**Trust Board**

**Tuesday, 25th November 2008 at 10:00 am**
**Conference Room – LAS HQ**

**AGENDA**

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| 1. | Apologies: | | |
| 2. | Minutes of the meeting held on 30th September 2008 | | Enclosure 1 |
| 3. | Synopsis of the Part II meeting held on 30th September 2008. | | Enclosure 2 |
| 4. | Matters arising | | |
| 5. | Chairman's remarks | SR | Oral |
| 6. | Report of the Chief Executive | PB | Enclosure 3 |
| 7. | Financial Report, Month 6 2008/09 | MD | Enclosure 4 |
| 8. | Report of the Medical Director | FM | Enclosure 5 |
| 9. | **Approve proposed approach to Stroke** | FM | Enclosure 6 |
| 10. | Approve CAD 2010 Contract Award | PS | Enclosure 7 |
| 11. | Discuss revised Car Leasing Scheme | CH | Enclosure 8 |
| 12. | Approve Full Business Case for new A&E and PTS vehicles | MD | Enclosure 9 |
| 13. | Approve Information Management & Technology Strategy | PS | Enclosure 10 |
| 14. | Approve Risk Management Policy amendments | MD | Enclosure 11 |
| 15. | Note update re. Foundation Trust Programme | MD | Enclosure 12 |
| 16. | Update regarding Corporate Social Responsibility | MD | Presentation |
| 17. | Approve annual review of Standing Orders and Financial Regulations | MD | Enclosure 13 |
| 18. | Update re. SIP 2012 | KJ | Enclosure 14 |
| 19. | Receive Charitable Funds Annual Report | CS | Enclosure 15 |
| 20. | Receive draft Audit Committee's minutes | CS | Enclosure 16 |
| 21. | Receive draft Clinical Governance Committee's minutes | BM | Enclosure 17 |
| 22. | Receive draft Service Development Committee minutes | SR | To follow |
| 23. | Report of the Trust Secretary on tenders opened and use of the Seal since the last Trust Board meeting. | CMc | Enclosure 18 |
| 24. | Opportunity for members of the public to ask question | | |
| | Date of next meeting: 10.00 am on 27th January 2008, Conference room, LAS HQ, Waterloo Road. | | |

Enclosure 1

**LONDON AMBULANCE SERVICE**

# TRUST BOARD

**Tuesday 30th September 2008**

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

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| **Present:** | Sigurd Reinton | Chairman |
| | Peter Bradley | Chief Executive |
| | Non Executive Directors | |
| | Beryl Magrath | Non Executive Director |
| | Caroline Silver | Non Executive Director |
| | Ingrid Prescod | Non Executive Director |
| | Brian Huckett | Non Executive Director |
| | Roy Griffins | Non Executive Director |
| | Sarah Waller | Non Executive Director |
| | Executive Directors | |
| | Martin Flaherty | Director of Operations |
| | Mike Dinan | Director of Finance |
| | Fionna Moore | Medical Director |
| | Caron Hitchen | Director of Human Resources & Organisation Development |
| **In Attendance:** | | |
| | Kathy Jones | Director of Service Development |
| | Peter Suter | Director of Information Management & Technology |
| | David Jervis | Director of Communications |
| | Martin Nelhams | Head of Estates |
| | Mark Mitten | Member of Patients' Forum Ambulance Service (London) |
| | Gary Orris | Member of Patients' Forum Ambulance Service (London) |
| | Michaela Neuigan | St George's Healthcare NHS Trust (until 11.30) |
| | Darren Coyle | South West London & St George's Mental Health NHS Trust (until 11.30) |
| | Tracey Tyer | British Sign Language Interpreter |
| | Zane Hema | British Sing Language Interpreter |
| | Christine McMahon | Trust Secretary (Minutes) |

The Chairman apologised to Board colleagues for the lack of quality control exercised in respect of some of the reports circulated with the Agenda as they were unacceptably long and detailed, and not pitched at the right level for the Board.

**96/08 Declarations of Further Interest**

**There were no declarations of further interest.**

**Although not a declaration of interest, the Chairman informed the Board that he is a member of the Advisory Board of The Foundation (a management consultancy company) which had recently bid for a NHS contract. Following legal advice, he was assured that, as the value of the contract was considered to be immaterial and he would have no direct**

**involvement in the work that may be undertaken, there was no conflict of interest. (Postscript: The bid by The Foundation was unsuccessful.)**

**97/08 Opportunity for Members of the Public to ask Questions**

**There were no questions from members of the public.**

**98/08 Minutes of the Meeting held on 29th July 2008**

**Agreed:**
1. **The minutes of the meeting held on 29th July 2008.**
2. **That the minutes of the Trust Board be circulated as soon as possible following the meeting. ACTION: Trust Secretary**

**Noted:**
3. **Minute 80.08: although the reference to the London Airwave Radio Project (LARP) was correct it was clarified that five LAS vehicles had been fitted with the necessary equipment in September 2008 but that the original full implementation date of November will not be achieved due to the delays being experienced by the national Airwave Radio Programme (ARP) programme.**

**99/08 Synopsis of the Trust Board's Part II meeting held on 29th July 2008**

**Noted:**
1. **The contents of the synopsis of the Trust Board's Part II minutes.**
2. **That a meeting will be held with representatives of the Patients' Forum Ambulance Services (London) to discuss the requirement that members of the forum give an undertaking of confidentiality in respect of the non-public meetings they attend at the LAS.**

**100/08 Matters arising from the minutes of the meeting held on 29th July 2008**

**Noted:**
1. **Minute 78/08: the Chairman said he had not written to David Nicholson concerning the latter's remarks about the potential role of the ambulance service in reducing admissions to hospitals. He said that the points he would have made had been addressed in the Healthcare Commission's report on Urgent and Emergency Services.**
2. **Minute 83/08: that a Social Worker had been recruited to assist the PALS team with the on-going work relating to Frequent Callers Further thought will be given as to how the Social Worker's expertise could be used elsewhere in the Trust e.g. by Clinical Telephone Advisers or EOC.**

**101/08 Chairman's remarks**

The Chairman said that, following Sir George Greener's resignation, Mike Bell had been appointed interim Chairman of NHS London until Sir Richard Sykes takes up the post in December 2008. Mr Bell will be visiting the Trust to review Healthcare for London including the proposed Stroke Programme and the approach to Unscheduled Care.

The Chairman has invited, Baroness Barbara Young, Chairman of the Care Quality Commission to visit the Trust in the next few weeks. The Care Quality Commission

will replace the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission with effect from April 2009.

Both the Chairman and other members of the Board attended meetings recently at which David Sissling, Programme Director for Healthcare for London, gave a presentation on the progress of the Healthcare for London's programmes. The Chairman said there had been some dissatisfaction expressed by attendees at the meetings concerning the pace of progress in regard to Stroke due to the need for public consultation. Following legal advice from the Trust's solicitors, Capsticks, the Trust is proposing, through the commissioning process, to take patients having a stroke directly to hospitals that have hyper acute stroke units. The Chairman said he did not believe the introduction of a third telephone number (in addition to 999 and NHS Direct) that people could ring for advice was necessarily an appropriate way to respond to people who call 999 with problems that are neither serious nor life threatening.

The Director of Service Development said that work was being undertaken with NHS Direct in the hope of being able to present a joint proposal for an integrated response hub pilot somewhere in London as part of the Unscheduled Care workstream in Healthcare for London (H4L).

The Chairman said the Board of the Ambulance Service Network had decided not to hold AMBEX, its annual conference, in 2009. The Chairman said he accepted that AMBEX did little to publicise the work of the ambulance service to the rest of the NHS but was concerned the opportunity to do a better job of sharing new clinical developments and best practice in the UK and with colleagues abroad (which is what AMBEX was meant to do) would be lost since no alternative has yet been proposed.

The Chairman said the Trust had lodged a complaint on security grounds with Lambeth Borough Council's planning department concerning the application by Transport for London (TfL) to erect toilets in front of headquarters.

POST MEETING NOTE: following the Board meeting confirmation was received that Lambeth Borough Council had rejected TfL's application.

**102/08** **The Chief Executive's report**

Chief Executive presented the report and highlighted the following:

The Trust has been involved in every aspect of the implementation of the Healthcare for London in particular Stroke, MI and Urgent Care.

The Patient Transport Service has submitted bids for a number of contracts; the PTS Strategy will be discussed by the Service Development Committee in October prior to its presentation to the Board in November.

The New Ways of Working (NWOW) programme has commenced. Barnehurst, one of the chosen complexes, held the first ever complex away day which was attended by a 100 members of staff based at the Barnehurst complex. The feedback received was that the event was successful and the Chief Executive said that full details of the feedback were available if desired. Work will be undertaken with the management and members of staff of the complex during the next six months to implement the NWOW approach. Chase Farm, the other chosen complex, will be holding an away day in November 2008.

London Airwave Radio Project (LARP): problems were experienced with the airwave radios deployed during the Notting Hill Carnival and the Trust is working with the Department of Health and Airwave to address the matter. The rollout of

LARP across England is unlikely to take place this calendar year and the Trust is awaiting a revised plan from the Department of Health and Airwave.

CAD 2010: the Full Business Case, approved by the Trust Board in July, will be considered by NHS London's Capital Investment Committee in October 2008. The Chief Executive said that a paper concerning the transition arrangements from CTAK to CAD 2010 will be presented to the Board for consideration. **ACTION: Director of IM&T.**

A&E: operationally it has been a difficult few months for the Trust which has coincided with an intense focus by the Commissioners and the Department of Health on the percentage of Category B calls that receive a response within 19 minutes. The Trust will receive an additional £6.4m from Commissioners to support Category B 19 minute performance in 2008/09.

Discussions were continuing with Commissioners in respect of funding for 2009/10; an early decision will enable the Trust to recruit, train and deploy additional members of staff by early 2009/10 in order achieve sustainable 95% Category B 19 minute performance. ORH[1] has been asked to review overall resourcing levels with a view to delivering sustainable performance through to 2011/12. In order to do so it will be necessary to add sufficient resource to reduce overall ambulance utilisation rates to circa 50 to 55%. There will be presentation to the Service Development Committee in October 2008 outlining progress and an initial view on potential staffing requirements. **ACTION: Director of Operations.**

Performance trajectories for the remainder of the year for Category A and Category B calls have been agreed with Commissioners. Additional funding will be received during the remainder of the year which is linked to performance remaining in line with the trajectories. The Trust was on track to achieve the trajectory for September with 74% of Category A calls receiving a response within 8 minutes and 84% of Category B calls receiving a response within 19 minutes. The trajectories for October are 76% for Category A calls requiring a response within 8 minutes and 88% for Category B calls requiring a response within 19 minutes.

The Chief Executive said there was a delicate balance to be struck between the two performance targets, as deploying additional resources to achieve one often had a detrimental impact on the other. Overall demand in September was relatively flat, but this masked significant demand increases at weekends. September had also proved challenging in staffing terms and this had undoubtedly pegged back performance.

Performance in the Control Room was affected by the problems experienced with the computer system which Board Members were informed about as it occurred. The problems experienced with the current computer system demonstrated the fragility of the existing system and every effort is being made to maintain its stability prior to the introduction of CAD 2010.

PTS' performance in September was good, both quantitatively and qualitatively.

The implementation of Active Area Cover has been very successful and the Chief Executive thanked both Board colleagues and Staff Side Representatives for their efforts in reaching an agreement. A review will be undertaken in six months time to assess its impact; to date there have been relatively few adverse comments received from front line members of staff.

Recruitment is ongoing to meet the additional staffing levels required by the Trust. It is planned to recruit 150 posts above establishment of 2913 to allow for slippage in the recruitment process, and in anticipation of additional funding from the

1 ORH: Operational Research in Health

Commissioners to ensure that 75% of Category A calls receive a response within 8 minutes and that 95% of Category B calls receive a response within 19 minutes from April 2009.

The Board's attention was drawn to a Channel 4 documentary series entitled "The ambulance: 8 minutes to disaster". Copies of the programme were available if Board members had not seen the programme.

It was NOTED that:

The deployment of Fast Response Units (FRUs), to approximately 30% of Category B calls had led to a gain of 5-6 percentage points in Category B performance but adversely affected response times to Category A calls by 4-5 percentage points. The response to Category A calls within 19 minutes has remained stable. In recent weeks there have been problems staffing ambulances due to school holidays and people wishing to take annual leave, allied to a low level of interest in overtime. Some FRUs that have been despatched to Category B calls have also had to remain on scene longer than normal because of the poor availability of ambulances. The review of utilisation rates currently being undertaken by ORH will enable the Trust to identify when/where it should deploy resources to ensure lower and therefore safer, levels of utilisation; to improve response times and decrease multiple despatch rates.

The response to the recent problems experienced with the hardware of the existing computer system in the Control Room has included further testing of the fall back control room situated at Bow. The Director of IM&T said that the current system did not allow for a completely seamless switchover between Bow and EOC, though this will be possible with CAD 2010.

The existing contract of employment required members of staff to seek approval from their line manager prior to taking up second jobs. A copy of the revised policy will be circulated to the Non-Executive Directors. **ACTION: HR Director.** The Board requested further information concerning the numbers of staff with second jobs was requested. The HR Director said that the information is held locally and an indicative figure will be obtained. **ACTION: HR Director**

There was support for the recruitment above the establishment figure in recognition of the importance for the Trust to have the additional staff in post. There has been a good response to the Trust's recruiting advertisements with 2,000 applicants being short listed for assessment.

Discussions have commenced with the Trust's Commissioners and NHS London regarding the funding of education and training for a three year period; a decision may be made by December 2008.

An utilisation chart will be included in the next Chief Executive's report. **ACTION: Chief Executive.**

The dates and times of programmes relating to the ambulance services, and in particular the LAS, will be circulated to Non Executive Directors in advance of the broadcasts. **ACTION: Director of Communications.**

The mini Patient Report From (PRF) is completed by FRU members of staff as they arrive at an incident first and is then used by Ambulance Crews to complete the full PRF. The Director of Operations said that work will be undertaken with FRUs that respond to Category B calls to ascertain if they can be redeployed once they are satisfied the patient's condition is stable and their continuing presence is not required.

**103/08 Financial Report, Month 5, 2007/08**

The Financial Director presented the Month 5 financial report and highlighted the following:

Income exceeded expenditure by £82,000. The budgeted position to Month 5 is for expenditure to exceed income by £971k hence there is a year to date favourable variance of £1,053k.

PTS reported a loss to date of £460k, against a planned surplus of £36k. The loss arose due to the excessive use of third party providers and a recovery programme has been put in place to deal with this.

Additional spending on overtime was being partially offset by reduction in other costs within the Trust.

The year end forecast is a surplus of £0.952m against a planned surplus of £1.140m.

Key assumptions in forecast included: additional PCT funding to £5.895m; non pay savings forecast of £0.961m; decreased SPPP provision £239k; additional overtime and incentive spend to £5.895; unfunded over-establishment of workforce plan £448k; estimated slippage against workforce plan £847k; funding for training equipment for Hannibal House £483k and PTS breaking even.

Capital programme 2008/09: a detailed breakdown of capital projects was given including information on procurement, estates and the higher than anticipated capital costs for CAD 2010

It was NOTED that:

Consideration will be given to adding the potential risk of staffing being over establishment to the Trust's Risk Register. **ACTION: HR Director**

Funding for the CBRN (Chemical, Biological, Radiological and Nuclear) team was received for 2008/09 and included funding for HART (Hazardous Area Response Team). Discussions were taking place with the Department of Health in respect of a Service Level Agreement for the future provision of HART.

Although no additional funding has yet been received in respect of the work being undertaken by the Trust to prepare for the Olympics, the Finance Director said he was confident the money will be received. The Trust has submitted a detailed paper to the Department of Health, with supporting evidence, setting out its funding requirements.

The Cost Improvement Programme (CIP) has a target of 3% savings of the cost base. There had been some criticism following the undertaking of the FT diagnostic concerning the common practice in ambulance services of achieving savings based on vacancy management and removing the savings from budgets. The Finance Director said that the receipt of additional funding mid-year did not help in the maintenance of the approach outlined above.. An analysis of the CIP will be presented to the Service Development Committee. **ACTION: Finance Director**

The basis for the CIP is to ensure an organisation undertakes a fundamental review of its cost base whilst ensuring it meets its performance objectives. The Chairman said there needed to be more visibility of this matter at board level and said it would be added to the Board's forward planner. **ACTION: the Chairman**

Concern was expressed that PTS was bidding for 11 contracts given its current financial status. The Finance Director said a recovery plan was in place to address PTS' financial situation and that the 11 bids listed in the Chief Executive's report included existing contracts. The Finance Director apologised to the Board for an

error in the report; the reference to PTS bidding for a contract with Moorefield Eye Hospital NHS Foundation Trust was a mistake as this will be a national contract.

The Finance Director presented the Investment to Save benefits realisation report. It was a fairly self-critical review of the Investment to Save programme that outlined the benefits realised from the Investment to Save expenditure. The Finance Director said that a lot of good work had been undertaken, although the savings achieved were less than initially anticipated. The Finance Director said that, in terms of the wider London NHS economy, the LAS had delivered by spending the majority of its allocated funds in 2007/08.

The report stated that CRB (Criminal Record Bureau) checks had not been undertaken for all front line staff. The HR Director said the majority of members of staff who have patient contact did receive CRB checks; it was not possible to complete the project within the deadline of 31st March 2008.

The Finance Director said that a benefits realisation analysis will be undertaken of the Lost Property Bags which were recently introduced.

The Internal Auditors, BSM Bentley Jennison, have been asked to undertake an audit of the benefits realisation programme and report to the Audit Committee.

**104/08** **Annual Audit & Inspection Letter**

**Noted: The recommendations contained within the Annual Audit and Inspection Letter.**

**105/08** **Report of the Medical Director**

The Medical Director presented her report and highlighted the following:

An update on Serious Untoward Incidents (SUIs) showed that although the number of incidents considered as potential SUIs had increased the number declared had fallen.

Jan – Dec 2007: 49 incidents were considered as potential SUIs with 6 declared
Jan – Aug 2008: 39 incidents were considered as potential SUIS with 3 declared

The emerging trends were delayed responses and clinical issues. The number of incidents involving the Police due to patients collapsing following violent struggle has decreased from six in 2007 to one in 2008 to date, as have obstetric and maternity cases (six in 2007 compared with two in 2008 to date). There has been an increase in the number of SUIs involving psychiatric patients (one in 2007 and four in 2008 to date). The report included a list of articles featured in the LAS News alerting staff to the learning outcomes of SUIs.

The Trust has received a grant from the National Institute for Health Research's Health Technology Assessment Programme, in partnership with the Welsh and East Midlands Ambulance Services, to undertake a research project measuring the costs and benefits of a new protocol that enables paramedics to assess and refer patients aged 65 or over who have fallen to a community based falls service. The trial will commence 2009, which includes a one year period to ensure the services and trial data collection and management processes are in place. Therefore, patient recruitment is expected to take place in 2010.

The Stroke Association is funding a research project aimed at enhancing the recognition of stroke by ambulance personnel. The study is a collaborative project being undertaken in partnership with Barts and the London NHS Trust, Homerton University Hospital NHS Foundation Trust and the University of Hertfordshire. Currently, all UK ambulance services use the Face Arms Speech Test (FAST) to identify if a patient has experienced a stroke, which has limitations in identifying

posterior circulation strokes that are characterised by visual field disturbances. The study aims to test if an in-hospital stroke recognition tool, the Recognition of Stroke in the Emergency Room (ROSIER), which has been shown to increase the diagnostic accuracy amongst A&E physicians, improves the identification of stroke in the out-of-hospital setting.

Additional funding has been received from Philips Medical Systems to expand an existing SMART CPR study to include the West as well as the East and South LAS Operational Areas. The SMART CPR study examines the impact of a predictive algorithm on the Philips FR2+ AED on survival from cardiac arrest. The algorithm analyses the patient's initial cardiac rhythm and predicts whether an immediate shock is likely to result in return of a pulse or if a period of CPR prior to the delivery of a shock would be more beneficial.

The LAS has prepared two publications examining the incidences and characteristics of out-of-hospital cardiac arrests that are attended to by the LAS using data from a four year period. These publications will be submitted to leading peer reviewed journals that specialise in the cardiac field.

Governance: six policies and procedures were circulated to the Board for approval. These policies and procedures were previously approved by the Senior Management Group and the Board was asked to ratify these. The Trust is required to have Board approval for these policies and procedures prior to the assessment by the NHS Litigation Authority in mid October.

A further six policies and procedures have been developed which formally acknowledge that the LAS followed the JRCALC guidelines, and also where applicable, other national guidelines pertinent to ambulance service pre-hospital care.

Richmond and Twickenham PCT (RTPCT) Controlled Drug Local Intelligence Network (LIN) have recently agreed to act as the lead LIN on behalf of all the other London LINs as far as the reporting structure for incidents involving controlled drugs are concerned. The agreed structure is that the LAS will submit a quarterly LIN Report to RTPCT, (nil returns are mandatory), and that the Medical Director as the Accountable Officer, or in her absence The Senior Clinical Adviser to the Medical Director will attend the scheduled meetings. Details of the recent report submitted for April –June 200 was included in the Medical Director's report.

Copies of two Medical Director's bulletin and Clinical Newsletter for August were circulated at the meeting.

Drugs: Oramorph was now available for use by paramedics with effect from October 2008. Clopidogrel (super aspirin) was now available for patients with ST elevation (acute coronary event) in accordance with JRCALC guidelines; the Trust was sourcing small bottles of water to allow for the administration of this drug.

Infection Control: the Trust has taken steps to implement the Department of Health Infection Control Guidelines and to support the infection control measures being undertaken by Acute Trusts. These include: sleeve protectors; disposable tourniquets; hand wipes; alcohol gel and surface wipes. The cannulation packs include labels to identify pre-hospital placement.

Recognition of Life Extinct (ROLE) in children: HM Coroners and the London Safeguarding Children Board have finally reached an agreement regarding ROLE in children. All children over the age of 2 years if found deceased and resuscitation is NOT appropriate will remain on scene and the ROLE procedure will be adhered to. Infants under the age of 2 years found deceased and resuscitation is NOT appropriate will be taken to the nearest A&E that accepts paediatrics where they can be examined by the on call paediatrician.

It was NOTED that:

The Trust's host ethics committee is based at Lewisham NHS Trust and provides ethical approval for trials being undertaken by the Trust. Research proposals include the requirement to assess data arising from the trials at given points.

The receipt of research funding demonstrated the regard in which the LAS and its Research and Audit department were held; the Medical Director said she will pass on the Board's commendation to the department.

The drug Oramorph was being used by front line crews when appropriate i.e. when intravenous access was difficult to obtain. The Board will be kept informed of its usage.

The Chairman and Non-Executives were unhappy with being asked to agree the six policies and procedures at such short notice and wished to see better planning in place in future. The clinical policies and procedures had been reviewed by the Medical Director and the Chairman of the Clinical Governance Committee.

The Chairman said he had recently met Professor Roger Boyle, National Director for Heart Disease and Stroke, who had most complementary about the contribution of the LAS' Cardiac Lead, Mark Whitbread. The Medical Director said she will pass on those comments.

In regard to ROLE, the rationale for two years was that less than two years old the cause of death may be sudden and be related to a cot death syndrome; in children older than two the death is more likely to be due to trauma or be known about in advance due to an existing medical condition.

**Agreed: To ratify the six policies and procedures:**

- **Policy for consent to examination or treatment**
- **Procedure for the handover of patients**
- **Procedure for the issue and use of drugs by LAS staff**
- **Claims handling policy and procedure**
- **Incident reporting procedure**
- **Stress management policy**

**106/08 <u>The Final Serious Untoward report regarding the death of Paramedic Ron Pile.</u>**

The Director of Operations presented a detailed report outlining the SUI investigation into the death of Paramedic Ron Pile who had been killed in a road accident whilst training to be a motorcyclist responder.

The Board expressed its condolences to the widow and family of Ron Pile on their loss. The Chairman said he had spoken to Mrs Pile at the recent Awards Ceremony when Ron Pile was posthumously awarded a twenty year medal, and she expressed her gratitude for the support received from the LAS, in particular from Steve Colhoun, the Ambulance Operations Manager of Romford Complex.

**Noted: The contents of the report which included the verdict by the Coroner that Paramedic Ron Pile's death had been accidental and that the procedures in place to select and train LAS motorcycle responders were exemplary.**

**107/08 <u>Approval of two strategies: Long Term Conditions and Older People</u>**

The Director of Service Development gave a presentation outlining the key priorities in the treatment of Older Patients and patients with Long Terms Conditions. The

strategies had been drafted following work with a number of external stakeholders. Once approved by the Board the strategies will be disseminated widely both to staff and the general public. The strategies will be included within the Service Improvement Programme and incorporated into the existing programmes of work with their implementation monitored. The Director of Service Development said that although the strategies may appear to be relatively un-ambitious the resources required to deliver the training to staff and educate the general public will be significant.

It was NOTED that:

There was no mention of Connecting for Health due to the fact that currently the ambulance service does not have access to patient's information held on the data system. It was decided to adopt a low technology approach initially in respect of the immediate implementation of the strategies.

In regard to the education, it was recognised that work will be undertaken to educate General Practitioners concerning the Urgent and Emergency Care provided by the LAS, in particular when the LAS attends a GP's patient and the patient is not conveyed to hospital. The two strategies will be communicated to the various stakeholders who participated in the drafting of the strategies and to the wider public.

The decision had been taken to have an Older People's Strategy rather than one that focussed on dignity as age is a significant factor in health, particularly for people from a social and economically deprived background. In line with Department of Health guidelines it was decided to use the age of 65 as a starting point for the Older People's strategy, although it is recognised that many people who are 65 are still fit and well. The older an individual is the more likely it is that there will be complicating factors involved in addition to the incident for which assistance is being sought, e.g. the interaction of various medications for pre-existing conditions.

**Approved The Long Term Conditions and Older People strategies.**

**108/08 <u>Ratification of Chairman's Urgent Action: amended LAS Risk Management Policy</u>**

The Chairman, on behalf of the Board, approved the amended Risk Management Policy which had been revised in advance of the forthcoming assessment by the NHS Litigation Authority. The Risk Management Policy was revised following consideration by the Risk Compliance & Assurance Group (RCAG), the Audit Committee and the Senior Management Group.

**Ratified: : 1. The Chairman's Urgent Action approving the LAS' Risk Management Policy further to clarification in paragraph 2.2 regarding the consideration of clinical risks by the Clinical Governance Committee, RCAG and the Audit Committee.**

**Noted: 2. That the Board will be provided with information concerning the cost of insurance and how much it has to pay over and above the premium. ACTION: Finance Director will provide the insurance report to the Service Development Committee, December 2008.**

**109/08 <u>Approval of FT Programme Plan</u>**

The Finance Director presented the FT Programme Plan and reported that work was being undertaken to recruit staff to support the programme e.g. Membership Managers. The Plan addresses the key issues (Integrated Business Plan; delivery of

CAD 2010 and Finance) identified in the feedback received from Malcolm Stamp following the conclusion of the FT Diagnostic.

The Board's attention was drawn to the work undertaken to date since the feedback received from Malcolm Stamp. This included: the appointment of a project manager to take forward the programme including the development of the Integrated Business Plan; further development of the Business Strategy; a workshop has been arranged with Commissioners to agree demand projections as part of the Trust's Integrated Business Plan.

The Programme will be managed as one of the Service Improvement Programmes with regular monitoring by the Programme Board and the Strategic Services Group.

It was NOTED that:

Section ER3 referred to formal and regular patient surveys not being undertaken. The Director of Service Development said that the Healthcare Commission had ceased conducting annual patient surveys for the Ambulance Service as the results were generally positive with little learning being achieved. In 2006 MORI, on behalf of the LAS, undertook a quantitative and qualitative survey of a sample of Londoners; the findings were quite positive and provided the Trust with some learning points. It was recognised that this survey would be used to provide a benchmark to measure the Trust's future performance.

The 64 page feedback received following the FT Diagnostic will be responded to as part of the application process.

The Northumbria Healthcare NHS Foundation Trust uses text messaging to obtain instant feedback from patients and this is something the Trust may consider in the future.

The reference in section BP4 that 'every other ambulance service has changed their CAD in the past 18 months and will identify lessons from implementation' was incorrect and that statement should be omitted. **ACTION: Finance Director**

**Approved:**
1. **The FT Programme Plan.**
2. **That FT progress reports will be a standing item on future Service Development Committees and Trust Boards agendas.**

**110/08 <u>Presentation regarding the Trust's estate & approval of Business Case relating to 4th Floor, Loman Street.</u>**

The Director of Finance gave a presentation outlining the various projects and developments taking place in regard to the Trust's estate.

It was NOTED that:

PTS leases, where possible, are co-terminus with the duration of the contract.

The concern expressed by members of staff regarding the air quality at the proposed new ambulance station in Neasden due to a nearby waste transfer station had received attention from the Estates Department. Representatives of the Estate department had met with the Environmental Agency and had been assured that all the necessary arrangements were in place and that there were no injunctions or restraints in force.

The Chairman said there should where possible be close dovetailing between the Clinical and Estates strategies.

Business Case: 4th Floor Loman Street

The Finance Director presented the business case for the lease of 4th Floor, Loman Street which will accommodate the Olympics and the Foundation Trust team. The cost included a rent free period of one year to take account of the refurbishment work that will take place and so the report should have stated that the rental will be £198,000 from Year 2.

Brian Huckett expressed concern that business case did not set out the number of staff being accommodated in the new property or mention the costs of security. The Head of Estates said that the Loman Street building had its own security during out of hours and that there was a separate access to each floor which required security passes.

Brian Huckett said that he would have liked clarification as to the non-financial benefits reported on page 136 and what the term 'pairings' meant. The Head of Estates said that the approach adopted was standard NHS business case methodology; the advantage of Loman Street was the proximity to the finance department on the 3rd floor as opposed to being situated in a different building. The Director of Service Development said that pairings referred to the ranking system used. The Chief Executive said that in future an explanation will be included.

Brian Huckett asked about the reference to the allocation of car parking spaces for office based staff and it was confirmed that this was standard practice as some members of staff are required to drive and therefore need a car parking facility.

**Approved: The business case for 4th Floor Loman Street.**

**111/08 Receive Business Continuity Update**

The Finance Director presented the Business Continuity plan, originally drafted in July 2008 but updated to include the learning from the recent problems experienced with CTAK. One of the amendments referred to the Fall Back Control testing processes support for business continuity systems.

**Noted: The contents of the Business Continuity Update.**

**112/08 Receive update regarding Service Improvement Programme 2012**

The Director of Service Development presented an update concerning the Service Improvement Programme which included explanations as to why the following projects had been identified as being of red status (i.e. not on track and cause for concern): Mobile Office; Referral Pathways; Re-engineer Income Collection; Asset Tracking; Performance Measurement Phase 2 and London Airwave Radio Project (LARP).

The underlying reasons for the delays were the availability of resources in respect of people or technology, or to circumstances beyond the Trust's control i.e. delays being experienced by the national ARP. The Director of Service Development said a new manager was being recruited to oversee the continuing development and improved usage of Referral Pathways. Work was being undertaken to address the reported data processing issues through the use of an offsite data warehousing facility.

**Noted: 1. The progress of the Service Improvement Programme and the reasons why the projects were not on track and were cause for concern.**

2. **That the Chairman commended the style and content of the report which he said was well presented and contained the right level of detail.**

**113/08 Draft Minutes of the Annual Charitable Fund Committee, 8th September 2008**

Caroline Silver, Chairman of the Charitable Funds Committee, presented the minutes of the Annual Meeting held on 8th September 2008. The Committee received the annual report and management accounts for 2007/08; as planned the Funds were being gradually run down.

Investec, the Fund's Investment Advisers, reported that the return on funds invested in 2007/08 was -12%, which though disappointing was not surprising given the economic climate and the volatility of the financial markets. The Committee had agreed that the current investment policy should continue unchanged but be kept under review. The Committee discussed the ethical component of the investment portfolio. It was recognised as the funds invested in the general investment portfolio were relatively small it was decided to leave the management of the portfolio unchanged and to concentrate on maximising investment income for the Fund.

**Noted: The draft minutes of the Annual Charitable Fund Committee, 8th September 2008.**

**114/08 Draft Minutes of the Audit Committee, 8th September 2008**

The Chairman of the Audit Committee, Caroline Silver, presented the draft minutes and highlighted the following:

1. That the Audit Commission gave an unqualified opinion on the Trust's 2007/08 annual accounts.
2. That a new Local Counter Fraud Service (LCFS) Officer had been appointed.
3. The contents of the Internal Auditor's reports, in particular the findings of the Records Management audit of the handling of Patient Report Forms.
   The Chairman of the Audit Committee said there was a theme emerging from the internal audits undertaken suggesting that corporate policies and procedures were not being complied with throughout the organisation and that further was needed to improve trust wide compliance.
4. That following a tendering process, RSM Bentley Jennison, had been re-appointed as the Trust's Internal Auditors.
5. A work programme was in place to ensure the Trust complies with the requirements of the International Financial Reporting Standards (IFRS).
6. The Audit Committee reviewed and amended its terms of reference (included in the Risk Management Policy).
7. The Committee's meeting on 10th November will include a review the Trust's external financial reporting process (e.g. FIMS).

**Noted: The draft minutes of the Audit Committee, 8th September 2008.**

**115/08 Draft Minutes of the Clinical Governance Committee, 4th August 2008**

The Chairman of the Clinical Governance Committee, Beryl Magrath, presented the draft minutes of the Clinical Governance Committee 4th August 2008, highlighting that the Committee had:

- Revised its terms of reference (contained in the Risk Management Policy);

- Reviewed the proposed revision of the Area Governance report which will improve the quality of the information received by the Committee.

**116/08** **Report on tenders opened and the use of the Trust Seal since the last Board meeting**

Two tenders have been opened since the last Trust Board:

*Croydon resurfacing*
FM Conway Ltd Millane Contract Services Ltd Coniston Ltd
Frankham Consultancy Group

*A&E E Ambulance conversion*
U V Modular WAS Vehicles (UK) S MacNellie & Son

Use of the Trust's Seal: there have been two entries, reference 119 and 124 since the last Trust Board meeting. The entries related to:

| | |
|---|---|
| No. 119 | Lease 69b Bounds Green Road N11 between the LAS and the London Borough of Haringey |
| No. 120 | Lease & Licence for alterations for second floor Hannibal House, Elephant & Castle Shopping Centre between the LAS and Key Property Investments (Number Five) Limited. |
| No. 121 | Assignment of Unit 28, Bermondsey Trading Estate, London between the LAS and Servicetec Limited. |
| No. 122 | Lease of 32 Southwark Bridge Road, London between Equisys Plc and LAS |
| No. 123 | Floor Hannibal House, Elephant & Castle Shopping Centre between Key Property Investments (Number five) Limited and the LAS |
| No 124 | Section 106 Agreements re. 164 Harlesden Road, London NW1 between the Mayor and Burgesses of the London Borough of Brent and the LAS. |

**Noted:**
1. **The report of the Trust Secretary on two tenders received**
2. **That the Trust's seal had been used six since the last Trust Board meeting.**

**117/08** **Any Other Business**

There was no other business.

**118/08** **Opportunity for members of the public to ask questions**

The members of the public present had no questions for the Trust Board.

**119/08** **Date of next meeting**

Tuesday, 25th November 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 12.42

Enclosure 2

# LONDON AMBULANCE SERVICE NHS TRUST

## TRUST BOARD
## Part II

## Summary of discussions held on 30th September 2008
**held in the Conference Room, LAS HQ, London SE1**

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

On the 30th September 2008 in Part II the Trust Board noted that:

A meeting will be held with the Patients Forum Ambulance Service (London) to resolve the matter of Forum members giving an undertaking of confidentiality to the Trust when they attend LAS' internal meetings

The LAS will continue its efforts to have all the recognised Trade Unions sign up to the new consultative arrangements.

Enclosure 3

**LONDON AMBULANCE SERVICE NHS TRUST**
**TRUST BOARD MEETING 25th NOVEMBER 2008**

# Chief Executive's Report

## 1 SERVICE DEVELOPMENT

### Healthcare for London

Work continues to ensure that the ambulance service is involved in and contributes to NHS London's work on Healthcare for London.

Clinical and policy staff remain engaged in all of the workstreams to an appropriate extent.

Current progress includes:

Stroke
HfL has issued its final stroke strategy and have invited expressions of interest from acute trusts to be designated hyper-acute stroke units. As we understand it, the numbers of such units will be low but acute trusts not in the centre of London are being encouraged to consider seeking designation, as this is supported by the incidence of stroke. HfL is proposing that all acute strokes be taken to these centres, whatever the time of onset of the stroke, since it can be expected that the care will be of the highest standard in these units whether or not the patients are eligible for thrombolysis.

Meanwhile a small number of PCTs have approached the LAS requesting that certain units be bypassed. These requests reflect the current arrangements for stroke treatment and are not intended to prefigure nor determine the outcome of the designation process or the consultation that will follow. This issue is to be discussed elsewhere on today's Trust Board agenda.

Trauma
The five hospitals shortlisted to develop their proposals for trauma networks have now done so and have been visited by accreditation teams. The outcome of that process should be announced shortly.

The LAS internal working party continues to meet and has been working up an options paper on the LAS response to changes in the configuration of trauma units.

Unscheduled Care
Conversations continue with HfL over the possibility of piloting a response hub model. In parallel we are talking with our commissioners over whether this can go forward as a service development.

Local Hospital Feasibility
Kathy Jones and Fionna Moore have met with the project manager for this workstream to discuss how to ensure that LAS would continue to take as many patients as appropriate to these units and to any community-based services they will run in due course, as it would affect their viability if this did not prove possible.

Polyclinics
Four PCTs will be early implementers of polyclinics: Harrow, Redbridge & Waltham Forest, Hounslow and Lambeth. We are ensuring contact with each of these developments in order to ensure an LAS presence of some sort. This could range from simply being able to take patients to the polyclinics through to having staff based there as part of the clinical team.

## 2 SERVICE DELIVERY

### 2.1 A&E Operations (graphs 1 – 14)

In light of the continuing challenging performance and sub-optimal staffing, the Trust has remained at REAP Level 3 'service pressure' and has been implementing the relevant actions associated with this level. A review of the various REAP actions is underway to ensure that they remain current and that they are routinely being applied across the Trust . There is a danger of course that when we have been at REAP 3 for a long period of time the impact of the actions associated with is diluted. The current review is designed to ensure that this does not happen. As reported at the last Board robust performance management arrangements are in place and working well with both the Central Delivery Unit (CDU) and the Area Delivery Units (ADUs) now permanently staffed through to end April.

Active Area cover has continued to produce benefits. For the month of October there were over 7,700 recorded deployments. A good indicator of the benefits derived from its use has been the fact that 10% more calls have been electronically dispatched to Ambulances than in previous months. The performance difference between electronic and manual dispatch for Category A calls on Ambulances is about 25%, so there is strong potential for further gains as Active Area Cover becomes more embedded and further work is done within EOC to use the automated dispatch function for ambulances more effectively.

Chase Farm Complex held their successful New Ways of Working Away Day on 10th and 11th November at a hotel in Dartford. The aim of this event was to progress the plans for Chase Farm in order to deliver the New Ways of Working programme for their complex. A range of forums including clinical leadership, rostering and staff welfare were convened and aims agreed for the coming months. Presentations included learning from the implementation of team based working in Great Western Ambulance Service that could be applied at Chase Farm.

The new Emergency Care Practitioner Development plan and the Emergency Bed Service Development plan were both presented and discussed at the recent Service Development Committee. Both plans outlined the improvements planned for these LAS services between 2008 and 2012. Debates included the possible inclusion of palliative care beds in the EBS bed finding services and the role of ECPs in delivering clinical leadership at their local complexes.

CTAK was more stable in late September, but there were some outages in October caused by hardware upgrades and various other faults. These are described in greater detail later in the report. As always such failures have a significant impact on performance and have

contributed in part to the poor outturn for October. There were also some issues that affected the secondary triage system PSIAM used by Clinical Telephone Advice(CTA) in mid November when the system was unavailable for several hours and a temporary fix had to be implemented using the Bow server and Laptops until the problem could be resolved.

Work is continuing to ensure that the benefits associated with the new gazetteer are fully implemented. Whilst the gazetteer is now stable and working, many of the anticipated benefits have yet to be enabled. These include the live monitoring of call takers which will give accurate and live information in areas such as log in/log out and call duration which will allow us to more effectively manage down the variations in call-taking performance. In addition the ability to more accurately identify frequent callers will be enabled to allow us to focus our efforts on reducing demand from this cohort of service users.

We are currently carrying out a review of the working arrangements in the Urgent Operations Centre (UOC) to ensure that it is working at its full potential and maximising its support to the core A&E Fleet. The review will be overseen by the new ADO for control services Phil Flower and will be completed by the end of November. .

CTA recruitment is still proving to be problematic both internally and externally. Attempts to recruit from the nursing profession have produced very little success to date. CTA currently has 43 whole time equivalents in post against a funded establishment of 70. This is clearly hindering its ability to achieve the previously agreed levels of workload. The next strand of work is to explore the feasibility of providing remote CTA at LAS sites outside HQ. We are certain that this will improve our ability to recruit further staff to CTA which is an essential component of our performance improvement strategy for the remainder of the year.

The scoping of the project to pilot GPs working in EOC is progressing well. The purpose of this project is to identify any potential benefits from having GPs working in the control room environment. This will involve assisting in the prioritising and ringing back of calls which are being 'stacked' because we have no available resource to send together with general support to CTA in terms of resolving Category C calls. The initial stage of the project will commence at the end of November and will run for four weeks. The plan is then to make adjustments to the scheme and run it again for a further period of four weeks. A final review will then take place and a decision will be taken as to whether to roll it out as a permanent function within control services. The overall aim will be to add value both by decreasing clinical risk to our patients and by reducing overall demand by resolving more calls over the phone.

In October we hosted a Gold training session at headquarters for the LAS and NHS London Golds to help explore each other's role in a major incident. This training was well received by all and plans are in place to carry out a regular programme of joint training and familiarisation in the near future.

November was a busy month for events. The Emergency Planning Unit put in place our well exercised plans to cover the Lord Mayor's show, the central London Remembrance ceremony and the 90$^{th}$ anniversary ceremony for the armistice of the First World War. These events were managed successfully with our partners, St. John Ambulance. The planning for the service response to the challenge of New Year's Eve is now well underway and the Emergency Planning Unit is fully engaged in this process.

Across the weekend of 1st & 2nd November the Emergency Planning Unit put in place plans to cover 20 large public firework displays across the capital.

The new revised copy of the Green Guide (Safety of Spectators at Sports Grounds) has been published. The Emergency Planning Unit is currently reviewing this document to look at the implications for the LAS and it will also be reviewed by the National Emergency Preparedness Board over the coming weeks.

**Accident & Emergency service performance and activity**

The table below sets out the A&E performance against the key standards for the first half of 2008/9 and for the first 16 days of November.

| | **CAT A8** | **CAT A19** | **CAT B19** |
|---|---|---|---|
| ***Standard*** | ***75.0%*** | ***95.0%*** | *90.%** |
| Year to date | 73.07% | 98.06% | 82.90% |
| September 2008 | 73.92% | 98.27% | 83.90% |
| October 2008 | 72.95% | 98.26% | 85.36% |
| 1-16 November | 70.5% | 97.88% | 81.93% |

* Commissioned Target for 2008/9 (Please note National Target is 95%)

- The overall demand increase so far this year is running at 2.44% to end October although we expect this to approach the anticipated 3-3.5% as the final quarter progresses.
- Category A performance reached 73.92% in September exceeding Trajectory but has remained poor through October and into early November. This has in the main been due to fluctuations in staffing and workload coupled with some technical problems within the control rooms. In October there was an overall workload increase over the previous year of 3%. The cause of this was mainly Category C calls, where there was an average daily increase of 8% over the previous year. Category B saw an increase of 4% and there was an overall fall in Category A call workload of 1.5%.
- It is important to retain some perspective here in that Call Connect performance last September and October was 63.8% and 64.4% with virtually identical staffing levels. The levels now being achieved against a higher workload still represent a step change in performance.
- Weekend resourcing difficulties remain one of the biggest challenges and each weekend consistently shows a pattern of very high demand through Friday and Saturday night shifts which current resourcing simply cannot match. This leads to ambulance utilisation in the 80 to 90% bracket and the trust runs out of ambulance resource leading to the stacking of multiple 999 calls and poor performance. Plans are in hand to address this issue through the current recruitment processes in 08/09 and the commissioning round for this year which is seeking to attract a further significant investment in staff during 09/10
- Category B performance has shown some slow but steady improvement through September and October but has proved more challenging in November. as can be seen

by the figures in the table above. The number of Category B calls attended by FRUs was increased at the end of September and beginning of October from about 12% to 30%. This brought about an expected improvement in Category B performance of about 5%, but had a significant negative effect on Category A performance. We are currently running with a 'middle ground' position of circa 18% Category B workload on the FRUs .

- Call taking achieved 95% for September which was a healthy improvement over August. However, there was a slight fall back in October to 93%. Whilst two of the weeks did achieve 95%, the other two saw performance fall to as low as 89.5% which in part was caused by the CTAK issues mentioned earlier.
- Hospital pressures have been profound in the recent months with daily delays for ambulances at multiple hospitals across London. These issues, which appear to be worsening , are significantly hampering our ability to deliver call connect targets. Work is in hand with Commissioners and NHSL to raise the profile of these hospital delays and we will begin to provide comprehensive information on such delays to Acute Trusts, Commissioners and NHSL from late November. This detailed quantitative information coupled with ongoing support through NHSL will hopefully provide the improvements which are required.
- Whilst we have clearly had performance improvement plans in place for many months we have now undertaken a comprehensive review of those plans and taken into account not only our own experience of improving performance but also examples of best practice from around the country. The result is a revised plan which contains a number of High Impact/High Priority initiatives coupled with an extensive list of lower priority initiatives and enablers. This is a Pan-LAS improvement plan and will require input and action from each Directorate within the service. Progress against these initiatives is being monitored weekly at SMG level .
- The continuing performance challenge has of course resulted in significantly increased focus from both our Commissioners and NHSL. We are meeting regularly with both and are currently revising our performance trajectories which will need to be submitted by end November. Concern is inevitably growing that the Trusts will not be able to reach the 75% Cat A target for the year and whilst we remain confident that there is sufficient time available to us to do so, it is clear that the next six weeks are a crucial time for the LAS.
- Staffing has generally improved during September and October with the exception of the half term week in October which proved exceptionally challenging. . We remain heavily reliant on high volumes of overtime working and this will not change substantially until post April 09 when the majority of the staff being recruited this year will be fully trained.
- The Board will be aware that we have constructed this year's recruitment of 'Student Paramedics' to create two separate clinical placements of one month duration. We will begin to use these staff in a supervised capacity on front line work from mid December onwards and this will improve the staffing situation in December, February and March.
- The overtime arrangements for December have been published early this year along with an agreement with staff side to suspend the overtime list system to a "first come first served" system during this period which started on the 10th November. This

agreement has allowed us to plan overtime early and early indications are encouraging in terms of the effect on December staffing. As always the most difficult period will remain December 24th through to January 1st .

## 2.2 PATIENT TRANSPORT SERVICE (graphs 15 – 18)

Commercial

The LAS was invited to make presentations via the London Procurement Project exercise for the following contracts:

- Barnet, Enfield and Haringey Mental Health Trust (new business)
- Barking, Havering and Redbridge Hospitals (part existing business)
- Lewisham Hospital (new business)
- North East London Mental Health Trust (existing business)
- North West London Hospitals (new business)
- Royal National Orthopaedic Hospitals (existing business)
- South London and the Maudsley Mental Health Trust (existing business)

Bromley Hospitals and Queen Mary's Hospital NHS Trusts have dropped out of this process, deciding instead to extend their contracts with the LAS until 31st March 2010.

In the case of Barnet, Enfield and Haringey Mental Health Trust, we were asked to make a further presentation to users of the service, where competition for the contract was limited to the LAS and M&L.

Outside of the above process the LAS has also made a presentation to South West London and St George's Mental Health Trust (existing business). We are in competition with OSL and GSL.

Results of all of these tender exercises are due to be announced at the end of November 2008.

Performance

Performance on the quality statistics continue to remain consistent for October 2008 at:

- Arrival time: 90%
- Departure time: 93%
- Time on Vehicle: 95%

## 3 HUMAN RESOURCES

**Workforce Plan implementation**

Recruitment of Student Paramedics is on-going with 300 recruited to date. Of these c80 are waiting to obtain their C1 driving licence and have yet therefore to be allocated to training courses. There are currently an additional 370 applications at various stages of the recruitment process. The recruitment event held on 18th October was very successful. 79 people were assessed; 43 were interviewed; 31 people were appointed.

The second floor of Hannibal House being developed is on track and due to become available as planned on the 24th November 2008.

**HPC Validation**

The Trust has received the report from the Health Care Professions Council validation team following their assessment visit in September.

This validation was focussed on our training for Paramedics which includes both the existing training programme for Emergency Medical Technicians progressing to qualified paramedic and for the more recently introduced student paramedic programme.

This is the first time ambulance trusts have had their training programmes validated by the HPC and the LAS are pleased with the report received which provides a number of recommendations and conditions to be met within a timescale yet to be determined in agreement with the HPC team. Most of these relate to new mandatory elements of training for Paramedics such as ethics and law. These new elements are in the final stages of development which is being lead by the LAS for potential uptake nationally.

The Trust also received a commendation within the report for the support available to staff and students, in particular recognising the value of the LINC scheme at the LAS.

**Unions and Partnership Arrangements**

The revised joint consultative arrangements, agreed by the majority Unison members of the Staff Council, are being established from November 2008, with the first meeting of the new Staff Council being held on 20 November. Given the refusal of GMB, TGWU and Amicus unions to sign up to the agreement initially, it was felt appropriate to delay implementation for a short period whilst discussions continued to seek to reassure these unions and gain their acceptance of and involvement in the new structures. Amicus has since signed the agreement, and TGWU has indicated that it will do so. Discussions with GMB continue in the hope that it will also take up its seats.

Nationally, Unite the Union, the new union to be formed by the merger of TGWU and Amicus, has balloted its staff on industrial action up to and including strike action. The ballot has resulted in votes in favour on both counts, albeit the union has indicated that it will not take action that "emergency cover will be maintained at all times". Before taking action the union must give seven days notice, and any initial action must begin with 28 days of the ballot closing (12th November). Unite has fewer than 200 members in the Trust , and once any planned action is known the potential impact on service delivery will be assessed.

**Flu**

A series of clinics staffed by ECPs has been held to offer flu jabs to all staff on a voluntary basis. Sixteen separate sessions were offered at venues around the trust, an increase on previous years. The trust is also represented on the pan-London HR Pandemic Flu planning group.

**NHS London**

Work is progressing well and is on track to submit a proposal to the SHA for a three year Education and Development investment plan by December 2008.

The Director of Human Resources and her team are working closely with NHS London representatives and other stakeholders (including commissioners and Health Care for London) to develop the plan and gain support at the earliest stages of development.

The LAS, through the Director of Human Resources and Organisation Development are fully engaged in the implementation of the recently launched "Workforce for London - A strategic framework".

**Retrospective CRB checks**

All staff approached have now responded to the request to complete the required CRB check.

To date 109 checks have been 'positive'. This includes 13 cases which have already been disclosed to the Service by the individual. Each 'positive' check has been considered by a single panel to decide what further action might be necessary. 26 cases required a full investigation under the disciplinary procedure, and 14 are ongoing. It remains that only one member of staff has been dismissed as a result of this exercise and one member or staff resigned with immediate affect.

This has been a significant exercise which has been conducted smoothly, consistently and with minimum disruption.

**Equality & Diversity**

The Trust has commenced delivery of its new Diversity training module which has received excellent feedback from those attending. This is being supported by a new e-learning module accessed via the Trust's intranet.

Ricky Lawrence has now returned from his secondment to the Department of Health and Janice Markey, Diversity Manager designate commences with the Trust on 1 December.

**Workforce information**

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

Sickness levels continue to be monitored and managed closely and have remained stable in September at 5.26% for the Trust continuing to be within target.

Staff turnover remains stable within the year with no significant changes in any area of the Trust.

Against the A&E establishment of 2913 we have 215 vacancies as at 31 October 2008. The report above gives progress of recruitment to these vacancies.

**Trust Sickness Levels**

| Financial Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|
| 2007/08 | 5.73% | 5.73% | 6.10% | 6.25% | 6.05% | 5.80% | 6.33% | 6.47% | 6.34% |
| 2008/09 | 4.79% | 4.49% | 4.64% | 4.96% | 5.41% | 5.26% | | | |

**A&E Ops Sickness Levels**

| A&E Ops Areas | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 | Apr-08 | May-08 | Jun-08 |
|---|---|---|---|---|---|---|---|---|---|
| A&E Ops East | 6.78% | 7.03% | 6.92% | 6.64% | 6.23% | 5.63% | 4.67% | 4.18% | 5.27% |
| A&E Ops South | 6.39% | 6.58% | 7.00% | 7.02% | 6.36% | 5.91% | 4.86% | 4.18% | 3.62% |
| A&E Ops West | 6.32% | 6.23% | 6.52% | 7.78% | 6.77% | 6.61% | 6.41% | 5.69% | 4.96% |
| Control Services | 7.19% | 7.27% | 6.83% | 6.98% | 6.79% | 5.40% | 4.45% | 5.11% | 5.55% |
| PTS | 8.43% | 8.24% | 7.13% | 8.27% | 9.86% | 8.36% | 6.80% | 6.02% | 7.30% |
| **Trust Total** | **6.33%** | **6.47%** | **6.34%** | **6.61%** | **6.32%** | **5.66%** | **4.79%** | **4.49%** | **4.64%** |

**Staff Turnover**

| Staff Groups | Apr-06/Mar-07 | Apr-07/Mar-08 | May-07/Apr-08 | Jun-07/May-08 | Jul-07/Jun-08 | Aug-07/Jul-08 | Sep-07/Aug-08 | Oct-07/Sep-08 | Nov-07/Oct-08 |
|---|---|---|---|---|---|---|---|---|---|
| A & C | 11.04% | 13.13% | 13.48% | 15.29% | 14.20% | 14.79% | 13.35% | 14.59% | 15.38% |
| A & E | 4.64% | 5.13% | 5.36% | 5.46% | 5.75% | 5.58% | 5.47% | 5.44% | 5.64% |
| CTA | 0.00% | 5.13% | 11.11% | 10.26% | 10.00% | 8.51% | 10.87% | 8.51% | 9.09% |
| EOC Watch Staff | 11.04% | 11.70% | 12.80% | 11.85% | 13.57% | 12.57% | 12.20% | 12.87% | 13.31% |
| Fleet | 5.08% | 10.91% | 13.21% | 13.21% | 13.21% | 13.21% | 7.55% | 5.66% | 11.32% |
| PTS | 6.16% | 11.02% | 11.86% | 12.60% | 12.50% | 12.34% | 11.97% | 12.61% | 12.55% |
| Resource Staff | 1.96% | 2.04% | 2.08% | 2.08% | 2.08% | 2.08% | 2.08% | 2.13% | 2.13% |
| SMP | 6.72% | 6.74% | 6.99% | 7.83% | 8.12% | 7.36% | 7.32% | 7.37% | 6.88% |
| **Trust Total** | **5.87%** | **6.83%** | **7.24%** | **7.51%** | **7.80%** | **7.57%** | **7.27%** | **7.35%** | **7.57%** |

**A&E Establishment as at October 2008**

| Position Titles | Funded Establishment | Staff in post | Variance | Leavers |
|---|---|---|---|---|
| Team Leader | 175.00 | 158.58 | 16.42 | 2.00 |
| ECP | 86.00 | 50.19 | 35.81 | 0.00 |
| Paramedic | 830.00 | 849.13 | -19.13 | 2.00 |
| EMT | 1220.00 | 1328.78 | -108.78 | 8.00 |
| Student Paramedic | 300.00 | 105.00 | 195.00 | 0.00 |
| A&E Support | 232.00 | 163.79 | 68.21 | 3.53 |
| EMD1 | 54.00 | 64.02 | -10.02 | 1.00 |
| EMD2 | 90.55 | 110.95 | -20.40 | 4.22 |
| EMD3 | 100.76 | 65.42 | 35.34 | 0.00 |
| EMD Allocator | 78.00 | 66.06 | 11.94 | 0.00 |
| CTA | 70.00 | 42.78 | 27.22 | 0.00 |
| **Total** | **3236.31** | **3004.70** | **231.61** | **20.75** |

# 5 INFORMATON MANAGEMENT & TECHNOLOGY

## CTAK ISSUES

It was previously reported that there were problems with CTAK during August and September 2008. Over this last period problems have continued, causing a varying degree of disruption to EOC and operational performance.

### 7 and 8 October 2008

Following on from previous hardware problems, there was a planned downtime to complete further remedial work to improve the overall stability of CTAK. At 02:00 on 7 October the system was taken down and EOC reverted to paper as planned. The remedial work was successfully completed by the CTAK Systems Manager and a Senior Dell Support Engineer. However, as the EOC users were brought back on line (at around 06:00), problems were reported with the system issuing duplicate incident numbers. Further work was required to resolve this before EOC could be fully restored at 08:10 and EOC business continued as normal.

The problem was that when the system was restarted, it reset the incident counter and hence, tried to re-issue incident numbers issued between midnight and 02:00. This has never happened previously and is not connected with the remedial work undertaken with the hardware. At 14:45 EOC reported some problems with mapping and associated services on server 1. This continued and overall problems with system stability grew, resulting in the decision at 18:00 to return EOC to paper. Stability was restored by running the entire system on server 0, allowing EOC to commence using CTAK from approximately 19:00, albeit without FREDA (FRED was working) or performance information being available.

Work continued through the evening to effect a repair to allow performance information to be restored from approximately 23:30. The system was left in a stable state for the rest of the night, but without the functionality of FREDA. Work recommenced at 08:00 on 8 October, focusing on effecting parallel repairs and reconfiguration to bring server 1 back on line and to share the load and re-balance the system. Full functionality was restored (FREDA) at 16:30.

There is no one single cause of the problems described above. There is no logical explanation as to why the incident counter reset itself. The system has been restarted on many occasions before and this has never occurred. Investigations into the underlying software code have not yet offered any explanation. The underlying cause of the second problem is clearly linked with the hardware and its complex configuration. Work during this problem and further investigations by the hardware supplier, has identified the preferred option of a complete hardware replacement for the CTAK servers. Since the new hardware has greater capacity, this will simplify the overall configuration. Work has commenced on a sequence of activities to replace the hardware platform, which is anticipated to take place in January 2009. Running the CTAK application on a newer version of the operating system and new hardware will not be without its own risks and problems. However, taking everything into account, it would be a greater risk to leave CTAK on its existing hardware until CAD 2010. There is also the potential for newer hardware to provide some improved performance for EOC.

**16 October 2008**

At 08:02, EOC experienced problems with mapping and sessions freezing. An operational consideration was made to go to paper, but this did not actually happen. At 08:23 IM&T support staff were on site and commenced investigations. Temporary fixes were implemented to allow users to restore system stability. The underlying problem appeared to be corruption in some database tables, either caused by some software error or a hard disk fault.

During the day, EOC remained fully operational on CTAK while hardware and software investigations continued. The response by the hardware maintainer was very supportive. They put staff and equipment on standby ready in the event of a hardware error being found. However, all diagnostics were run successfully and it was decided that none of the hardware would be changed and the maintainer stood down. A resolution to the error in the database was found and tested; however, implementation required a complete take down of the system.

Given shift changes and operational pressures, this was scheduled for later in the evening. In a planned and controlled manner, EOC reverted to paper and CTAK was taken off-line at 21:00. Remedial work was completed and EOC commenced logging back in at about 22:30. Some problems arose with icons on maps that required further intervention and the system was declared fully stable at approximately 23:55. IM&T staff remained on site until 01:00. As a preventative measure, a new IM&T support team was on site from 07:00 (17 October). However, no further problems arose and the system has remained stable since then.

**AWARD WINNING: FRED/FREDA**

The NHS London awards evening was held on 30 October 2008. Not only did the LAS win the best software/technology category, but also won the big prize of the night – NHS innovator of the year 2008, on the basis that our innovation had the biggest impact on the most number of patients in London.

This was an excellent achievement for everyone in CTAK Development and Support and also Paul Webster from A&E Operations - an excellent example of bringing business and technology together to deliver real business benefit. As reported above, it has been a particularly difficult time for the CTAK/A&E team recently so a real pleasure for them to have a good news story. This is a fantastic achievement; something that everyone in IM&T and A&E Operations should be very proud of.

**DATA CENTRE**

The HQ Data Centre has been at capacity (in terms of power) for some time and this has lead to a hold being imposed on a number of projects needing to implement new servers. Work has been undertaken to stabilise the uninterruptible power supply, however, these measures have only recovered the situation to a point of safe stability.

In order to address the main issue, a contract has been let with BT to provide an outsourced data centre in the city. Work is currently on track to commence implementing some new services into this new data centre before Christmas, with the full migration being completed by March 2009.

## 6 COMMUNICATIONS

**New corporate website – www.londonambulance.nhs.uk:** The Service's new website was launched this month. The site has been developed to meet a number of objectives.

- To increase awareness of opportunities to work for us.
- To increase understanding of how and when to use our service.
- To educate people about what to do in a life-threatening medical emergency.
- To promote our work amongst healthcare professionals.
- To provide advice and reassurance during a crisis.
- To encourage Londoners to become members of our foundation trust, and facilitate that membership (future).
- To engage with Londoners and encourage their feedback.

Features on the site include a recruitment section where all job vacancies are advertised, and applicants can download the forms they need to apply for a post. Different career opportunities are also explained and are supported by staff case studies.

The site provides advice on when people should call 999 and what to do in life-threatening emergencies, for example when someone is having a heart attack or cardiac arrest. This information has been translated into a number of different languages based on the usage statistics of Language Line.

A section has been developed specifically for other healthcare professionals, outlining the services we can provide to them. And there is also a facility to trigger a special section in the event of a major incident, which will take over the website's homepage.

The new site takes account of accessibility standards, and the content has been written in plain English. Use of the site will be evaluated on a regular basis and the findings will inform future developments.

### Media

**Media training:** Senior operational staff including four assistant directors of operations and nine ambulance operations managers have recently received media training. The training equips staff with the skills to carry out TV, radio and press interviews on a range of Service issues.

**Staff safety:** The use of risk registers by ambulance services received media attention in early November, and members of staff were interviewed on Radio 5 Live and Radio 2 about their experiences of physical and verbal abuse.

### Staff recognition

**NHS champions:** Three members of staff are finalists in the NHS Champions Awards 2008. Emergency Medical Dispatcher (now student paramedic) Katie Vallis was nominated for helping Guardian journalist Leo Hickman deliver his wife's baby over the telephone. Paramedic Rob Bentley made the finals for saving the life of a seriously premature baby born in the living room of his mother's home. And Romford Ambulance Operations Manager Steve Colhoun was nominated for the support he gave to his complex staff following the

tragic death of motorcycle paramedic Ron Pile. The winners will be announced at an awards ceremony in central London on 11 December.

**NHS 60:** Camden Paramedic Andrea Gibbs has been recognised for her contribution to the community in a book to celebrate the 60th anniversary of the health service. *Extraordinary*, which was launched this month, features 60 staff across the NHS.

**Patient and Public Involvement (PPI)**

**Tower Hamlets project:** The first emergency life support training session for women was held in September at the Montefiore Children's Centre in Tower Hamlets. Eleven young mums, two dads and several babies attended. Feedback from participants was excellent, and the questions they asked demonstrated their understanding of what they had learned.

Following the success of last year's Bengali classes for staff at Silvertown, another course is planned from January for a further eight participants.

Tower Hamlets PCT and Dr Foster held a session for staff on the Get the Right Treatment health education pack. The Silvertown staff who attended are now keen to extend the training to their colleagues. There are also plans to extend Get the Right Treatment to schools, using different scenarios which will be relevant to young people.

**Public Education:** The pilot development programme for public education staff started in October, with two modules looking at The Developing Practitioner (the value of reflective practice and learning sets) and Coaching (so they can support others through the programme in the future). Twelve members of staff are taking part in the programme, which will continue until January.

The Public Education Strategy Steering Group is considering which books and other resources would be suitable for us to use with children. It has been agreed that resources should be focused initially on key stage 2 (age 10-11), as this is the age group we have the most contact with via Junior Citizens Schemes.

**NHS Centre for Involvement:** The Centre has compiled a report on our progress since last year's assessment of PPI within the Service. This is extremely positive, particularly highlighting our commitment to PPI by having a non-executive director on the PPI Committee, and the introduction of community involvement officers.

**PPI activity:**

- A range of community events have been held over the summer, including several focusing on gun and knife crime. We are now considering making an educational DVD on this topic.
- Approximately one to three open days per week have been held to recruit community responders in different areas of London.
- We had a stand at an event in Hounslow for people with learning disabilities, which has led to a request for us to work more closely with this group.
- A mental health stakeholder event was held by the Policy, Evaluation and Development team, to update our mental health strategy. The day was very productive and well-attended, including mental health service users and professionals.

- With the ambulance operations managers, the PPI Manager is beginning to meet the host organisations for Local Involvement Networks (LINks). Initial meetings have been very positive and it is expected that LINKs will be a good way for the Trust to liaise with patients and the public in the future.

**Peter Bradley CBE**
Chief Executive Officer

18 November 2008

Enclosure 5

**LONDON AMBULANCE SERVICE NHS TRUST**

**Trust Board 25th November 2008**

**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 since my last report in September. 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 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.

Seventeen alerts were received from 19th July 2008 to 30th October 2008. All alerts were acknowledged; three requiring some form of action. Two of those requiring action relate to the use of wheelchairs and the method of securing those chairs in ambulances, the third is regarding the use of the NHS Number as a unique patient identifier.

With regards to the wheelchair alerts, (received on the 27th and 28th October 2008), the LAS Safety and Risk Department are still assessing their relevance. That said there is no need to take any immediate action as the LAS has the ability to secure all types of wheelchairs within their vehicles. The completion date for action on these two alerts is 27th January 2009 for the alert issued on the 27th October 2008, and 10th December 2008 for the alert issued on the 30th October 2008.

The alert regarding the use of the NHS Number as a unique patient identifier on clinical records requires a completion date of 18th September 2009. This alert instructs all NHS organisations in England and Wales that provide primary, secondary and all other types of care such as community pharmacy should now ensure that by 18th September 2008 patients are identified primarily by the use of their NHS number. For UK Ambulance Services there appears to be no explicit guidance on this subject. It is therefore suggested that the topic is discussed by the Clinical Governance Committee. Possibly the only practicable solution here is to provide a box on the PRF to record the NHS number of a patient where known.

**Update on Safeguarding Children and Vulnerable Adults**

Revised Sudden Unexpected Death in Infants (SUDI) procedures presented to NHS London and London Safeguarding Boards. These have now been agreed by HM Coroners, thus resolving an area of potential conflict for crews, and allowing a pan - London approach for the LAS staff who attend children who die at home.

We will be undertaking a work plan based on the report from the benchmark exercise we undertook and will be in close liaison with the (now) London SHA lead who of course sits on our SCAP Group.

We are working on a response to the new *No Secrets* consultation

Work to improve administration of referral procedures is underway although we have some IT issues that we hope will be resolved shortly. We are also planning to pilot electronic direct referrals by crews at the NWOW sites, hopefully from January.

## 2. Second domain – Clinical and Cost Effectiveness

**New Drugs:**

Clopidegrel trial: ethical approval for this study has now been granted. However, following the decision by JRCALC to approve the use of this drug in STEMIs we anticipate introducing this drug for the routine treatment of these patients from January 2009

Oral Morphine: supplies are now available to paramedics. An approach is being made through Pharmacists and the Directors of Clinical Care Group, to the Medicines and Healthcare Regulatory Authority (MHRA) to reintroduce unit drug vials, to facilitate the national re introduction of a practical form of oral morphine.

Oxygen: the LAS implemented the British Thoracic Society Guidelines for Emergency Oxygen use on 6$^{th}$ October. A teaching package has been developed for Complex Training Officers to highlight the changes. Despite the Guidelines being publicised nationally we have to support crews who are challenged by hospital staff who are unaware of the changes.

**NICE Guidelines:**

The only NICE Guideline published recently which is of direct relevance to ambulance services is that on acute stroke. The LAS is currently compliant with these guidelines.

**New Research Projects**

**EVAR study:**

The LAS will contribute to a Healthcare Technology Assessment (HTA) funded multicentre study randomising patients with an abdominal aortic aneurysm to either conventional or endovascular repair. Our role in this study will be to transport patients to regional vascular centres and to minimise fluid resuscitation prior to arrival.

**DANCE study:**

Funding is being sought for the 'Direct Angioplasty for NSTEMI Acute Coronary Events' study, where patients with chest pain and ECG changes suggestive of ischaemia, but not classical ST segment elevation are transported direct to one of the eight heart attack centres for early (as apposed to immediate) angiography. All eight centres have expressed an interest in this project.

**Clinical Update Newsletter**

The October edition (issue 13) covers issues arising around suspension trauma, emphasises the need for pain relief in acute coronary syndrome, the importance of regarding 12 lead ECGs as part of the clinical record and collecting them centrally. It also highlights the appropriate use of the LA277 form (for reporting violent or abusive patients) and the need to limit the reporting of medically unwell patients for inclusion on the High Risk Address Register.

This edition contains the 'ECG of the Month'.

*Copies of this bulletin will be available at the meeting.*

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

Appendix 1 provides a summary of findings from the National Ambulance Clinical Performance Indicator for stroke.

**3. Third Domain – Governance**

**Clinical Support Desk - update**

A total of 710 calls were logged during the month of October, a significant increase on September. A sharp rise in education questions from the Room and calls from A&E support crews has added to the call volume.

**Workload:**

The administrative duties being undertaken by the team continues to rise, in particular around Patient Specific Protocols and palliative care plans. Staff have been encouraged to record administrative time, since it is a significant amount of work. Work on frequent callers continues to save a large but unquantifiable number of ambulance journeys. More urgent care crews are accessing the desk with regard to non-conveyance, although it is noticeable in some cases that the desire to leave a patient at home has been inappropriate. UOC controllers have been asked not to contact GPs before talking to the paramedic on the Desk, because experience has shown that a number of these patients require conveyance to hospital.

The team have arranged a large number of referrals – often liaising with senior medical staff at receiving facilities. This has saved significant numbers of journeys with reduced need for inter-facility transfers.

Increasingly calls about Capacity and Consent are being resolved by the team, reducing the number of hospital journeys. However it is evident that many staff are not familiar with the LAS capacity tool.

Nine calls were referred on to the Medical Directorate on call person for further advice.

The continued shortfall in staffing has resulted in cover at some times being provided remotely by mobile telephone, although less so than in previous months. With the increasing volume of work and reliance on documents stored in EOC, this is proving harder to maintain. Recruitment to the vacant positions on the team has been disappointing, though some Team Leaders are now assisting with the cover arrangements.

**Appendix 2** provides details of the call volume and types

## 4. Fourth Domain – Patient Focus

### Amendments to the Mental Health Act

The following changes were introduced on 1st November 2008.

**Name change to roles**
Approved Social Worker (ASW) title replaced with Approved Mental Health Professional (AMHP). For ambulance staff this is simply an administrative change. They should, however, be made aware of the change.

**Changes to legislation around 'Place of Safety'.**
New legislation allows for patients to be moved between several locations as long as they are assessed within 72 hours of the original detention. This means that patients can be moved from (for instance) the Emergency Department to a more appropriate setting. This change will need to be cascaded to staff.

**The introduction 'Supervised Community Treatment Orders' or 'CTOs'.**
Allows for a patient to be discharged from hospital to continue treatment at their, or a relative's home. If the conditions of the order are broken then it can be revoked and the patient returned to hospital for detention.

Having undertaken discussions with Camden PCT it appears that the role of the LAS in this process will be no different to that of Section 135 assessments. The volume of recalls from CTOs is expected to be very low. Current estimates are for about 50 such orders to be revoked, per month, across London.

A query was raised re numbers of patients on CTOs and potential for an increase in the number of calls to the LAS as a result. This should not be of concern as:

i) CTO is a similar tool to the old supervised discharge. So this is not a new cohort of patients being discharged to the community which were previously only detained in hospital.
ii) If a patient keeps getting recalled then clearly the CTO is not working and they should be returned to Section 3 detention (which lapses but remains in place when under CTO).

iii) Volume will not be huge. Camden, one of the busier boroughs for MH, estimates 24 patients at any one time being subject to a CTO.

**Actions recommended:**

These changes will be communicated to staff through articles in the Routine Information Bulletin (RIB), the LAS News and through cascading a briefing by local Mental Health 'champions,' the Clinical Support Desk and the Department of Education and Development.

## 5. Fifth Domain – Accessible and Responsive Care

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

## 5. Sixth Domain – Care Environment and Amenities

**Infection Control**

The post of Infection Control Co-ordinator was advertised but no suitable candidate was identified. An interim part time appointment has been made while the post is readvertised externally. Current initiatives being taken forward include trialling a disposable tourniquet (Ilford area); sourcing an IV cannulation pack to include sterile gloves; sourcing surface wipes, hand wipes and personal issue alcohol gel and sourcing arm protectors. The revised Infection Control Manual will be issued when the format [e.g. electronic / paper] is agreed.

An education and development strategy – which will include LAS News articles, Pulse articles, a personal issue IC pack for each staff member, and e-learning initiatives, is under preparation.

From a national perspective, the Clinical Director of South Central Ambulance Service is undertaking a baseline audit of infection control procedures currently in place in English Ambulance Services.

## 7. Seventh Domain – Public Health

Nothing further to report

**Recommendation**

THAT the Board notes the report

Fionna Moore,
Medical Director
**14th November 2008**

**Appendix 1.**

Clinical Audit & Research Summary Report for the Trust Board

**Summary of Findings from Cycle One of the National Clinical Performance Indicators: Stroke**

Author: Stephen Gadd & Gurkamal Virdi

Clinical Audit & Research Unit, Medical Directorate

## 1. Introduction

The National Clinical Performance Indicator (CPI) programme was developed by the National Ambulance Clinical Audit Steering Group (NACASG) to allow the comparison of clinical performance between ambulance services with the overall aim of improving patient care. All ambulance services in England take part in the programme, which currently evaluates five clinical areas: STEMI, Cardiac Arrest, Stroke, Hypoglycaemia and Asthma. The NACASG has set three cycles (from May 2008 to November 2010) with each clinical area audited three times at six month intervals. The first cycle of the National CPI audit is underway and this report presents the findings from the stroke indicator.

## 2. Method

The first 300 records with a clinical indication of stroke from 1 July 2008 were examined. Compliance to undertaking three aspects of patient care for patients with suspected stroke was assessed (see table below). In addition, a set of exceptions were established to take into account clinically justifiable reasons for aspects of care *not* being undertaken. These were not included in the calculation of compliance.

| Inclusion Criteria | Aspect of Care Assessed | Exceptions |
|---|---|---|
| Patients with a clinical diagnosis of stroke | Face, Arm, Speech Test (FAST) recorded | Patient unconscious<br>Patient refusal<br>Patient does not understand<br>Head trauma/injury |
| | Blood glucose recorded | Patient refusal<br>Patient does not understand<br>Head trauma/injury |
| | Blood pressure recorded | Patient refusal<br>Time critical features (airway problem, reduced consciousness) |

## 3. Results

- A FAST was undertaken in 94% of cases in comparison to the national average of 87%. The LAS achieved the highest compliance rate of all ambulance services for the FAST indicator.

- For the recording of blood glucose, the LAS achieved 97% compliance against the national average of 85%. This was the second highest compliance rate of all ambulance services for the blood glucose indicator.

- For the recording of blood pressure, the LAS achieved 100% compliance against the national average of 98%. The LAS was one of only two ambulance services that achieved 100% compliance for the blood pressure indicator.

## 4. Recommendations

The results from the first cycle of the National Stroke CPI audit are positive, with the LAS scoring above the national average for each aspect of care audited.

A problem identified in this audit was the need for an additional exception for the FAST assessment. Previous neurological impairment (e.g. a previous stroke) limits the usefulness of this test and this was not reflected in the exceptions. This suggestion was passed on to the NACASG for inclusion in the following audit cycles.

**Appendix 2.**

**Data from Clinical Support Desk – October 2008**

Figure 1: Workload by hour

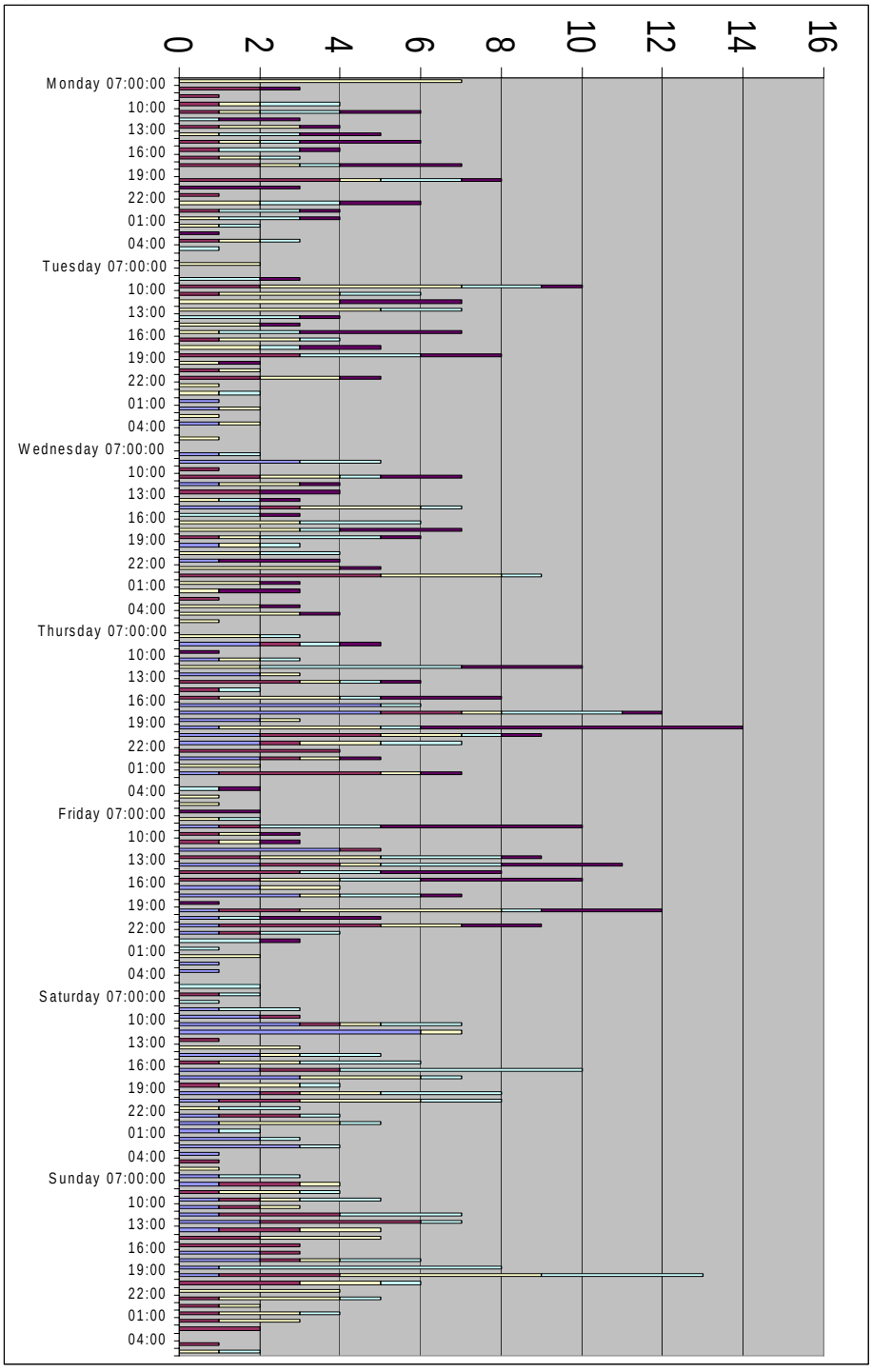
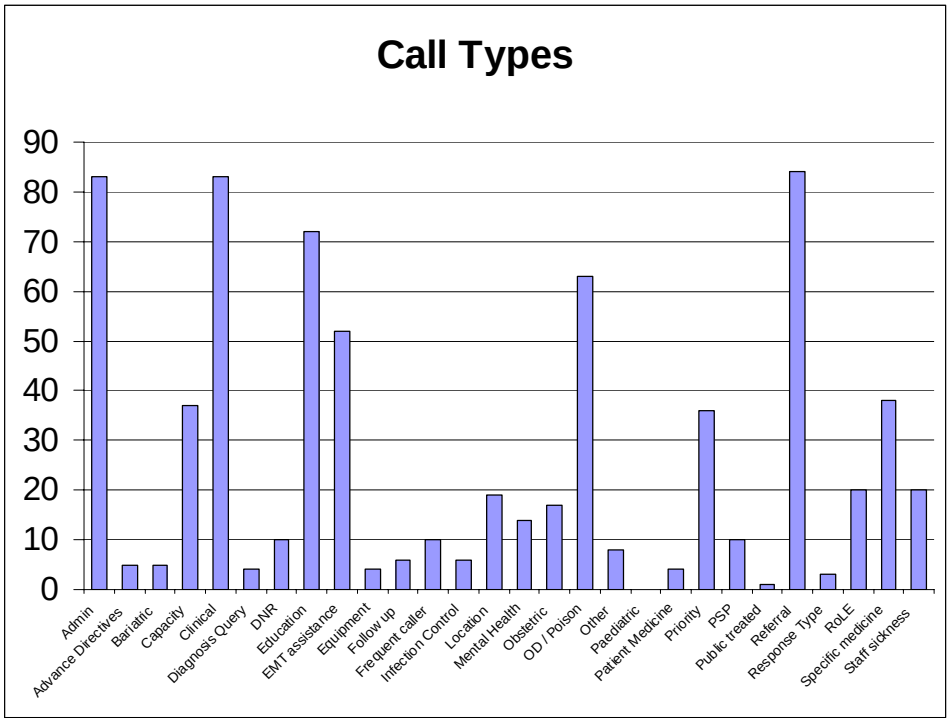


Figure 2: Call Types




**Admin** refers to duties that do not relate directly to a call (e.g. drawing up Patient Specific Protocols, checking transplant lists etc.)
**Advance** relates to questions about advance directives
**Capacity** is defined as any question surrounding capacity / consent
**Clinical** Questions are any non drug related treatment questions
**Diagnosis** Query relates to a question about the meaning / significance of a diagnosis
**DNR** relates to a do Not resuscitate Order
**Education** relates to learning points raised by EOC staff
**EMT1** relates to giving support to an urgent care crew to avoid tying up an A&E crew
**Equipment** relates to the suitability of a type of equipment
**Follow up** relates to a crew request to see what happened to a patient
**Frequent caller** relates to a plan drawn up with PALS
**Location** refers to a check as to where a service is
**Mental Health** relates to any issue other than capacity
**Obese** relates to arrangements to move heavy patients
**Obstetrics** relates to any aspect of obstetric care
**Overdose** relates to queries resolved through Toxbase
**Patient Medication** relates to questions surrounding normal use of a patients own medicines
**Priority** relates to the order of despatch of calls being held on the sector
**Public Treated** relates to treating patients – generally in reception
**Referral** Pathways relates to the appropriateness of a destination
**Response** Type relates to the type of response (eg. A&E, PTS, EMT1) that might be suitable

**ROLE** relates to death and bodies (not DNR)
**Specific Med** relates to a technician or paramedic drug
**Staff Sickness** relates to the health needs of a member of staff

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Proposed approach by the LAS towards Stroke

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For approval

3. Summary

Several factors are driving acute stroke care in London:

1. Healthcare for London's (HfL) Stroke Strategy For London
2. Availability of 24/7 access to screening, assessment and thrombolysis at certain units in London and the LAS's eagerness to take advantage of this
3. PCT requests to divert their patients away from sites with poor outcomes/towards sites with better outcomes.

HfL's process for designating Hyper Acute Stroke Units and the time permitted for their development of services mean it will be well into 2010 before a pan London network is fully established.

Unilateral decisions to convey patients to where the best care is available could undermine public consultation around the HfL Strategy.

The risk of undermining the public consultation can be avoided by openly engaging with PCTs to set up pathways for their patients into existing 24/7 stroke units **pending the development of local options as part of the HFL process.**

Other actions are required before requests from individuals or groups of PCTs can be delivered. Therefore these diversions should not go live until 01/01/09 at the earliest.

Apart from internal communications the only requirement for LAS to deliver this would be the upgrading of strokes (where an on set of symptoms was within 2 hours) to Red from Amber on AMPDS.

4. Recommendation

THAT the Trust Board AGREE that:

**1.** A comprehensive survey of PCTs is carried out to establish which of them wish to designate a preferred location for thrombolysis-eligible FAST+ patients, and for discussion to be coordinated via the joint commissioning arrangements.

2. A stakeholder communications plan be agreed to make clear that this is a temporary measure until local services are set up (as part of the HfL strategy), and is no way intended to influence future stroke centre designation.
3. Destination acute stroke units are consulted on their capacity to receive patients.
4. Extra demand on resources is modelled and PCTs approached for extra funding if/where applicable, both for interim measures and full pan-London strategy.
5. For operational clarity, as far a possible, all interim changes take place at the same time, the target date being 01/01/09 at the earliest.

## 1. Purpose of Paper

To secure Trust Board approval for London Ambulance Service's proposed strategy for

i) meeting changes in the way PCTs ask us to deliver care for their stroke patients;

ii) delivering optimum care for stroke patients (where available) in the light of Healthcare for London's Stroke Workstream schedule.

## 2. Background

> *Stroke is the second most common cause of death and the single most important cause of physical disability in London. In 2007, stroke accounted for well over 4,400 deaths (both in and out of hospital) in the capital, of which nearly 25% may have been prevented. Nearly one percent of Londoners have suffered a stroke, and many more than one. The impact on hospital services is huge, with over 11,000 Londoners admitted to hospital with a stroke each year.*[2]

The London Ambulance Service (LAS) clearly have a direct impact on the care stroke patients receive and can diagnose c80% of strokes with the simple FAST test. Up to 15% of stoke patients could benefit from thrombolysis but this sub-set can only be identified after a CT scan. Thrombolysis is only effective if administered within three hours of on set of symptoms (although trials are underway to test effectiveness up to six hours) so it is vital that all patients with an onset of symptoms within two hours are quickly delivered to a centre where they will be:

- fast-tracked for a CT scan to identify whether their stroke is thrombolysable;
- thrombolysed (where appropriate) by a trained clinician in a safe environment within 3 hours of on set of symptoms.

## 3. Healthcare For London –Strategy Update

3.1. Healthcare for London (HfL) have developed a London Strategy for Stroke and their recommendations were published on 14th November 2008. They deal with three distinct parts of the pathway: Public Awareness and Prevention, Acute Stroke Services and Rehabilitation and Community Care.

3.2. The easiest part of this strategy to implement, and the part of specific interest to the LAS, will be the acute section where many centres are already, or already on their way to being, able to accept patients 24/7 and, if appropriate, deliver thrombolysis round the clock.

3.3. Acute Stroke Services

- The preliminary acute stroke strategy offered three options for future stroke care models:
  - Option 1: A larger number of smaller size hyper-acute stroke units (HASUs) to deal with those patients who could benefit from thrombolysis. Those who are not eligible will go to a standard HASU (with no thrombolysis).

[2] Preliminary acute stroke strategy for London: Healthcare for London, August 2008.

- o Option 2: A number (9-14) of smaller (10-14 beds) HASUs to which all stroke patients are admitted before being transferred to a local stroke unit once stable/after 72 hrs.
- o Option 3: A smaller number of larger HASUs to which all stroke patients are admitted before being transferred to a local stroke unit once stable/after 72 hrs.

- LAS favoured Option 3 as the best way of ensuring units received the volume of patients required to deliver world class care, delivered via a pathway that is easy for our crews to use. However, this was qualified by stating that the impact on LAS of longer job cycle times would need to be analysed, and that extra funding was likely to be needed if performance was to be maintained.
- Consultation, and an acknowledgment that current stroke stoke provision is focused in the centre of London whereas incidence (best predicted by age rather than, for example, deprivation) is highest on the outskirts, has encouraged Healthcare for London to recommend option 2.
- HFL felt option 1 would not deliver the step change required and option 3 would be too difficult to implement.

3.4. The HfL strategy is based around all stroke patients being conveyed to a HASU (c 8,600 by ambulance per annum) not just those who would potentially benefit from thrombolysis.

3.5. Next steps in implementing HfL Strategy:

| **Stage** | **Date** |
|---|---|
| Strategy published | Nov 2008 |
| Applications for centres to become Stroke Units, Hyper Acute Stroke Units and TIA clinics | Nov 2008 |
| Assessment of applications | Dec 2008 |
| Public consultation | Jan-Mar 2009 |
| JCPCT decision on Stroke Centre Configuration | Jun 2009 |
| Go live | From Q3 2009 |

NB: although the decision to go ahead with specific centres will be taken summer 2009, it is expected that some centres may take much longer (up to a further 18 months) to be in a position to accept stroke patients from LAS. This means we could be well into 2011 before a genuine pan-London pathway is in place.

Furthermore, at the latest HfL stroke conference, Dr Chris Streather (clinical lead for the project) confirmed that it may not be a pre requisite for HASUs to offer 24/7 access to thrombolysis from day 1 of their operation. LAS will need to be aware of those locations where thrombolysis is available and not take it for granted that it will be offered by all HASUs as soon as they open.

The original schedule for implementation was significantly shorter than this. One of the reasons for its extension appears to be that HfL wish the consultation for the Stroke strategy to run alongside that of the Major Trauma strategy.

## 4. London Operational Update

4.1. Several acute trusts are already ready to receive FAST+ patients from LAS 24/7, whilst in other areas PCTS have requested LAS convey their patients to specific centres, often bypassing local A&Es.

4.2. Two areas of London have requested LAS to divert patients to a different stroke unit to avoid delivering sub-optimal care:

- Bexley PCT, Greenwich PCT and Bromley have requested that thrombolysis-eligible patients be taken to KCH as of 1st November.
- Due to concerns regarding outcomes for stroke patients at their King George's Ilford site, Barking, Havering and Redbridge Hospitals Trust (BHRT) have reconfigured their stroke services onto one site. As of 15th October LAS have been asked not to convey stroke patients to King George's Ilford. They will now be conveyed to either Whipps Cross or Queen's Hospital (Romford) depending on their location.

4.3. In South West London the five PCTs, local acutes and LAS set up a pilot in February 2008 to provide 24/7 assessment and thrombolysis to stroke patients.

Mayday, Kingston and St Helier hospitals provide quick access to CT scans, consultant assessment and thrombolysis 0900-1700, Mon-Fri. Outside of these hours, FAST+ patients who can be conveyed to South West London and St George's (SWLStG) to arrive within two hours of the onset of symptoms are taken there directly as there is 24/7 access to quick CT scans, consultant assessment and, where appropriate, thrombolysis.

This pilot will now run until June 2009 (when the decision of the Joint Committee of Primary Care Trusts regarding HfL's recommendations is due to be published).

4.4. As well as SWLStG, other trusts able to accept FAST+ patients 24/7 and deliver thrombolysis are:

- St Thomas
- Kings College
- UCH
- Charing Cross
- Royal Free

4.5. This piecemeal change in 24/7 provision presents a challenge to PCTs. On the one hand they have services available 24/7 that they may use to potentially deliver better outcomes for patients. On the other, they do not wish to be seen to be reconfiguring ahead of the London-wide consultation on Stroke due to run from January 2009. To do so could see them accused of riding roughshod over the process and introducing significant service change without proper consultation.

4.6. As has been noted (3.3) highest demand for stroke services is in outer London. However, by requesting their patients are conveyed to centres currently able to deliver 24/7 stroke care (see 4.3) PCTs will necessarily be pushing their patients towards central London, inadvertently widening the gap between the provision of good (currently central London) and poor (i.e. outer London – where it is most needed) stroke care. However not do so would be to deny those living on the outskirts access to the best available care.

4.7. LAS are keen to convey patients to the most appropriate location for their condition, and do not wish to delay quick access to 24/7 hyper acute stroke care to patients in specific parts of London.

4.8. LAS have received legal advice stating that if PCTs were to request LAS convey their patients to specific locations *pending the outcome of the HfL consultation*, this would not prejudice the process. The SHA are aware of this advice.

4.9. Research conducted by ORH illustrated that in order to deliver a centralised stroke strategy for FAST+ patients in one old SHA area would require an additional 2 ambulances.

## 5. Impact on LAS

5.1. LAS attended 8,600 patients who were FAST+ between April 2007 and March 2008, so there is a significant potential impact on job cycle times should we decide to convey all FAST+ patients further distances to specialist HASUs.

5.2. The South West London Experience

- From February 2008 LAS have participated in a Stroke Pilot in South West London designed to offer 24-7 access to thrombolysis in the area through a hub and spoke model. The spokes operate a service with quick access to CT scans from Mon-Fri between 0900 and 1700, whilst the hub is open 24-7.
- Criterion for referral is that onset of symptoms is within 2 hours.
- Despite apprehension around the volume of patients LAS would be asked to convey further distances, demand did not materialise.
- Over an 8 week period from 1st Feb 2008, 42 patients were eligible for the pathway. This equates to slightly more than 1 patient per PCT per week.

5.3. During the design of the pathway LAS ensured that repatriation to a local stroke unit from the hub centre would be the responsibility of local PTS providers and so did not encumber A&E resources.

5.4. In order to improve the number of patients who can be thrombolysed within 3 hours of onset of symptoms, LAS will investigate the impact of prioritising FAST+ patients who present within 2 hours of on set of symptoms from the current level of Amber to Red A.

## 6. Conclusion

6.1. LAS can have a huge impact on the quality of stroke care received by patients throughout London by identifying those patients who could potentially benefit from thrombolysis, and conveying them quickly to a specialist centre where they will receive an immediate CT scan.

6.2. No extra training for crew staff is required to deliver this but new protocols will need to be issued, advising crews on which patients should be taken where.

6.3. In an ideal world large service improvements such as this would be implemented in one hit across the whole Service. However, given the difficulties presented by HfL's schedule and the differing levels of provision currently available it could be mid 2010 before such a pan-London approach is possible.

6.4. It is therefore right and proper to proceed with referrals to stroke units where:

- The patient would potentially benefit from thrombolysis (i.e. has presented to us within two hours of onset of symptoms)
- We are certain the stroke unit can deliver quick access to CT scans thrombolysis 24/7.
- There is a clear mandate from the local PCT to undertake.
- All parties and stakeholders understand that this is an interim solution pending the decision of the JCPCT.

6.5. The Healthcare for London project envisages that all stroke patients will be conveyed to a HASU. This is not something LAS will be in a position to deliver without extra resources.

## 7. Recommended actions for LAS

7.1. LAS to open discussions with individual PCTs regarding their preferred location for thrombolysis-eligible FAST+ patients.

7.2. LAS to be absolutely clear that this is a temporary measure until local services are set up (as part of the HfL strategy), and is no way intended to influence future stroke centre designation.

7.3. LAS to consult destination acute stroke units on capacity to receive patients.

7.4. LAS to model extra demand on resources and approach PCTs for extra funding if/where applicable, both for interim measures and full pan-London strategy.

7.5. LAS to model impact of triaging strokes which present within 2 hours of onset of symptoms as Red instead of Amber.

7.6. LAS to upgrade strokes (where an on set of symptoms was within 2 hours) to Red from Amber on AMPDS, in order to support targets for quick access to CT scans for thrombolysable patients.

7.7. Given requirements 4.3 and 4.4, LAS should not go ahead with the proposals put forward by Bexley (and Greenwich and Bromley) PCTs until 01/01/09 at the earliest.

7.8. LAS to ensure only patients who have presented within two hours of on set of symptoms are eligible for interim pathways.

7.9. LAS to gather data on the number of lives which will be saved and disabilities which will be avoided by quick access to scanning, assessment and thrombolysis.

7.10. LAS to liaise with the DH to anticipate the likely impact of their March 2009 awareness campaign.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# CAD 2010 Contract Award

1. Sponsoring Director: Peter Bradley

2. Purpose: *For Approving*

3. Summary

The objective of the CAD 2010 Project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. The objective of this paper is to seek approval from the Trust board to conclude final negotiations with the chosen supplier, Northrop Grumman Information Technology Global Corp (NG) and award the contract in their favour.

The total cost to the Trust over the whole life period is £51.940M, consisting of £33.336M revenue and £18.574M capital. This includes all LAS costs of staff as well as those of NG for hardware, software, implementation and support services.

An independent consultant has been providing independent advice to the lead NED's, that has proved very useful. It is recommended to keep this arrangement and enhance with further support from the consultants associated organisation, Methods consulting.

4. Recommendations

THAT the Trust Board:

1. DELEGATE authority to the CEO to sign the CAD 2010 contract in favour of Northrop Grumman Information Technology Global Corp (NG), subject to:
   - Confirmation from the Director of Finance and Investment, NHS London that he is satisfied with the further due diligence on the financial robustness of NG.
   - Final contract clarifications do not substantially alter the contract in terms of scope, or vary the overall contract value by more than 1%.
2. AGREE that the external consultant who has provided independent assurance thus far is retained along with further support from Methods Consulting

**Trust Board – 25 November 2008**

**CAD 2010 AWARD OF CONTRACT**

Introduction

The objective of the CAD 2010 Project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. Full details of the project have been continually reported to the Trust Board and are not repeated here. The objective of this paper is to seek approval from the Trust Board to conclude final negotiations with the chosen supplier, Northrop Grumman Information Technology Global Corp (NG) and award the contract in their favour.

As reported previously to the Trust Board, the current CAD system has been in use for over ten years. Whilst it has served the Trust well, particularly in terms of its functionality, it is now in need of replacement. Recent reports to the Trust Board have highlighted concerns over its reliability and change is now becoming a priority, particularly ahead of the Olympics.

PROCUREMENT APPROACH

The procurement was conducted according to the Office of Government Commerce (OGC) Competitive Dialogue Model. An advertisement was placed in the Official Journal of the European Union (OJEU) inviting expressions of interest. Thirteen expressions of interest were received and following evaluation of the bids, six bidders were invited to participate in dialogue (ITPD). This was then refined and two suppliers (Intergraph and Northrop Grumman) were invited to take part in further dialogue and were subsequently invited to submit final tenders (ITSFT). Following evaluation of the final tenders submitted by Northrop Grumman and Intergraph, a Final Tender Evaluation Report was produced, recommending the selection of Northrop Grumman as the preferred supplier for CAD2010.

sha approval

Given the overall value of the contract, approval is required from the SHA. The full business case has been subject to full scrutiny by the SHA Capital Investment Unit, and a presentation made to the Capital Investment Committee. A letter confirming approval of the business case, subject to two conditions has been received (Appendix 1). These are defined below along with the current LAS position:

Condition 1: "The CIC requires you to agree robust mitigation plans with commissioners to address the identified risk of a performance dip at the time of implementation."

Current Position: The whole transition process will be subject to very detailed planning that will involve Commissioners and the Trust Board. Part of this will be plans to mitigate the potential for performance dip during transition.

Condition 2: "The CIC notes your plans to conduct further due diligence on the financial robustness of the supplier prior to contract signing. Please share the outcome of this work with me before proceeding."

Current Position Work is currently underway to satisfy this requirement and the Director of Finance anticipates being able to write shortly to the SHA Finance Director confirming suitability.

The overall position of the SHA is taken into account within the recommendations in this report.

Summary timeline

The following summary timeline sets out the key milestones in terms of procurement, evaluation, audit and approval processes.

| **Dates** | **Milestone** |
|---|---|
| May 2005 | Project initiation, including establishment of Project Board |
| June 2006 | Gate 1 Review |
| July 2006 | Strategic Outline Case approved by Trust Board |
| January 2007 | Gate 2 Review |
| January 2007 | Outline Business Case approved by Trust Board |
| March 2007 | Strategic Outline Case approved by SHA |
| March 2007 | OJEU procurement commenced |
| May 2007 | 13 expressions of interest received from prospective bidders |
| June 2007 | 6 bidders invited to participate in dialogue |
| June 2007 | Outline Business Case approved by SHA |
| Sep - Nov 2007 | 1st stage dialogue with suppliers (6 in total) |
| December 2007 | Two suppliers (Intergraph & Northrop Grumman) selected to go forward to next stage |
| Jan – April 2008 | 2nd stage dialogue with Intergraph & Northrop Grumman |
| May 2008 | Intergraph and Northrop Grumman submit final tenders |
| June 2008 | Final Tender Evaluation Report – preferred bidder Northrop Grumman |
| June 2008 | Trust Board approves Northrop Grumman as preferred bidder |
| June / July 2008 | Gate 3 Review |
| August 2008 | Full Business Case submitted to SHA |
| September 2008 | Start of working with Northrop Grumman under “Letter of Intent” |
| October 2008 | Presentation of Full Business Case to SHA Capital Investment Committee |

| | |
|---|---|
| November 2008 | SHA Approval of Full Business Case |

Current Contract Status and Solicitor's report

The contract, based upon an OGC model, has been subject to extensive review and negotiation. There remain a number of open items that are subject to final refinement, none of which materially affect the overall contract.

The Trust solicitors, Capsticks, were engaged to advise on the procurement process, particularly the selected competitive dialogue process. This approach allowed detailed discussions with suppliers throughout. This has been extremely beneficial in terms of defining and understanding both the technical and user requirements. They have remained engaged in the project and have provided advice throughout the negotiation process. For assurance purposes, appended to this report are the following documents from Capsticks:

- a covering letter (Appendix 2)
- a table highlighting the key risks (Appendix 3)

The provision of a mapping product is one issue that is likely to be the subject of early change control, post contract signature. Currently the contract allows for the LAS to retain its current mapping product and for this to be provided under current contract arrangements. Continuing negotiations will review this arrangement to investigate if this service would be better provided under the NG contract.

The Directors of IM&T and Finance have personally reviewed the entire contract (and schedules) with Capsticks, the Project Manager and Head of Procurement. They are both satisfied to recommend this contract to the Trust Board for approval.

Costs and affordability

The whole life project is based upon three years for development and an initial seven years live running period, hence ten years in total.

The total cost to the Trust over the whole life period is £51.940M, consisting of £33.336M revenue and £18.574M capital. This includes all LAS costs of staff as well as those of NG for hardware, software, implementation and support services.

The separated NG costs are £8.664M capital and £2.549M revenue.

Within the NG revenue are the seven year costs for maintenance and support. These are set at a fixed price of £200,694 per year, for each of the seven years.

In addition to the costs above, the maintenance for the additional five years extension (should it be invoked) is set at £232,586 per year, for each of the subsequent five years.

Average annual incremental revenue costs equate to 0.6% of the 2008/09 Trust budget. A capital loan of £10M is included in the FBC. It is the view of the Finance Director that the project is affordable from both the capital and revenue perspectives.

Trust board assurance

One of the recommendations from the SHA at the time of the OBC was to utilise an independent consultant to advise the Trust Board, and in particular the lead NEDs. As a result of this, a consultant was engaged with a view to supporting the Trust Board up to award of contract.

This arrangement has worked particularly well and at this stage has been reviewed by both lead NEDs and the Director of IM&T. There is unanimous agreement that this

arrangement should be continued.

The consultant concerned is an associate of Methods Consulting (who is a significant player in central government). Further discussions have identified that Methods Consulting would be willing to offer one of their Directors to provide an additional quality assurance role. This would then add value to the work of the existing consultant being underwritten by the 'Methods' brand.

Recommendations

The Trust Board delegates authority to the CEO to sign the CAD 2010 contract in favour of Northrop Grumman Information Technology Global Corp (NG), subject to:

- Confirmation from the Director of Finance and Investment, NHS London that he is satisfied with the further due diligence on the financial robustness of NG.
- Final contract clarifications do not substantially alter the contract in terms of scope, or vary the overall contract value by more than 1%.

That the external consultant, who has provided independent assurance thus far, is retained along with further support from Methods Consulting.

Peter Suter
Director of Information Management & Technology

**Appendix 1**

NHS
London

Southside, 4th Floor
105 Victoria Street, London
SW1E 6QT
Telephone: 020 7932 3752
Fax: 020 7932 3800

www.london.nhs.uk

Mr Martyn Salter
Corporate Processes Programme Manager
London Ambulance Service NHS Trust
Headquarters
220 Waterloo Road
London SE1 8SD

7 November 2008

Dear Martyn,

**CAD2010 – FULL BUSINESS CASE**

Thank you to you and your colleagues for attending the Capital Investment Committee (CIC) this week to discuss the CAD2010 Full Business Case.

I am pleased to confirm that the CIC approved your case, subject to 2 conditions:

1. The CIC requires you to agree robust mitigation plans with commissioners to address the identified risk of a performance dip at the time of implementation.

2. The CIC notes your plans to conduct further due diligence on the financial robustness of the supplier prior to contract signing. Please share the outcome of this work with me before proceeding.

I look forward to hearing from you in due course.

Yours sincerely,

Paul Baumann
Director of Finance and Investment
NHS London

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**Appendix 2**

The person dealing with this matter is:
**Chris Brophy**
Direct dial 020 8780 4674
Direct fax 020 8780 4842
Email cbrophy@capsticks.com

Capsticks

Your ref:

Our ref: CJB/SLC/044444

20th November 2008

Mr Richard Deakins
London Ambulance Service NHS Trust
220 Waterloo Road
SE1 8SD

By email only

Dear Mr Deakins

**CAD2010 Project**

We enclose the risk report on the contract for the CAD2010 Project, based on the draft of the contract as at 20 November 2008.

Yours faithfully

Capsticks

**Capsticks**

**Appendix 3**

**CAD2010 Project – Risk report to London Ambulance Service NHS Trust (the "Authority")**

## A. Introduction

This report highlights the key legal terms in the current draft of the contract for the CAD2010 project. It sets out the significant legal risk to the Authority (if any) attached to those key terms.

Although the contract has been developed and issues have been clarified, the key legal terms of the contract set out here have not significantly changed since the draft of the contract issued at the stage of issuing Invitations to Submit Final Tenders. This report therefore builds on the report we issued at that time and the two reports should be read in conjunction.

The Authority should note that the contract is in its final stages of development and so is subject to further amendment.

Part B of this report highlights the key legal risks to the Authority arising out of the key legal terms of the contract. Part C sets out the key legal terms and the significant legal risks attached (if any) in more detail.

## B. Key legal risks

We consider that the key legal risks to the Authority arising from the key legal terms set out in Part C of this report are:

- Clause 4 – procedure for acceptance of non-Tested Deliverables
- Clause 9 – risks associated with not taking a Fully Managed Service
- Clause 44.3 and Schedule 3 – obligation to comply with Authority Responsibilities, especially those with a timeframe attached
- Clause 52.2 – limitations on Contractor's liability
- Schedule 2.5 – absence of Authority Security Policy
- Schedule 6.1 – risks associated with Project Schedule
- Schedule 7.1 – structure of Milestone Payments
- Schedule 10 – cap on claims under parent company guarantee, as compared with caps on liability in contract
- Risks in relation to software provided by third parties that are part of the Contractor System, namely Northgate and Oracle

## C. Key legal terms and significant legal risk to the Authority (if any)

| Reference | Key legal term | Significant legal risk to the Authority (if any) |
|---|---|---|
| Parties and clause 70.4 | London Ambulance Service NHS Trust ("Authority")<br>Northrop Grumman Information Technology Global Corp ("Contractor") | Risk to the Authority in contracting with a company outside of the UK, however the Contractor must maintain an address for service in the UK, which addresses this risk. |

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| Clause 2 – due diligence | Acknowledgement from Contractor that it will rely on its own enquiries and due diligence in entering the contract. Further acknowledgement that it has inspected the Authority's system and sites for its suitability. | N/A |

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| Clause 4 – Testing and Milestone Achievement Certificates | Once the Contractor successfully completes Testing for all Deliverables in a Milestone, the Authority must issue a Milestone Achievement Certificate in 10 Working Days.<br><br>Acceptance of non-Tested Deliverables:<br>• there is no contractual "link" between non-Tested Deliverables and the issue of Milestone Achievement Certificates; and<br>• there is no process for the parties to agree the detail of what is required in each non-Tested Deliverable nor is there any acceptance criteria. | The Authority is at risk of breach if it does not submit a Milestone Achievement Certificate in this time.<br><br>Acceptance of non-Tested Deliverables;<br>• risk of uncertainty as to the timing of when the Authority must issue the Milestone Achievement Certificate and consequently there is uncertainty as to when the Milestone Payment is triggered (some of which are quite substantial and relate to Milestones where none of the Deliverables in it are being Tested); and<br>• unless the Authority is comfortable that each non-Tested Deliverable is adequately described elsewhere in the contract, there is no detailed, substantive basis which the Authority can use to determine whether a non-Tested Deliverable is acceptable. However, such detail could be agreed between the parties outside of the contract. |
| Clause 5 – Correction Plans | The Contractor must submit a Correction Plan if it does not Achieve a Milestone. The Authority must notify the Contractor within 7 Working Days if it approves the Plan. If not, the Contractor must re-submit the Plan and the Authority then has 5 Working Days to approve it. If the Authority does not respond to the Contractor within these timeframes, the Contractor may begin to implement the Plan and if the Authority subsequently rejects the Plan, the Contractor may claim its costs from the Authority in following the rejected Plan. | The Authority is at risk if it misses these timeframes. This has been addressed somewhat by a requirement that the Contractor send a notice to the project manager and the contract manager if a timeframe has been missed. |
| Clause 6 – delay due to Contractor default | If there is a delay to a Milestone due to Contractor default, the Authority may require the Contractor to reimburse it for all proven losses, costs etc incurred by the Authority by reason of the delay. | N/A |
| Clause 7 – delay due to Authority Cause | If there is a delay to a Milestone due to Authority cause, the Contractor is allowed: an extension of time, relief from failure to achieve the Milestone and compensation from the Authority. Compensation is limited to direct loss and/or expense incurred as a result of the delay caused by the Authority. | The Authority is at risk of paying compensation, although these contractual provisions reduce the risk that the Authority would otherwise have had at common law to pay damages. See also the caps on Authority liability in clause 52.3, discussed below. |

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| Clause 8 – Delay not due to one party | If a delay is not due to one party, the Authority and Contractor must negotiate to determine the extent to which the delay is attributable to each party. If the parties cannot agree, they must refer the matter to dispute resolution for expert determination. | Each party at risk of paying compensation for their own delay, as per clause 6 and 7 discussed above. |
| Clause 9 – Services | The Contractor must provide the Services in accordance with the Authority's requirements in Schedule 2.1 (Services Description) and the Contractor Solution in Schedule 4.1. | N/A |

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| Clause 9 – Additional Services | The Authority must provide 90 days notice if it requires the Contractor to provide a Fully Managed Service. | The main risk to the Authority here is if it does not take the Fully Managed Service from the Contractor. This is because it brings some of the responsibility – and therefore some of the risk – for support and maintenance of the Contractor System over to the Authority. For example, when not on a Fully Managed Service, the Authority must install any patches and upgrades itself. If, because of an Authority error during installation, the Contractor System becomes Unavailable, or is otherwise not performing in accordance with Schedule 2.1 requirements, then the Authority will not have recourse to the Contractor. The Authority's risk here is minimised to the extent that it is properly resourced and has sufficiently experienced personnel to undertake the activities that would be undertaken by the Contractor under a Fully Managed Service.<br><br>Having a Fully Managed Service may also help overcome the issue of when a period of Unavailability should be deemed to start, as Contractor personnel will be on-site.<br><br>The Authority is further at risk of not having the Fully Managed Service at the time it is required if the requisite 90 days' notice is not given. |
| Clause 10 – Service Levels | The Contractor must provide the Operational Services to meet or exceed the Service Levels. | The risk to the Authority is that Service Levels are its sole remedy (save for in relation to serious default allowing termination). |
| Clause 11 – effect of Authority default during Operational Services | If the Contractor is unable to provide the Services/meet Service Levels due to Authority default, it will not incur Service Credits and will still be entitled to the Charges as if the Services had been provided/Service Levels had been met. | The Authority is at risk of having to pay the full Charges even though the Contractor has not performed the Services, if such non-performance is due to the Authority's default. |
| Clause 13 – Quality | The Contractor must comply with the Quality Plan and the Authority may audit compliance. | N/A |
| Clause 14 – Services Improvement | The Contractor has an ongoing obligation to identify new or potential improvements to the Services. | N/A |
| Clause 15 – equipment | Title to and risk in the Contractor Equipment listed in schedule 4.1 passes from the Contractor to the Authority at the ATP Milestone Date and the Contractor will have relief | The Authority bears the risk of loss or damage to the Contractor Equipment in Schedule 4.1 from ATP. |

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| | from Service Credits if they are not met due to loss or damage to the Contractor Equipment. Until that time, and in relation to all other equipment, the Contractor is responsible. | |
| Clause 17 – VAT indemnity | Each party indemnifies the other for any failure to account for VAT, when the indemnifying party was responsible to account and the failure to account has caused the other party to incur liability. | Mutual risk to both the Authority and the Contractor. |
| Clause 18 – right of set off | The Authority may retain or set off any amount owed to it by the Contractor against any payments it must make to the Contractor. | N/A |
| Clause 23.1 – Sub-contracting | The Contractor must not sub-contract without the prior written consent of the Authority, which is not to be unreasonably withheld or delayed. | The risk is that the Authority is not able to withhold consent in its absolute discretion and so must consent to sub-contracting if the requirements of clause 23 are met. |
| Clause 23.10 – Competitive Terms | The Authority may require the Contractor to replace existing commercial terms if the Authority is able to find ones that are more favourable. | N/A |
| Clause 24 – Audits | The Authority is able to verify the accuracy of the Charges and compliance with the contract. | The Authority bears risk of paying further Charges if it has underpaid the Contractor. |
| Clause 29 – Employment indemnity | Each party indemnifies the other for any Employee Liabilities arising out of claims made by an employee of the other party that was caused by the indemnifying party's employee(s). | Mutual risk to both the Authority and the Contractor. |
| Clause 35 – IP licences from Contractor | The Authority obtains a perpetual and irrevocable licence to use the Contractor Software, Specially Written Software and Third Party Software. | The Authority does not obtain ownership of the Specially Written Software, however in this instance such ownership would not be useful without ownership of the core Contractor Software. |
| Clause 35.5 – use of software by other government bodies | Any other Crown Body or Contracting Authority who wishes to licence the Contractor Software including any Specially Written Software or Project Specific IPRs may do so and shall not be charged any further development fees, or licence fees for the Specially Written Software or Project Specific IPRs (but it may charge maintenance fees). | N/A |
| Clause 39 – Escrow | The Contractor Software and Specially Written Software is placed in escrow. | N/A |

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| Clause 44 – Contractor obligations | The Contractor must comply with the general obligations set out in this clause regarding eg, resourcing, problem resolution, interface requirements etc. | N/A |
| Clause 44.3 and schedule 3 – Authority responsibilities | The Authority must comply with the obligations in schedule 3, which arise from the Contractor Solution in schedule 4.1. | The Authority is at risk of breach of contract if it fails to comply with these obligations. However, the main risk is that if the Authority does not comply with its obligations in Schedule 3 – especially where there is a contractual timeframe or deadline attached to the obligation – the Contractor will be able to rely on this as evidence that there has been a Delay due to Authority Cause, allowing the Contractor an extension of time for any of its dependent obligations, as well as allowing it to claim compensation.<br>A particular risk to the Authority in Schedule 3 is in Item 83. The Authority is already aware that the User Acceptance Testing will take longer than specified, meaning that a change control request will need to be issued early in the development phase, which could increase price and impact on scheduling of the Contractor's obligations and timetable for delivery of the Contractor System. |
| Clause 45.1 – warranties | Each party warrants that it has the power to enter the contract; has duly signed the contract; there are no suits or actions pending against it; and, the contract will be valid and binding on it. | The Authority is at risk of breach of warranty if any of these representations are untrue. |
| Clause 45.2.4 – warranty regarding software | The Contractor warrants that throughout the term of the contract all software used shall be currently supported versions. | N/A |
| Clause 46 and schedule 10 – guarantee | The Contractor's parent company must execute a guarantee within 30 days of the date of the contract, which provides a guarantee and indemnity to the Authority for the Contractor's performance of the contract. | N/A |
| Clause 47 – Change in Law | If there is a Change in Law that impacts the Contractor in its contract with the Authority and in relation to contracts with other customer(s), then the Contractor is able to obtain an amendment to the Charges and/or relief from compliance with obligations. For any other Change in Law | N/A |

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| | there shall be no such relief. | |
| Clause 49 – BCDR | The Contractor must prepare and comply with a BCDR Plan. | N/A |
| Clause 51 – IPR indemnity | The parties indemnify each other for claims made by an owner of intellectual property rights if the indemnifying party has infringed those rights by eg, licencing them to the other party. | Mutual risk to the Contractor and the Authority. |
| Clause 52.2 – limitations on Contractor liability | The Contractor's liability to the Authority is capped as follows:<br>- VAT, employment and IPR indemnity: unlimited<br>- damage to property: £5 million<br>- Service Credits: 30% of the annual Charges<br>- all losses for events occurring during the period: from the start of the term until one year after CPP the cap is the total Charges for that time; from one year after CPP until the end of the term the cap is the total Charges for that time; for the option period is the cap is total Charges for the option period. | The Authority is at risk if its actual losses exceed a cap. |
| Clause 52.3 – limitations on Authority liability | The Authority's liability to the Contractor is capped as follows:<br>- VAT, employment and IPR indemnity: unlimited<br>- damage to property: £5 million<br>- Termination Payment: £1.18 million<br>- Compensation payment: £1.12 million<br>- all losses for events occurring during a year shall be capped at the Charges for that year. | N/A |
| Clause 52.4 – indirect loss | Neither party is liable to the other for indirect, special or consequential loss or damage, nor for loss of profits, turnover, business opportunities or damage to goodwill. | Mutual risk to the Contractor and the Authority. |
| Clause 54 – Term | The initial term is 7 years from the ATP Milestone Date. The extension period is for up to 5 years. | N/A |

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| Clause 55.1 – Authority termination rights | The Authority may terminate the contract following the occurrence of any of the listed termination events. | N/A |
| Clause 55.3 – Authority termination for convenience | The Authority may terminate the contract at will on written notice, subject to payment of the Termination Payment and Compensation Payment. | The Authority is at risk of paying the Termination Payment and/or Compensation Payment to the caps above, if it terminates for convenience or if the Contractor terminates for Authority default. |
| Clause 55.6 – Contractor termination right | The Contractor may only terminate for non-payment of undisputed Charges. | The Authority is at risk of termination if this occurs. |
| Clause 60 – Step-In rights | The Authority may step-in to the contract and perform it on behalf of the Contractor at the Contractor's cost should a step-in trigger occur. Step-in triggers include any default that would allow the Authority to terminate, Force Majeure, Service Credits reaching a specified threshold etc. | N/A |
| Clause 61 – Alienation | The Contractor may not assign the contract without Authority consent. | N/A |
| Schedule 2.2 – Service Levels | The Authority may levy Service Points if the Contractor fails to achieve one of the four Service Levels in this schedule. These Service Points then become translated into Service Credits, which are deducted from the Charges during the operational phase.<br><br>The first Service Level is in relation to Availability and the Contractor accrues Service Points depending on how long during each month the system is Unavailable. This Service Level therefore hinges on what elements of the system must be up and running for it to be considered "Available".<br><br>Note that this is an open issue and the definition of "Availability" has gone from a general definition, encompassing the call taking and dispatch related functions of the system, to a table of critical transactions. | One risk to the Authority in relation to this schedule is that it is quite complex and it will only be effective to the extent that it allows the Authority to calculate and levy Service Points and then translate them into Service Credits.<br><br>In relation to the definition of Availability, if using a table of critical transactions as the definition significantly narrows the concept of Availability, then this reduces the opportunity of the Authority to levy Service Points in this regard. |

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| Schedule 2.5 – Security Requirements | In this schedule, the Contractor must develop and implement a Security Plan. Such Security Plan should be developed so as to comply with, and be consistent with, the Authority's Security Policy, however this is not going to be available at completion of the contract. Therefore, provisions have been included in the schedule such that the Authority is able to include the Security Policy as a requirement of the contract through the change control provisions. | The Authority is at risk of having to pay additional costs if they are necessary to compensate the Contractor for compliance with the Security Policy and/or amending its , once it is introduced (although these costs are not completely "at large" i.e. they should be consistent with any rates etc set out in the Financial Model). Also, when putting through the change control, there is a risk that some of the relevant provisions throughout the contract will be forgotten to be amended i.e. those provisions that are required to be amended so that the Contractor must comply with the Security Policy and ensure that the Security Plan is consistent with it. |
| Schedule 6.1 – Implementation | This Implementation Plan is governed by this schedule and within the Implementation Plan will sit a Project Schedule, setting out timeframes for completion of tasks by both the Authority and the Contractor between Milestone Dates. | If the Authority misses a timeframe for one of its tasks, the Contractor will be able to rely on this as evidence that there has been a Delay due to Authority Cause, allowing the Contractor an extension of time for any of its dependent obligations, as well as allowing it to claim compensation. Therefore, the more detailed the Project Schedule and the more timeframes it imposes on the Authority, the more risk there will be to the Authority. The Authority does have approval rights over the Project Schedule and therefore must ensure that when it is being developed, it is careful to only agree to timeframes that it is confident it can meet and then it must be adequately resourced to meet them. |
| Schedule 7.1 – charging and invoicing | The Authority must pay Milestone Payments during the development phase and Service Charges during the operational phase. | The Authority must pay the Milestone Payments once a Milestone has been Achieved and the Service Charges are payable monthly. The way in which the Charges have been structured provide an inherent risk to the Authority as:<br>• they are "front loaded", meaning that the Contractor will have recouped most of its costs and received most of its profit from the project during the development phase, such that the financial incentive for it to perform well during the operational phase becomes much weaker; and<br>• the most substantial Milestone Payments are to be paid before Authority to Proceed ("ATP"), rather than at or after ATP, such that the Authority is required to make the majority of its payments regardless of whether it passes Gateway 4 and regardless of whether it ever "goes live" with the Contractor System. |

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| Schedule 7.3 – value for money | The Authority may benchmark the Charges. | N/A |
| Schedule 7.4 – financial distress | This schedule, which gives the Authority escalating remedies should the Contractor or its parent company come into financial distress (as indicated by credit ratings) is being resisted by the Contractor and is an open issue. The Contractor proposed alternative provisions, allowing the Authority to require bank guarantees be put in place should the credit rating of its parent company fall, but these have now been withdrawn. The Authority is requesting that these alternative provisions be restored. | Without "financial distress" provisions, the Authority will not have the ability to ring-fence some or all of the payments it makes to the Contractor, in case it needs to claws-back some of these in a default or insolvency situation. The Authority also does not have a right to pre-emptively terminate the contract if it sees the financial stability of the Contractor or its parent slipping. However, such protections are not always required and may not be suitable for a contract of its type. Relevant considerations are the confidence of the Authority in the financial strength of the Contractor and its parent and any other protections it may have under the contract, such as the parent company guarantee. |
| Schedule 9.1 – TUPE indemnity: Authority | The Authority indemnifies the Contractor for costs associated with a staff transfer from the Authority to the Contractor upon commencement of a Fully Managed Service or on the Effective Date or ATP Milestone Date. | The Authority is at risk of claims under this indemnity, although it considers that either no staff will transfer or, if they do, they will be redeployed by the Authority. |
| Schedule 9.1 – TUPE indemnity: Contractor | The Contractor indemnifies the Authority for costs associated with a staff transfer from the Contractor to the Authority upon termination or expiry of the contract. | N/A |

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| Schedule 10 – Parent Company Guarantee | The Contractor must procure that its parent company provide a guarantee for any payment or other monetary claim that the Authority may have against the Contractor. The Authority must, however, make the claim against the Contractor in the first instance and there is a cap on the guarantee, in the amount of the total Charges over the life of the contract plus £10 million. | As set out above, there are three indemnities in the contract under which the liability of the Contractor is unlimited. If the Authority has a claim under one of these indemnities and the Contractor does not pay out, then the Authority will need to seek recourse under the parent company guarantee. If the amount of the Authority's claim under the indemnity is greater than the cap in the guarantee, the Authority will not be able to make a demand from the guarantor for the total amount of the claim. |
| Northgate and Oracle | The Contractor is subcontracting part of the Services to Northgate, with whom the Authority has an existing relationship for its current CTAK system. The current proposal is that the Authority will continue its current arrangements with Northgate for the system being provided by the Contractor. That is, its existing licensing and support and maintenance arrangements will continue and the Authority will also supply the hardware required for the Northgate element of the system. It is open in the contract as to whether the Authority should have the option to request the Contractor to take over the support and maintenance of the Northgate software and/or supply the hardware required. The Authority is proposing that it will request Northrop Grumman to take over the support and maintenance of the Northgate software and has requested the Contractor to provide pricing for this.<br>The Authority will also use its current licensing arrangements with Oracle, which is part of the Third Party Software under the contract, and this may or may not include support and maintenance. The provisions in relation to support and maintenance if Third Party Software are open. | The risk to the Authority is that if support and maintenance of some elements of the system is a responsibility that rests with the Authority, then if anything goes wrong with these elements this would provide relief to the Contractor. This is the same for any hardware elements of the system provided by the Authority. The Contractor would be excused from meeting its Service Levels (such as providing 99.999% Availability) and it could make a claim for compensation. It also opens up debate as to what element of the system caused a service failure and who was responsible. |

**D. Reliance**

This report is produced for the Authority in relation to its own internal contractual review process and may not be relied upon by any other entity or for any other purpose. It is not intended to be an exhaustive review of all legal issues and risks, it does not deal with purely technical, commercial or insurance issues and it is not a substitute for a full reading of the contract and taking other advice where appropriate.

**CAPSTICKS**
20 November 2008

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Lease Car Policy

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

2. Purpose: For discussion

3. Summary

The draft Lease Car Policy (sent electronically) is a new policy aimed at formalising the process of provision and associated conditions relating to lease cars within the London Ambulance Service.

The key areas of clarification & difference between current practice and policy proposal are:

- Clearly set criteria and considerations with regard to eligibility for a lease car:
  - Regular and significant business travel incurring a minimum set mileage
  - Consideration of alternatives such as mileage allowance
  - Regular on call or response requirements
  - Necessary (regular) conveyance of bulky items
  - Vehicles are allocated to the post not to the post holder
- Base car definition (1800cc engine size and CO2 emissions 190 or below)
  - Prohibition of sports & convertible cars from the scheme
  - Clear sliding scale variance to base
- Personal contribution to insurance
  - Excess liability clarified
- New conditions on staff for additional drivers
  - User responsibility for premiums on drivers under 21

Existing users will be consulted prior to the final policy being brought to the Trust Board in January for approval with an intended implementation date of 1 April 2009.

A lease car policy for Directors will be drawn-up for consideration by the Remuneration Committee once this policy has been approved.

4. Recommendation

THAT the Trust Board DISCUSS the draft policy and offer views on its current content.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# LDV Replacement Business Case

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

Attached is an executive summary from the Combined Business Case (CBC) outlining the case for replacing the existing LDV ambulance fleet with 100 Mercedes ambulances over two years. The case is affordable and within the Trusts delegated limit.

Work is underway to analyse the optimal financing route given both current economic conditions and the introduction of IFRS. Approval will be sought from the Trust Board in January 2009 for the recommended financing approach.

The full CBC is available for review and has been circulated separately to the main agenda (electronically).

4. Recommendation

THAT the Trust Board APPROVE the procurement of the vehicles.

# 1 Executive Summary

## Introduction

The purpose of this Combined Business Case (CBC) is for internal London Ambulance Service (LAS) use where combining the Outline and Full Business case requirements can save time and effort, and the overall cost is within the LAS financial approval authority. This business case draws upon both the LAS Strategy Plan 2006/7 to 20012/13 and the Fleet update presented to the Trust Board in March 2008. It refers to recent independent research on fleet size and an urgent requirement to address an ageing fleet of front line ambulances. This CBC draws the conclusion that the Trust should replace 100 of the oldest ambulances with new ones because:

- The need to replace old and worn out vehicles remains strong
- Costs to repair vehicles will become higher as the age of vehicles increases

The preferred option arising from this analysis of costs and benefits is that 100 new ambulances should be purchased to replace older vehicles. The final decision on how these vehicles are financed will be made following a subsequent comparison of lease and purchase options. This business case is based on the option that vehicles are purchased, partially using existing capital resource limit (CRL) for the 08/09 and 09/10 financial years.

1.1.2 This CBC also confirms that the Trust has the capability to manage the project as evidenced by recent projects, the introduction of the PTS range of vehicles since 2002 covering some 140 different specification vehicles, and more recently 148 RRUs during 2006 and 2007/8. Other members of the project team were involved in previous deliveries of the 260 Mercedes AEU's since 2004/5.

## Strategic Case

The Trust has an ageing fleet because of under-investment in the 1990s. The age profile of the fleet is improving, but as at March 2008, 35% of the fleet is greater than 6 years old and 20% of the fleet is more then 9 years old. Older ambulances are costly to maintain, increase overall vehicle downtime and reduce the capacity to achieve performance targets, with a consequent impact on patient care.

A number of drivers for the replacement of ambulances have been identified including meeting Government performance targets, improving staff health and safety, reducing vehicle downtime due to defects and repairs and reducing running costs.

This business case proposes that 100 of the latest LAS specification, CEN compliant, A&E ambulances are procured to replace the 100 oldest vehicles in the fleet. The ambulances will be Mercedes diesel vehicles with a removable box body and tail lift. This will be the fifth batch of this vehicle type that the Trust has procured

The Trust's fleet replacement strategy specifies that ambulances should be replaced after 6 years. The Trust is procuring vehicles in batches of 100 to achieve a more even spread in the age profile of ambulances to avoid too many vehicles needing to

be replaced at one time in the future. However, the requirement for a sensible age spread needs to be balanced against the risks posed by the ageing fleet.

For this reason, this Combined Business Case has been prepared for Trust Board approval in November 2008 in order to allow 100 replacement ambulances to be procured and put into service by July 2009.

Economic Case

There are five investment objectives and targets for this business case:

- Provide 100 CEN Compliance ambulance vehicles designed to the latest LAS Specification ready for deployment commencing January 2009.
- To improve the availability of A&E ambulances by reducing instances of off-the-road downtime caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- Meet Health & Safety requirements to reduce back injuries caused by manual trolley bed vehicle loading; by up to 50% like for like by installing mechanical tail-lifts
- To meet the aims of the Strategic Plan 2006/7 to 2012/13 by responding to our patient's needs with the appropriate service.

1.3.2 This business case has considered two options open to the LAS - Do Nothing and a capital purchase of 100 vehicles, 35 in the 2008/09 financial year and 65 at the beginning of the 2009/10 financial year. It has been found that the preferred option is the capital purchase largely due to the Weighted Benefit Score applied to both these options.

Financial Case

The financial case uses figures consistent with the economic case but with VAT and non-cash elements (such as depreciation) included.

The financial case shows that there is a net cost in all years of the project, starting at £0.6 million in year 1, rising to £2.5 million in year 2 as a result of equipment and full-year depreciation costs, reducing to approximately £1.5 million in each year of the remaining life of the project. An overall Trust surplus position is maintained however, throughout the period of investment.

Once the approval to replace the assets has been received, an economic comparison between leasing and purchasing will be undertaken and the affordability of the lease option tested if appropriate.

This business case has been shown to be affordable and is within the Trust's delegated limits, thus commissioner support has not been sought.

Commercial Case

During 2003/04, the LAS replaced 130 frontline A&E ambulances with new Mercedes ambulances with aluminium modular box bodies. The Trust subsequently replaced two batches of 60 replacement vehicles in 2004/5 and 2005/6. A number of this later batch of vehicles included trial innovations such as carbon fibre bodies, new tail lifts and solar panels to assist with power management. These trials offered operating benefits, in particular the carbon fibre bodies, since these offered a lower operating mass resulting in lower fuel consumption. When the trial vehicles were introduced, however, the vehicle was loaded with other equipment and the expected benefits were not realised. In addition, carbon fibre is reputedly simpler and quicker to repair than aluminium, offering potential reductions in vehicle repair times. Moulded carbon fibre interiors could also improve infection control through reducing dirt trapping joints and seams.

The contract for build of ambulance bodies has been tendered via the newly awarded PASA NHS framework agreement. A formal tender evaluation group was formed and reviewed each supplier's submitted tender response using criteria such as price, quality, compliance to the specification, ability to meet the vehicle delivery schedule.

The tender evaluation has been completed for the build of ambulance bodies therefore, this business case has been drafted using the prices from the tender, and current costs the LAS incurs. Approval for this business case is sought on the basis that final prices are within reasonable proximity of the quoted prices in the financial analysis of this document.

Management Case

This project will be managed by the Operational Support Fleet Project Manager using the PRINCE 2 methodology. This model is the NHS standard and has been used by the LAS for many successful procurement projects since 2002.

The stakeholders' expectations are that vehicles commence operational deployment starting from December 2008 and that all vehicles are in service by the end of July 2009. This is an ambitious and challenging schedule to achieve. However, these timeframes cannot be confirmed until contracts are placed with the individual equipment suppliers and their production schedules are known.

Staff involvement is of course critical to the success of this project, the ambulance being the key resource of the Trust. The design of the new ambulance has had the direct involvement of staff through the A&E Vehicle and Equipment Working Group. Equally importantly, all staff have had the opportunity to make direct suggestions for changes to the vehicle design. Where practicable, these have been incorporated into the specification for these vehicles.

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# IM&T Strategy 2008/09 – 2012/13

1. Sponsoring Director: Peter Bradley

2. Purpose: For Approval

3. Summary

The objective of the Information Management & Technology Strategy is to set the blueprint for how Information Management & Technology (IM&T) will deliver and support the LAS over the next 5 years. It is focused to ensure that it supports people and clinical issues, not just IM&T. It is important to stress that it is not set in stone and will be revised during this period based upon business need and changing requirements

The attached paper sets out how effective implementation of the IM&T Strategy can support the future business requirements of the LAS, as well as a high level view on the attached summary of the strategy.

The IM&T Strategy has been informally reviewed on several occasions and it was formally reviewed by the Service Development Committee in June 2008. All comments received have been incorporated and the strategy amended accordingly.

The actual IM&T Strategy 2008/09 – 2012/13 document has been circulated separately to the main agenda (electronically).

4. Recommendation

THAT the Trust Board APPROVE the IM&T Strategy 2008/09 – 2012/13.

**Trust Board – 25 November 2008**

# IM&T STRATEGY 2008/09 – 2012/13

## Introduction

The objective of the IM&T Strategy is to set the blueprint for how IM&T will deliver and support the LAS over the next 5 years. It is focused to ensure that it supports people and clinical issues, not just IM&T. It is important to stress that it is not set in stone and will be revised during this period based upon business need and changing requirements.

The underlying driver for the strategy is the Trust's Strategic Plan 2006/07 - 2012/13, that sets the direction for the London Ambulance Service NHS Trust (LAS) and outlines how it will be implemented in the wider context of developments in the NHS. The IM&T Strategy is defined as one of the enablers to support the delivery of this plan. There are additional drivers in the form of increasing demand for operational performance, healthcare for London, Lord Dazi's recent review and application for Foundation Trust status. None of these however alter the overall direction set out in the strategy, or require changes that cannot be supported by it.

The next section of this paper sets out how effective implementation of the IM&T Strategy can support the future business requirements of the LAS, while the last section provides a view on the defined approach of the strategy. The actual strategy is appended to this paper.

## The future vision

The CAD 2010 project has delivered a new, fully integrated CAD system supporting two control rooms (each with 100% spare capacity for resilience). Reliability is 99.9%+ with complete system failures now unheard of. New functionality is released twice a year through upgrades provided by the commercial provider of the CAD software.

The LAS has fully implemented Airwave. Every crew member carries a digital radio that provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies. Data is now routinely passed across this system alerting staff to calls, and in the case of non MDT vehicles, passing the actual call details.

Electronic PRFs are fully installed in all response vehicles. Details of the call automatically populates the ePRF 'tablet' (hand portable PC device) and where patient details are known, appropriate medical information is downloaded from the Spine. Mandatory fields ensure 100% data compliance. If the patient is to be transported, then all recorded details are downloaded to the receiving centre (hospital or urgent care centre of some type), e.t.a. is automatically calculated, hence reception staff know what to expect and when. The ePRF tablet also acts as information centre for the Paramedic. It has access to various clinical guidelines and provides basic translation software for deaf people and commonly used languages. It is in continuous development as a vital Paramedic aid.

All staff book on/off duty, time recording will therefore automatically satisfy the requirements of the working time directive. Additionally, when booking on duty, all clinically qualified staff will be issued with an Airwave radio, that in turn will show their availability to the CAD system. All clinically qualified staff will be expected to be available to respond to local calls to perform physically local BLS duties, irrespective of

their other duties. 'Hot desking' is common place, with staff having a transportable telephone number (can by moved to any fixed or mobile handset) and are able to log onto their user accounts and files from any LAS PC. All data is input once, as close to the original collection point as possible, normally via a web browser. Hence, through streamlined business processes and work flow applications, paper forms are no longer sent to data input functions. Once entered, data is then re-used by a defined suite of systems, thus removing the need for duplicate data entry.

All managers who have a justified business requirement will have a laptop computer (or similar device) equipped will full remote access, allowing 24 X 7 access to all corporate services. All staff will have access to basic e-mail (known as web mail) from any internet terminal – essentially giving free access to Trust e-mail from home computers or internet cafés. Vitally, a new culture will have emerged where staff use this technology to work smarter, not harder – this access will not simply be work added to the 'day job'.

A new suite of services are now available for people who do not speak English and/or who cannot use the telephone as an able bodied person would. This includes direct internet services and text messaging via translator services that then interact with the control room. New national targets have been agreed for these types of calls, as 8 minutes from initial call answer is recognised as being not realistically achievable.

There is a single repository for all staff data, the national ESR system that includes records of personal issue equipment. Application forms are now all electronic and from moment of initial enquiry, the entire employee process is automated. Extraction routines take data from ESR and populate other systems that need data about people (e.g. telephone directory). This includes setting the access level that each member of staff has for information systems. Self service is fully implemented allowing staff to self-manage certain personal attributes (e.g. Bank details, address, telephone extension).

Management Information is provided by a suite of reporting tools that reside on all desktop and remote access computers. There are different levels of tools and staff are able to generate reports as and when they require them, according to their access rights. The central Management Department provides expert analysis for the most complex queries, reports on overall trends, provides predictions, continually develops the tools and acts as guardian of data standards.

There is a 24X7 IM&T Support desk that acts as a single focal point for ALL IM&T support. Utilising interactive tools, the support technician is able to remotely access the faulty equipment or service. 70% of the calls receive a 'fix' at the point of the call being received. That is, the technician is able to restore at least a basic service to the customer, and where necessary, complete fault resolution to be undertaken in slow time. Increasingly customers will use 'self service'. Through a web browser they will be able to log onto the service desk and report their problem. They will also be able to access a series of tools and help scripts to assist in 'self fix' and also monitor progress of their fault.

Staff training and education has evolved. All employees are required to have a basic level of IM&T literacy, irrespective of their role (e.g. e-mail, basic word processing). Many training modules are now delivered by web-based e-learning packages, including many clinical modules. Traditional classroom based training is still delivered, but it is more an exception rather than normal practice. Importantly, staff accept that they are responsible for their ongoing training – this is not something 'done to them' by managers. The concept of IM&T Super User is now well established. This role is a recognised responsibility undertaken by appropriate staff at each main LAS location. The person provides local user support and has a direct liaison with the IM&T Directorate, which provides ongoing support and training.

The approach defined in the IM&T Strategy

In order to deliver the vision defined above, the actual strategy is delivered in a number of discrete sections, each covering a specific aspect of IM&T. An important element of this strategy is the acknowledgement and full support for the national programme for information technology, also known as Connecting For Health. The approach is to utilise products that are readily available, including N3, the secure national network, NHS Mail and the ePRF solution.

There will be a clear focus on IM&T customer service and delivery. A number of measures will be developed including business benefits realisation, appropriate programme and project management, and ensuring the right IM&T staff, with the right skills, are in place. Customer driven service provision will underpin every activity of IM&T support and delivery, utilising the IT Infrastructure Library (ITIL) best practice framework. There will be empowerment through the creation of an IM&T Super Users Programme - the European Computer Driving Licence (ECDL) will be available as a base-line standard for staff and an effective file management and e-mail archiving system will be implemented.

Compliance to ensure effective Information Governance and Security is rightly mandated. Any data stored on a PC or other removable device in a non-secure area or on a portable device such as a laptop, PDA or mobile phone will be encrypted. There will be clear focus to ensure that security controls are not disproportionate to achieving the desired business objective. An Information Governance Group will oversee all aspects of Information Governance and Security on behalf of the LAS.

Much work will be undertaken in the early years of this strategy to enhance the underlying technical infrastructure. IPT Telephony Voice/data/video will be the cornerstone, where voice information is managed in the same way as traditional data traffic. In terms of performance, the aim is to enable any user to access core services with consistent performance from any LAS workplace. A technical architecture will be implemented to ensure that all data is held in a centralised information repository (data warehouse). Through the provision of appropriate tools, decision makers will be provided with desktop access to their required information. Routine/standard reports will be instantly accessible with the opportunity for managers to create their own reports using various tools.

In terms of new software provision, the starting point will be to gather initial requirements and undertake a feasibility study. Solutions will be delivered through amending an existing system, implementing a third party product, interfacing or by in-house developments, using web technologies where appropriate. There will also be a drive towards working collaboratively with the wider emergency services family to produce joined-up solutions. The replacement of the existing Computer Aided Despatch system will be the cornerstone of work during the next three years.

Recommendation

That the Trust Board approve the IM&T Strategy, 2008/09 – 2012/13.

Peter Suter
Director of Information Management & Technology

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Risk Management Policy

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary

The Risk Management Policy that was approved by the Trust Board in September 08 had to be updated following on from the recommendations from NHSLA Assessment in October 08.

The updates are as follows:

- The attendance of the members of the following committees need to be at least 50% of meetings (RCAG, CGC and Audit Committee)
- The Risk Management Structure of LAS needs to reflect the relationship between Clinical Governance Committee and Risk and Compliance Assurance Group

The Risk Management Structure document and the Risk Management Policy have been circulated electronically with changes highlighted.

4. Recommendation

THAT the Trust Board APPROVE the amendments to the Risk Management Policy and structure

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Foundation Trust update

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: To update the Trust Board on progress with the application for the LAS to become a Foundation Trust

3. Summary

The Foundation Trust application is now being managed as a programme by the Director of Finance who is the Senior Responsible Owner and reports progress made with the application against the high level plan agreed by the Board on September 30th. Programme updates are given to the Strategic Steering Group in a similar way to the programmes of the Service Improvement Programme.

The programme board chaired by the Chief Executive Officer has met twice and oversees the achievement of progress for all aspects of our application against timescales. This work has been subdivided into seven Workstreams led by senior managers and the progress made with each work stream is highlighted below.

**Governance and membership workstream**

- Interim membership manager appointed.
- Tender prepared for computerised membership database management
- Membership rationale and strategy in draft stage

**Consultation and communication workstream**

- Drafting of consultation documents underway for consultation to begin on 26th January 2009 for 12 weeks
- Work begun to use internal management meetings to explain the process by which the LAS is applying to become an FT

**Business Marketing & Strategy workstream**

- 2 Facilitated workshops held with participation by SMG, Chairman and NEDs
- Third workshop to be held to fully develop marketing position which will then be included in the Integrated Business Plan (IBP)

**Commissioner Engagement Workstream**

- Commissioners have advertised for a Commissioning Manager to support our FT application
- Commissioners invited to join FT Programme Board

**Business Plan Workstream**

- the structure for the integrated business plan has been agreed building on the work produced from the FT Diagnostic pilot programme

**Workforce development**

- the HR strategy will be attached as an appendix to the IBP
- New ways of working and Organisation Development and People programmes under review with detail to be included in the IBP

**Finance**

- Monitor completing work on the modification of the Long Term Financial Model ready to be tested by our finance team
- Strategic Financial Model being developed to allow detailed financial projections to be prepared

4. Recommendation

THAT the work done to progress the FT application is NOTED by the Trust Board.

Enclosure 13

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Standing Orders, Financial Instructions And the Scheme of Delegation

4. Sponsoring Executive Director: Michael Dinan

5. Purpose: For approval

6. Summary

The Standing Orders, Financial Instructions and Scheme of Delegation have been reviewed and updated in line with the NHS Model Rules published in March 2006.

Attached are the proposed changes to the Standing Orders and the Financial Instructions. The documents have been circulated separately to the main agenda (electronically).

The Audit Committee considered the proposed amendments to the Standing Orders and Financial Instructions, including Scheme of Delegation, at its meeting in November 2008 and approved submission of the amended documents to the Trust Board

4. Recommendation

THAT the Trust Board APPROVE the amended Standing Orders, Financial Instructions and Scheme of Delegation.

**Review of the Standing Orders, Financial Instructions and Scheme of Delegation.**

The Standing Orders and Financial Instructions have been reviewed in collaboration with colleagues and a comparison undertaken against the NHS Model Rules published in March 2006. The Standing Orders, Finance Instructions and Scheme of Delegation were reviewed in 2006/07 and approved by the Trust Board in March 2007.

Please note that in the documents 'strike through' denotes a proposed deletion and underlining indicates an addition or amendment.

## 1. Standing Orders

The main changes to the Standing Orders are:

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|---|---|
| Appendix 2 (2.4): | The EU thresholds have been changed to reflect the new amounts in effect from January 1st 2008; |
| Appendix 2 (9.4) | A section referring to the use of electronic tendering and the safeguards in place has been added. |
| Appendix 3, 5 & 9. | The inclusion of the amended terms of reference for the Audit Committee; the Clinical Governance Committee and the Charitable Funds Committee.<br>In September 2008 the Trust Board approved the Risk Management Policy which contained the recently revised Terms of Reference for the Audit Committee and the Clinical Governance Committee. |

## 2. Financial Instructions

The main changes to the Financial Instructions are:

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|---|---|
| 11.1.5 | This has been updated to include reference to the most up to date guidance from the Department of Health in relation to delegated limits for capital investment. |
| 11.3.2 | This has been updated to include reference to the most up to date guidance relating to the maintenance of an asset register recording fixed assets. |

The Local Counter Fraud Specialist reviewed the Standing Financial Instructions (SFIs) and considered them adequate and fit for purpose. Suggestions as to how the SFIs could be improved have been incorporated within the document, primarily Section 2.4 – Fraud and Corruption. These include:

| | |
|---|---|
| 2.4 | The inclusion of definitions of what constitutes fraud or corruption; providing a definition will provide assistance to those who are unsure what fraud or corruption is; |
| 2.4.2 | The inclusion of the contact details for the LCFS; |
| 2.4.6 | Reference to the Trust's Fraud and Corruption Policy and where it can be found i.e. the Pulse. |
| 9.1.2(c) | Reference to the London Ambulance Services' authorised signatories list, as well as the authorised signatories' policy. |
| 9.2.6(d) | Cross-reference to the Trust's Gifts and Hospitality policy, which is set out in Appendix VI of the Trust's Standing Orders. |

## 3. Scheme of Delegation

There were no changes proposed to the Scheme of Delegation as it was substantially reviewed in 2006/07.

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Service Improvement Programme 2012 update

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting.

3. Summary

The report provides an update on progress in implementing the Service Improvement Programme (SIP2012).

The following reporting procedure to Trust Board and Service Development Committee was approved by the Trust Board in September 2007:

a. Trust Board – every meeting;

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

4. Recommendation

THAT the Trust Board NOTE the progress made with the Service Improvement Programme 2012 outlined in the report.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 25th November 2008

**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 seven sections, one for each of the sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- 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 as at the date indicated on the chart by the vertical line.

Trust Board members are invited to raise any questions for programme lead directors to answer at the meeting.

**3. Overview of programme structure**

The service improvement programme has previously been made up of the following five sub-programmes:

- *Access and Connecting (the LAS) for Health* led by the Director of Information Management and Technology);
- *Improving our Response* (known as the "Operational Model") led by the Director of Operations;
- *Organisation Development and People* led by the Director of Human Resources and Organisation Development;
- *Preparing for the Olympics* led by the Director of Operations;
- *Corporate Processes and Governance* led by the Director of Finance.

There has also been a supporting *Stakeholder Engagement and Communications Strategy* led by the Director of Communications. It has been decided by the Senior Management Group (October 2008) that two additional programmes should be incorporated within SIP2012 which are also covered by this report:

- *New Ways of Working* led by the Chief Executive;
- *Foundation Trust Application* led by the Director of Finance.

## 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).

Improving our Response

*Referral pathways*

The project manager is on sick leave which is causing a delay. An interim solution is being progressed to aid delivery of this initiative with the approval of a six month secondment and once the results of the banding exercise are finalised the role will be advertised internally. It is now clear that the deliverable of a comprehensive set of referral pathways in each PCT area which are routinely used by staff will now move into 2008/09.

Corporate Processes and Governance

*Re-engineer Income Collection*

The project has been on hold due to deployment of the project manager on other work.

*Asset Tracking*

The project is on hold due to capacity constraints on power to the server room, IM&T have steps in hand to address this issue at which point the project can progress.

Access

*London Airwave Radio Programme (LARP)*

The centrally-driven project plan needs revision following the testing failure of the last version of the radio control software (ICCS), as yet no plan has been issued. A meeting has been arranged with Department of Health and suppliers to discuss the key issues and agree a way forward. A draft local migration plan has been completed with input from key operational staff. This is being held until there is a better understanding of the new timeline with migration deferred until the new financial year as Senior Users have indicated that a rollout of digital radios cannot be completed during January (winter pressures) or February and March (year-end performance pressure).

However, the Service Level Agreement is in final draft in preparation for the Project Board and the service for the current 200 radios is now being considered for inclusion in the main DH ARP contract. This will provide better service to the users and simplify the management of equipment maintenance and servicing. A budget bid has been presented to SSG for extending radio support from weekdays to weekends. Dual fitting of vehicles has now been completed and it is intended to move on to fit 53 new PTS vehicles, 60 new ambulances and 12 new MRU's. Training is on hold until there is further information on the rollout schedule, MRU/CRU users are to be trained to provide early access.

*Text Emergency Access for Speech or Hearing Impaired People (TEASHIP)*

There is no new information regarding the lack of progress with the national initiative lead by the Department for Communities and Local Government '999' liaison committee. Progress of this initiative will continued to be monitored with the intention of ensuring call taking and triage procedures cater for any increase in the volume of calls received from the RNID bureau. In the meantime planning of a pilot study to evaluate the feasibility and viability of an in-house solution has begun (whereby text messages will be received directly from the public and handled initially by EBS staff within UOC). It is intended that this study focuses on the needs of deaf or deafened people, drawing upon community links.

New Ways of Working

*Team Based Working*

Team based working involves:

- Establishment of working arrangements conducive to the formation of real teams (e.g. a watch system, annualised hours and self-rostering);
- Complex roster reviews;
- Review of management/supervisory post numbers and specification of roles;
- Leadership and staff development;
- Establishment of Team Briefings.

Progress is dependent upon and awaiting outcomes of ORH modelling, a clinical leadership paper and work on proposed clinical models to shape what Team Based Working will look like. However, work is beginning on roster/working practice reviews at Barnehurst following the Complex away day. Work also will continue regarding the gap analysis required to define requirements, identify leadership structure changes and develop a local training plan.

**5. Recommendation**

That the Trust Board notes the progress made with the Service Improvement Programme 2012.

**Kathy Jones**
**Director of Service Development**

Enclosure 15

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

# Annual Report of the Trustees of the LAS Charitable Fund

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

Charitable funds received by the Charity are accepted and held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Act 1990 and these funds are held on trust by the corporate body.

The Annual Report and the Annual Accounts of the LAS Charitable Funds for the year ended 31stMarch 2008 are attached for the Board's attention; they have previously been reviewed by the Charitable Funds Committee and the Audit Committee.

4. Recommendation

THAT the Trust Board NOTE the contents of the Annual Report of the LAS Charitable Funds for the year ended 31st March 2008.

Enclosure 16

London Ambulance Service NHS TRUST

**Summary of the minutes**
**Audit Committee - 10th November 2008**

**1. Chairman of the Committee** **Caroline Silver**

**2. Purpose:** **To provide the Trust Board with a summary of the proceedings of the Audit Committee.**

**3. Agreed:**

- That the revised Standing Orders and Financial Instructions be presented to the Trust Board for approval in November 2008
- The draft 2008/09 Internal Audit Plan, with two amendments suggested by the Committee.

**Noted:**

The contents of the following presentations given by members of the Finance Department:

- the progress to date in preparing for the introduction of the International Financial Reporting Standards (IFRS) and the possible impact it may have on the Trust's financial accounting practices.
- the Finance Information Management System (FIMS) and how it is reconciled with the monthly financial reports received by the Trust Board and the Service Development Committee.
- the work being undertaken to improve the Trust's Auditors Local Evaluation score in order to achieve 'excellent' for Use of Resources in 2009-10.
- the web based integrated governance tool, Performance Accelerator, which will be used to gather evidence of compliance for the ALE, the NHSLA, the Healthcare Standards as well as the Trust's Balanced Scorecard.
- the 2009-10 budget planning process;
- the routine work undertaken to reconcile the Balance Sheet and the process for cashflow management.
- The progress that has been made in respect of Reference Costs; the Finance Director will present a report to the Service Development Committee in December.

The Charitable Funds Annual Report and Accounts which will be presented to the Trust Board in November 2008.

The declaration of hospitality by the Chairman of the Trust Board and the Director of Information, Management & Technology.

That consideration will be given as to whether a risk should be placed on the Trust's Risk Register in respect of the potential complexities surrounding the financial treatment of CAD 2010. The Director of Finance said he would discuss the matter with the Director of Information, Management & Technology

**Minutes received from:**
RCAG, 21st October 2008

**Recommendation:**

THAT the Trust Board NOTE the minutes of the Audit Committee, 10th November 2008.

**LONDON AMBULANCE SERVICE NHS TRUST**
**AUDIT COMMITTEE**
**9.30pm, Main Meeting Room, Loman Street SE1**

**Monday, 10th November 2008**

| | | |
|---|---|---|
| Present: | Caroline Silver | Non-Executive Director (Chair) |
| | Sarah Waller | Non-Executive Director (from 10.25 until 12.30) |
| | Brian Huckett | Non-Executive Director |
| | Roy Griffins | Non-Executive Director (until 12.30) |
| In Attendance: | Peter Bradley | Chief Executive (until 12.00) |
| | Mike Dinan | Director of Finance |
| | Michael John | Financial Controller |
| | Helen Berry | Head of Financial Management |
| | Martyn Salter | Corporate Processes Programme Manager |
| | Ken Thompson | Head Cashier |
| | Michelle Johnson | Capital Accountant |
| | Andy Bell | Finance Manager, A&E |
| | Ashal Odedra | Finance Analyst |
| | Elizabeth Leramoh | Finance Analyst |
| | Christine McMahon | Trust Secretary (Minutes) |

## 45/08 Minutes of the last Audit Committee meeting held 8th September 2008 and Matters Arising

**Agreed:**

1. **The minutes of the last Audit Committee meeting held on 8th September 2008.**

**Noted:**

2. **Minute 31.08: correspondence has been received from the Inland Revenue seeking further information concerning meal breaks relating to PTS staff. They have also requested to renew the existing dispensation arrangements for a further three/four years. Following a decision by the Inland Revenue the Trust will have discussions with the 31 PCTs concerning the back to back agreement that are in place.**
3. **Minute 31.08: the Finance Director said that to date 19 (an improvement on the figure of 16 reported to the Audit Committee in September) PCTS have signed the 2007/08 Service Level Agreement further to the recommendation contained in the Audit Commission's 2007/08 governance report. Work is on-going to have the remaining agreements signed by both parties. ACTION: Finance Director.**
4. **Minute 34:08: Sue Exton provided the Chief Executive with a paper outlining the assessment criteria used to ascertain a Trust's ALE rating.**

## 46/08 International Financial Reporting Standards (IFRS) Update

The Financial Controller said that work was ongoing to prepare the Trust prior to the introduction of IFRS in 2009-10.

It was likely that ambulance operating leases will be required to be treated as financial leases, which will affect the Income and Expenditure account and the Balance Sheet. The full impact of this change on the Trust should be known by the end of the month. The matter will be discussed with Commissioners and it may be that additional funding is required to offset the impact on the Trust's Income & Expenditure account.

Work was also being undertaken in respect of the Trust's fixed assets; stock valuation and annual leave to ensure they are accounted for correctly under IFRS. The Trust may

consolidate the Charitable Funds within its accounts although the relatively low value of the Fund may mean it is considered immaterial as it is less than £50k. A further report on the progress of implementing IFRS will be presented to the Committee in March 2009.
**ACTION: Financial Controller**

Baker Tilly, who has been retained by the Trust to advise on the implications of IFRS, are currently reviewing the Trust's accounting policies.

The Finance Director said that the Finance Directors of the Ambulance Services were working closely to ensure a consistent approach was adopted towards the implementation of segmental reporting e.g. in accordance with the spirit of the IFRS guidance PTS was likely to be treated as the only separate business line, with EBS a possibility, although neither exceed 10% of the Trust's turnover.

**47/08 Review of the Trust's external financial reporting process (FIMS)**

Finance Information Management System (FIMS) is a financial tool used by the Department of Health to monitor the financial performance of the NHS. The Trust is required to submit an annual financial plan to the London Provider Agency (LPA) which is signed by the Chairman of the Trust Board and the Chief Executive. During the year it, along with other NHS bodies, it is required to submit monthly financial updates and detailed quarterly financial reports and to report any significant variation from the plan to the LPA.

Due to timing issues the FIMS is different from the LAS' annual budget. The Internal and External auditors undertake a reconciliation of the information submitted to the LPA and the monthly financial reports received by the Trust Board/Service Development Committee. This year, as the Director of NHS Finance wishes to submit the NHS accounts to Parliament prior to the summer recess; the deadline for NHS Trusts to submit their final accounts has been brought forward. The Trust is working with the external auditors to ensure that a "hard close" of the accounts takes place at Month 9 and is then audited at month 12 in line with the revised deadline for submission of audited accounts.

The Director of Finance demonstrated the reconciliation of the recently submitted FIMS to the Month 6 financial report received by the Trust Board.

In the past, intra-trust balances have been an issue for the Trust but this has improved in recent years, with the Trust using the dispute resolution mechanism as/when necessary. One of the challenges for the finance department will be accounting for PTS' intra trust balances as Trusts are invoiced for journeys that exceed the amount agreed in the contract agreed between the individual Trust and PTS.

The Finance Director said that the Trust's financial risks (which were reported to the Trust Board as part of the regular financial report) included:

- not achieving the Cost Improvement Programme which was currently £600k;
- not receiving the additional funding for the Olympics
- not receiving the additional funding from the Commissioners due to the Category A8 minute and Category B19 minute performance targets not being achieved.

In previous years there were issues in reconciling the FIMS and the monthly finance report to the Trust Board due to timing differences as the FIMS report was usually required before the monthly finance report had been completed. The Finance Director said that work was being undertaken to create a 'technical bridge' between the FIMS and the monthly financial report to the Trust Board which could be included in the report received by the Trust Board as an added assurance.

Foundation Trusts were not required to submit FIMS to the London SHA as they are regulated by Monitor, who in turn reports to the Department of Health.

## 48/08 Review criteria of the Auditors Local Evaluation

The Committee reviewed the elements that made up the Trust's current ALE score and the measures that were being adopted to enable the Trust to achieve a rating of 'excellent' for 2009-10. The minimum score required to achieve an excellent (4) rating is two level fours from Financial Management, Financial Standing or Value for Money. The Committee discussed the areas of work being undertaken to improve the Trust's ALE score; these included in particular the liquidity ratio, corporate social responsibility; being more proactive in respect of counter fraud and in addressing the needs of hard to reach communities in society.

It was recognised that to date no ambulance service has achieve excellent for use of resources whilst the majority of Foundation Trusts have achieved an 'excellent' score.

It was noted that the Trust's ALE score will be affected by having only 19 of the 31 PCTs have signed the 2008-09 Service Level Agreements (SLAs). **ACTION: The Chief Executive said he would personally intervene if necessary to ensure that the remainder of the SLAs were signed.**

**Performance Accelerator**

The Corporate Processes Programme Manager gave a presentation on how the web based integrated governance tool, Performance Accelerator, will be used to evidence and to monitor the Trust's compliance with the ALE.

As/when the Audit Commission changes the definitions of the KLOE[3] the system is automatically updated. The system will be used to gather evidence electronically in respect of the Trust's Risk Register, the Balanced Scorecard etc and is expected to be fully operational by the end of this financial year. In due course, the Non Executives will be able access to the system whereby they would be able to 'drill' down and view the evidence for compliance.

The Committee was assured that there were security safeguards in place to ensure that the integrity of the system was protected. The system enables the Trust to capture the required evidence once, to do so electronically and to have an integrated approach to governance across the Trust.

## 49/08 Business Planning and budgeting process 2009/10

The Head of Financial Management outlined the 2009-10 budgeting process The 2009/10 financial plan, which will be submitted to the SHA, the Department of Health and for FT preparation, will be developed using the Strategic Resource Model which will feed into the Strategic Financial Model.

The Strategic Resource Model will provide the number of crew staff and vehicles needed for an assumed activity level. This model is reconciled with the information provided by ORH to give baseline resources for a given level of activity. Scenario modelling will be done by flexing assumptions build into the model such as job cycle time, relief %'s etc.

The resources calculated by the Strategic Resource Model will feed into the A&E Resources Model to give the numbers of A&E operational staff by staff group. This information feeds into the Strategic Financial Model which will calculate the cost of the LAS for a given level of activity/service.

Baseline budgets for 2009/10 are calculated for each directorate "top- down"; and will be prepared by each directorate by the end of November. These templates will be completed in conjunction with directors, departmental managers and finance analysts. During the New Year detailed budgets will be built "bottom – up"

[3] KLOE – the individual elements that make up the ALE.

The deadline for SPPPs is 19th December and, following an initial review by the Finance Team, the Strategic Services Group will review the bids in January approving some, deferring others,

It is expected that the deadline for the submission of the 2009-20 financial plan to the SHA will be the end of January although no official notification as yet been received. A draft 2009-10 budget will be presented to the Service Development Committee in December with a further draft (possibly final) budget being presented to the Trust Board in January 2009.

Individual budget holders sign off their annual budgets, in terms of Operations this is done at senior management level i.e. by Area Operation Managers. The ratio of support staff to operational staff was reviewed and benchmarked against other ambulance trusts. Requests for extra resourcing, e.g. additional staffing, was reviewed by the Senior Management team.

The Finance Director said that the major capital projects being undertaken in 2009-10, CAD 2010 and LARP, will result in a decrease in the Trust's cash balances and may require the Trust Board to approve a loan facility.

The Financial Director said that the model produced by ORH was reviewed against data held by the Trust; the recent modelling work undertaken by ORH has suggested that to sustain the Category A8 minute and B19 minute performance targets in 2009-10 the Trust will require approximately 500 additional front line staff. This will be a major investment by the Trust.

**50/08 Balance Sheet Reconciliation**

The Capital Accountant outlined the process for reconciling the control accounts on the Balance Sheet and outlined the process for monitoring capital expenditure.

It was suggested that consideration should be given as to whether there should be a risk on the Trust's Risk Register in respect of the accounting complexities relating to CAD 2010 and if necessary this will be proposed at the next meeting of the RCAG. **ACTION: Finance Director.** The Finance Director said that the finance team were liaising with the Audit Commission on how the Trust accounted for CAD 2010.

Both the internal and external auditors undertake an annual review of the balance sheet reconciliation process.

The payroll / holiday systems having previously flagged by internal audit, the Committee was assured that there were processes in place to ensure that former members of staff ceased to be on the payroll once they have left the organisation, e.g. AOMS review the monthly nominal rolls to ensure that only current members of staff receive a salary. Nationally, the NHS undertakes an annual review of all NHS payroll records to identify individuals employed by more than one organisation.

**51/08 Cashflow management**

The Head Cashier gave a presentation outlining the Trust's management of its cashflow. Last year's cashflow management was challenging due to the receipt of £8m from NHS London which had to be spent within the 2007-08 financial year. In general the Trust had a relatively simple and straightforward cashflow cycle.

The annual dividend paid by the Trust (and all NHS Trusts) to the Treasury is a public dividend and reflects the cost of finance to the Trust; unlike the dividend paid by commercial organisations it is not discretionary.

The Trust is required to invest any of its surplus cash with the Paymaster General for which it receives interest. Foundation Trusts have greater freedom in how they invest their surplus cash.

## 52/08 Reference costs

The Corporate Process Programme Manager and the Finance Director updated the Committee on the progress that has been made in respect of reference costs which built on the work initially undertaken by Vicky Clarke, Senior Finance Manager

The presentation outlined the process adopted to identify appropriate reference costs which were produced using Activity Based Costing principles, e.g. incidents analysed into 96AMPDS main categories; emergency transfers/urgents; major incidents/airports; other; transferred for telephone advice and unclassified/uncoded. Costs excluded included: PTS; HEMS; decontamination and EBS.

For illustrative purposes data was presented using information held concerning Category A 8 minute performance which demonstrated the trend of AMPDS codes was similar year on year. The LAS was fortunate in that it held a lot of information concerning the number of incidents; the type of response despatched; the length of the job cycle etc. Benchmarking has been undertaken with other urban based ambulance services with the LAS falling midway in respect of the reference costs. The Finance Director said that as part of the Ambulance Leadership Forum the Finance Directors were in regular discussion as to how reference costs should be calculated e.g. whether PTS should be included.

The Finance Director said that 'downtime' was treated as an overhead. In 2004-5 the National Audit Office undertook an extensive audit of all the NHS Trust's reference costs.

The 90 or so incidents presented to the Committee will eventually be grouped so as to appear as three or four categories of reference costs.

**Noted: The progress to date in respect of reference costs and that a further report will be presented to the Service Development Committee in December. ACTION: Finance Director.**

## 53/08 Review standing orders and financial regulations

Good practice requires the Trust to review its Standing Orders and Financial Regulations on a regular basis. Following the substantial number of amendments made in 2007-08 only a few changes were proposed this year, including the updating of the EU threshold; the introduction of electronic tendering and some minor housekeeping changes reflecting changes in job titles etc.

Following a query from Sarah Waller as to whether the limit was too low, the Finance Director said that he would consider whether the level of £3,000 should be revised upwards.
**ACTION: Financial Director**

**Agreed: That the revised draft of the Standing Orders and Financial Regulations be presented to the Trust Board for its approval with the recent amendments to the terms of reference agreed by the Audit Committee and the Clinical Governance Committee being visible.**

## 54/08 2008/09 Audit Plan

**Agreed 1. The draft audit plan submitted to the Committee with the addition of two further audits;**

- **an audit to provide assurance in respect of the Risk Management & Assurance Framework**
- **an audit to be undertaken following the introduction of a new policy/procedure/other important update to ascertain its implementation and adoption across the Trust.**

**Noted: 2. That the amended 2008-09 Audit Plan and a copy of the Trust's Risk Register will be forwarded to the Chairman of the Audit Committee who**

**will discuss the proposed 2008-09 audit plan with RSM Bentley Jennison. ACTION: Chairman of the Audit Committee.**

## 55/08 Receive Charitable Funds Annual Accounts

The Financial Controller presented the Charitable Funds Annual Accounts which were approved by the Charitable Funds Annual Committee meeting on 8th September 2008. Following their presentation to the Trust Board they will be submitted to the Charity Commission.

**Noted:**
1. **That the value of the Fund had fallen by 25% between 31st March 2007 and 31st March 2008 and it was likely that it has fallen further given the recent fall in share prices on the Stock Market.**
2. **That the Fund had higher than expected income due a charitable donation received from the Edhi Foundation, and higher than forecasted expenditure.**
3. **That following consideration of the investment policy adopted by Investec the Committee had recognised that it would be unwise to change its investment strategy at this moment in time, but would keep the matter under review.**

## 56/08 Standing Committee Items

**Noted:**
1. **The declarations of hospitality by the Chairman of the Trust Board and the Director of IM&T.**
2. **That there was no waiving of the Standing Orders since the Committee met in June 2008.**

## 57/08 Draft minutes of the Risk Compliance and Assurance Group (RCAG)

In the absence of the Chief Executive, the Finance Director (who was unable to attend the recent RCAG meeting) presented the draft summary sheet and draft minutes of the recent RCAG meeting. The Chairman of the Audit Committee, who is a member of the RCAG and was at the meeting, said the summary of the minutes reflected what was discussed and the decisions taken at the meeting. In particular, the RCAG had discussed the need for better management of morphine on stations.

**Noted: The draft minutes of the RCAG meeting, 21st October 2008.**

## 58/08 Audit Committee work plan and timetable for meetings in 2009.

**Noted:**
1. **That it was not thought necessary to have any work around Foundation Trust discussed by the Audit Committee as it was being discussed on a regular basis by the Trust Board and the Service Development Committee.**
2. **That the meeting in November 2009 will focus in more detail on FIMS and the reconciliation of the Control Accounts. ACTION: Finance Director**

## 59/08 Any Other Business

Date of next Audit Committee meeting: 2.30pm, 3rd March 2009, Conference Room, LAS HQ which will be preceded at 2.15pm by a private meeting between the Audit Committee and the Auditors.

Meeting finished at 12.45

Enclosure 17

London Ambulance Service NHS TRUST

**Summary of the minutes**
**Clinical Governance Committee - 12th November 2008**

**3. Chairman of the Committee** **Dr Beryl Magrath**

**4. Purpose:** **To provide the Trust Board with a summary of the proceedings of the Clinical Governance Committee (CGC).**

**3. Agreed:**

1. Minor changes to the Committee's Terms of Reference i.e. job titles and included receipt of an annual report from PTS and BASICs.
2. To approve and ratify a number of policies and procedures which had either being drafted or revised as part of the NHSLA Level 1 assessment. The Trust successfully passed the clinically related standards with further work to be undertaken in other areas, there has been good progress made in completing the action plan drawn up to address those other areas.

**Noted:**

3. That three themes emerged from the Areas' Clinical Governance reports:
   - a decrease in the level of training that was taking place at complex level due to the Complex Trainers being required to train the recently recruited Student Paramedics.
   - Operational pressures and a high vacancy amongst Team Leaders has led to a fall in the level of PRFs being reviewed, with the overall level of CPI completion falling to 30%.
4. The need for all vehicle drivers to undertake a full Vehicle Daily Inspections (VDI) as soon as practically possible, as drivers were responsible in law for the roadworthiness of the vehicles they were driving .Front line staff have been provided with record sheets to record the VDI which they are expected to undertake at the start of their shift.
5. The approach being adopted by the Trust to the DH's End of Life Care Strategy and that the Trust will be discussing the implications of the Strategy with PCTS and Commissioners.
6. The implications of the Mental Health Act for the Trust.
7. The progress to date in implementing the action plans that were in place to mitigate the clinical risks included on the Trust's Risk Register
8. That the Trust has appointed an Infection Control Co-ordinator, AOM Trevor Hubbard, on a part time, interim basis.
   Work has commenced to implement the DH's 'clean hands' infection control campaign and the Committee will be kept informed of progress.
9. That it was highly probable that as the Trust was under 'severe pressure' there will be an increase in the receipt of complaints due to possible delays in responses.
10. That the Trust's Solicitors were reviewing the revised High Risk Address Register policy; it will be presented in due course to the Trust Board for approval.
11. That the Trust has appointed a Diversity Manager, Janice Mackay, who will be taking up her post with effect from 1st December 2008.
12. The contents of the Medical Director's report
13. The contents of the Risk Information Report

**Minutes/oral reports received from:**

14. Infection Control Group (7/11/08) It was noted that in future every patient must receive a fresh red blanket, the used blankets are exchanged at hospital, however there is a continuing shortage of red blankets
15. PPI Committee (6/10/08) It was noted that the pilot staff development programme in public education had commenced. Tower Hamlets pregnant women and their spouses had welcomed life support training. The Silvertown ambulance staff were commencing a 2nd course in Bengali;
16. Clinical Audit Research Steering Group (17/10/08) The LAS has been awarded a research project grant by the Stroke Association;
17. Clinical Steering Group (20/10/08) The difficulties in accessing intubation training were noted
18. Training Services Group (20/10/08).
19. RCAG (21/10/08);
20. That the SfBH Group; the Race Equality Strategy Group and the Complaints Panel (reconstituted as the Feedback, Learning and Improvement Group' have not met since the last CGC meeting (August 08).

**Recommendation:**

THAT the Trust Board NOTE the draft minutes of the Clinical Governance Committee, 4th August 2008.

**LONDON AMBULANCE SERVICE NHS TRUST**

DRAFT Minutes of the Clinical Governance Committee (full)
2.30pm, 12th November 2008, Burns Room, Union Jack Club

**Present:**

| | |
|---|---|
| Beryl Magrath (Chair) | Non-Executive Director |
| Fionna Moore (Vice chair) | Medical Director |
| Nicola Foad | Head of Legal Services |
| Stephen Moore | Head of Records Management & Business Continuity |
| David Selwood | Corporate Logistics Manager (deputising for Head of Operational Support) |
| Margaret Vander | PPI Manager |
| Gary Bassett | Head of Patient Experiences (formerly Complaints/ PALS Manager) |
| Tony Crabtree | Assistant Director, Employee Support Services (from 3.05-until 4.10) |
| Gurkamal Virdi | Assistant Head of Clinical Audit (deputising for Head of Clinical Audit & Research) |
| Phil Flower | Assistant Director of Operations, Control Services |
| Stephen Hines | Clinical Support Manager, UOC (until 4.10) |
| Martin Cook | Acting ADO South (deputising for ADO, South) |
| Paul Gates | Acting ADO East (deputising for ADO, East) (until 4.10) |
| Jon Knott | Acting ADO West (deputising for ADO, West) |
| Keith Miller | Clinical Education Manger (deputising for Assistant Director, Organisation Development) |
| Matthew Barker | Interim Head of Governance |
| Christine McMahon | Trust Secretary (minutes) |

**In attendance:**

| | |
|---|---|
| Dr Fenella Wrigley | Assistant Medical Director, Control Services |

**Apologies**

| | |
|---|---|
| Sarah Waller | Non Executive Director |
| Ingrid Prescod | Non Executive Director |
| John Selby | Senior Health & Safety Adviser |
| Bill O Neill | Assistant Director, Operations Development |
| Rachael Donohoe | Head of Clinical Audit & Research |
| Richard Webber | Deputy Director of Operations |
| Paul Woodrow | Assistant Director of Operations (ADO), South |
| Peter McKenna | ADO West |
| Jason Killens | ADO East |
| Lizzy Boville | ADO |
| Chris Vale | Head of Operational Support |
| Paul Tattam | Ambulance Operations Manager - D Watch |

The Chairman welcomed Phil Flowers, ADO Control who recently joined the LAS and Dr Fenella Wrigley, Assistant Medical Director, Control Services

## 55/08 Minutes of the Clinical Governance meeting held on 4th August 2008

**Agreed The minutes of the previous meetings held on 4th August 2008.**

## 56/08 Matters Arising

**Noted:**

1. ***Minute 42/08:*** **That AOM Trevor Hubbard, who has a nursing background, has been appointed as the Trust's part time, interim Infection Control Co-ordinator.**
2. ***Minute 42/08(6)*****: the data collected concerning the Audit of Clinical Telephone Advice (CTA) calls will be shared with CARU. ACTION: ADO, Control Services**
3. ***Minute 42/08 9(11):*** **the Trust has appointed Janice Mackay as Diversity Manager and she will be joining the Trust on 1st December 2008.**
4. ***Minute 45/08:*** **the ADO Control said that the random review of PSIAM had been included within a general review of the CTA function and the findings will be presented to the next Clinical Governance Committee. ACTION: ADO, Control Services**
5. ***Minute 45/08:*** **it was generally agreed that being at REAP level 3 would see an increase in complaints as delays in responding to calls will result in an increase in the level of complaints.**

6. ***Minute 47/08:*** **the Head of Patient Experiences said that the High Risk Address was being reviewed at complex level and managed by Management Information. The draft revised High Risk Address policy was currently being reviewed by the Trust's Solicitors and would be presented to the Trust Board for formal adoption in due course. The Trust will commence writing to those patients maintained on the High Risk Address Register as soon as possible accordingly.**
7. ***Minute 53/08:*** **the Corporate Logistics Manager said that work has commenced in implementing the 'clean hands' campaign, and adapting it for the ambulance service. For example, the LAS has suggested that regional local champions are recruited rather than 72 local champions from each ambulance station. 13 products will be introduced during the next few months to enable front line staff to comply with the guidance in the 'clean hands' campaign. Work was also being undertaken to review the configuration of the ambulance's interior so as to accommodate the increasing amount of kit that is being required. The Chairman of the Committee said that Baroness Young, Chairman of the Care Quality Commission, will be visiting the LAS and representation will be made in respect of the national health guidelines and how they needed to be made more relevant for the ambulance service.**
8. **That the Complaints Panel is to be reconstituted as the 'Feedback, Learning & Improvements Group' with the objective of enabling the Trust to evidence the development of the LAS as a learning organisation with a focus on using feedback as a driver for change and improvements.**

**57/08** **Clinical Governance Committee's terms of reference**

The Chairman of the Clinical Governance Committee, in response to a question from the ADO, Control said that the Committee was more of an integrated governance committee rather than focussing solely on clinical matters.

**Noted**

1. **That a few of the job titles required amending e.g. Emergency Medicine Consultant. ACTION: Trust Secretary**
2. **That the following will be asked to provide an annual report to the Committee:**
   - **BASICs ACTION: E&M Consultant St Mary's**
   - **other Voluntary Agencies ACTION: Deputy Director of Operations**
   - **PTS ACTION: Head of PTS Modernisation**

**58/08** **Area Governance Report**

*Control Services:*

The ADO Control presented the report for Control Services

- Call taking performance had slipped from 95% to 93% in September due in part to the CTAK system failing four times in the last few weeks.
- With staff side support the shift pattern in Control was reviewed so that there was additional staffing at times of higher demand.
- Demand in September was high, with an extra 5500 calls received. A significant percentage, 60% were Red calls which had a knock on impact on the Trust being able to achieve 75% Category A8 minute performance target.
- Following discussions with the Director of IM&T it has been agreed that in order to maintain the stability of the CTAK system there will be a minimum of upgrades undertaken until after the Christmas/New Year period.
- The Clinical Support Desk has been increasingly utilised by both front line staff and Control Room members of staff. Efforts are on-going to recruit to full establishment.
- A project is being undertaken in conjunction with CAMIDOC to evaluate the role of General Practitioners in providing Medical Support to the Control Room.
- Work around quality assuring the interpreting service provided by LanguageLine was being

undertaken. The Assistant Head of Clinical Audit said that as LanguageLine was on the PASA Framework it would have had to evidence a high degree of quality assurance, e.g. ISO 9000.

The Clinical Support Desk Manager gave a brief report on the work undertaken by the Clinical Support Desk. In addition to providing clinical support to colleagues the members of staff were also reviewing

the Palliative Care files to ensure they were kept current. The Clinical Support Desk Manager was hopeful that the Support Desk would be at full establishment by Christmas 2008.

One of the pieces of work undertaken by the Clinical Support Desk (CSD) is identifying potentially serious incidents that were not triaged using AMPDS, e.g. when critical transfers were being requested key words had to be used in order for the correct response to be obtained. The LAS feedbacks to the national AMPDS group on the anomalies it has identified.

The Committee was informed of work that the CSD has undertaken with other Healthcare Providers in respect of a bariatric patient and a patient under Section 106, both of whom were experiencing delays in being admitted to hospital.

The CGC noted that the work of the CSD was increasing exponentially, which was not sustainable with the existing staffing. A considerable amount of time was taken up with administrative issues in particular PSPs and palliative care plans

*East Area:*

The A/ADO East presented the Area's Clinical Governance report and highlighted the following:

- The level of CPI completion had fallen by 20% since August; efforts were ongoing to improve the completion of CPIs by having additional staff trained to complete the CPIs. Of those CPIs that have been undertaken there were positive trends in regards to the delivery of care.
- The Area's next report to the Committee will include an analysis of complaints received which will include a review of factors such as the time of day/the nature of the shift or how the call was presented by Control to the crews. Multidisciplinary Forums – further work is required to ensure that these forums fulfil the expectations that Commissioners have and to have full PCT involvement. The Interim Head of Governance suggested that 3-6 months a report should be presented to the Commissioners on joint working arrangements. The introduction of world class commissioning should assist in enforcing this.

The Assistant Head of Clinical Audit and Research clarified that in respect of FR2 95% data this is based on the small number of PRFs audited only and that across the LAS less than 20% of FR2 data cards are being downloaded.

*South Area:*

The A/ADO South presented the Area's Clinical Governance report and highlighted the following:

- The level of CPI completion had fallen
- Posters will be placed on complexes highlighting the experience of patients
- The level of PDR completed has been uneven across the Area with some complexes having high levels of completion whilst others have faced challenges
- LA52s – DSOs making sure checking and investigation, records keeping not being looked at complex by Health & Safety representatives.
- Due to the Trust's focus on recruiting additional front line staff the Areas have less training resources than normal; the Clinical Education Manager said that the current shortfall of trainers on complexes should be addressed with the addition of 18 new trainers in the early part of 2009.
- The South Area's health and safety meetings have governance as a standing item on their agenda and a case study is considered at every meeting.
- Multidisciplinary forums: there were four multidisciplinary panels operating in the South and the next report to the Clinical Governance Committee would contain details on the work being undertaken.

The Committee's Chairman suggested that members of staff were more likely to complete LA52s in respect of a failure in equipment or other NHS professionals. It was recognised that the culture of the organisation and the NHS in general is not to report near misses because of fear of recrimination. The Medical Director indicated that work was being done to encourage front line staff to do so in order that learning can be shared across the organisation.

The Medical Director said that the rate of CPI completion was poor at 30%. The Assistant Head of Clinical Audit said to ensure accuracy of reporting that CARU can provide the Areas with comprehensive reports concerning the level of CPI completion for their respective clinical governance reports.

There was a discussion concerning the requirement that all members of staff who drive LAS vehicles undertake a VDI check prior to driving on the road so as to assure themselves that the vehicle is roadworthy. A "short" VDI,(taking 2-3 minutes) could be used if called out immediately on starting a shift, however this was no substitute for a full VDI, which should be undertaken as soon as practically possible, as this was the law. Staff will be provided with pads to record the daily VDI of the vehicle as well tyre gauges to ensure that the tyres are at the correct pressure.

*West Area*

The A/ADO West presented the Area Clinical Governance Reporting, and highlighted:

- That work was being undertaken in respect of the complaints received, the majority of which were concerned with attitude and behaviour, to analyse whether the correct triage was undertaken by AMPDS and if this could have been a contributory factor to incidents that gave rise to complaints about attitude and behaviour. An example of the approach adopted in response to a complaint whereby a front line member of staff undertook reflective journal as part of a learning exercise which was found to be productive, in addition the member of staff was given a four week rotation in a paediatric clinic. The Head of Patient Experiences complimented colleagues on this learning approach and offered his support accordingly.
- Work was being undertaken with the director of Operations in Barnet Local Authority and local Police Service concerning addresses on the High Risk Address Register with information being shared to ensure that records were kept up to date as possible. Similar work is also being undertaken by the AOM for Hanwell. In addition, multidisciplinary work was taking place concerning under age drinkers with information being shared with the necessary authorities as/when necessary.
- Driving licence checks were part of the ongoing PDR process and were a standing item at the local governance meetings. Measures were being taken to ensure that additional training was offered to crews who had more than one RTA. The introduction of the daily record of VDI should decrease the number of 'Found on Inspection' reported by the workshops. The Committee was informed that as/when a central database for vehicles is introduced it will be it will assist with capturing the data on RTAs and FOIs.

The Committee NOTED that a common theme in the Area reports was the shortfall of Training Officers due to the focus on training the Student Paramedics which should be addressed by a further cohort of Training Officers being trained and available to the Areas within the next two/three months. The additional members of front line staff will also facilitate current members of staff being able to be released for training.

**59/08 Medical Directorate Update**

The Medical Director introduced Fenella Wrigley, Consultant in Emergency Medicine at the Royal London Hospital, who has been appointed Assistant Medical Director with responsibility for Control Services. Dr Daryl Mohammed, Assistant Medical Director (Primary Care) will be extending his role to assist the team managing the South Area. He will continue to support the ECP Programme. Funding has been secured for two further part time Assistant Medical Director posts. Andrew Lingen Stallard has taken up his post as Consultant Midwife Adviser to the LAS. Andrew is acting as a point

of contact for Obstetrics Units, attending the Heads of Midwifery meetings, advising on our protocols and teaching, and providing opinions on potential claims and enquires.

*Healthcare Commission rating*: the LAS has been rated as 'good' and 'good' for both its quality of services and use of resources for the second year in succession.

*NHSLA Level 1:* the Trust successfully passed the clinically related standards with further work to be undertaken in other areas; there is an improvement plan in place which if completed successfully by November 21st should allow us to pass all the required standards.

*NICE guidelines:* the only new NICE Guidance of relevance to ambulance services relates to the management of acute Stroke. The LAS has already implemented the pre hospital guidance. A decision was awaited from Healthcare for London to take forward the next steps in targeting hyperacute stroke units for both thrombolysis and rehabilitation.

*Drugs:* Oral morphine solution has finally been introduced following negotiations with Frimley Park Pharmacy who agreed to repackage the drug in 20 ml aliquots, Boehringer Engleheim having withdrawn all but the 200 ml bottles. The Directors of Clinical Care, along with some of their allied Pharmacists, are pressing the MHRA to reintroduce Unit Drug Vials of oral morphine solution as a cheaper and more consistently available solution.

*Cardiac Care Strategy:* survival to discharge following out of hospital cardiac arrest (calculated on the Utstein template) was 15.8% for the year 2006/07. The results for 2007/08 are an Utstein survival rate to survival of 12%. ROSC figures exceeding those of the preceding year. Patients resuscitated following VF arrest in a public place, where a defibrillator has been available and accessed, continue to have a much higher survival rate.

All patients with STEMI diagnosed by LAS staff are currently taken direct to the nearest of the eight locations in London offering primary angioplasty (Heart Attack Centres HACs). A trial is underway in East London where non STEMIs are taken directly to the London Chest Hospital. A pan London randomised trail (the DANCE study) is planned with all HACS prepared to sign up.

**60/08** **Clinical policies/procedures**

The Committee **APPROVED or RATIFIED** the following new over-aching policies to illustrate use of JRCALC guidelines and outline roles and responsibilities of staff: The policies were circulated two weeks prior to the Committee meeting to allow adequate time for members of the Committee to review and raise any queries prior to the meeting.

**RATIFIED:**

1. *Paediatrics* following clarification as to CARU's role.
2. *Resuscitation,* following amendments to the identified responsible post holders (e.g. Head of Clinical Governance) and clarification as to CARU's role.
3. *Obstetrics,*
   ACTION: A/Head of CARU to provide Head of Record Management with appropriate wording to include in the policy re. auditing of Obstetrics CPI.
   ACTION: Interim Head of Governance to amend reference to conveyance to new born babies in section 6.3
4. *Emergency Care Practitioner*
5. *Advising Staff where Deviation from Guidelines is considered*

***APPROVED:***

6. *Community First Responders*
   ACTION: further feedback from colleagues (e.g. Assistant Director – Employee Support Services and the AOM Waterloo, the Local Community First Responder Co-ordinator)
   NOTED: that as the Community First Responders were not included within the CPI process consideration should be given to developing a mechanism put in place to record their clinical performance). ACTION: Assistant Head of Clinical Audit and Research

**Comment [B H D1]:** What is this for?

NOTED: that the Committee will receive an update on this policy at its meeting in April 2009. ACTION: Interim Head of Governance

7. *Re-presentation of Frequent Callers Policy: ACTION:* deletion of reference to the LAS having a legal duty to attend a call where key symptoms are reported.

**61/08 Additional policies relating to risk management for approval**

The contents of the following policies and procedures were reviewed in order to meet the requirements of the NHSLA Risk Management Standards for Ambulance Trusts. The following policies and procedures were circulated two weeks in advance of the meeting to enable members of the Committee to consider the contents and raise any queries prior to the meeting. The Committee **APPROVED** the following polices/procedures:

*Hygiene, Infection Prevention and Control*

- Infection Control Policy,
- Infection Control Co-ordinator role
- Infection Control Manual

*Risk Management Learning*

- Health, Safety & Risk Management Training & Provision of Health & Safety Information (including Training Needs Analysis, Education and Development Plan 2008/09)
- Policy Statement on Staff Induction

*The Policy for Pre-Hospital Blood Taking*

*OP/028 The Procedure for Patient Specific Plans*

*OP/032 the Alternative Response Procedure*

ACTION: Head of Records Management to incorporate amendments suggested by the Head of Patient Experience and the Medical Director within the document.

NOTED: that due to the Manual Handling policy not being completed in time to present to the Committee approval will be sought from the Senior Management Group prior to its submission to the NHSLA. ACTION: the Manual Handling policy to be presented to the Clinical Governance Committee in February 2009.

POST MEETING UPDATE: the following documents were approved by the Senior Management Team at their weekly diary meeting on 17th November 2008:

- Hand Hygiene and Care Policy; Organisational Learning and Improvement through Feedback
- Complaints, Incidents and Claims and Manual Handling Policy.

The Senior Management Group was pleased to hear from the Medical Director that the documents had been discussed in detail and consider by subject matter experts as well as being formally reviewed at Clinical Governance Committee.

**62/08 End of Life Care Strategy**

The Medical Director gave a brief presentation on how the Trust was implementing the Department of Health's End of Life Care Strategy. Work will be undertaken to enhance the knowledge and confidence of front line members of staff so as to offer suitable treatment to patients who are at the end of their lives in order that they can remain at home e.g. staff can legally administer a named drug for a named patient if that drug is in the house (with the proviso that only Paramedics undertake intravenous injections); it is acceptable to stop resuscitation if there is sufficient evidence that of End of Life Care plan and it is acceptable in many circumstances to hold the patient's hand and allow them to quietly die.

The End of Life Care Strategy is based on the best available evidence and builds upon the experience(s) of hospices and specialist palliative care services as well as the Marie Curie Delivering Choice Programme. There will be specific modules in the induction and Continuing Professional Development

courses that will address the issues that can arise when crews are called to attend patients who are at the end of their lives.

**Noted:**

1. **The contents of the End of Life Care Strategy**
2. **That the LAS is in discussion with PCTs and Commissioners concerning the End of Life Care Strategy.**
3. **That discussions will take place with AMPDS regarding the inclusion of a specific patient category applicable to patients who are affected by the End of Life Care Strategy and a predetermined response time included (to be agreed with the Commissioners).**
4. **That the Trust has forged very good links with Palliative Care Teams on pan London basis.**
5. **That the Clinical Support Desk has been contacted by front line staff for guidance when they were attending someone who is at the end of their life.**
6. **That the different ethnic communities in London will have different attitudes and ceremonies relating to death which front line staff need to be sensitive to.**

## 63/08 Update re. Stroke

The Head of Policy, Evaluation and Development updated the Committee on the approach being adopted in respect of Stroke. A further report will be presented to the Trust Board in November, requesting that the Trust Board support the approach outlined below.

**Noted:**

1. **That Several factors are driving acute stroke care in London:**
   - **Healthcare for London's (HfL) Stroke Strategy For London**
   - **Availability of 24/7 access to screening, assessment and thrombolysis at certain units in London and the LAS' eagerness to take advantage of this**
   - **PCT requests to divert their patients away from sites with poor outcomes/towards sites with better outcomes.**
   - **That HfL's process for designating Hyper Acute Stroke Units and the time permitted for their development of services mean it will be well into 2010 before a pan London network is fully established.**
2. ***2.*** **That the risk of undermining the public consultation can be avoided by openly engaging with PCTs to set up pathways for their patients into existing 24/7 stroke units *pending the development of local options as part of the HFL process.***
3. **Apart from internal communications the only requirement for LAS to deliver this would be the upgrading of strokes (where onset of symptoms was within 2 hours) to Red from Amber on AMPDS.**

## 64/08 Implications of changes to the Mental Health Act

The Head of Policy, Evaluation and Development updated the Committee on the implications of the recent changes to the Mental Health Act, which were effective as from 1st November 2008.

**Noted:**

1. **That the Approved Social Worker (ASW) title has been replaced with Approved Mental Health Professional (AMHP). For ambulance staff about which crews will need to be informed.**
2. **That the new legislation allows for patients to be moved between several locations as long as they are assessed within 72 hours of the original detention. This means that patients can be moved from (for instance) the Emergency Department to a more appropriate setting. This change will need to be cascaded to staff.**

3. **That the introduction 'Supervised Community Treatment Orders' or 'CTOs' allows for a patient to be discharged from hospital to continue treatment at their, or a relative's home. If the conditions of the order are broken then it can be revoked and the patient returned to hospital for detention.**
4. **That having undertaken discussions with Camden PCT it appears that the role of the LAS in this process will be no different to that of Section 135 assessments. The volume of recalls from CTOs is expected to be very low. Current estimates are for about 50 such orders to be revoked, per month, across London.**
5. **That these changes will be communicated to staff through articles in the Routine Information Bulletin (RIB), the LAS News and through cascading a briefing by local Mental Health 'champions,' the Clinical Support Desk and the Department of Education and Development.**

**65/08** **Clinical Risk**

The Committee received an update on the clinical risks on the Trust's Risk Register including the progress made with action plans that are in place to mitigate clinical risks on the Risk Register.

**Noted:** **The progress to date in implementing the action plans that were in place to mitigate the clinical risks included on the Trust's Risk Register.**

**66/08** **Risk Information Report**

The Committee received the Risk Information Report which covered two quarters between the period 1st April to 30th September 2008. It analyses themes and trends that have been identified in each section.

**Incident Reporting**

- The report outlines the total number of clinical incidents reported to the Safety and Risk Department based on LA52 completion.
- In total 539 clinical incidents were reported, with 121 of these recorded as having an impact on the patient (Q2=63 [191]; Q3=58 [227]).
- When comparing the total number of clinical incidents reported in quarter 1, there is a slight decrease in actual and near miss incidents.

**Clinical Negligence Claims, Potential Claims and Contentious Inquests**

- The report identifies the caseload opened and emerging themes.
- Of the 514 inquiries by Coroner's Officers between 1 April 2008 and 30 September 2008 in respect of inquests where the Trust was asked to provide documentary and / or oral evidence fourteen inquests were deemed to be contentious for the Trust
- A round table review of clinical negligence / contentious inquest files closed between 1 April and 30 September 2008 was conducted on 9 October 2008 to identify the individual and organisation learning and to recommend any further action to Clinical Governance Committee and Risk Compliance and Assurance Group. The output from the review is reported in Table 3 and 4 of the report.

**PALS and Complaints**

- The report highlights the issues of delay and attitude and behaviour linkage which continues to be the subject of poor patient and stakeholder experience. It details recent measures that have been implemented to improve performance and address the issue of patient consent to non-conveyance.
    - 62 % of written complaints have been concluded within 25 working days.
    - 168 out of the 214 complaints received in the period required an acknowledgement and of these only
    - 1 exceeded 2 days. 3 complainants progressed to the Healthcare Commission.

- Outcome reporting requires complete a review as currently this is measured by completion rather than quality and should reflect agreed actions once the case has been completed.

- The Head of Patient Experiences also explained that Making Experiences Count programme and the moving towards analysis of the totality of feedback rather than the historic focus on 'complaints'. RTPC and the DH support this approach.

- The PALS/Complaints functions have been combined and the department will be henceforth be known as the Patient Experiences Department. The Head of Patients Experience said that work was ongoing with the Healthcare Commission (and its successor the Care Quality Commission) and the Ombudsman on the small number of complaints that the Trust has not been able to resolve locally.

Work was being undertaken regarding a policy for dealing with intoxicated and violent patients which will be presented for approval to SMG in December, and a policy on Statement of Duties will be presented to the RCAG in February 2009.

The DVD that was co-produced with the Metropolitan Police concerning positional asphyxia was considered to be very informative but that further work was required to ensure that front line crews were aware of the need to continually monitor patients who were being restrained whilst being transported to hospital. It was suggested that rather than an additional DVD being produced the issue for LAS crews could be addressed by additional dialogue being added to the voiceover at the close of the DVD, and by Trainers/DSOs having discussions with front line staff when the DVD was shown in training sessions.

There had been concern voiced at the Round Table held to identify lessons from claims and incidents concerning the level of CPD training being undertaken by the Trust. The Medical Director said that Senior Management Team had recently received a report confirming that 2000 front line members of staff had accessed at least on of the modules in the last two years with 320 front line members of staff not accessing any. It was anticipated that following the training and subsequent deployment of the recently recruited members of staff, existing members of staff will be able to attend the current and additional modules that will be rolled out in 2009.

**Noted:**
1. **That further efforts would be undertaken to ensure that there is greater analysis undertaken of the trends discerned by the different departments that contribute to the report in order to identify any learning for the Trust. ACTION: Interim Head of Governance**
2. **That the Chairman of the Committee requested that graphical information be presented where possible to illustrate trends.**

**67/08** **<u>Review Assurance Framework</u>**

The Interim Head of Governance said that the Trust was using the web based tool, Performance Accelerator, to electronically capture evidence of compliance which will also facilitate monitoring of the Assurance Framework

**Noted:** **That the Trust was using Performance Accelerator to evidence and monitor compliance with the Assurance Framework**

**68/08** **<u>Preparation for Annual Health Check 2008-09</u>**

**Noted:** **That the Trust was using Performance Accelerator to evidence and monitor compliance with the requirements of the Annual Health Check 2008/09.**

**69/08** **Update re. compliance with NHSLA standards**

The Committee received a progress report as to the Trust's compliance with the NHSLA Level 1 standards and what were the outstanding areas of work.

**Noted:**
1. **The progress in implementing the action plan arising from the initial NHSLA Level 1 assessment, there are two deadlines for completion of the work, 21st November and mid December, and the Trust is on schedule to meet both those deadlines.**
2. **That Laila Abraham has been appointed Interim Head of Governance following Matthew Barker's appointment as Transformation Workstream Lead by St George's NHS Acute Trust.**

**70/08** **Reports from Groups/Committees**

1 *Risk Compliance & Assurance Group – 21st October 2008*

**Noted:** **The minutes of the RCAG meeting that took place on 21st October 2008**

2 *Patient Pubic Involvement Committee – 6th October 2008*

**Noted:** **The minutes of the recent Patient Public Involvement Committee meeting. The PPI Manager highlighted the following from the minutes:**
- **The commencement of the pilot public education staff development programme**
- **The undertaking of the first emergency life support training session for pregnant women in Tower Hamlets**
- **The continuance of the Bengali lessons for staff based at Silvertown ambulance station**
- **The appointment of Community Involvements Officers by the two NWOW complexes: Barnehurst and Chase Farm.**
- **That work had begun in relation to the recruitment of members for the Foundation Trust application.**

3 *The Infection Control Group, 7th November 2008*

**Noted:** **The oral update provided by Corporate Logistics Manager, who highlighted that:**
- **work was being undertaken in respect of the red blankets used on ambulances ; these will be swapped out by crews when they transport patients to hospital**
- **front line crews will need to be familiarised with the new process for cannulation**
- **work was being undertaken by the Emergency Preparedness Unit & the Business Continuity Group on the possible practical implications for the Trust of an event such as Pandemic Flu e.g. the impact on the service provided by the Logistics department to the rest of the Trust.**

4 *Clinical Steering Group, 20th October 2008*

**Noted:** **The oral update provided by the Medical Director; the Clinical Steering Group discussed airway management and the challenges the Trust will face in accessing hospital placements for new members of staff (including student paramedics) to learn and practice advanced airway management.**

5 *CARSG – 17th October 2008*

**Noted:**

1. **The minutes of the recent Clinical Audit & Research Steering Group meeting. The Medical Director highlighted that:**
   - **The LAS has been awarded a research project grant by the Stoke Association**
   - **That the LAS was a member of two national groups, National Ambulance Research Steering Group (aligns research resources across Ambulance Trusts, raises the profile of research and encourages evidence based practice) and the National Ambulance Clinical Audit Steering Group (develops collaborative projects, including National Clinical Performance Indicators).**
   - **National Clinical Performance Indicators have been developed in the areas of: STEMI; cardiac arrest; stroke; hypoglycaemia and asthma. Each Ambulance Trust has been asked to report fortnightly on one indicator as an ongoing quality improvement measure. The administration of Morphine for STEMI patients will be reported fortnightly as part of the National Clinical Performance Indicators.**
   - **Furosemide audit has been reinstated into CARU's work plan.**
2. **That an interim Head of CARU has been appointed whilst Rachael Donohue was on maternity leave and is expected to take up the post in November 2008.**

6 *Training Services Group, 20th October 2008*

**Noted:** **The oral update provided by the Clinical Education Manger concerning the Training Services Group meeting on 20th October 2008; the focus of meeting in October had been the development of the Student Paramedic training course.**

**72//08** **Dates of next meeting:**

Full: 2pm 23rd February 2009; Core: 2pm, 27th April 2009

Meeting concluded at 18.15

Enclosure 18

**LONDON AMBULANCE SERVICE NHS TRUST BOARD**

**TRUST BOARD 25th November 2008**

# Report of the Trust Secretary
# Tenders Received & the Use of the Trust Seal

## 1. Purpose of Report

i. The Trust's Standing Orders require that tenders received be reported to the Board. Set out below are those tenders received since the last Board meeting.

ii. It is a requirement of Standing Order 32 that all sealings entered into the Sealing Register are reported at the next meeting of the Trust board. Board Members may inspect the register after this meeting should they wish.

## 2. Tenders Received

There have been 4 tenders received since the last Trust Board meeting.

*Romford – extension to increase staff facilities*

| | | |
|---|---|---|
| Building Associates | Millane Contract Services Ltd | Coniston Ltd |
| Lakehouse Contracts | | |

*AEDs*

| | | |
|---|---|---|
| Zoll | Physio Control | Laerdal |

*Refurbishment & alteration of 32 Southwark Bridge Road*

| | | |
|---|---|---|
| Building Associates | TCL Granby Ltd | Coniston Ltd |
| Lakehouse Contracts | Fairhurst Ward Abbotts | |

*Remodelling of Smithfield Ambulance Service*

| | | |
|---|---|---|
| Expert Property Solutions | Coniston Ltd | Fisk Construction Ltd |
| Lakehouse Contracts | | |

## 3. Use of Seal

There have been 2 entries, 125-126 since the last Trust Board meeting. The entries related to:

No. 125 Assignment Lease of Unit 28 , Bermondsey Trading Estate between the LAS, Servicetec Ltd and Industrial Property Investment Fund

No. 126 Lease re. 4th Floor 46 Loman Street between the LAS and Good Harvest Properties.

## 4. Recommendations

THAT the Board NOTE this report regarding the receipt of tenders and the use of the seal

Christine McMahon
Trust Secretary