	2.13%	2.13%	0.00%	0.00%	0.00%	2.04%	4.26%	4.17%	4.17%	4.17%	4.17%
SMP	7.37%	6.88%	6.61%	6.99%	6.77%	6.75%	6.94%	5.84%	5.47%	5.24%	5.43%
Trust Total	**7.35%**	**7.57%**	**7.50%**	**7.39%**	**7.30%**	**7.18%**	**6.82%**	**6.32%**	**6.14%**	**5.77%**	**5.64%**

A&E Establishment as at August 2009

Position Titles	Funded Establishment	Staff in post	Variance	Leavers
Team Leader Paramedic	194.00	172.82	21.18	0.00
ECP	74.00	66.65	7.35	1.00
Paramedic	1005.00	840.45	164.55	5.42
EMT	956.00	1211.47	-255.47	5.50

Student Paramedic	704.00	476.00	228.00	8.00
A&E Support	328.00	218.06	109.94	1.00
EMD1	54.00	93.75	-39.75	2.00
EMD2	90.55	91.07	-0.52	0.00
EMD3	100.76	83.58	17.18	0.00
EMD Allocator	78.00	67.48	10.52	0.00
CTA	50.00	35.82	14.18	0.00
Total	**3634.31**	**3357.15**	**277.16**	**22.92**

4 COMMUNICATIONS

Swine flu: Internal communication about swine flu has continued with the production of a second flu newsletter, issued to all staff, offering guidance on keeping well and informing staff what to do if they do fall ill. A two-page article in September's LAS News answered some of the questions asked by staff about flu. The intranet continues to be updated with news and clinical guidance.

Annual Report: The annual report for 2008/09 has been published and sent to all key stakeholders. The report features case studies of patients and staff, an interview with outgoing Chairman Sigurd Reinton and a summary of the first year of the Service's largest ever recruitment campaign. It also highlights how the Service reached 25 per cent more patients with life-threatening injuries or illnesses within eight minutes compared to 2007/08.

Consultation meetings: The Chief Executive and Medical Director are now half way through the consultation meeting programme which began at the beginning of September.

To date the majority of meetings have been with frontline staff and a range of issues have been raised. These include the lack of training, the application of the attendance policy, use of area cover, the condition of vehicles, airwave radios, relationships between frontline and control services staff and performance pressures. A number of clinical issues have been raised, and are covered in the Medical Director's report.

The programme of 42 meetings continues through to early December with frontline, control services, support, fleet, logistics, and patient transport staff.

A more detailed report will be prepared at the end of the consultation programme.

Service funeral for a former member of staff: Staff attended the funeral service of Laurie Strugnell, a well-regarded former member of the emergency planning department, who died in July. Representatives of the London Ambulance Service, including the Chief Executive, were joined by colleagues from other agencies, voluntary aid societies, the retirement association and the Department of Health at Laurie's funeral.

Media issues

Technician shot: The Evening Standard ran a story on the shooting of a Whipps Cross single responder who was shot twice in the back with an unknown weapon while returning to her car after treating a patient. This was followed up with an article on the front page of the *Waltham Forest Guardian*, along with a comment piece in the paper's editorial section.

Ambulance catches fire: On 1 September an LDV ambulance caught fire outside St Helier Hospital as it arrived to transfer a patient. Thankfully, there were no serious injuries due to the quick actions of the crew who removed oxygen canisters from the vehicle. The story was picked up by the Sun, the BBC London website, LBC, the Evening Standard, the Sutton Guardian and the Wimbledon Guardian.

Cycle responders: The theft of two cycles that were taken when staff were inside a patient's home in Finsbury was covered in *the london paper* and the *Islington Gazette*. On a positive note, the BBC spent a day with the Trust's cycle response unit at Heathrow Airport. A three-minute video was produced for the BBC website and a report was also broadcast on the breakfast show of Radio 5 Live. These featured interviews with several

of the airport's cycle paramedics as well as a patient whose life was saved by the team when he went into cardiac arrest.

Football clashes: Violent clashes both before and after a West Ham v Millwall football match led to some media interest in the Service's response.
One of the investigating police officers also later praised the actions of a crew who attended a patient who had been stabbed.

Other stories: The story of a New Malden-based emergency medical technician who is heading to Afghanistan to volunteer as a medic with her Territorial Army regiment was picked up by local papers. Jess Smith will spend up to four months in the country.

Two delay stories featured in the local press in August. One concerned an eight-year-old boy who had an hour wait for an ambulance on Clapham Common following a fall. This was covered by the Streatham Guardian. The second story published in the Southwark News was to a call involving a young girl who had injured a finger. The family took a taxi to hospital after there was confusion about whether or not an ambulance was being sent.

The unusual date of 09.09.09 attracted media coverage for the Service. The Times ran a double-page spread in the Times2 supplement about all three emergency services and featured a ride-out with a crew from Camden. The East London Advertiser picked up on a news release issued by the Service in which the Chief Executive praised the work of all the emergency services in the capital.

PPI activity report

Public education:

- The second development programme for staff involved in public education activity is taking place over 8 days in October and November. Twelve members of staff from different parts of the Service are to take part in the programme, which will include sessions on presentation skills, risk assessment, planning public education sessions, coaching and delivering key messages.

Category C Service User Survey:

- A new group has been formed to explore the findings of the Category C survey and take forward actions and recommendations arising from it. This work will link with other projects focusing on developments affecting this group of patients.

Foundation Trust membership:

- The Patient & Public Involvement Manager is working with the Head of Communications and the FT Membership Manager to develop a programme of communication and involvement activities with Foundation Trust members.

Winter and flu planning:

- The Patient & Public Involvement Manager is working with the Communications team to develop a public campaign to convey some of our key messages this autumn and winter.

Patient Care Conference:

- The Patient Care Conference planned for September 2009 has been postponed until January, due to the venue having withdrawn its availability.

Patients' Forum:

- The Trust recently held an 'induction' meeting for new members of the LAS Patients' Forum. A number of managers from across the Trust gave a brief presentation about their topic or area, and invited questions from the 17 Forum members in attendance.

Peter Bradley CBE
Chief Executive Officer

17 September 2009

London Ambulance Service
NHS Trust

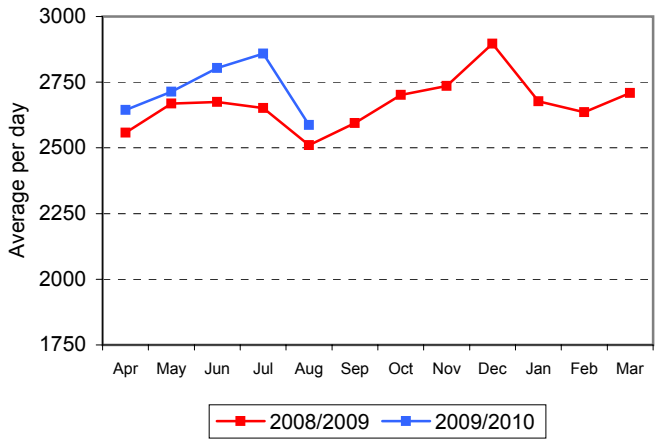
Information Pack for Trust Board

August 2009

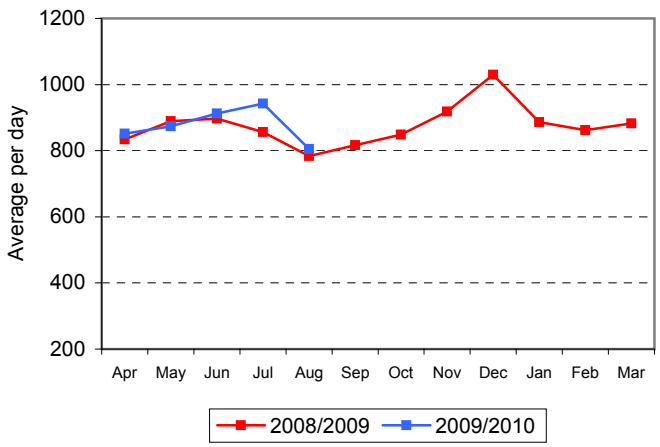
Please note: PRF input/uplifts are not yet complete for August 09

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity - August 2009

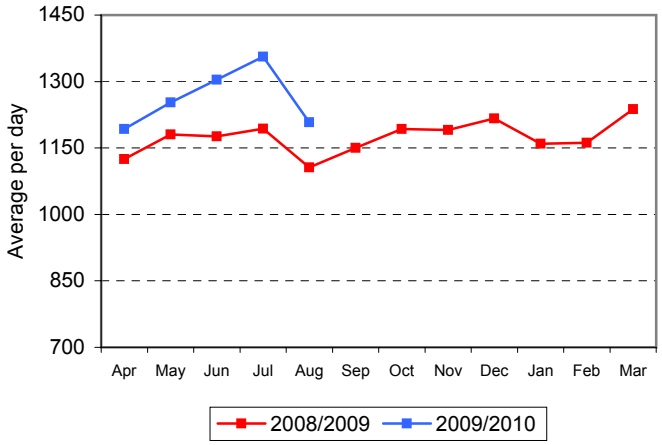
Graph 1
Average number of Cat A, B & C incidents per day



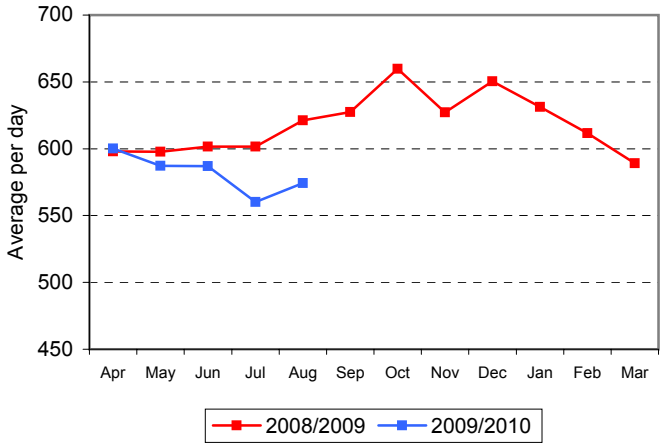
Graph 2
Average number of Cat A incidents per day



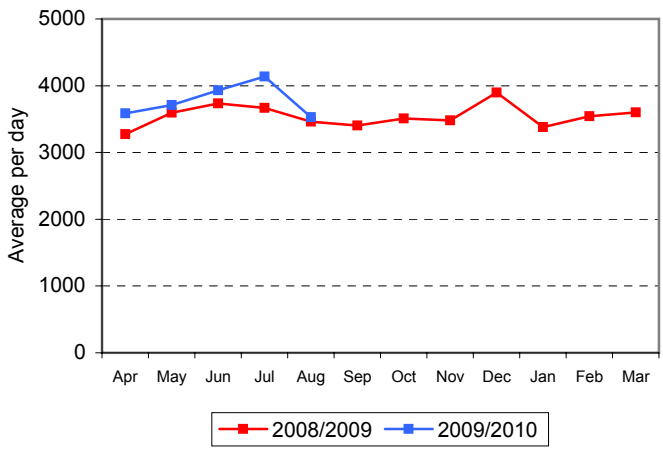
Graph 3
Average number of Cat B incidents per day



Graph 4
Average number of Cat C incidents per day

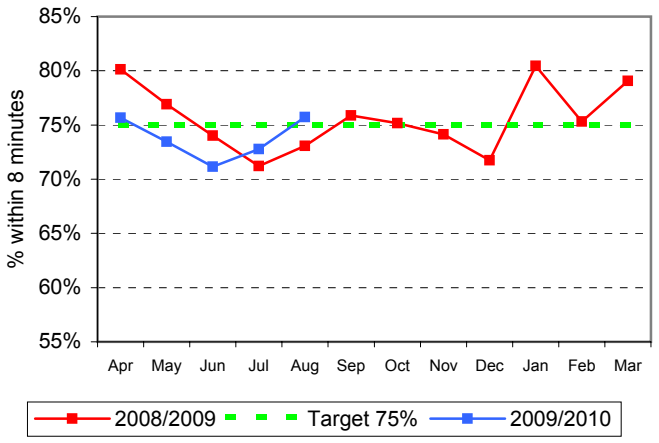


Graph 5
Average number of 999 calls received per day

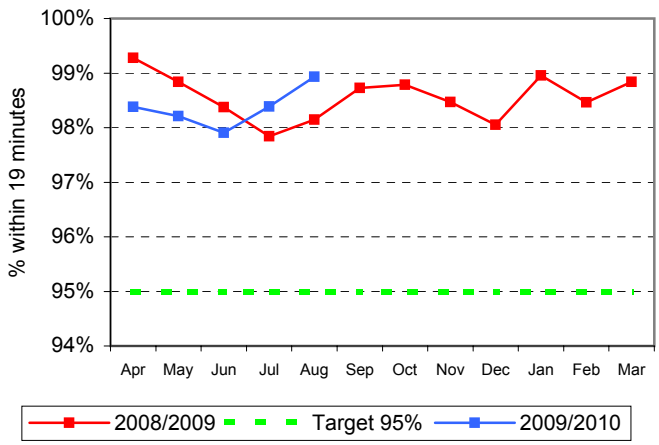


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - August 2009

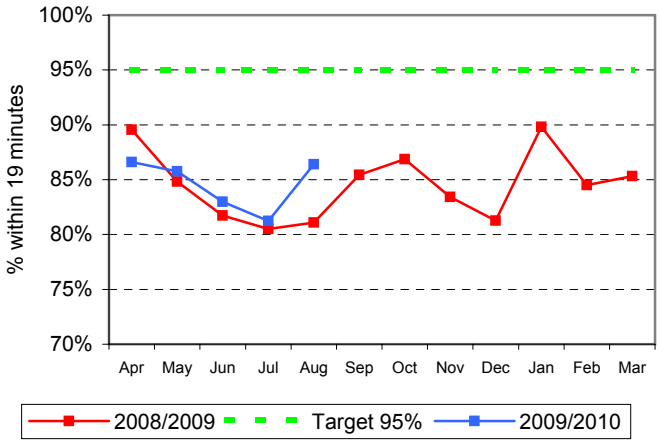
Graph 6
Category A 8 minute performance



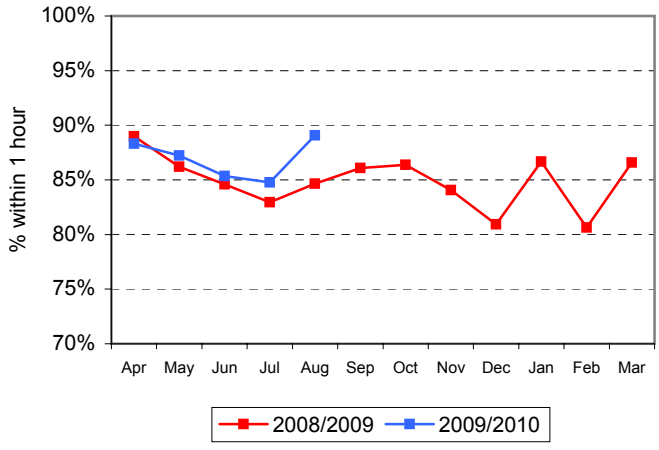
Graph 7
Category A 19 minute performance



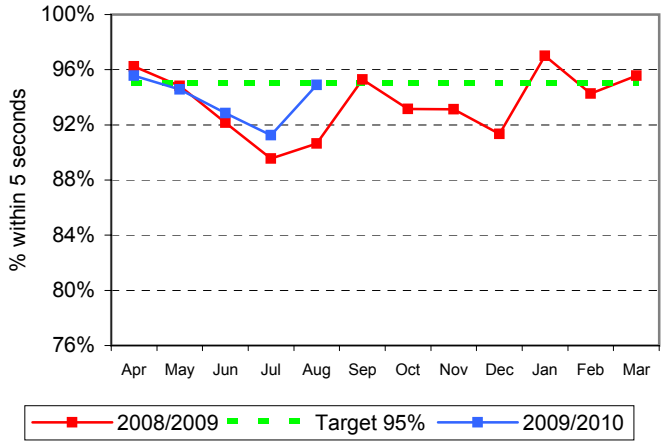
Graph 8
Category B 19 minute performance



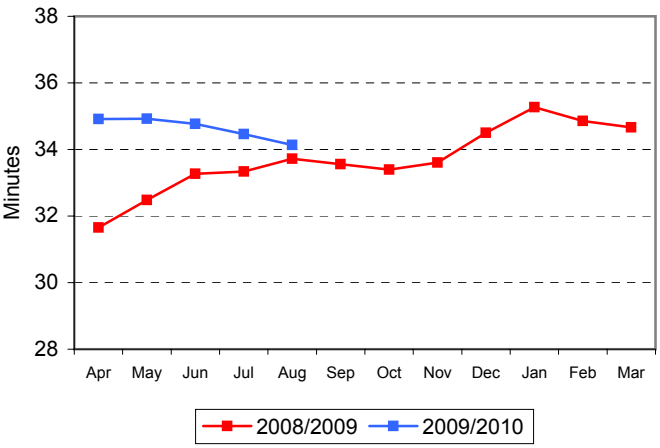
Graph 9
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)



Graph 10
Percentage of calls answered within 5 seconds

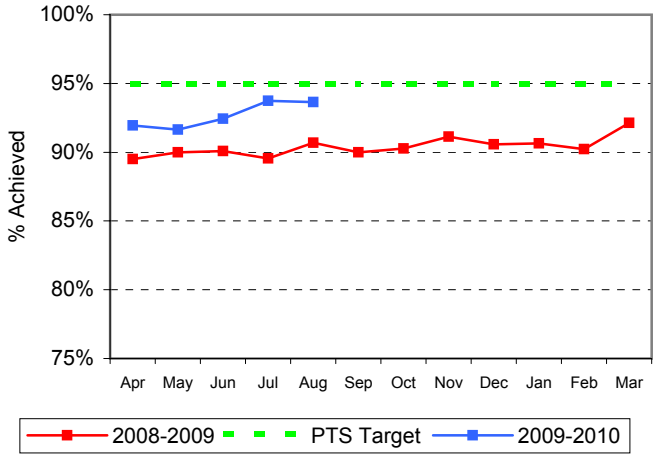


Graph 11
Average hospital turnaround time

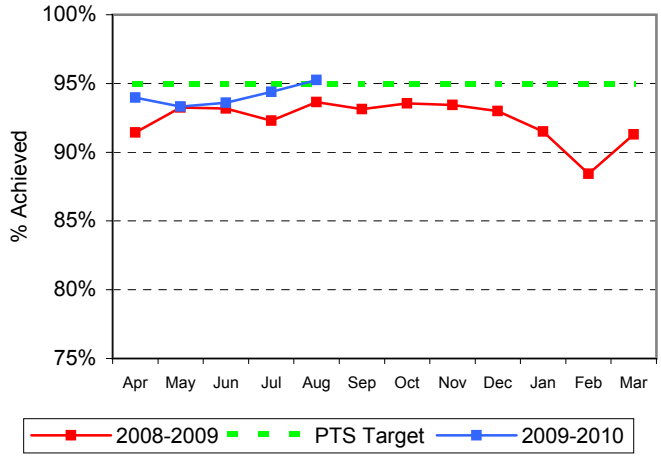


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - August 2009

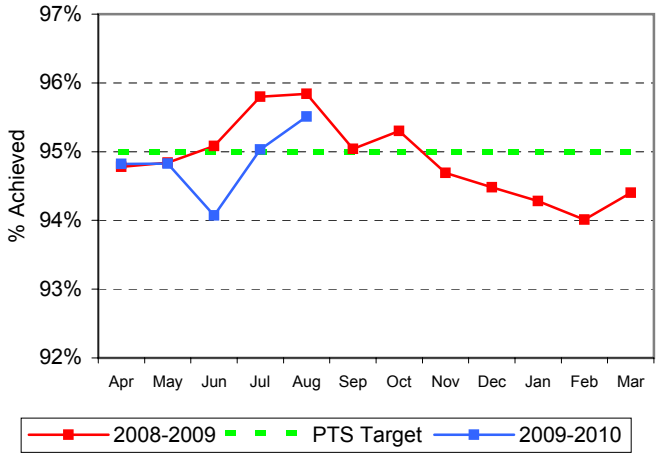
Graph 12
Arrival at Hospital Against Appointment Time



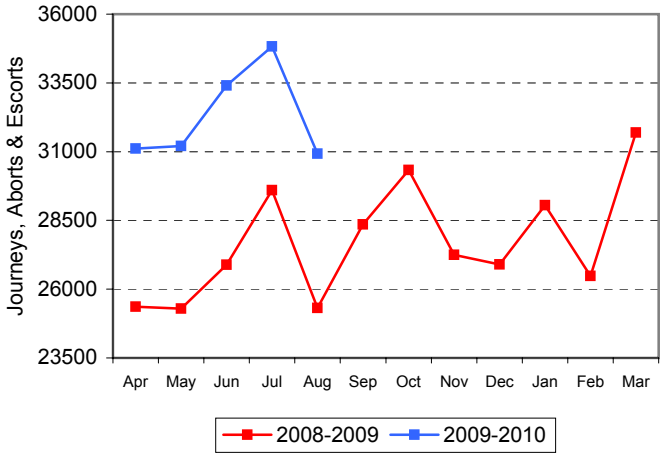
Graph 13
Departure Against Ready Time



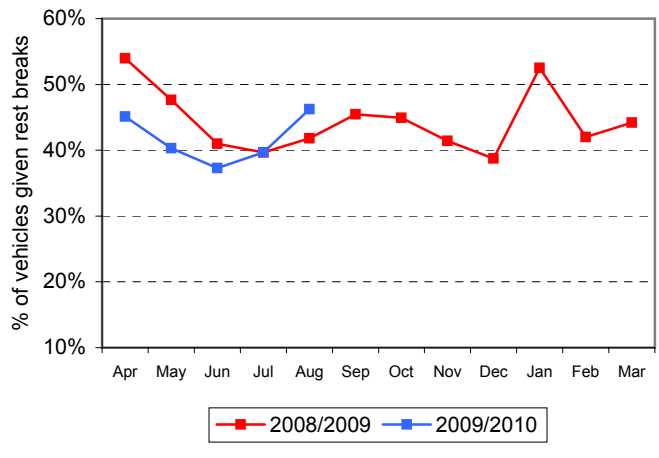
Graph 14
Time spent on Vehicle



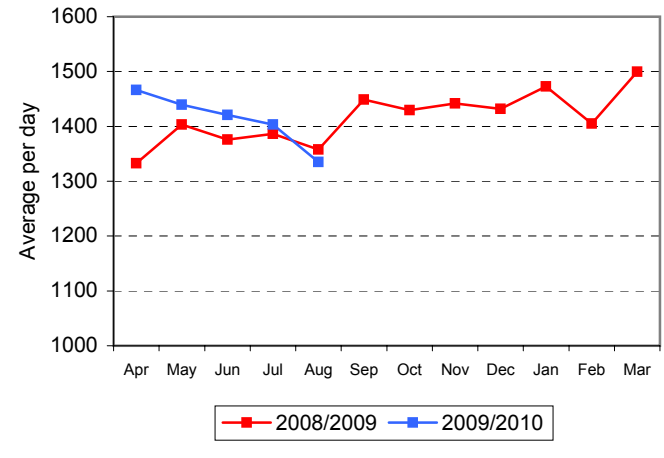
Graph 15
PTS Total Activity



Graph 16
% of vehicles given a rest break

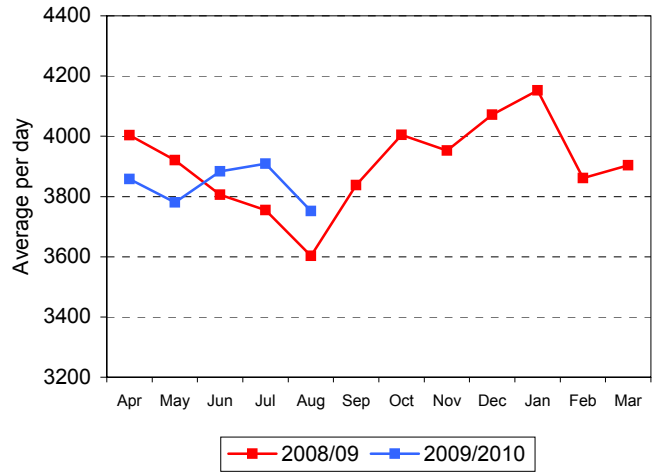


Graph 17
EOC hours staffed per day

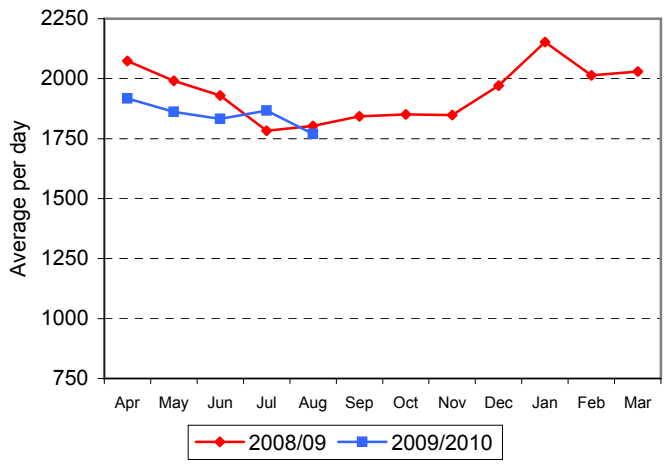


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - August 2009

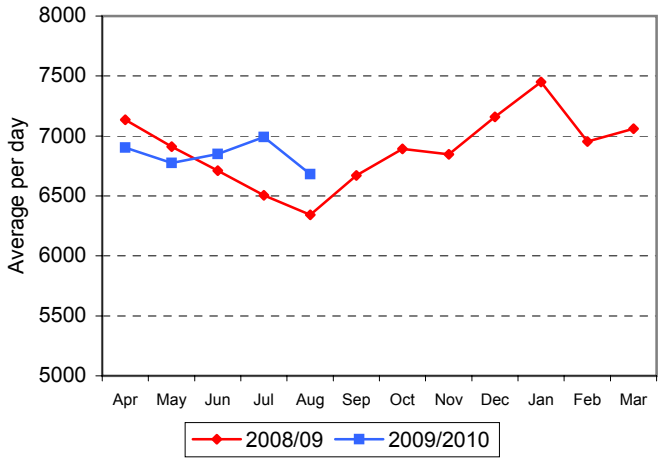
Graph 18
Ambulance Hours average available per day



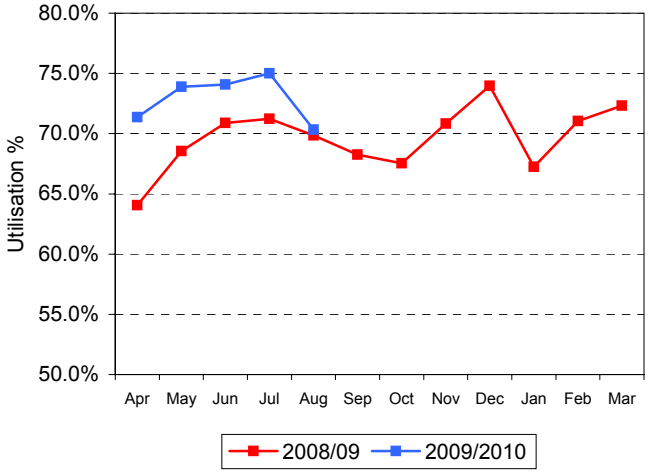
Graph 19
FRU hours average available per day



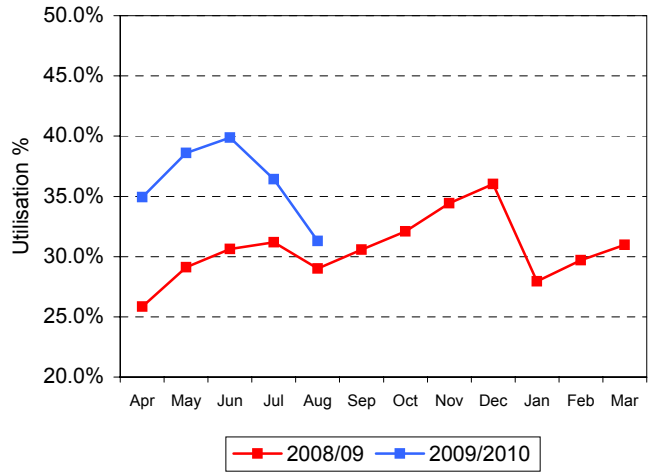
Graph 20
All Vehicle Hours average available per day



Graph 21
Ambulance Utilisation



Graph 22
FRU Utilisation



TRUST BOARD - 29 September 2009

Document Title	**M5 Finance Board Pack**
Report Author(s)	**Finance Department**
Lead Director	**Mike Dinan**
Contact Details	**0207 7463 2585**
Aim	**Information**

Key Issues for the Board

The result for the month is a surplus of £482k, the year to date shows a surplus of £1,046k. The full year surplus forecast to be £1,650k. The forecast profile has changed to reflect the activity undertaken to support performance. The full year forecast surplus has changed by £40k.Total average monthly cost year to date was £23.1M. Total average monthly cost for the full year is forecast to be £23.4M.

Mitigating Actions (Controls)

Monitoring of expenditure and associated cost improvement plans . Intervention as required.

Recommendations to the Board

To note the contents of this report.

Equality Impact Assessment

Has an EIA been carried out?	No
(If not, state reasons)	Not relevant for this paper

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

The key risks are around the achievement of the Cost Improvement Plan, the receipt of all budgeted income and the financial impact of responding to increased demand. Failure to achieve the financial targets set will impact on the standing of the LAS.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate Objectives that the report links to

Achieve financial targets including control total, PTS profitability and efficiency savings

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD
August 2009/10 (MONTH 05)

Contents:

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31 August 2009 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	23,143	23,469	(326)U	116,280	117,645	(1,365)U	(1.2%)U	280,552	281,930	(1,378)U
Total Operational Costs	21,283	21,937	654F	108,603	110,468	1,865F	1.7%F	261,758	267,371	5,613F
EBITDA	**1,860**	**1,532**	**327F**	**7,676**	**7,176**	**500F**	**0.53%F**	**18,794**	**14,559**	**4,235F**
EBITDA Margin	***8.0%***	***6.5%***	**1.5%**	***6.6%***	***6.1%***	**0.5%**		***6.7%***	***5.2%***	**1.5%**
Depreciation & Interest	1,378	1,054	(323)U	6,631	5,272	(1,359)U	(25.8%)U	17,144	12,653	(4,492)U
Net *Surplus/(Deficit)*	**482**	**478**	**4F**	**1,046**	**1,905**	**(859)U**	**26.3%U**	**1,650**	**1,906**	**(256)U**
Net Margin	***2.1%***	***2.0%***	**0.1%**	***0.9%***	***1.6%***	**-0.7%**		***0.6%***	***0.7%***	**-0.1%**

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending August 31st 2009

Year to Date

• For the year to date, income exceeds expenditure by £1,046k. The budgeted position is for income to exceed expenditure by £1,905k, hence there is a year to date adverse variance of £859k.
• This is mainly due to the fact that Income is lower than plan by £1,365k due to provisions against Category B performance related income.
• PTS is reporting a profit to date of £299k against a planned surplus of £140k which reflects higher than planned activity.

Month

• In the month there is a £482k surplus against a planned surplus of £478k resulting in an favourable movement of £4k.
• PTS reported a surplus of £75k which results from increased activity.

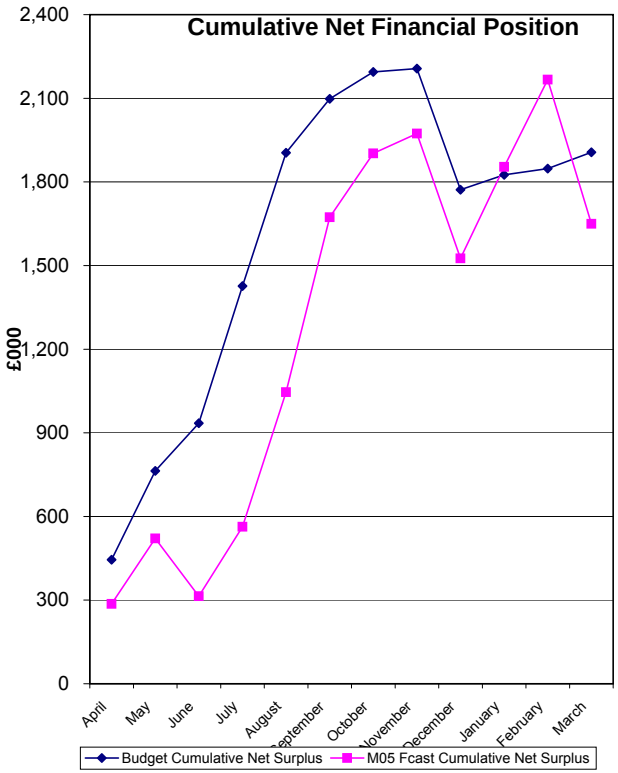
Forecast

• The year end forecast is £1,650k surplus against a planned surplus of £1,906k.
• Forecast Income has reduced against plan by £1 due to a CAT B Penalty provision of £1.5m. There is a partial offset caused by an increase in variable income.
• Forecast Pay expenditure shows an adverse variance of £1,682k largely due to pressure on agency spend in Corporate Services
• Forecast Non Pay is less than plan by £2,500k mainly due to additional CIP savings required.
•The loss on the two properties planned to be disposed this year has been increased by £298k.
•Total average monthly cost year to date is £23.1M the total average monthly cost for the rest of the year is forecast to be £23.4M

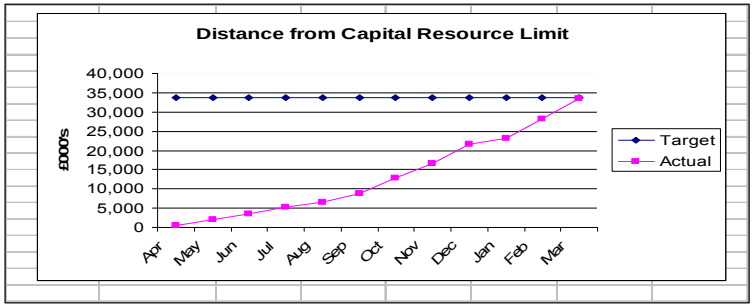
London Ambulance Service NHS Trust

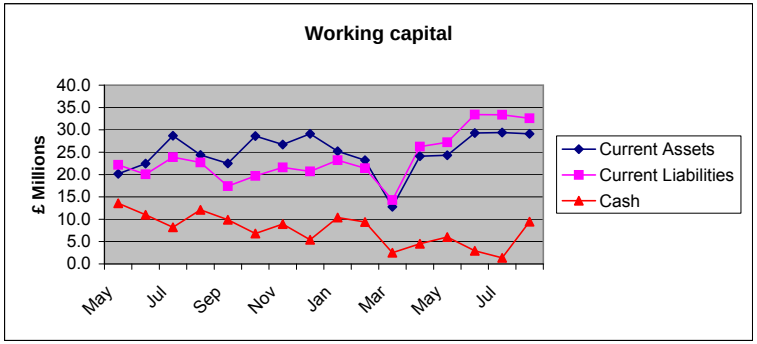
Summary of Financial Performance for the month ending 31st August (Month 05)

Income and Expenditure



Balance Sheet





Ratios	June	July	August	
Asset turnover ratio	2.12	2.11	2.10	●
Debtors % > 90 days	3.3%	4.1%	13.0%	●
PSPP NHS	89%	69%	100%	●
PSPP Non NHS	81%	79%	91%	●

Key Financial Indicators

	June
A&E Overtime (£000) / Day (Month)	56
A&E Overtime (% of paybill)	9.87%
Subsistence (£000) / Day (Month)	6.82
Subsistence per head £	46.99
Third Party Transport expenditure / Day (Month)	6,540
Total operational cost per incident	267
A&E Gross Surplus (YTD) (% of Income)	24.9%
A&E Net Margin (YTD) (% of Income)	0.1%
PTS Gross Margin (YTD) (% of Income)	7.54%
Cat B performance (cumulative)	85.07%

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 August 2009 (Month 5)

£000s

	MONTHLY SPEND												
	April *Actual*	May *Actual*	June *Actual*	July *Actual*	August *Actual*	September *Forecast*	October *Forecast*	November *Forecast*	December *Forecast*	January *Forecast*	February *Forecast*	March *Forecast*	Total
Income	**22,954**	**23,240**	**23,606**	**23,337**	**23,143**	**24,262**	**23,509**	**23,363**	**23,210**	**23,378**	**23,321**	**23,228**	**280,552**
Pay Expenditure													
A&E Operational Staff	9,143	9,201	9,318	9,474	9,433	9,880	10,079	10,315	10,317	10,462	10,520	10,462	118,603
Overtime	1,695	1,552	1,680	1,417	1,514	1,400	1,166	934	914	529	505	531	13,836
Overtime Incentives	443	781	513	415	178	300	0	0	292	0	0	0	2,923
A&E Management	1,023	1,024	1,072	1,023	1,031	1,066	1,075	1,075	1,078	1,078	1,078	1,078	12,702
EOC Staff	1,008	1,044	1,039	1,066	1,047	1,088	1,078	1,126	1,126	1,126	1,126	1,126	13,002
PTS Operational Staff	491	527	511	494	487	499	493	493	494	493	493	493	5,968
PTS Management	82	76	78	96	88	84	84	84	84	84	84	84	1,011
Corporate Support	2,855	2,965	2,813	2,925	2,990	2,936	2,931	2,931	2,928	2,903	2,910	2,958	35,046
Sub Total	**16,740**	**17,168**	**17,025**	**16,910**	**16,767**	**17,253**	**16,908**	**16,960**	**17,234**	**16,676**	**16,717**	**16,733**	**203,091**
Average Daily	*558*	*554*	*567*	*545*	*541*	*575*	*545*	*565*	*556*	*538*	*597*	*540*	*556*
Non-Pay Expenditure													
Staff Related	368	340	300	235	287	288	288	317	338	303	268	248	3,580
Subsistence	170	184	208	174	156	128	118	122	106	118	96	106	1,685
Training	131	158	70	167	51	374	160	179	166	202	143	156	1,958
Medical Consumables & Equipment	517	450	498	836	573	528	536	546	470	502	532	561	6,548
Drugs	3	33	44	29	17	35	35	35	35	35	35	35	365
Fuel & Oil	367	375	389	386	365	378	378	378	407	378	378	378	4,557
Third Party Transport	154	220	196	150	223	122	117	117	117	122	122	122	1,779
Vehicle Costs	902	107	1,004	753	767	723	717	714	716	712	714	715	8,544
Accommodation & Estates	1,018	1,019	1,082	1,138	947	1,054	1,067	1,050	1,149	1,050	1,051	1,050	12,674
Telecommunications	592	617	800	981	582	710	784	697	737	684	701	662	8,546
Depreciation	623	1,255	976	965	1,023	1,061	1,077	1,092	1,107	1,145	1,145	1,145	12,616
Other Expenses	727	464	732	399	548	606	720	706	686	720	703	773	7,784
Profit/(Loss) on Disposal FA	1	0	2	1	1	1	1	1	1	1	1	656	648
Sub Total	**5,566**	**5,223**	**6,296**	**6,212**	**5,539**	**6,007**	**5,994**	**5,951**	**6,033**	**5,970**	**5,887**	**6,606**	**71,284**
Average Daily	*186*	*168*	*210*	*200*	*179*	*200*	*193*	*198*	*195*	*193*	*210*	*213*	*195*
Financial Expenditure	**362**	**613**	**493**	**35**	**354**	**374**	**379**	**381**	**391**	**405**	**405**	**406**	**4,528**
Average Daily	*12*	*20*	*16*	*1*	*11*	*12*	*12*	*13*	*13*	*13*	*14*	*13*	*12*
Monthly Expenditure	**22,668**	**23,004**	**23,814**	**23,087**	**22,660**	**23,634**	**23,281**	**23,292**	**23,658**	**23,050**	**23,008**	**23,745**	**278,902**
Cumulative	**22,668**	**45,672**	**69,486**	**92,573**	**115,234**	**138,868**	**162,149**	**185,441**	**209,099**	**232,149**	**255,157**	**278,902**	
Monthly Net	**286**	**235**	**(208)**	**249**	**482**	**628**	**229**	**71**	**(448)**	**328**	**313**	**(517)**	**1,650**
Cumulative Net	**286**	**521**	**314**	**563**	**1,046**	**1,674**	**1,902**	**1,974**	**1,526**	**1,854**	**2,167**	**1,650**	

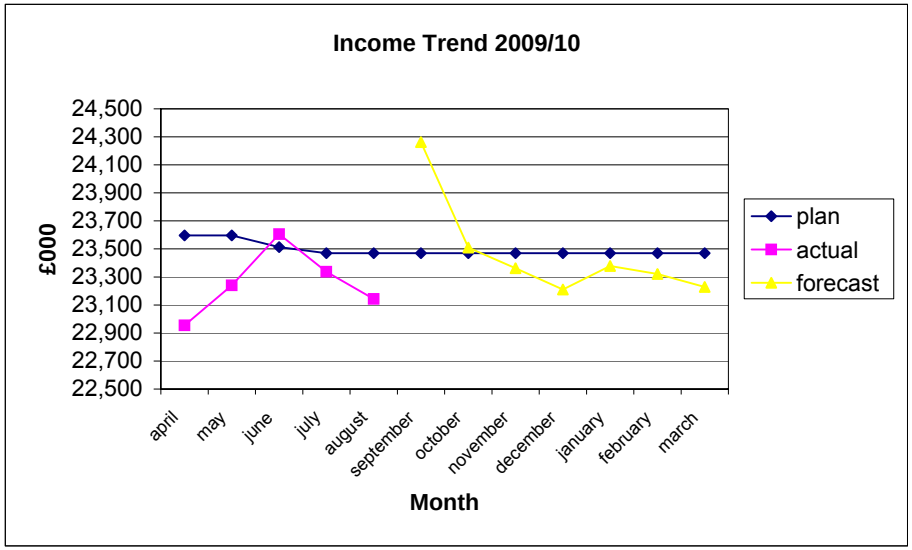
LONDON AMBULANCE SERVICE NHS TRUST

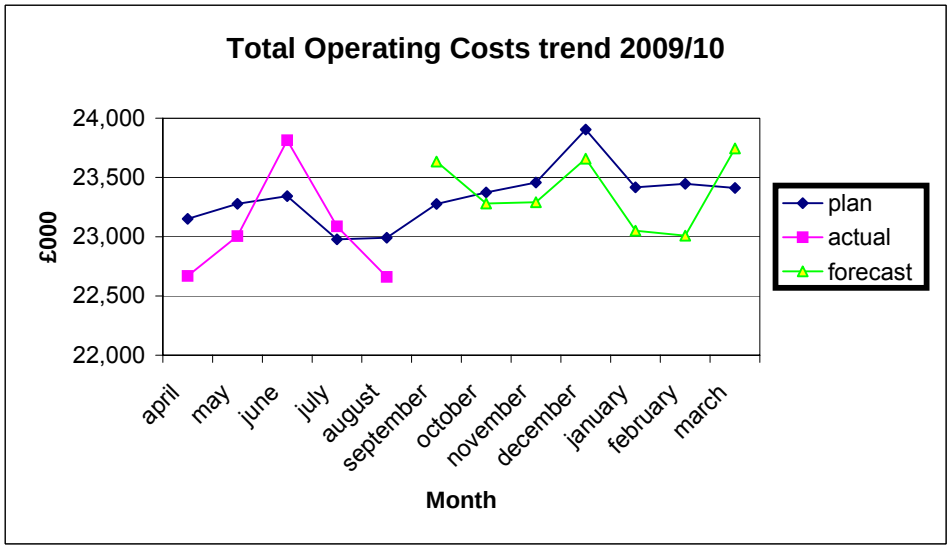
Comparison of annual forecasts at Month 5 and Month 4
As at 31st August (Month 5)

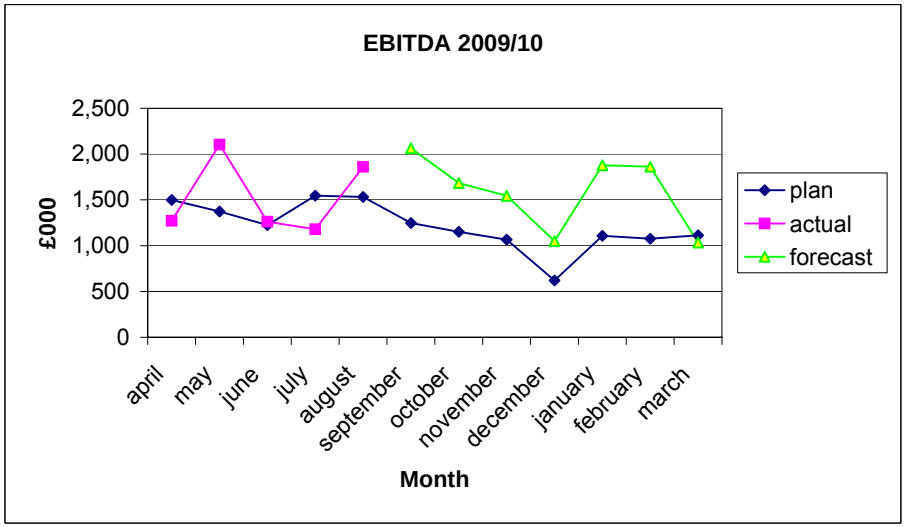
	Forecast Month 5	Month 4	Variance	
Income	**(280,552)**	**(278,546)**	**2,007**	**£2.1m reduction in CAT B Penalty from £3.6m to £1.5m**
Pay Expenditure				
A&E Operational Staff	118,603	119,163	560	£284k slippage against workforce plan (Also 17 Uni Paras have not yet started (17 x £4k = £68k) plus over forecast of 20 A&E Support (20 x £2.5k = £50k) . Previous month also contained Backpay for EMT 4's not reduced in forecast £86k. Paramedic Course of 36 expected to be completed but wasn't (£1k x 36 WTE = £36k). £265k decrease in projected cost of Student Paramedics Yr 2 due to lower average salary than expected (£3250 - £3000 = £250 x 151wte x 7 months)
Overtime	13,836	13,301	(535)	September and October Forecasts have been increased by £330k to account for expected demand pressures due to Swine Flu.
Overtime incentives	2,923	3,469	546	August Incentive lower than expected (£339k) as a result September incentive reduced by £100k and December incentive reduced by £80k
A&E Management	12,702	12,612	(91)	Forecast increased due to additional management costs not within budget plus planned recruitment of Additional Area Production managers and Investigation officers
EOC Staff	13,002	12,967	(35)	
PTS Operational Staff	5,968	6,070	103	Reduction in expected staff costs due to reduced contracts going forward
PTS Management	1,011	999	(12)	
Corporate Support	35,046	34,673	(373)	318k increase in agency staff in M05 (In August there was an £80k increase in Professional Agency Costs for IM&T transferred from Consultancy. Increase in FT Agency Costs of £66k and £160k increase in Ops Support Agency forecast as previously underforecast). 30k IM&T Cust Services new starter not in M04 forecast.
Sub Total	**203,091**	**203,253**	**162**	
Non-Pay Expenditure				
Staff Related	3,580	3,541	(39)	£20k increase in forecast for Long Service Awards
Subsistence	1,685	1,674	(11)	
Training	1,958	2,278	321	Reduction in expected usage of Hired Training Vehicles £111k. £140k reduction due to reduction in MPET funding of ECP training costs.
Drugs	365	388	23	
Medical Consumables & Equipment	6,548	6,524	(24)	
Fuel & Oil	4,557	4,586	29	
Third Party Transport	1,779	1,678	(101)	£71k increase mainly due to unexpected holiday cover in PTS in M05.
Vehicle Costs	8,544	8,569	25	
Accommodation & Estates	12,674	12,538	(136)	£95k increase for blankets previously unforecast, £34k increase in Make Ready costs for LARP for September and October for additional drivers for Radio Fitting
Telecommunications	8,546	8,416	(130)	Increase in forecast for expected cost of Data Network line Rental (IPT project) costs pending review with IM&T (£65k)
Depreciation	12,616	12,709	93	Based on revised Dep'n calculations in August
Other Expenses	7,784	5,810	(1,974)	Includes CIP of 4,168k, variance mainly due to CIP to be achieved reduced in line with reduction in Cat B penalty
Profit/(Loss) on Disposal FA	648	346	(302)	Adjustment for Park Royal
	71,284	**69,056**	**(2,228)**	
Financial Expenditure	**4,528**	**4,547**	**19**	
Total Expenditure	**278,902**	**276,856**	**2,047**	
Net	**-1,650**	**-1,690**	**-40**	

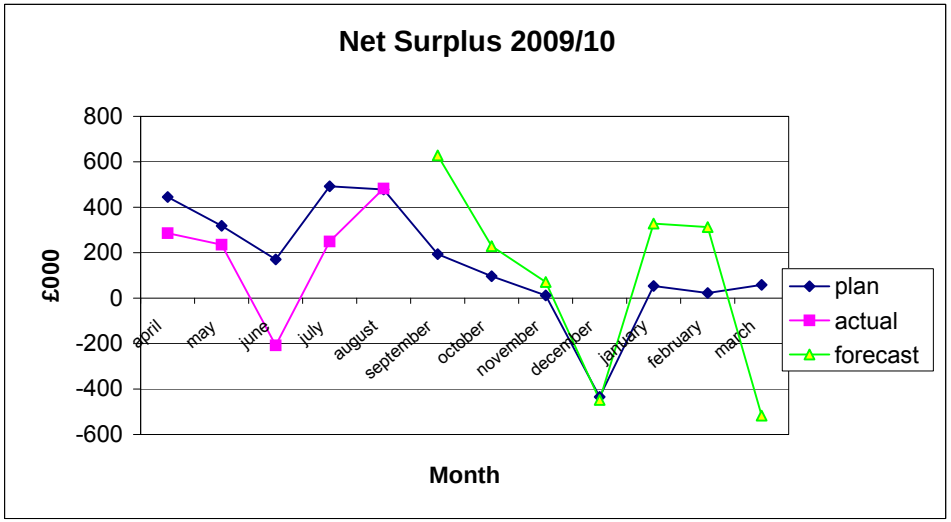
London Ambulance Service NHS Trust

Month 05 Trust Board report - forecast data









LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 August 2009 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	9,433	9,803	371F	46,568	47,778	1,210F	2.5%F	118,603	119,869	1,266F
Overtime	1,514	1,258	(256)U	7,857	7,066	(791)U	(11.2%)U	13,836	15,505	1,669F
Overtime Incentives	178	0	(178)U	2,330	1,000	(1,330)U	(133.0%)U	2,923	1,000	(1,923)U
A&E Management	1,031	1,013	(18)U	5,173	5,058	(115)U	(2.3%)U	12,702	12,152	(550)U
EOC Staff	1,047	1,045	(2)U	5,204	5,236	32F	0.6%F	13,002	12,797	(206)U
PTS Operational Staff	487	448	(39)U	2,510	2,398	(112)U	(4.7%)U	5,968	5,534	(434)U
PTS Management	88	105	17F	420	533	113F	21.2%F	1,011	1,268	257F
Corporate Support	2,990	2,771	(219)U	14,548	13,888	(660)U	(4.8%)U	35,046	33,285	(1,761)U
	16,767	**16,444**	**(323)U**	**84,610**	**82,957**	**(1,653)U**	**(2.0%)U**	**203,091**	**201,409**	**(1,682)U**
Non-Pay Expenditure										
Staff Related	287	320	33F	1,530	1,600	70F	4.4%F	3,580	3,838	258F
Subsistence	156	121	(35)U	891	608	(284)U	(46.7%)U	1,685	1,458	(227)U
Training	51	207	155F	576	1,034	458F	44.3%F	1,958	2,482	524F
Drugs	17	35	18F	120	175	55F	31.6%F	365	420	56F
Medical Consumables & Equipment	573	479	(94)U	2,873	2,393	(480)U	(20.1%)U	6,548	5,743	(804)U
Fuel & Oil	365	377	11F	1,883	1,896	12F	0.7%F	4,557	4,534	(23)U
Third Party Transport	223	88	(135)U	943	439	(504)U	(114.8%)U	1,779	1,054	(725)U
Vehicle Costs	767	1,260	493F	3,533	6,331	2,798F	44.2%F	8,544	15,149	6,605F
Accommodation & Estates	947	882	(66)U	5,205	4,408	(797)U	(18.1%)U	12,674	10,580	(2,094)U
Telecommunications	582	707	125F	3,572	3,537	(35)U	(1.0%)U	8,546	8,485	(61)U
Depreciation	1,023	652	(371)U	4,843	3,259	(1,584)U	(48.6%)U	12,616	7,822	(4,795)U
Other Expenses	548	989	441F	2,871	4,945	2,074F	41.9%F	7,784	11,868	4,084F
Profit/(Loss) on Disposal FA	(1)	29	30	(4)	146	150F	103.0%F	648	350	(298)U
	5,539	**6,145**	**606F**	**28,836**	**30,771**	**1,934F**	**6.3%F**	**71,284**	**73,783**	**2,500F**
Financial Expenditure	**354**	**403**	**48F**	**1,788**	**2,013**	**225F**	**11.2%F**	**4,528**	**4,831**	**303F**
Total Trust Expenditure	**22,660**	**22,991**	**331F**	**115,234**	**115,740**	**506F**	**0.4%F**	**278,902**	**280,024**	**1,121F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 August 2009 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	22,276	22,712	(436)U	111,814	113,559	(1,745)U	(1.5%)U	270,578	272,543	(1,964)U
Sector Services	13,586	13,476	(110)U	67,615	67,664	49F	0.1%F	164,192	165,703	1,512F
A&E Operational Support	1,389	1,273	(116)U	7,621	6,380	(1,241)U	(19.5%)U	18,449	15,281	(3,168)U
Control Services	1,632	1,492	(140)U	8,210	7,489	(721)U	(9.6%)U	19,656	18,158	(1,497)U
Planning and Specialised Ops	214	358	144F	1,096	1,823	727F	39.9%F	4,164	4,318	153F
Total Operations Cost	**16,821**	**16,599**	**(222)U**	**84,542**	**83,355**	**(1,187)U**	**(1.4%)U**	**206,461**	**203,461**	**(3,001)U**
A&E Gross Surplus/(Deficit)	**5,455**	**6,113**	**(658)U**	**27,273**	**30,204**	**(2,932)U**	**(9.7%)U**	**64,117**	**69,082**	**(4,965)U**
	24.5%	26.9%	(3.0%)U	24.4%	26.6%	-2.2%		23.7%	25.3%	-1.7%
Medical Directorate	93	100	7F	464	500	36F	7.2%F	1,173	1,203	30F
Service Development	121	98	(24)U	453	489	37F	7.5%F	911	1,174	263F
Communications	187	197	10F	975	984	9F	1.0%F	2,288	2,362	74F
Human Resources	1,729	1,825	96F	9,219	9,292	73F	0.8%F	21,780	21,497	(283)U
IM&T	1,072	1,196	124F	5,922	5,978	56F	0.9%F	14,434	14,348	(87)U
Corporate Services	99	80	(19)U	452	399	(53)U	(13.3%)U	2,514	959	(1,556)U
Finance	1,623	2,071	448F	8,589	10,356	1,767F	17.1%F	18,545	24,855	6,310F
Chief Executive	118	126	8F	578	629	51F	8.1%F	1,496	1,510	14F
Total Corporate	**5,042**	**5,692**	**650F**	**26,652**	**28,628**	**1,976F**	**(6.9%)U**	**63,141**	**67,906**	**4,766F**
A&E Net Surplus/(Deficit)	**413**	**421**	**(7)U**	**621**	**1,576**	**(956)U**	**60.6%F**	**976**	**1,176**	**(199)U**
A&E Net Margin	1.9%	1.9%	(0.0%)U	0.6%	1.4%	-0.8%	-60%	0.4%	0.4%	-0.1%
Patient Transport Service	**35**	**20**	**15F**	**299**	**140**	**160F**	**114.2%F**	**628**	**278**	**350F**
Trust Result *Surplus/(Deficit)*	**448**	**440**	**8F**	**920**	**1,716**	**(796)U**	**46.4%F**	**1,605**	**1,454**	**151F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 August 2009 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	19,919	20,219	(300)U	99,594	101,094	(1,500)U	(1.5%)U	241,126	242,626	(1,500)U
HEMS Funding	11	11	(0)U	53	54	(1)U	(2.4%)U	127	131	(3)U
Emergency Bed Service	92	92	0F	462	461	1F	0.2%F	1,108	1,105	2F
CBRN Income	642	645	(2)U	3,211	3,223	(12)U	(0.4%)U	7,706	7,735	(29)U
BETS & SCBU Income	51	51	(1)U	245	256	(11)U	(4.2%)U	588	613	(25)U
A & E Long Distance Journey	21	33	(12)U	167	167	0F	0.1%F	415	400	15F
Stadia Attendance	65	85	(20)U	445	425	20F	4.7%F	1,089	1,019	70F
Heathrow BAA Contract	52	44	8F	253	222	31F	14.0%F	789	532	257F
PTS Income from FTs	80	27	53F	400	133	267F	200.4%F	1,044	320	724F
A&E Income from FTs	20	13	7F	74	63	11F	17.7%F	165	150	15F
Olympics Income	45	160	(115)U	218	800	(582)U	(72.8%)U	1,920	1,920	0F
HART Income	287	363	(76)U	1,679	1,815	(137)U	(7.5%)U	4,028	4,357	(329)U
Injury Recovery Income	109	77	31F	528	387	141F	36.4%F	1,262	929	333F
MPET Income	915	870	45F	4,658	4,351	307F	7.0%F	9,802	10,443	(641)U
	22,308	**22,690**	**382**	**111,985**	**113,450**	**1,465**	**(1.3%)U**	**271,171**	**272,280**	**(1,109)U**
PTS Income	787	731	56F	4,065	3,952	113F	(2.9%)U	8,930	9,067	(138)U
Other Income	48	49	(0)U	230	243	(12)U	(5.1%)U	452	582	(130)U
Trust Result	**23,143**	**23,469**	**(326)U**	**116,280**	**117,645**	**(1,365)U**	**(1.2%)U**	**280,552**	**281,930**	**(1,378)U**

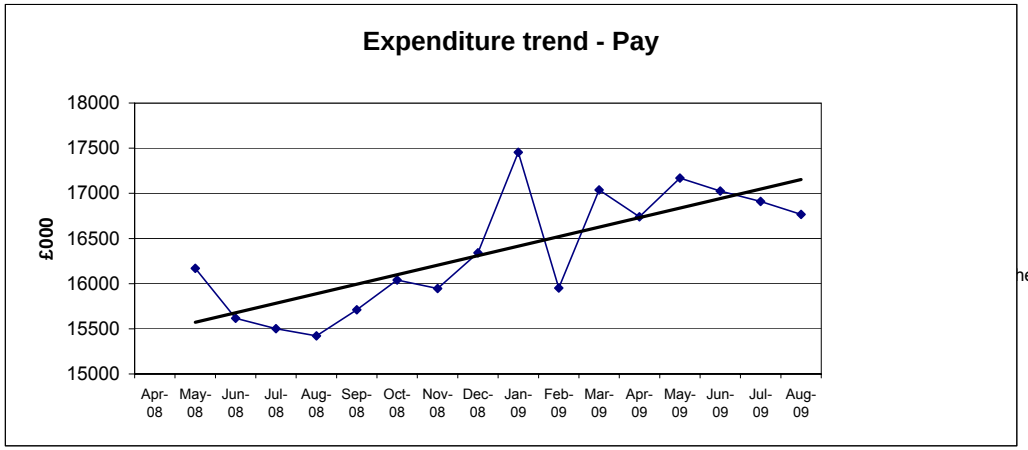
LONDON AMBULANCE SERVICE NHS TRUST

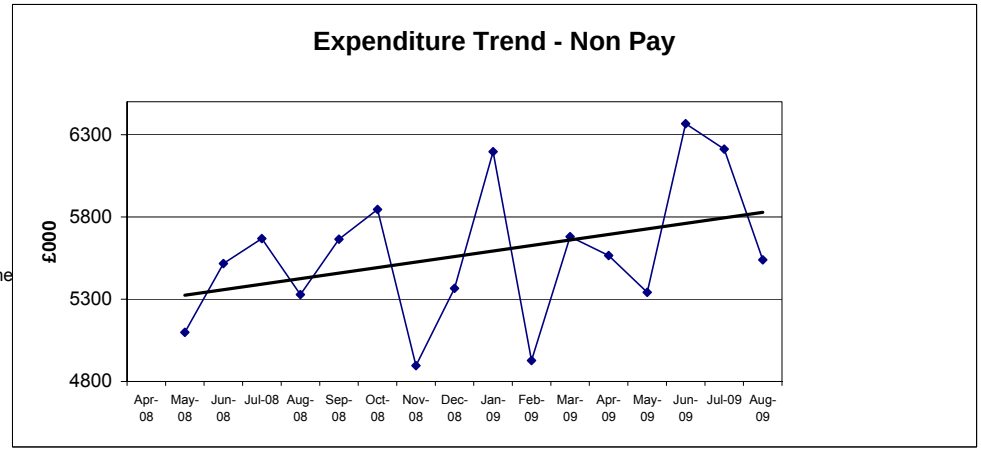
Expenditure Trends Including Last Year
As at 31st August 2009 (Month 5)

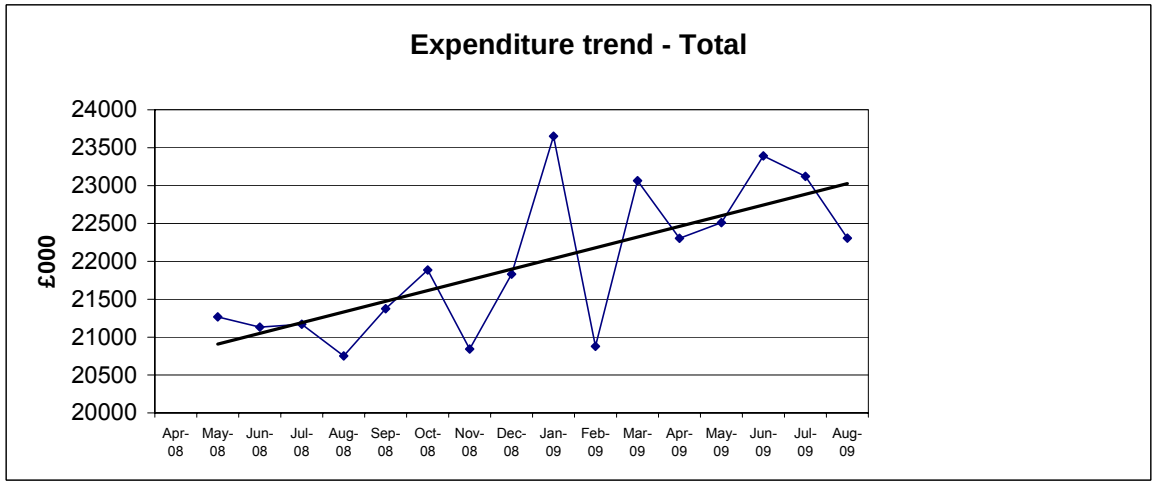
	August	September	October	November	December	January	February	March	April	May	June	July	August
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**21,219**	**22,551**	**23,328**	**19,982**	**22,955**	**22,728**	**22,590**	**21,790**	**22,954**	**23,240**	**23,606**	**23,337**	**23,143**
Pay Expenditure													
A&E Operational Staff	8,249	8,329	8,471	8,474	8,624	8,677	8,624	8,880	9,143	9,201	9,318	9,474	9,433
Overtime	1,566	1,620	1,739	1,601	1,712	1,710	1,495	1,735	1,695	1,552	1,680	1,417	1,514
Overtime Incentives	530	584	541	596	848	1,753	893	274	443	781	513	415	178
A&E Management	949	967	979	970	1,024	1,001	980	1,001	1,023	1,024	1,072	1,023	1,031
EOC Staff	982	985	948	962	918	965	1,007	990	1,008	1,044	1,039	1,066	1,047
PTS Operational Staff	476	454	485	468	470	464	448	479	491	527	511	494	487
PTS Management	91	83	88	93	60	80	74	79	82	76	78	96	88
Corporate Support	2,581	2,690	2,791	2,781	2,687	2,804	2,431	3,600	2,855	2,965	2,813	2,925	2,990
Sub Total	**15,423**	**15,710**	**16,041**	**15,946**	**16,342**	**17,455**	**15,952**	**17,038**	**16,740**	**17,168**	**17,025**	**16,910**	**16,767**
Average Daily	*498*	*507*	*517*	*532*	*527*	*582*	*515*	*550*	*558*	*554*	*567*	*545*	*541*
Non-Pay Expenditure													
Staff Related	258	260	355	223	186	326	219	430	368	340	300	235	287
Subsistence	200	195	152	167	222	149	147	336	170	184	208	174	156
Training	85	65	226	10	131	167	120	262	131	158	70	167	51
Drugs	49	9	47	49	26	34	51	41	3	33	44	29	17
Medical Consumables & Equipment	433	547	486	374	494	526	396	367	517	450	498	836	573
Fuel & Oil	399	400	427	392	421	403	357	378	367	375	389	386	365
Third Party Transport	89	105	95	115	125	153	121	173	154	220	196	150	223
Vehicle Costs	948	1,013	1,128	1,017	1,153	1,225	836	1,507	902	107	1,004	753	767
Accommodation & Estates	833	874	926	938	1,052	1,013	1,085	1,187	1,018	1,019	1,082	1,138	947
Telecommunications	510	749	582	613	537	973	615	926	592	617	800	981	582
Depreciation	611	611	609	609	596	608	606	712	623	1,255	976	965	1,023
Other Expenses	574	540	813	394	477	621	392	750	727	464	732	399	548
Profit/(Loss) on Disposal FA	1	0	0	2	67	0	0	0	1	0	2	1	1
Sub Total	**4,987**	**5,366**	**5,845**	**4,897**	**5,489**	**6,197**	**4,942**	**5,664**	**5,566**	**5,223**	**6,296**	**6,212**	**5,539**
Average Daily	*161*	*173*	*189*	*163*	*177*	*207*	*159*	*183*	*186*	*168*	*210*	*200*	*179*
Financial Expenditure	**342**	**299**	**310**	**366**	**337**	**360**	**362**	**363**	**362**	**613**	**493**	**35**	**354**
Average Daily	*11*	*10*	*10*	*12*	*11*	*12*	*12*	*12*	*12*	*20*	*16*	*1*	*11*
Monthly	**20,751**	**21,375**	**22,196**	**21,210**	**22,168**	**24,012**	**21,256**	**23,064**	**22,668**	**23,004**	**23,814**	**23,087**	**22,660**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends over the last 24 months as at 31st August 2009 (Month 5)







CAPITAL PLAN AUGUST 2009

Recommendations to the Board To note the contents of this report.

Cost Category	Actuals YTD M05	Forecast M6-12	FYE Forecast YE	2009/10 BUDGET
Finance Lease - Ambulances	0	17,098	17,098	17,103
Fleet	4,717	-2,956	1,761	1,761
IM&T	1,671	8,146	9,817	9,817
Equipment	61	2,865	2,926	2,927
Estates	178	1,641	1,819	1,819
Total:	**6,626**	**26,794**	**33,420**	**33,426**

Current CRL:	**16,500**
CRL To be extended for New 165 Ambulances purchased on Finance Lease	**17,103**
New CRL:	**33,603**

NOTES:

We have forecast that PTS vehicles will remain Capital expenditure.
The 100 ambulances on the 0809 business case are forecast as Capital turning to Lease in M08.
The 100 ambulances on the 0809 business case may need to be finance lease, if so the CRL will need to be adjusted.
The new business case for 65 ambulances is currently included in this forecast as leased (finance lease leading to CRL adjustment)

LONDON AMBULANCE SERVICE NHS Trust

Statement of Financial Position
As at 31st August 2009

	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Non-Current Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Intangible assets	6,752	9,564	9,603	8,989	11,219	10,680	10,680	10,680	10,680	10,680	10,680	10,680	10,680
Property, Plant and Equipment	121,789	117,135	109,296	109,857	108,225	109,201	110,427	113,285	115,840	119,755	120,186	124,152	127,092
Trade and Other Receivables	12,462	12,484	12,507	12,654	12,716	12,781	12,711	12,733	12,755	12,777	12,799	12,821	11,747
Total Non-Current Assets	141,003	139,183	131,406	131,500	132,160	132,662	133,818	136,698	139,275	143,212	143,665	147,653	149,519
Current Assets													
Inventories	2,600	2,547	2,508	2,510	2,293	2,265	2,265	2,265	2,265	2,265	2,265	2,265	2,265
NHS Trade Receivables	2,773	4,339	1,680	8,978	10,641	2,003	2,115	2,040	2,025	2,010	2,027	2,031	3,538
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Receivables	6,140	5,769	5,629	5,659	5,988	5,958	5,908	5,858	5,808	5,758	5,708	5,658	5,674
Accrued Income	0	3,619	5,638	6,034	5,996	6,905	7,164	7,126	7,385	6,126	6,077	5,751	3,115
Prepayments	4,561	3,329	2,843	3,221	3,223	2,552	2,497	2,663	2,763	2,663	2,563	2,463	2,363
Investments	0	0	0	0	0	8,900	0	0	0	0	0	0	0
Cash and Cash Equivalents	2,533	4,513	6,013	2,925	1,353	545	11,566	8,139	16,374	18,582	16,947	13,090	5,081
Current Assets	18,607	24,116	24,311	29,327	29,494	29,128	31,515	28,090	36,619	37,403	35,586	31,257	22,035
Non-Current Assets Held for Sale	0	1,700	1,700	1,709	1,709	1,709	1,709	1,709	1,709	1,709	1,709	1,709	0
Total Current Assets	18,607	25,816	26,011	31,036	31,203	30,837	33,224	29,799	38,328	39,112	37,295	32,966	22,035
Total Assets	159,610	164,999	157,417	162,536	163,363	163,499	167,042	166,497	177,603	182,324	180,960	180,619	171,554
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0
Trade Payables	7,531	6,518	6,333	6,851	6,672	6,545	6,901	6,914	6,854	6,915	6,821	6,728	6,293
Other Liabilities	3,887	9,845	9,868	9,728	9,579	9,481	9,685	9,540	9,562	9,177	8,443	7,960	2,980
PDC Dividend Liabilities	0	350	820	1,230	1,120	1,400	0	280	560	840	1,120	1,400	0
Capital Liabilities	1,926	132	149	162	80	83	870	810	1,757	2,279	2,355	3,136	188
Accruals	3,571	4,290	5,305	5,164	4,651	5,048	4,351	3,851	3,851	3,851	3,851	3,751	3,253
Deferred Income	0	930	561	6,171	7,162	6,550	6,164	5,868	5,662	5,301	4,210	3,119	1,500
DH Capital Loan Principal Repayment	0	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	3,602	3,602	3,602	3,562	3,549	3,536	3,536	3,536	3,536	3,536	3,536	3,536	3,536
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Current Liabilities	20,517	25,667	26,638	32,868	32,813	32,643	31,507	30,799	31,782	31,899	30,336	29,630	17,750
Net Current Assets/(Liabilities)	(1,910)	149	(627)	(1,832)	(1,610)	(1,806)	1,717	(1,000)	6,546	7,213	6,959	3,336	4,285
Total Assets less Current Liabilities	139,093	139,332	130,779	129,668	130,550	130,856	135,535	135,698	145,821	150,425	150,624	150,989	153,804
Non-Current Liabilities													
DH Capital Loan Principal Repayment	0	0	0	0	1,000	1,000	5,000	5,000	5,000	10,000	9,937	9,937	9,687
Borrowings	25,002	25,002	25,002	24,141	23,856	23,567	23,567	23,567	33,567	33,567	33,567	33,567	40,305
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	11,931	11,884	11,832	11,789	11,707	11,820	11,871	11,805	11,857	11,909	11,843	11,895	8,737
Total Non-Current Liabilities	36,933	36,886	36,834	35,930	36,563	36,387	40,438	40,372	50,424	55,476	55,347	55,399	58,729
Total Assets Employed	102,160	102,446	93,945	93,738	93,987	94,469	95,097	95,326	95,397	94,949	95,277	95,590	95,075
Financed By Taxpayers' Equity													
Public Dividend Capital	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523
Revaluation Reserve	32,810	33,129	24,394	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348
Donated Asset Reserve	9	9	8	8	8	8	8	8	8	8	8	8	8
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Retained Earnings	12,237	12,204	12,439	12,278	12,527	13,009	13,637	13,866	13,937	13,489	13,817	14,130	13,615
Total Taxpayers' Equity	102,160	102,446	93,945	93,738	93,987	94,469	95,097	95,326	95,397	94,949	95,277	95,590	95,075
Control Total	0	0	0	0	0	0	0	0	0	0	0	0	0

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 August 2009 (Month 5)

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
Operating surplus/(deficit)	648	848	281	213	835	1,001	607	451	(58)	731	716	546	6,819
Depreciation and amortisation	623	1,255	976	965	1,023	1,061	1,077	1,092	1,107	1,145	1,145	1,145	12,614
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	0	(129)	(62)	(62)	(64)	(83)	(89)	(91)	(99)	(112)	(112)	(112)	(1,015)
Dividend Paid	0	0	0	0	0	(1,680)	0	0	0	0	0	(1,680)	(3,360)
(Increase)/Decrease in Inventories	53	39	(2)	217	28	0	0	0	0	0	0	0	335
(Increase)/Decrease in NHS Trade Receivables	(1,566)	2,659	(7,298)	(1,663)	8,638	(112)	75	15	15	(17)	(4)	(1,507)	(765)
(Increase)/Decrease in Long Term Receivables	(22)	(23)	(147)	(62)	(65)	70	(22)	(22)	(22)	(22)	(22)	1,074	715
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	371	140	(30)	(329)	30	50	50	50	50	50	50	(16)	466
(Increase)/Decrease in Accrued Income	(3,619)	(2,019)	(396)	38	(909)	(259)	38	(259)	1,259	49	326	2,636	(3,115)
(Increase)/Decrease in Prepayments	1,232	486	(378)	(2)	671	55	(166)	(100)	100	100	100	100	2,199
Increase/(Decrease) in Trade Payables	(1,013)	(185)	518	(179)	(127)	356	13	(60)	61	(94)	(93)	(435)	(1,238)
Increase/(Decrease) in Other Payables	5,944	(441)	457	415	414	190	(159)	(9,992)	(399)	(748)	(497)	(4,994)	(9,810)
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	719	1,015	(141)	(513)	397	(697)	(500)	0	0	0	(100)	(498)	(318)
Increase/(Decrease) in Deferred Income	930	(369)	5,610	991	(612)	(386)	(296)	(206)	(361)	(1,091)	(1,091)	(1,619)	1,500
Increase/(Decrease) in Provisions & Liabilities	(47)	(52)	(43)	(82)	113	51	(66)	52	52	(66)	52	(3,158)	(3,194)
Net Cash inflow/outflow from operating activities	4,253	3,224	(655)	(53)	10,372	(383)	563	(9,070)	1,705	(75)	470	(8,518)	1,833
Cashflows from Investing Activites													
Interest received	2	0	(6)	3	4	3	4	4	2	2	2	1	21
(Payments) for property, plant & equipment	(2,275)	(1,724)	(1,569)	(2,238)	(1,996)	(1,500)	(3,995)	(2,700)	(4,500)	(1,500)	(4,330)	(7,033)	(35,360)
Proceeds from disposal of property, plant & equipment	0	0	3	1	1	1	1	10,001	1	1	1	1,053	11,064
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	(8,900)	8,900	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(2,273)	(1,724)	(1,572)	(2,234)	(10,891)	7,404	(3,990)	7,305	(4,497)	(1,497)	(4,327)	(5,979)	(24,275)
Net Cash inflow/outflow before financing	1,980	1,500	(2,227)	(2,287)	(519)	7,021	(3,428)	(1,765)	(2,792)	(1,572)	(3,857)	(14,497)	(22,442)
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	1,000	0	4,000	0	0	5,000	0	0	0	10,000
Loans principal repaid to DH	0	0	0	0	0	0	0	0	0	(63)	0	(250)	(313)
Capital element of finance lease	0	0	(861)	(285)	(289)	0	0	10,000	0	0	0	6,738	15,303
Net Cashflow inflow/(outflow) from financing	0	0	(861)	715	(289)	4,000	0	10,000	5,000	(63)	0	6,488	24,990
Increase/(decrease) in cash & cash equivalents	1,980	1,500	(3,088)	(1,572)	(808)	11,021	(3,428)	8,235	2,208	(1,635)	(3,857)	(8,009)	2,548
Cash, cash equivalents and bank overdrafts at 1.4.09	2,533												2,533
Cash, cash equivalents and bank overdrafts at 31.3.10	4,513	6,013	2,925	1,353	545	11,566	8,139	16,374	18,582	16,947	13,090	5,081	5,081

Financial Risks (To be included in new Risk Register)

Risk	Gross Value £k	2009/10 Fcast £k	Impact	Liklihood	Score	Comments/Mitigation
A&E penalty	7,100	1,500	Major	Possible	12	Review with PCTs in light of increased activity and failure to achieve hospital tirnaround
A&E Variable Income	1,600	1,600	Major	Unlikely	8	On track
CIP	11,600	11,600	Major	Possible	12	Shortfall in existing CIP offset by other savings in forecast
Other Income (MPET, HART, CBRN)	21,200	1,000	Moderate	Unlikely	6	Better use of Service Line Reporting to identify risk with followup
Olympics 2012	750	750	Moderate	Possible	9	Review with NHSL (1/10/09)
Economic & Environment (Fuel, NHS cuts, Swine Flu)	500	400	Minor	Possible	6	Review monthly
Other Non Core Business Profitability (PTS, BAA, Stadia)	250	250	Insignificant	Unlikely	2	Better use of Service Line Reporting to identify risk with followup

Cost Analysis

	Plan £k	m5 Ytd £k	2009/10 Fcast £k	
Planned CIP				
A&E Incentive	6,100	(1,300)	4,800	Incentive stopped from Sept
A&E Overtime	1,600	(791)	1,669	Reduced required due to additional staffing
Agency Cost/Corporate Support	2,000	0	739	Additional PTS activity matched by income, additional workshop support,
Reduce Subsistence	700	0	600	Additional staff will allow more rest breaks
Procurement	600	350	700	Vehicle Insurance, uniforms, legal, training equipment
Corporate Processes	400	75	400	Telecoms , T&A,
Accident Damage	200	186	250	Review of old claims, Intrroduction of IDR
Subtotal	11,600	(1,480)	9,158	
Additional Cost Saving				
A&E staff		1,210	1,266	Slippage in recruitment, revised cost of SP2
Staff Related		70	258	Delay in recruitment
Vehicle slippage		199	491	Slippage in new ambulance delivery
Dividend		763	1,832	Revised balance sheet estimate
PTS Restructure		113	257	In line with strategic plan
Other			126	Interest Payable
Subtotal		2,355	4,230	
Total	11,600	875	13,388	

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th September 2009

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 by the LAS since my last report in July.

Action plans for all previous SUIs are up to date with no actions outstanding.

Central Alerting System (CAS) formerly the Safety Alert Broadcasting System (SABS):

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

17 alerts were received from 10th July to 10th September 2009. All alerts were acknowledged; two required action, one relating to 'Clear view' pregnancy testing kits and the other to manual wheelchairs. Both actions have been completed.

The Safer Practice Notice relating to the risk of not using the NHS Number as the national identifier for all patients has been clarified in an alert issued on 10th September 2009. This Notice acknowledges the difficulty that a number of healthcare organisations, including ambulance services, will face in complying with the recommendations. It suggests that healthcare organisations should prepare for the time when they can access and search for NHS Numbers by using the number if available, in correspondence with the patient; requesting the number from another organisation where correspondence is received from an organisation which can access the number and by assisting patients to know more about their number through displaying the NHS Connecting for Health leaflet.

Controlled Drugs Concerns

1. The Safer Management of Controlled Drugs Annual Report 2008 was published by the CQC in August 2009

The key recommendations within the report are:

1. **Organisations should have mechanisms to replace accountable officers immediately when vacancies arise and to notify CQC of the change.**

Almost all relevant health organisations now have accountable officers in place who are responsible for monitoring controlled drugs. However, there has been significant turnover of accountable officers, particularly in PCTs where 41% changed their accountable officer at least once between January 2007 and December 2008.

2. **That a more robust method to ensure that 72-hour fentanyl patches, which are used to manage chronic pain, are applied at appropriate intervals is explored.** Fetanyl patches are applied to relieve pain and last for 72 hours. They are often used in palliative care situations both in care homes and where care is provided by visiting carers in a person's home. The former adult social care regulator, the Commission for Social Care Inspection, advised that it in some cases it was difficult to manage and monitor the use of the three-day patches as the days to change the patches are different each week. This could mean that patches are changed too late, leaving the patient in pain.

3. **Organisations should ensure there are enough "authorised witnesses" for destroying obsolete drugs.** Organisations must appoint authorised witnesses to be present when obsolete drugs are destroyed. The Royal Pharmaceutical Society of Great Britain advised that earlier problems relating to accumulation of obsolete controlled drugs had improved as more authorised witnesses were appointed. However, it said that some organisations need to both appoint additional witnesses and recognise existing witnesses in order to prevent accumulation of drugs, which could create a risk to security.

4. **Local intelligence networks must make sure they inform relevant bodies about their formation and leadership and that they know where to submit reports.** The Royal Pharmaceutical Society of Great Britain reports that effectiveness of local intelligence networks is variable and information sharing between organisations and the networks requires further development. During 2008, some PCTs changed the set-up of their local intelligence networks, sometimes establishing networks that cover more than one PCT. This created uncertainty about leadership and reporting. While these issues have now been resolved, it is important that local intelligence networks are clear about their remit and responsibilities.

Of these recommendations

1. Noted but not relevant at present.
2. Not relevant; fentanyl is not currently approved for use by paramedics.
3. Our policy covers this; the LAS does not hold a destruction licence. Instead all our out of date drugs, in particular our out of date morphine, are returned back to the Pharmacy at Frimley Park. This feature of any future drug procurement contract(s) must remain as it simplifies our procedures.
4. The LAS reports to and works closely with the Richmond and Twickenham Local Intelligence Network

2. Second domain – Clinical and Cost Effectiveness

London Trauma System Launch
The launch of the London Trauma System on 10th September was a well attended event with representatives from all 4 networks, PCTs inside and outside London and the LAS. The National Trauma Director gave the keynote address and members of the Medical Directorate presented the Major Trauma Decision Tree and information on the likely workload that both the Major Trauma and Trauma Centres may receive once the Networks go live.

Clinical Update for Team Leaders

The programme for a two week Clinical Update course for all Team Leaders has been finalised. This will be rolled out from the beginning of October until January 2010.

Clinical Issues arising at the Chief Executives Consultation meetings.

Eleven of the presentations to the 26 Complexes have now been completed. Feedback on clinical issues has been positive, with the plans for introduction of new equipment being welcomed. The issues which have been raised include lack of Continued Professional Development for existing staff, concerns about lack of equipment on vehicles, with enthusiasm for the personal issue of certain items, staff feeling isolated when on active area cover and concerns that some hospital staff are not aware of LAS (and national) guidance.

Clinical Quality Standards Quarterly Report (April – June 2009)

To raise the profile of clinical quality standards the first of a series of quarterly reports was presented to the Senior Management Group on 9th September. Appendix 1 highlights relevant measures of indirect clinical outcome which have suffered through the sustained drive to maintain performance. More detail will be presented in subsequent reports.

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

Discussions on three of the cardiac related projects are moving forward. The 'DANCE' study has received some funding so it may go ahead next year. The EUROMAX study, (European Ambulance ACS Angio X trial - the use of bivalirudin), is being progressed with the drug company at a meeting on 15th September. The British Heart Foundation has been approached regarding funding the study on the use of pre hospital adenosine, in narrow complex tachycardias.

Training of staff involved in the ROSIER study (recognition of stroke in the Emergency Room) has commenced with Dr Patrick Gompertz leading a training session for staff at City & Hackney and Tower Hamlets Complexes.

Appendix 2 contains summarises the LAS response to the DH requirements to support Research in the NHS and indicates how the LAS is becoming involved in health Innovation and Education Clusters.

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3. **Third Domain – Governance**

The Governance Development Unit reports that the Trust is performing well against the assessment of Core Standards, due November 2009.

Safeguarding update

EBS has assumed responsibility for the administration of safeguarding referrals. A communications strategy is being devised to alert staff and external safeguarding colleagues of the processes involved.

New arrangements in relation to reporting and audit are also being put into place from 5th October. This will enable

- Local authority accountability in relation to acknowledgement and outcome reporting which will be fed back to the staff involved
- Governance responsibilities in monitoring the volume of local Complex activity and the identification of any emerging trends
- Challenging practice in relation to delayed referrals

Safeguarding activity data will be shared with all London local authorities, local Safeguarding Children's Boards, London Adult Protection Network, NHS London and our commissioning PCTs. This will also be made available to Clinical Governance Committee and the area governance groups.

The Trust's Safeguarding Declaration 2009 is included under agenda item 11 (tab 11).

4. Fourth Domain – Patient Focus

Update from Urgent Operations Centre (UOC)

Subject: 'Selecting the Right Care Pathway for every Call' – a trial extending the use of alternative pathways for selected Green and Amber calls.

Two tranches of calls, one of Amber 2 determinants, the other of Amber 1 determinants have been agreed and submitted to the Emergency Call Prioritisation Group (ECPAG). The trial of clinical telephone advice on the first tranche will commence in approximately 3 weeks.

5. Fifth Domain – Accessible and Responsive Care

Nothing further to report

6. Sixth Domain – Care Environment and Amenities

Infection Prevention and Control

The Infection Prevention and Control Coordinator hosted a conference for the newly recruited IPC Champions on18th August. To date 36 champions have been recruited, including 5 PTS, representatives from the training department, 2 from EOC and 5

department leads (estates, patient experience, facilities, logistics etc). From Operations there is a clinical mix from A&E support staff through Team Leaders and DSOs. All Complexes are represented.

The conference was well attended and delegates heard from the IP&C lead from West Midlands Ambulance Service NHS Trust as well as receiving an update on progress in implementing new guidance and equipment. A training session in fitting FFP3 masks was provided, enabling the Champions to undertake this in their operational areas.

Care Quality Commission Outcome Report

On Friday 4th September the London Ambulance Service received the interim report from the Care Quality Commission regarding their recent unannounced inspection of the Trust to review our compliance with the prevention and control of infection element of the Health & Social Care Act 2008.

The CQC visit was part of a programme of visits to all ambulance trusts across England during July and August to measure compliance against 17 elements of the Act.

The inspection team visited at the end of July and undertook visits to 7 ambulance stations across all areas of the trust, inspected 23 ambulances both on stations and at 4 emergency departments across the capital.

They interviewed a number of staff and managers as part of their review and at the end of the 2 day visit provided the trust with some interim feedback which has previously been distributed to the senior team.

The interim report stated that following their inspection they “found no evidence that the Trust had breached the regulation to protect patients, workers and others from the risk of acquiring a healthcare-associated infection.”

Of the 17 areas considered 9 gave no cause for concern but 8 had areas where improvements could be made. Specifically these were in the provision of infection control training, auditing of our vehicles and premises for cleanliness, cleanliness of our vehicles and our premises, including information for staff on how to do this, adequate hand washing facilities for staff involved in patient care, the re-use of single use items, the supply and provision of laundry and the use of aseptic technique when undertaking cannulation.

As a result of the initial feedback from the CQC, an infection control programme has been developed to address these points and to demonstrate that we can improve in these areas for the future. The CQC are likely to undertake an unannounced visit again in the coming weeks and will want to be assured that the trust is acting on the recommendations and improvements identified.

A copy of the programme and the 11 work streams within it is provided under Board agenda item 12 (behind tab 10). This programme had been prepared following the initial feedback and the CQC had received a copy of this prior to the arrival of our interim report.

Nationally, 4 of the ambulance trusts have been found to be in breach of the regulations and have experienced negative media publicity as a result of this.

7. Seventh Domain – Public Health

Pandemic Flu Update

The Trust is required to approve a Statement of Assurance to the SHA relating to our preparedness in the event of an influenza pandemic. This is provided under agenda item 10.

Recommendation

- That the Board notes the report

Fionna Moore,
Medical Director
15th September 2009

Appendix 1

LONDON AMBULANCE SERVICE NHS TRUST

Quarterly report to SMG

Clinical Quality and Standards Report

1st April – 30th June 2009

Introduction

Providing safe and high quality clinical care is a fundamental responsibility of the LAS and its Senior Management Group. Historically SMG has focused primarily on the tasks of managing a large and complex organisation leaving clinical issues primarily to the Clinical Governance Committee and to the Medical Directorate. In order to ensure that SMG members are familiar with some of the clinical quality and standards issues that the LAS faces this report highlights issues over the 1st quarter of 2009. The topics have been selected as indirect indicators of clinical performance.

This initial report should be regarded as work in progress. Many of the areas covered would benefit from more work and more detailed reporting.

1. Patient experiences

1.1 SUI reports and lessons learnt.

No serious untoward incidents declared during this quarter. The action plans on previous incidents are up to date. Investigations into clinical incidents have suggested the following areas for improvement

- Importance of undertaking a dynamic risk assessment.
- The need for crews to be aware of the information and advice given to callers, particularly around accessing premises at night

1.2 Frequent callers

Continuing activity in this area

- Broadening the remit - for example the rough sleepers on buses issue which is a particular problem in the Hainault area, though mirrored across London. which is being taken up by the Mayor's office
- approx 300 cases closed but 140 still open;
- we are the first ambulance Trust in the UK to have appointed a social worker, who is a part of the FC team
- we will shortly be publishing much more information about the work on the Trust website (I will see if we can achieve a link from *the Pulse*)
- staff are encouraged to make referrals to Frequent.Caller@lond-amb.nhs.uk

2. Clinical Performance Indicator completion

The current target for CPI completion is 95%. This unacceptably poor level of performance is partially due to REAP 4, but possibly also due to the lack of focus by Team Leaders and local management teams.

Area	CPI Completion			
	April	May	June	Overall
East	32%	27%	20%	26%
South	35%	49%	44%	43%
West	51%	58%	36%	49%
LAS	**41%**	**47%**	**36%**	**41%**

3. PDR completion

The process for recording PDRs is that, once completed a PDR record is logged with Area HR, to be collated centrally. During Q1 virtually no PDRs were undertaken (or reported); due to high REAP levels, staff shortages, and other demands on managers and operational staff's time. There is some anecdotal evidence that some Complexes are continuing to undertake PDRs, but the numbers are unclear.

4. Delivery of education

4.1 Paramedic training:

Course venue	Number of staff Funded	Number of staff rostered	Variance	Reason for variance
Higher Education	8	8	0	
Direct Entrants Paramedics (Hannibal House)	18	23	+5	Identified need for greater support
APL Paramedics Fulham)	8	8	0	
Other Centres	3.6	4.5	+0.9	Identified need for greater support
A&E support	10	10	0	

This table illustrates the significant requirement for experienced training officers in delivering paramedic training over a number of different sites. It does not reflect the levels of manning, as Training Officers dedicated to these courses are not infrequently either redeployed to cover other courses, or unavailable through annual leave and sickness.

4.2 Availability of Training Officers on Complexes

14 out of 26 Complexes have eitherTraining Officer vacancies or secondments to other roles. The East Area is the least affected.

4.3 Feedback from training courses

The Education Standards Manager closes the majority of Paramedic and Student Paramedic courses. These sessions are an invaluable source of feedback from the students. This is now captured through the Clinical Education Steering Group which meets monthly. We plan to look at the current themes emerging from this feedback and ensure that where necessary appropriate actions are put in place to address any concerns or areas for improvement.

Currently key issues arising from course feedback is discussed with the Head of Training, Education Centre Managers, Course Directors and the management team. Examples of key themes which have arisen and led to changes in practice are:

- **Availability of pre learning material.**

Pre learning packs are now provided for EMTs who have successfully completed the paramedic assessment process as soon as they are accepted onto a course. They now receive this material at least 3 months before the course commences.

- **Changes to residential accommodation arrangements at Fulham.**

This remains a contentious issue for students. However the three weeks accommodation now covers the initial 2 weeks and the final week, where students are undertaking their OSCEs.

- **Modules and Tutors whose performance is always highly rated**

The delivery of trauma module is consistently rated very highly; messages from this course are being used to further develop other tutors. The characteristics of highly rated Tutors are personal credibility and specialist knowledge.

- **The importance of consistent messages**

Students pick up variations in delivery of educational material; this is a particular issue where trainers who may be less familiar and prepared to deliver a session are brought in at short notice.

5. ECP training, tasking and conveyance

5.1 New ECPs

Training has been underway since February 2009 for two cohorts of trainee ECPs. One cohort of 6 graduates of the full or part time BSc in Paramedic Science is undertaking the Post Graduate Certificate at University of Hertfordshire. The other cohort of 14 students is undertaking the Diploma in Health care Practice (ECP) at St George's. Both are on modules 2 and 3 (out of 8) with a planned completion date of Sept 2010. All are undertaking both supervised and autonomous clinical shifts.

5.2 Existing ECPs

A small number of staff are finally completing outstanding modules. 2 days of PGD training has been provided to 15 – 20 ECPs, under the supervision of Dr Daryl Mohammed. A clinical day, run by the Clinical Lead Team was provided for 15 members of the team, focussing on case studies, and management of headache, eye and ENT conditions.

Clinical placements are protected for members of staff in training but not for existing staff. The current arrangement is that ECPs spend 20% of their time on non operational duties; this may include undertaking placements, but also includes delivering the LAS vaccination programme, assisting Education and Development in delivering sessions on training courses, case reviews and reflective practice at Complex level.

5.3 Tasking, conveyance and concerns
The ECP Review was finalised in July 2009 and is due for further discussion at the October SMG. S:\DIARY MEETINGS SMG\2009 Meetings\September 09\1st September\LAS ECP Commissioning report.doc

The headline issues for ECPs are around lack of availability of placements for development when REAP levels are high, concerns around the future roll out of the project in the light of the proposed band 6 paramedic position, utilisation rates, which rose to 55% when ECPs were involved in tasking decisions, and conveyance rates where fewer patients are transported, and less LAS Resources used when an ECP is involved in the decision making.

6. Delivery of CPD

No formal CPD was delivered during this period. However informal sessions continue, both at Complex level and where staff attend sessions such as the Diploma preparation evenings at Fulham, HEMS Clinical Governance Days etc., in their own time. These sessions are generally not captured.

Fionna Moore
September 2009

Appendix 2

Clinical Audit and Research Unit Report

Developments in Research

1. Requirements to support Research in the NHS

Professor Dame Sally Davies wrote in July 2009 to advise Chief Executives of NHS Trusts to remind them that:

The **NHS Constitution** confirms:
- the commitment of the NHS *"to the promotion and conduct of research"*.

The **Handbook to the NHS Constitution** states:
- •*"the NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them".*

The **NHS Operating Framework** states:
- *"the NHS must play its full part in supporting health research"*;
- *"all providers of NHS care will need to increase their participation in research"*;

- *"the national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years"*; and
- *"Strategic Health Authorities (SHAs) are expected to ensure that NHS Trusts work with the National Institute for Health Research Comprehensive Clinical Research Network locally to contribute to this progressive increase"*.

The **Guidance for SHAs regarding their Duty to Promote Innovation** states that SHAs will report on:

- *"the actions the SHA has taken to support the work of the NIHR Clinical Research Networks locally and to develop the collaborative capacity of the NHS to join in research studies and trials."*

The **Government Response to Review and Refresh of Bioscience 2015** states:

- • *"Rather than asking each Trust to designate a Board member to take responsibility for research, the DH believes that it would be more effective for Trusts to set goals for research within their organisation and report on their achievement at least annually to the Board and in their annual report. The Department will be writing to the service shortly about this";*
- *"The letter which the Department will be writing to the service will ask Trusts to set goals for research in their organisation";*
- *" The letter will ask Trusts to publish the average time it takes for the local research approval process to be completed";*
- *"This letter will also ask Trusts to ensure that they use the NIHR Coordinated System for gaining NHS permission and that they do not develop unnecessary additional activities or bureaucracies locally."*

The London Ambulance Services has taken steps to:

- promotes research and development to increase participation by LAS staff and patients in well designed studies.
- ensure all research is fully compliant with the NHS requirements for management and governance
- support health research which meets the requirements of the LAS research strategy
- fully engage with the Networks of the National Institutes for Health Research (NIHR) to facilitate increasing participation in research and the development of new studies in out of hospital care.

The DH is to invite NHS Trusts *to set goals for research within their organisation and report on their achievement at least annually to the Board and in their annual report*. The Clinical Audit and Research Unit (CARU) are taking steps though the Clinical Audit and Research Steering Group (CARSG) to prepare the ground for respond to this development.

CARU has produced an annual report for Research and Development for the DH since 1997. 2009 saw that last such annual report submitted. CARU plans to produce an annual statement for research which will report data on research approval process, participation in research studies and other relevant details of the research activities of the LAS.

2. North West London - Health Innovation and Education Cluster.

The NHS Next Stage Review proposed the development of Health Innovation and Education Clusters (HIECs). HIECs are to be partnerships between NHS organisations (primary, secondary and tertiary care), the higher education sector (universities and colleges), industry (healthcare and non- healthcare industries) and other public and private sector organisations.

Their purpose is to enable high quality patient care and services by:

- bringing the benefits of research and innovation directly to patients; and
- strengthening the co-ordination of education and training so that it has the breadth and depth to support excellence

DH is making available £10 million to support the creation of HIECs across England in 2009/10, with more to follow in 2010/11 and 2011/12.
The LAS has been invited to take part in the North-West London (NWL) HIEC. Partners in the NWL HIEC include imperial College and the University of Herts.

At this stage the organisers, based at Chelsea & Westminster Hospital are inviting organisations in their locality to express interest in taking part. A formal commitment will be invited later in the year.
The LAS has expressed an interest in taking part in the NWL HIEC. Further information on the HIECs can be found at;
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098891.pdf

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 29th September 2009

Document Title	Winter/Pandemic Flu Planning Extended Executive Summary with attached SHA assurance framework
Report Author(s)	Martin Flaherty
Lead Director	Martin Flaherty
Contact Details	LAS HQ A&E Secretariat
Aim	Information and Approval of Assurance

Key Issues for the Board

To note the LAS Winter/Pandemic Flu Plan for 2009/10 and the scale of potential workload increases associated with a second wave of Pandemic Flu.

To approve the SHA assurance Framework Template

Mitigating Actions (Controls)

n/A

Recommendations to the Board

That the Board notes the LAS Winter Plan for 2009/10

That the Board approves the SHA Assurance Template

Equality Impact Assessment

A National EIA has been carried out on all aspects of the national winter planning framework and the LAS plan mirrors this in terms of clinical principles and actions.

Key Issues from Assessment

None

Risk Implications for the LAS (including clinical and financial consequences)

The scale of potential demand increases which could be seen this winter should a second wave of Pandemic Flu take place are considerable and will generate clinical, financial and reputational risks. These are well understood and mitigating actions are contained within the detailed planning documentation.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Implications all covered within the body of the Winter Plan.

Corporate Objectives that the report links to

General objective to plan effectively for Winter

London Ambulance Service NHS Trusts

Winter/Pandemic Flu Planning 2009/10

Extended Executive Summary for Trust Board Meeting of 29th September 2009

1. Background

1.1 Every Ambulance Service Trust in England has a structured capacity plan to enable them to respond to the ever-increasing demand for their services each winter. Each Trust also has both a Winter Plan and a General Pandemic Flu Plan in place.

1.2 The winter of 2008/9 was the coldest for many years with some exceptional adverse weather events, particular during February 2009. This led to an unprecedented demand for ambulance services, resulting in many trusts reaching REAP 4 during this period. The winter of 2009/10 will be even more challenging given the prospect of a second wave of Pandemic Flu and its associated demand increases coupled with staff absence.

1.3 The Ambulance Service Chief Executive Group (ACEG) has, therefore, agreed an enhanced national strategic approach to Winter and Pandemic Flu Planning for 2009/10 to ensure all eventualities are addressed in a collaborative way and to define a consistent approach to rising pressure across the country.

1.4 As a result a national programme has been put in place, led by the National Ambulance Director DH Peter Bradley, which has produced a common planning framework to be used by all ambulance trusts across the country to guide and inform their own local planning arrangements.

1.5 The LAS has been extensively involved in this national work and has led on several of the workstreams. The LAS Winter and FLU Planning Framework 2009/10 has therefore been modelled on this national guidance and also draws on various DH publications providing guidance on the levels of preparedness which Ambulance Trusts are expected to provide.

1.6 In addition the LAS has provided most of the comprehensive data set which has enabled detailed modelling by DH on the potential impact of Pandemic Flu on 999 call demand The LAS planning assumptions are therefore fully in line with current DH modelling

1.7 The full Winter and Flu Planning Framework together with appendices has been made available to Board Members via the normal Trust Board Extranet.

1.8 The following Extended Exec Summary details the main content and issues and will be supported by a presentation and a further discussion at the Board.

2. Winter Planning Assumptions

2.1 The planning assumptions for Winter 2009/10 have as always taken into account the normal seasonal rises in demand seen through the winter and have been augmented by the experience of the very heavy snowfall in Feb 2009. In addition they are very heavily influenced by the most recent modelling around Pandemic Flu.

2.2 It is almost certain that the UK will see a second wave of Pandemic Flu during this winter and the following Headline assumptions have been published by DH.

Assumption	Illustrative numbers, England	Data source for assumption
30% of population will become symptomatic during a pandemic, and *of these symptomatic cases:*	Of the 51.9m people in England, roughly 15.5m will become symptomatic. And *of these 15.5m:*	SPI-M pandemic planning profiles
15% will consult a GP	Roughly 2.3m will consult a GP	SPI-M pandemic planning profiles
6.9% will call an ambulance	Roughly 1.1m will call 999 for an ambulance	London Ambulance Service; QSurveillance; NPFS
4.0% will receive an emergency response at the scene	Roughly 0.6m will receive an emergency response at the scene of the call to 999	London Ambulance Service; QSurveillance; NPFS
2.5% will require a conveyance from the scene	Roughly 0.4m will be conveyed from the scene of the call	London Ambulance Service; QSurveillance; NPFS
1% will require hospitalisation	Roughly 0.2m will require hospitalisation	SPI-M pandemic planning profiles

2.3 The second wave of the pandemic will last 15 weeks and the numbers of patients infected rises very rapidly from week 4 to week 7 following which there will be a slower decline in numbers of patients back to low levels by week 15.

2.4 The figure of 6.9% of patients who are infected calling 999 is based on LAS data generated by the experience of Swine Flu through the earlier part of the summer. It is clear from the current modelling that the LAS could expect to see significant increases in demand from week 4 through to week 11 of the cycle. During the peak period from week 5 through to week 11 demand levels could significantly outstrip those seen during the winter of 2008/9.

2.5 During the peak weeks described above additional actions will be taken to specifically manage patients with Swine Flu by utilising other agencies such as the Pandemic Flu Service and NHS Direct to manage many of these patients.

3. The Resource Escalation Plan REAP

3.1 The Board will be aware that the Trust uses a dynamic capacity management plan known as the REAP system to respond to rises in demand. This was developed in the LAS and has now been adopted nationally by all other ambulance trusts.

3.2 As part of the national programme work the REAP system has been revised to take into account the impact of last winter and to deal with the demand levels anticipated should a second wave of Pandemic Flu be seen during this winter.

3.3 It should be noted that the REAP system is an overall capacity management tool designed to progressively increase resource capacity to deal with increased demand. It is in use all year and can be flexed to deal with a rise in demand or a shortfall in staffing due to any cause.

3.4 The national review has added another level (Level 6) to the scheme designed to deal with demand increases in excess of 30% , reviewed triggers and also created more uniformity in the mitigating actions which will be taken to ensure that responses are provided based on clinical need.

3.5 The levels are as detailed below and more detail can be found in the full plan.

REAP Level 1	Normal Service
REAP Level 2	Concern
REAP Level 3	Moderate Pressure
REAP Level 4	Severe Pressure
REAP level 5	Critical
REAP level 6	Potential Service Failure

3.6 The mitigating actions are described in detail in the main document but include actions to boost capacity together with specific actions designed to increase the use of in house telephone advice coupled with appropriate referral to NHS Direct and the Pandemic Flu Service. At times of extreme demand it also allows for the implementation of the Trusts 'Managing Excess Demand' plan which has a three staged approach designed to ensure that responses continue to be made on the basis of clinical need.

4. Contingency Planning

4.1 Extensive contingency planning and resilience building has been taking place across the summer and plans are well established to improve the resilience of the entire organisation in preparation for winter.

4.2 Detailed below is a high level summary of the actions which have been taken in each area.

4.3 Control Services

- An Additional 52 staff are being recruited to EOC and these will all be available for call taking. In total this represents a circa 25% in call takers over the existing establishment levels. 28 of these were already funded this year as preparation for CAD 2010 and the remainder have been temporarily added to the establishment to improve resilience. It is envisaged that these staff will be available by end December.
- We have advertised for support staff to be trained in 999 call taking and 30 staff have volunteered to date. Plans are in place to train these staff in the essential skills required during October.
- Agency staff will also be recruited if required and trained to take 999 calls within the LAS to provide additional resilience.

- Additional call taking places are available within our Fall Back Control room at Bow and these will be used if needed.
- Many staff from EOC have moved into operational roles in recent years and plans are in place to bring them back into the control room if that is where they are most needed during peak demand weeks this winter.
- Additional CTA staff will be provided again by drawing in staff with previous training in CTA who are currently in operations.
- Mutual Aid will be sourced for other UK Ambulance Trusts as required to boost control services staffing .

4.4 Area Based Operations

- Operational staffing is increasing week on week due to the current recruitment campaign which places the LAS in a very good position in terms of general staffing. Operational in –post numbers will increase from 2686 in August to 3027 at end December making 341 additional staff available to deal with demand increases during the expected timescale for a second wave of Pandemic Flu
- Enhanced Resource Centre Opening hours
- Enhanced Area Delivery unit opening hours
- Extended Overtime and incentivisation arrangements as required.
- Increased utilisation of Private Ambulance Services and Voluntary Ambulance services.
- Consideration to re-deploying PTS staff to support A&E Ops
- Consideration of redeploying trainees to support A&E Ops
- Additional FRUs being provided by each complex staffed by managers and team leaders
- Extended arrangements for Senior Mangers to provide leadership and command roles on a 24/7 basis
- Consideration of recalling recently retired staff to enhance existing bank schemes.
- Utilisation of Mutual Aid arrangements to secure operational staff from other UK ambulance Trusts.

4.5 Other Directorates Resilience Planning

- All business continuity plans have been reviewed and refreshed following a specific Pandemic Flu business continuity event held in July 2009.
- Business critical teams such as those in IM&T that manage critical systems have developed bespoke plans to maintain services.
- Operational Support have stockpiled three months supplies of all consumables and specific equipment related to Pandemic Flu including large volumes of PPE material for staff.
- Arrangements have been made to ensure limited supplies of bunkered fuel should there be any disruption of fuel supplies.
- Supplies of ‘snow socks’ and other equipment required to deal with a major winter weather event have been stockpiled.

4.6 Vaccination Arrangements

- The Trust is actively encouraging all its staff to take up the offer of both the seasonal flu vaccine and Swine Flu vaccine once it is available. Early indications from a staff survey have indicated that significant numbers of staff might take up the vaccination .
- PGDS have been written and circa 100 Paramedics trained to administer the vaccine to LAS staff on a local basis .
- Fridges and vaccination equipment have been procured and are being delivered to stations.
- Discussions are ongoing to gain agreement from DH to a direct supply of vaccines to LAS sufficient to treat all operational front line staff and managers including control room staff.

5. Clinical Strategy

5.1 The national framework includes a clinical section which covers the following areas:

- Management of swine flu patients to ensure that response and conveyance is clinically driven.
- The protection of staff and patients through common PPE and infection control standards
- The clinical prioritisation methodology to be used when managing excess demand.

5.2 The LAS clinical strategy is in line with the national work and the LAS Medical Director remains closely involved . It should be noted that this is a dynamic process and it is envisaged that the clinical strategy may well need to be flexed nationally and locally as a second wave of the pandemic develops.

5.3 The clinical strategy will adhere to the following principles.

- The existing AMPDS triage tool will continue to be used to understand the exact clinical condition of each patient so allowing effective prioritisation.
- The Pandemic Flu Card 36 will continue to be used throughout the winter to manage Flu Patients.
- Appropriate referrals will be made for patients suffering from Swine Flu to both the Pandemic Flu Service and NHS Direct.
- LAS CTA will continue to use PSIAM the secondary clinical assessment tool.
- EOC staff and front line ambulance staff will have detailed call/patient management flowcharts to follow for swine Flu patients which will be authorised by the Medical Directorate and the subject of regular review.
- EOC and Front line crews will be supported by an enhanced Clinical Support Desk in EOC.
- Consideration will be given to additional GP support to the Control Room to assist in the management of Swine Flu patients.
- The LAS managing excess demand plan will be clinically driven ensuring that when responses need to be prioritised at times of high demand it is done so based on clinical need ensuring that the sickest patients receive responses first.
- Staff and patients will be protected with appropriate PPE.
- Infection control regimes will be in line with nationally agreed standards

6. HR Issues and Workforce Resilience

6.1 The full plan contains a comprehensive section on the management of HR/Workforce issues during this winter which cover the following areas;

- Enhanced Partnership working with Trade Union Colleagues
- Management of absence
- Management of annual leave
- Flexible working arrangements
- Childcare/dependant responsibilities
- Time off for public duties
- Temporary adjustments to disciplinary and grievance policies
- Redeployment of staff to other duties

- Re-engagement of retired staff
- Bank staff working arrangements
- Mutual Aid arrangements
- Working Time provisions
- Arrangements during periods of travel disruption.

7. Communications Strategy

7.1 LAS has had the lead in developing a National Communications Strategy for Winter 2009/10 based around the following principles.

- General Winter and Flu communications
- Pressure related communication linked to each REAP Level
- Business Continuity planning for communication teams
- Post incident and recovery communication.

7.2 The LAS communication strategy is comprehensive and has been constructed in line with the above principles and will set out to achieve the following objectives.

- To provide staff and the public with health advice including information about keeping well.
- To inform the public about making the right choices to access care if they are unwell.
- To explain the service's plans for dealing with increased pressures and how it will respond within the constraints that it may face.
- To gain support from key stakeholders , particularly NHS stakeholders for the proposed measures that will be taken if pressure levels increase significantly.
- To encourage users of the 999 system to take action that will help reduce pressure in the 999 system .
- To recognise the challenges faced by staff during high demand and the contribution they are making to maintaining levels of service and support them in this.

8. Role of a National Coordinating Centre

8.1 The national winter planning programme has established a National Coordinating Centre (NCC) for Ambulance Trusts across the UK. It will be hosted by the LAS in its HQ building and the accommodation and technical infrastructure is in place.

8.2 The NCC will have the following functions:

- Monitoring Flu activity and pressure levels across UK ambulance services.
- Coordinating Requests for Mutual Aid
- Feedback on and dissemination of national policy decisions regarding Pandemic Flu

8.3 The NCC will not be in operation routinely and will only be triggered if one or more services declares REAP level 5 or 6. LAS will staff it for the initial seven days following which staffing will be provided on rotation by the other UK Ambulance Trusts.

8.4 The LAS in keeping with all other Trusts has agreed to provide mutual aid to other services when requested by the NCC and in line with a pre-agreed national memorandum of understanding (MOU).

9. Recovery Phase

9.1 It must be accepted that if there is a second wave of Pandemic Flu this winter resulting in significant demand increases over a prolonged period it will be a very challenging time for the service. Once we come out of this second wave there will be pronounced fatigue levels amongst staff and managers and this will take some time to recover from . It is anticipated therefore that a return to 'normality' will take place over several weeks.

Martin Flaherty
Deputy Chief Executive

Winter and Flu Resilience plans checklist

Organisation name: London Ambulance Service

Board meeting date: 29 September 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is red predicted completion date	Page / para ref in Flu and Winter resilience plans
	Health economy wide issues					
1	**Leadership** - organisations in the Health Economy demonstrate joined up multi-agency approach to planning. Flu Resilience plans for each organisation in the Health Economy have been shared and agreed. Agreements in place on any local cross borough border issues to ensure patient care is seamless.	Y	Y			52
2	**Local leaders** - every organisation has senior leadership arrangements in place to manage Flu and Winter resilience which is clearly documented. There is a reliable system in place for keeping the CEO, Board and Flu Lead Director appraised of progress, receiving exception reports and for escalating their involvement as required.	Y	Y			37
3	**SITREP reporting** - every organisation has in place robust procedures to comply with all SITREP reporting processes.	Y	Y			52
4	**Resilience plans tested** - assurance that both Winter and Flu resilience plans have been tested or exercised particularly known stress points in the plan.	Y	Y			38
5	**Infection control** - plans take into account both Swine Flu and also major increase in activity in 'surge' conditions.	Y	Y			44
6	**Escalation processes** – there is a clear well communicated multi-agency plan for health economy response to 'surge' demand that is owned and shared with all key health and social care partners in the health economy. The trigger levels to move to each escalation level are well defined and understood by all agencies.	Y	Y			13
	Patients					
7	**Antiviral Collection Points - f**acilities in place so that anyone with suspected swine flu gets issued with antivirals within 48 hours including those patients without a GP and vulnerable groups - include PCTs full roll out plan of ACPs.	N				
8	**Vaccination programme** for each PCT's patients is in place and is flexible enough to respond to vaccine supply issues and priority group issues.	Y	Y			40
	Winter resilience plans					
9	**Discharge processes** – multi-agency co-ordination to minimise the number of delayed transfers of care.	N				
10	**A&E performance** - specific plans to cope with 2 known dips in A&E performance early December and early January.	Y	Y			11
11	**Business continuity** - evidence that organisation has a robust plan to respond to issues such as bad weather (snow).	Y	Y			28
	Flu Pandemic second wave resilience					
12	**Enhanced capacity in 'surge' demand**- details of capacity that can be made available in each organisation for each key service including staffing and equipment resources. Details of the trigger levels to release this capacity into the organisation.	Y	Y			15
13	**Capacity modelling** - each health economy has taken account of worst case scenario set out by DH in July 2009 and has plans in place to respond to the peak weeks of the pandemic.	Y	Y			9
14	**Essential services** - plan identifies clinical and non-clinical essential services that must continue to be provided or that can be scaled back in a pandemic, as well as identifying critical and non-critical functions	Y	Y			28
15	**Logistics** - plans identify and regularly review key vital supplies, without which the trust could not function, and include local plans as to how these supplies can be maintained (e.g. utilities, food, linen, medical supplies).	Y	Y			51
16	**Communication** - plan for effective communication to staff, patients and the wider community before, during and after the pandemic.	Y	Y			58
17	**Recovery from pandemic** -plan includes detail on recovery from a pandemic.	Y	Y			75

Winter and Flu Resilience plans checklist

Organisation name: London Ambulance Service

Board meeting date: 29 September 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is red predicted completion date	Page / para ref in Flu and Winter resilience plans
	Specific organisational capacity issues					
18	**Acute hospital capacity**– senior clinical decision making for initial assessment of emergency admissions / inpatient capacity / A&E - UCC interface / Maternity Services Capacity – clear policies exist which prioritise women who need hospital care and limit unnecessary admission.	N				
19	**Critical care capacity**– organisation has been through critical care checklist provided by DH (available early August) and have specific plans to increase capacity by 100% to respond to Flu and clear and agreed prioritisation plans.	N				
20	**Primary care capacity** - including normal GP capacity and out of hours services. Plans in place to ensure that those most likely to access healthcare services have care plans to reduce the likelihood that they will be admitted.	N				
21	**Intermediate care capacity** – implementing simplified access criteria, enhancing admission avoidance and palliative care services.	N				
22	**Social care capacity** – streamlining placement process, understanding total potential nursing and residential home capacity in each Borough with ability to utilise capacity. Plans in place to ensure social care workforce resilience	N				
23	**Mental Health capacity**- robust acute psychiatric liaison services to minimise A&E breaches and timely assessment of inpatients.	N				
24	**Ambulance capacity** - plans from each hospital to deliver the required 'hand over' waiting time targets.	N				
25	**Diagnostic and therapy capacity** – enhanced levels of services working 7 days per week in both primary and secondary care.	N				
	Staffing					
26	**Seasonal and Swine Flu vaccination plans** for organisation's staff, that prioritises staff to be vaccinated according to service needs.	Y	Y			40
27	**Medical staff plans** - demonstrate that have recruited sufficient staff to cover EWTD rotas in all critical services and that number of medical staff available take account of the busiest times of day. If the decision is taken nationally for a temporary derogation of WTD compliance to be instated, the terms and conditions of job offers to all medical staff are amended to reflect this.	N				
28	**Maximise available staffing levels** in all roles during an influenza pandemic, including arrangements for temporary postponement of all training, appropriate re-deployment of staff, re-employment of newly retired staff or staff who have left recently, flexible working arrangements (part-time to full-time, working at home, etc) and refresher course for staff who have a clinical background, but who no longer practice.	Y	Y			28
29	**Response to likely absence levels** due to sickness, carer responsibilities and the impact of the anticipated closure of schools, that are not reliant on temporary staffing solutions. Cover arrangements are in place for all key members of staff who may be taken ill, such as CEO, the Board, senior clinicians, and Flu Resilience team. Review of all policies that may affect staff attendance to ensure that they clarify how staff should report sickness during the pandemic.	Y	Y			28
30	**Engagement with the Trade Unions** to ensure their contribution and support for staff arrangements over the period of the pandemic	Y	Y			58

Note:
PCTs may wish to complete separate checklist for Commissioning and Provider functions

London Ambulance Service NHS Trust

TRUST BOARD - 29 September 2009

Document Title	Declaration on Safeguarding Vulnerable Children
Report Author(s)	Gary Bassett
Lead Director	Dr Fionna Moore
Contact Details	LAS HQ
Aim	To inform the Trust Board of the Safeguarding Declaration submitted to the SHA.

Key Issues for the Board

To note the Declaration which has been submitted to the SHA.

Mitigating Actions (Controls)

N/A

Recommendations to the Board

That this Declaration is noted.

Equality Impact Assessment

Has an EIA been carried out? N/A

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

N/A

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

The NHS London Safeguarding Lead would be asked to assist the Trust in meeting its statutory requirements

Corporate Objectives that the report links to:

To provide a safe environment for all patients

London Ambulance Service
NHS Trust

Executive Office
Headquarters
220 Waterloo Road
London
SE1 8SD

Tel: 020 7921 5221
Fax: 020 7921 5127

Safeguarding Declaration

Following the review by the Care Quality Commission (CQC) - http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/specialreviews/2008/09/safeguardingchildren.cfm -
all NHS Trusts were asked to publish a declaration of arrangements in relation to safeguarding.

The following sets out the London Ambulance Service position according to the policy and practice issues identified.

1. The Trust meets its statutory requirements in relation to Criminal Records Bureau checks for all staff that have contact with children, including control services staff who manage 999 calls.

2. The Trust's child protection policy is available at our website - http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection.aspx

Work is being undertaken to identify any issues arising from instances of where children attended as a result of a 999 call are not conveyed to hospital.

The Trust has in place a system for staff to action any safeguarding concerns. Guidance is available to all Trust staff on our intranet.

3. All eligible staff receive training in safeguarding responsibilities in accordance with the Trust's policy and practice.

4. The Trust lead for Safeguarding is Fionna Moore, Medical Director, who also chairs our Safeguarding Group who have a responsibility for strategic policy and practice.

The Trust has dedicated staff to manage the administration of safeguarding referrals placed by ambulance staff, to receive and action requests for information from safeguarding professionals and contribute to Serious Case Reviews. Local ambulance complex management representatives participate in safeguarding related meetings pan-London. Further information about our structure and practice is available at http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/the_referral_process.aspx

5. The Lead for Safeguarding at Trust Board level is Fionna Moore, Medical Director, who regularly reports on safeguarding activity and issues to the Trust board. Regular audit and reporting about safeguarding activity has been put into place as part of a change management process the Trust has introduced.

6. The Trust has a specific provision in relation to safeguarding practice in its contract with other providers who undertake work on our behalf.

The Trust reports on safeguarding activity to our Primary Care Trust commissioners.

3rd September 2009

Peter Bradley CBE
Chief Executive Officer

London Ambulance Service NHS Trust

TRUST BOARD - 29th September 2009

Document Title	CQC Inspection on the prevention and control of infections
Report Author(s)	AOM Trevor Hubbard
Lead Director	Dr Fionna Moore
Contact Details	Medical Directorate, LAS HQ
Aim	To note the CQC inspection report received by the Trust on 6th September and the action plan which demonstrates progress against the recommendations.

Key Issues for the Board

Two documents are presented; the CQC inspection report, received on 6th September, following the unannounced visit at the end of July, and the action plan produced in response to the feedback provided at the conclusion of the visit and subsequently updated.

Mitigating Actions (Controls)

To note the action plan prepared to take forward the IP&C agenda and to address the recommendations contained within the report. The action plan represents work in progress and has already demonstrated improvements in our ability to undertake Complex based audits.

Recommendations to the Board

That the Board notes the report and action plan

Equality Impact Assessment

Has an EIA been carried out? N/A

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Risks of not implementing the IP&C agenda and addressing the recommendations contained within the report are both clinical and will adversely impact on the reputation of the Service. The CQC may well undertake an early follow up re inspection to assess progress against their recommendations.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

As above.

Corporate Objectives that the report links to:

To provide a clean safe environment for both patients and staff.

Inspection report

The prevention and control of infections
London Ambulance Service NHS Trust

Region:
London

Provider's code:
RRU

Type of organisation:
Ambulance trust

Type of inspection:
Enhanced

Sites we visited:
Seven ambulance stations, 23 emergency ambulances and one paramedic motorcycle. For further information see background information

Date of inspection:
29 & 30 July 2009

Date of publication:
16 September 2009

Introduction to our inspections

NHS organisations that provide healthcare directly to patients must be registered with the Care Quality Commission. To be registered, they must meet the Government's new regulation to protect patients, workers and others from the identifiable risks of acquiring a healthcare-associated infection (HCAI). Examples of HCAIs are *Clostridium difficile* and meticillin-resistant *Staphylococcus aureus* (MRSA).

In the financial year 2009/10, the Care Quality Commission is inspecting up to half of all NHS trusts that provide healthcare, to assess whether they are meeting the new regulation on HCAIs and following the supporting Code of Practice and related guidance. We are inspecting all eleven ambulance trusts.

Our assessors make unannounced visits, to ensure that they see the services as a service user would see them. We focus on certain areas of practice to form a 'snap shot' of the trust's activities related to infection prevention and control. This allows us to identify issues that are a potential risk to service users' safety or that could affect their experience of care. The findings and judgements we report are based on the evidence we collect in specified areas of a trust on the days of inspection only.

We plan the scope of our inspections before our visit using the analysis of data. For ambulance trusts, we perform an enhanced inspection over two days using at least 17 measures. We may look at additional measures in more detail if we have identified these as a risk in planning or at the inspection itself.

The measures that we assess each trust against are based on the Code of Practice on HCAIs and related guidance. We use this information to judge whether the trust is compliant with the government regulation on HCAIs.

Where we identify a breach of the regulation we make requirements. The trust must act on these within the specified timeframe. For further information please refer to the enforcement policy on our website at www.cqc.org.uk.

We may find some areas for improvement on the inspection, yet judge a trust to be compliant with the regulation overall, as it is protecting patients, workers and others from the identifiable risks of HCAI, so far as is reasonably practicable. In these cases, we make recommendations to the trust about how it can strengthen its approach and expect the trust to act upon these quickly.

We will typically make an unannounced follow up visit to the trust within one month, for every trust with recommendations and requirements to gain assurance that it has acted on them.

Background on the trust

The London Ambulance Service NHS Trust has 69 ambulance stations across London, and covers approximately 620 square miles. For the purpose of this inspection, we looked at seven ambulance stations, the trust headquarters, and vehicles used for care delivery and the transportation of patients to various care settings.

The Healthcare Commission rated the trust as 'good' for quality of services and 'good' for use of resources in the annual health check for 2007/08. As part of this assessment, the trust met the core standards related to infection control, decontamination, and a clean, well-designed environment.

The trust had not previously been inspected against the Code of Practice on HCAIs.

At the time of the current inspection, the trust was registered with the Care Quality Commission without conditions, based on an assessment of its compliance with the regulation on HCAIs.

Our overall judgement

On inspection, we found no evidence that the trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

How we made our judgement

Of the 17 measures we inspected, we had no areas for concern about nine and found areas for improvement in the remaining eight. The following tables provide further information.

For this inspection, we:

- Analysed information on how the trust manages infection prevention and control.
- Examined policies and procedures.
- Visited seven ambulance stations (Pinner, Kenton, St. John's Wood, Deptford, Waterloo, Romford and Ilford), and inspected 23 emergency ambulances and one paramedic motorcycle.
- Inspected vehicles at the following accident and emergency departments: St. Thomas' Hospital, Queen's Hospital, The Royal London Hospital and Central Middlesex Hospital.
- Had discussions with ambulance crews, station managers, duty station officers, paramedics, the chief executive, the medical director (also the director of infection prevention and control), the practice learning manager, the director of operations, the head of governance, the head of operations support (cleaning & decontamination lead), head of operations directorate (from the cleaning contract company) and the ambulance operations manager for infection prevention and control.

Measures where improvement was needed

Ensuring that workers involved in patients' care receive appropriate information, training and supervision on how to prevent and control infections

(For full wording see Code of Practice criterion 1 and guidance 1d).

What we found on the inspection

The trust provides information to staff using leaflets, fliers and a staff magazine. However, during interviews with staff we found that staff members were not always aware of updated infection control practices including information on swine flu, the use and cleaning of seat covers, and the use of detergent wipes in ambulances.

The senior trust staff expect crews to be supervised in practice by the team leaders and the duty station officers. However, interviews with some of these staff showed that this was not happening in practice and they were not aware of supervision of infection prevention and control activities as part of their role. In addition, ambulance crew members reported that they were not

supervised in practice.

About 20 staff members were interviewed and no one had had their annual update training on infection control in the last 12 months. Senior managers also confirmed that annual update training had been put on hold.

Our recommendation
The trust should review its management systems to ensure that workers involved in patients' care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection.

Performing a programme of audit to ensure that policies and practices are being followed

(For full wording see Code of Practice criterion 1 and guidance 1e).

What we found on the inspection

The trust did not have a programme of audit to ensure that policies and practices are being followed. Most of the ambulance staff and station managers who were interviewed lacked awareness of audits in respect of HCAI and cleaning.

The trust does have a 12-point tool to be used by staff to audit the levels of cleanliness of ambulances and was able to provide a number of completed audits. However, no evidence was seen of re-auditing and, apart from one station, there was no evidence of action plans. There was no monitoring by the trust of the contractor's standards of cleanliness.

Our recommendation
The trust should review its programme of audit, to ensure that there is effective checking of key policies and that practices are being followed.

Ensuring that the environment for providing healthcare is suitable, clean and well maintained

(For full wording see Code of Practice criterion 2 and guidance 2e).

What we found on the inspection

More than half of the ambulances we inspected had not been cleaned to acceptable standards. For example, we saw thick levels of dust on cupboards, window ledges and the tops of cleaning solution holders in most ambulances. Cupboard doors were smeared with dust and trolley straps were grimy in most of the ambulances. The seams in three patient mattresses out of twenty examined were grimy and had collected dirt.

At three ambulance stations we saw single-use mops intended for cleaning ambulances being reused; there was no written guidance regarding the use and replacement of mops.

Our recommendation
The trust should ensure the environment for providing healthcare is suitable, clean and well maintained.

Having cleaning arrangements that detail the standards of cleanliness required and making cleaning schedules available to the public

(For full wording see Code of Practice criterion 2 and guidance 2f).

What we found on the inspection

We did not see any cleaning schedules displayed in any of the ambulance stations nor were they available on request at these stations. Some staff members were not clear about the appropriate use of wipes, detergents and the protocols for cleaning of ambulances.

Our recommendation

The trust should ensure that there are cleaning arrangements that detail the standards of cleanliness required and that cleaning schedules are well displayed.

Having an adequate provision of suitable hand-washing facilities and antibacterial hand rub

(For full wording see Code of Practice criterion 2 and guidance 2g).

What we found on the inspection

Detergent wipes used to decontaminate hands were present in less than half of the ambulances inspected.

Our recommendation

The trust should ensure it provides suitable hand-washing facilities and antibacterial hand rub.

Using effective arrangements for the appropriate decontamination of instruments and other equipment, which are detailed in appropriate policies

(For full wording see Code of Practice criterion 2 and guidance 2h).

What we found on the inspection

The inspection team observed single-use items, such as those used for airway management (endotracheal tubes and laryngoscope blades), being stored without packaging in paramedic bags. The ambulance operations manager for infection prevention and control confirmed that the trust's policy requires that the packaging for single-use items remains intact until the item is used. Approximately 30 out of 60 neck braces designed for single use only were seen stored without packaging; three neck braces were very dirty.

Ambulance stations did not have appropriate facilities for decontamination. For example, there were no detergent wipes or cleaning equipment for crew members to decontaminate equipment such as spinal boards.

Our recommendation

The trust should ensure it uses effective arrangements for the decontamination of instruments and other equipment and these should be detailed in appropriate policies.

The supply and provision of linen and laundry reflecting national guidance (Health Service Guidance (95)18)

(For full wording see Code of Practice criterion 2 and guidance 2i).

What we found on the inspection
Most staff members were unaware of the policy of managing infected linen. At two ambulance stations clean blankets were seen stacked on dirty shelves in a general store room.

Our recommendation
The trust should ensure that the supply and provision of linen and laundry reflects national guidance (Health Service Guidance (95)18).

Following appropriate policies and protocols on aseptic technique (a procedure that is performed under sterile conditions)

(For full wording see Code of Practice criterion 8 and guidance 8b).

What we found on the inspection
There were no policies or protocols in relation to intravenous peripheral line insertion (a procedure by which a soft flexible catheter is placed into a vein). No audits are conducted in relation to peripheral line insertion.

Our recommendation
The trust should ensure that staff follow appropriate policies and protocols on aseptic technique.

Measures where we had no concerns on inspection
The board having an agreement that outlines its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks (For full wording see Code of Practice criterion 1 and guidance 1a).
Having appropriate mechanisms for the trust's board to ensure that sufficient resources are available to effectively prevent and control HCAIs (For full wording see Code of Practice criterion 1 and guidance 1c).
Having a policy for (as appropriate) the admission, transfer, discharge and movement of patients between departments and within and between healthcare facilities (For full wording see Code of Practice criterion 1 and guidance 1f).
Having a policy for uniforms and work wear to ensure that staff wear clothing that is clean and fit for purpose (For full wording see Code of Practice criterion 2 and guidance 2j).
Gain the co-operation of staff, contractors and others involved in the provision of healthcare in preventing and controlling infection (For full wording see Code of Practice criterion 5).
Following appropriate policies and protocols on standard precautions for infection control (For full wording see Code of Practice criterion 8 and guidance 8a).
Following appropriate policies and protocols on the safe handling and disposal of sharps (For full wording see Code of Practice criterion 8 and guidance 8e).
Following appropriate policies and protocols on the management of staff exposure to blood-borne viruses and preventative treatment after exposure (For full wording see Code of Practice criterion 8 and guidance 8g).
Following appropriate policies and protocols on the decontamination of reusable medical devices (For full wording see Code of Practice criterion 8 and guidance 8j).

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The Health and Social Care Act 2008. Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Department of Health, January 2009. Available at:
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The Health and Social Care Act 2008 (Registration of regulated activities) Regulations 2009. Department of Health, March 2009. Available at:
www.opsi.gov.uk/si/si2009/uksi_20090660_en_1

The previous Code of Practice on HCAIs (used by the Healthcare Commission for inspections up to 31 March 2009)
The Health Act 2006: Code of practice for the prevention and control of healthcare associated infections. Department of Health, January 2008. Available at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

National guidance on laundry and linen supplies
HSG (95)18: Hospital laundry arrangements for used and infected linen, Department of Health, April 1995. Available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH_4017865

London Ambulance Service Infection Control Programme 2009

Work Stream 1	**Membership**	**Purpose**	**Reports To**	**Progress**
Vehicle and Equipment Cleanliness	IPC AOM; Chris Vale; LSS; Staff Side Rep; PTS Rep	To ensure that vehicles are cleaned to a high standard and meet NPSA regulations To ensure that processes are in place to monitor and audit cleaning of vehicles and equipment To review elements of the Infection Control Manual to support vehicle cleaning To ensure decontamination process in place and procedure agreed and written To provide information to support the re-tender of vehicle cleaning services	ICSG CGC	Weekly audit process now in place for LAS staff to undertake audits Champions will undertake these from next week on each shift that they are working 1st Meeting 24/09/09
Work Stream 2	**Membership**	**Purpose**	**Reports To**	**Progress**
Premises cleaning	IPC AOM; Nicola Smith; Karen Merritt; LSS; Lakethorne; Staff Side Rep;	To ensure that premises are cleaned to a high standard and meet NPSA regulations To ensure that the processes are in place to monitor and audit the cleaning of all Trust premises To review cleaning products in conjunction with the Infection control Manual	ICSG CGC	Quarterly audit review meeting completed Champions to undertake weekly audit from Sept 09 1st Meeting 23/09/09
Work Stream 3	**Membership**	**Purpose**	**Reports To**	**Progress**
Sluice Rooms	IPC AOM; Nicola	To identify the role of the sluice room within the	ICSG	1st Meeting 18/08/09

	Smith; Chris Vale; LSS; Staff Side Rep; Martin Boatwright	London Ambulance Service To produce a specification for future builds in line with requirements To identify remedial works required and identify a programme of work to update complex areas To ensure that stations comply with COSHH regulations	CGC	Spec agreed to be tested 2nd Meeting 30/09/09
Work Stream 4 Linen Exchange	**Membership** IPC AOM; Karen Merritt; Gordon Ballard; Laundry Rep; Staff Side Rep; Will Kearns; PTS Rep	**Purpose** To allow 1 for 1 exchange of linen after each patient contact by exchanging at hospital To ensure that linen is appropriately distributed and stored on stations To ensure that an adequate supply is guaranteed for patients To review the process and work with commissioners to ensure that all Trusts comply with our requirements to meet the DH Guidelines 2008	**Reports To** ICSG CGC	**Progress** 1st Meeting 19/08/09 2nd Meeting 2/10/09
Work Stream 5 DH Guidelines Implementation	**Membership** IPC AOM; Karen Merritt; Ian Lee; Alistair Drummond; Alison McKee; Ian Bullamore;	**Purpose** To ensure that all of the recommendations outlined in the DH Ambulance Guidelines 2008 are adhered to and implemented.	**Reports To** ICSG CGC	**Progress** Regular group has met to update progress and action outstanding issues

	Jason Challen; Jane Worthington	To ensure that staff and the public are aware of all changes To ensure that all training reflects the new guidance		Next meeting
Work Stream 6 Board Assurance Framework	**Membership** IPC AOM; DIPC; Chris Vale; Alistair Drummond; Laila Abraham; Ian Lee	**Purpose** To develop Key Performance Indicators that can be reported to the Board and to the Public to ensure that the Trust complies with the Health & Social Care Act 2008 and in line with Trust Objectives. To ensure that a framework for reporting exists and provides quality information and assurance to the Board.	**Reports To** ICSG Trust Board	**Progress** KPI list for agreement and implementation for a monthly report to TB
Work Stream 7 Training	**Membership** IPC AOM; Ian Bullamore; Tony Crabtree; DIPC; Staff Side Rep; Jason Challen; Carole Livett; Jane Worthington	**Purpose** To ensure that all training meets the new DH Guidelines and that a regime is in place to ensure that all staff both clinical and non clinical receive regular IPC updates	**Reports To** ICSG TSG	**Progress** Initial meeting planned for 2/10/09
Work Stream 8 IPC Champions	**Membership** IPC AOM; Jason Killens; Ian Bullamore; Alistair Drummond; Staff Side Rep; Jason Challen; Carole Livett	**Purpose** To provide local IPC information to staff To provide update training on new equipment and changes in practice To undertake regular audits of premises, vehicles and hand hygiene practice	**Reports To** ICSG CGC	**Progress** Champions Launch 18/08/09 1st Meeting planned for 2/10/09

		To link with local Trusts to raise IPC awareness and provide a link to linen exchange for the future To become local specialists in infection prevention and control		
Work Stream 9 Single Use Items	**Membership** IPC AOM; Chris Vale; Ian Lee; Alistair Drummond; Alison McKee; Ian Bullamore	**Purpose** To reduce the need for decontamination by providing suitable single use items To reduce the risk of HCAI relating to invasive practice	**Reports To** ICSG CHS VEWG CGC	**Progress** Decontamination policy currently being written No group yet formed
Work Stream 10 Patient Environment Access Group	**Membership** IPC AOM; DIPC; Chris Vale; Alistair Drummond; Patient Rep; Staff Side Rep; Nicola Smith; LSS; Ian Bullamore; DSO rep; Margaret Vander; PTS Manager	**Purpose** Terms of reference in accordance with set NPSA guidelines to include overview of operations, ownership of the process, a process for review, feedback and improvement, public perception, exception reporting and staff training.	**Reports To** ICSG CGC Trust Board	**Progress** This requires further discussion with MV and FM to structure and purpose before this is progressed. E-mail to MV 1/09/09

Work Stream 11	Membership	Purpose	Reports To	Progress
Needlestick Injuries	IPC AOM; Ian Lee; Safety & Risk rep; LSS; Ian Bullamore; Fatima Fernandes	To review management of sharps injuries and oversee root cause analysis To review and implement changes in national policy to ensure safe practice for our staff	ICSG CHS	To be agreed as work stream by DIPC

Key

ICSG	Infection Control Steering Group
CGC	Clinical Governance Committee
CHS	Corporate Health & Safety
VEWG	Vehicle & Equipment Working Group
TSG	Training Services Group
DIPC	Director for Infection Prevention & Control (FPM)
AOM IPC	Ambulance Operations Manager for IPC (TH)
DSO	Duty Station Officer
LSS	Lightbridge Support Services (Make Ready Provider)
PTS	Patient Transport Services

London Ambulance Service NHS Trust

TRUST BOARD - 29/09/2009

Document Title	Finance and governance declarations Q2 2009/10
Report Author(s)	Mike Dinan & Sandra Adams
Lead Director	As above
Contact Details	sandra.adams@lond-amb.nhs.uk
Aim	To provide assurance to the Trust Board on key finance and governance issues for submission to NHS London.

Key Issues for the Board

- To note the governance declaration submitted for Q1 following approval by the Chairman and Chief Executive.
- To note that the final performance figure for Q2 will not be available until after 30th September 2009.
- To approve, subject to the caveat above, the finance and governance declarations for Q2 prior to submission to NHS London by 15th October 2009.

Mitigating Actions (Controls)

- Assurances relating to the finance declaration are contained in the Finance Director's report to the Trust Board.
- Assurances relating to the governance declaration are covered in reports from the Chief Executive, the Medical Director, and agenda items 10, 11 and 12.

Recommendations to the Board

To approve the declarations for Q2 2009/10.

Equality Impact Assessment

N/A for this report.

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

None identified.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

None identified other than those reported on the agenda and within the declaration.

Corporate Objectives that the report links to

- Ensure the Service complies fully with the Health & Social Care Act in relation to infection control & prevention

- Successfully apply to become an NHS Foundation Trust
- Achieve 75% category A, >90% category B performance
- Achieve financial targets

MH Trusts & LAS - Quarterly Governance Assessment

This document is completed for all the functions of the Trust. Please indicate your answer to each question by ticking the box on the right hand side. Please add details in the comments field below if the response is **NO** to any statement. If the response is **NO** please also include in the comments field a timeline for compliance.

The Chair and Chief Executive on behalf of the Board are required to confirm that:

1) Board composition and processes	**YES**	**NO**
a) There have been no external or internal audit reports that raise issues of compliance within the last quarter.	☒	☐
b) The Board currently has no vacancies for:		
I. non-executives	☐	☒
II. Executives	☐	☒
c) The Trust has met the deadline for all returns required by the SHA, Department of Health and other regulators.	☒	☐
d) There is an organisation development programme in place, which includes developing talent and leadership and continuous development of staff. This will include signing up to local Learning and Development Agreements.	☒	☐

Comments: One NED vacancy since 30 April 2009; NED skill mix under review. Interviews held for Director of Health Promotion/DIPC (registered nurse) but no appointment made. Under review.

2) Compliance with statutory duties		
a) The Trust has schemes and action plans in place to ensure that it complies with its statutory duties under equality legislation.	☒	☐
b) The Trust has up to date HR information disclosing the diversity of the organisation's direct workforce.	☒	☐
c) All services are compliant with the requirements under the European Working Time Directive.	☒	☐
d) The Board Risk Assurance Framework has been formally considered and approved by the Board during the last quarter.	☐	☒

Comments: *BAF reviewed in March 2009 by Trust Board. Risk management procesess including the BAF to be reviewed and updated in Q3. Risk register has been reviewed by the Audit Committee and the Risk Compliance & Assurance Group during Q2.*

3) External assessment		
a) There have been no clinical governance concerns raised by the CQC during the last quarter against any of the services the organisation provides.	☒	☐
b) The Board received a formal report in the past quarter detailing the current and predicted CQC Quality of Services score.	☒	☐

Comments:

4) Clinical governance and performance management

a)	The organisation has been compliant with all CQC Core Standards during the last quarter.	☒ ☐
b)	The Trust has effective processes in place to address any clinical governance issues that have occurred in the last quarter that could impact on Core Standards.	☒ ☐
c)	No services have been issued within an improvement notice by the CQC in the last quarter. Please give detail below of any improvement notices.	☒ ☐
d)	No services have been issued with performance notices by other regulators.	☒ ☐
e)	The Trust has met the SHA SUI reporting requirements in the last quarter.	☒ ☐
f)	The Trust has had no incidents of 'Never Events' within the last quarter.	☒ ☐
g)	The Board has received a report on patient safety incidents taken from the STEIS reporting system, including themes and lessons learnt, in the last quarter.	☒ ☐ ☒ ☐
h)	The organisation has a clear strategy in place for improving clinical quality around patient safety, clinical effectiveness and patient experience that sets specific, measurable and challenging goals.	☒ ☐
i)	The Board has received a report on clinical quality, including lessons learnt, in the last quarter.	☒ ☐
j)	The Board has a corporate framework in place for the management and accountability of data quality.	☒ ☐
k)	The Board has received a report on patient complaints, including themes and lessons learnt, in the last quarter.	☒ ☐

Comments: The Trust received the HCAI inspection report from the CQC on 4th September and reported that there had not been any breaches of the regulation. There were no aresa for concern in 9 areas and areas for improvement in 8. The Trust has implemented an action plan supported by audit to address the areas for improvement.

5) Emergency preparedness

a)	The organisation has a robust Business Continuity Plan in place.	☒ ☐
b)	There is a named Director in post responsible for:	
	I. emergency planning	☒ ☐
	II. Flu.	☒ ☐
c)	The organisation has a workforce plan to cover Flu.	☒ ☐

Comments:

6) Safeguarding children

a)	The Board has completed an urgent review of arrangements for Safeguarding children as set out in July 2009 letter from David Nicholson and published a corresponding declaration.	☒ ☐
b)	The Board conducted a formal review of safeguarding arrangements in the last quarter.	☒ ☐
c)	There have been no Serious Case reviews during the last quarter.	☒ ☐
d)	The Trust has a Board Level Director with responsibility for Safeguarding Children.	☒ ☐
e)	The following safeguarding professionals are in post:	
	I. Named Nurse	☒ ☐
	II. Named Doctor	☒ ☐
	III. Named professional (LAS only)	☒ ☐

Comments:		
7) Relationship management		
a)	The Trust has robust and constructive relationships with all its providers, sector commissioners and Sector Acute Commissioning Unit.	☒ ☐
b)	Provider and Commissioner financial quarterly projections reconcile.	☒ ☐
Comments:		
8) Patient and staff involvement		
a)	The Trust has conducted local surveys of patients and the population in the last quarter.	☐ ☒
b)	The Trust has a plan in place to address the areas of weakness identified in the Inpatient Survey (Mental Health Trusts only).	☐ ☐
c)	The Trust has a staff engagement policy in place.	☒ ☐
Comments:		
9) Business Strategy & Procurement		
a)	The Trust has developed, with Board approval, a business strategy and business case for any material dis/investment of services and/or related assets in accordance with DH and NHS London requirements.	☒ ☐
b)	Where material service changes are planned:	
	I. There has been formal engagement with Commissioners to assess the impact and to resolve any issues.	☒ ☐
	II. There has been an assessment of the implications for the Trusts own services and of the financial implications and risks.	☒ ☐
	III. The Trust has complied with national policies and guidelines, prevailing best practice and governance arrangements.	☒ ☐
c)	All contracts with annual values over levels prescribed by OJEC have been signed off by all parties.	☒ ☐
Comments:		
10) Financial Governance		
a)	The Board has developed and agreed a formal action plan to achieve an improvement in financial standing of at least one level in the ALE rating score, or maintain its standing if the maximum score has already been attained.	☒ ☐
b)	The Board, or its designated Finance Sub-Committee, and Executive team are fully engaged in monitoring the delivery of the planned improvements to ALE rating scores.	☒ ☐
c)	The Trust has a plan to improve all Better Care Better Value indicators and the Board has monitored progress since the last quarter.	☐ ☒
Comments: There are no BCBV indicators specific to ambulance trusts however relevant measures are tracked through the Trust Board report and balanced scorecard.		

11) Financial Management and Forecasting		
a)	The CIP has been monitored and risk-reviewed by the Board and the planned value for the quarter has been achieved or, if not achieved, there is a remedial plan in place.	☒ ☐
b)	Where there are material changes in contracted volumes in the quarter, the trust has engaged in formal communication with the associated Sector Acute Commissioning organisation / PCT to agree relevant PCT activity levels and financial implications and to resolve any issues.	☒ ☐
c)	There is no expectation of significant additional working capital loan or temporary PDC requirements over and above plan.	☒ ☐
Comments:		

12) Other issues
Any other actual or potential issues not addressed in the questions above?
Comments: Performance against category A - 8 minutes: xxxx%; category A - 19 minutes: xxxx%; category B-19 minutes: xxx%

Signed on behalf of the Board	
Chief Executive and Accountable Officer (print name only)	**Chair** (print name only)
Richard Hunt	Peter Bradley
Trust name: London Ambulance Service NHS Trust	

London Ambulance Service NHS Trust

TRUST BOARD - 29 September 2009

Document Title	**FOIA Policy**
Report Author(s)	**Peter Suter**
Lead Director	**Peter Suter**
Contact Details	**020 7463 2566**
Aim	**Re-approval of Trust FOIA Policy**

Key Issues for the Board

The FIOA Policy is due for re-approval by the Trust Board. The existing policy has been refined over the last 3 years and the current version has served us well. It has been reviewed by Peter Suter, Garry Bassett (Patient Experiences), Nicola Foad (Legal Services) and the following amendments made:

1: Dates amended respectively
2: Wording tidied up
3: Appropriate name changes applied (Ministry of Justice and Patient Experiences)
4: Section 5.1 'Patient Experiences responsibilities' has been updated to provide a generic approach to monitoring based upon current legislation.
5: Section 6 - Appeals has changed to Recourse – to reflect a softer approach if someone is dissatisfied. The appeal still remains to the Information Commissioner.
6: Section 6 – A timeframe has been set for review by Director of IM&T – nothing is defined within the act, so the figure of 20 days has been used, picking up on the 20 day limit defined for the initial request.
7: The original section 7, 'complaints' has been removed as section 6, 'Recourse' now provides appropriate cover.

Mitigating Actions (Controls)

None required

Recommendations to the Board

To re-approve the FOIA Policy.

Equality Impact Assessment

Has an EIA been carried out? The author has reviewed the policy in detail, giving consideration to the new Equalities Act and concluded that there is no impact. (it is essentially about implementing existing legislation)

Key Issues from Assessment

None

Risk Implications for the LAS (including clinical and financial consequences)

Compliance with current legislation

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) Transparency of information.
Corporate Objectives that the report links to Compliance with current legislation.

London Ambulance Service NHS
NHS Trust

Trust Policy Freedom of Information Act 2000.

Introduction

The Freedom of Information Act 2000 (FoI) was implemented in the UK in its entirety on 1st January 2005. It is an Act to make provision for the disclosure of information. The main drivers for the Act are the Government's commitment to greater openness, transparency and greater accountability in the manner in which Public Authorities conduct their affairs. It grants individuals, private or public organisations from anywhere in the world 'Rights of Access' to information held by Public Authorities.

All Public Authorities, with the exception of those deemed to be Security Bodies under the auspices of this law, must comply with this legislation. Everyone within the Trust has a legal obligation to assist an individual in making a request for information.

The Freedom of Information Act extends to all areas of operation of the Trust and affects all records generated by the Trust's various business processes. It is the intention of the Trust to walk in the 'Spirit of FoI' and fulfil its obligations under the Act.

This policy should be used in line with the policies & procedures named below:

- TP-009 Access to Health Records, Disclosure of Patient Information, Protection & Use of Patient Information.
- TP-012 Data Protection Policy.
- TP-014 Procedure for Ambulance Observers.
- TP-017 Patient Identifiable form used, generated or stored by the LAS.
- FoI Processes Levels 1(a), 1(b) and 2 (published on the Intranet).

The purpose of this policy is to set out the Trust's approach to the implementation of the Act within the LAS.

The FoI Act encompasses records in any format and of any age. It is important to note that the Environmental Information Regulations, the Data Protection Act and the Human Rights Act are excluded from this policy.

This policy was reviewed during July 2009 and amended as necessary to reflect practical experience of dealing with the FoI Act.

What is a Request for Information under FoI?

To make a request for information under the FoI Act, the request must be valid. For a request to be deemed valid, the requirements defined in Section 8 of the Act must be satisfied. These are that the request must:

- Be in writing (letter, fax or email) and be legible. Text messages are not acceptable.
- Provide sufficient description to enable the Public Authority to identify and locate the requested information.
- State the name of the applicant.
- Provide a physical address for correspondence (not applicable to emails, as an email address will suffice).

The Freedom of Information Act 2000 was enacted to provide access to information and not to documents. The Act is written to recognise the fact that there will be good reasons in some cases not to disclose or release the requested information. Provision for the exclusion of such information from a request for information is achieved through the application of exemptions to the requested information.

An exemption is a feature defined under the FoI Act that prevents the disclosure and/or release of certain categories of information. There are 23 exemptions in total. Exemptions fall broadly into 2 categories:

- Absolute exemptions.
- Qualified exemptions.

A Qualified exemption is subject to a Public Interest Test whilst an Absolute exemption is not (please refer to Section 3 and Appendix 1 for a further explanation).

Key Aspects of the Act

The key aspects of the FoI Act are that it:

- Grants members of the public or organisations (public or private) statutory rights to request information held by Public Authorities. This extends also to information which the Trust holds about other organisations or individuals (in some instances).
- Confers on members of the public a legal right to request information in a specific form.
- Puts Public Authorities under a legal obligation to comply with requests for the information it holds unless an exemption from disclosure applies.
- Legally obliges Public Authorities to adopt, implement and maintain a Publication Scheme.
- Expects Public Authorities to follow the guidance provided in the Codes of Practice issued under Part III of this Act. Namely:

    1. Section 45 Code of Practice on Discharge of Public Authorities' Functions defined under Part I of the Freedom of Information Act 2000.

    2. Code of Practice on the Management of Records under Section 46 of the Freedom of Information Act 2000.

The FoI Act is chiefly governed by the 'Right to Know' i.e. to know how Public Authorities manage their organisation's affairs.

Obligations of the Trust (LAS) under the Act

On receipt of a written request, the Act confers on the Trust 2 principal statutory obligations with respect to the disclosure and release of information. These are:

- A requirement to adopt, implement and maintain a Publication Scheme.
- A requirement to respond to requests for information. There are 2 key aspects to this second requirement. There is:
    1. In the first instance, a 'Duty to Confirm or Deny' whether Trust indeed holds the requested information.
    2. Secondly, if the information is held by the Trust, there is a 'Duty to Provide' the requested information to the applicant within 20 working days.

Objectives of this Policy

1. To provide corporate direction on how the Trust will implement the FoI Act.

2. To create an awareness of the FoI Act, provide general guidance for staff and members of the public.

3. To ensure that all staff are aware of their obligations under the FoI Act.

1. STATEMENT OF INTENT

1.1 The Trust encourages a culture of openness and, therefore, welcomes the principles of the FoI Act. The intention is to embrace the FoI Act both in terms of its legal requirements as well as the 'Spirit of the FoI Act'. It is the policy of the Trust to provide information, when properly requested, rather than finding reasons not to. It is however important to clearly state that the absolute requirement for patient confidentiality will not be compromised by this policy.

1.2 In support of the previous statement, it is the intention of the Trust to publish as much information as reasonably possible. A Publication Scheme will be maintained to ensure that as much information as possible is readily available through the Trust's (public) Internet site.

1.3 The Trust has appointed the Director of Information Management & Technology to be accountable on its behalf for the effective implementation of the FoI Act. He/she will seek appropriate professional support (e.g. Caldicott Guardian, legal advice) when necessary, and may also delegate some of the responsibilities on a day-to-day basis as appropriate.

1.4 The Trust will ensure that effective monitoring and reporting procedures are in place, maintain a register of outcomes of all requests for information and complaints, provide suitable training for staff and ensure compliance with the 20-day deadline. FoI activity will be formally monitored through the Information Security Governance Committee (Joint Chair –the Caldicott Guardian and the Director of Information Management & Technology).

1.5 The Trust will only apply exemptions where absolutely necessary in accordance with the law and based on guidance from the Ministry of Justice and the Information Commissioner. The Trust will, therefore, ensure that the appropriate personnel are trained in their correct application.

1.6 The Trust will exercise its right to apply disbursements and fees where appropriate.

1.7 It is the intention of the Trust that all staff are brought to the required level of awareness on FoI and associated issues. This would include the nomination of Departmental and/or Directorate FoI Advisers.

2. MANAGEMENT OF REQUESTS FOR INFORMATION

2.1 Where the Trust has existing processes for providing information to members of the public (and external organisations), these should remain. Therefore, requests for information generated as part of a Department's existing processes should be treated as non-FoI requests. They should be logged or dealt with as they would have been done pre-FoI. This Policy will not apply to such requests. The overriding principle should, wherever possible, be 'business as normal'.

2.2 Under the FoI Act, there is no requirement for the applicant to label or designate a request as a FoI request. Timescales around existing processes, therefore, should be reviewed to ensure compliance with the 20 day requirement under the FoI Act to provide requested information.

2.3 All requests for information outside of normal business processes, or those specifically defined as FoI requests, will be centrally managed by the Patient Experiences Department (PED). Such requests should, therefore, be forwarded to the PED office for the attention of the FoI Co-ordinator.

2.4 Under the Act, the Trust is not obliged to deal with vexatious requests. These are determined by the information requested and not by the individual. The question at hand is whether the request is a genuine endeavour to access information or whether it is aimed at disruption of the service or harassment of a specific member of staff.

2.5 The Trust is under no obligation to comply with a repeated request from the same person, unless a reasonable period has elapsed. In this situation, a corporate decision will be made taking into account the overall cost of the repeated request(s) and the lapse in time between each of them.

3. EXEMPTIONS

3.1 Whilst it is not the intention of the Trust to employ the use of exemptions as a means to prevent the disclosure or release of information, exemptions will be applied where warranted. This is subject to the outcome of the Prejudice Test and/or the Public Interest Test (these are explained in Appendix 1).

3.2 Each decision surrounding the application of the Prejudice test, the Public Interest Test, an exemption and details of non-compliance (with the 20 day deadline) will be documented by the PALS team.

3.3 Exemptions, the Prejudice Test and the Public Interest Test will be applied centrally, under the direction of the Director of Information Management & Technology, by the

PED team. Specialised expertise or further advice will be sought as appropriate, where required.

3.4 The Trust by virtue of its day-to-day business and tendering processes is privy to information that relates to various organizations. This information is categorized as 3rd party information and it should be recognised that this could pertain to both Public and Private organisations. The Trust believes that commercially sensitive 3rd party information should remain confidential and will, within the confines of the FoI Act, make every effort to protect this information and adhere to confidentiality.

3.5 In instances where the request for information relates to that which the Trust holds about a 3rd party, the Trust, will prior to disclosure seek consultation with the organisation(s) to whom the request relates. However, should the outcome of the Public Interest Test favour disclosure, the Trust will have no option other than to comply and disclose the requested information.

4. FEES AND CHARGES

4.1 In accordance with the Ministry of Justice guidelines:

- Requests for information to the value of £450.00 (based on the cost of staff time at a rate of £25.00/hr) will be provided free of charge.
- A fee will be levied for requests costing over and above £450.00 (i.e. the fee levied will be the total cost minus £450.00).
- Where disbursements are over and above the cost of a first class stamp, (As a guideline, between 8-10 sheets of paper) consideration will be given to making relevant charges.

5. ROLES AND RESPONSIBILITIES

5.1 Patient Experiences Department (PED)

The PED will;

- provide a central co-ordination function for FoI requests to ensure appropriate co-ordination within the Trust for the retrieval of information.
- document each decision surrounding the administration of the Prejudice test, the Public Interest Test, the application of an exemption and details of non-compliance within the 20 day limit.
- provide a FoI activity report to the Information Security Governance Committee.
- ensure that the Publication Scheme is maintained in conjunction with the Press Office.
- monitor FoI requests in line with current Diversity and Equalities legislation.

5.2 Departmental and Staff Responsibilities

All staff must;

- assist in supporting a general request for information. Therefore staff should provide reasonable help in ensuring such requests are appropriately forwarded to the PED. Clearly, this must not be at the expense of operational duties.
- forward any written requests for information that are not in line with the normal business to the PED team.
- familiarise themselves with the FoI Policy and procedures.
- notify any forthcoming departmental changes to the PED team via the FoI Co-ordinator.

5.3 Director of Information Management & Technology

The Director of IM&T will;

- be accountable (on behalf of the Trust) for the effective implementation of the FoI Act.
- take responsibility for the application of exemptions, seeking legal advice where necessary.
- delegate responsibilities as appropriate.
- ensure that there is regular reporting to the Information Security Governance Committee.
- ensure that this policy is reviewed.

6. RECOURSE

6.1 In the event that an information requester is dissatisfied with the outcome of a request for information they have the right to seek a review. In the first instance, this should be addressed to the Director of Information Management & Technology who will provide a response within 20 Days of receiving the review request.

6.2 Should the Information Requestor remain dissatisfied with the outcome of the review by the Director of Information Management & Technology then a final review request should be addressed to the Director of Corporate Services who will arrange for a panel of Non-Executive Directors to review the case.

6.3 If all of the above actions fail, the final recourse is for an approach to the Information Commissioner.

References: Freedom of Information Act 2000.

Data Protection Act 1998

Human Rights Act 1998

TP / 009 - Access to Health Records, Disclosure of Patient Information, Protection & Use of Patient Information.

TP / 012 - Data Protection Policy

TP / 014 - Procedure for Ambulance Observers

TP / 017 - Procedure for any Patient Identifiable Form Used, Generated or Stored.

Signature: 

Peter Bradley, CBE

Chief Executive Officer.

The Prejudice Test & The Public Interest Test

With respect to both the Prejudice Test and the Public Interest Test, each case must be considered on its individual merits in accordance with the guidance from the Information Commissioner. All decisions will be documented.

The Prejudice Test

The Prejudice Test is one that is applied to certain elements of an exemption. This is to assess whether prejudice may be caused to the 'interests' (defined within the scope of the exemption) through the release and/or disclosure of the requested information.

A number of exemptions are identified under the Act where the Prejudice Test should be considered, namely:

- Relations within the United Kingdom; Section 28.
- The Economy; Section 29.
- Law Enforcement, Section 31.
- Audit Functions; Section 33.
- Prejudice to the effective conduct of public affairs; Section 36.
- Health & Safety; cited at Section 38.
- Commercial Interests; Section 43.

It is the 'interest(s) represented within the elements of a particular exemption that is/are tested for prejudice. In each case, where disclosure would prejudice any of the elements defined within the scope of the exemption, the Prejudice Test will apply. For example, under Section 31, where the disclosure of information may prejudice the prevention or detection of a crime, the information will be withheld without the need to apply the Public Interest Test.

The elements subject to the Prejudice Test differs for each exemption. Once it is ascertained that there is no risk of prejudice, the Public Interest Test can be applied. In all cases, the Prejudice Test will always precede the application of the Public Interest Test.

It is important to note that the Test of Prejudice does not always apply to every element of an exemption. Therefore, reference should always be made to the FoI legislation to check where this is applicable.

The Public Interest Test

The Public Interest Test in each case determines whether the interest of the public is better served by the release of the requested information or whether it is better served by the withholding or non-disclosure of that information.

The objective of the Public Interest Test is to make reasoned judgments as to whether the information is disclosed or not for the benefit of the general public. In principle, the following favour disclosure:

- Accountability.
- Public Participation.
- Public Awareness.
- Justice to an Individual.
- Research.

Whilst the following favour non-disclosure:

- Exemption Provisions.
- Interests of 3rd Parties.
- Efficient and Effective Conduct of Service.
- Flow of Information to Service.
- Fair Treatment of an Individual.

In relation, to the Public Interest Test, the following considerations are not valid reasons for non-disclosure:

- High Office.
- Policy Development.
- Candour & Frankness.
- Disclosure of Confusing or Misleading Information.
- Information / Record do not / does not reflect the reason for the decision (e.g. Minutes).
- Draft Documents.
- Government Protective Marking Scheme.
- Embarrassment.

Exemptions List

Absolute Exemptions includes Information:

- S.21 Reasonably Accessible by other means.
- S.23 Supplied By, Or Concerning Certain Security Bodies.
- S.32 Contained in Court Records.
- S.34 Disclosures that would infringe Parliamentary Privilege.
- S.36 Disclosures Prejudicing the Effective Conduct of Public Affairs.
- S.40 Personal Information.
- S.41(1) Information Provided in Confidence.
- S.44 Information Covered by Prohibitions on Disclosure.

Qualified Exemptions include information:

- S.22(1) Information intended for Future Publication.
- S.24 National Security.
- S.26 Defence.
- S.27 International Relations.
- S.28 Relations within the UK.
- S.29(1) The Economy.
- S.30(1) Investigations & Proceedings: Criminal Investigations & Proceedings by Public Authorities.
- S.30(2) Information relating to the obtaining of information from confidential sources.
- S.34 Parliamentary Privilege.
- S.35 Formation of Government Policy.
- S.36* Effective Conduct of Public Affairs.
- S.37 Royalty / Honours.
- S.38(1)(a) Health &Safety: where disclosure would be likely to endanger the physical or mental health of any individual.
- S.38(1)(b) Health & Safety: where disclosure would be likely to endanger the safety of any individual.

- S.39 Environmental Information.
- S.40* Personal Information.
- S.42 Legal Professional Privilege.
- S.43 Commercial Interests -Trade Secrets.

Hybrid Exemptions:

*These exemptions have a mixture of absolute and qualified access rights conferred on them

- S.36 Effective Conduct of Public Affairs.
- S.40 Personal Information.

London Ambulance Service NHS Trust

TRUST BOARD - 29th September 2009

Document Title	**Policy and procedure for the development and management of procedural documents**
Report Author(s)	**Stephen Moore**
Lead Director	**Sandra Adams**
Contact Details	**stephen.moore@lond-amb.nhs.uk**
Aim	Effective control, management and monitoring of procedural documents is an essential part of good governance practice and contributes to the assurances required by the Trust Board on safety, quality and transparency. The policy and procedure applies to all LAS policies, procedures, protocols, strategies and plans that are in development or under review by the Trust.

Key Issues for the Board

Following the NHSLA assessment which took place in October 2008 it was decided to make further changes to the existing separate Policy (TP/001) and Procedure (TP/002) for the Development and Management of Procedural Documents in order to fully bring them into line with NHSLA requirements. They have both been thoroughly reviewed and to eliminate duplication have now been combined into one document.

The new document describes in detail the system to be followed for a single approach to the effective development, implementation, monitoring and review of procedural documents. It will now underpin the work that is required to introduce a completely consistent approach to the development, content, and management of all procedural documents across the Trust and upgrade all existing policies and procedures to ensure that they meet the standard required for the next NHSLA assessment to take place in 2010.

The main additions and changes are:-

- More comprehensive coverage of Trust documents. In addition to policies, procedures, and forms the Policy and Procedure now includes protocols, strategies, plans, and guidance within its scope.
- Directors and senior managers now have responsibility for approving the development of new procedural documents and identifying authors (owners).
- The format of policies and procedures has been developed further and now includes sections for Responsibilities and Definitions.
- A simplified approval process (see Appendix 5) for policies and procedures.
- A checklist is now included at Appendix 1 and a flowchart at Appendix 6 to assist authors in the development process.
- The index numbering system (section 10.2) has been amended and simplified to reduce the possibility of confusion when the changes are implemented.

- Increased emphasis is placed on the Implementation Plan for policies and procedures as it is an NHSLA requirement for Level 2 that the Trust shows in some detail how new policies and procedures will be implemented (including the provision of appropriate training and awareness) and how compliance and effectiveness will be regularly monitored.

Mitigating Actions (Controls)

- The policy is set in the format recommended by the NHSLA as good governance practice
- The Head of Records Management maintains the document library
- Appendix 5 details the approval process through the existing committee structure
- All approved policies and procedural documents will be available on The Pulse for easy access by staff.

Recommendations to the Board

To ratify the policy and procedure following its approval by the SMG on 9th September 2009.

Equality Impact Assessment

An EIA has been undertaken as per the current trust format and as prescribed within the policy itself. Consultation is underway regarding a proposed new process for undertaking an EIA and the outcome of this will be adopted within this policy.

Key Issues from Assessment

Information and communication may be an issue and we need to ensure the document is accessible to staff in different formats. There are no known risks of discrimination with this policy.

Risk Implications for the LAS (including clinical and financial consequences)

Non-compliance with levels 1 & 2 of the NHSLA risk management standards for ambulance trusts.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Implementation of this policy is essential for the achievement of level 2 of the NHSLA risk management standards.

Corporate Objectives that the report links to

- Successfully apply to become and NHS Foundation Trust
- Achieve financial targets

London Ambulance Service NHS
NHS Trust

Policy and Procedure for the Development and Management of Procedural Documents

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To describe in detail the system to be followed for a single approach to the effective development, implementation, monitoring and review of procedural documents.
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Sponsor Department: Governance Development Unit

Author/Reviewer: Head of Records Management & BC. To be reviewed by Jul 2010.

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
11/08/09	0.4	Director of Corporate Services	Minor – Appendix 4 inserted
30/07/09	0.3	Head Records & BC. Head of Governance, Records Manager	Minor – scope, responsibilities, definitions, 7.5, 7.10, 8.1, appendices
16/06/09	0.2	Head Records & BC. Head of Governance, Records Manager	Minor – amendments made throughout
17/3/09	0.1	Head Records & BC	Amalgamation & revision of TP/001 & 002

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

For approval by:	**Date approved**	**Version**
SMG		1.0
Ratified by:		
Trust Board		

EqIA completed on	**By**
26/08/09	S.Adams
Staffside reviewed on	**By**

Published on:	**Date**	**By**	**Dept**
The Pulse		Records Manager	GDU
LAS Website		Records Manager	
Announced on:	**Date**	**By**	**Dept**
The RIB		Records Manager	GDU

Links to related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/029	LAS Records Management Policy	

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

1. Introduction

As an organisation the London Ambulance Service NHS Trust (LAS) acknowledges that the effective management of document creation within the Trust is an essential part of good governance practice.

Effective control, management and monitoring of procedural documents (as defined in the scope (section 2) contributes to the assurance of:

- safe operations
- risk reduction
- staff awareness of current practice
- delivery of high quality patient care
- effective quality control
- transparency for external stakeholders

2. Scope

This policy and procedure applies to all LAS policies, procedures, protocols, strategies, and plans produced or reviewed by the Trust. It details the approach that the LAS will take in the development, management, implementation, and monitoring of these procedural documents. It also applies to guidance documents except where these are of purely a local nature.

3. Objectives

1. To describe in detail a single approach for the effective development, implementation, monitoring and review of procedural documents.

2. To produce procedural documents following an agreed corporate style and format.

3. To bring all procedural documents together and manage them in such a way that they will be available as part of one electronic system accessed through the Trust's intranet.

4. To define roles and responsibilities for staff, committees and groups of the Trust.

5. To define an approval, and, where appropriate, ratification route for all policies and procedures and embed full ownership and management accountability for

document implementation, staff awareness, and compliance that is monitored for effectiveness.

6. To develop and consult on relevant policies and procedures in partnership with Staff Side colleagues.

4. Responsibilities

4.1 The LAS Information Governance Group has overall responsibility for monitoring compliance with this Policy and Procedure and the effectiveness of the system for managing procedural documents.

4.2 The LAS Trust Board, Committees and Groups have responsibility for approval, ratification and monitoring policies and procedures as detailed in Appendix 5.

4.3 Directors/Senior managers have responsibility for approving the development of new procedural documents apart from guidance of a purely local nature. They are also responsible for defining the approval process for all other procedural documents.

4.4 The Head of Records Management is responsible for operational management and development of the system.

4.5 GDU staff are responsible for the day-to-day management of procedural documents and co-ordination of the system.

4.6 Document authors are responsible for:

- ensuring that they follow this policy and procedure when developing new procedural documents;
- consulting widely with all stakeholders when developing or reviewing a document;
- ensuring that all requirements laid down by legislation and standards are considered and incorporated in their documents;
- reviewing them in a timely manner when requested by the GDU and within the timeframe specified in the procedural document itself;

- managing the review process and securing the approval of the new/ reviewed procedural document. (See appendix 5)

4.7 Managers throughout the Trust are responsible for ensuring that staff are aware of, and comply with, all relevant procedural documents.

4.8 All members of staff have a responsibility to read and be aware of the content of appropriate new and revised documentation at the earliest opportunity following issue or publication.

5. Definitions

5.1. Procedural Document

The term 'procedural document' is used throughout this document as an umbrella term for all document types within scope and as detailed below..

5.2 Policy

A policy is a high level statement of principles for action or intent that guides the decision-making and activities of the organisation and describes how an aspect of service provision or governance will be achieved.

5.3 Procedure

A written, approved specification for execution of an activity - often composed of steps, using established methods or forms - designed to achieve a uniform approach to compliance with applicable policies.

5.4 Protocol

In the context of the LAS a protocol is a convention or a predefined written procedural method which guides how an activity, normally clinical, should be performed.

5.5 Guidance

Practically advises how a task may be completed or best practice within which to work. The exercise to which the guidance applies may not be Trust wide and may vary between divisions/ departments / stations. Guidance may also be produced to supplement a procedure.

5.6 Strategy

A long term plan of action, designed to achieve a particular goal in relation to the Trust's strategic aims.

5..7 Plans

A detailed scheme setting out a number of steps or decisions that may be followed in the future in order to achieve a certain aim or objective.

5.8 A document may be one or a combination of the above. The Records Manager will advise if required.

5.9 Consultation -the process where internal/ external Stakeholders are asked for their comments and agreement of the document. It will include groups such as staff, staff side, HR, finance, service users, *Note*: to consult does not infer negotiation.

5.10 Approval -to sanction and officially confirm that a document is appropriate to the Trust and projects the Strategic Objectives. This is carried out through the committees and groups which provide assurance to the Trust Board (See Appendix 5).

6.0 Development of documents

6.1 Any member of staff may identify a need to develop a new document or amend an existing document that affects the way services, functions and activities are performed and delivered.

6.2 All documents to be developed / reviewed must have the prior approval of the relevant **Director/ Senior Manager**. If appropriate, the relevant Human Resources Policy Lead should be involved. The **Director/ Senior Manager** will identify whether to proceed to draft with the application.

6.3 The relevant **Director/ Senior Manager** will identify an **author (Owner)** to develop the new document. The task may be delegated to a group of individuals or an appropriate manager. Staff Side representation will be included if appropriate. **The flowchart at Appendix 6 should be read by the author prior to commencement of work on the document.**

6.4 Once approval for the creation of the document is obtained, the **Director/ Senior Manager** will send an email notification to Records Management stating that approval has been given, the working title of the document and name of author.

6.5.1 The author of a document is required to consult widely with all stakeholders whenever a new document is being developed, or an existing document is due for review. The author should forward a copy of the draft to Staff Side and where appropriate the author should approach external bodies as part of the consultation process. The author will keep a record of this consultation process and notify GDU Records Management of the details of those consulted.

The document, if a policy or procedure, will then follow the agreed approvals route (see Appendix 5).

6.6 All draft documents should follow the trust document template (see Appendix 3). Note: the Implementation Plan must be completed and the Equality and Human Rights statement must be included.

6.7 The Checklist for the Review and Approval of Policies and Procedures (Appendix 1) should be completed by the author and emailed to Records Management prior to the document being submitted for approval.

6.8 Once the proposed document has reached its final draft, the author must send a copy of the document to GDU Records Management email address (RecordsManagement@lond-amb.nhs.uk).

New documents will be issued with a *Unique Reference Number by the Records Manager*, prior to being submitted for approval.

6.9 An Equality Impact Assessment (EqIA) (see Appendix 4) must be completed by the owner for each procedural document, with the exception of some guidance material. Once completed the owner must ensure that the EqIA is signed off by the appropriate Director before it is returned to the Diversity Manager with a copy to GDU Records Management. The date of completion of the EqIA will be recorded on the Document Control sheet at the front of the document. No policies/procedures will be accepted onto the agenda of a group/committee for approval without an Equality Impact Assessment in place.

6.10 The author will submit a policy or procedure for approval to the relevant committee or group (See appendix 5) and notify the Records Manager of the committee/ group and date. For all other procedural documents it will be the responsibility of the Director/ senior manager to define the approval route to be taken.

6.11 Should a procedural document require urgent approval, a committee senior to the one normally designated may take on this role.

6.12 Following approval, the author will forward the approved document to the Records Manager for conversion into a PDF read only file.

6.13 An approved master copy of the document will then be stored electronically by GDU. The document will be added to the LAS Intranet site (The Pulse) for staff to access; it will also be made publicly available through the Trust's Publication scheme on the LAS website if considered suitable for release under the Freedom of Information Act 2000 (FOIA).

The flowchart for the stages for procedural document development is at Appendix 2 .

7. Issue, implementation and monitoring of new and revised documents

7.1 Issue

The issue of documents will be announced in the Routine Information Bulletin (RIB) by GDU who will place a full electronic version and a summary of the document on *'the pulse'* and where appropriate a copy on the LAS website. The date of the announcement will be recorded in the Document Profile and Control section. All procedural documents will normally be converted to PDF format prior to placement on the Trust's intranet and internet sites. For ease of use policies and procedures on the intranet will be bookmarked. Hyperlinks to related listed documents will be added wherever possible.

7.2 Implementation plan & monitoring

The Implementation Plan is an integral part of each policy and procedure and will be provided by the author. This records the intended audience, details of dissemination and distribution, communications and awareness, training to be provided if required, and monitoring of compliance. (see template at Appendix 3 for further details).

Methods of monitoring compliance will include the identification of relevant standards and key performance indicators. Policies and Procedures may also be subject to internal or external audit, to ensure full compliance is taking place as required.

To ensure effective compliance with Procedural documents the possibility of introducing an electronic system which will manage their lifecycle and

enable staff to receive training on, and increase awareness and understanding of, procedural documents will be investigated.

8. Review system

8.1 It will be the responsibility of author/ Owner to ensure that policies and procedures and other documents that have been allocated a review period are reviewed in a timely manner. To facilitate this, the Records Manager will notify the owner three months prior to the review date and a list of document review dates will be made available on the Pulse.

8.2 Review of a document will require a further Equality Impact Assessment to be carried out if major changes are made.

8.3 The standard review period for a policy or procedure will be three years and this is the maximum period allowable before a review must take place. However, the author may decide on a shorter review period as it is the responsibility of the author of a document to ensure that it is kept up to-date, relevant and evidence based in light of best practice. The review period should also be set to reflect external requirements or anticipated changes where these are less than three years. Documents may be reviewed, following the consultation process in section 7, at any time if required. Any policy and procedure review, which in the opinion of the GDU results in only minor updates of an administrative or organisational nature, will not require further approval by the appropriate Trust committee.

9. Style and Format

9.1 Procedural documents will conform to the approved Trust style, as detailed on the Pulse.

9.2 The following format specification will be applied to create an approved corporate style document (see example template of a policy or procedure in Appendix 3

9.3 **Document title box** to follow the format as in Appendix 3.

9.4 All text entered in the 'Document Title' box and throughout the document to be in font style **Arial** font size 12 for both upper and lower case entries and **bold** type except for the Document Profile and Control section which

will be in Arial 11. All text in the title box, headings and sub-headings should be in **bold** font.

9.5 The **Document profile and control** section must be completed by the author and the GDU as appropriate in order that version control is maintained. Authors must add references to relevant source information, policies and procedures, research data, training and guidance documents, health standards, legislation and accreditation systems that have a bearing on or relevance to the document.

9.6 Where abbreviations are used in any part of the document these will be written out in full where they first occur, immediately followed by the abbreviation typed inside brackets, e.g., London Ambulance Service NHS Trust (LAS).

10. Document and version control

10.1 Document control & archiving

The Document Profile and Control section at the start of each document provides important metadata – information on the ownership, document status and development history, version, approval, publication, and details of references and related documents.

The master documents will be electronic and maintained by the GDU in linked areas of the Trust's intranet, the Pulse. All current policies will also normally be placed in the Trust's Freedom of Information Publication Scheme on the external Website. Procedures may also be included in the Publication Scheme where there may be a particular public interest in the subject area concerned. All policies and procedures may be downloaded and/or printed from these sites but as these are controlled documents staff will no longer be issued with personal copies and they are only current at the time of download/print and are not to be regarded as definitive documents. Departmental representatives on the Information Governance Working Group will have the responsibility to check that paper files of policies and procedures and protocols are not maintained anywhere in the Trust as they can rapidly become out of date.

The GDU will maintain archived electronic copies of all superseded and obsolete policies and procedures for 25 years and previous versions are available upon application to GDU Records Management.

10.2 Version control

Version control will be used to manage all procedural documents and will follow major or minor versions (i.e. v.1 or v1.1) format.

The GDU will allocate an alphanumeric index number to each document according to the type of document:

- **T**rust **P**olicies and procedures will commence with **TP**
- **O**perational **P**rocedures will commence **OP**
- Service forms will be allocated a new **LA** number
- **Pl**ans will commence with **PL**
- **St**rategies will commence with **ST**
- **Pr**otocols will commence with **PR**
- **Gu**idance will commence with **GU**
- **H**uman **R**esource will commence **HR**
- **H**ealth and **S**afety will commence with **HS**
- **C**ontrol **S**ervice **O**perational **P**rocedures will commence with **CSOP**

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A document control footer will be completed by the author which should contain the document reference number, the title of the document and the page number and total number of pages. For filing and archiving purposes the filename and path should be included as a footer to the document.

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website. This will be co-coordinated by the GDU.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document by the GDU.
Training	It is planned to provide specific training from 2010 onwards for those members of staff who are required to develop, write and review procedural documents. GDU will co-ordinate this.
Monitoring	This policy and procedure will be monitored through the Information Governance Group (IGG). The IGG will meet quarterly and on an ad hoc basis as required. It is expected that all documents within the defined scope will comply with this policy and procedure. The GDU will review compliance with the policy and procedure on a quarterly basis. To ensure compliance and effectiveness of this document, an audit of procedural documents will be undertaken every two years by the GDU. This will involve a random sample of all documents, including those archived within the previous two years. The results of the audit will be presented to the Information Governance Group who will ultimately be responsible for the development and monitoring of any identified actions within the scope of the audit.

Appendix 1

Checklist for the Review and Approval of Policies and Procedures

To be completed by the owner of the document prior to submission for approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol, procedure, strategy, plan?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Are individuals involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Content**		
	Is the Purpose of the document clear?		
	Is the objective/s of document clear?		
	Does the scope define the remit of the document?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are the references cited in full?		

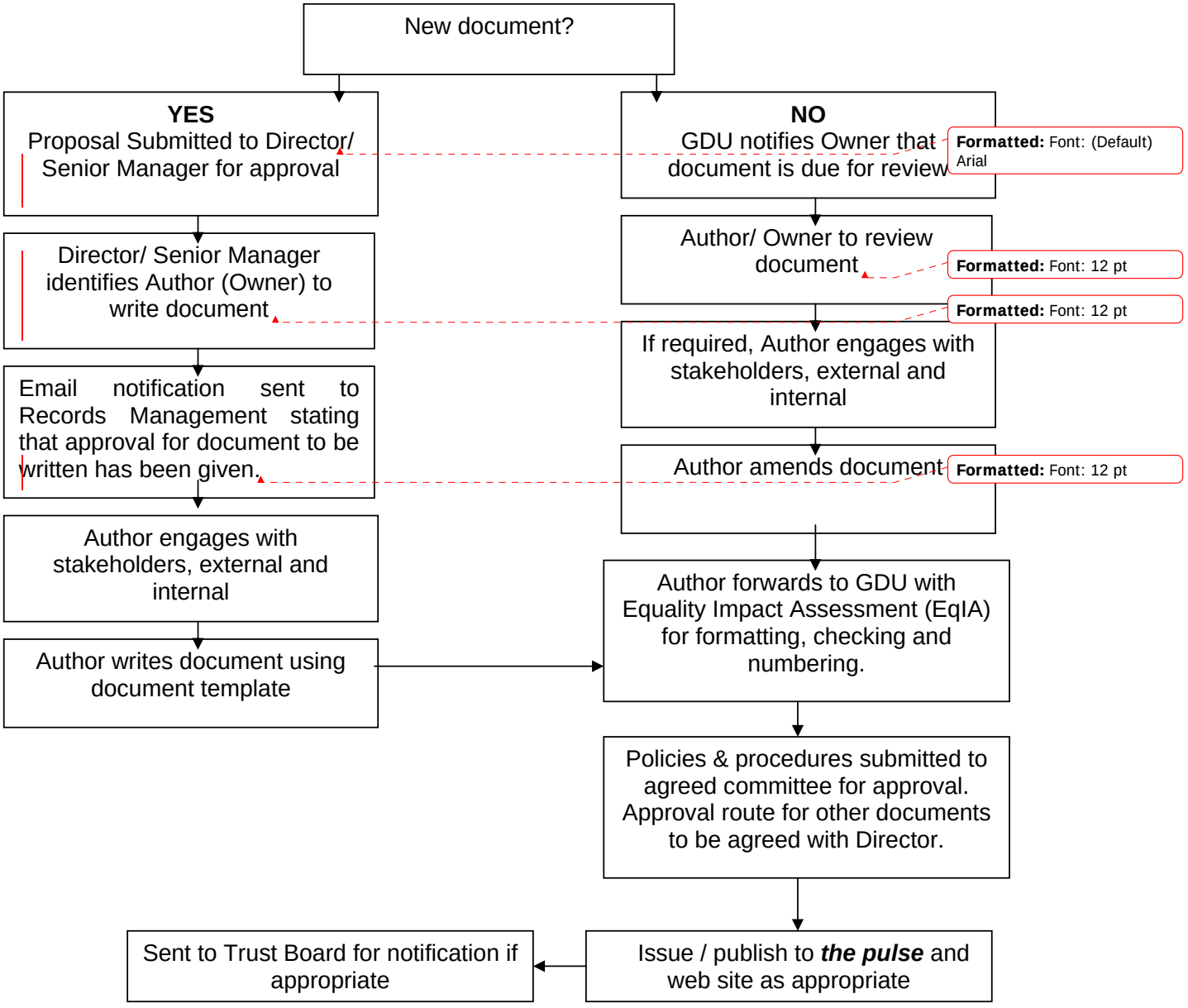
	Title of document being reviewed:	Yes/No/ Unsure	Comments
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
7.	**Dissemination and implementation**		
	Intended audience - Is the intended audience identified?		
	Dissemination - Is it identified how the document will be made available to staff?		
	Communication - Is it identified how the document (change/ creation) will be publicised?		
	Training - Does the plan include the necessary training/support to ensure compliance?		
	Monitoring - Are there measurable standards or KPIs to support monitoring compliance of the document?		
	Monitoring - Is there a plan to review or audit compliance with the document?		
10.	**Review date**		
	Is the review date identified?		
	Is the frequency of review identified?		
11.	**Overall responsibility for the document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

Please send completed checklist to GDU Records Management at RecordsManagement@lond-amb.nhs.uk

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

Appendix 2

Stages for Procedural Document Development



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Appendix 3

London Ambulance Service NHS
NHS Trust

Document Title

DOCUMENT PROFILE and CONTROL.

Purpose of the document:
****

.

Sponsor Department: **********

Author/Reviewer: **********. To be reviewed by xxx 2012.

Document Status: Draft/ Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
XX/XX/XX	0.2	**********	Minor - **********
	0.1		

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

For Approval By:	**Date Approved**	**Version**
**********	XX/XX/XX	1.0
Agreed by Trust Board (If appropriate):		
**********	XX/XX/XX	

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

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

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**

1. Introduction

This provides the background narrative explaining the purpose and reason for the document.

2. Scope

It should be clearly stated what areas the procedural document covers and what is excluded from the coverage of the document.

3. Objectives

To set out concisely (by number if necessary) what the document aims to achieve and provide.

1. **********
2. **********

4. Responsibilities

The responsibilities and duties of postholders and committees must be clearly defined.

Post Holder 1 - **********
Post holder 2 - **********

5. Definitions (optional)

List and describe the meaning of terms used in the context of the document where required for clarity.

********** **********
********** **********

This is where the author writes the details of the specific document. There will be instances where for clarity of governance or administrative convenience a policy and procedure are combined into one document.

6. First Heading

6.1 **********

6.2 **********

7. Second Heading

7.1 **********
****

8.1.2**********

8.1.3**********

8.1.4**********

7.2. **********
****

- **********
- **********

Implementation Plan

To be completed by the author

IMPLEMENTATION PLAN TEMPLATE		
		Notes
Intended Audience		Indicate whether the document applies to all staff or certain sections of staff
Dissemination		Detail where document is to be made available e.g. on The Pulse and the LAS Website
Communications		Indicate how staff will be informed of the document and made aware of its contents
Training		If training is required indicate how this will be provided to relevant staff
Monitoring	In this section specify: ▪ Which aspect of the document will be monitored ▪ How that monitoring will be achieved, e.g., Audit ▪ Who will have the responsibility for the monitoring ▪ When the monitoring will take place and the frequency of it, e.g., annually in September ▪ How the results from the monitoring will be fed back into the document and/or monitoring process	If a policy/procedure or similar document indicate how adherence to the content will be monitored, i.e., through Internal Audit; Committee; quality checks.

[Appendix x]

Appendices. Any standard forms, local protocols and checklists that come within the scope of the document should be numbered and referenced at the appropriate place in the text, e.g. ‘see Appendix 1’ Each appendix should be attached at the back of the document and numbered in bold upper case letters and figures at the top right hand corner of the page. Alternatively where documents are referred to in the text they may be accessed through electronic hyperlinks.

Appendices must be made reference to within the main body of the document. They should provide additional evidence or explanation of a subject.

Appendix 4
LA035

Equality Impact Assessment Guidance and Form

Guidance

Equality impact assessments are a way of finding out whether your actions or proposals will affect some communities or groups of people differently. Such differential treatment could lead to unfair decisions and unlawful treatment by the LAS: careful and thorough assessments should help to avoid this.

Use this guide to carry out impact assessments on any functions. By functions we mean:

- policies
- services
- decision making
- action plans which accompany or form part of strategy documents
- any other activity or action you carry out.

Directories and Heads of Service must decide which of their functions will be impact assessed, based on a number of factors, including:

- the impact on external customers and if this will differ for different communities
- likelihood that staff or customers will be affected differently
- whether the function will affect relations between communities
- any statutory obligations that apply
- whether the function is specifically designed to tackle discrimination or disadvantage.
- whether the function will affect an individuals human rights

And **any function which is new, is being substantially changed, or is under review should have an impact assessment.**

The assessment is based on barriers that can exclude people or lead to some people being treated differently than others. As you go through the assessment, think about the likely effects on human rights and of the barriers on the following areas and groups:

- disabled people
- women and men
- people from black and minority ethnic communities, including refugees and asylum seekers and Gypsies and Travellers
- lesbians, gay men and bisexual people
- trans people
- older and younger people

- people of different religions and faiths
- and other groups who might not have equal access to your service.

A small group should carry out the assessment, including people who know the function well. The group should also include someone who can make sure that any actions feed in to service improvement plans, for example Heads of Service, managers and a policy, performance/ planning officer.

Keep records of your decisions and the actions needed through all eight stages of the assessment: minutes of meetings, reports or other notes. If you wish, you can use the form we have provided. Alternatively, you can structure a report of the assessment that covers the eight stages. You will probably need to refer to or make links with other documents.

The record of your completed assessment should be forwarded to your Director and or to the relevant management team for approval and comments.

Impact assessment stages

1. **Aims**

   Briefly outline the function that you are assessing. In two or three lines, say what it is meant to do and who will be affected by it.

2. **Fact finding**

   Gather any information that will help you to assess the function's impact on the diverse population, for example, research, statistics, performance indicators, reports from earlier consultation, monitoring results or expert knowledge. If there are any gaps in the information, decide how you will remedy this.

   You might decide to carry out some public consultation to get more information. But bear in mind that you will also need to consult later on, following the assessment stage.

3. **Assessment**

   A series of assessment questions are on page 5 of this guide.

   For the first round of assessments, officers with an equality background will be assisting teams to work through the assessment questions.

   By going through the questions you will think about whether there are any barriers to equal treatment. Whilst some barriers might only affect particular groups, you will find that many will affect a number of communities and groups.

Think about whether any barriers will affect an individual's human rights.

Then think about the actions you will take to avoid or prevent these barriers.

4. **Think of alternatives**

   If your assessment highlights serious differences in effect or treatment, you might have to do things differently.

   For plans, proposals or decisions this could mean coming up with an alternative and starting the process again.

   For services, build improvements into your action plans.

5. **Consultation**

   Find out what other people think of your ideas for actions: members of the public, service users, members of staff and staff groups, equality officers.

   Plan any consultation carefully, making sure your aims are clear from the start.

   Avoid consultation fatigue: find out first whether any similar consultation exercises have taken place and use their findings. If you do this, and feel confident that your actions will have clear benefits, you might find that you don't actually need to consult at this point.

   Make sure you consider views carefully and give feedback to people you've consulted.

6. **Action plans and targets**

   Finalise your actions, make sure they are SMART.

   Set targets for improvements.

   Ultimately, these actions should form part of your service improvement plans, where you will allocate responsibility, timescales and resources to make sure they are carried out.

7. **Monitoring and feedback**

   Decide when and how you will review your action plans and the progress against targets. This could include further consultation once a policy or change has been implemented, or arrangements to take and respond to feedback at any time.

If issues arise that you could not have anticipated during the impact assessment, they should be picked up as part of the service improvement process. Adapt your action plans as needed to deal with these new issues, after discussing this with relevant managers or colleagues

8. Tell people what you are doing

Publicise your decision, service changes or new policy.

Let people know how you incorporated their opinions after you consulted them.

Stage 3

Equality impact assessment questions

These questions take you through the sorts of barriers that can make it difficult or impossible for certain groups and communities to:

- use services
- get a job or progress in a career
- benefit from policies, functions or decisions
- find out about what the London Ambulance Service does
- get their opinions heard.

Think about the current situation and your plans for the future. Will your policies, plans or decisions make things better or worse for some groups? What will you do to improve things?

Built environment

Are the buildings, premises and environment easy for everyone to find, get into or use? Are they accessible, safe and user-friendly?

Example: A planned office move must take into account the needs of disabled staff, both current staff and those who might be recruited in future.

Location of premises and services

Are some communities particularly well or badly served by the location of your premises? Are you changing the location or reducing the number of premises? What effect will this have?

Example: A Health Service Unit closure should not disadvantage service users from communities which are concentrated in particular parts of the city, for example if their travelling distance to the Health Unit would be significantly longer than for other service users.

Information and communication

Do you have a strategy that makes communication as accessible to as many people as possible?

Does it include written, face to face, telephone and electronic communication?

Will information reach as wide an audience as possible?

Example: Staff producing a newsletter should have carefully considered their audience at the start. Decisions about translation, formats and distribution will follow from this.

Customer care and staff training

Have all staff who deal with the public been trained to provide a service to diverse communities?

Do all managers know what their legal responsibilities are?

Are there any particular training needs for specific services or arising from a change of policy?

Example: Reception staff know how to book interpreters if needed and have clear, written instructions available.

Stereotypes and assumptions

Are functions or services based on knowledge, assumptions or stereotypes that might exclude some people, families or partners? Have functions or services been developed around a particular type of service user or an "ideal" service user?

Example: Staff carry out an audit of their leaflets and forms to make sure they can be used by single parents or carers and same sex couples, not just heterosexual couples.

Timing

Do your opening times, appointment and waiting systems, timescales or deadlines suit everyone?

Example: An open day should be planned so that it doesn't clash with any religious festivals.

Costs of the service

If people have to pay for a service, or if a service provides particular benefits or concessions, is this fair for everyone?

Are there extra or hidden costs for some people?

How will changes to these costs affect different groups?

Example: Leisure centres give free entry for carers or support workers who assist disabled people. This means that disabled people who need assistance do not have to pay for two people.

Commenting on the function: consultation

Do you have a plan for consultation?

Does it include:

- clear reasons for carrying out consultation?
- consulting with and getting feedback from a range of communities, organisations and individuals?
- using the most appropriate and accessible methods?
- using results from previous consultations?
- consulting with people who use services and those who don't?

Barriers that are specific to the function

Are there any other barriers that haven't been covered? These could be specific to the function or type of function.

Example: A varied menu at an event provides for a range of diets.

LA035

Equality Impact Form

Function/ policy being assessed: ----------

Directory/ service or corporate function: ----------

Date of assessment: ----------/--------/----------

Contact person for the assessment: ----------

Members of the assessment group:----------

---

1. Aims of the function/ policy

2. Current achievements and fact finding

Sources of information used, with references, location or links.
Anything you have learnt from previous consultation results with references or links. In particular any evidence you may have that impacts upon: **race, disability, gender, age, religion and belief, sexual orientation and human rights**

3. Assessment and actions needed

Initial ideas for actions can go here. You will refine them further at stage 6. Please note the impact assessment will not be accepted unless group(s) affected is listed with a link to the action required. Primary areas to consider are: **race, disability, gender, age, religion and belief, sexual orientation and human rights**

Barrier	Group affected	Action needed	Responsibility	Timescale	Resources
Built environment					
Location					
Information and communication					
Customer care and staff training					
Timing					
Stereotypes and assumptions					
Costs of the service					
Commenting, consultation					
Specific barriers					
Human Rights					
Other					

5. Future consultation

Plans and aims for further consultation.

Who with, when, method of consultation.

6. Action plans, targets and priorities

Explain how the action plan will tie into service improvement plans, directorate action plans and local delivery plans

7. Monitoring and feedback

Details of how you will review action plans and progress. **All impact assessment action plans must be reported back internally and to the equality and diversity facilitators 6 monthly as a minimum.**

8 Tell people what you are doing

Information on how you will publicise decisions, actions and service improvements. How will you make this available to the public?

Appendix 5

Policy and Procedure Approval Process

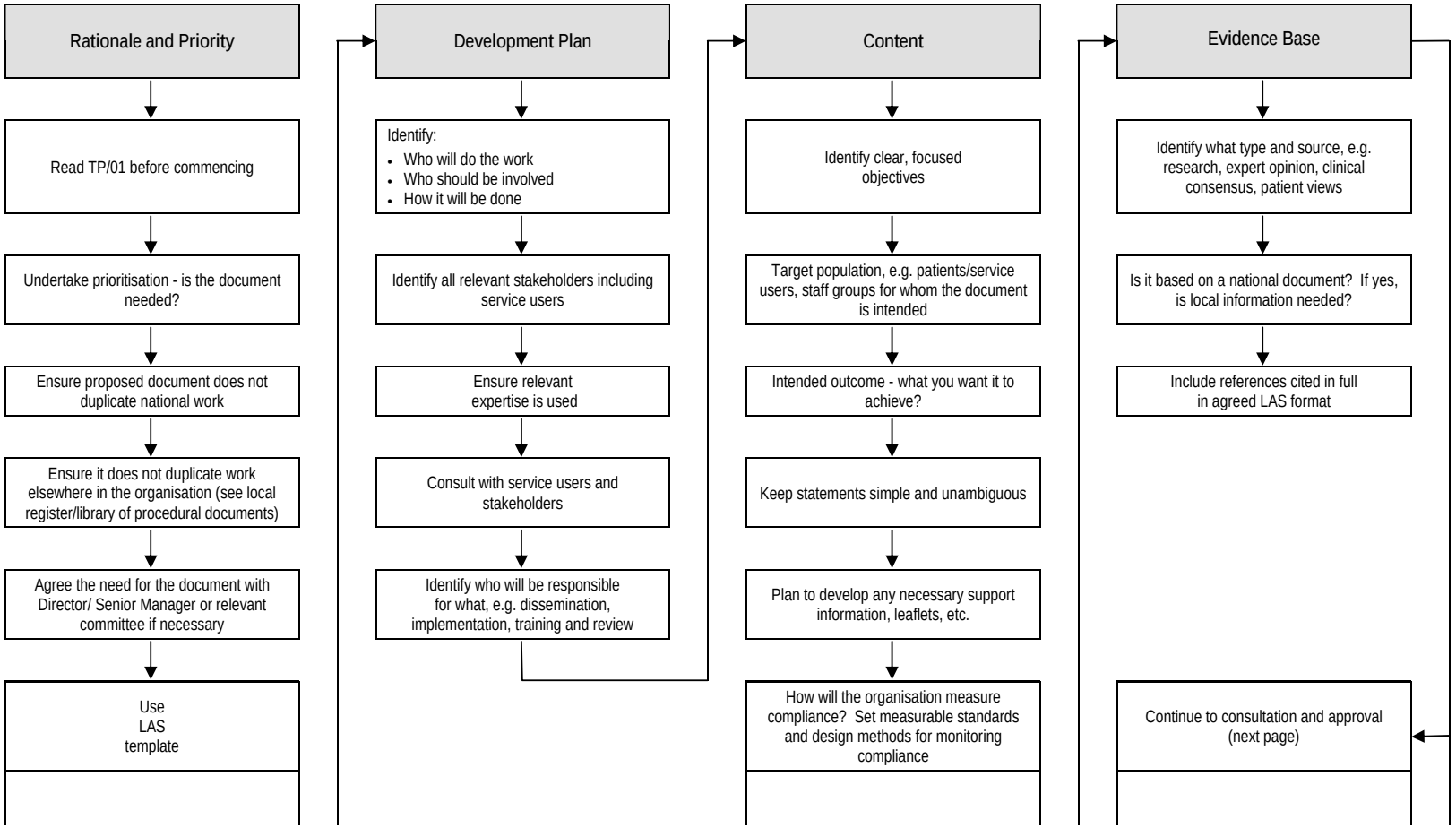
Type	Director/ Owner	Joint Consultation – Staff Council/ CH&SC	Approving Committee
Finance, Audit, Fraud	Director of Finance	No	SMG then Audit Committee
Non Health & Safety Risk including Assurance Framework, and legal	Director of Corporate Services	No	Risk Compliance and Assurance group then Audit Committee
Business Continuity, vehicle and equipment risks	Director of Finance		Audit Committee
Procedural documents which relate to clinical matters including infection control	Medical Director	Yes	Clinical Governance Committee Infection control policies and related procedural documents should be signed off by the Infection Control Group first.
IM&T and Information Governance including Records Management, Data Protection and Freedom of Information	Director of IM&T & Medical Director	No	Information Governance Group
A&E Ops, Control Services, PTS, Logistics	Director of A&E Operations	Yes	Senior Management Group (SMG)
HR, Training, Diversity	Director of HR & Organisation Development	Yes	Senior Management Group (SMG)
Health and Safety	Director of HR & Organisation Development	Yes	Corporate health and Safety Group
Complaints, SUIs	Deputy Chief Executive	Yes	Feedback Learning & Improvements Group then RCAG
Driving & care of Trust vehicles		No	Motor Risk Group
Emergency Preparedness	Director of A&E Operations	Yes	Emergency Preparedness Strategy Group
Other, not covered by above.	As appropriate	As appropriate	As appropriate

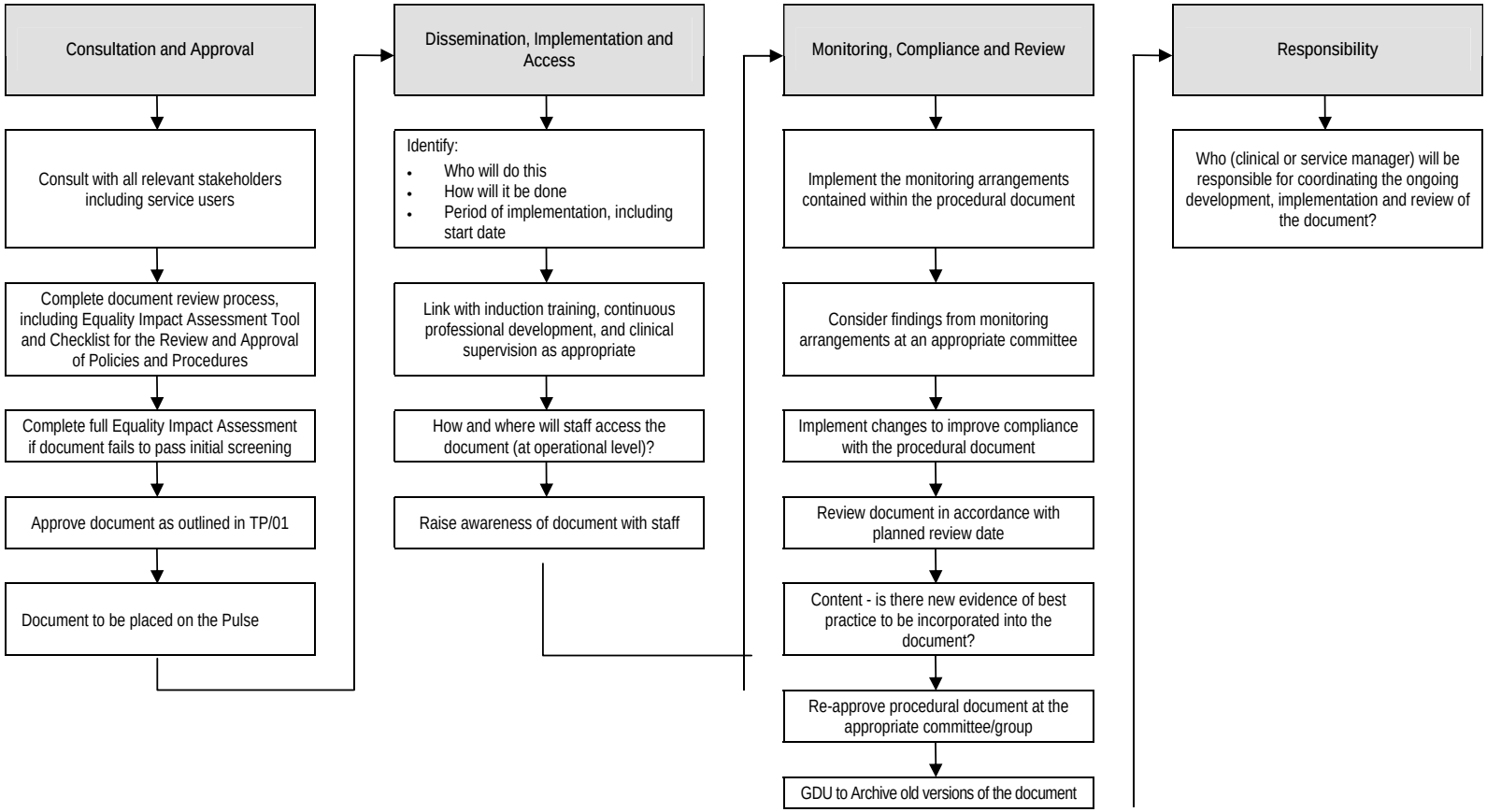
The approval route laid down in this table is applicable only to policies and procedures of the Trust. For all other procedural documents the approval process will be decided by the Director/senior manager sponsoring the document.

A few policies, such as Risk Management and Infection Control, will need to be approved by the Trust Board.

In some cases policies and procedures may also need to be ratified by a higher Committee/Group.

Flowchart for the Creation and Implementation of Procedural Documents Appendix 6




Consultation and Approval
Consult with all relevant stakeholders including service users
Complete document review process, including Equality Impact Assessment Tool and Checklist for the Review and Approval of Policies and Procedures
Complete full Equality Impact Assessment if document fails to pass initial screening
Approve document as outlined in TP/01
Document to be placed on the Pulse
Dissemination, Implementation and Access
Identify:
Who will do this
How will it be done
Period of implementation, including start date
Link with induction training, continuous professional development, and clinical supervision as appropriate
How and where will staff access the document (at operational level)?
Raise awareness of document with staff
Monitoring, Compliance and Review
Implement the monitoring arrangements contained within the procedural document
Consider findings from monitoring arrangements at an appropriate committee
Implement changes to improve compliance with the procedural document
Review document in accordance with planned review date
Content - is there new evidence of best practice to be incorporated into the document?
Re-approve procedural document at the appropriate committee/group
GDU to Archive old versions of the document
Responsibility
Who (clinical or service manager) will be responsible for coordinating the ongoing development, implementation and review of the document?

Appendix one
LA035

Equality Impact Form

Function/ policy being assessed: Policy and procedure for the development and management of procedural documents

Directory/ service or corporate function: Corporate Services

Date of assessment: 26/08/2009

Contact person for the assessment: Sandra Adams

Members of the assessment group: Laila Abraham & Sandra Adams

1. Aims of the function/ policy

To set the scope and framework for the development of all LAS policies, procedures, protocols, strategies and plans. This framework is viewed as essential for good risk management and governance and will form one of the risk categories assessed by the NHSLA at level 2.

2. Current achievements and fact finding

Sources of information used, with references, location or links. Anything you have learnt from previous consultation results with references or links. In particular any evidence you may have that impacts upon: **race, disability, gender, age, religion and belief, sexual orientation and human rights:**

No known impact from this policy however, as a framework for all procedural documents, it incorporates the EQIA and communication processes which need to be followed by all authors and owners of procedural documents in future and is therefore intended to redress the impact of previously styled policies and procedures, and to improve the quality of policy in line with best practice and equality legislation.

3. Assessment and actions needed

Initial ideas for actions can go here. You will refine them further at stage 6. Please note the impact assessment will not be accepted unless group(s) affected is listed with a link to the action required. Primary areas to consider are: **race, disability, gender, age, religion and belief, sexual orientation and human rights**

Barrier	Group affected	Action needed	Responsibility	Timescale	Resources
Built environment	N/A				
Location	Potential - those staff away from base locations	Ensure the policy is communic-ated effectively	All managers	October 2009	None specified
Information and communication	Disability; Dyslexia; Easy Read; Braille; Audio; Ethnicity eg where English is not the first language	To ensure that the document is accessible to all staff and can be provided in appropriate format on request	Director of Corporate Services; Head of Governance; Head of Records; GDU team	October to December 2009	Time – preparing documents for audio translation and other formats; Cost – producing alternative formats.
Customer care and staff training	To be confirmed	Awareness training and developing an understandi ng of the purpose and benefits of EQIA and monitoring	Equality & Inclusion team	December 2009 – February 2010	Within the E&I training plan
Timing	N/A				
Stereotypes and assumptions	N/A				
Costs of the service	To assess and	See adjacent	Head of Records; E&I	October 2009	To be confirmed

	confirm the costs of alternative formats		team		
Commenting, consultation	None specifically with groups	To be considered further	Director of Corporate Services; E&I team	October 2009	To be confirmed
Specific barriers	N/A				
Human Rights	There are no known risks of discriminati on with the implementa tion of this policy (see 2 above)				
Other	N/A				

5. Future consultation

The policy has been presented and discussed at the following committee meetings:
Strategic steering group – 15th July 2009
SMG – 9th September 2009 (approved)
It will be submitted to the Trust Board on 29th September 2009 for ratification.

Further consideration will be given to wider discussion about the implementation of the policy. It should be noted that this policy is intended to support the work of the Equality & Inclusion team in redressing the impact of previous policies and procedures and to improve the quality of policy in line with best practice and equality legislation.

6. Action plans, targets and priorities

Explain how the action plan will tie into service improvement plans, directorate action plans and local delivery plans

This policy is a core document within the NHSLA risk management standards for ambulance trusts and is intended to lead the development and improvement of the quality, format and consistency of Trust documents to ensure compliance with external requirements. The policy, and the actions identified in 4) above will feed into and support the SIP and will give local managers the guidance and framework they

need to provide high quality consistent documentation that supports Trust practice.

7. Monitoring and feedback

Details of how you will review action plans and progress. **All impact assessment action plans must be reported back internally and to the equality and diversity facilitators 6 monthly as a minimum.**

Implementation of the policy will be reviewed after 3 months (January 2010) and then fully in July 2010. It will also be subject to external review by the NHSLA assessor in October 2010. The Governance team will implement a programme of review of documents developed in the prescribed format to ensure it is workable locally. It should also be noted that there is consultation underway currently on the format of the EIA process and the approved format will be adopted within this policy.

8 Tell people what you are doing

Information on how you will publicise decisions, actions and service improvements. How will you make this available to the public?

Via RIB and The Pulse.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 29 September 2009

Document Title	SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE
Report Author(s)	Martin Brand, Head of Planning and Programme Management
Lead Director	Kathy Jones (Sponsoring Executive Director: Peter Bradley)
Contact Details	Service Development Department, Programme and Project Management Office
Aim	To update Trust Board on progress with the SIP

Key Issues for the Board

The report provides an update on progress in implementing the Service Improvement Programme (SIP2012).

It was agreed in September 2007 that a progress report would be presented to the Trust Board at every meeting.

Mitigating Actions (Controls)

See individual programmes and projects.

Recommendations to the Board

That the Trust Board:

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

Equality Impact Assessment

Has an EIA been carried out? (If not, state reasons)

SIP covered by Equality Impact Assessments and 26 March 2008 PPI event at The Oval

Key Issues from Assessment

See individual programmes and projects.

Risk Implications for the LAS (including clinical and financial consequences)

Not applicable overall – see individual programme and project updates for risks and issues.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

PPI – see comments under Equality Impact Assessment.

Corporate Objectives that the report links to

Delivery of the Service Improvement Programme (SIP2012) - 'A service that responds appropriately to all our patients'.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 29th September 2009

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Purpose

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

2. Approach to Performance Management of SIP 2012

The approach to performance managing the service improvement programme is based on tracking achievement of planned milestones. Using this approach the report consists of sections for each of the three sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A list of projects giving project progress status using a Traffic Light reporting system;
- A brief description of the live projects within the sub-programme concerned;
- A graphical representation of progress for each project focusing on planned milestone achievement.

Trust Board members are invited to raise any questions for programme lead directors to answer at the meeting.

3. Overview of programme structure

The structure of SIP2012 is as follows:

- *Clinical Development, Leadership and Workforce Programme* - led by the Deputy Chief Executive and focused on patients and staff, covering New Ways of Working, Organisation Development and People, Healthcare for London and new service development arising from Foundation Trust status;

- *Performance and Service Delivery Programme* - led by the Director of Human Resources and Organisation Development covering performance in its widest sense and the tangible infrastructure and operating systems which enable staff to provide patient care;

- *Preparing for the Olympics* - led by the Deputy Chief Executive.

There is also a supporting Stakeholder Engagement and Communications Strategy.

4. Exceptions

This section provides commentary on those projects (not individual milestones) identified as being of red status (i.e. not on track and cause for concern). This month there is only one project in this category, however it should be noted that several projects are of green status because they are in the process of being scoped, an activity which has itself been influenced by performance pressures diverting operational managers' attention.

Clinical Development , Leadership and Workforce Programme:

e-Learning project

- The lead developer has been pulled off the project to work elsewhere which has led to a cessation of work on the site. With the appointment of the e-learning manager the impact of this issue is less sever but there are still resourcing issues that will be examined by the e-learning manager as part of the review of the e-learning approach.

- Currently there are some problems with the Trust's IT infrastructure that is not able to fully support Moodle, the e-learning platform. This has meant that both off-the-shelf NHS packages and the externally developed Equality & Diversity module do not function sufficiently to be released. The team has agreed to test an external site to mitigate against these issues, so far this has been successful.

- Bandwidth speed and the absence of File Transfer Protocol (FTP) functionality within the Service has also slowed down the development work for the modules.

Corrective action

- The e-learning manager is now in post and is in the process of assessing the current situation in order to develop an action plan to unblock the issues with the development. By the next SMG meeting the e-learning approach and the associated action plan will have been developed and progress will recommence for the e-learning project. Until this has been developed, a recovery date cannot be assigned to the project.

5. Recommendation

That the Trust Board notes the progress made with the Service Improvement Programme 2012.

Kathy Jones
Director of Service Development

Inaugural Project E

WORK STREAM: PRODUCTION

Project Status Key:
- ✓ On track
- ! Not on track but under control
- ✗ Not on track and not in control

2009

MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

2010

JANUARY	FEBRUARY	MARCH

FIRST AND COMMUNITY RESPONDERS

PM:Chris Hartley Sharpe
PE: Martin Flaherty
Status: ✓

- 12 Community Responder schemes live
- 2nd Trainer recruited
- Community defibrillator and resuscitation will come under the initiative.
- Community responders dispatched from new single responder desk
- 18 live community responder schemes
- SPPP decision required
- Technical configuration changes for solo responders desk
- 21 live community responder schemes
- 24 community responder schemes live by 01.04.10
- A total of 48 schemes initiated by 01.04.10

HTA:Hospital Processes Project

Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Site visits complete (x8 hospital)
- Draft Report production
- Final draft of report produced
- Present report & action plan
- On-going local implementation by AOMs

HTA: Escalation matrix project

Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Deadline for Acute escalation policies
- Final cut-off deadline (Acute & FT)
- Start analysis of Escalation policies analysed
- Draft matrix & report
- Finalise report

HTA: Marketing & Communication Project

Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Marketing research complete
- Communication channels identified
- Stakeholder profile defined
- Communications Dept engaged.
- Finalised report

ROSTER REVIEWS

PM: Gary Hunt (supporting)
PE: Paul Gates
Status: ✓

- Agree milestones
- Initiate project board
- PID produced
- Review each station rota against ORH Recommendations
- Commence Rota Implementation

ANNUAL LEAVE

PM: Steve Sale
Status: ✓

- Project Board
- PID Produced
- Recommendation to A&E SMT
- Operation consultative forum agenda

RESOURCING TO ORH PLAN ACROSS 168 HOURS

PM: Gareth Hughes
PE: Richard Webber
Status: Being scoped

- Plan
- Area Plan
- Complex Presentation

MOBILE OFFICE

PM: Michael McGinn
PE: Jason Killens
Status: ✓

- Laptops selected
- Phase 1 trial starts
- Trial of two possible laptopns complete
- Final laptop chosen

31/08/09

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

WORK STREAM: DISTRIBUTION

Project Status Key:

- ✓ On track
- ! Not on track but under control
- ✗ Not on track and not in control

2009

MAY | JUNE | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | JANUARY | FEBRUARY | MARCH

PERFORMANCE OVERSIGHT

PM: Andy Heward

PE: Phil Flowers

Status: Being scoped

SINGLE RESPONDERS

PM: Jason Killens

Status: Being scoped

- East and South MRU desk operations merged (E/T Only
- Request CTAK changes via change
- Airwave goes live on MRU desk
- Trial new APL tracking at 100 metres or 1 minute refresh rate on MRU's
- Exploit full use of Airwave with new APL (tracking) with refresh Rate of 100 meters or 1minute
- 1. Dispatch staff rationalised to 1 paramedic 0630/1830, 1 Paramedic1130/2330 plus 1 EMD 24/7
- 2. Activation of CFR's, Co responders and static defibrillator sites transferred to single responders desk
- 3. Develop a dispatch protocol for static defibrillator sites
- 4. Develop an education piece for staff in EOC about what does not improve awareness of targets and action to deliver them
- 5. Switch CRU's from FREDA activation on codes similar to but not identical to PRU's
- 6. Develop performance management matrix for single responders within this work stream and ensure delivery of data from MI
- Develop automatic telephone dispatch system with automated message to all static defibrillator sites (similar to airport omni-crash system)
- 7. Develop an non-back-up regime for CRU/MRU despatch without automatic AEU backup
- 8. Investigate options for increasing frequency of CRU tracking updates
- 10. Programme MRU and CRU 'despatch walls' and input MPDS determinants re no back-up
- 9.Start static defib site project
- 11. Airwave feedback and improvements
- 12. Update briefing to be delivered to CFR teams

URGENT CARE DESPATCHING

PM: Paul Woodrow

Status: Being scoped

AMBULANCE ACTIVATION REDUCTION (30 SECONDS)

PM: Peter Mckenna

Status: Being scoped

FRU ACTIVATION REDUCTION (15 SECONDS)

PM: Jon Knott

Status: Being scoped

ACTIVE AREA COVER

PM: Andy Heward

PE: Paul Webster

Status: Being scoped

- PID Completed
- Baseline
- Initial Trajectories completed and
- Revised Monthly targets Released
- 8000AAC Deployments per Month
- Review AAC allocation
- 9000AAC Deployments per Month

REST BREAKS

PM: Andy Heward

PE: Paul Webster

Status: Being scoped

- PID Completed
- Baseline
- Initial Trajectories completed and
- Revised Monthly targets Released
- 50% resource allocated Rest Breaks
- 60% resource allocated Rest Breaks
- 70% resource allocated Rest Breaks
- Review rest break allocation

31/08/09

WORK STREAM: INFRASTRUCTURE

Project Status Key:
- On track
- Not on track but under control
- Not on track and not in control

2009

MAY | JUNE | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | JANUARY | FEBRUARY | MARCH

VEHICLE FLEET PROCUREMENT
PM: Nick Pope
PE: Chris Vale
Status:

Completed PTS Bariatric vehs
25 Vehicles delivered
Completed PTS Bariatric vehs

Event Control Rooms
Project Executive: Jason Killens
Project Manager: Andrew Zogbi
Status:

IM&T Specs costed for
Business Case finalised for Presentation and approval

LOGISTICS & FLEET REVIEW
PM: Chris Vale
PE: Richard Webber
Status: Being scoped

Paper Produced

EMERGENCY PREPAREDNESS REVIEW
PM: John Pooley
PE: Jason Killlens
Status: Being scoped

NEW WORKSHOP COMMISSIONING
PM: Chris Miles
PE: Chris Vale

Project Has been running for 2 years and Reporting under CPG

Agree design and
Agree specification of
Staff agreement to pay and
Staff Agreement to shift rosters
Communication of new working arrangements to all fleet and operational staff
Agree design and layout
Mobile workshop
Staff Agreement to shift rosters

Control Rooms
PM: Andrew Zogbi
PE: Martin Flaherty

Project Brief Produced
Inaugural Project Board Meeting
Stage 1 plan produced

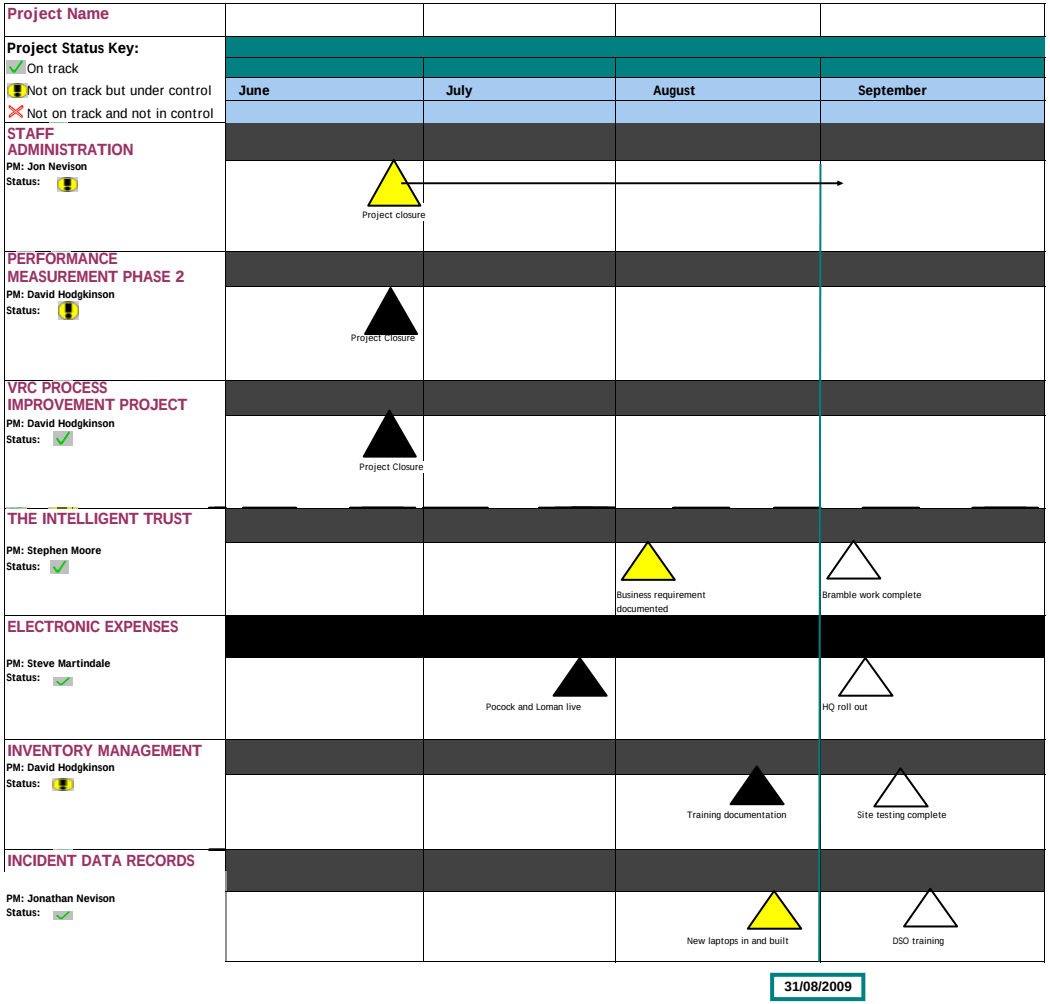
REAL TIME FLEET M/INFO
PM: Chris Miles
Status:

Training
Testing
Implementation
Post Implementation Review

31/08/09

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

Corporate Processes Governance Project Portfolio - Schedule Summary



Legend

- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage - requires intervention

FOUNDATION TRUST APPLICATION PROGRAMME - MAJOR MILESTONES

PROJECT STATUS KEY:
- On track
- Not on track but under control
- Not on track and not in control

2008: SEPT | OCT | NOV | DEC | JAN | FEB | MARCH | APRIL | MAY

2009: JUNE | July | Aug | Sept | Oct | Nov | Dec | Jan

FINANCE
Workstream Lead: Reuven Vazan
Status:

GOVERNANCE & MEMBERSHIP
Workstream Lead: John Wilkins
Status:

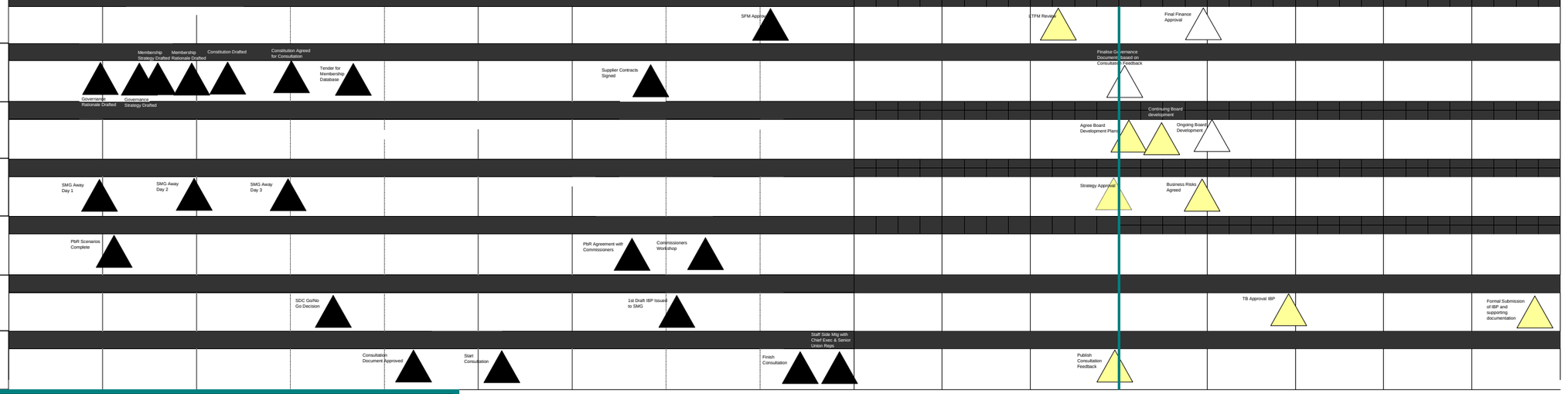
WORK FORCE DEVELOPMENT
Workstream Lead: Caron Hitchens
Status:

BUSINESS STRATEGY & MARKETING
Workstream Lead: Stewart Chandler
Status:

COMMISSIONER ENGAGEMENT
Workstream Lead: Stewart Chandler
Status:

BUSINESS PLAN
Workstream Lead: Kerrie Martsch
Status:

CONSULTATION & COMMUNICATION
Workstream Lead: Angie Patton
Status:



Legend

- Awaiting approval
- Planned milestone
- Milestone Achieved
- Minor Slippage but under control
- Critical Slippage - requires intervention

-

PROGRAMME PROGRESS REPORT FOR LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

PROGRAMME: London 2012 Olympic and Paralympic Programme

REPORTING PERIOD: 12/08/09 – 08/09/09

PROJECT STATUS SUMMARY: **6** ▲ **0** ▲ **0** ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

Programme Summary

The following projects are currently live:

Olympic Programme: Tranche 2	
Operational Planning (Alan Palmer)	▲
Workforce (Sandy Thompson)	▲
Skills Acquisition (Alan Taylor)	▲
Infrastructure and Support (Anna Kilpin)	▲
Communication and Involvement (Sandy Thompson)	▲
Commissioning Process (Anna Kilpin)	▲

OVERVIEW OF OLYMPIC PROGRAMME TRANCHE 2 PROJECTS

T2P1: Operational Planning
Project Executive: Peter Thorpe; Project Manager: Alan Palmer/Lewis Tasker
This project is focused on the operational components of LAS Olympic and Paralympic Games preparations. Incorporated in this project is the development of the Operational Plan and associated Contingency Plan for the London 2012 Olympic and Paralympic Games. Also encompassed within this project is the development of plans for implementation during the construction phase. A key area of focus will be the modeling of demand: in the Olympic and Paralympic venues, in relation to cultural events during the lockdown period, and that attributable to the 'Olympic effect' on London. The creation of the LAS Scenario Testing and Exercise Programme (STEP) sits within this project, and LAS participation in external STEP activity.

T2P2: Workforce
Project Executive: Peter Thorpe; Project Manager: Sandy Thompson
This project is focused on the refinement of workforce numbers and groups building on the work undertaken in Tranche 1. In response to the demand modeling undertaken in T2P1, this project will explore the supply options, considering Voluntary Aid Services, private providers, first responders etc, and determine how the LAS will meet the demand on its workforce during the Olympic and Paralympic Games. In addition, gold and silver officers will be 'selected' and a 'selection process' for the other staff groups required will commence.

T2P3: Skills Acquisition
Project Executive: Anna Kilpin; Project Manager: Alan Taylor
This project will build on the work undertaken in the Tranche 1 Clinical Skills Acquisition/Training Project further refining the areas where additional skills will be required for the Olympic and Paralympic Games. Operational, event management and clinical skills will be explored within this project. Furthermore, consideration of other training needs will occur with identification of the preferred mode/s of training provision and commencement of the skills acquisition programme.

T2P4: Infrastructure and Support
Project Executive: Peter Thorpe; Project Manager: Anna Kilpin
This project is comprised of three areas: Information Management and Technology (IM&T), Estates and Operational Support. Fundamental to the project is the development of additional event control capacity for the Olympic and Paralympic Games and the building/refurbishment of an Olympic complex. This will include the identification of sites for both, the building and equipping of the event control (including IM&T functionality) and the production of detailed plans for the Olympic complex. Also incorporated in the project are the finalisation of vehicle numbers/types and the commencement of any procurement / tendering process required.

T2P5: Communication and Involvement
Project Executive: Anna Kilpin; Project Manager: Lewis Tasker
This project focuses on communication with and involvement of staff, local communities and patients/public in London, including the development of a Stakeholder Management Strategy and a Communication and Engagement Strategic Plan. This project will oversee and co-ordinate the communication activity across Tranche 2 ensuring a joined-up and streamlined approach.

T2P6: Commissioning Project
Project Executive: Peter Thorpe; Project Manager: Anna Kilpin
This project has been introduced to oversee the production of the OIAMB outline business case and the subsequent commissioning process with NHS London and Richmond/Westminster PCT (i.e. lead PCT commissioner).

LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

Project Status Key:
- ✓ On track
- Not on track but under control
- ✗ Not on track and not in control

2009

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
T2P1: OPERATIONAL PLANNING **Project Executive: Peter Thorpe** **Project Manager: Alan Palmer** **Status:** ✓	Complete project initiation	Approach to LAS involvement in external exercising and testing	Venue specific contingency plans for construction phase v.1 Influencing of external exercising/ testing programmes commenced	Olympic effect - urban domain (core:999 calls): modelling profile Event demand in urban domain during lockdown period v.1	Olympic venue demand: modelling profile		LAS Command and Control structure designed Initial understanding of of special operations requirements (e.g. CBRN/HART)		Complete end stage review + scope next stage			
T2P2: WORKFORCE **Project Executive: Peter Thorpe** **Project Manager: Sandy Thompson** **Status:** ✓	Complete project initiation	Staff engagement strategy agreed *(request for change)*					Process for identifying gold/silver	Feasibility/role of private providers/ VAS/volunteers/ co + 1st responders All LAS workforce/ groups/nos identified (options appraisal v.1) HR issues relating to LAS staff	High level support structure for staff identified Decision regarding use of mutual aid Complete end stage review + scope next stage co+1st responders		HR issues with regard to mutual aid identified and Action Plan produced Identification of policy change required Olympic Specific Staff engagement plan produced (inc. specification for reward and recognition scheme)	
T1P3: SKILLS ACQUISITION **Project Executive: Anna Kilpin** **Project Manager: Alan Taylor** **Status:** ✓	Complete project initiation				Content of Olympic skills acquisition programme further refined Consideration of scope for skills acquisition re paralympians 2012 requirements current LAS provision: gap analysis	Authority to recruit an additional Training Officer for e-learning Authority to recruit an additional Training Officer to develop training packages End of stage review and scope next stage		Fully scoped approach for training delivery e.g. train the trainer? Commencement of training/educational session development	Approach for LAS provision of training for mutual aid (including overseas) Approach for LAS provision of training for volunteers		Timetable for *all* Olympic training required Timetable for training training the trainers (if preferred approach)	Timetable for induction/training provision for mutual aid Timetable for induction/training provision for volunteers End of stage review and scope next stage
T1P4: INFRASTRUCTURE AND SUPPORT **Project Executive: Peter Thorpe** **Project Manager: Anna Kilpin** **Status:** ✓	Complete project initiation Decision re: bespoke event control and outline brief Decision re: superstation and outline brief	Start search for 'event control' OR site for displaced staff Start search for for Olympic complex	IM&T high level requirements and main planning assumptions	IM&T baselining Final agreement reached re: vehicle types & additional key equipment needed	Requirements analysis Agree funding streams: A&E fleet End stage review/ scope next stage		Site identified for event control or displaced staff Gap analysis and option analysis	Risk and priority analysis	Commence tendering for vehicle framework		Specification, procurement, secure internal resource	Site identified for complex End stage review and scope next stage
T1P5: COMMUNICATION AND INVOLVEMENT **Project Executive: Anna Kilpin** **Project Manager: Lewis Tasker** **Status:** ✓	Complete project initiation Clarify definitions: staff, local community and patients/public	Write Tranche 2 Communication & Engagement Strategic Plan inc. key messages Review of Transfer of Knowledge: v.2 Write Stakeholder Management Strategy: v.2	Timetable/plan for involvement of, and engagement with staff - Tranche 2 Timetable/plan for involvement of, and engagement with, local community, patients/public Produce Strategic Plan for liaison with other UK ambulance services			Determine scope for development of community defibrillators for Olympics Complete end stage review + scope next stage	Establish initial contact (Olympic specific) with LINks within boroughs	Determine scope of LAS teams e.g. Events & Schools teams re: Health Promotion	Carry out EIA for Olympics/Paralympics			Complete 2nd Staff Survey
T1P6: COMMISSIONING PROCESS **Project Executive: Peter Thorpe** **Project Manager: Anna Kilpin** **Status:** ✓ OIAMB Business Case Development + LAS Programme alignment with 2012 Safety and Security Strategy *						Complete project initiation Initial scoping meeting with OSD Meet with OSD to review LAS submission to CSP + LAS Programme (re) aligned with 2012 Safety and Security Strategy *	OIAMB Business Case v1 submitted to NHSL/R&TPCT + Challenge process: NHSL/ R&TPCT complete + OIAMB Business Case v2 submitted to NHSL/R&TPCT /DH +		Conduct End Project Review			

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

PROGRAMME PROGRESS REPORT FOR CLINICAL DEVELOPMENT, LEADERSHIP & WORKFORCE

PROGRAMME: CLINICAL DEVELOPMENT, LEADERSHIP AND WORKFORCE PROGRAMME

REPORTING PERIOD: 12/08/2009 – 09/09/2009

PROJECT STATUS SUMMARY: 9 ▲ 4 ▲ 1 ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

Programme Summary

The following projects are currently live;

Organisation Development & People – Tranche 1	
Performance Management Framework (Steve Sale)	▲
Talent Management (Johnny Pigott)	▲
E-learning (Raja Habib)	▲
Learning Management Systems (Johnny Pigott)	▲
Organisation Development & People – Tranche 2	
Standards of Student paramedic Education (Gill Heuchan)	▲
FRU Role (Steve Sale) – being scoped	▲
Staff Well-Being (Fatima Fernandes)	▲
Staff Engagement (Kelly O'Brien)	▲
New Ways of Working	
Clinical Leadership (Jane Worthington)	▲
Leadership Development (Jo Anthony)	▲
Team based working (Hazel Smith)	▲
Communications (Alex Bass)	▲
Healthcare for London	
Stroke (Nick Lawrance)	▲
Major Trauma (Claire Garbutt)	▲
Referral Pathways (Grenville Gifford)	being scoped
Directory of Clinical Services (Grenville Gifford)	being scoped

OVERVIEW OF OD & PEOPLE PROJECTS – Tranche 1

Recruitment & Induction - project closed
Project Executive: Ann Ball Project Manager: Jo Davis

This initiative will revise the recruitment process to enable the organisation to assess and recruit candidates for values, attitudes and behaviours. This project will also help LAS to deliver diversity targets for achieving a more representative workforce and insuring fairness and equity for all candidates. The induction process will also be revised to reflect these same themes.

Leadership Development - project closed
Project Manager: Jo Anthony

This initiative is to establish and support new styles of leadership at all levels underpinned by the right skills; through continuing the current leadership programmes available and developing new leadership programmes. The programme will be comprised of a number of courses and qualifications aimed at specific groups within the organisation to support both the NWoW and OD & People Programmes.

Individual Performance Management
Project Executive: Ann Ball Project Manager: Steve Sale

The aim of this initiative is to develop a comprehensive performance management process that is accepted and used by all staff members. This performance management framework will enable all staff to accept responsibility and accountability for their personal performance, rewarding and recognising good performance, whilst identifying and supporting staff with poor performance, and where necessary enabling appropriate exit strategies.

Workforce Re-Configuration – project closed
Caron Hitchen

The aim of this initiative is to develop the workforce plan that supports the Operational Model and implements a staff profile that is representative of the population of London.

Modularised Training – project closed
Project Manager: Keith Miller

The aim of this initiative is to provide all staff with access to appropriate professional development through training and development packages delivered through a variety of media. There are currently three training modules in operation with the intention to develop a number more, prioritised by clinical need.

Talent Management
Project Executive: Bill O'Neill Project Manager: Johnny Pigott

The aim of this initiative is to provide a clear career development framework for all staff that allows staff to progress their career according to their choice and their own pace, whilst recognising and providing the opportunity for talented staff, anticipating and targeting opportunities for talented individuals and ensuring equality of access.

Staff & Union Engagement - project closed
Project Manager: Tony Crabtree

The aim of this initiative is to gain general staff and union understanding of, and constructive engagement with, the management of LAS. The project will deliver the principles of partnership working as well as the consultative framework in which management and the unions will work

together.

Training Restructure – project closed
Bill O'Neill

The aim of this initiative is to restructure the clinical education part of the department to meet the following requirements:

- greater emphasis on front-line staff's clinical development and continuing professional development than is currently the case
- facilitating the proposed changes to the workforce profile and skill mix; the main focus will move to paramedic development
- an enhanced internal capacity for upskilling EMTs, and developing existing EMTs to Paramedic level (bearing in mind the anticipated increase in the academic standing of the paramedic award from certificate to diploma), and in upskilling existing paramedics to the new standards of proficiency.

E-Learning
Project Executive: Bill O'Neill Project Manager: Johnny Pigott

The aim of this project is to develop e-learning modules that complement the modularised training modules currently being developed for class room delivery, enabling the training department to offer a blended approach to delivery of these modules. The project will also develop an appropriate platform from which these modules can be accessed and delivered. Modules include;

- 12 – Lead ECG
- Obstetrics
- Mental Heath
- Diversity
- Major Incidents

Team Briefings - being re-scoped to be included within the team working project
Project Executive: Project Manager: Alex Bass

The aim of this initiative is to explore the use of a team briefing system within the corporate services department. The system would be a face-to-face briefing from the senior manager to staff, to disseminate corporate information, discuss local issues, and feedback any issues centrally. The intention of the project is to provide a flexible framework for individual services to adopt and tailor for best fit.

Learning Management Systems
Project Executive: Greg Masters Project Manager: Johnny Pigott

The aim of this initiative is to develop a learning management system solution to enable both clinical and corporate training to be captured and managed through an electronic learning management system. This system will record, manage and flag up training / professional certification needs.

Workforce Plan Implementation – project closed
Project Manager: Ann Ball

The project is stage 2 of the workforce re-configuration with the scope to recruit 350 student paramedics by 31st of March, and deliver the student paramedic course. The project has been split into three mainstreams, the sourcing and operationalisation of additional external training facilities, the recruitment of the 350 staff, and the running of the student paramedic training course.

OVERVIEW OF OD & PEOPLE PROJECTS – Tranche 2

Standards of Paramedic Education
Project Manager: Gill Heuchan

This long-term initiation will transform the LAS's aspirations to deliver all pre-registration paramedic training to Diploma / Foundation Degree level from the current position. It will do this by using a combination of accredited work based modules and Higher Education Institute programmes.

FRU Role
Project Manager: Steve Sale

This initiative will deliver a new role into the Service that will operate FRUs with advanced clinical assessment skills to provide greater flexibility for the response to patient needs. This will most likely take the form of a pilot to examine its impact for patients but also across the service, before extending the roll out.

Workforce Deployment Model
Project Manager: Steve Sale

To achieve the most efficient and effective utilisation from the new skill mix in order to provide appropriate clinical response through;

- Matching the right clinical skills and numbers
- To the agree vehicles resource (via the Operational Response)

KSF / PDR Project
Project Manager: KSF Manager

The objective of this project is to support the overall Trust re-launch of the KSF / PDR process through;

- Developing the LAS approach to KSF / PDR process that can be consistently used by all departments for all staff through a diagnostic, pilot phase and evaluation
- Providing the mechanism, best practice, policy and support to begin the roll out the LAS approach to the KSF / PDR throughout the organisation within 8 months

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Staff Engagement
Project Manager: Kelly O'Brien

The aim of this initiative is to understand and response to the results of the staff survey and ensure that the views and feelings of staff are recognised, thereby improving engaging with all staff members.

Staff Well Being
Project Manager: Fatima Fernandes

This project will contribute to the cultural change of the LAS where staff well-being is a priority and staff feel valued. It will develop an overarching well-being strategy and implementation plan that will be piloted within a number of departments to measure its effectiveness before a Trust wide roll out.

Team Working
Project Manager: Bill O'Neill (to commence scoping)

The aim of this initiative is examine the current team working arrangements in corporate service, and learning lessons from NWoW examine where team working can be improved in order to improve organisational effectiveness and staff working.

The scope of this project will now include team briefings as this will be an important enabler for delivering a number of the team working concepts.

Training for Challenging
Bill O'Neill

The aim of this initiative is to develop and provide the full range of training and development for training for all staff to support providing and receiving 360 challenge, which addresses both professional and personal challenge.

Review of LAS Identity
Bill O'Neill

The objectives of the project are twofold;

- To review the use of rank markings within the organisation and its effect on internal relationships.
- To understand the impact of the LAS uniform upon the patients within the general public.

OVERVIEW OF NEW WAYS OF WORKING PROJECTS

Clinical Leaderships
Project Manager: Jane Worthington

This project aims to identify the clinical training requirements in order to achieve a fully trained staff base (including management) on New Ways of Working Complex sites.
Initially a training need analysis will be performed manually, based on information provided by IM. This will then be analyzed to develop training development plans for each member of staff, in conjunction with the Team Based Working project and Non-clinical Training Needs Analysis project and integrated with local clinical requirements

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Leadership Development
Project Manager: Jo Anthony

Major change, such as New Ways of Working, requires highly effective leadership and this project aims to align the management on each Complex with the requirements and intent of NWoW. Capacity and capability will be assessed on each Complex and identified development areas will be addressed. This might take the form of formal training, 1-1 coaching and feedback or team development work, as well as making recommendations for the ideal configuration of the individual management teams. Psychometric analysis and preference auditing will further inform this work and assist in creating a benchmark for ideal management/leadership skills. The project will also respond to any identified non-clinical development required for staff on Complex – e.g.: chairing forum meetings.

Team Based Working
Project Manager: Hazel Smith

This project involves working with staff and management at New Ways of Working Complexes in the formation and development of a team based working environment. Fundamental to this will be the need to move away from fixed rota systems towards more flexible working practices. Teams will be created and given the responsibility for providing the cover required to meet demand along with organisational objectives. The creation of teams and development of a team based working environment will enable communication and access to training/development to be improved and more focused. A teamwork culture will also be beneficial to the organisation in terms of improved attendance and performance.

Communications
Alex Bass

The NWoW Communications strategy has been developed by the communications department. It is currently awaiting feedback from Senior Management.
The communications strategy aims to integrate with other projects and form a holistic approach to communications to and from NWoW Complex staff and Complex / senior management.

OVERVIEW OF HEALTHCARE FOR LONDON PROJECTS

Stroke
Project Executive: Kathy Jones **Project Manager: Nick Lawrance**

The aim of this project is to scope, develop plans for implementation and respond to the regionalization of stroke services requiring LAS crews to convey FAST positive patients directly to one of eight hyper-acute stroke units in London.

Major Trauma
Project Executive: Kathy Jones **Project Manager: Claire Garbutt**

The aim of this project is to scope the implications of the regionalisation of trauma care in London for the LAS, and ensure we are best placed to effectively respond to the service changes. This will require LAS crews to identify, and convey major trauma patients directly to one of four major trauma centres in London.

Referral Pathways
Project Executive: Kathy Jones **Project Manager: Grenville Gifford**

Documented alternative and referral pathways were introduced from 2007 – 2008 as a project within the Operational Model programme however statistical evidence indicates that take up and the consequent reduction in traditional A&E conveyance has not yet been realised.

The objective of this project is to deliver increased and sustained utilisation of alternatives to A&E conveyance that is clinically safe and that aligns both with patients' expectations for treatment at home or in the community and needs of the service to improve efficient use of resources.

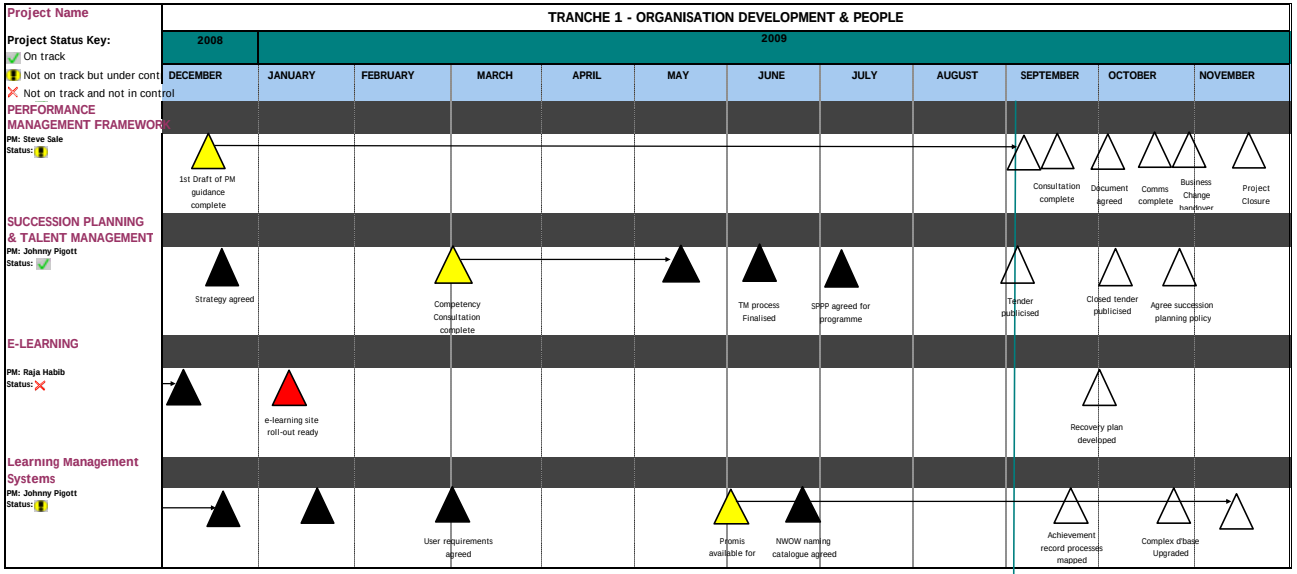
The approach shall be to identify and remove barriers to greater utilisation, to build crews confidence to select alternatives and where necessary to adapt the pathway's parameters to align with prevailing needs of both the service and patient.

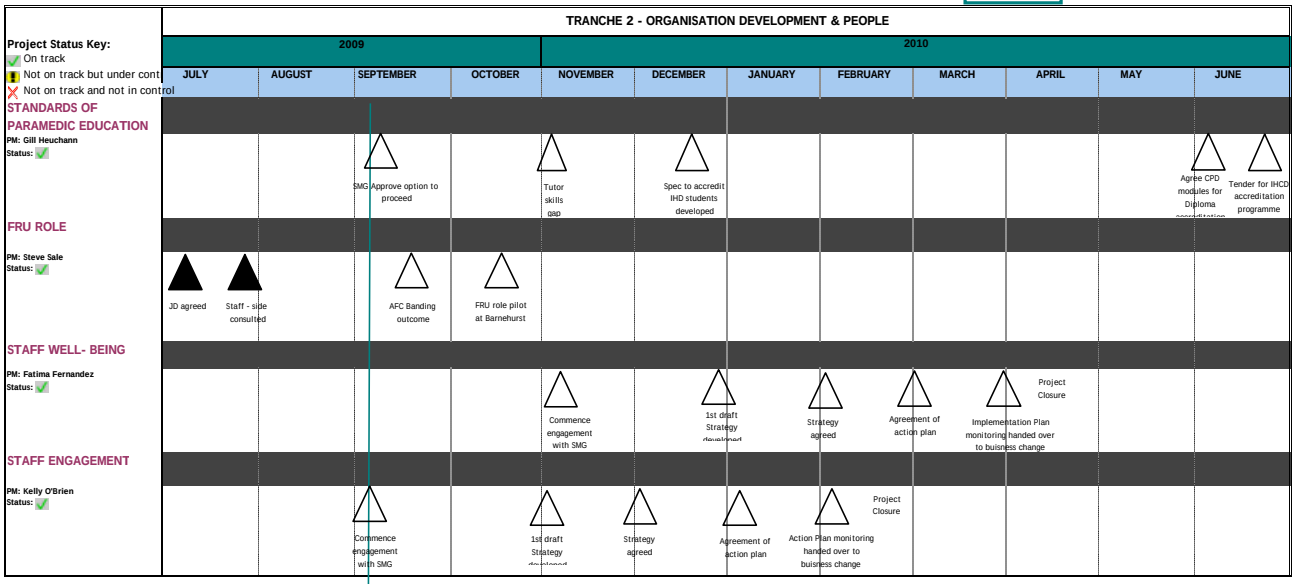
Directory of Clinical Services
Project Executive: Kathy Jones **Project Manager: Grenville Gifford**

As well as collecting and collating real time data about hospital capacity there is an emerging need to assess and track the capability and capacity of clinics and clinical services offering an alternative care pathway to those offered at A&E departments. For A&E departments this is currently done by EBS, which in liaison with acute trusts prepares and disseminates London Critical Capacity information, reflecting pressure on emergency treatment services at A&E departments across London to inform conveyance decisions. To extend the service will involve collecting and collating capacity data from a much larger number of service providers.

The purpose of the project is to identify and implement a computerized system to streamline this administrative task that will support reliable operational decision making with accurate, up to date and comprehensive management information.

ORGANISATION DEVELOPMENT AND PEOPLE - Workstream Summary

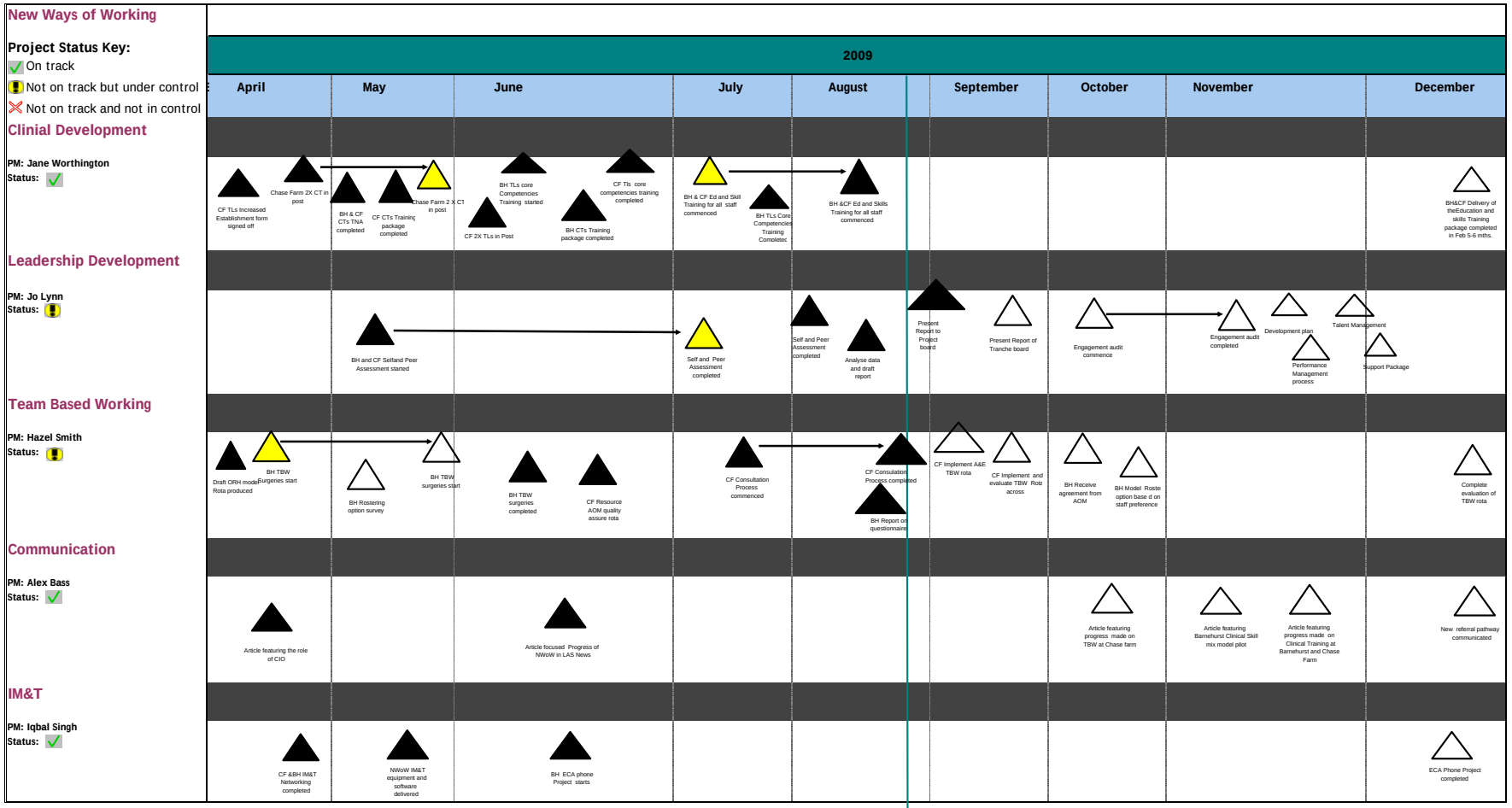




Legend

- Planned mileston
- Milestone achieve
- Minor slippage but under contr
- Critical Slippage- requires interventio

New Ways of Working - Schedule Summary



Legend

- Planned Milestone
- Milestone slipped
- Minor slippage but under control
- Critical Slippage - requires intervention

Barnehurst Milestones Report

Barnehurst New Ways of Working

Project Status Key:

- On track
- Not on track but under contro
- Not on track and not in control

2009

March | April | May | June | July | August | September | October | November | December | January | February

Complex Estates Strategy

PM: Mark Hales
Status:

- Woolwich Estates Work Completed
- St. Paul's Crays Estates work commenced
- St . Paul's Crays Estates work completed
- Barnehurst Estates Business Case Drafted
- Barnehurst Estates Scoping exercise
- Barnehurst Estate Business Case first Draft completed

Clinical Development

PM: Jane Worthington
Status:

- CT shortlisting
- 1 X CT interview
- CT Assessment
- TNA information collated
- 2 X CTs in post
- CTs development delivered
- TLs Core competency delivered
- All staff Ed & Skills Training Commenced

IM&T Project

PM: Iqbal Singh
Status:

- Monitor /Audit for 3-6 months
- Analysis results

ECA Phones

PM: Darren Farmers
Status:

- IM&T agreed to upgrade all ECA Phones
- IM&T agreed to upgrade all ECA Phones
- Audit form signed off
- Pre-Programme phones
- Agreed Referral Pathways numbers
- Audit form signed off
- Notify Spirit billing project of audit start date.
- Agree audit Process
- Develop audit pack
- Handover and unblock phones
- Maintain a database with all staff numbers
- Mid Audit review
- Analysis of the audit
- Draft report
- Audit 3-6 months

Leadership Development

PM: Jo Lynn
Status:

- Peer and Self Assessment
- Peer and Self Assessment
- Analysisk of the Results
- first draft Report completed

Team Base Working

PM: Hazel Smith
Status:

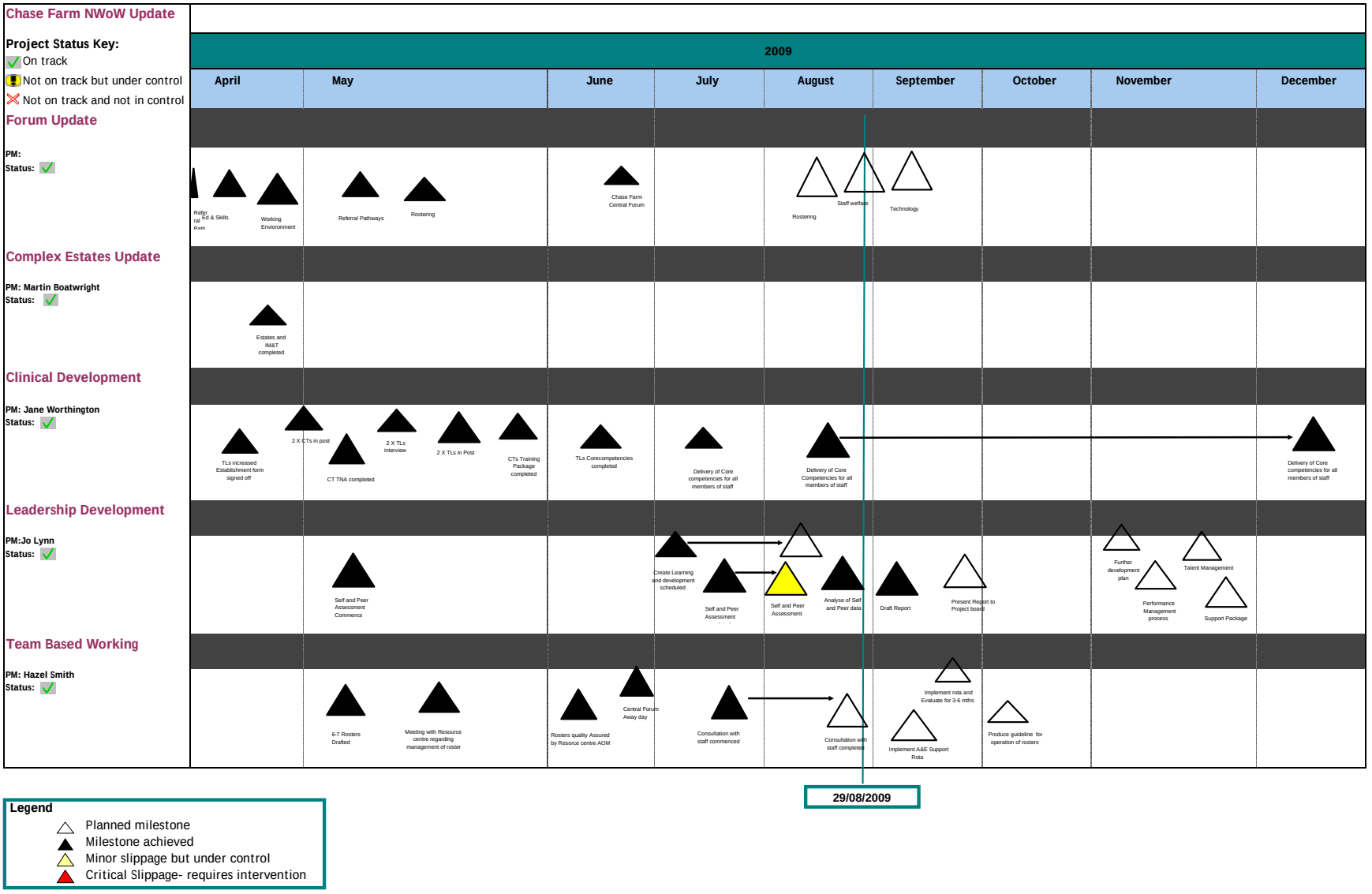
- TBW Surgeries completed across all three
- Questionnaires on staff roster option circulated to all staff.
- TBW Surgeries completed
- Questionnaire on staf f Roster options Returned
- Questionnaire on staf f Roster options Returned
- Evaluate Results
- Draft Report
- Model Roster option St. Paul's Crays
- Conduct SWOT Analysis
- Rostering AOM quality Assure Rota

29/08/2009

Legend

- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

Chase Farm - Schedule Summary



HEALTHCARE FOR LONDON - Workstream Summary

Project Status Key:
- On track
- Not on track but under control
- Not on track and not in control

	2009						2010					
	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	AUGUST	SEPTEMBER
STROKE PM: Nick lawarance Status:		Comms plan developed		Transition Plan agreed			Full Implmentation Plan agreed					
MAJOR TRAUMA PM: Claire Garbutt Status:	Development of training plan agreed	Comms plan developed	Trauma database developed	Start team leader training	Start all staff training		Complete team leader training	Agree transition plan for Phase 2	All staff trained	Phase 1 - Go Live		
DIRECTORY OF CLINICAL SERVICES PM: Grenville Gifford Status: being scoped												
REFERRAL PATHWAYS PM: Grenville Gifford Status: being scoped												

09/09/2009

Legend
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

PROGRAMME PROGRESS REPORT FOR PERFORMANCE AND SERVICE DELIVERY PROGRAMME

PROGRAMME: Performance and Service Delivery Programme

REPORTING PERIOD: Period End 01 September 2009

PROJECT STATUS SUMMARY: 29 ▲ 11 ▲ 0 ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

PROGRAMME SUMMARY

Workstream 1 – Technology	
CAD2012 (Nick Evans)	▲
Data warehouse (James Cook)	▲
LARP (Rony Zaman) (London Ambulance Radio Project)	▲
PTS system upgrade (Robert Utchanah)	▲
TEASHIP (Grenville Gifford) (Text Emergency Access for Speech or Hearing Impaired People)	▲
e-PRF	▲
Workstream 2 – A&E Capacity Production	
First and co-responders (Chirs Hartley-Sharpe)	▲
Hospital turnaround projects (Helen Lew)	▲
Roster reviews (Gary Hunt)	▲
Annual leave (Steve Sale)	▲
Resourcing to ORH plan across 168 hours (Gareth Hughes)	▲
Mobile office (Michael McGinn)	▲
Workstream 3 - A&E Resource Distribution	
Performance oversight (Andy Heward)	▲
Single responders (Steven Kime)	▲
Urgent care despatching (Paul Woodrow)	▲
Ambulance activation reduction (30secs) (Peter McKenna)	▲
FRU activation reduction (15 secs) (Jon Knott)	▲
Active area cover (Andy Heward)	▲
Rest breaks (Andy Heward) 10/06/2009- 08/07/2009	▲

Workstream 4 – A&E Infrastructure	
Vehicle fleet procurement (Nick Pope)	
Event control rooms (Gary Hunt)	
Logistics and fleet review (Chris Vale)	
Emergency preparedness review (John Pooley)	
New workshop commissioning (Chris Miles)	
Control rooms (Andrew Zogbi)	
Real time fleet management information (Chris Miles)	
Workstream 5 – Corporate processes	
Staff administration (Jonathan Nevison)	
Performance measurement phase 2 (David Hodgkinson)	
VRC process improvement (David Hodgkinson)	
The Intelligent Trust (Stephen Moore)	
Electronic expenses (Steve Martindale)	
Inventory management (David Hodgkinson)	
Incident data records (Jonathan Nevison)	
Workstream 6 – Foundation Trust and corporate governance development	
Finance (Reuven Vazan)	
Governance and membership (John Wilkins)	
Business strategy and marketing (Stewart Chandler)	
Commissioning engagement (Stewart Chandler)	
Business Plan (Kerrie Martsch)	
Workforce development (Caron Hitchen)	
Consultation and communication (Angie Patton)	

OVERVIEW OF ACCESS / CONNECTING for HEALTH WORKSTREAM

CAD 2010
Project Manager: Nick Evans

The purpose of this project is to replace the core Call Taking and Dispatch capabilities within Control Services, including replacement or development of any interfaces with existing systems, applications or services.

Data Warehousing
Project Manager: James Cook

Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse information. Information is not available from outside the LAS network and therefore it is not accessible to our partners and stakeholders.

To address these issues a data warehouse will be developed that stores LAS data. Eventually this data warehouse will encompass the whole of the LAS, including A&E and PTS data, resources, fleet, finance, estates, staff, recruitment and more. This project is the first step towards that goal and will limit the scope of its data to A&E data and vehicle manning and availability.

LARP (London Ambulance Radio Project)
Project Manager: Rony Zaman

As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable radios, EOC / UOC dispatcher equipment and the integration with CTAK.

PTS System; Meridian Mobile Technology
Project Manger: Robert Utchanah

The intension of this project is to introduce handheld information terminals to build upon the functionality of the upgraded Meridian booking, billing and management reporting system used to support Patient Transport Services operations.

The system eliminates paper-based dispatching. The use of handheld terminals to receive and feed back operational and management information related either to the patient or of relevance to the customer in a timelier manner and in a secure technological environment, is expected to deliver efficiency savings over time and a more flexible operation on a day-to-day basis.

TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)
Project Manager: Grenville Gifford

The objective is to provide the capability to respond to patients or their carers who have a

speech or hearing impairment that prevents use of the normal '999' facility.

A method piloted by several U.K. police services is to use texting from mobile telephones and at present would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.

Our intention is to adopt this solution for call taking and this was initially expected to be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up during 2008. Due to continuing delay and uncertain surrounding the national initiative the project is also investigating the feasibility of establishing an in-house solution that would deliver text messages directly to ambulance control rooms.

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ePRF (Electronic Patient Report Form)
Project Manager: John Wise

The weaknesses of the paper-based PRF system are well understood and documented. Its reporting capability is limited; its data capture processes are inherently inefficient and inaccurate; it is inflexible in response to changing requirements; its day-to-day operation involves an inappropriate use of clinical staff time.

The ePRF technology overcomes these limitations and provides the Service with a far more effective means of supporting its own strategic initiatives and those of the wider of NHS.

The aim of this project is to implement an ePRF which has the capacity to capture a complete and accurate set of personal, operational and clinical data for each patient encounter and to transmit it in real time for immediate access both within the service and by outside agencies such as receiving destinations and GP surgeries. It also provides paramedics on-scene with a repository of clinical guidance to support their decision-making about patient treatment and conveyance.

PRODUCTION WORKSTREAM

OVERVIEW OF A&E CAPACITY PRODUCTION PROJECTS

First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe
Project Executive: martin Flaherty

The LAS is looking to revise and expand existing responder schemes which broadly fall into one of three categories: Static defibrillator sites where staff who work in the vicinity are trained to provide Emergency Life support, Co-responders that work for established organisations and who respond to selected emergency calls as part of their work, and community responder who are groups of local people who volunteer to share the provision of a single responder within their local area.

Hospital Turnaround
Project Manager: Helen Lew
Project Executive: Lizzy Bovill

There are 3 projects within the scope of the 'Hospital turnaround projects portfolio' which aim to provide central enablers to support the business change to reduce hospital turnaround times through local implementation.

Project 1: Hospital process project:
To process map eight hospitals across London (Mayday, Princess Royal, Ealing, West Middlesex, Barnet, Chase Farm, Queens & Whipps Cross) with lengthy hospital turnaround times and identify bottlenecks and issues which are affecting the hospital processes and causing delays to the LAS. This work will allow the hospitals to be benchmarked against hospitals that have shorter turnaround times, and to share best practice. The output of this project will be a detailed report of the study and recommendations to improve the clinical and patient handover, which will require local implementation.

Project 2: Hospital escalation policies
Working with NHS London, this project aims to obtain Trust bed escalation policies (for Acute and Foundation Trusts) to establish how the Trust communicate bed issues to the LAS. The project aims to identify similarities and differences, best practice and make recommendations for the potential development of a Pan London policy.

Project 3: Marketing & Communication project
This project is focused internally within the LAS, and aims to scope the wider marketing and communication activities which are required to achieve a cultural change and reduce crew turnaround times (from handing over the patient to going green).

Please note it is through the development of central enablers which will support local implementation, that a reduction in hospital turnaround time will be achieved. The reduction in hospital turnaround time will be as a consequence of the business change.

Roster Reviews
Project Manager: Gary Hunt (support)
Project Executive: Paul Gates

This project will review all the rotas in the Trust by station and then changes will be made to bring them in line with the ORH recommendations as funded by commissioners.

The project already has reviewed the rotas in the East and South areas and changes have been identified to local managers. The local managers will then work with their staff on complex to change the rota's so as the cover is improved when demand required it. The

West area will have completed this piece of work by the end of July 09.
The first 40% of stations in each area have been identified against the highest demand. These rotas will be the ones changed first so as the performance gains and benefits can be realized readily.

The plan will have 40% or changes made by December 09 with a further 40% changed by the end of the financial year with the final 20% completed by the end of the first quarter next financial year.

The project is managed by area leads so as to keep the changes identified locally led.

Annual Leave
Project Manager: Steve Sale

The Annual leave review project is currently in the process of being scooped, the current policy is a trust wide document; however the greatest impact of the current policy falls on A&E operations.

The current annual leave year is in the process of transition from the traditional annual leave year April through to March to an individualised annual leave year based upon an individual staff members start date with the Trust. This change is being introduced to reduce the log jam of annual leave requests within the last quarter of the annual leave year which coincides with the peak demand time within operations. Also by staggering the annual leave year for individuals it should reduce the amount of annual leave carry over which in itself compounds the impact on resourcing.

The change of annual leave year has been agreed with our staff side who are actively supporting this change, a draft communication has been agreed and the intention is to implement the change from the 1st of September back dated to the 1st of April.

Resourcing to ORH Plan across 168 hours
Project Manager: Gareth Hughes
Project Executive: Richard Webber

ORH have now supplied the Trust a comprehensive Staffing plan for Ambulances' and FRU's.
The plan covers all 168 hours of the week by hour of day, day of week.
This initiative is to supply the tools to allow the Trust to monitor the Resourcing compliance from ProMis against the plan.
This will be broken down by Service, Area, Complex and Station.
Relief staff, overtime and finally AAC will be targeted to areas where compliance is not met.

Mobile Office
Project Manager: Michael McGinn
Project Executive: Jason Killens

This project is tasked with equipping DSO vehicles with laptops to enable staff to work remotely, giving them immediate access to information whilst also allowing them to spend more time out in the field. The project will establish hardware and software requirements, examine security concerns and establish the best way to transport the laptops in the vehicles.

OVERVIEW OF A&E RESOURCE DISTRIBUTION PROJECTS

Performance Oversight (CDU/EOC)
Project Manager: Andy Heward
Project Executive: Phil Flower

This workstream will scope and set up the performance management arrangements to give robust 24/7 oversight. It is currently envisaged that the CDU arrangements will be replaced by a robust set up in EOC

Single Responders
Project Manager: Jason Killens

This initiative will review the effective utilisation of single responders. It will cover FRUs, MRUs and CRUs and will oversee the tasking regime of these resources. The early intentions are that the responders will be moved the control of an individual allocator and a performance matrix produced to ensure that there is effective tasking and a reduction in dual dispatching.

Urgent Care Dispatching
Project Manager: Paul Woodrow

The purpose of this initiative is to review the dispatching regime for urgent care resources. The early intention of this project is to trial moving the dispatch of urgent care resources from UOC to the allocators in EOC whilst considering carefully the need to overview pre-planned work.

Ambulance Activation Reduction of 30 Seconds
Project Manager: Peter McKenna

This initiative will take forward the ORH recommendations whereby the activation time of ambulances is to be reduced by at least 30 seconds.

FRU Activation Reduction of 15 Second
Project Manager: Jon Knott

This initiative will review the tasking regime for FRUs and produce a reduction in activation of at least 15 seconds.

Active Area Cover (AAC)
Project Manager: Andy Heward
Project Executive: Paul Webster

This initiative will review both the current AAC arrangement and ensure increased and appropriate usage of AAC deployments.

Rest Breaks
Project Manager: Andy Heward
Project Executive: Paul Webster

This initiative is to review the allocation of breaks to maximize the allocation across all shifts with the intention of improving to over 80% allocation by year end.

OVERVIEW OF INFRASTRUCTURE WORKSTREAM PROJECTS

Vehicle Fleet Procurement
Project Manager: Nick Pope
Project Executive: Chris Vale

This project is responsible for delivering a 5 year fleet procurement and policy plan which was agreed by the Trust Board on 20th May 2008. This includes; ambulances, PTS, bariatric and training vehicles.

Event Control Rooms
Project Manager: Gary Hunt
Project Executive: Jason Killens

This project comprises the setting up and full implementation of an Event Control facility at Bow to manage major events (including the Olympic Games) until such time that new Control Room facilities for London have been established.

Logistics and Fleet Review
Project Manager: Chris Vale
Project Executive: Richard Webber

The Operational Support Department (OSD) is in the process of implementing a new 3 year strategy to implement and consolidate the further business changes necessary to provide world class logistical support. The strategy has required that a further review of logistical and fleet services is carried out to ensure services are customer focused and robust. An agreed strategy will then be implemented by a delivery plan, setting milestones for each year.

A number of substantive projects sit under the umbrella of the strategy. These include the reconfiguration of Fleet Workshops, vehicle procurement, enhanced logistics support, the retendering of Make Ready, and performance and quality improvements. A number of these projects sit in the LAS Corporate Governance and Process Programme.

The infrastructure workstream seeks to ensure all aspects of the OSD portfolio is fully reviewed, also that business change is effected in a considered and measured fashion to support improvements in operational performance and clinical care.

Emergency Preparedness Review
Project Manager: John Pooley
Project Executive: Jason Killens

This is work already underway within the Emergency Preparedness Unit and will ensure that the Unit is fit for purpose and that consideration is given to training and development of staff to further enhance the Trust's response to pre-planned events, major incidents and the Olympics.

New workshop Commissioning.
Project Manager: Chris Miles
Project Executive: Chris Vale

This project is a continuation of the Workshop Reconfiguration in tranche 1, and is delivering a new large scale workshop on premises to be identified in West London.

Control rooms
Project Manager: Julia Hilger-Ellis
Project Executive: Martin Flaherty

This project will scope, plan and then deliver 2 purpose built control rooms with sufficient capacity to provide resilience.

Real-Time Fleet Management Information
Project Manager: Chris Miles

The project consists of implementing TranMan across the whole of Fleet Support and ensuring that all business changes are implemented.

OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE (TRANCH 3) WORKSTREAM

Staff Administration
Project Manager: Jonathan Nevison

The project consists of a review and redesign of staff administration processes at complex level. Previous process mapping indicates that an interface between ESR and ProMis could substantially improve efficiency by reducing duplication and hard copy paper flows and the project is tasked with exploring this further. There is also an urgent need to replace the Station Operating System, which is becoming increasingly difficult to support.

Performance Measurement Phase 2
Project Manager: David Hodgkinson

This project is to implement Performance Accelerator, which will provide a repository for all the evidence required by external agencies, e.g. Healthcare Commission.

VRC Process Improvement
Project Manager: David Hodgkinson

This project is to review the processes used by the VRC with the intention of streamlining then and allowing faster resolution of problems. The intention is to provide information and capacity to solve potential problems proactively.

The Intelligent Trust
Project Manager: Stephen Moore

This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement SharePoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

Electronic Expenses
Project Manager: Steve Martindale

Select and implement an electronic system for claiming and authorising staff expenses. The systems must interface with ESR to eliminate manual input of data into the payroll system.

Inventory Management
Project Manager: David Hodgkinson

This project is to develop electronic stock management in the Trust enabling better management of stock levels and real-time stock information. This is being done using a new module within the Trust's accounting package. The initial stage is to roll-out a paper-based stock control system which will subsequently be automated.

Incident Data Records
Project Manager: Jonathan Nevison

This project is a continuation of the IDR project to roll out collision investigation and IDR download skills and technical capability to more DSOs.

OVERVIEW OF FOUNDATION TRUST WORKSTREAM

Finance

The objective of this Workstream is to produce information to feed into the IBP to prove that the London Ambulance Service is financially stable and able to remain financially viable and ultimately self sustaining in the long term through the use of trend analysis, forecasting and historic data. Finance also plays a key role in other Workstreams specifically in aligned Strategy

Historical Data and forecasting will provide a clear view of how we have performed and can expect to perform, enabling opportunities to improve efficiency across the business.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Providing Financial information for the Integrated Business Plan, such as
    - Historical Performance Analysis (2 year)
    - Income and Expenditure 5 year projection (best and worst case scenarios)
    - Income and Expenditure Historic Data (2 year)
    - Capex 5 Year Plan (best and worst case scenario)
    - Capex Historic Data (2 year)
    - Cash flow and Balance sheet 5 year Projections
    - Breakdown of Income Historic last 5 years per source/service
- Providing Benchmarking KPIs and Balanced Scorecard
- Developing Financial Models
- Participating in Business Risk Review and Performance Management (Workforce)

Governance & Membership

Governance and Membership is the largest Workstream in the Programme.

The Governance objective of this Workstream is to define how the Organisation will function following FT approval and specifically how the Organisation will be managed.

The Membership objective of this Workstream is to define the population of London, actively seek public buy-in (through the Consultation and Communication Workstream), and set up a mechanism for controlling membership interest.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Preparing the framework for a public 'owned' organisation
- Review the Organisation Structure
- Gathering information on the population of London, with a view to creating a membership base
- Maintaining a membership database after Foundation Trust status has been awarded
- Provide the means to create a membership database
- Provide a contact point for Membership enquiries

PROGRAMME PROGRESS REPORT FOR PERFORMANCE AND SERVICE DELIVERY PROGRAMME

Business Strategy & Marketing

The objective of this Workstream is to assess the market place in which London Ambulance Service plays a major role, identify opportunities and competition, thereby defining a strategy upon which the Organisation can strengthen its base.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Analysis of the market place in terms of opportunities and competition
- Prepare a Business Strategy which will give direction to the services we provide and aid decision making for the future
- Analysis of business risks, based on opportunities, competition and strategy.
- Prepare a Relationship Management Strategy, based on the above

Commissioning Engagement

The objective of this Workstream is to work with the PCTs to gain agreement and approval on the Foundation Trust application, ensuring that as an FT we can meet (and exceed) supplier-customer expectations.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Working with the Commissioners and building relationships with the Commissioners
- Develop a Payment by Results strategy
- Model Activity Projections.

Business Plan

The objective of the Business Plan Workstream is to collaborate and collate all the outputs from the other Workstreams to produce a robust Integrated Business Plan ensuring exceptional quality through use of action plans and reviews.

Scope:

The scope of work is to facilitate the Foundation Trust Application by:

- Developing the Integrated Business Plan
- Working with the other Workstreams to provide input to the IBP
- Submission of the IBP and supporting information to Monitor

Work Force Development

The objective of this Workstream is to enable the organisation to function efficiently and effectively by implementing strategy which reflects the changes being made to the organisation, the services we provide and how the organisation is managed.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Development of the Trust Board through a development plan
- Development of a workforce expansion programme
- Staff training

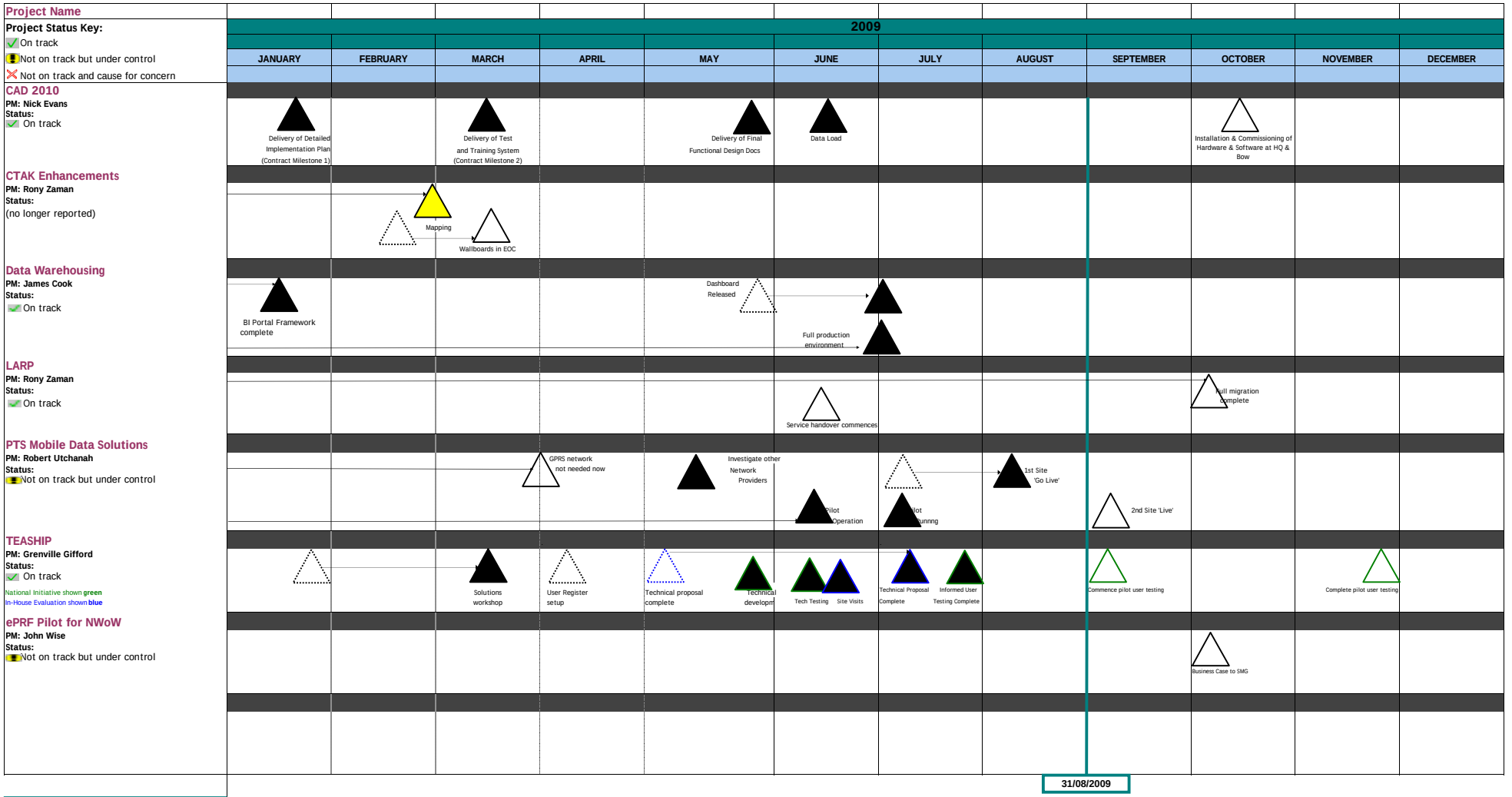
Consultation & Communication

The Consultation and Communication Workstream is to ensure that the Public and Staff are engaged in the Consultation process to facilitate membership to the Trust should the application be successful.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Communicating the desire to achieve Foundation Trust status to the Public, Staff, union, partners
- Preparation of communications for Public Consultations and Staff Briefings
- Make available relevant documentation, such as the Consultation Document, in a variety of formats.

Access CfH Schedule Summary



London Ambulance Service NHS Trust

TRUST BOARD - 29 September 2009

Document Title	**CAD 2010 Project Update**
Report Author(s)	**Peter Suter & Nick Evans (CAD 2010 Project Manger)**
Lead Director	**Peter Suter**
Contact Details	**020 7463 2566**
Aim	**To update the Trust Board on project progress**

Key Issues for the Board-

Key points to note:

1: Current progress in terms of design and development and how requests for change are being managed.

2: The training plan, based upon customer visit to the USA.

3: The overall project timetable that has now been developed.

4: Supplier engagement – it is anticipated that Ken Uffleman, Director of Public Safety Integrated Systems (who is responsible for this project for NG) will be present at the Trust board during discussion on this paper.

5: Arrangements that the Trust Board has in place for independent assurance of the project.

Mitigating Actions (Controls)

None required

Recommendations to the Board

To note the progress of the project.

Equality Impact Assessment

Has an EIA been carried out? No – update report. The project will conduct its own EIA.

(If not, state reasons)

Key Issues from Assessment

None

Risk Implications for the LAS (including clinical and financial consequences)

The aim of the project is to replace the mission critical Command & Control System. Therefore significant risks associated from every perspective.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Control room staff training is the main implication.

Corporate Objectives that the report links to

Response to calls both from a KPI and clinical perspective.

TRUST BOARD – 29 SEPTEMBER 2009

CAD 2010 UPDATE

1. INTRODUCTION

1.1 The objective of this paper is to provide the Trust Board with an update of the CAD 2010 project. This is the project to replace the mission critical command and control system, CTAK, with the Northrop Grumman (NG) product CommandPoint. Full details of the requirement for this project have been previously reported and are not repeated here.

2. DESIGN AND DEVELOPMENT

2.1 The key activities during this stage are the design and development of the modifications required to meet those LAS requirements not fully met by the off-the-shelf CommandPoint product. The current stage ends with the completion of Factory Acceptance Testing (FAT).

2.2 NG has produced Functional Design Documents (FDDs), each of which describes how one or more of the LAS requirements will be satisfied. To date, 42 of 43 Functional Designs have been finalised by NG and approved by the LAS. Following approval of each FDD, Northrop Grumman is carrying out the associated development work, after which they will conduct Factory Acceptance Testing (FAT).

2.3 The outstanding design relates to the PSIAM (the call management system used in the Urgent Operations Centre) interface. The PSIAM supplier, Priority Solutions requires NG to sign an integrator's licence, in effect agreeing to support all PSIAM functionality, before they will release details of their Applications Programming Interface (API). NG is unwilling to sign an agreement that requires them to provide interface functionality and conform to a test certification process that is outside of the LAS requirements. Discussions between the three parties have resulted in the LAS producing a workflow document that specifies the functionality required in the interface. This could form the basis of a revised integrator's licence to be signed by NG. However, negotiations continue at an executive level to resolve this matter.

2.4 In parallel with the NG design and development work, the LAS is carrying out internal design and development activities to enable integration between CommandPoint and legacy LAS applications. This includes the development of interface simulators that will be used by NG during development and testing. There has been some difficulty with the simulators that has caused some delay in delivery to NG.

3. REQUESTS FOR CHANGE

3.1 A number of Requests for Change (RfCs) to the original requirements have been raised. These have been considered by the Senior Users and Project Executive to identify those required at go-live and those that can be delivered in a later software release. Following these discussions, five RfCs have been submitted to NG relating to functionality required at go-live. NG plans to deliver the five RfCs during the existing project schedule in order that they will be ready for the first CAD Train the Trainer training.

3.2 Given the scale and complexity of this project, further RfCs will be inevitable. This will be particularly pertinent where, for operational reasons, business process changes have been made since the contract was awarded. Given the potential cost and time delay associated, every effort will be made to minimise these.

4. TRAINING

4.1 End-user training will be delivered by LAS Training Officers, supported by Work-based Trainers (WBTs). They will receive Train the Trainer training from NG to enable them to deliver the training.

4.2 Training will be delivered at the dedicated training facility in Southwark Bridge Road. The capacity of the each of the classrooms has been increased to allow training of up to twenty six students at any one time.

4.3 A delegation from the LAS including Keith Miller (Clinical Education Manager) and John Hopson (ADO Control Services), visited Sedgwick County, Kansas during July to meet with NG's training lead and with users, managers and training officers of a site using CommandPoint alongside ProQA (triage software used by the LAS to prioritise calls). The information gathered during this trip has been incorporated in the Training Strategy being developed by Rita Bicette, the CAD2010 Training Lead.

4.4 The proposed training approach involves pre go-live training for all staff in their primary job function (Call Taking or Dispatch), although a number of staff will require training in both disciplines to allow flexibility in the control room during the go-live period. Both Call Taking and dispatch courses will be 30 hours in duration. Following go-live and a period of stable running, staff will receive further training to allow them to carry out the full range of control room duties. Those previously trained in Call Taking will receive training in dispatch and vice versa. Splitting the training into pre and post go-live components allows the duration of pre go-live training to be reduced to 15 weeks (originally 20 weeks).

4.5 The proposed 'single cutover' transition approach results in a period of up to four months between some staff receiving initial training and starting to use CommandPoint. In order to minimise the risk of 'training fade' and degradation of skills, the training approach includes regular maintenance training to ensure that skills are maintained.

4.6 A recruitment exercise has resulted in the recruitment of seven Work Based Trainers who will also participate in User Acceptance Testing. The position will be re-advertised in order to recruit three additional WBTs to bring the number up to the ten identified in the Project Resource Plan.

5. TESTING

5.1 It is essential that the CommandPoint system is comprehensively tested before it is deployed in the live environment. The approach to testing is to adopt the industry standard three stage model as described below:

- Factory Acceptance Testing (FAT) will be conducted by NG at their US site in Chantilly, VA, following completion of the development work. NG's Factory Test Plan has been approved by the LAS. NG is currently producing Factory Test Specifications that are being reviewed by the CAD Test consultant Crispian Jago. FAT is currently scheduled for December 2009 and January 2010 and will be witnessed by members of the LAS CAD2010 Project Team.
- Site Integration Testing (SIT) will follow FAT. SIT will be carried out by NG at the LAS test facility in Southwark Bridge Road utilising the LAS interfaces and new NG software and equipment installed at HQ and Bow. Planning and extensive co-ordination will be put into place to minimise impact to operational services.
- User Acceptance Testing (UAT) is the final stage of testing that will be carried out by LAS Software Testers at Southwark Bridge Road.

5.2 The LAS test environment will include simulators replicating the functionality of each of the CAD interfaces and an MDT test environment. These simulators are currently under development.

6. ESTATES

6.1 The test and training premises at 32 Southwark Bridge Road are now operational and are used by both LAS and NG personnel. The accommodation includes two classrooms, a testing room, a meeting room and a number of offices. Formal opening of the facility by the Chief Executive took place on 15 June 2009.

6.2 Additional desks have been installed in the two classrooms to facilitate the larger class sizes proposed in the training strategy.

6.3 The Estates Department has carried out modifications to the Live and DR sites at HQ and Bow in readiness for the installation of the new hardware required to support CommandPoint. Installation of the new hardware is due to be completed by 14 October 2009.

7. TRANSITION

7.1 The LAS transition approach (as approved by the Trust Board), is a single cutover from CTAK to CommandPoint, facilitated by a short period of paper operation. The exact date of the cutover is dependent on the final delivery of the software and duration of User Training (see 'Project Timescales' below).

7.2 The transition approach detailed above is a variation of that specified in the original contract with NG. A Request for Change has been submitted to NG to accommodate the change of approach.

7.3 The Detailed Transition Plan will be completed once the training strategy has been finalised. This will describe the activities to be undertaken in the periods prior to, during and immediately after the cutover from CTAK to CommandPoint.

8. COMMUNICATIONS

8.1 The CAD2010 Project Team continues to work closely with the Communications Department. The Stakeholder Engagement Strategy and Stakeholder Communications Plan have been updated and approved. Plans are in place for a regular bulletin to communicate with control room staff. It has been agreed that the title of the bulletin should be 'CommandPoint Bulletin'.

8.2 An article on CAD2010 will appear in the September 2009 issue of LAS News. The article describes some of the features of the CommandPoint product and looks at the work the CAD2010 Project Team is carrying out to deliver the new system

8.3 To ensure engagement of Staff Side, CAD2010 is a standing agenda item at the Control Services Staff Committee. Richard Chow has recently been identified as the Staff Side representative for CAD2010.

9. SUPPLIER ENGAGEMENT

9.1 Jackie Nostaja (NG Project Manager) and Steve Watson (NG Technical Manager) have relocated to London for the duration of the project. They are supported by teams based in the US, who participate in meetings via teleconference and visit the UK as required.

9.2 NG has allocated Ken Uffelman, Director Public Safety Integrated Systems, as the Director responsible for the successful delivery of this project. He regularly meets with me via teleconference and will in due course visit the UK. NG is also keen to meet with the Chairman, Chief Executive and other executives as appropriate.

10. RESOURCING

10.1 Three members of staff from EOC have been seconded to the CAD2010 Project to carry out design reviews and collect and maintain reference data. The project thanks Control Services for their co-operation and support.

10.2 The CAD2010 Project is funding backfill for thirty staff in EOC. Twenty of these are to enable the release of staff to attend user training; the remaining ten are to cover the release of the ten Work based Trainers.

11. PROJECT TIMESCALES

11.1 The current priority is to finalise the overall project timetable in order to establish a realistic transition date. There are a number of factors that will ultimately affect the final transition date:

- Successful delivery of software, including resolution of bug fixes and potential functionality refinement.

- Scheduling of simulators and five additional RFCs and impact on plan.
- New RFCs.
- Training, including skills refreshment.
- Management of project across Christmas period.

11.2 Taking all of these factors into account, a high level stage plan is set out at Appendix 1. It identifies 25 January 2011 as the date for when the system will be ready for service. However, in terms of planning, a final contingency period has been added projecting the actual transition date to be 22 February 2011.

12. PROJECT RISKS

12.1 The Project Risk Log lists all the identified risks to the project. There are currently seventy one open risks. The probability (P) and impact (I) of each risk is assessed on a five point scale. The product of the probability and impact of the risk gives a measure of the significance of the risk.

12.2 Currently there are eight risks with a significance of twelve or greater; these are listed within Appendix 2. They are under constant review by the Project Manager.

13. TRUST BOARD ASSURANCE

13.1 In addition to the project's own internal assurance processes, additional measures are in place to provide the Trust Board with assurance in relation to the overall project. These arrangements are:

- Government Gateway project review. Gates 1, 2, and 3 have been completed and reports shared confidentially with the Trust Board. Gate 4, readiness to go Live, will be scheduled towards the end of 2010.
- Two non Executive Directors, Roy Giffins and Brian Huckett provide an independent view for the Trust Board. They in turn are supported by Carrie Armitage, an experienced IT Consultant who has open access to all aspects of the project.
- The CEO and Senior Management provide oversight on the project via internal programme management arrangements.
- Trust audit arrangements will be used to review certain aspects of the project (e.g. the procurement process).

13.2 The next report will be to the Trust Board in November 2009 and will include details of milestone payments and the current budget.

14. RECOMMENDATION

Trust Board to note the progress of the project.

Peter Suter
Director of IM&T
CAD 2010 Project Executive.

APPENDIX 1: HIGH LEVEL PROJECT STAGE PLAN

Stage 4 – Design and Development		
Description	**Deliverables**	**Date**
Installation & Commissioning	Deliver System Infrastructure Inventory List Install/Configure Hardware and Software at Authority Facilities	14/10/09
Development	Deliver Factory Test Plan Deliver Factory Test Specification Complete Factory Test Deliver Security Plan Deliver Service Management Plan Deliver Factory Test Report	23/02/10
Stage 5 - Testing		
Description	**Deliverables**	**Date**
Completion of Interface Testing	Deliver System Administrator Training Materials Provide CAD System Administrator Training	19/04/10
Testing	Deliver SIT Plan Deliver SIT Specification Configure/Test Interfaces on Live Systems Complete SIT Deliver SIT Test Report	05/07/10
Train the Trainer Training	Deliver Super User Training Materials Provide Super User Training Deliver System Overview for Managers Training Materials Provide Data Files Training Provide System Overview for Managers Training Provide Authority Testers Training Deliver CAD Call Taker Train-The-Trainer (TTT) Training Materials Deliver Cutover Plan Deliver CAD Dispatcher TTT Training Materials Provide CAD Call Taker TTT Training Deliver Final FSD Deliver Exit Plan User Acceptance Testing **Provide CAD Dispatcher TTT Training**	15/09/10
Stage 6 - Migration		
Description	**Deliverables**	**Date**

APPENDIX 2: MOST SIGINIFICANT PROJECT RISKS

Risk 095 - Insufficient Floor Walkers (P4, I4)
Summary: There is a risk that the planned number of WBT / Testers and other staff available to provide 'Floor Walker' support, within the Control Room, during implementation of CommandPoint, will be insufficient leading to performance degradation, extending the period of 'Floor Walker' support and/or the delivery of additional training or regression to CTAK, causing cost and time overruns.

Mitigation actions: Early identification of all LAS personnel who could fulfil this role. Should more be required, this will be addressed through discussions internal to the LAS and with Northrop Grumman, identifying additional resources required to be available at and post go-live. Identification of 'expert users' on each watch during initial user training.

Risk 094 - Significant Service Impact interrupts of delays training (P4, I4)
Summary: There is a risk that the Service will suffer a significant detrimental impact to the resource capacity of the Control Room (for example, through increased REAP level, high volume sickness, major incident) leading to reduced attendance at training; or the cancellation or postponement of the training schedule, resulting in an extension of the training period and a delay in the date of Go Live, causing a cost and time overrun.

Mitigation actions: Seek agreement that CommandPoint training should be outside of REAP. 'Float' of control room staff provides additional capacity to minimise disruption to control services business as usual.

Risk 097 - Skills Maintenance Training not sufficiently supported (P4, I4)
Summary: There is a risk that the Skills Maintenance Training does not receive sufficient support and co-operation from Control Services managers leading to training fade and skills degradation, resulting in the preparation and delivery additional training, causing a cost and time overrun.

Mitigation actions: Control Services managers have been fully engaged during planning of training approach. The output of this work, the Final Training Strategy, clearly identifies that Control Services managers are responsible for ensuring attendance at maintenance training. Attendance at maintenance training will be monitored by Training Officers, who will escalate all instances of non-attendance to the appropriate management authority.

Risk 092 - Loss of Key Personnel (P3, I4)
Summary: There is a risk that key personnel may become unavailable due to unforeseen events, for example accident or illness, causing a lack of knowledge and capability in areas crucial to the success of the project, resulting in delay to the project whilst a replacement resource is identified and recruited.

Mitigation actions: The resource plan identifies "Lead", "Assist" and "Support" resources for all key project activities to ensure that activities can continue if lead resource becomes unavailable.

Risk 091 - Inability to Recruit/retain Control Room Staff (P3, I4)
Summary: There is a risk that an inability to recruit and or retain sufficient numbers of Control Services staff will prevent the EOC Resource Centre from releasing the number of staff to support the planned training programme, leading to time and cost overruns

Mitigation actions: Early recruitment of 'float' staff to ensure sufficient staffing of EOC to support training activities.

Risk 081 - Training fade (P3, I4)
Summary: There is a risk that the Skills Maintenance Training will not sufficiently reduce training fade or prevent skills degradation, resulting in the preparation and delivery of additional training, causing a cost and time overrun.

Mitigation actions: The Final Training Strategy addresses this by limiting the duration of pre go-live training and including compulsory maintenance training to ensure retention of learning.

Risk 010 - Interfaces with MDT and Legacy Systems (P3, I4)
Summary: There is a risk that the development of interfaces with MDTs and other legacy systems will prove to be more complex than anticipated, resulting in a need for additional discussions between the LAS and the supplier to clarify technical details, resulting in cost and/or time overrun.

Mitigation actions: Early investigation, documentation and discussion of current interfaces to CTAK in order to identify potential issues. Development of interface simulators to enable testing of interfaces during development activities in advance of Factory Testing. All interfaces to be fully tested during Site Integration Testing and User Acceptance Testing.

Risk 009 - Lack of User Buy-In (P3, I4)
Summary: There is a risk that lack of buy-in to the solution by operational users will cause cost and/or time overrun, especially during implementation.

Mitigation actions: Early communication with operational users, including CommandPoint bulletin to update users on current position of project. Close engagement with staff side, including identification of staff side CAD2010 representative.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 29 September 2009

Document Title	Foundation Trust: Public consultation response and evidence of staff engagement and involvement
Report Author(s)	Angie Patton
Lead Director	Sandra Adams
Contact Details	
Aim	To provide a summary of the London Ambulance Service's public consultation on its proposed governance arrangements as a foundation trust and its future plans

Key Issues for the Board

The Service ran a public consultation from 9 February to 15 May 2009 to seek the view of key audiences on its proposed governance arrangements as a foundation trust and its future plans.

The response to the consultation has been evaluated and the Trust has responded to the issues that were raised by stakeholders.

This document details how the public consultation was carried out, the feedback that was received and the Trust's response to the issues raised.

Having considered all the feedback, the Trust has decided to change some of the governance arrangements outlined in its consultation document.

The key changes are:

- Public constituencies

  There will now be six public constituencies in London (instead of 11) which will be closely aligned with the six health sectors under which commissioners operate. In addition there will be a public constituency – Outside London - covering the strategic health authority areas bordering London which will enable people who work in the capital but don't live there to become members and have a say in the Service.
- Number of public governors

  The number of public governors has been increased from 11 to 13 (two per public constituency in London and one for our Outside London constituency).
- Staff groups

  Within the staff constituency there will be two staff groups. One will be for support staff and the other for frontline staff. The frontline staff group will be represented by two governors as it is the largest staff group, and support staff will be represented by one governor.

Mitigating Actions (Controls)

Recommendations to the Board To note the evaluation of the public consultation and the Trust's response to the issues that were raised.
Equality Impact Assessment Has an EIA been carried out? (If not, state reasons) **Key Issues from Assessment**
Risk Implications for the LAS (including clinical and financial consequences)
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)
Corporate Objectives that the report links to To successfully apply to become an NHS foundation trust.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 29/09/2009

Document Title	Progress report on the application to become an NHSFT
Report Author(s)	Sandra Adams
Lead Director	Sandra Adams
Contact Details	020 7921 5243
Aim	To update the Trust Board on the application to become an NHSFT and to highlight the process, timescales and risks.

Key Issues for the Board

- To note the progress made to date with the FT work streams within the performance and service delivery programme
- To note the 3 stages and timelines for historical due diligence
- To note the proposed changes within the application process as a result of the Mid Staffordshire review
- To note the current and potential risks facing this process

Mitigating Actions (Controls)

The Director of Corporate Services meets regularly with the FT lead and the FT project board needs to be re-established. Regular updates will be made to the SMG meetings.

Recommendations to the Board

To note the progress report.

Equality Impact Assessment

N/A for this report.

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

See section 5 of the report.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

N/A to this report.

Corporate Objectives that the report links to

Good employment practice and organisation development – objective 15: successfully apply to become an NHS Foundation Trust.

London Ambulance Service NHS Trust

Trust Board

Progress report on the application to become an NHSFT

29th September 2009

Introduction

The aim of this report is to update the Trust Board on our application to become an NHSFT and to highlight the process, timescales, and some of the risks currently facing us.

1. Integrated business plan (IBP)

The IBP is in draft form and is currently being reviewed and updated and should be ready for discussion with SMG, the SDC and the Trust Board during October and November 2009. A lot of work has already gone into the plan and there have been a number of contributors for specific sections providing the backbone of the document. This now needs to be updated to reflect the changes and developments within the service over the past 9 months and to incorporate the 2009/10 financial and performance plans. The intention is that the IBP tells the story of the LAS going forward for the next 5 years. The plan is structured as follows:

- Executive summary
- Trust profile
- Strategy
- Market assessment
- Services
- Financial evaluation
- Risk
- Leadership & workforce
- Governance arrangements.

A summary version of the IBP is being drafted which is intended to be used by managers for briefing staff and for talking to external stakeholders about the FT application. The overall aim should be to engage stakeholders and gain their support for our plans and our FT application.

The IBP is an essential document that needs to be understood and owned by the Trust Board and by those shaping and contributing to it.

The final, and fully integrated, business plan will be submitted to the SHA and Department of Health FT team during the application stage. By this stage the IBP will incorporate the:

- Fully completed long term financial model (LTFM);
- Governance rationale;
- Model core constitution;
- Consultation response and staff engagement;

- Membership strategy.

2. Performance and service delivery programme – FT work streams

The position as at 1st September 2009 was as follows:

- Finance – not on track but under control: the updated LTFM for ambulance FT applicants has now been received from Monitor and is being presented to the Board on 29th September. Similarly work is progressing on the payment by results structure.
- Membership – on track: approximately 1700 public members recruited to date, with an ongoing programme of recruitment and engagement and tied in with the existing PPI programme;
- Business strategy & marketing – on track: analysis provided for the draft IBP;
- Commissioner engagement – not on track but under control: there is an ongoing programme of engagement with commissioners on strategic issues and the FT position needs to feature routinely so as to draw commissioners in;
- Business plan – on track: development of the draft IBP and collation of the information required for historical due diligence which comprises stages 1, 2 & 3 of the application process;
- Workforce development – on track: workforce expansion programme underway and board development plan to be updated;
- Consultation and communication – on track: consultation closed in July and the feedback report is due to be approved at the September Trust Board meeting after which it will be published. Changes arising from the process have been incorporated into the governance and membership arrangements.

3. Application process and timescales

Grant Thornton, chartered accountants, have been appointed by NHS London/the Department of Health to undertake the historical due diligence stages for the LAS application. We met with their representatives and the NHS London lead, Mark Brice, on 6th August, to discuss the process and timelines.

There are now 3 stages to the historical due diligence review process prior to an FT application being forwarded to the Secretary of State.

a) Stage 1: 3 weeks – principally a governance review (90%) and high level review of the LTFM (10%). This stage includes interviews with board members and key members of staff involved in risk and governance. The draft report is produced at the end of week 2 for review and then a final report in week 3 which is presented to the Trust Board for sign-off. The outcome of the review is RAG rated and will state recommendations, timescales, and a work programme for the rest of the FT application;
b) Stage 2: 3 weeks – principally financial analysis, audit-style, and following a similar process to Stage 1, with a draft report in week 2, and the final report presented to the Board in week 3 for sign-off;

c) Stage 3: 5 weeks – the working capital review undertaken by Grant Thornton and Monitor. This follows the same sign-off process as Stages 1 & 2.

The overall application process will take 12 weeks, if all goes smoothly, and will require 3 formal board meetings, one at each stage in order to formally sign-off the findings and a Board Memorandum.

Following the Mid-Staffordshire NHSFT review there are now additional stages within that first phase. These are focussed on the quality of the services provided by the Trust and our approach to managing clinical governance (see appendix one). Monitor intends to consult on the changes to the assessment process and to incorporate the final requirements in an updated *Guide for Applicants* by April 2010.

The Care Quality Commission (CQC) now undertakes an organisational risk profile (ORP) which takes 7 weeks and commences at the same time as Stage 1. This forms part of the Quality threshold that SHAs now have to sign-off (through the soon to be formed Medical Directors' Forum) prior to forwarding an FT application to the Secretary of State. The criteria for the Quality threshold are:

i) not scoring 'Weak' on quality of services for the most up to date review by the Healthcare Commission or CQC. Where the quality of services is 'Fair' then a strong case will need to be provided why the Trust is proceeding to FT status;
ii) unconditional registration by the CQC; and
iii) overall level of concern on CQC ORP is 'Business as usual' or 'Minor concern'.

Once the SHA have forwarded the application to the Secretary of State it can then take 4 weeks for approval to be passed to Monitor.

The Monitor Assessment Phase takes 12 weeks and covers 3 key areas to ensure that the LAS is

- legally constituted;
- financially viable; and
- well governed.

It was clear from our meeting with Monitor's assessment team that they are not anticipating any applications from ambulance trusts for another 6-12 months. Once we are through Monitor's assessment phase we will be authorised to operate as the London Ambulance Service NHS Foundation Trust.

4. Where are we now?

The IBP is under review and being updated and the intention is to seek SMG and Board approval in the next few months. The FT project team are working their way through the HDD requirements, gathering evidence, updating processes, and working with relevant leads to fill any gaps that emerge.

We have met with Monitor's assessment team who are visiting all Ambulance Trusts to ensure that the assessment process is fit for purpose and

appropriate to the service. We did have a meeting arranged with NHS London in the first half of September however this is currently on hold pending a Chief Executive to Chief Executive meeting on 1st October. From those meetings we anticipate having a much clearer view on the timelines for the application, and on what is required of us by our stakeholders in order for them to support us. If we are given the go-ahead in the next few months we could be commencing the HDD process in January 2010 which could lead to authorisation in July/August 2010.

5. Risks

There are a number of risks currently facing us as we take forward the FT application and these include:

- A lack of stakeholder engagement and support – principally through the PCTs. We can address this through greater engagement about the IBP and our strategic plans;
- The changeover of the lead commissioner responsibility from R&T to Westminster – this could create a time lag whilst the new lead develops an understanding of the LAS and we develop the relationship and gain engagement & support however we see this as a positive development and an opportunity to engage the new commissioners early on. We are aware that they have already been approached by Monitor as part of the latter's preparation for the meeting with the LAS earlier this month;
- Performance – the 08/09 annual health check quality of service score could be 'Fair' rather than 'Good' if the extenuating circumstances request is not upheld; performance against the category B target may mean that NHS London stipulate 3 months sustained achievement of the target before they support our application. We will know the outcome of the 08/09 score in October but will be able to estimate this within the next few weeks. Performance against the trajectories for category A & B will become clearer as we move through the next few weeks;
- Lack of clarity about timescales and what are the absolute requirements from our stakeholders before they support our application. This will become clearer once we have met with the SHA in October;
- Board development – we need to ensure that we have identified and are putting in place any requirements around board development and to agree the skills and expertise required for the forthcoming non-executive appointments.

Summary

This report is intended to brief the Trust Board on where we have got to with the FT application and what the process will be once we are ready to go. It will be useful to test the assumptions about the timescales and the risks we are facing and also to explore what becoming an NHSFT will mean for the LAS, over and above the standard NHSFT benefits.

Sandra Adams
Director of Corporate Services

15th September 2009

Monitor
Independent Regulator
of NHS Foundation Trusts

4 Matthew Parker Street
London
SW1H 9NP

T: 020 7340 2400
F: 020 7340 2401

4 September 2009

By email:
To Chairs, CEs and FDs of NHS foundation trust applicants
Cc: SHAs, FTN, FT Unit

Dear Applicant

Monitor's response to the internal audit report into Mid Staffordshire NHS Foundation trust

Following the publication of the Healthcare Commission's report into significant failings in quality of care at Mid Staffordshire NHS Foundation Trust, Monitor commissioned its internal auditors KPMG to examine how our methods and processes could be improved. The purpose of this review was not only to learn potential lessons, but also to share them with others in the healthcare system.

This letter gives an overview of the recommendations made in the internal audit report and provides details of the implications for the assessment process and current applicants.

Findings

The internal report makes fourteen recommendations, each of which we accept and against many of which we have already made progress. There are two main themes:

1. **The need for better sharing of information across the healthcare system.** Monitor has already taken action in this area. We have agreed arrangements with the Care Quality Commission (CQC) to ensure that we are informed about concerns that they might have about the quality of care delivered by foundation trust applicants and that these concerns are resolved before a decision is taken to authorise the applicant. Arrangements have also been agreed to share information about under-performing foundation trusts and to coordinate any action. These agreements are part of the Memorandum of Understanding which Monitor and the CQC have now signed, and which is available on our website.

2. **The need for Monitor to focus on developing an approach to assuring itself that appropriate clinical governance is in place in applicant or existing foundation trusts.** By clinical governance we mean the combination of structures and arrangements in place at, and immediately below, the board level, to manage and monitor clinical performance, plan and manage continuous improvement, identify performance that may be below standard or out of line, investigate it and take action.

We felt it was important to publish this report and the actions we are taking to address the issues it raises. The internal audit report, along with our response document, can be found on our website www.monitor-nhsft.gov.uk.

Although the recommendations of the report are intended for Monitor, they have implications for how we work with our partners. We have shared and discussed the report with both the CQC and the Department of Health and we all agree that improved sharing of information and better coordination will help ensure that there are neither gaps in the system nor duplication. This has to be for the benefit of patients and service users.

Implications for the assessment process

There are two recommendations included within the report that relate specifically to the assessment process:

1) obtain stronger assurances at assessment on the state of quality; and
2) stronger focus required on quality and clinical governance.

As a result of these recommendations and in line with our management response Monitor is now focussing on two key work streams;

- **Defining the quality criteria for authorisation** - Monitor will work with the CQC and the Department of Health to define the quality criteria that applicants must meet to be authorised as a foundation trust. This work will take into consideration the registration requirements of the CQC and the 2010 Operating Framework; and

- **Strengthening the approach to the assessment of clinical governance** - We have already initiated an external study in this area which will provide conclusions on how we will test the board's approach to managing clinical governance (including the impact of cost improvements on clinical quality).

Once we have completed these work streams we will consult on the proposed changes to the assessment process. We expect the consultation to begin at the end of this year, with the final requirements set out in an updated *Guide for Applicants* by 1 April 2010. The resulting changes to the assessment process will be effective for all applicants referred to Monitor from 1 April 2010.

Transition arrangements

As a result of the recommendations there are also some implications for current applicants (including deferred and postponed trusts) which will take immediate effect.

The internal audit report makes a recommendation to define our approach to assessing clinical quality performance in the transition period before the CQC introduces the full system of registration for hospitals in 2010 and whilst we undertake the work streams above. We have defined our approach in this area in our response which is summarised below:

Current applicants should be aware that in the transition period, in addition to the existing work programme to assess clinical quality performance, we will require applicants to demonstrate that:

1) they continue to meet the quality threshold set by the Department of Health at the time of Secretary of State referral (see below);
2) they have a minimum governance rating on service performance as set out in the 2009/10 Compliance Framework of at least amber;

We will also continue to review the information provided by the CQC contained in their organisational risk profile reports to ensure that:

- the risk rating attributed to the overall level of concern is no worse than minor concerns;
- the risk rating attributed to the confidence of the trust's ability to meet regulatory requirements is at least confident; and
- the trust is not under investigation, nor are investigations planned and there are no preliminary inquiries into mortality data.

In relation to the Department of Health Quality criteria in point (1) above, as detailed in their letter dated 18 August to SHA Chief Executives, the Department is now requesting that FT applications submitted for consideration for Secretary of State support must meet the following quality criteria:

i) Not scoring 'Weak' on quality of services for most up to date annual review from Healthcare Commission/Care Quality Commission (CQC). Where the quality of services score is 'Fair' then a strong case will need to be provided why the trust is ready for proceeding to FT status;
ii) Unconditional registration with CQC; and
iii) Overall level of concern on CQC organisational risk profile 'Business as usual' or 'Minor Concern'.

Monitor will therefore apply these Department of Health tests before concluding on its authorisation decision for all applicants with an authorisation decision post 1 September 2009.

Should you require any further clarification of our response to the Internal Audit recommendations please contact Miranda Carter, Assessment Director, who is leading on our work to address the assessment findings from the report.

Yours sincerely

Stephen Hay
Chief Operating Officer, Monitor

London Ambulance Service NHS Trust

TRUST BOARD - 29/09/2009

Document Title	Membership Strategy
Report Author(s)	Shirley Rush
Lead Director	Sandra Adams
Contact Details	020 7593 1938
Aim	To update, and seek approval from, the Trust Board on the revised Membership Strategy.

Key Issues for the Board

As an appendix to the Integrated Business Plan the Membership Strategy forms part of the Trust's application for NHS Foundation Trust status. The strategy now incorporates governance arrangements determined after the consultation process was completed.

The Membership Strategy describes the Trust's approach to membership recruitment, engagement and retention as part of the application process and after it has been authorised.

The strategy defines the Trust membership and sets out actions to help it deliver the objectives. It outlines how the Trust will evaluate its success in delivering the strategy and how it will continue to develop and benefit from an active and involved membership.

The strategy follows the guidance from Monitor and uses the template it includes.

The details of its development were presented at the Board Away day.

Mitigating Actions (Controls)

Guidance followed is referred to above.

A membership group chaired by the Director of Corporate Services has been established to monitor, implement and ensure alignment with Patient and Public Involvement and Public Education Strategies.

Recommendations to the Board

To approve the strategy.

Equality Impact Assessment

An EIA has been carried out but will require further review and monitoring as the membership strategy is implemented. See below re risk.

Key Issues from Assessment

To be confirmed.

Risk Implications for the LAS (including clinical and financial consequences) Maintaining engagement with stakeholders in the London health economy and all ethnic groups that constitute London's hyper diverse population will be a challenge and may not be fully achievable.
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) None identified at this stage but see above re EIA and risk.
Corporate Objectives that the report links to Good employment practice and organisation development – objective 15: successfully apply to become an NHS Foundation Trust.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 29th September 2009

Document Title	Foundation Trust Application
Report Author(s)	John Wilkins
Lead Director	Sandra Adams
Contact Details	john.wilkins@lond-amb.nhs.uk
Aim	The aim of this paper is to highlight a number of key areas of the Constitution for discussion and decision prior to submission to lawyers to ensure it is a legal document within the framework of the 2006 Act. The draft constitution is attached together with a brief note identifying the areas for discussion.

Key Issues for the Board

- Transitional arrangements including terms of office for the initial Chair and non-executive directors
- Composition of the Trust Board executives and clarification on non-voting directors contribution to the Board
- Balance between Executive Directors and Non-Executive Directors
- Development of Board infrastructure e.g. the appointment of a Senior Independent Director

Mitigating Actions (Controls)

Monitor's guidance for applicant NHS Trusts provides the framework for the Constitution. Legal advice will be sought on the next version of this document which will form a key component of the terms of authorisation when we become an NHS Foundation Trust.

Recommendations to the Board

Further discussion on core detail e.g. before SDC, TB away day(s) at the end of October.

Equality Impact Assessment

The programme has complied with statutory requirements in regards to equality and diversity. The programme has neither a positive or negative impact in terms of age, disability, gender, race, religion or belief, or sexual orientation.

The programme has worked closely with the Equality & Diversity team to ensure that membership to the LAS is compliant with legislation and an EIA has been completed.

Key Issues from Assessment

None.

Risk Implications for the LAS (including clinical and financial consequences)

Associated findings from the key issues will be incorporated into Corporate Risk Management and the Governance Chapter of the Integrated Business Plan to be submitted to Monitor as part of the application.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) The LAS needs to be able to demonstrate that it is legally constituted, well governed and financially viable to achieve Foundation Trust status.
Corporate Objectives that the report links to Good employment practice and organisation development – objective 15: successfully apply to become an NHS Foundation Trust.

London Ambulance Service NHS Trust
Trust Board
29th September 2009

Draft constitution
Key areas for discussion

Introduction

The Constitution is based on the template provided from Monitor and sets out the governance arrangements for the organisation to be run and to operate as an NHS Foundation Trust. It addresses the core assessment question asked by Monitor – Is the applicant legally constituted? To be legally constituted the proposed Constitution must be compliant with Schedule 7 of the National Health Service Act 2006 (Section 30, Constitution of Public Benefit Corporation). It is a requirement of the NHS Foundation Trust application process that the draft constitution has been scrutinised by lawyers before a final draft is prepared and submitted to Monitor, with amendments and additions clearly identified from the template.

The Trust Board has the opportunity to define some aspects of the Constitution in order to make it workable to suit local circumstance. The important issue is that the Constitution works for the LAS. There are a number of issues that need to be clarified and agreed as early priorities and this paper highlights several of those for discussion at this month's Board.

(Numbers and pages used below refer to those used in the draft Constitution)

1. Transitional arrangements

- Appointment of initial Chairman and initial Non-executive Directors
  - Sections 22 & 23 pg 9&10

The Council of Governors, through a formally established nominations committee, appoints the chairman and non-executive directors of an NHS Foundation Trust. This does not apply to the initial chairman or NEDs who would be appointed for the unexpired term of office. If, on appointment, that period is less than 12 months the appointment will be for 12 months. The Constitution allows us to specify any transitional arrangements to take the board of directors from NHS Trust to NHS Foundation Trust.

Action: The Trust board needs to determine an acceptable transitional period of appointment for the existing chair and non-executive directors. It also needs to decide on the composition of the nominations committee for the appointment of non-executive directors so that this can written into the Constitution.

2. Composition and infrastructure of the Board of Directors

- Board of Directors – composition
  - Section 20 pg 9

The composition of the Board of Directors will need to be defined and will need to include the executive directors and specifically the chief executive (and accounting officer), finance director, a registered medical practitioner or registered dentist, and a registered nurse or midwife.

Increasingly NHS Boards are supported by senior directors without voting rights. The role of such directors needs to be specified within the Constitution to ensure that they are stated attendees at board meetings and can contribute to the debate.

Action: The Trust Board needs to confirm:

a) the status for the nursing director;

b) the role of directors with non-voting rights;
c) the balance of Directors, executive and non-executive, including building flexibility into the Constitution to increase numbers for specific purposes, skills, when necessary; and
d) the requirement for a Senior Independent Director, whether we want this role, what the role would require, and whether this should be the Vice-Chairman of the Trust Board or another non-executive director. Key to this would be confirmation that all existing non-executive directors are independent.

Summary
The Trust Board is asked to consider the items highlighted for action and to agree the position that can be reflected in the draft Constitution. The FT team can then seek legal advice on the draft Constitution.

John Wilkins
FT Project lead

Sandra Adams
Director of Corporate Services

14th September 2009

London Ambulance Service NHS Trust

TRUST BOARD - 29th September 2009

Document Title	Foundation Trust Application
Report Author(s)	John Wilkins
Lead Director	Sandra Adams
Contact Details	john.wilkins@lond-amb.nhs.uk
Aim	This paper summarises the key aspects of the governance arrangements as the LAS proceeds in its application to become an NHS Foundation Trust.

Key Issues for the Board

- Summarises the key governance aspects and highlights areas where further discussion or development is required.

Mitigating Actions (Controls)

The governance arrangements are being prepared in line with Monitor's guidance for applicant NHSFTs, the Code of Governance, and the Compliance Framework for NHSFTs.

Recommendations to the Board

To note the progress made in defining the governance arrangements.

Equality Impact Assessment

Further work is required on the potential impact of the proposed governance arrangements, particularly with regard to membership and the Council of Governors.

Key Issues from Assessment

To be confirmed.

Risk Implications for the LAS (including clinical and financial consequences)

There will be financial implications for managing the membership and the Council of Governors however there is a budget and this will need to be reviewed and finalised for 2010/11 onwards.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

The LAS needs to be able to demonstrate that it is legally constituted, well governed and financially viable to achieve Foundation Trust status.

Corporate Objectives that the report links to

Good employment practice and organisation development – objective 15: successfully apply to become an NHS Foundation Trust.

London Ambulance Service NHS Trust
Trust Board
29th September 2009

A summary of the governance arrangements required for an NHS Foundation Trust and the work to date to prepare for application

Introduction
The following paper summarises the key aspects of our organisational governance arrangements as we develop our application to become an NHS Foundation Trust. The paper describes the specific arrangements for the Council of Governors following the formal consultation process. The arrangements will be developed further over the next few months with specific reports made to the Trust Board, particularly in relation to the structure of the Board of Directors and the strengthening of risk management arrangements.

1. Membership arrangements
Membership of the LAS NHS Foundation Trust is defined in the Membership Strategy which will be discussed separately. Members will be allocated to the constituency appropriate to their status ie. Public and geographic, or staff and class. This reflects the outcome of the consultation process.

a) Public membership and constituency arrangements
There will be 6 public constituencies that are geographically focussed and mirror the current configuration of Primary Care Trust sectors within NHS London, and there will be one public constituency termed 'Outside London' to reflect the SHA boundaries adjacent to NHS London. Public members will be allocated to the constituency within which they live. The 7 public constituencies will be as follows:

North West London (2)
North Central London (2)
Outer North East London (2)
Inner North East London (2)
South East London (2)
South West London (2)
Outside London (1).

Numbers in brackets denote the number of public governors for each constituency.

b) Staff membership/constituency
There will be one staff constituency that is divided into two classes: front line and support. This reflects the make up of the workforce for the LAS. More detailed work needs to be undertaken to understand how staff membership will work, how staff will be allocated to the correct class, and processes to manage arrangements for new staff, staff that leave, and staff that opt out from membership.

2. Council of Governors:
The Council of Governors will be chaired by the Chair of the Board of Directors and it will comprise twenty-three seats as follows:

a) Elected governors:
13 Public
3 Staff = 2 Front-line and 1 support
b) Nominated governors
5 Partner Organisations

1 PCT
1 Local Authority.

The Council of Governors will be supported by the Trust's committee secretary and the Director of Corporate Services. Members of the Trust Board will be invited to attend each meeting and the members of the senior management group will play a key role in the meetings. Public and staff members will be welcome to attend the meetings of the Council of Governors.

3. The Role of the Council of Governors

The Council of Governors represents the interests of foundation trust members and partner organisations in the local community. Its core function is to hold the board to account for the performance of the trust and to exercise the statutory duties defined in the National Health Service 2006 Act which gives governors the authority to:

- Appoint or remove the chair and non-executive directors;
- Approve the appointment of the chief executive;
- Decide the remuneration and allowances, and other terms and conditions of office, of the chair and other non-executive directors;
- Appoint or remove the trust's auditor;
- Receive the trust's audit report; and
- Scrutinise the trust's annual plan.

Governors represent members and are responsible for engaging with them and the greater community as defined in the guidance (Developing the role of NHS foundation trust governors). This includes:

- Working with existing voluntary organisations;
- Making and maintaining contact with service users both directly and through representative organisations
- Providing support services for membership and systems to manage them
- Developing members' engagement and activity

Monitor's Code of Governance states that :

- Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct
- The Council of Governors will hold the Board of Directors to account for the performance of the trust, including ensuring that the Board of Directors acts so that the foundation trust does not breach the terms of its authorisation
- The Council of Governors will regularly feed back information about the trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected them or appointed them.

4. Engagement with Partner Organisations

The Trust's Board of Directors is expected to appropriately consult and involve members, patients, clients and the local community and has responsibility for ensuring that satisfactory dialogue with its stakeholders takes place.

The partner organisations referred to in the consultation will be invited to learn about the role of governor and our arrangements for the Council of Governors as part of our application process and we hope through this process to actively engage them and invite them to nominate a representative governor on the Council.

5. Board of Directors

The NHSFT should be headed by an effective board of directors which is collectively responsible for 'the exercise of powers and the performance of the NHS Foundation Trust.'

The governance arrangements within our application will need to set out the overall size and constitution of the Board, as well as the eligibility criteria for non-executive directors, the terms of office, and the roles and responsibilities of the Board including the committee structure.

6. Risk management

Monitor requires NHS Foundation Trust boards to operate effectively, efficiently and economically and uses a risk-based approach for regulation. This is set out in the Compliance Framework with three components:

- Annual risk assessment
- In-year monitoring; and
- Intervention

The Trust Board's approach to risk management will be reviewed and strengthened as the application process progresses in preparation for Monitor to assign risk ratings in three areas:

- Finance
- Governance, and
- Mandatory Goods and Services.

The risk ratings assigned by Monitor will determine the intensity of in-year scrutiny that it visits upon the NHS Foundation Trust. These board and risk management arrangements will be developed from existing arrangements and will demonstrate a comprehensive compliance status with all key national requirements i.e. Core Standards, NHSLA Standards and CQC registration requirements. Monitor is strengthening its processes for assessing applicant Trusts and monitoring compliance of NHS Foundation Trusts for quality and clinical governance.

Summary

This report very briefly describes the key areas of governance for an NHS Foundation Trust and explains where we have started to make specific arrangements. There is more work to be done to define our governance arrangements as part of the application process and this will be brought back to the Trust Board over the next few months.

John Wilkins
FT Lead

Sandra Adams
Director of Corporate Services

11th September 2009

London Ambulance Service NHS Trust

TRUST BOARD - 29 September2009

Document Title	Training Plan
Report Author(s)	Gill Heuchan, Assistant Director of professional Education Development
Lead Director	Caron Hitchen, Director of Human Resources and Organisation Development
Contact Details	Caron.hitchen@lond-amb.nhs.uk
Aim	To inform the Trust Board of the future plans for clinical training of the clinical workforce

Key Issues for the Board

The training plan approved by the Senior Management Group sets out the scope and capacity of the current known Clinical Education commitments for the period from October 2009-March 2011.

A summary of the plan is attached. The full document will be published and will inform the detailed training prospectus which will be available to staff.

In addition to identifying the commitment to clinical training over the coming 18 months, the plan redefines CPD to align the LAS terminology with the wider NHS and the Health Professions Council definition of CPD. In particular, it is made explicit what training is deemed as statutory (required by law) and mandatory (required by the Trust).

Whilst comprehensive, the Clinical Training plan does not represent an exhaustive list and may be subject to change to reflect the rapidly changing clinical environment and identified service need.

The clinical education plan will be delivered through a variety of media which recognise that the LAS employees are adult learners; there is an expectation that staff will take responsibility for their own learning needs and will access the opportunities which are presented to them. Programmes may have elements of self directed learning which are critical to course completion, and staff are expected to complete these as part of the overall programme.

The development and delivery of high quality clinical education is as important to the LAS as the activity to deliver programmes. This being the case during the period of this plan the clinical education team will be developing people measures as part of the balanced score card approach. The uptake against provision of the programmes planned will be monitored with a target of 85% attendance. Reasons for non-attendance and cancellations will be collated and analysed in order to identify trends and patterns which indicate the need for future revision and to assess the risk to the public, staff and the Trust of the training not being delivered.

The Clinical Education and Development Team are developing the systems and processes to initiate qualitative measures in relation to clinical education provision. This will include the development of systems and processes to peer review course content as well as assure the quality and consistency of programme delivery. These processes will apply to centralised training and training delivered within the New Ways of Working complexes to ensure

consistency of quality content and delivery.

Mitigating Actions (Controls)

Recommendations to the Board

To note the summary of the Clinical Training Plan and support the delivery of the plan.

Equality Impact Assessment

A full EIA has not been carried out specifically for this plan as training activity and access is routinely monitored and reported against the required equality strands. Assessment will therefore continue to be an on-going process.

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Training against this plan will be provided in order of priority to those staff not having received training for the longest period and/or with issues of concern being identified.

Corporate Objectives that the report links to

The plan links to the SMG objective to deliver training against the training plan in addition to meeting statutory and regulatory requirements.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 29 SEPTEMBER 2009

Abstract from the Clinical training Plan October 2009 – March 2011

INTRODUCTION

1.1 Clinical Education is valued by staff and the Trust, it is critical to the successful management of risk and continuous quality improvement and as such it is a core activity for the LAS. This training plan sets out the scope and capacity of the current known Clinical Education commitments for the period from October 2009-March 2011. It is intended to inform the Senior Management Team, of the proposal in order that they can approve the Training Plan prior to it being made available to staff. Once approved it will inform the detailed training prospectus which will be published for staff.

1.2 This plan, will be the benchmark against which successful delivery will be measured, the primary focus for this period will be delivery of the plan in relation to quantitative measures, and these will include the numbers of courses committed to, numbers of courses run and uptake/DNA's. Within the period work will be undertaken to develop qualitative measures and to strengthen curriculum development and quality monitoring of programme delivery.

1.3 This Clinical Training Plan recognises the aspirations and strategic direction of the Trust to increase the workforce capacity and capability through delivery of more post registration development, core training and continuing professional development training at complex level. Whilst maintaining a comprehensive programme of initial and pre registration courses at our training centres to satisfy the aspirations of the workforce plan.

1.4 The training opportunities outlined in this plan are based on the identified needs of clinical staff. These needs have been evaluated against the resources available and the release of capacity within operations in order to maintain service delivery levels to provide the plan for the period October 2009-March 2011.

1.5 In the period covered by this plan the Trust is facing a number of competing priorities and challenges. These include the transformational change to clinical education delivery through implementation of New Ways of Working whilst the Trust is undertaking an unprecedented workforce expansion which has generated a significant increase in clinical education activity.

1.6 The Clinical Training plan does not represent an exhaustive list and may be subject to change to reflect the rapidly changing clinical environment and identified service need.

1.7 The clinical education plan will be delivered through a variety of media which recognise that the LAS employees are adult learners; there is an expectation that staff will take responsibility their own learning needs and will access the opportunities which are presented to them. Programmes may have elements of self directed learning which are critical to course completion, and staff are expected to complete these as part of the overall programme.

2. DEFINITIONS

2.1 The LAS has for some time had internal definitions for clinical training which are not recognisable outside of the Trust. This plan has redefined some of the terminology previously used in order to align the LAS to other ambulance and NHS services and sectors thus making it clear for employees, potential future employers and external validators the range of scope of development offered to and accessed by LAS clinical staff.

2.2 The clinical education and development outlined within this plan is defined as:

- **Core Training (previously known as Continuing Professional Development)**- training which is required by law (Statutory) or by the Trust (mandatory) as a requirement of the job role.

- **Technical & Clinical Training** -initial training required to undertake a specific job role

- **Pre-Registration Paramedic Programmes-** preparation for registration with the Health Professions Council as a Paramedic

- **Control Services Training and Clinical Telephone Advice-** Training specific to roles in control services and urgent care services.

- **Continuing Professional Development (this term used in this context aligns the clinical training programmes to requirements of the Health Professions Council, HPC)** - education and development opportunities which support registered practitioners to meet their professional bodies' requirement for continuing professional development. These development opportunities are also available to EMTs.

- **New Ways of Working (NWoW)** - within the NWoW complexes trainers deliver all elements of core training and local level complex specific programmes.

- **Emergency Preparedness Programmes-** these are programmes delivered to clinical staff to ensure that they are prepared and equipped with the knowledge and skills to deal with civil contingencies and major incident situations. (NB some elements of this provision are required in statute).

- **Education Projects-** these are clinical education programmes which relate to specific trust projects and programmes which usually require a one off delivery to ensure implementation.

SUMMARY
October 2009-March 2011

Course Title	Staff Group/Type	Training Type	Number of places planned.
Major Incident training	All clinical staff/ type of programme dependant on the job role.	Core-Statutory	See section 9
Moving and Handling with equipment training	All clinical staff	Core-Statutory and NHSLA	**666**
Resuscitation (ALS and BLS) training with LMA and drugs update	All Clinical staff	Core NHSLA	**666**
Patient Transport Services to A&E support worker conversion course	PTS staff wishing to progress to A&E support roles.	Clinical and Technical.	**36**
Direct entry A&E support courses	New employees wishing to work in A&E support roles.	Clinical and Technical.	**123**
Driving courses			
Emergency Driving Course	Control services staff who may be required to drive emergency vechiles under emergency conditions.	Core- Statutory, Control Services, Clinical and Technical	**14**
D1	Staff with the skills to drive Trust vechieles under nornmal circumstances.	Clinical and Technical.	
D2	Staff with a need to have an advanced level of driving skill for emergency driving.	Core -Statutory Clinical and Technical.	
		Combined total for D1 & D2	**900**

Course Title	Staff Group/Type	Training Type	Number of places planned.
Fast Response Unit(FRU) Driver training	An Update for staff deployed on fast response units.	Core -Statutory Clinical and Technical.	**186**
Team Leader Courses	Newly appointed team leaders	Core -Statutory, Clinical and Technical	**25-30**
Instructional Methods/Instructor Qualifying Courses	Operational staff wishing to become intructors.	Clinical and Technical	**12 IM** **12 IQ**
Direct Entry Student Paramedic Course	New employees wishing to regisiter as paramedics.	Pre registration	**204**
Full time Bsc/Foundation Degreees in Paramedic Science.	Higher educaiton students wishing to regisiter as paramedics.	Pre registration	**71 in 2009** **81 in 2010**
EMT to Paramedic Conversion Course	EMTs wishing to progress to the role of registered paramedic.	Pre registration	**168 full time** **48 part time**
Emergency Medical Dispatcher Call Taking Course	New members of staff employed to process calls in the Emergency Operaitons Centre (EOC).	Control Services	**112**
Emergency Medical Dispatcher Dispatch Course	Members of staff who need to understand the policy and proceudre for dispoacthine operations responses	Control Services	**112**
Work Based Trainer Course (EOC)	Exisiting members of EOC staff who wish to progress to be work based trainers in EOC.	Control Services	**6**
Clinical Leader Update	Clinical leaders who are due an update.	Continuing Professional Development (CPD)	**156**

Course Title	Staff Group/Type	Training Type	Number of places planned.
Operational Managers Clinical Update Days	DSO's and AOM's who require a clinical skills update.	CPD	**160**
Training Officer Updates	Traiing Officers who require clinical and technical skills update.	CPD	**70**
Practice Placment Education Programme (Pped's)	Clinical staff who mentor and assess pre registration students and newly qualified staff	CPD	**400**
Preceptorship	Pped's who wish to delvelop to be precptors for newly qualified paramedics.	CPD	**40**
Part time Diploma Degree and Msc in Paramedic Science	Qualified paramedics and EMTs who wish to undertake further education.	CPD	**Diploma 20** **Bsc 20** **Msc 20**
EMT development modules	EMTs 3 staff who wish to progress to EMT 4	CPD	**See individual elements under core training.**
NWoW	All clinical staff team leaders, DSOs and AOMs	Core- Statutory and NHSLA, CPD	**See individual elements section 8**
Emergency Preparedness (EP)	All clinical staff	Core- Statutory	**See individual elements section 9**
Command point (CAD2010)	All control services based staff.	Clinical Education Projects.	**400**
Olympics	Identified clinical staff	Clinical Education Projects.	**Olympic education plan in develeopment see also section 10.4**
Ad hoc training	All clincial staff as identified.	Clinical Education Projects.	**See individual elements section 10.6**

London Ambulance Service NHS Trust

TRUST BOARD - 29/09/2009

Document Title	Trust Secretary report
Report Author(s)	Sandra Adams
Lead Director	Sandra Adams
Contact Details	020 7921 5243
Aim	To update the Trust Board on key board governance items

Key Issues for the Board

- To note the 2009/10 register of directors' interests
- To approve the proposed committee programme for 2010
- To note the forward planner as at September 2009
- To note the progress made with the review of the format of papers for the Trust Board and the SDC

Mitigating Actions (Controls)

These key documents are maintained by the Trust Secretary.

The register of interests is a public document and is available for inspection on request. This will be routinely reviewed by the Trust Secretary and all directors have a responsibility for informing her of any changes to interests as and when these occur.

Recommendations to the Board

To approve the 2010 committee programme and to note the register of interests and forward planner.

Equality Impact Assessment

N/A for this report.

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

None identified

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

None identified for any board items in September 2009.

Corporate Objectives that the report links to

Good employment practice and organisation development – objective 15: successfully apply to become an NHS Foundation Trust.

DISTRIBUTION LIST 17/08/09

Abraham, Laila	Head of Governance
Adams, Sandra	Director of Corporate Services
Baker Millard, Katherine	Assistant Director of Operations, East
Ball, Ann	Deputy Director of Human Resoures
Bassett, Gary	Patient Advice Liaison Service Manager
Bates, Paul	Senior Training Officer
Bell, Andrew	Operations Finance manager
Billups, Patrick	Educational Governance Manager
Bovill, Lizzy	Assistant Director of Operations
Bradley, Peter	Chief Executive
Brand, Martin	Head of Planning & Programme Management
Brown, Judy	Senior HR Manager, Corporate Services
Buchanan, Andrew	Senior HR Manager, South
Callan, Michael	Assistant Management Accountant
Cassidy, Paul	Ambulance Operations Manager
Chandler, Stewart	Acting Head of Business Development
Clarkson, Claire	Conference, Induction & Awards (CIA) Manager
Comerford, John	Deputy Head of PTS
Cook, Julie	Senior HR Manager, West
Crabtree, Tony	Assistant Director of Human Resources
Damiani, Michael	Deputy Management Information Manager
Daw, Nic	Head of Modernisation & Performance
Deakins, Richard	Head Of Procurement
Dervis, George	CAD Systems Manager
Dinan, Michael	Director of Finance
Downard, John	Head of Software Development & Support
Flaherty, Martin	Deputy Chief Executive
Flower, Phil	Assistant Director of Operations, Control Services
Foad, Nicola	Head of Legal Services
Freeman, Tracey	Olympics Project Accountant
Giordana, Davide	Senior Financial Analyst
Griffins, Roy	Non-Executive Director
Hailstone, John	Clinical Education Manager
Hay, Alan	EBS Operations Room Manager
Heuchan, Gill	Assistant Director of Human Resources
Hitchen, Caron	Director of HR and Organisation Development
Hopson, John	Assistant Director of Operations, Control Services
Huckett, Brian	Non-Executive Director
Hunt, Richard	Chairman
Islam, Asif	Head of Finance
John, Michael	Financial Controller
Jones, Kathy	Director of Service Development
Killens, Jason	Deputy Director of Operations
Lawrance, Nick	Head of Policy, Evaluation and Development
Livett, Carole	Learning and Organisational Development Manager
Longstaff, Peta	Assistant Medical Director
Magrath, Beryl	Non-Executive Director
Markey, Janice	Equality & Inclusion Manager
Masters, Greg	Senior HR Manager, East
McKee, Alison	Senior Buyer
McKenna, Peter	Assistant Director of Operations, West
Meehan, Sue	Management Information Manager
Miller, Keith	Clinical Education Manager
Mohammed, Darryl	Assistant Medical Director
Moore, Fionna	Medical Director

Moore, Stephen	Head of Records Management
Nelhams, Martin	Head of Estates
Nicholas, Martin	Senior Health, Safety and Risk Advisor
O'Neill, Bill	Assistant Director of Human Resources
Patton, Angie	Head of Communications
Perilli, Sonja	Head of Security & Service Delivery
Piscitelli, Giuseppe	Interim Head of IM&T Customer Service
Pooley, John	Head of Emergency Preparedness
Sale, Steve	Head of Workforce Modernisation
Salter, Martyn	Corporate Processes Programme Manager
Selby, John	Senior Health & Safety Advisor
Selleck, Stephen	Capital Projects Manager
Silver, Caroline	Non-Executive Director
Stainthrope, Andrew	Interim Head of Clinical Audit and Research
Suter, Peter	Director of IM&T
Thomson, Neil	Assistant Medical Director
Thorpe, Peter	Ambulance Operations Manager London 2012 Olympic & Paralympic Games
Vale, Christopher	Head of Operational Support
Vander, Margaret	Patient & Public Involvement Manager
Vazan, Reuvan	Strategic Finance Lead - Foundation Trust
Walker, Karen	Corporate Finance Manager
Waller, Sarah	Non-Executive Director
Watts, Tracey	Senior HR Manager
Webber, Richard	Director of Operations
Whitbread, Mark	Assistant Head of Training/Cardiac Lead
Whitmore, David	Senior Clinical Advisor
Wilkins, John	Foundation Trust Lead
Woodrow, Paul	Assistant Director of Operations, South
Worthington, Jane	Clinical Advisor
Wrigley, Fenella	Assistant Medical Director
Wynn, Vic	Head of IM&T LARP

2010 Meetings Calendar

Committee	Chair	Time	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Annual General Meeting	Richard Hunt	2.00 - 4.00pm									**28**			
Annual C/Funds Committee	Caroline Silver (NED)	2.00 - 3.00pm												
Trust Board	Richard Hunt	10.00am - 1.00pm	**26**		**30**		**25**		**27**		**28**		**30**	
Service Development Committee (SDC)	Richard Hunt	10.00am - 1.00pm		**23**		**27**		**29**		**31**		**26**		**14**
Audit Committee	Caroline Silver (NED)	2.00 - 5.00pm			**8**			**7**			**13**		**8**	
Clinical Governance Committ	Beryl McGrath (NED)	2.00 - 5.30pm	**25**			**19***			**26**			**25**		
Risk Compliance & Assurance Group (RCAG)	Peter Bradley (CEO)	2.00 - 5.00pm		**8**			**17**			**23**			**22**	
Strategic Services Group (SSG)	Kathy Jones (Director of Service Development)	9.00am - 2.00pm	**6**		**3**		**5**		**7**		**8**		**3**	
Senior Managers Group (SMG)	Peter Bradley (CEO)	9.00am - 4.00pm	**12**	**3**	**10**	**14**	**12**	**9**	**14**	**11**	**14**	**14**	**10**	**8**
Remuneration Committee	Richard Hunt				**30**	**27**								

Denotes formal sub-committee of the TB

Refreshments booked.

*10.00am - 1.00pm

FORWARD PLANNER

Date	Service Improvement inc. CAD 2010	FT Process	Governance	Strategic & Business Planning	Other	Committee dates
29 Sept 2009 TB	CAD 2010 update	To receive a progress report on the application process including:	CQC Infection Control inspection report		*CEO report including Health & Safety *Receive minutes of the Audit & Clinical Governance Committees *Medical Director's report * Finance Director's report * Performance report	AGM 29/09/09 2.00 - 4.00pm
		Historical Due Diligence stage1: * Long term financial model and financial assumptions * Integrated business plan * Membership strategy * Constitution * Governance arrangements * Timescale	Governance return - Q1 Q2	Business cases: * Lease of ambulances * Workshop West * Silvertown Olympic suite		SSG 2/09/09 9.00am - 2.00pm
			Review format and level of TB/SDC papers.			SMG 9/09/09 9.00am - 4.00pm
			FOI Act policy for approval			Charitable funds 29/09/09
			Safeguarding children and vulnerable adults			Audit Committee 7/09/09, 2 - 5pm
			Winter Plan for approval inc statement of Flu resilience preparedness			
			Balance scorecard - presentation			
			Training Plan - to note.			
27 Oct 2009 SDC Awayday	Olympic and Paralympic games - presentation by Peter Thorpe (MF)	To receive an update on the application process and to review and agree the IBP		Full Business Case for EPRF.	*CEO report including Health & Safety *Receive minutes of the Audit &	CGC 19/10/09 2.00 - 5.30pm

FORWARD PLANNER

Date	Service Improvement inc. CAD 2010	FT Process	Governance	Strategic & Business Planning	Other	Committee dates
			Board Committee structure review		Clinical Governance Committees *Medical Director's report * Finance Director's report * Performance report	SMG 14/10/09 9.00am - 4.00pm
	New ways of working - presentation (MF)		2009/10 core standard declaration.			RCAG 12/10/09 2.00 - 5.00pm
24 Nov 2009 TB	Full update on CAD 2010	To receive an update on the application process	Receive report on new generic Equality & Diversity Strategy (CH)	Full Business Case for EPRF - for approval.	*CEO report. *Medical Director's report *Receive minutes of the Annual General Meeting 29/09/09	Audit Committee 9/11/09, 2 - 5pm
	Performance & Service Delivery (CH)		Receive report on PALS/complaints/ appreciation (MF)			SSG 4/11/09 9.00am - 2.00pm
	Skills Escalator - to note the move to the Higher Education training model		Counter fraud update.	Estates strategy - for approval	Receive minutes of CGC 19/10/09	SMG 11/11/09, 9.00am - 4.00pm
			Annual reviews of standing orders and standing financial instructions.		Receive minutes of Charitable Funds Committee 29/09/09	
			Risk management review, inc. Board assurance framework and corporate risk registrar..			

FORWARD PLANNER

Date	Service Improvement inc. CAD 2010	FT Process	Governance	Strategic & Business Planning	Other	Committee dates
			2009/10 core standards declaration.		Receive minutes of Audit Commmittee 9/11/09	
15 Dec 2009 SDC	Clinical development, leadership & workforce (MF)	Stages 1 & 2 HDD * SHA appproval * Monitor application timescale * SoS approval * Monitor application timescale * Key risks	Governance return - Q3 Ethics CSR progress		*CEO report *Medical Director's report	TBC
26 Jan 2010 TB	Olympic and Paralympic games	Stages 1 & 2 HDD * SHA appproval * Board to Board (provisional)	Governance CQC registration submission		*CEO report *Medical Director's report	CGC - date TBC 2.00 - 5.00pm
23 Feb 2010 SDC	Performance & Service Delivery	Stages 1 & 2 HDD * SHA appproval *Board to Board (Provisional) Board to Board (provisional)	Review chairmanship of sub-committees.	Estates 1/4 review PTS review	CEO report *Medical Director's report	TBC
30 March 2010	CAD 2010 full update Clinical dev, leadership & workforce	Stage 3: Application Board to Board (provisional)	Governance return Q4		CEO report *Medical Director's report	Audit Committee 08/03/10 2.00 - 5.00pm
27 April 2010 SDC	Olympic & Paralympic games	Stage 3: Application Board to Board (provisional)	Annual Report and Accounts 2009/10		CEO report *Medical Director's report	CGC - date TBC 2.00 - 5.00pm

FORWARD PLANNER

Date	Service Improvement inc. CAD 2010	FT Process	Governance	Strategic & Business Planning	Other	Committee dates
25 May 2010 TB	Performance & Service delivery	Annual Plan (FT) 2010/11 submission	KA34 compliance		CEO report	TBC
					*Medical Director's report	
29 June 2010 SDC	Clinical dev, leadership & workforce.				CEO report	Audit Committee 07/06/10 2.00 - 5.00pm
					*Medical Director's report	
27 July 2010 TB	Olympic & Paralympic games.	**Authorisation as an NHSFT**				TBC
		Inaugural meeting of the Council of Governors				
31 Aug 2010 SDC						
28 Sept 2010 TB						
26 Oct 2010 SDC						
30 Nov TB						
14 Dec 2010 SDC						

Presentations
Approval
Compliance