LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 29th November 2005 at 10am

In the Conference Room, LAS Headquarters, 220 Waterloo Road, London, SE1

A G E N D A

1.	Declarations of Further Interest.	
2.	Opportunity for Members of the Public to ask Questions.	
3.	Minutes of the Meeting held on 27th September 05. Part 1 and II	Enclosure 1& 2
4.	Matters arising	
5.	Chairman's remarks	
6.	Report of the Chief Executive	Enclosure 3
7.	Month 7 Financial Report.	Enclosure 4
8.	Report of the Medical Director	Enclosure 5
9.	Infection Control policy for approval	Enclosure 6
10.	Infection Control annual report	Enclosure 7
11.	Agreement with Metropolitan Police – for noting	Enclosure 8
12.	Incident Reporting Procedure for approval	Enclosure 9
13.	Serious Untoward Incident policy for approval	Enclosure 10
14.	Records Management policy for approval	Enclosure 11
15.	Claims policy and procedure for approval	Enclosure 12
16.	CAD user requirements for approval	Enclosure 13
17.	Service Improvement Programme – update	Enclosure 14
18.	Progress on Governance review	Verbal
19.	Report from Trust Secretary on tenders opened since last board meeting	Enclosure 15
20.	Draft Service Development Committee minutes – 25th October 2005	Enclosure 16
21.	Draft Minutes of the Clinical Governance Committee –31st October 2005	Enclosure 17
22.	Any Other Business.	

23. Opportunity for Members of the Public to ask Questions.

24. Date and Venue of the Next Trust Board Meeting.

    31st January 2005, 10.00am at 220 Waterloo Road, London SE1

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 27th September 2005

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Barry MacDonald	Non Executive Director (departed 12.20)
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Colin Douglas	Non Executive Director (arrived 10.50)
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
	Martin Flaherty	Director of Operations
Apologies:		
	Toby Harris	Non Executive Director
In Attendance:		
	Mairead Doyle	Director of PTS (Acting)
	David Jervis	Director of Communications
	Peter Suter	Director of IT and Information Technology
	Kathy Jones	Director of Service Development
	John Wilkins	Head of Governance
	Angie Patton	Head of Communications
	Gemma Hart	Communications Manager
	John Hopson	ACAO CAC
	Ian Todd	Head of Urgent Care
	Claire Glover	Governance Manager
	Laverne Harris	Governance Manager (newly appointed)
	Martin Brand	Head of Planning and Programme Management
	Malcolm Alexander	Chairman of the LAS Patients' Forum
	Henry Gillard	Member of Patients' Forum
	Colin Hill	Member of the public
	Christine McMahon	Trust Secretary (Minutes)

88/05 **Declarations of Interest**

There were no declarations of interests.

89/05 **Opportunity for Members of the Public to ask Questions**

There were no questions.

90/05 **Minutes of the Meeting held on 26th July 2005**

Agreed: The minutes of the meeting held on 26th July 05 as a correct record of that meeting.

91/05 **Report of the Chairman**

The Chairman spoke of the momentous changes that have been signalled over the summer with the proposed reconfiguration of the Ambulance Services in England and the changes to the roles and configuration of Strategic Health Authorities and Primary Care Trusts (PCTs). Making patient choice a reality is at the core of the proposed reforms. plurality of provision is key to choice and services will be provided by NHS Trusts (all of which are expected to become Foundation Trusts), independent sector providers and the voluntary sector. In future PCTs' role will be to regulate the market, ensure plurality of provision and ensure that participants in the market are fit for purpose. He recommended careful reading of the 'Commissioning a patient led NHS', published on 28th July 2005 which outlined the proposed reforms.

In London, Julie Dent has been appointed Project Director of a review group that will make recommendations for the number of PCTs and SHAs. A firm of consultants (OPM) has been asked to help, by managing a consultation exercise with all interested parties. The Director of Service Development reported that she had talked with a representative of OPM on behalf of the LAS on 26th September 2005. **ACTION: Director of Development to circulate LAS's submission to the OPM to the Trust Board for information.**

The Chairman and the Chief Executive visited Essex Ambulance Service on the 26th September 2005 so as to understand how that organisation has implemented integrated response hubs which include provision of out of hours GP cover. They had been impressed with the innovative approach being taken by Essex AS e.g. providing 'minders' who stayed overnight with elderly patients following their discharge from hospital, ensuring that they received care and assistance in their homes. In response to a question from Beryl Magrath the Chairman felt that Essex had benefited from having a county wide SHA and a small number of PCTs. Beryl Magrath requested that the Chairman circulate a brief note on his visit to Essex AS identifying the factors that had galvanised the various agencies to work together. The Chairman replied the various agencies had been able to work well together because they were able to take a broad perspective as the PCTs had responsibility for large areas and there was only one SHA. The Director of Service Development added that the fact that Essex AS received zero star rating in 2003 had highlighted the need for change and the requirement for additional funding. **ACTION: The Chairman.**

There is an expectation that all Trusts would be Foundation Trusts by 2008. The LAS will therefore need to be in a position to apply for Foundation Trust status within the next two years. The Chairman reported that the Appointments Commission will be looking to appoint future Non-Executive Directors with the change to Foundation Trust status in mind. The Finance Director commented that with regard to Foundation Status the biggest issue for the LAS will be Payments by Results. The Chairman reported that he has suggested to Sir Nigel Crisp that a formula for pricing ambulance services be adopted that borrows from that used when British Telecom (BT) was privatised. The starting point would be the current level of cost incurred in responding to 999 calls, including the costs incurred 'downstream' of the ambulance service to se and treat patients. Each year, that amount would be increased by reduced in real terms be used when ambulance services are implementing Payment By Results.

The Chairman of the LAS Patients' Forum commented that it was important that the effective relationships forged between health and social care was not lost if the number of PCTs diminished. The Director of Service Development thought the reconfiguration will work on three different levels: (a) a London wide organisation responsible for taking a strategic overview of health services in London, (b) a smaller number of PCTs who would be able to give sufficient time and attention to commissioning services and (c) locally focussed service delivery.

Members were reminded that the LAS's annual public meeting will be held on 3rd October 2005 at 4pm, following the Annual Patient Care Conference. Both events will be held at the East Winter Gardens, Canary Wharf.

The Chairman, on behalf of the Trust Board, thanked Mairead Doyle, who has been acting Director of PTS since June 2005, for all her efforts and hard work since she joined PTS in September 2000. She is leaving the LAS to emigrate to Australia. Mairead thanked the Board, and especially her colleagues, for the support they have offered in the last six months.

93/05 **Report of the Chief Executive**

The Chief Executive reported that though July had been a very difficult month, the LAS had responded well to the events of 7th and 21st July and had received widespread praise for its efforts. July's Category A 8min performance was 74%.

Category A 8 min performance in August was 77% was achieved through exceptional measures such as the deferment of planned training and non-essential meetings and restrictions on holidays. In addition team leaders were asked to spend 100% of their time on the road and where necessary managers manned ambulances.

Category A 8 min performance in September has been disappointing and investigations are ongoing to identify why.

The Category A 8 min performance for the year to date is 74% with 95% being achieved for CAT A 14 minutes.

The Chief Executive stated that at year end he was hopeful that the LAS would achieve Category A 8 and 14 minutes targets and that there would be demonstrable improvements in Category B and Doctors Urgent performance.

The Director of Operations informed the Trust Board that a new senior operations team had been appointed: Russell Smith (Deputy Director of Operations); John Hopson (ACAO CAC); Michael Boyne**;** Peter Horne and Richard Webber (Assistant Directors of Sector Operations). Furthermore the recommendations from the review of the Sector Operating Model are being considered and will be implemented. The new Urgent Operations Centre will be opened by the end of November.

Agenda for Change: although the banding levels for Paramedics and Team Leaders have been agreed, it has not been possible to agree banding levels for Emergency Medical Technicians. In accordance with the agreed procedure the matter has now been passed to the South West London Strategic Health Authority for resolution.

Complaints: the Chief Executive reported that the Professional Standards Unit has had a change in management and the role of the unit is being reviewed. Although the number of complaints has declined, attitude and behaviour continues to be a matter of concern. Measures are being considered on how the Trust can learn from Serious Untoward Incidents.

Sickness: it was highlighted that CAC's sickness level has improved to 8% in September which was considered to be good news.

Overseas travel: the Board was asked to approve two requests for overseas travel

CAC: the Board was asked to give approval for a visit by two members of CAC staff to Richmond Ambulance Authority in Richmond, Virginia USA in November 2005. Costs for travel are expected to be approximately £1200.

The Chief Executive asked the Board's approval for permission to travel to Australia in October 2005; he has been invited to speak at the Convention of Australian Ambulance Services in Canberra on 14th October 2005 and will also be visiting a number of Ambulance Services in Australia. All the travel costs and accommodation are being met by the Australian Ambulance Service.

In conclusion the Chief Executive stated that work was being completed to ensure that the basics were achieved this year in order that the Trust will be in strong position in the new financial year.

Sarah Waller queried the increase in job cycle time. The Chief Executive thought this might be due to traffic congestion which had risen in recent weeks and slower than usual mobilisation times.

Graph 3 which showed substantial increase in Category A calls (50%) compared to the same period in 2004/05; it was acknowledged that the graph is not very helpful and it will be reviewed. The revised graph will include both red calls and DoH Category A calls. **ACTION: The Chief Executive**

Barry McDonald queried the graph showing CAC staffing which indicated that performance is down but the numbers in post were static. The ACAO CAC confirmed that there had been a high incidence of sick leave taken during the summer which had been exacerbated by fewer new recruits. Sickness is being actively managed and the recruitment process has been reviewed with active steps being taken to ensure full establishment in CAC by March 2006.

Sarah Waller queried which of the contracts reported where PTS has expressed an interest was the LAS the existing contract holder. The Acting Head of PTS confirmed that PTS were in Havering and Kingston but were not in Royal Free Hospital, Bromley or the Royal Brompton and Harefield.

In response to a question from Sarah Waller the Chief Executive confirmed that the Home Office, the Office of the Deputy Prime Minister and the DoH were in discussions but in the meantime the LAS was taking steps to ensure that front line crews' have appropriate insurance cover in the event of a CBRN incident.

The Chief Executive confirmed for Beryl Magrath that the CAC ACAO and the Director of Information Management and Technology were working together to identify a technical solution that will enable the sector desk to avoid unnecessarily despatching multiple responses to incidents.

With regard to the continuing high number of complaints received concerning attitude and behaviour the Chief Executive outlined measures that have been put in place. The one week Continuing Professional Development (CPD) course includes modules relating to attitude and behaviour; there will an evaluation of the course to ascertain its effectiveness. It is anticipated that complaints will decrease as a result. To date 200 staff (team leaders and managers) have undergone the CPD course and the course will be rolled out to all front line crews over the next two years.

In response to a question from the Chairman of the LAS Patients' Forum the Chief Executive confirmed that the LAS had invoked the Mutual Aid Agreement on 7th July 2005; assistance had been rendered by surrounding counties' ambulance services, St John Ambulance and the Red Cross. No private ambulance service was used.

The Chairman of the Patient's Forum referred to a recent statement by Unison regarding MRSA and asked whether it had been found on ambulances. The Medical Director confirmed that the Trust has an Infection Control Policy which includes precautionary measures to guard against the spread of infections. With the introduction of the Make Ready Scheme ambulances are much cleaner; tests have shown that there has been a significant decrease in bacteria found in ambulances. There has been no evidence of MRSA. Although staff are not routinely screened for MRSA they do use disposable gloves when treating patients.

Agreed: 1. The requests by CAC staff to travel to USA and the Chief Executive to travel to Australia.

Noted: 2. The report.

94/05 Month 5 Finance Report

The Finance Director reported that though in Month 5 the Trust had spent £1.5m more than it had received in income, it is anticipated that there will be £54,000 surplus at year end. Month 5 includes two significant adjustments; the inclusion of overtime payments incurred in July and a worsening PTS situation. An estimate has been done of the costs incurred following 7th July and this has been submitted for reimbursement to the DoH.

The Finance Director reported that the South West London Strategic Health Authority (SWLSHA) has been informed that the Trust is on track to achieve financial balance. A commitment to make a £2m surplus as requested by the SWLSHA is still under consideration. He was confident that an additional £1.5 CBRN funding which the LAS should have received earlier in the year will be received shortly.

The Finance Director reviewed the report with the Trust Board, highlighting that with effect from September weekly overtime reports were being generated so as to fully understand the cost implications. An adjustment of £382k has been necessary in September as there had been an understatement of overtime costs incurred in July. Sarah Waller asked for reassurance that there will be no re-occurrence of similar adjustments required in the future.

Work is being undertaken to ensure that PTS breaks even by March 2006; the Finance Director is undertaking a detailed contract review and measures are being put in place to manage the use of 3rd parties and the issuing of credit notes. The October Service Development Committee will receive a detailed report following the contract review. **ACTION: Finance Director.**

Croydon PCT is unwilling to fund the existing ECP programme currently operating in their area. The Trust Board was assured that in future a standard Service Level Agreement, which will include a pricing scheme, will be put in place prior to further deployment of ECPS.

The Finance Director assured Barry McDonald that he was confident that all the possible cost pressures including Agenda for Change banding decisions have been taken into account and a break even position was feasible for the LAS in March 2006.

Sarah Waller queried the request from the SWLSHA for an additional £2m surplus. The Chief Executive confirmed that there is an expectation that it will be linked to funding the LAS might receive and that the £2m would be brokered. Sarah Waller asked whether the brokerage agreement was in writing. **ACTION: Finance Director to check and report back to the Trust Board.**

Noted: The report

95/05 **Report of the Medical Director**

The Medical Director presented her regular report to the Trust Board, using the seven domains of the Healthcare Commission as a structure:

2nd Domain – the Board was informed that the Trust is currently using Version 3 (2004) of the clinical practice guidelines issued by JRCALC. The NHS Litigation Authority (NHSLA) requires that the Board formally note the use of the JRCALC guidelines and the areas where the Trust is not compliant with the guidance (e.g. the use of high flow oxygen for patients suffering acute coronary syndrome or stroke). An extensive review of the literature is being undertaken by the International Liaison Committee on Resuscitation who will be publishing new evidence based guidance in December 2005. The LAS will review its policy based on this information. Other areas of non-compliance include the use of rescue boards for transportation, the use of cervical collars and pre hospital thrombolysis. There are also three drugs advocated in the Guidelines not currently available to LAS staff (ipratropium, hydrocortisone and chlorphenamine) which will be introduced, depending on the availability of space in the drug bags.

The Trust Board was asked to note that the Complaints Panel met on 19 August 2005 and will meet again on 5th October 52005; the panel included a representative of the Patients' Forum and efforts were underway to recruit a front line staff representative.

The Board was informed that in July an Independent Review considered a complaint regarding the care given to Mr DW, a 77 year old brittle asthmatic who suffered cardiac arrest while in the care of the LAS in January 2003. The panel made a total of 15 recommendations which have been accepted by the LAS and will be taken forward by the Chief Executive, the Head of Education and Development and the Medical Director.

4th Domain – a DVD 'Cardiac Arrest' which portrays the use of Language Line by the LAS in providing assistance to a non-English speaking relative of a heart attack victim was launched in early August at the Brent Sikh temple. It was very positively received.

The Board's attention was drawn to the clinical audit report r[illegible]ding 'a summary of regional clinical audit of the care and treatment of patients with asthma. The audit highlights what the LAS does well and how we can do better. The findings will be shared with Team Leaders in early October.

Beryl Magrath asked about nalbuphine which morphine is replacing and was assured that the drug has not been banned and the LAS is running down stocks.

The Medical Director confirmed for Colin Douglas that additional security measures will be introduced to ensure the proper management of morphine. Colin Douglas requested that the Board receive an update in January on the introduction of morphine. **ACTION: The Medical Director**

The Chairman of the Patients' Forum reported that work is being undertaken in Camden interviewing severe asthma sufferers and their carers about their experience of using the Ambulance Service. He proposed that the findings of the research be presented in due course.

Agreed: **1. To approve Version 2004 of the National Clinical Guidelines**
Noted: **2. The Medical Director's report**

96/05 **Standards for Better Health – a draft statement of compliance**

The Finance Director presented the draft statement of compliance to the Trust Board. It was confirmed that the Healthcare Commission expects the majority of the Trust Board to sign the draft statement of compliance in October following the SDC meeting. As yet the actual statement of compliance has not being received from the Healthcare Commission.

In light of the concerns raised by individual Board Members regarding the draft statement of compliance a further report will be presented to the Service Development Committee in October. The Chairman in particular found the degree of repetition in the statement wearisome; it was pointed out that to some extent the language used in the statement is prescribed by the Healthcare Commission but efforts would be made to eliminate as much as possible any unnecessary repetition. Queries were raised concerning the statement that no risk had been identified for the following standards C6, C8a, C11a, C13b, C13c and C18. The Head of Governance confirmed that the statement had been drafted using the Standards for Better Health guidelines issued by the Healthcare Commission and in consultation with leading members of the Senior Management.

It was reported that the statement had been shared with the South West London Strategic Health Authority and with the 32 London Borough's Overview and Scrutiny Committees. Their comments will be added to the document when it is presented in October.

From 2006 onwards the Trust will be required to make an annual declaration of its performance against the Standards for Better Health. It was anticipated that the Assurance Framework will enable performance to be more transparent.

Noted:

1. **That the draft statement will be re-submitted in October 2005 to the SDC for consideration;**
2. **That Members of the Trust Board will be invited to sign the draft declaration following the SDC meeting in October.**
3. **That the Finance Director wished to record his thanks to Claire Glover, Governance Manager for her outstanding work on the Standards for Better Health. Claire is leaving the LAS to join Northampton NSH Trust.**

97/05 **For Approval – Consent Policy**

The Medical Director reminded the Trust Board that when it approved the Consent Policy in March 2005 it was with the understanding that the policy would be reviewed by the Trust's Solicitors. The revised Consent Policy was presented to the Trust Board for approval. It has been amended following advice from the Department of Health and the Trust's solicitors, Capsticks. It was recognised that the revised policy is not particularly ambulance focused as it has been written in the DoH with acute hospitals in mind. Nevertheless, the DoH has insisted that it be adopted by the LAS.

Members of the Trust Board were unhappy with the content and wording of the policy in several areas and there was considerable discussion. As the DoH apparently requires the service to adopt the policy as written, it was agreed that the LAS will do so but undertake an audit in six months to provide evidence to the DoH of the need to change important parts to make them appropriate for use in ambulance service. It was recognised that the Trust is legally exposed if it does not have something in place to which staff can refer to.

Agreed

1. **That the revised Consent Policy be introduced with the proviso that an audit be undertaken in six months time to ascertain the practical implementation of the policy.**
2. **That although the Board was in sympathy with the majority of the Policy there were aspects of the document that it wished to see revised in due course so as to better serve the needs of front line crews and patients.**

98/05 **Electronic Staff Records Project Plan**

The Director of HR informed the Trust Board that the LAS has begun implementation of the Electronic staff records as part of the national procurement programme integrating HR and payroll systems. The project was launched in August 2005 and it is anticipated that it will go live in July 2006. The timing of the project, which is set nationally, is unfortunate as it is taking place at a time when HR and payroll staff are heavily involved with the implementation of Agenda for Change.

The Trust Board will receive regular reports on progress against set milestones. **ACTION: The HR Director**

In response to a question from Sarah Waller the Director of HR confirmed that St Georges Hospital and Kingston PCT were 'live' sites. With regard to Foundation Trusts, although they are not required to adopt ESR they will be strongly encouraged to do so and there are practical reasons why they will wish to do so as during their careers NHS staff frequently move between Trusts.

Noted: The report

99/05 **Progress report – Governance Review**

Beryl Magrath gave a brief verbal update on progress to date with the governance review she has been undertaking with the assistance of the Head of Governance. Non-Executive and Senior members of the Management Group have been interviewed and their views noted on the present governance arrangements.

A draft report will be presented to the SDC in December 2005 with a final report presented in January 2006.

The findings to date suggest that there are good systems in place but there is some room for rationalisation

Noted: The report on progress to date with the governance review.

100/05 **Update Urgent Care**

The Head of Urgent Care gave a brief presentation to the Trust Board regarding the progress to date in preparing for the opening of the Urgent Operation Centre at the end of November. The technical infrastructure will be in place by April 2006.

It was reported that Whitework and the role of the Emergency Technician 1 (EMT1) are being reviewed. Whitework was originally envisaged as being a step down for front line crews but for a number of reasons this has not been the crew's experience. With regard to the EMT1 role there have been difficulties with recruitment and retention and the role is being reviewed.

There was some discussion concerning Emergency Bed Service (EBS); it was recognised that there is potential for EBS to improve its capacity and become a one-stop shop for health professionals across London. It could also an important source of the information needed to make the planned integrated response hubs effective.

Clinical Telephone Advice (CTA) is at full establishment and new software systems will in place by November. Guys and St Thomas' NHS Trust have offered consultant and physician advice to ECPs and CTA on a 24/7 basis; this will be piloted over a three month period. Currently 50% of the calls handled by CTA do not require the sending of an A&E response.

The Chairman of the Patients' Forum asked about the function currently performed by EBS for GPs. Following a call being received and triage undertaken GPs are given a timeframe for a response, in only about 2% of cases do GPs over-ride the decision in preference for a quicker response. The existing skill mix of the EBS is recognised by the LAS and its existing portfolio of services will continue.

Noted: 1. **The update regarding the Urgent Care Operations Centre.**
2. **That new software is being evaluated and a procurement decision will be made in November.**

101/05 **Update CAD**

The Director of Management Information and Technology reported that work undertaken to date identified that CAD 2010 is a larger and more complex project than originally envisaged.

Following an analysis of requirements a further report will be presented to the Trust Board in November setting out proposals for the acquiring of CAD 2010. **ACTION: The Director of Management Information & Technology.**

Noted: **The report**

102/05 **Update on Service Improvement Programme**

The SIP Manager presented his regular report on the progress of the Service Improvement Programme. As of September 2005 58 of the 285 items initially included in the programme remain outstanding.

Of the 40 outcomes, 16 are expected to be completed by March 2006, 6 will not be completed and the remaining 18 outcomes are thought to be at risk of not being completed. The Chief Executive confirmed that there will be sustained efforts to maximise the number of outcomes completed by March 2006.

The report included an overview of a number of projects which the Chairman thought exemplary in its completeness and clarity.

Sarah Waller enquired about the issues surrounding the non-completion of Clinical Performance Indicators (CPIs). It was reported that different approaches have been adopted in an effort to maximise completion of CPIs but to no avail. Discussions are being held on how the system could be made simpler, it has been suggested that the process could become a web based activity and the number of measures reduced so as to improve data collection. It is intended that the information gathered through reviews of the CPIs be part of the clinical supervision undertaken by Team Leaders. The Director of Operations agreed with Sarah Waller that something needs to be done and said that the role of the Team Leader is being reviewed.

The Chairman commented on the graph which showed 'Green calls receiving an alternative response (and not a front line crew) between June 2004 and July 2005'. The graph showed that, contrary to expectation, the proportion of Green calls receiving an alternative response is flat or declining. The Director of Service Development agreed that improvements will need to come from improving utilisation rates and making better use of the Urgent Operations Centre especially when the technological element are in place from April 2006.

Noted: **The update regarding the Service Improvement Programme.**

103/05 **Update on Seven Year Plan**

The Director of Service Development gave a presentation which set out the progress to date on drafting the Trust's seven year plan (2006-2012). Following consultation with numerous stakeholders six aspirations have been identified; six programmes of work are being devised which will focus on delivering the aspirations.

Discussions are taking place with members of staff who will have responsibility for delivering the programmes to ensure they feel involved and engaged. In due course Gantt charts will be drawn up to track the project's progress. Work is being undertaken by the Finance Director on identifying a suitable performance management framework; he is consulting with senior managers on how they want to be measured.

The Director of Service Development confirmed that the SIP Manager and the Head of Finance are working closely together on the 2006/07 budget, which will be year 1 of the 7 year plan, so as to ensure there is a joined-up approach.

The Trust Board expressed broad agreement with the outlined contents of the seven year plan; it was thought that it had the right infrastructure to match the direction the service needs to move in.

Colin Douglas raised the issue of diversity and what efforts were being made to address the under-representation of black and minority ethnic groups in the LAS. The Head of Urgent Care said that the workforce plan which is being drafted will include specific measures to address this issue. It was suggested that the revised EMT 1 role will be an ideal opportunity to improve the diversity of front line crews.

Following the publication of 'Commissioning a Patient Led NHS' the Director of Operations reported that there have been informal approaches received on how the LAS might take responsibility for delivering some of the services currently provided by PCTs. The Senior Management Group is considering the matter and a report will be presented to the Trust Board in due course. **ACTION: The Director of Service Development.**

Noted: The report

104/05 **Report from the Trust Board Secretary – tenders opened since the previous board meeting and the use of the Trust seal.**

Four tenders have been received since the July Trust Board meeting:

12/05	Refurbishment of Croydon AS	Griffiths Construction Axis Europe Plc Wyatt Wright Builders & Decorators Lakehouse Contracts TCL Granby Ltd
13/05	Replacement of boiler at Camden AS	AV Services LKF Mac Mech (Longbroke) Beckhenham & Bromley

14/05	Provision of clinical telephone advice software	Plain software Priority dispatch corporation
15/05	Replacement of Edmonton AS's roof	Maguire Brothers Harvey (London) Ltd Weatherproof Advance Roofing Russell Trew Ltd

The Trust Seal has been employed once, reference 90, since the July Trust Board meeting. The entry related to the lease of Hillingdon Fire Station from the London Fire and Emergency Planning Authority.

Noted: The report

105/05 Draft Minutes of the Clinical Governance Committee

The Medical Director highlighted the following items from the draft minutes of the Clinical Governance Committee's meeting in August 2005: CPIs; Clinical Governance Annual Report; PALS; tracking a patient; ethnic monitoring; drug management scheme and record keeping

Noted: The draft minutes of the Clinical Governance Committee – August 2005.

106/05 Opportunity for Members of the Public to ask Questions

Henry Gillard wished to express his thanks to the Senior Clinical Adviser to the Medical Director for his help in drafting a proposed Advance Directives policy. The policy will be considered by the Clinical Governance Committee when it meets on 31st October 2005.

107/05 Date and Venue of the next Trust Board Meeting

Tuesday, 29th November 2005 in the Conference Room, LAS Headquarters, 220 Waterloo Road, London, commencing at 10.00 am.

The meeting concluded at 1.20pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 27th September 2005

Held in the Conference Room, LAS Headquarters, 220 Waterloo Road, 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 27th September 2005 in Part II the Trust Board briefly discussed the events of 7th July and Agenda for Change.

Enclosure 5

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

REPORT OF THE MEDICAL DIRECTOR

1. Sponsoring Executive Director: Dr Fionna Moore

2. Purpose:

   To note improved compliance with Healthcare standards and NHSLA level 3 assessments. To approve specific guidance presented as appendices to the report.

3. Summary

   The report updates the Board on progress against the seven domains of the Standards for Better Health, with a particular focus on clinical issues. Updates from the Clinical Audit and Research Unit are included.

4. Recommendations

   THAT the Trust Board:

   1. Approves the Guidance for checking of Driving Licences
   2. Approves the Guidance for statement writing and note taking during interviews as an appendix to the Complaints Procedure approved in December 2004
   3. Notes the improved compliance with Healthcare standards and NHSLA level 3 assessments subject to policies being approved elsewhere on the agenda.
   4. Notes the remainder of the report.

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th November 2005

REPORT OF THE MEDICAL DIRECTOR

Standards for Better Health

The Draft Declaration was submitted by the deadline, to the Healthcare Commission, signed by 12 of the 14 Board members. The London regional office of the Healthcare Commission accepted the Head of Governance's explanation as to why two Board members had not signed.

The process to support the Draft Declaration has been audited by Internal Audit who found that "a suitable assessment had been made in respect of the degree of compliance with each of the standards." The audit report will be presented at the next meeting of the Audit Committee to give the Board assurance.

1. First Domain – Safety

Policies and procedures: The Serious Untoward Incident Policy is presented to the Board for approval elsewhere on the agenda. It replaces the Procedure for Rapid Follow up of Serious Untoward Incidents. It has been developed using advice from the NPSA and the NHSLA, from the previous guidance in place to manage Serious Untoward Incidents. It has also been drafted incorporating the views of the Complaints Panel. It will be reviewed in January 2006 to monitor compliance with parliamentary legislation being developed on NHS complaints and redress.

Compliance with core standard C4 is enhanced by the Infection Control Policy which the Board is asked to approve elsewhere on the agenda as part of the item on Infection Control. This policy is a requirement of the NHSLA level 3 assessment and is supported by the Infection Control Manual which is used nationally as a model of best practice.

The Incident Reporting Procedure has been amended as part of the NHSLA level 3 assessment and the Board is asked to give approval under a separate agenda item. This amended procedure will improve compliance with Core standard C1.

Safety Alert Broadcasting System (SABS): Only one of the Safety Alert Broadcasting System (SABS) bulletins received since September 2005 raise concerns relevant to the Service. This was MDA/2005/060 which relates to the connections of cables and paddles on the Lifepak 12 monitor/defibrillator. This issue had been identified and acted on by the LAS prior to release of the bulletin. All of the Lifepak 12s have now been checked and serviced.

Equipment: Disposable airway equipment has now been distributed to all complexes. This includes disposable laryngoscope blades and masks. The use of a fully disposable bag, valve mask set is being investigated. Issues around equipment are detailed in the Infection Control Annual Report.

New ambulances will be fitted with the Ferno Pegasus stretcher which is 10Kg lighter than the current stretcher, which will make it more manoeuvrable and help to address crews' concerns around manual handling risks.

2. Second domain – Clinical and Cost Effectiveness

Chief Executive's Consultation Meetings

Clinical presentations have been made to twelve complexes to date. The issues covered include new and proposed clinical developments, areas of good practice, the importance of utilising complaints to improve patient care and to highlight areas where clinical practice needs to improve. Feedback has focused on the over prioritisation of calls using AMPDS, the risk to some patients thought to be at low risk, where an inappropriate delay may be experienced and the conveyance of patients in early, normal labour. Some EMTs have expressed concern that the Service intends to recruit paramedics through higher education rather than selecting and training existing members of staff.

New drugs

Morphine has now been delivered to all complexes and paramedics are authorised to use it as soon as they have completed the training designed to ensure that the procedures around access and documentation are fully understood.

Cardiac Care update

The LAS now takes responsibility for the training of staff who respond to cardiac arrests in public places through the National Defibrillation Project. Since January 2005 five patients managed by the London scheme have survived to discharge from hospital. This should be seen in the context of sixty six survivors nationally since the end of 2000, when the scheme was introduced.

Telephone advice

Emergency Care Practitioners and Clinical Telephone Advisers can now access telephone advice from Consultant Physicians working with the National Poisons Information Service in a three month trial which commenced in mid November. The benefit of this service will be audited by the Clinical Audit and Research Unit.

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

These are included in Appendix 1and include an audit on the care of patients presenting with ST elevation myocardial infarction for the year 2004 -2005 along with an update on Clinical Performance Indicator monitoring within the Service.

3 Third Domain – Governance

Risk Management: Compliance with core standard C9 is enhanced by the Records Management Policy that was a core component of the keynote presentation by the Head of Records Management at the Clinical Governance Committee. The Board is asked to approve this policy which appears as a separate item on the agenda.

The Board is asked to approve the amended Claims Policy and Procedure for clinical negligence, personal injury, property and other liability claims, which appears as a separate item on the agenda. The amendment is a requirement of the NHSLA level 3 assessment and improves compliance with core standard C7.

Compliance with core standard C10 is improved as a result of the Motor Risk Management Group completing the Guidance for checking of Driving Licences. This document is a requirement of the NHSLA level 3 assessment. (Appendix 2). The Board is asked to approve this document.

Internal Audit have also reviewed the processes which support the Policy on Registration of Professional and Clinical Staff as part of their Report on Education and Development. This report will be presented to the Audit Committee and will provide the Board with further assurance of compliance against C10.

A proposal for the next trust-wide risk proposal will be considered at the next meeting of the Risk Management Committee and will enhance compliance with Core standard 7c.

Fourth Domain – Patient Focus

Patient Care Conference: The Patient Care Conference was held on 2nd October and attended by 111 people, including patients, members of staff and other health Care Professionals. Feedback has been very positive, the Conference was thought to be enjoyable, the programme informative and the occasion an opportunity to gain information about the Service. The venue was not universally popular, both in terms of the location and the facilities.

Complaints Procedure: The Complaints Procedure is currently under review and the amended version will be presented to the Board for approval in 2006 after the issue of legislation on NHS complaints and redress. “Being Open” Policy has been issued by the National Patient Safety Agency and this will also have an impact on the revision of the Complaints Procedure. The Complaints Procedure is also expected to include the current guidance on the call out procedure for Investigations Officers as an appendix, when the fully revised procedure is presented to the Board for approval in 2006.

The Board is asked to approve the Guidance for statement writing and note taking during interviews as an appendix to the Complaints Procedure (Appendix 3). This guidance should have been included when the Board approved the Complaints Procedure in December 2004. This appendix will allow compliance with criteria required by the NHSLA as part of the evidence for the level 3 assessment.

This domain is also covered through the report of the PPI Manager (CEO's report)

Fifth Domain – Accessible and Responsive Care

This area is covered through the report of the PPI Manager (CEO's report)

Sixth Domain – Care environment and Amenities

The 'Make Ready' scheme is now operating at 16 complexes.

Seventh Domain – Public Health

The Emergency Planning Unit is working closely with the Health Protection Agency to produce guidance for the Service on Pandemic Influenza. A document published in October 'Infection Control in Hospitals and Primary Care Settings' gives clear and practical guidance. The Education Standards Manager, who sits on the LAS Infection Control Steering Group is representing the Ambulance Service Association in discussions on the implications for ambulance services, and is therefore well placed to feed back on any changes to the existing procedures.

Fionna Moore
18th November 2005

Appendix 1

Summary of the ST Elevation Myocardial Infarction Report (2004-05)

Authors: Dr Rachael Donohoe and Debbie Evans, Clinical Audit and Research Unit

Introduction

This report summarises the findings of the ST Elevation Myocardial Infarction Annual Report (2004-05) and relates to 362 STEMI patients who, between 1st April 2004 and 31st March 2005, were diagnosed by LAS crews using a 12-lead ECG as suffering an ST elevation myocardial infarction (STEMI).

Since November 2004, all STEMI patients coded using the new illness code 87 (confirmed MI by 12-lead ECG) have been included, substantially increasing the numbers of patients available for analysis. Thirty-four patients were excluded from the dataset due to inadequate documentation on the Patient Report Form (PRF) to confirm an ST-elevation myocardial infarction.

Key Findings

- 83% of STEMI patients were administered aspirin by LAS crews. 8% of patients were not given aspirin for a valid reason that was documented on the PRF. 9% of patients were not given aspirin and there were no reasons documented for the non-administration.
- Initial pain scores were recorded on 59% of PRFs. A further 33% of patients had their pain assessed using a method other than the numerical pain scoring system. 8% of patients did not have any form of initial pain assessment documented on the PRF.
- Interestingly, a greater number of patients (62%) had a final pain score recorded. A further 16% of patients had their pain assessed using a method other than the numerical pain scoring system. 22% of patients did not have any form of final pain assessment documented on the PRF.
- 39 patients (11%) who had an initial numerical pain score of between 5 and 10 (moderate to severe pain) reported that their pain either stayed the same or increased. Of these, 56% (n=22) were administered pain relief (Entonox, Nalbuphine or Tramadol) or had a valid exception documented. Therefore, 44% of patients (n=17) who were in constant or increasing, moderate to severe pain at the time of their initial set of observations, did not receive any pain relief and there were no exceptions or reasons for this non-administration documented on the PRF.

- 74% of STEMI patients were attended by LAS crews within the 8 minute target.
- Only 15% of patients arrived at hospital within 30 minutes of the emergency call; with the average call to door time taking 40 minutes.

Response Time Intervals	Average Time (minutes)	Range (minutes)
999 call* – arrival on scene	7	1 - 77
Arrival on scene – arrive patient	1	0 - 8
Arrival on scene – leave scene	25	6 - 79
Leave scene – arrival at hospital	8	1 - 59
999 call* – arrival at hospital *(call to door)*	40	21 – 101
Arrival at hospital – thrombolysis** *(door to needle)*	20	0 - 118
999 call* – thrombolysis** *(call to needle)*	60	30 - 159
Arrival at hospital – primary PTCA***	64	25 - 143
999 call* – primary PTCA***	107	80 - 186

** Time when the incident location and the patient's chief complaint have been obtained (ORCON time).*

*** Includes only those patients who received a thrombolytic drug (excludes primary angioplasty).*

****Based on 14 patients only*

The findings of this report demonstrate that the majority of STEMI patients receive from our crews the care that they should according to both the National Service Framework for Coronary Heart Disease and the Joint Royal Colleges Ambulance Liaison Committee's

national clinical guidelines. However, the findings also highlight a lack of documentation of pain assessment and pain relief. Both of these issues were raised in the previous STEMI Annual Report and, along with recent LAS clinical audits (Sickle Cell Crisis[1] and The Use of Tramadol[2]), indicate an ongoing concern for the LAS.

Points for Action

- Crews must be encouraged to facilitate data collection and the reporting of care by placing their 12-lead ECG rhythm strips in the envelope provided for submission to Mark Whitbread.
- Illness code 87 should be used for all patients with a confirmed MI by 12-lead ECG.
- Pain assessment must be undertaken for all patients, especially before and after pain relieving drug administration.
- Crews must clearly document any exceptions to treatment, especially the non-administration of pain relief drugs.

[1] *A snapshot clinical audit examining the management of Sickle Cell Crisis*, August 2004, LAS.
[2] *A snapshot audit examining the use of Tramadol in the London Ambulance Service*, May 2004, LAS.

APPENDIX II

Clinical Performance Indicators Update

Authors: Yolanda Mapes, Clinical Audit and Research Unit

Clinical Performance Indicators (CPIs) are a method of looking at patient care as documented on the Patient Report Form (PRF). Our aim is to improve patient care by auditing crews' performance against what is identified as best practice by the JRCALC National Clinical Guidelines and standards such as those outlined in the National Service Frameworks. The current CPIs have been revised and updated and will be rolled out across the LAS in December 2005. The key changes to the CPIs and the CPI database used by the Team Leaders are outlined below:

- The number of aspects of care that we look at through the CPIs has been reduced by removing most non-clinical aspects of care. We have also added aspects of care as a result of new priorities, for example, ethnicity, information about paediatric patient's nursery, school or carer and blood glucose measurements for any patient who is at risk of developing diabetes

- The new CPI database is web based; therefore, there is only one copy of the database held on a central server rather than on each complex computer. Any further improvements can be made immediately as needed

- Staff names have been added to the database following consultation and subsequent agreement from staff side representatives. This will facilitate the whole process for the Team Leaders and staff particularly for feedback

- The information for feedback will be generated automatically by the CPI database which will produce a feedback form for each member of staff. This will show, by indicator, the number of audits that have been carried out for that person and the average compliance. It will automatically summarise areas of good practice and any areas for improvement which means that the feedback sessions will be objective and can be used by a Team Leader who may not have undertaken the CPI audit

- Staff will have a better idea of how they are performing because the summary will cover all their PRFs audited over a period of time. They will be able to use the information provided in their feedback sessions for their personal development review (PDR) portfolios and to evidence the quality of the documentation of their care and to show chronological improvements and development in their care as documented on the patient report form

- In the future, when all staff have individual log-ins they will be able to access their own CPI information once feedback has been given and use this to monitor their own development needs. We also hope that it will be possible to link the FR2 data and other clinical data with the database. Therefore, staff will be able to view this information as it relates to them

- Different levels of access will be allowed to different staff groups who will benefit from the information held on the database. For example, Ambulance Operations Managers will be able to access the database to see how their Team Leaders and complex are performing and Complex Training Officers will be able to access the database to carry out the quality assurance of the CPI process which will ensure consistency of the auditing of CPIs across the Service.

These important changes are aimed at facilitating the whole CPI audit process for the Team Leaders and staff and can now be used for information and development by all staff across the Service.

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

INFECTION CONTROL POLICY

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For approval

3. Summary

The objective of the Infection Control Policy is to provide a clear and comprehensive policy in order to assure infection control and decontamination arrangements throughout the Trust.

The policy outlines areas of responsibility and monitoring arrangements, the tasks of the Infection Control Steering Group, infection control procedures, training and education, cleaning specifications and the introduction of new equipment.

4. Recommendation THAT the Trust Board approve the Infection Control Policy.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

ANNUAL REPORT OF THE INFECTION CONTROL STEERING GROUP

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For approval

3. Summary

The report summarises the developments and initiatives undertaken by the ICSG during the last year. The four broad areas of work covered are audits, education and communications, products and facilities, and occupational health.

Significant progress has been made with :-

- Improved ambulance and equipment cleanliness (Make Ready)
- Roll out of single use medical equipment
- Hand washing technique programme
- Development of Infection Prevention CPD training model for staff
- New laundry and clinical waste contracts

Audit arrangements have been reviewed by the ICSG. A new audit will be undertaken in January 2006 by the Governance Development Unit aimed at setting a baseline for infection control standards across stations. These will be followed up by 3 monthly self assessment using a tool agreed with the AOM's.

Compliance with core standard C4 of the Healthcare Commission Annual Health Check has also been achieved

4. Recommendation

That the Trust Board note the annual report of the Infection Control Steering Group

Annual Report
of the
Infection Control Steering Group
16th November 2005

1. Infection Control Steering Group

Background

1.1 The LAS has well developed infection control procedures which were introduced throughout the organisation during 2001. They have all been incorporated into an easy to use reference manual, which integrates relevant background information with procedural instructions for all operational staff and managers of the Service. The manual has been provided on an individual issue basis, and was designed both as the key training tool in the new procedures, as well as a follow-up reference source for staff whilst on duty. Its presentation and format allows for easy update and replacement of any page or section, as future changes may dictate.

1.2 The topic of Infection Control is included as an integral element of all LAS clinical training programmes, and also forms part of the Corporate Induction programme for all new members of staff. Furthermore, the subject is utilised within the new entrant selection process for candidates wishing to enter the Emergency Medical Technician grades of staff. In addition, Infection Control forms a key area for individual staff review within the Service-wide Team Leader Operational Workplace Review arrangements that have recently been implemented.

1.3 Infection control compliance has in the past been measured through Controls Assurance Standard processes and through local management supervision. Although the CAS annual return is no longer required, the Trust continues to use the standard criteria to audit and monitor its progress in respect of infection control. Work has been undertaken to understand the implications of achieving Standards for Better Health. Core and development standards related to infection control align with current work plans and monitoring of performance aligns naturally with the terms of reference of the Infection Control Steering Group (ICSG).

1.4 The Medical Director holds overall responsibility for infection control arrangements. The sponsor for infection control, with day to day responsibility for developing and implementing the infection control action plan, is the Head of Operational Support with an Educational Standards Manager acting as clinical lead.

1.5 The ICSG reports on progress with infection control arrangements to the Medical Director through the Clinical Risk Group which in turn reports to the Clinical Governance Committee of the Trust Board. The Medical Director is a member of the Trust Board and includes a summary of infection control arrangements within her formal report.

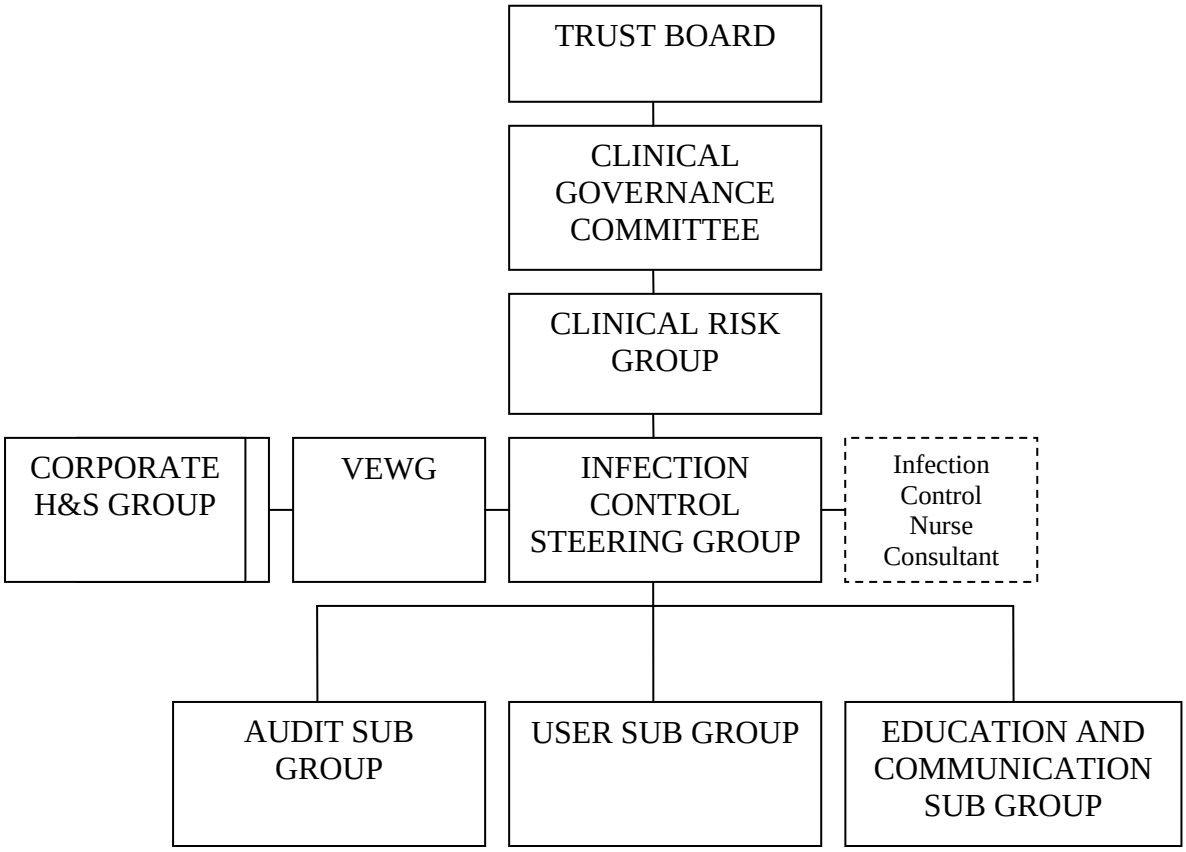
2. Terms of Reference

2.1 The purpose of the Infection Control Steering Group is:

To provide a robust mechanism for assuring infection control arrangements, providing advice on infection control matters and providing a framework for improving infection control arrangements in order to improve patient care.

2.2 The group comprises staff representatives, senior managers from the Department for Education and Development, Governance Development Unit, an external Infection Control Nurse Consultant, Human Resources, Occupational Health, PTS, Logistics Department, A&E management and Estates Department.

2.3 The reporting mechanisms are as outlined below:



2.4 The group will submit quarterly reports to the Clinical Risk Group and an annual report on behalf of the Medical Director for the Clinical Governance Committee. A summary of infection control matters will be included in the Medical Director's report to the Trust Board.

3. Healthcare Standards

3.1 The ICSG has provided the Trust with the first domain – Safety – of the Annual Health Check. Infection control initiatives have been key to achieving compliance with the domain outcome defined by the Department of Health as follows "Patient Safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients"

3.2 To evidence compliance with core standard C4 so that the Draft Declaration could be submitted to the Healthcare Commission the Infection control group has been able to cite the following developments

- ✓ *Make Ready Scheme rolled out to 16 complexes out of 25*
- ✓ *Positive support for the Make Ready Scheme provided by the LAS Patients Forum submitted as part of the Trust's Draft Declaration to the Healthcare Commission on 31 October*
- ✓ *One off deep clean performed on non Make Ready Vehicles*
- ✓ *Products –single use devices, paper towels used trust-wide in compliance with NHS guidance*
- ✓ *Hand Hygiene – refocused sector training provided*
- ✓ *Hand hygiene posters in every ambulance station*
- ✓ *Infection Control Manual and updates given to all operational staff*
- ✓ *MRSA monthly swabbing of vehicles*
- ✓ *Single use equipment awareness training co-ordinated by Education and Development managers as members of the Infection Control Group*
- ✓ *Infection Control Audit resulted in corporate recommendations being disseminated trust wide*

4 <u>Work completed and work in progress</u>

4.1 There are four broad areas of work covered by the ICSG so far:

- Audit
- Education and Communications
- Products and Facilities
- Occupational Health

Audit

Background

4.2 The Governance Development Unit (GDU) undertook a baseline audit of Infection Control standards across the service in January of this year; all but 5 complexes were audited by GDU staff and operational, admin and CAC staff who have undergone audit training from the GDU Audit Manager.

4.3 From the audit papers returned, a set of corporate recommendations were circulated within the ICSG and progress on these recommendations was reported on at the last ICSG meeting in August. It was also agreed that following this baseline assessment, the service should progress infection control standards by introducing regular complex self assessments, based on the measures used in the original audit; it was also agreed that the ICSG would await agreement from the AOM Group in respect of these proposals, before individual audit reports were sent out to each complex.

4.4 In view of the length of time elapsed since the last audit took place, the ICSG have agreed as a way forward that a re-audit will take place in January 2006. Individual complexes will follow up their Infection Control Audit Report with 3 monthly self assessments (using a self assessment tool) against the baseline assessment. This process will also apply to PTS sites in agreement with local PTS managers.

4.5 All quarterly reports will be gathered and co-ordinated by the GDU, and findings will be summarised and discussed at future quarterly ICSG meetings.

Progress made since the Infection Control Audit

4.6 Since the last audit took place, significant progress has taken place with many of the corporate recommendations made as a result of the service-wide audit – this in turn has resulted in across the board progress being made at many complexes; examples of this are:

- The requirement for operational staff to ensure that they sign for all issued documentation, including issue of individual Infection Control Policy Manuals, continues to be reinforced at all local complex level meetings by AOM's DSO's, Trainers and Team Leaders.

- Hand washing technique posters are in the process of being distributed by trainers in A & E complexes as well as non-operational buildings and departments across the service.

- Significant progress has been made with sluice areas on a number of complexes and only two stations without sluice facilities need to have work completed; a program of upgrade for existing sluice areas will be put in place.

- Category 3 PPE Bulletin has been published in the RIB and has gone out to all active users; this outlines the location of Category 3 equipment and Service Policy & Procedures for staff dealing with this type of incident.

- Currently, 16 out of 25 complexes have 'make ready' in place; the contracts include responsibility for vehicle and station cleaning. It is anticipated that the remaining 9 complexes will have 'make ready' introduced during the 1st quarter of 2006 (see paragraph 9)

- A new laundry contract has been agreed which includes new blanket hygiene/cleaning standards. Bagging and disposal of blankets at complex level continues to be monitored by the Laundry contractor/Service Tender Drivers and local Logistics Managers and any problems are reported to the Head of Logistics.

- Likewise, disposal of clinical waste and sharps is monitored by the Services Facilities Manager and the waste contractor jointly. A new clinical waste contract has been agreed from April 2007. Posters are also being placed near to clinical waste bin sites on all stations which remind staff to ensure the correct procedure for disposal of clinical waste and sharps bins.

5 Education and Communicatiions

5.1 During the last year we have developed and finalised an educational strategy and have begun to implement it. This has involved an exploration of various methodologies and suppliers of higher education in the area of Infection Prevention.

5.2 The educational proposals have been modified following discussion with Kingston University in favour of developing a CPD module which would be deliverable either at the university site or at one of our own education and development centres. The content of this CPD module is commensurate with the content agreed by the Infection Control Steering Group. A six week interactive CPD module with web based support is now being developed in partnership with Kingston University and following the successful outcome of this development we will formally approach Kingston University to build this module into the CPD Programme.

5.3 A programme of service wide training has been commenced to famililarise staff with the "six steps" hand washing technique. This re-enforced by the poster campaign being undertaken throughout the service

6. Products and facilities

6.1 The ICSG has initiated a range of projects to improve practical infection control arrangements:

- All fabric roller towels on all stations replaced with paper towel dispensers
- Funding approved and a work plan implemented to ensure that all stations had a sluice fitted. A condition survey will be undertaken early in 2006 to ascertain if older sluices require replacement or deep clean.
- Lever taps are being installed in washrooms as and when facilities are refurbished
- Trial of disposable laryngoscope blades, masks, and bacterial filters completed. Rolled out to stations in November for staff familirisation
- Disposable Bag and Mask kit to be rolled out early 2006 following evaluation
- New safety cannula to be introduced late 2005.
- Trials of latex free gloves to continue to assess suitable products.

6.2 The ICSG will continue to work closely with the A&E Vehicle and Equipment Working Group to identify suitable products. New arrangements will be considered for streamlining product assessment, dispensing with lengthy trials where there is a low clinical risk. Better use will also be made of products which have been assessed and approved by the NHS Purchasing and Supply Agency

7. Occupational Health

7.1 The Service continues to work with Occupational Health to improve arrangements for recall of staff for boosters and inoculations. Appointment letters sent direct to staff have a limited effect, so work is underway to establish a network of clinics on LAS premises with regular visits by OH nurses. Line managers will be provided with a list of staff who require vaccinations along with the schedule of clinics and appointments, and will be asked to ensure that appointments are made and attendance facilitated/monitored.

8 Infection Control Risk Register

8.1 The ICSG monitors risks that appear on the Trust risk register that relate to infection control matters. The risk register is tabled at each meeting of the group to monitor and report on progress in reducing each risk. The group also monitors any trends in reported incidents to identify new risks.

8.2 There are currently 8 infection control related risks (1 high, 3 medium and 4 low priority) all of which are being managed directly by the work programme of the group or independently by departments reporting into the group.

9 Make Ready Update

9.1 The Make Ready Scheme is the method by which the Trust ensures that ambulances are clean, fully equipped and ready for operation. At November 2005, there were 16 complexes with Make Ready facilities. The scheme will be fully rolled out to all 25 complexes by 30th March 2006.

9.2 The scheme is monitored through a set of 13 Key Performance Indicators. Weekly performance data against KPIs is produced. Make Ready performance is reported to the Make Ready Steering Group on a monthly basis. Arrangements are in hand to cascade information down to local area performance and monitoring groups.

9.3 Four of the 13 KPIs are directly relevant to the ICSG:

- KPI 1 – Every available ambulance Made Ready once every 24 hours
- KPI 2 – Standard of ambulance cleanliness
- KPI 3 – Conformity to ambulance inventory
- KPI 5 – Standards of station cleanliness

All KPI targets are set at 100%.

9.4 A summary of KPI performance is attached at annex 1. Good performance has been regularly achieved across all categories.

9.5 Regular swab tests are taken on vehicles subject to Make Ready from four fixed locations subject to change every three months, The swabs are processed by an independent laboratory and reported on monthly.

9.6 Results indicate that the total viable count of all bacterial types on the rear drop down step of an ambulance dropped from more than 30,000 to 3,000. The range of bacteria including E Coli and Salmonella on the trolley bed dropped from 510 to less than 10. All swabbed areas effectively indicated a zero count of staphylococcus bacteria (MRSA) both before and after Make Ready cleaning.

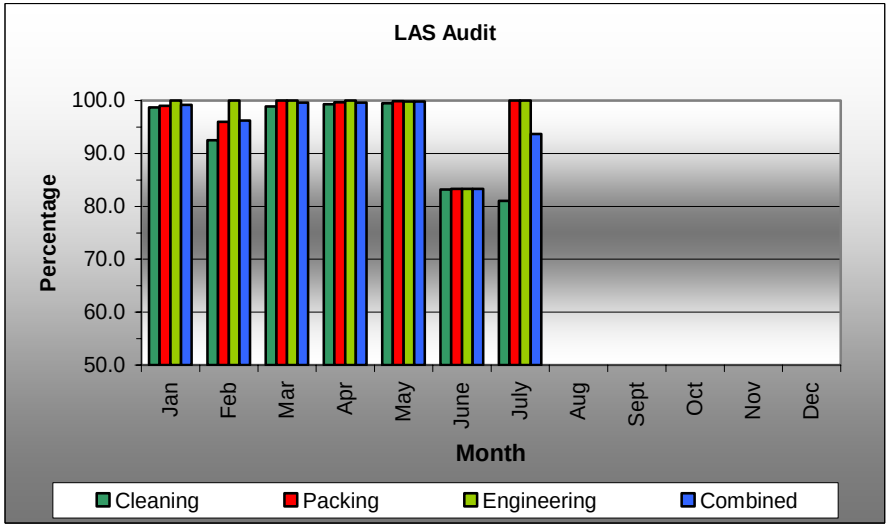
10 Patient and Public Involvement

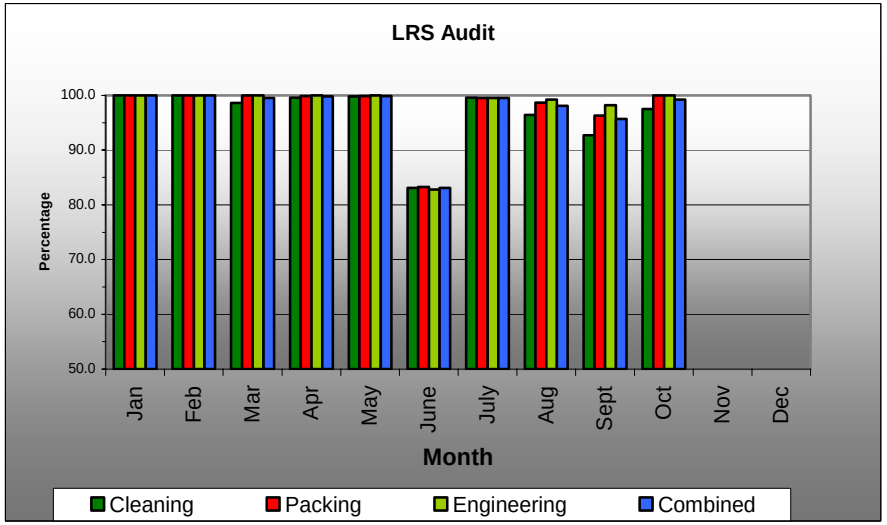
10.1 The Trust has now appointed a PPI Manager who is reviewing the PPI Strategy and collating a data base of PPI activity across the LAS. The PPI Strategy includes principles for working with public and patients generally and will include infection control development and monitoring arrangements.

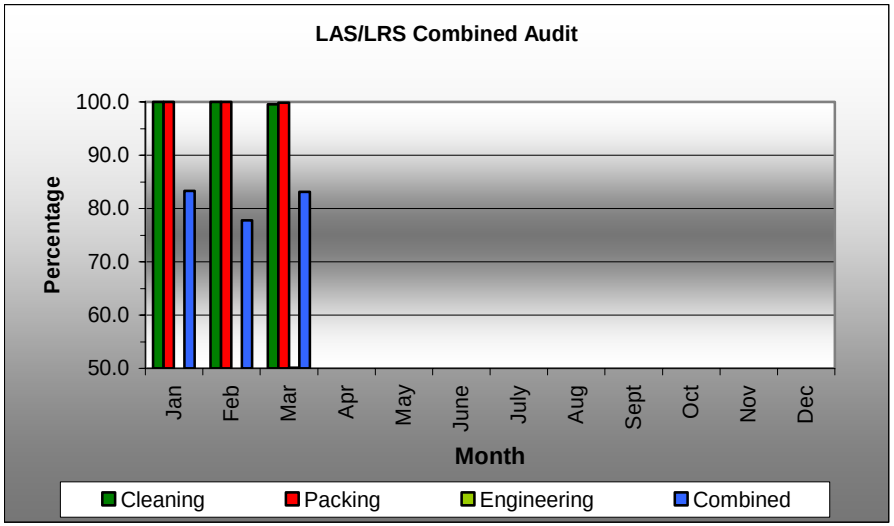
10.2 Service-users and the LAS Patients' Forum attended an event earlier this year where a range of issues regarding the engagement of stakeholders within LAS provision were discussed. Questions were answered in relation to infection control generally and the Make Ready Scheme specifically. Positive support for the Make Ready Scheme has been provided by the LAS Patients Forum.

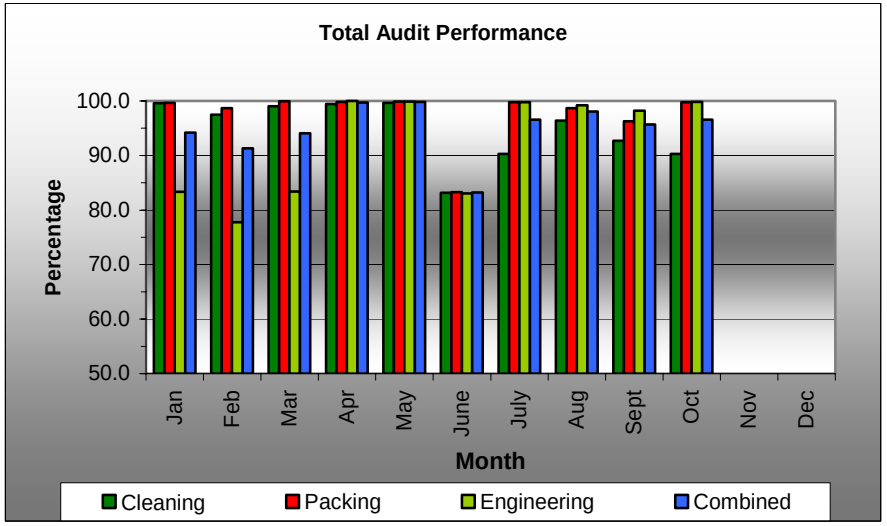
Chris Vale
Head of Operational Support (Acting)

Annexe 1

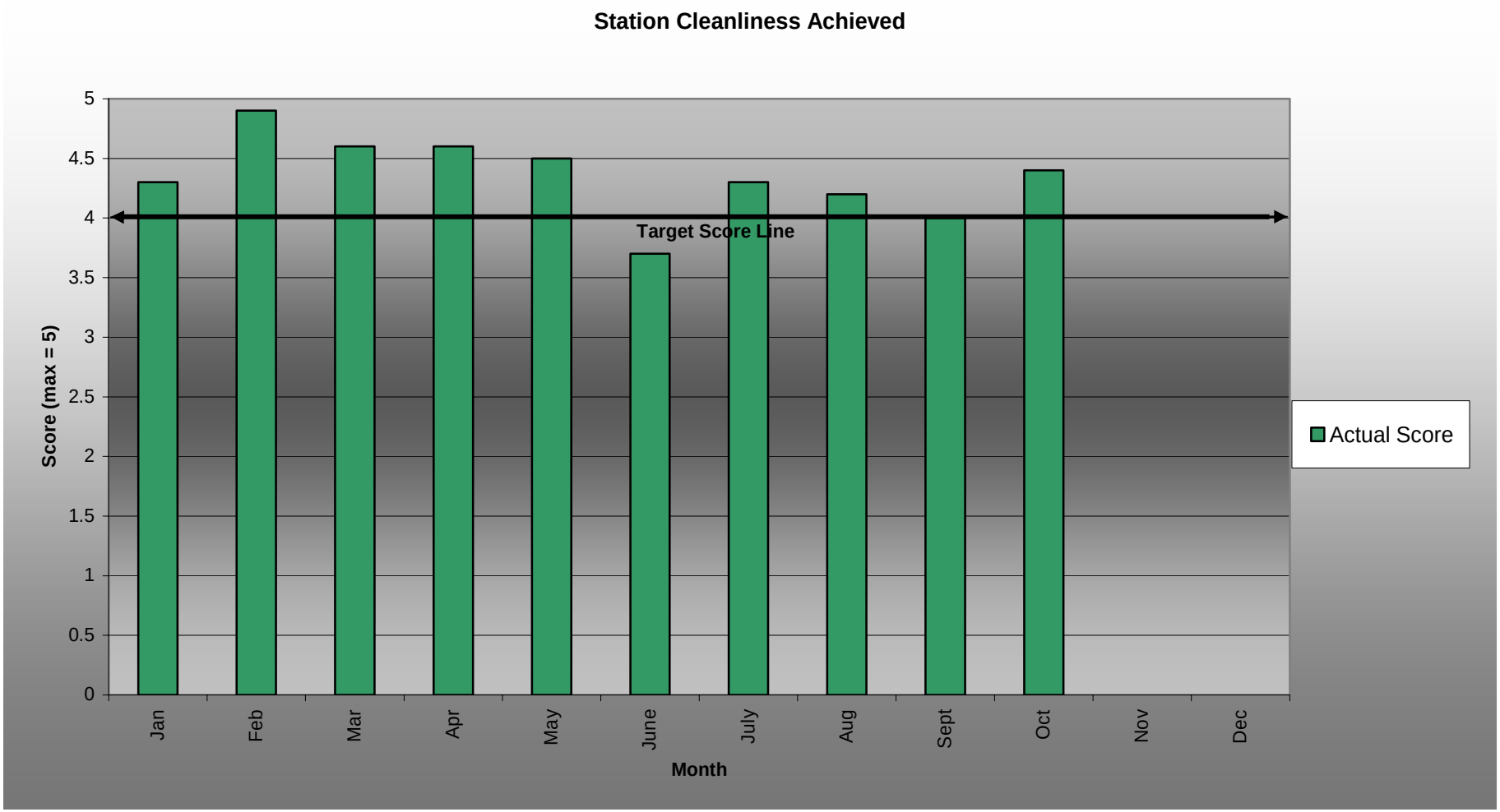

LAS Audit
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Month
Cleaning
Packing
Engineering
Combined


LRS Audit
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Month
Cleaning
Packing
Engineering
Combined


LAS/LRS Combined Audit
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Month
Cleaning
Packing
Engineering
Combined


Total Audit Performance
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Month
Cleaning
Packing
Engineering
Combined

ANNEXE 1


Station Cleanliness Achieved
Score (max = 5)
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Target Score Line
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Month
Actual Score

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

Agreement between the LAS and the Metropolitan Police Service

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For noting

3. Summary

The document outlines a working practice agreement between the LAS and the Metropolitan Police Service covering the following areas:

- Appropriate transportation of patients
- Section 136 of the Mental health Act
- Emergency treatment of patients without capacity who withhold consent

The objective of the document, which is a statement of intent and best practice, rather than a legally binding contract, is to ensure consistency across London in the provision of a safe, secure and supportive service to patients and the general public.

The agreement consists of both explanatory text and flowcharts. Both support the LAS Consent Policy and Capacity Tool.

An impending problematic inquest gives a degree of urgency to finalise and implement this agreement

4. Recommendation

THAT the Trust Board note the work done to date and the progress achieved

Agreement between the London Ambulance Service NHS Trust and the Metropolitan Police Service on the transportation of patients to hospital

Introduction

This document outlines a working practice agreement between the London Ambulance Service (LAS) and the Metropolitan Police Service (MPS) in the following areas:

- Appropriate transportation of patients
- Section 136 of the Mental Health Act
- Emergency treatment of patients without capacity who withhold consent

The object of this agreement is to ensure consistency across London in the provision of a safe, secure and supportive service to patients and the general public. It is not intended to create a legally binding contract but is a statement of intention and best practice that the MPS and LAS will use their best endeavours to observe.

Principles

It is recognised that working relationships between the LAS and MPS at the front line are generally extremely good. This document aims to formalise these working relationships and clarify roles and responsibilities.

Any action taken by the LAS and MPS must be:

- Proportionate
- Legal
- Accountable
- Necessary
- Based on best available information

and in accordance with the Human Rights Act and other legislation, specifically the Health and Safety at Work etc Act 1974 and all other relevant statutory provisions and recognised codes of practice.

In accordance with the Mental Health Act Code of Practice, all service users will 'be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any of these characteristics'.

Appropriate transportation of patients

In general, patients requiring treatment following assessment by an ambulance crew will be taken to hospital by ambulance. However, there may be occasions when ambulance transport is not appropriate, i.e. if there is a risk of the patient harming themselves, a member of the ambulance crew or any other person. In reaching this decision, the ambulance crew should consider the following:

- The patient's behaviour at the time
- Any relevant history
- Any risks presented to the patient, LAS crew or others

Where practicable, police officers and other professionals on scene, as well as the patient and / or carers should be involved in this risk assessment.

If police are not already present, and the ambulance crew determine that such a risk exists, consideration will be given to asking for police to attend the scene. In these cases it will be the responsibility of a member of the ambulance crew to provide the police officer(s) with a briefing of the circumstances and the identified risk factors, and precisely what assistance is requested.

[Flowchart A, Stage 1]

Where:

- the patient is under arrest or otherwise lawfully detained, **or**

- where papers have been completed under Sections 2,3 or 4 of the Mental Health Act following an assessment on private premises, and the Approved Social Worker so requests

and it is agreed between the ambulance crew and the police officer(s) that it is necessary and proportionate to convey the patient in a police vehicle to hospital this course of action will be followed, with the following conditions:

1. In all cases a member of the ambulance crew will accompany the patient in the police vehicle in order to maintain constant observation

2. The ambulance will closely follow the police vehicle to the hospital **[Flowchart A, Stages 2 and 3]**

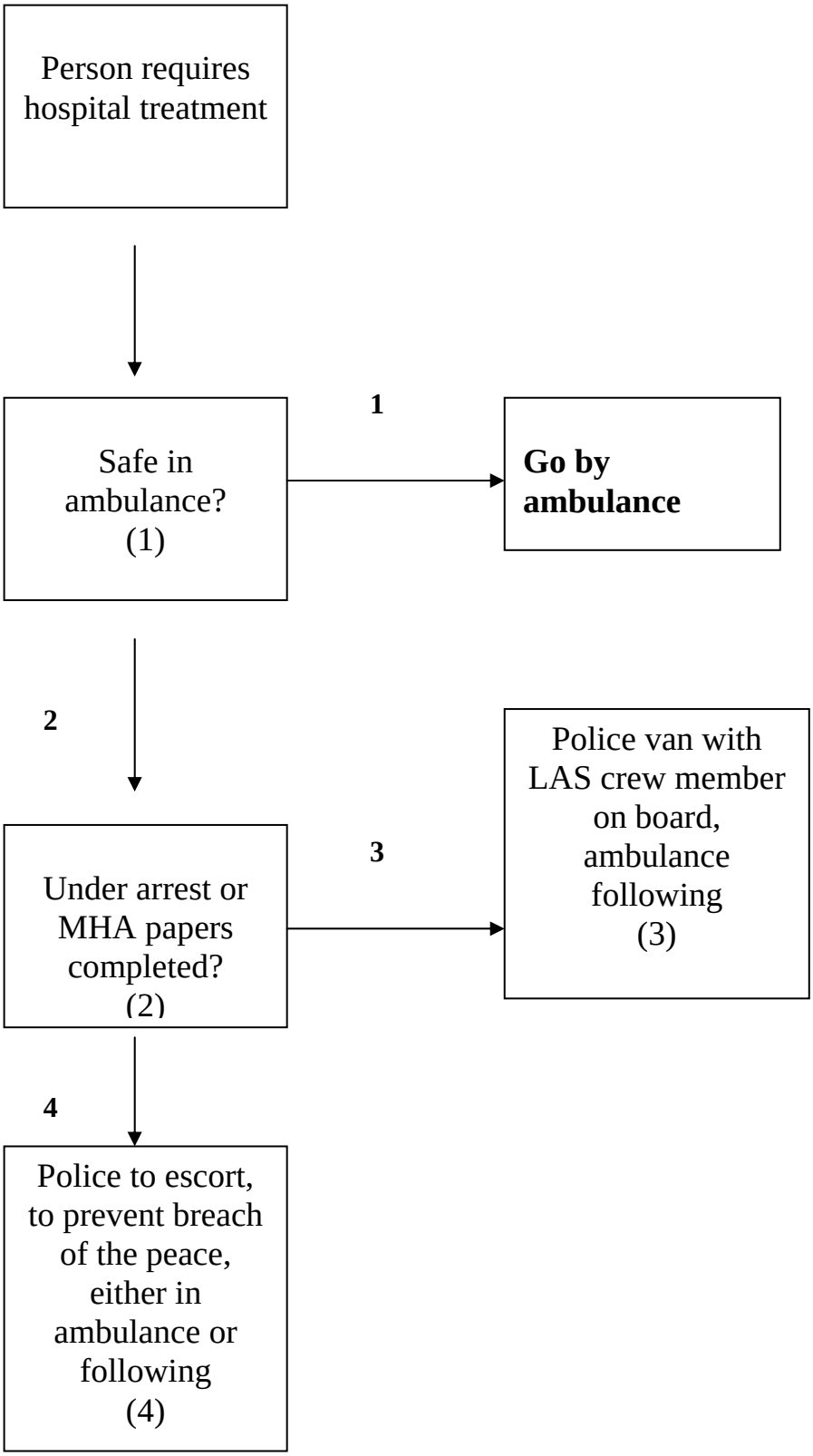
Where the patient is not under arrest nor detained under the Mental Health Act as above, a police vehicle **cannot** be used to transport the patient. Consideration will be given by the ambulance crew and police as to whether it is proportionate and necessary for police to assist the ambulance crew either by a police officer(s) travelling in the ambulance or by a police vehicle accompanying the ambulance to hospital. In these cases the role of police will be to prevent crime and a breach of the peace, which requires there to be a real and immediate threat or actual harm to a

person or his property unless action is taken, and the action taken must be reasonable and proportionate to the threat posed.

[Flowchart A, Stages 2 and 4]

A police vehicle will **not** be used to carry out inter-hospital transfers.

Flowchart A
Transportation to hospital (excluding inter-hospital transfers*)*



Section 136 of the Mental Health Act

The LAS and MPS are committed to providing a safe, secure and supportive response to people undergoing a mental health crisis in a public place. It is recognised that patients may also have underlying medical conditions that require emergency hospital treatment. For this reason, it is considered appropriate to convey by ambulance wherever possible patients detained by a constable under Section 136 of the Mental Health Act. However, it is recognised that there will be occasions when it is not safe to transport in an ambulance, and that the patient needs to be conveyed in a police vehicle supported by the crew of an LAS ambulance.

Section 136 of the Mental Health Act states:

> "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…"

In every London Borough the police have agreed with mental health trusts a place of safety, which is not a police station. In some boroughs the agreed place of safety is a psychiatric reception unit; in others it is the A&E department.

Patients detained under ~~a~~ Section 136 should, as a rule, be conveyed to a place of safety by ambulance, in recognition of:

- their human rights
- duty of care (both LAS and MPS)
- respect for their dignity
- public perception

The guiding principle is that, if there is a requirement for medical treatment, this outweighs the need for assessment under the Mental Health Act.

The MPS policy is that, where acute behavioural disturbance is suspected, the patient should be treated as in need of emergency medical treatment and should be conveyed to hospital by ambulance. Officers are unlikely to know whether the patient has a cardiovascular problem or a psychiatric disorder, or indeed whether the patient is abusing drugs. All these factors may increase the risk of death. The main features of this extreme state are a period of agitation, excitability, perhaps paranoia, coupled with great strength, aggression and non-pain compliance. Sudden collapse and death may follow (source: Police Complaints Authority).

If the ambulance crew decide that the patient requires medical treatment at hospital, they will determine the destination hospital (usually the nearest A&E department) in accordance with LAS procedures. The police officer(s) will retain custody of the person and accompany the person to hospital in the ambulance.

[Flowchart B, stage 2 and 6]

Where the ambulance crew decide that medical treatment at hospital is **not** required, the police officer will request that the person is taken by ambulance to the place of safety designated by the local Section 136 protocol.
[Flowchart B, stage 4]

However, there may be occasions when ambulance transport is not appropriate, i.e if there is a risk of the patient harming themselves, a member of the ambulance crew or any other person. In reaching this decision, the ambulance crew should consider the following:

- the patient's behaviour at the time
- any relevant history
- any risks presented to the patient, LAS crew or others

Where practicable, police officers and other professionals on scene, as well as the patient and/or carers should be involved in this risk assessment.
[Flowchart B, stage 5]

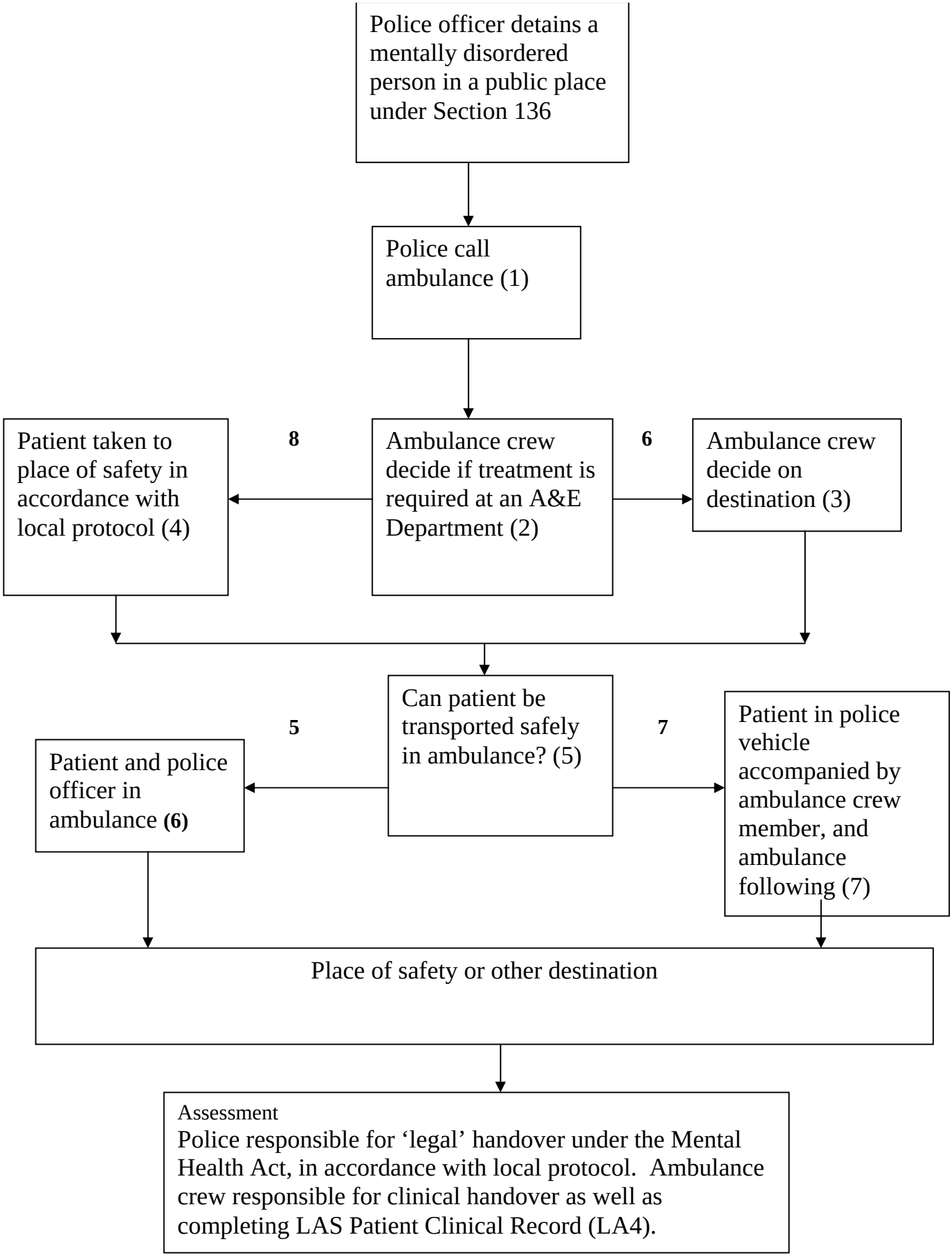
If it is agreed between the ambulance crew and the police officer(s) that it is necessary and proportionate to convey in a police vehicle, this course of action will be followed, with the following conditions:
In all cases a member of the ambulance crew will accompany the patient in the police vehicle in order to maintain constant observation
The ambulance will closely follow the police vehicle to the place of safety

[Flowchart B, stage 7]

The police officer(s) are responsible for a 'legal' handover under the Mental Health Act, in accordance with the local protocol. The ambulance crew are responsible for providing a clinical handover to the staff at the hospital or other place of safety. It is not expected that the ambulance crew will remain at the place of safety once they have handed over the patient's clinical care.

[Flowchart B, stage 8]

Flowchart B
Section 136 Mental Health Act



Part 3

Emergency treatment of patients without capacity who withhold consent to treatment

If adult patients are not capable of making their own health care decisions, based on an assessment of their capacity (see appendix), LAS staff will have to consider intervention against their wishes under the 'doctrine of necessity'. The Common Law recognises the doctrine of necessity. This applies where a person will come to serious harm unless a procedure is carried out but that person is lacking capacity at that point to give a valid consent to treatment. Where the doctrine of necessity is to be invoked LAS staff are aware that the reasons for its use are to be documented on the patient's clinical record form (LA4). LAS staff will also have access to an aide memoire that will assist in making a decision whether to invoke treatment under the doctrine of necessity. Whilst it would be good practice to involve carers, the urgent circumstances may not allow this to take place. It is also understood that the actions taken by either the LAS or Met Police under the doctrine of necessity are only to assist in getting a patient to a place of safety, be it either an Accident or Emergency Department or another centre of care.

Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the patient of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, the LAS has a duty to intervene safely and provide care.

In circumstances where the ambulance crew feel the patient will physically resist efforts to take them to hospital, they may request the police to attend to provide assistance or support in removal of the patient by force if necessary. The ambulance crew will provide a full briefing to the police officers, including the results of their assessment of the patient's capacity, and give a clear request of the nature of the assistance required from the police.

The role and powers of police in supporting the LAS in these circumstances is limited solely to prevent crime and/or a breach of the peace, which requires there to be a real and immediate threat of harm or actual harm to a person or his property unless action is taken, and the action taken must be reasonable and proportionate to the threat posed.

The police officer will record the matter in an Evidential Report Book and a member of the ambulance crew will endorse the report to the effect that s/he believes the patient lacks the mental capacity to consent or withold consent to treatment, that urgent treatment is required to prevent loss of life, and that police assistance is requested to prevent crime and/or prevent a breach of the peace because s/he believes that there is a real and immediate threat of harm or actual harm to a person or his property unless action is taken.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

INCIDENT REPORTING PROCEDURE

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For approval

3. Summary

The Incident Reporting Procedure sets out the trusts arrangements and guidance for the management of incidents and enables compliance with health and safety requirements including Healthcare core standard CI and the NHSLA and other agencies as identified in the policy.

4. Recommendation

That the Trust Board approves the Incident Reporting Procedure

	**London Ambulance Service** **NHS Trust** **Incident Reporting Procedure** **Circulated to: LAS Departments, All Stations, Training and Resource Centres, CAC and PTS.** **For Use By: All Staff.**

Introduction

Effective Accident and Incident Reporting is important for enabling the London Ambulance Service (LAS) to identify areas of risk. In order for the information to be used fully, it is vital that the management of incident reporting is consistent across the Trust, and that staff working at all locations, are made fully aware of this procedure.

The NHS Controls Assurance Standards, Clinical Negligence Scheme for Trusts, National Patient Safety Agency, Risk Pooling Scheme for Trusts, Safety Alert Broadcasts and the Counter Fraud Security Management Service place requirements on the London Ambulance Service (LAS) and all other NHS Trusts, to have procedures in place for the reporting of Incidents.

Staff should be aware that this procedure applies equally to incidents involving staff, patients, contractors, visitors and members of the public who are affected by the work of the Trust. For serious untoward incidents including fatalities, major injury, system breakdowns etc, managers and staff should refer to the Procedure for Rapid follow up of Serious Untoward Incidents (TP/006). For concerns about colleagues working practices, staff should refer to the Whistle Blowing Policy & Procedure.

The aim of incident reporting is not to apportion blame, but to learn from experience and improve practice accordingly. Where errors have been made the preferred option is to provide guidance or retraining to those staff involved. Staff will only be disciplined where there is evidence of willful negligence, acts of maliciousness or gross/repeated misconduct.

Health and Safety Incidents can be defined as an event or omission that has caused injury or ill health to staff, visitors, or members of the public who are affected by the activities of the Trust. Such events include; work related accidents, ill health brought on by work-related activity, injuries sustained as a result of road traffic accidents, and equipment failings. Staff should also report incidents that occur at home where an injury has been sustained. The use of Incidents in this procedure, is the term used for describing Patient Safety Incidents/Near Misses, Health and Safety Events/Near Misses, and all acts of Violence or Verbal Abuse

Patient Safety Incident. Any unintended or unexpected incident which could have or did lead to harm for one or more patients. Examples of such incidents include clinical error, equipment failures affecting the treatment of a patient, and delays in providing patient treatment. Further examples are detailed later in the procedure. Clinical Governance encourages the reporting of all Patient Safety Incidents in order to identify and reduce clinical risk. The National Patient Safety Agency (NPSA) has been established as a central point for NHS Trusts to report Patient Safety Incidents in order for the wider NHS to learn lessons from events on a national basis

Physical Violence includes any event where physical assault has been suffered by a member of staff. This includes violence that can be attributed to patients' clinical condition, and sexual assault

Non-Physical Abuse includes any act of intimidation, verbal abuse anti-social behaviour, homophobia, sexism, racial abuse or victimization of disabled people.

Patient Safety Near Miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient.

Non Clinical Near Miss includes any event where injury or loss has been avoided, but there is potential for the event to reoccur. Such events include health and safety incidents or dangerous occurrences involving the Trust's fleet or estate.

Hazard Anything with the potential to cause harm

Objectives of the Procedure

1. To provide a safe environment for staff, patients, visitors and contractors

2. To raise awareness of the importance of consistent and accurate incident reporting.

3. To ensure managers and staff at all levels are aware of their personal responsibilities in incident reporting, and investigation, and the actions that need to be taken following an incident.

4. To define the categories of incidents that need to be reported.

5. To describe the Grading System to be used for assessing the impact of each incident, and the likelihood of recurrence, and to use the risk score for establishing the extent of the investigation to be undertaken.

6. To reduce the level of untoward incident levels by developing robust systems for minimising the potential for recurrence.

7. To ensure that everyone in the organisation can learn lessons from Health and Safety and Patient Safety Incidents

8. To reduce staff absence attributed to industrial injury.

Procedure

1.0 Reporting Incidents

1.1 All incidents involving either Physical Violence or Non-Physical Abuse will be reported on the Abuse and Risk Address Information Form LA277 (2004/2005) and all other Health and Safety and Patient Safety Incidents should be reported on an Incident Report Form LA52, (2004/2005) following the guidance given in Appendix A. The report should be completed within twenty four hours, of the event occurring. When a member of staff is unable to complete the form due to ill health or injury, their line manager should complete the form on their behalf. The report together with any associated investigation, should be forwarded to the Safety and Risk Department within seven days.

1.2 It is important that names and contact details of witnesses to all incidents are recorded to assist with subsequent investigations.

1.3 When reporting any incident, staff should report only facts, rather than offering opinions

1.4 Injuries resulting from Road Traffic Accidents should be reported on an LA52. However damages resulting from Road Traffic Accidents should continue to be reported on form LA420

2.0 Reporting Physical or Verbal Abuse

2.1 All acts of Physical Violence or Non-Physical Abuse should be reported by completing a LA277 (2004/2005) –see Appendix A-1.

2.2 Where physical violence has occurred the investigating manager should notify the Staff Safety Officer, within 48 hours of the incident. This will allow early liaison with the police, in an attempt to obtain a successful prosecution against the perpetrators of assaults against staff. A major factor for the police when deciding whether to charge someone for an offence is the body of evidence available. This includes independent witnesses to the assault. It is important that contact details for the police officers attending the incident are obtained, in order for the Staff Safety Officer to liaise with the Counter Fraud and Security Management Service, Police, and Crown Prosecution Service.

2.3 The NHS Security Management Service require the to should be informed of all incidents of physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort.

3.0 Reporting Patient Safety Incidents

3.1 When reporting Personal Safety Incidents, staff should provide as much detail as possible about the treatment provided to the patient, both prior and subsequent to an incident occurring. Where known, the outcome should be recorded in respect of how the incident has affected the patient's clinical

condition. In the first instance the incident should be reported to the line manager who will decide the appropriate person to undertake the investigation. All Personal Safety Incidents should be brought to the attention of the Senior Training Officer, or the Senior CAC Training Manager.

3.2 All equipment that fails during use, or drug packs with out of date drugs etc should be taken out of use immediately. Staff should complete an LA52, and attach the yellow copy of the report to the equipment, or the drugs pack and then follow the Exchange in the Event of Equipment Failure Procedure (OP/025), or return the drugs and LA52 to the used drugs locker as appropriate. Guidance on equipment classified as a medical device can be obtained from the Safety and Risk Department.

3.3 Other examples of Patient Safety Incidents that should be reported include;

- Adverse outcome due to failure to follow National Clinical Guidelines, protocols, procedures or instructions, including Advanced Medical Priority Dispatch System (AMPDS).
- Adverse clinical outcomes as a result of following National Clinical Guidelines, protocols, procedures or instructions, including AMPDS.
- Patient injuries sustained as a result of equipment failure, mishaps or falls whilst in LAS care.
- Drug administration errors.
- Concern about treatment provided by other Health Care Professionals
- Delays in providing treatment that result in an adverse effect on the patients clinical outcome.
- Suspected or proven clinical risk resulting from delays in AMPDS and allocation of calls in CAC
- Suspected or proven adverse outcome from Clinical Telephone Advice

3.4 Delays caused by system failures in CAC, in either call taking, or vehicle allocation should be reported, by the Senior Operations Officer in charge of the Control Room, at the time of the incident.

4.0 Health and Safety and Patient Safety Near Misses

4.1 The need to report near misses is as important for the LAS as the reporting of incidents that have caused actual injury, ill health, or loss.

4.2 Examples of near misses that should be reported include:

- The failure of clinical or non-clinical equipment during a patient care episode.
- Mistaken clinical judgment
- Procedures, Clinical Guidelines, protocols or practices, found to be unsafe.
- Hazards associated with the Trust's Estate or Fleet.

5.0 Grading of Incidents

5.1 All reported incidents will be graded according to the actual impact, and also the potential future risk to patients, staff and the organisation should a similar incident occur again. This will help to establish the level of local investigation and causal analysis that should be carried out. Guidance on how to grade Incidents is given in Appendix B

6.0 Responsibility of Chief Executive

The Chief Executive takes overall responsibility for Risk Management within the LAS.

7.0 Responsibility of Director of Human Resources and Organisational Development

Responsibility for Health & Safety and the Incident Reporting Procedure has been delegated to the Director of Human Resources.

8.0 Responsibility of All Line Managers

It is the responsibility of managers at all levels to implement this procedure, and to ensure that a book of LA52/LA277 (2004/2005) incident reporting forms are made available in their area of work. It is important that managers make personal contact with all members of staff reporting incidents, in order to provide them with an opportunity to discuss the incident, and for managers to provide immediate support following an incident. Incident Reports should be forwarded to the Human Resources, and Safety and Risk Departments, within seven days of the event occurring. Copies of the Abuse and Risk Address Information Reports should be forwarded to the Operational Information, Safety and Risk Department and your HR Department.

9.0 Responsibilities of Ambulance Operations Managers, Regional Operations Managers (PTS) Senior Operations Manager – Planning and Risk

Ensuring that Service wide, Complex, Regional and CAC Incident Statistics are monitored, local trends are identified, and that proactive actions are taken

when individual members of staff report disproportionately high levels of incidents.

10.0 Specific Responsibilities of Duty Station Officers, PTS Site Managers, Senior Operations Officers (CAC), Training Officers & Department Heads

Ensuring that incidents are graded and investigated, identifying contributory factors pertinent to the event, in accordance with Appendix B - Grading and Learning from Incidents. To provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident. Where an incident has resulted in either a serious injury, or fatality to either a member of staff or a patient, managers should refer to the Procedure for Rapid Follow Up of Serious Untoward Incidents (TP/006).
Managers' specific responsibilities are:-

- To provide guidance to staff, and to ensure measures are taken to prevent a recurrence of an incident.
- To refer staff for retraining as appropriate.
- To ensure all acts of physical abuse are reported by telephone to the Staff Safety Officer, as soon as possible after the incident.
- To offer support, and referrals for occupational health, welfare, counseling services & re-training as appropriate.
- To ensure LA52/LA277 (2004/2005) are completed in full, prior to distribution to the Safety & Risk, Operational Information and Human Resources Departments.
- Ensure that all incidents graded "High" are referred to Professional Standards Unit within 48 hours of the incident occurring.
- To report all incidents to the Health and Safety Executive, in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) see Section 14.

11.0 Responsibilities of Senior Operational & CAC Training Officers & Training Officers

- To make staff aware of the importance of incident reporting, and to encourage the reporting of Patient Safety and Health and Safety Incidents through day to day contact with staff.
- To oversee the investigation of Patient Safety Incidents ensuring lessons learnt from the reporting of incidents, are passed to operational staff through training initiatives etc.

- To ensure that the results of equipment inspections are relayed to the member of staff who reported the fault.

- To ensure the patients clinical outcome is identified as part of the investigation in to clinical untoward incidents.

- To identify areas of clinical risk in their Complex or area of responsibility.

12.0 Responsibility of A/E Team Leaders, PTS Crew Team Leaders and CAC Quality Assurance Advisers

A/E and PTS Team Leaders, CAC Quality Assurance Advisers have the following specific responsibilities in clinical and non-clinical incident investigation. It is expected that they will assist in investigations led by Ambulance Operational Managers, Duty Officers and PTS Site Managers;

- To encourage the reporting of all Incidents, amongst their team and other operational staff;

- To ensure any equipment that has failed during the treatment of a patient is identified with an LA52, prior to being sent to Equipment Stores for repair/inspection as specified in Exchange in the Event of Equipment Failure Procedure (OP/025);

- To provide feedback to the member of staff reporting the incident, following completion of the investigation.

13.0 Responsibility of Staff Safety Officer, Ergonomics Adviser and Safety and Risk Adviser

The Staff Safety Officer, Ergonomics Adviser and Safety and Risk Adviser will review all LA52s to identify reporting trends, and to ensure appropriate follow up action, grading and investigation has been taken following an incident. Specific responsibilities include;

- Supporting staff who have been the victims of assaults in respect of liaison with the police and Crown Prosecution Service.

- Advising managers on their investigation of untoward incidents or accidents.

- Informing the Trust of trends in incident reporting and the issues raised in action plans resulting from incident investigations.

- Providing reports on incident levels to the Clinical Risk Group, and the Corporate Health and Safety Committee.

- Developing procedures and strategies to achieve a reduction in incidents.

- Informing the Counter Fraud Security Management Service of all Physical Assaults (see Section 15)

14.0 Responsibility of All Staff

- All staff are required to report accidents, incidents, near misses, or dangerous occurrences that affect themselves, patients or members of the public.
- To document any information given by patients, relatives or members of the public on the LA52 or LA277.
- To remove immediately from use any piece of faulty equipment.
- To co-operate in the investigation of Incidents, providing witness statements and any other information that will assist with an investigation.

Involving External Agencies:

The guidance below sets out when to inform external agencies about an incident.

15.0 Safety Alert Broadcast System (SABS)

The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health (DOH), National Patient Safety Agency (NPSA), NHS Estates and the Medicines and Healthcare Products Regulatory Agency (MHRA) to ensure that risks that arise from incident reporting can be highlighted to all Trusts

The Safety and Risk Adviser is the nominated manager responsible for distributing Safety Alerts in the LAS and for reporting incidents where issues may have been raised that affect other NHS Trusts.

16.0 Counter Fraud Security Management Service (CFSMS)

The CFSMS are tasked with reducing levels of physical abuse to NHS staff. The Staff Safety Officer will report all incidents of Physical Abuse to the CFSMS.

17.0 National Patient Safety Agency (NPSA)

The NPSA has established a central point for NHS Trust's to report Patient Safety Incidents. This is in order for the wider NHS to learn lessons from events on a National basis.

18.0 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

There is a statutory duty on all employers, to report notifiable Incidents to the Health and Safety Executive. Incidents to be reported include;

- Any absence over three days (not including the day of the incident) that results from an industrial injury.
- Any fracture (other than to fingers, thumbs, or toes).
- Any amputation.
- Any dislocation of the shoulder, hip, knee or spine.
- Loss of sight (whether temporary or permanent) burns (chemical/heat) or other penetrating injuries to the eye.
- Injuries due to electric shock or burns which require resuscitation, or which result in hospitalisation for more than twenty four hours.
- Unconsciousness due to asphyxia or exposure to a harmful substance.
- Acute illnesses that require medical treatment or that result in unconsciousness due to chemical or biological substances being inhaled, ingested or absorbed through the skin.
- Acute illnesses requiring medical treatment, which are believed to be due to infected material or to biological agents or their toxins.

Managers are responsible for reporting incidents to the HSE on form F2508 within seven days of the event occurring. A further copy of the form should be forwarded to the Safety and Risk Department. F2508s can be forwarded to the HSE via e-mail www.riddor.gov.uk.

References: **Health and Safety at Work Act (1974)**
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
LAS Procedure for Rapid Follow up of Serious Untoward Incidents (TP/006)
Exchange in the Event of Equipment Failure (OP/025)
LAS Whistle Blowing Policy & Procedure
LAS Complaints Procedure (TP/004)
POMs Act
LAS CAC Procedure for Lengthy Delay of Calls
LAS Staff Safety Policy
LAS Post Violence Support Procedure
LAS Violence Prevention Procedure

Signature:

Peter Bradley
Chief Executive/Chief Ambulance Officer

Appendix A

INCIDENT REPORTING PROCEDURE FOR STAFF, PATIENTS AND OTHERS

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety & Risk Department, or via CAC.

The LA52 (2004/2005) report form must be completed as soon as possible after the event and be accurate and detailed.

The LA52 (2004/2005) replaces all previous versions of the LA52.

On completion of the form:-		
TOP COPY (White) goes to Safety & Risk Dept, Pocock Street, SE1 (External Mail)	MIDDLE COPY (Gold) goes to Sector/Dept HR Office	BOTTOM COPY (Green) retained in originating Station/Office/Dept

If the incident victim as a result of their injuries (or any other reason) is unable to complete the Incident Report Form, it must be completed on their behalf, preferably by their Line Manager, with the outline details of the incident and probable cause.

All incidents involving physical or non-physical abuse must be reported on an LA277(2004/2005).

Guidance on Completion

1 Indicate the Station/Department where you are based and who you reported the incident to.

2 Record your personal details, including job title, age etc. Please confirm whether you give consent to a copy of the form being given to your Health & Safety Representative.

3 Cross the appropriate box highlighting the type of incident that occurred.

4 Record when and where the incident occurred, include map references as appropriate.

5 Describe what cause the incident giving factual details only. Continue on a separate sheet if required.

6 Indicate the relevant factors if the incident was of a non-clinical nature.

7 Supply the names and contact details for the incident, attaching witness statements where available.

8 Indicate the relevant factor for incidents of a clinical nature.

9 Confirm whether any Personal Protective Equipment was worn/in use at the time of the incident.

10 Detail any injuries or ill health suffered by anyone involved in the incident.

11 Specify any equipment involved in the incident; Trolley Beds, Chairs, Vehicle Patient Care Equipment etc, recording makes, models, fleet and serial numbers.

12 Provide your signature, record the date of completion and provide a contact telephone number.

13 For completion by the Line Manager – Mangers investigating an incident should ensure all actions taken following an incident are recorded, by ticking the relevant boxes. Managers should grade the incident in accordance with the Incident Grading Matrix and confirm the results of investigations and actions taken to avoid a recurrence. The Manager investigating the incident should indicate how long an employee is known/likely to be unable to do their usual role. It is the duty of the Manager investigating the incident to complete a Health & Safety Form F2508 in accordance with the Reporting of Incidents Diseases and Dangerous Occurrences Regulations (RIDDOR) where an employee has been absent for a period greater than three days not including the day of the occurrence, following the incident. Copies of the form should be sent to the Health & Safety Executive within 10 days, with a further copy forwarded to the Safety & Risk Department.

Appendix A-1

PROCEDURE FOR THE REPORTING OF ABUSE AND SUBMISSION OF ADDRESS TO THE HIGH RISK ADDRESS REGISTER

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety and Risk Department or via CAC.

The LA277 (2004/2005) replaces all previous versions of the LA277 and LA52 in terms of reporting Physical and Non-Physical Abuse, and adding addresses to the High Risk Address Register.

The LA277 (2004/2005) report form must be completed as soon as possible after the event, and should be accurate and detailed.

On completion of the form:

TOP COPY (White) goes to the Operational Information Department, Headquarters (External Mail)	SECOND COPY (Pink) goes to Safety & Risk Department, Pocock Street, SE1
THIRD COPY (Gold) goes to Station/Department HR Office	FOURTH COPY (Green) retained in originating Station/Office/Department

If the incident victim as a result of their injuries (or any other reason) is unable to complete the LA277 Report Form, it must be completed by the Line Manager, with the outline details of the accident and probable cause.

1 Record where you are based and who you initially reported the incident to.

2 Record your personal details including job title, length of service etc. Please confirm whether you give consent to a copy of the form being provided to your Health & Safety Representative.

3 Record the category of incident by crossing the appropriate box.

4 Record when and where the incident occurred.

5 Describe what led up to the incident. All occurrences of physical abuse should be reported to the police in order to build up evidence against those who assault staff. Continue on a separate sheet if necessary.

6 Record the names and details of those involved in the above. Please also indicate what factors are relevant to the incident.

7 Record the names and contact details for any witnesses to the incident.

8 Was a stab vest or any other Personal Protective Equipment in use at the time of the incident.

9 Identify any injury, ill health, disease or emotional distress suffered as a result of this incident.

10 Provide your signature, record the date of completion and provide a contact telephone number.

11 For completion by the Investigating Manager. A discussion with the staff member reporting the incident must form part of the investigation. All actions taken following the incident should be recorded by ticking the relevant boxes. All incidents should be graded in accordance with the Incident Grading Matrix. You must also confirm whether the address of the perpetrator of the abuse should be added to the High Risk Address Register. Confirm whether any period of absence followed this incident. It is the duty of the Manager Investigating the incident to complete a Health & Safety Executive form F2508, when a member of staff has been absent for a period greater than 3 days not including the day of the occurrence. Copies of the form should be sent to the Health & Safety Executive, with a further copy forwarded to the Safety & Risk Department.

Appendix B

Guidance on Grading, Investigation & Root Cause Analysis of untoward and adverse events.

1.0 INTRODUCTION

This document provides guidance to staff within the LAS on how and when investigation processes should be undertaken following an adverse event.

Whilst adverse events almost automatically lead to reactive risk management i.e. damage limitation and immediate remedial action. They should also be seen as an opportunity for proactive risk management i.e. learning from what has happened and looking ahead to see how such incidents can be prevented from reoccurring; thereby reducing future risk to the Trust.

In order to learn from these events it is necessary to obtain the facts and details of the incident. These must be recorded as soon after the incident as reasonably possible. Further, more detailed information can be gathered and collated as the investigation progresses. The depth and level of investigation will be dictated by the severity of the event/incident. When the key facts of the incident have been identified, then measures can be taken to prevent, or reduce the likelihood of similar circumstances combining again, with adverse results.

All staff therefore have a part to play in this area of risk management, whether it is in terms of completing accurate records (on PRFs, LA52s, LA400s or LA277s,) or if it is acting as an Investigating Officer/manager conducting the investigation and analysing the outcomes.

2.0 DEFINITIONS

For the purpose of this guidance the term **Incident** refers to any Health Care Event or Health and Safety Incident, Complaint or Near Miss.

Immediate Cause is defined as the factor(s) which triggered the actual incident.

Contributory Factor is defined as the circumstance(s) which contributed to the occurrence of the incident, but which, by itself or themselves, would not have caused the incident to arise.

Root Cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

3.0 INCIDENT GRADING

All reported incidents will be graded according to the severity of the actual impact, and also the likely future risk to patients, staff and the organisation should a similar incident occur again. This grading will also help to establish the level of local investigation and causal analysis that should be carried out.

Incidents will be graded by individuals (identified in the procedure) using the matrix below. The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an actual incident or a near miss.

Risk Scoring

Not all incidents need to be investigated to the same extent or depth. To assess the level of investigation required, the impact of the incident and the likelihood of a recurrence both need to be considered. For incidents where Physical Violence, Non-Physical Abuse or Lifting Handling and Carrying are factors, the likelihood should be based on the staff members previous reporting history. For all other categories the likelihood should be based on general reporting trends. To assess the likelihood of recurrence, managers responsible for grading should refer to the Quarterly Incident Statistics, Complex Statistics and the levels of similar incidents that have been reported. Having assessed each incident against the risk grading matrix, the amount of investigative and analysis effort should be in relation to the risk scoring (Refer to Appendix B, Section 4.0)

Risk Scoring					
1 Impact					
Catastrophic			**High**		
Major			**Medium**		
Moderate					
Minor			**Low**		
None		**Insignificant**			
Descriptor	Rare	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency	**Not expected to occur annually**	**Expected to occur at least annually**	**Expected to occur at least every 6 months**	**Expected to occur at least monthly**	**Expected to occur at least weekly**
Probability	**< 1%**	**1 – 5%**	**6 – 25%**	**26 – 60%**	**> 60%**
	Will only occur in exceptional circumstances	**Unlikely to occur more than once annually**	**Reasonable chance of occurring**	**Likely to occur**	**More likely to occur than not**
Likelihood of Recurrence					

	Impact	Examples
None	Verbal abuse without a direct threat. Near miss with a limited potential for adverse outcome or injury or with limited likelihood for recurrence. Reported absence of equipment that was not required during a shift.	• Missing Blankets from Vehicle • Swearing without a direct threat
Minor	Cuts and bruises. Sharps injury with no infection control risk. Verbal abuse with a direct threat. Strain, sprain or minor back injury. Absence up to three days. Patient and non-patient related near misses with potential to cause harm. Patient safety incident with no long term effects.	• Delay in treating large laceration resulting in increased shock • Slip on oil resulting in bruising but with no absence • Unused sharps injury
Moderate	Dislocation, fractures, Physical Assault, Reportable diseases or Dangerous Occurrences. Any Industrial Injury absence greater than three days. Sharps injury with an infection control risk. Patient related adverse event with a moderate effect on the patient's condition.	• Sager Splint collapsing whilst in Traction • O2 Cylinder or equipment falling and narrowly missing patient • Staff related back injury due to equipment failing resulting in an absence greater than 3 days • Assault with or without injury
Major	Fatality. Multiple Injuries, and Injuries requiring hospitalization. Injuries likely to cause a disability. Patient related adverse advent where the incident had a significant, and direct impact on the patient's clinical condition.	• Defib failing to shock a shockable rhythym • Unrecognised Oesophageal Intubation • Manual Handling injury resulting in hospitalisation
Catastrophic	Multiple fatalities.	• Multiple patients injured due to RTA involving a LAS vehicle

4.0 LEVEL AND NATURE OF LOCAL INVESTIGATION AND ANALYSIS

Once the event has been graded the appropriate response should be actioned, in compliance with the table below. If the investigation reveals issues that were not at first apparent from the LA52, the incident should be re-graded and additional actions undertaken appropriate to the Risk Score.

Dependant on the nature of the incident, e.g.: Violence, Manual Handling; further guidance on additional actions to be taken can be obtained from the Trust's Health & Safety manual (also on the Intranet).

Category	Actions **AOMs. DSOs, PTS Site Managers, Senior Operations Managers (CAC), Senior/Training Officers & Department Heads**	Analysis	Outcome
Yellow (Insignificant)	▪ Support and discuss incident with staff member ▪ Check thatLA52/LA277 completed ▪ Identify previous reporting history for this staff member – have similar incidents been reported previously ▪ Consider whether appropriate to add this address to High Risk Address Register	▪ Incident to be entered on to incident Database	▪ Carry out immediate Remedial Action
Green (Low)	▪ Cross reference LA52/LA277 with PRF's and other documentation ▪ Carry out Actions as for category yellow	▪ As for category yellow ▪ General Analysis of cause and contributory factors	▪ Immediate Remedial Actions, and Recommendations where appropriate
Blue (Medium)	▪ Carry out Actions as for category yellow and green ▪ Carry out thorough investigation and consider referring to PSU for RCA	▪ As for category yellow and green ▪ General Analysis of cause and contributory factors which may lead to RCA	▪ Immediate Actions, or Recommendations and Action Plan
Red (High)	▪ Full investigation by PSU or nominated Investigating Officer	▪ Root Cause Analysis	▪ Action Plan and Improvement Strategy

5.0 GENERAL GUIDANCE ON INVESTIGATION PROCESSES

Incident investigations should:

- Identify reasons for substandard performance
- Identify underlying failures in management systems
- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm
- Satisfy mandatory and LAS reporting requirements

The investigation needs to be prompt and thorough. Where possible, remedial action or solutions should be recommended. If the investigation is not undertaken as soon as practicable after the event, conditions and recollections fade and evidence is lost.

There are five components of any investigation:

i. **Collect evidence** about what happened.
ii. **Assemble and consider** the evidence.
iii. **Compare** the findings with relevant standards, protocols or guidelines, whether these are particular to LAS or National, to establish the facts, draw conclusions about causation.
iv. **Make recommendations** for action to minimise risk of recurrence.
v. **Implement** the recommendations and track progress.

i) Collecting Evidence.

The sources of information and methods that can be used in investigation typically fall into the three following categories:

- **Direct observation** is crucial to avoid losing important evidence about the scene, equipment, environment, vehicles and machinery involved, etc. Where possible photographs should be taken, particularly when it is impractical to preserve evidence or maintain the scene of the incident in a permanent state.

- **Documentation** which identifies what occurred leading up to and at the time of the incident and this should be included as part of the investigation. Evidence of prior risk assessment, work place inspections, servicing and maintenance history may all be relevant to the investigation

- **Interviews** should be undertaken with the personnel involved in the incident, and any witnesses identified and their full contact details and signatures as soon as possible after the event.

Adverse incidents seldom arise from a single cause; there are usually multiple underlying failures in management systems/procedures which have created the circumstances leading to the incident.

ii) Assembling and Considering the Evidence

Investigations should identify both immediate and underlying causes, including human factors/errors. Immediate causes must take into account the patient, the task, the work environment and weather conditions, all the persons' involved (either individually or as part of a crew or team), time of day and any machinery, vehicles or equipment used. Underlying causes can be management and systems failures organisational, cultural, personal/health and contextual factors that all contribute to explain why the event(s) occurred. Getting to the root of the problem will help ensure the development of an effective improvement strategy and if the incident is properly and thoroughly investigated then this should prevent or significantly reduce the likelihood of recurrence.

iii) Comparing findings with relevant standards & protocols

The next stage of the investigation is to compare the conditions and sequence of events against relevant standards, guidelines, protocols, approved codes of practice, etc. This will help to minimise the subjective nature of investigations and to generate recommendations which have the maximum impact and relevance. The objectives are to decide:

- Whether suitable and sufficient standards / procedures / controls / risk assessments, undertaken and were they being implemented to prevent untoward incidents occurring in the first place
- If standards / procedures etc exist, are they appropriate and sufficient?
- If the standards / procedures were adequate, were they applied or implemented appropriately?
- Why any failures occurred
- Were safe systems and procedures accidentally or deliberately breached?

iv) Make Recommendations

Where an investigation identifies immediate or underlying causes involved, recommendations should be made to take remedial action immediately or make recommendations for possible solutions to prevent recurrence within an action plan. Copies of the action plans should be forwarded to the Staff Safety Officer, together with a copy of the LA52/LA277(2004/2005), and the findings of the associated investigation. Action plans that have Trust wide implications will be reported to the Clinical Risk Group and Corporate Health and Safety Group.

v) Implement the Changes/Action Plan

Where an investigation has resulted in an Action plan being created or a change in working practice, progress should be monitored and recorded.

6.0 ROOT CAUSE ANALYSIS

Unless the fundamental, or root causes of adverse events are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in risks. Adverse incidents rarely arise from a single cause; there are usually underlying
failures in management systems which have helped to create the circumstances leading to the incident.

Full Root Cause Analysis will in the majority of circumstances; be undertaken by the Professional Standards Unit, with the assistance of other managers with expertise in specific areas. Where necessary, this group will also seek advice from external experts and organizations e.g. the NPSA, NHSLA, HSE.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident.

RCA would normally include the following steps:

- Identify the incident.
- Preserve direct evidence from the scene
  & make detailed records / complete LA52/LA277(2004/2005)/F2508.
- Provide a chronology.
- Gather documentary and other evidence.
- Arrange and carry out interviews.
- Identify related factors.
- Analyse related factors.
- Use NPSA RCA models.
- Decide on and cost the options for improvement controls.
- Provide a report.
- Ensure implementation of improvement strategy, phased if necessary.

7.0 COMMUNICATION OF LEARNING POINTS

Implementing recommendations and Improvement Strategies, and monitoring the effectiveness of action taken, will provide a certain level of evidence to demonstrate that the LAS is learning from adverse events. This may be on an individual or Trust Wide basis. It is necessary to ensure that lessons are learnt and changes are made and communicated so that the Trust can demonstrate continuous improvement as an organization.

It will be the responsibility of Managers and Investigating Officers to feed back to individuals with regard to lessons learned from Incidents and to monitor progress against action plans drawn up.

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

SERIOUS UNTOWARD INCIDENT POLICY

1. Sponsoring Executive Director: Fionna Moore, Medical Director

2. Purpose: For Approval

3. Summary

This policy describes how the LAS and its staff should manage Serious Untoward Incidents as they arise. It incorporates current guidance from the National Health Service Litigation Authority and the National Patient Safety Agency.

It is a requirement for the LAS to comply with the NHSLA level 3 Assessment currently taking place and will improve compliance with Healthcare Standard C7 within the Governance Domain of the Standards for Better Health

4. Recommendation

THAT the Trust Board approves the policy

	London Ambulance Service NHS Trust Rapid follow up of Serious Untoward Incidents Policy **For Use By: All Staff – draft for Board approval,**

Introduction

Detailed guidance is given below

The LAS are committed to cooperating fully with external agencies as regards the differing mechanisms that may be employed in reviewing an incident and will share information with other agencies accordingly, providing that any relevant statutory responsibilities (Data Protection, Freedom of Information Acts) are met.

For the purpose of this specific procedure, a Serious Untoward Incident (SUI) is defined as:

- an event during which the actions or omissions of London Ambulance Service NHS Trust (LAS) personnel , or use of equipment under their control, may have contributed to the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS.

- an event involving the LAS which will be likely to may produce significant legal, media or other interest which, if not properly managed, may result in loss of the Trust's reputation or assets.

- an event during which the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS may have resulted from a delay in dispatching appropriate LAS resources, or where a delay may have been a contributory factor in those outcomes.

The LAS are committed to cooperating fully with external agencies as regards the differing mechanisms that may be employed in reviewing any adverse incident and will share information with other agencies accordingly, providing that relevant statutory responsibilities (Data Protection, Freedom of Information Acts etc.) are met. The LAS will also involve and include other agencies in SUI investigations as appropriate. e.g. if an LAS employee reports a criminal offence has occurred during the incident then the Police will be contacted immediately.

Objectives

The purpose of this document is to describe a procedure that, when followed, will allow the LAS and its staff to:

1. Understand what constitutes an SUI and be provided with guidance on how to deal with these potentially stressful events.

2. Respond quickly and positively to an incident, mitigating the consequences and evidencing that its main concern is for the wellbeing and best interests of patients, staff and those working on behalf of the LAS.

3. Take a consistent approach to the management of such incidents.

4. Apply these systems this procedure in an open and transparent way.

5. Involve and fully inform stakeholders, staff, other organisations/professionals, patients and their families, in line with Department of Health guidance on best practice.

6. Deal with cases where poor practice is identified as a contributory factor in a sensitive and fair manner in accordance with the Trust's workforce policies.

7. Consider the individual needs of staff, patients, their relatives and carers within the wider system, particularly regarding their cultural and/or religious needs.

8. Learn from all incidents and prevent reoccurrence as far as possible.

9. Address the lessons to be learnt from such incidents from both operational and organisational perspectives, recognising that the majority of incidents in health care occur because of failure in systems rather than individual practice alone.

Audit

The Trust will know that this policy procedure has been effectively implemented when:

- Full compliance with policy has been achieved and has been evidenced through use of the audit tool * and audit standards (see below Appendix 1)
- It is demonstrated that contributory factors in an SUI are identified, action taken /recommendations are communicated, implemented reviewed in accordance with the Trust's Risk Management Framework
- In those cases where disciplinary action is used it is apparent that gross negligence has been found -
- There is evidence of patient / public involvement
- There is evidence that the support offered reasonably meets everyone's needs including cultural and religious requirements.

* audit tool refers to the audit tool presented at the meeting on 5th October

The LAS commits to monitor full compliance with this procedure and the routine achievement of the above objectives to ensure that the audit cycle is completed every time an SUI is declared. The methodology and standards for the audit is included in **Appendix one**. The purpose of the audit is to ensure that lessons have been learned and patient care has been improved as a direct result of a SUI investigation.

Procedure

The following sets out the procedure where a SUI has been declared, either by the London Ambulance Service NHS Trust (LAS) or an external agency e.g. NHS Trust, Police Authority or other emergency service, social care agency. It should however be recognised that other mechanisms exist within the NHS and social care to review the management of an incident. .

Following declaration of an SUI all identified personnel will be informed within 24 hours of the incident occurring, where contactable; the matter will be followed up by a full incident review.

The LAS is committed to being open with patients who have been unintentionally harmed. Being open involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and reassuring patients/carers that lessons learned will help prevent the incident recurring.

The LAS policy of Being Open is being developed (at the time of publication of this document) in line with the National Patient Safety Agency's national 'Being Open' Policy that was launched in September 2005. When it is published it should be read in conjunction with this document.

1.0 Reporting of Incidents Identified by Operational Staff

1.1 It is vital that in the event of an adverse incident which appears to fit the above criteria, an appropriate Senior Manager is alerted accordingly. Crucial to the effective management of an adverse incident is speed of communication.

1.2 The decision to declare an SUI and apply the procedure to an incident will be made by the Chief Executive Officer (CEO) and/or the Director of Operations and/or the Medical Director within 24 hours of it being reported. The requirements of the SUI guidance issued by the South West London Strategic Health Authority (SWLSHA or its successor) must be met during the process of every SUI – see **Appendix 2**. The Director of Communications will be informed if the procedure is invoked.

2.0 Reporting of Incidents by Other Means

2.1 Information regarding incidents may come from various sources. If When an incident is reported through an internal source such as an enquiry made to the Patient Advice & Liaison Service (PALS), a complaint to Professional Standards Unit (PSU), or notification of a 'problematic' coroner's inquest to

Legal Services, where it is apparent that the SUI criteria may apply, the CEO and /or Director of Operations and/or the Medical Director should be notified accordingly.

2.2 The Communications Directorate, Legal Services, PALS & PSU should all be simultaneously informed when an SUI is declared to enable a consistency of approach to enquiries from interested parties and avoid any duplication of investigation.

2.3 In the case of Central Ambulance Control (CAC), if an incident becomes apparent as it occurs, CAC must record all relevant details of the incident on the Call Receipt Form (AS1), using the electronic call log. If there is no pre-existing CAD log for the incident, one should be created. All decisions and records of who is informed about the incident and by whom must be recorded in the log. The Senior Operations Officer should inform the duty 'Silver' (Site managers) of any incident that they believe may constitute an SUI and a decision made whether to inform the duty 'Gold'(senior manger responsible.

3.0 Management of the Incident

3.1 The CEO/Director of Operations will delegate the appointment of a Case Manager as appropriate

3.2 As soon as possible a SUI Group consisting of the CEO and / or the Director of Operations, the Director of Communications, the Medical Director or their representatives and any other persons invited by the Group must be organised. The Grgroup will meet and be facilitated by the Case Manager This Group will meet regularly to and will monitor developments, maintain a strategic overview and to enable the specific management of the review and dissemination of the outcome.

3.3 The CEO, Director of Operations and Medical Director will be kept informed of developments, as will any other appropriate managers where it is deemed appropriate to do so.

4.0 Responsibilities of Case Manager

The responsibilities of the Case manger are;

4.1 To monitor the progress of the investigation and ensure the procedure is followed correctly.

4.2 To immediately appoint a Family Liaison Officer (FLO) to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives and the SUI Group. The role of the FLO is defined in **Appendix 3**. **Any information given to staff, patient(s), relatives and the public must be documented**. Every effort will be made to ensure that patient(s) and/or relative(s), staff and other persons potentially affected by the incident are informed at the earliest opportunity and in advance of any public announcement. This will be facilitated by the FLO.

4.3 To immediately appoint a Staff Liaison Officer (SLO) to identify any other support and provide regular feedback and support, as appropriate for staff. All staff involved should be informed when this procedure has been invoked.

4.4 To ensure the immediate appointment of an an appropriate Investigation Officer to coordinate the enquiry, as chosen by the Case manager..

To ensure that full details of the incident are relayed to the SWLSHA (or its successor) and other NHS organisations as appropriate. The Communications Directorate will be responsible for informing and updating the Department of Health, which may include the Chief Medical Officer. The Case Manager should ensure that the SUI process and reporting comply with strategic health authority requirements. SUI Information must be provided so that it enters at the top of the South West London SHA flow chart set out in **Appendix 2**. This is the current requirement, however this may alter when the review of London SHAs is complete. If subsequent changes are made to the process by any other strategic authority level NHS body, then this procedure will need to be amended and the amendment agreed by the Trust Board.

4.5 To ensure that a comprehensive record of the incident is maintained (see **Appendix 4**) as part of the FLO's role. Included in this record should be a note describing all information that is given by the LAS to the patients, carers, relatives and families of those involved in the SUI during the SUI investigation and afterwards. Any information given to those potentially affected directly by the incident and/or the public must also be documented.

4.6 To ensure that the SHA, National Health Service Litigation Authority (NHSLA), Health & Safety Executive are kept informed and updated during the progress of the SUI management.

4.7 Ensure the appropriate debriefing and support for all staff involved in the incident.

4.8 Ensure timely and effective dissemination of the final SUI report is made, internally and externally. This report must routinely contain recommendations and an action plan including a time scale for implementation of them.

4.9 See **Appendix 4** for model investigation protocol.

5.0 Reporting requirements

5.1 The Case Manager will convene a meeting of those contributing to the SUI management process in order to prepare a final report for the CEO, Director of Operations, Medsical Director and the Trust Board. . SUIs will be reported to the Trust Board as part of the CEO's report. Every report must include a root cause analysis .and The report will also include details relating to:

- Making recommendations for further action to be taken / lessons to be learnt to prevent recurrence.

- Implementing agreed action measures.

- Ensuring feedback to the patient(s) and/or relatives and/or staff and/or member(s) of the public of the outcome of the investigation and the action taken/proposed. In respect of clinical incidents, in addition to formal written response to the patient/relatives outlining the investigation findings, consideration should also be given to offering a meeting with the senior staff involved in the investigation process

  Note: In the event that, following a SUI, concurrent related internal investigations are ongoing (e.g. disciplinary investigation involving staff), such investigations will not delay the resolution of clinical issues including the final response to patient/relatives or ; agreeing with relevant parties any additional media notification, as necessary/ and appropriate.

- Ensuring that arrangements are in place for the relevant external stakeholders including the SWLSHA and National Patient Safety Agency (NPSA) to be notified of the outcome of the investigation and the actions taken or proposed.

- The CEO and/or relevant Director will be responsible for advising the Trust Board of the outcome of the investigation and the action taken or proposed.

- Monitoring of agreed action measures will be undertaken as part of the wider Incident Reporting System arrangements via the Risk Management Group and/or Clinical Governance Committee, Complaints Panel and for keeping these committees advised of progress against agreed action plans.

The focus of SUI reports will be on delivering outcomes aimed at preventing recurrence and improving patient care. This focus will be monitored by the Complaints Panel to ensure these benefits occur. The SUI Review Group should also include a review reflecting on how it managed the incident, in order to continuously improve the quality and effectiveness of this procedure

6.0 Responsibilities of CEO and Trust Board

6.1 There may be instances depending on the type of incident when it is appropriate to establish a serious incident team independent of the Trust. This decision should be made by the CEO and Trust Board.

7.0 Communications with the LAS Trust Board

7.1 The CEO / Director of Operations will ensure that other Executive Trust Board Directors are informed of the incident and updated on developments.

7.2 The CEO / Director of Operations will inform and liaise with the Chairman of the Trust who will inform Non Executive Trust Directors.

7.3 The resulting report and Action Plan will be disseminated internally and externally as appropriate

7.4 The report and Action Plan will be made available to the LAS Complaints Review Panel to ensure outcomes have been achieved, lessons learned and prevention of reoccurrence noted.

7.5 The Case Manager will be responsible for informing and liaising with relevant Health Authority(s) and provider(s).

7.6 The SUI Review Group will decide on any other organisations to be informed and how and when that will occur.

8.0 Patient and Public Involvement

8.1 ***"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately…. this open approach minimises the trauma they feel."*** (Seven Steps to Patient Safety NPSA 2003)

8.21 All areas of health care are moving towards greater public involvement. It is recognised that this can be a complex matter so the Trust supports this approach in supporting the patient and public involvement by :-

- The FLO visiting the patient/relatives to explain the process to them and to ascertain any questions/issues raised.

- Making available the final report and action plan and offering any advice about the options available in respect of pursuing matters. This should involve a further meeting to explain the report.
- Inviting patients /relatives to be a part of any ongoing development and/or audit

8,23 If a patient /relative does attend a meeting it is suggested that they bring along a 'friend' for support. This person will not be does not need to be actively involved in the review and will need not be a legal representative.

9.0 Media Relations

9.1 The Director or Head of Communications will be responsible for media relations, and liaising with those responsible for media relations in other organisations.(or the Medical Director subject to clinical concerns)

9.2 If the LAS takes a proactive stance on the incident – i.e. the LAS plans to inform the media of the incident before the media is aware, the Director of Communications will ensure that patient(s) and relative(s) are aware of any LAS statement of to the media. This will be done through the appointed FLO.

9.3 Relatives and patients will be notified before any statement is made by the Trust to the media.. Similarly, if the LAS is reacting to media inquiries, the Director of Communications will ensure that patient(s) and relative(s) are aware of media interest and the content of any LAS statement. These functions will usually be facilitated by the appointed FLO.

9.4 No member of staff will provide statements independently of this process.

9.5 For serial incidents and dealing with multiple enquiries the following arrangements will be made:

A 'hot-line' will be set up by the Communications Directorate in accordance with the *CHI/Healthcare Commission's "Guidance for the NHS in Establishing and Running Rapid Response (Telephone) Help Lines" 2003* to deal with all calls coming in from the media and public about the incident. PSU, PALS and Legal Services teams will also be briefed accordingly. The Director of Communications will delegate these arrangements within his directorate so that there is a process to ensure staff are available and skilled to assist. The designated room will be the Communications Directorate Office and will mirror arrangements in the Trust's Major Incident Plan, when SUIs occur that may potentially affect large numbers of people or where serial incidents may occur e.g. exposure/screening problems, terrorist attacks.

9.6 The Director of Communications in liaison with will ensure that the Chief Executive or Director of Operations acts as sole spokesperson for the will appoint a senior representative of the Trust to act as spokesperson for the LAS LAS in the event of a press conference, radio or TV interviews. In the event of the Chief Executive not being available to meet all media facility requests, the Director of Communications, in liaison with the Chief Executive, will decide on a second spokesperson.

References:

The London Ambulance Service NHS Trust Major Incident Plan
Safer Practice Notice 10 National Patients Safety Agency 15 September 2005[1]
Serious Untoward Incident Guidance (South West London SHA – May 2005 – pending ratification).
Incident Reporting Procedure
Complaints Procedure TP/004
The Protocol for the Investigations & Analysis of Clinical Incidents (Prepared by University College Hospital)
C.N.S.T. Standards 2002
NHSLA Standards 2003
Building a Safer NHS for Patients (An Organisation with Memory). April 2001, DoH 23720 1P 2K
Strategic Health Authority SUI policy.
Seven Steps to Patient Safety (NPSA 2003)
Criteria for Assessing Core Standards (Healthcare Commission 2005).

Signature:

Peter Bradley CBE
Chief Executive Officer

Appendix 1

1.0 Standards and Audit Instructions

This audit should be routinely undertaken at the conclusion of an SUI investigation and reviewed by the LAS Complaints Panel.

Standard 1
There will be an up-to-date SUI policy available on Pulse and the LAS website; general instruction publicised in RIB and LAS News; specific memoranda to AOMs and DSOs.
Audit instruction:
Has the above been completed? Check SUI file.

Standard 2
In the event of a SUI being declared, the policy will be adhered to and the checklist completed.
Audit instruction:
Check SUI checklist

Standard 3
Following a SUI a full incident review will take place within 28 working days and a report completed within 45 working days
Audit instruction:
Did a clinical incident review take place? When was the report finalised?. If the incident is non clinical an incident review should still occur. This standard assumes that a root cause analysis would be undertaken routinely as part of every incident review.

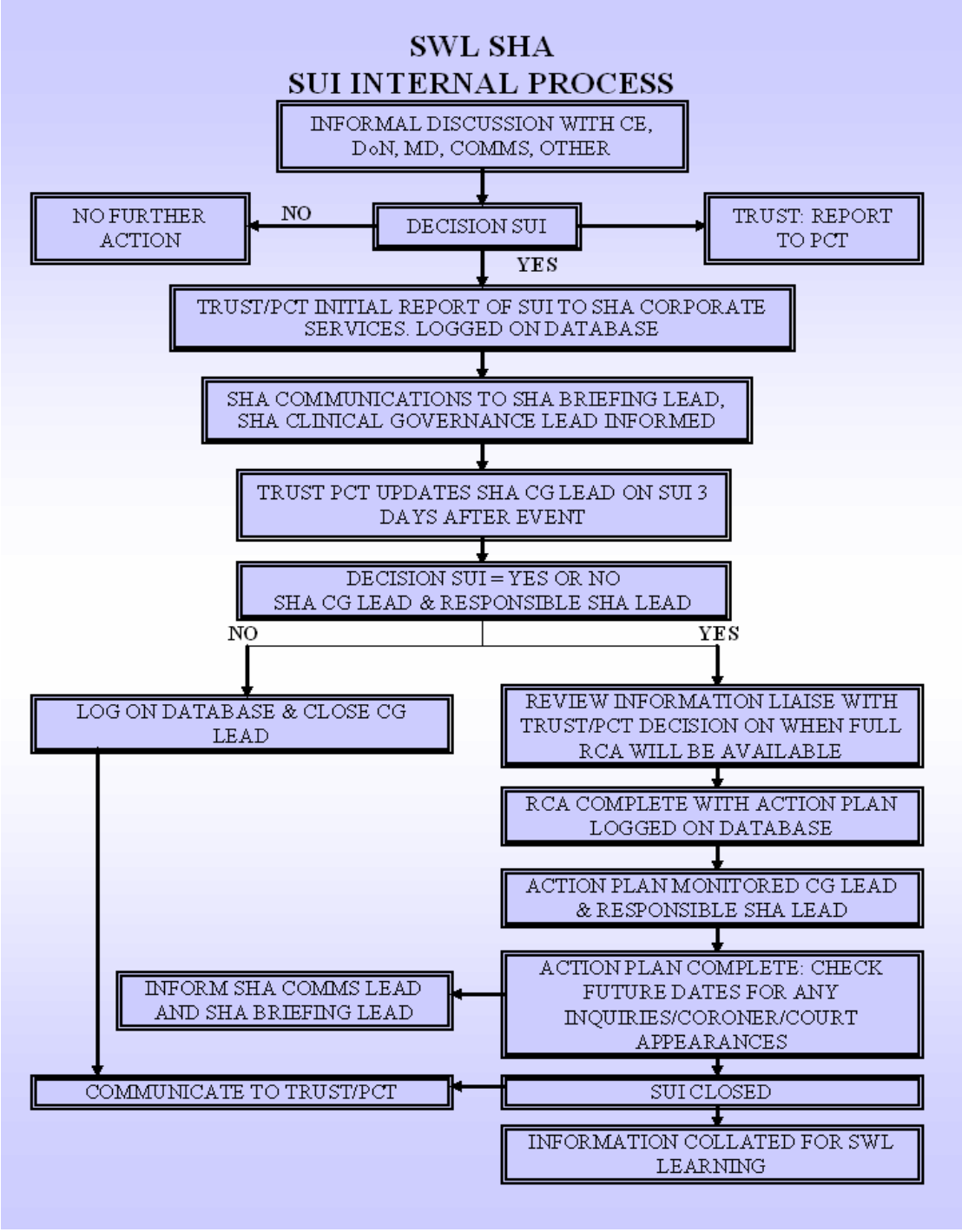
Standard 4
The support needs of those involved (patient, relatives, staff) will be considered immediately and the need for ongoing support reviewed at the point of declaring an SUI
Audit instruction:
Was support offered? Check SUI file; consider employing feedback mechanisms.

Standard 5
Carers/relatives will be offered a named contact for support and information.
Audit instruction:
Were relatives offered a named contact? Check SUI file

Standard 6
The risk management service will notify the Strategic Health of any SUI which meets their criteria within 72 hours*
Audit instruction
Was the SHA informed? Check SUI file

**In extreme cases the Trust will notify the SHA immediately*

Appendix 2


SWL SHA
SUI INTERNAL PROCESS
INFORMAL DISCUSSION WITH CE, DoN, MD, COMMS, OTHER
NO FURTHER ACTION
NO
DECISION SUI
TRUST: REPORT TO PCT
YES
TRUST/PCT INITIAL REPORT OF SUI TO SHA CORPORATE SERVICES. LOGGED ON DATABASE
SHA COMMUNICATIONS TO SHA BRIEFING LEAD, SHA CLINICAL GOVERNANCE LEAD INFORMED
TRUST PCT UPDATES SHA CG LEAD ON SUI 3 DAYS AFTER EVENT
DECISION SUI = YES OR NO
SHA CG LEAD & RESPONSIBLE SHA LEAD
NO
YES
LOG ON DATABASE & CLOSE CG LEAD
REVIEW INFORMATION LIAISE WITH TRUST/PCT DECISION ON WHEN FULL RCA WILL BE AVAILABLE
RCA COMPLETE WITH ACTION PLAN LOGGED ON DATABASE
ACTION PLAN MONITORED CG LEAD & RESPONSIBLE SHA LEAD
INFORM SHA COMMS LEAD AND SHA BRIEFING LEAD
ACTION PLAN COMPLETE: CHECK FUTURE DATES FOR ANY INQUIRIES/CORONER/COURT APPEARANCES
COMMUNICATE TO TRUST/PCT
SUI CLOSED
INFORMATION COLLATED FOR SWL LEARNING

Appendix 3

Family Liaison Officer –role description

The primary focus of the Family Liaison Officer (FLO) is to act as a conduit to convey information to and receive queries from relatives and others concerning an event, which has been declared a Serious Untoward Incident (SUI) by the London Ambulance Service NHS Trust. (LAS). The FLO must always keep a record of any information given to staff, patient(s) and/or relative(s) and the public to comply with the requirements set out in sections 9.3and 4.2 of the SUI Policy.

- The main purpose of the FLO is to keep the service user, relatives ,carers and others with a direct responsibility for their welfare, fully briefed about the progress of the investigation process, how the incident is being managed, and to provide advice relating to the implementation of LAS policy and procedures. The FLO may also offer information about other agencies such as the Healthcare Commission and the Independent Complaints Advocacy Service (ICAS) who can provide advice about the NHS Complaints Procedure.

- The FLO does not have an active role in the investigation of the incident, although the FLO may facilitate communication channels between LAS NHS Trust investigations so that the relationship between them is connected to the chronology of the investigation.

- The FLO must always maintain a contemporaneous summary log of the progress of the incident inquiry including a record of all contacts by LAS NHS Trust staff with the Service User, family, relatives and carers. This record will also be routinely available to LAS NHS Trust staff, complainants, Investigators and representatives of those involved in the incident.

- In the event of a request for information about the SUI from the media, the FLO should immediately refer the enquirer to the Communications Directorate.

- The FLO has no role in advising on or defending the position of the London Ambulance Service NHS Trust (LAS NHS Trust) regarding the Serious Untoward Incident (SUI) in which their staff have been indirectly or directly involved. The FLO is a source of accurate information for the service user, relatives, carers and others with a direct interest in/responsibility for the welfare of those involved in the SUI.

- The FLO should not offer opinion or comment on matters related to the incident or the inquiry into it, to the Service User/complainant/Relative/Carer/ Representative other than to explain the implementation and progress of the application of the LAS NHS Trust SUI Policy process to the incident or the relationship of it to NHS complaints procedures.

- The FLO must always connect and respond in a timely manner with those seeking information, and be able to demonstrate that the parties with a direct interest (as described above) in the welfare of the service user have good access to all appropriate information about the incident. To facilitate this the FLO will hold a minimum of at least one initial meeting with them.

- The FLO must liaise with all departments of the LAS NHS Trust to ensure the information requirements from the incident are addressed and complied with.

SUI Checklist

Appendix 4

The following points must be part of every SUI process undertaken by the LAS. It is by no means exhaustive:

Being Open – This advice reflects the approach to "Being Open" issued by the NPSA[1]

Preliminary meeting with the patient and/or their carers

Who should attend?
A lead member of staff who has completed training with appropriate experience will attend the preliminary meeting with the patient and/or carers.

It is important to ensure that those staff who attend the meetings can continue to do so to aid continuity.

The person taking the lead should be supported by at least one other appropriate member of staff, such as risk manager, medical director or member of the healthcare team treating the patient.

Ask the patient and/or their carers who they would like to be present

Consider each team members communication skills; they need to be able to communicate clearly, sympathetically and effectively.

Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting.

When should it be held?
As soon after the incident as possible.

Consider the patients and/or their carer's home and social circumstances.

Check they are happy with the timing.

Offer them a choice of times and confirm the chosen date in writing.

Do not cancel the meeting unless absolutely necessary.

Where should it be held?
Use a quiet room where you will not be distracted by work or interrupted.

Do not host the meeting near to the place where the incident occurred if this may be difficult for the patient and/or their carers.

Discussion

How should you approach the patient and/or their carers?
Speak to the patient and / or their carers as you would want someone in the same situation to communicate with a member of your family.

Do not use jargon or acronyms: use clear, straightforward language.

Consider the needs of patients with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities.

What should be discussed?
Introduce and explain the role of everyone present to the patient and/or their carer and ask them if they are happy with those present.

Acknowledge what happened and apologise on behalf of the team and the organisation. Expressing regret is not an admission of liability.

Stick to the facts that are known at the time and assure them that if more information becomes available it will be shared with them.

Do not speculate or attribute blame.

Suggest sources of support and counselling.

Check they have understood what you have told them and offer to answer any questions.

Provide a named contact who they can speak to again.

- **Follow – up**

Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines.

The patients notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the patient and/or their carers have been told, and a summary of agreed action points.

Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counselling, as appropriate.

Quick reference guide to *Being Open (NPSA 2005)*

- Obtaining a full set of the contemporaneous records,
- Producing a chronology of events,
- Seeking internal or external clinical advice
- Using management information data
- Identifying the key staff involved in the incident,
- Deciding who needs to be interviewed and the order in which the interviews will take place,
- Ascertaining the final outcome,
- Ascertaining the key problems and when they arose,

- Produce a draft report for the SUI Review Manager to sign off following consultation with the SUI Review Group

Interviews will be undertaken by members of the SUI Review Group following consultation with the Investigation Officer to:

- Establish the chronology and role played by the member(s) of staff and asking each interviewee to identify the main problems without apportioning blame.

- Establish to what extent action was guided by National Clinical Guidelines and,if not, how reasonable it was to depart from those guidelines and protocols.

- Identify the contributory factors e.g. work load, availability of equipment, training and distinguishing the specific and general contributory factors.

An analysis, using ‘root cause’ methodology must always be done of an SUI as stated in the policy to establish at least the minimum facts below

- What happened?
- How did it happen?
- Why did it happen?
- What can be done to change things and prevent it happening again?
- Where and when can the LAS monitor that actions and recommendations from the report have been implemented and improved patient care?

Enclosure 11

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 29TH NOVEMBER 2005

RECORDS MANAGEMENT POLICY

1. Sponsoring Executive Director Mike Dinan

2. Purpose: For approval

3. Summary

This policy is necessary to ensure that the Trust complies with the required statutory and NHS guidelines in the management of its records. It defines a structure for the LAS to ensure adequate records are maintained and managed, lists the objectives necessary to achieve a fully integrated approach to the management of the Trust's records, and outlines the approach to implementation.

4. Recommendation

THAT the Trust Board approves the Records Management Policy

	**London Ambulance Service NHS Trust** **Trust Policy Records Management** **Final Draft November 2005.** **For Use by All Staff**

Introduction

The London Ambulance Service NHS Trust (LAS) is dependent on its records to operate efficiently and account for its actions. This policy defines a structure for the LAS to ensure adequate records are maintained and they are managed and controlled effectively and at best value, commensurate with legal, operational and information needs.

Our organisation's records are our corporate memory, providing evidence of actions and decisions and representing a vital asset to support our daily functions and operations. They support policy formation and managerial decision-making, protect the interests of the LAS and the rights of patients, staff and members of the public who have dealings with the LAS. They support consistency, continuity and efficiency and productivity and help us deliver our services in consistent and equitable ways.

Records management, through the proper control of the content, storage and volume of records, reduces vulnerability to legal challenge or financial loss and promotes best value in terms of human and space resources through greater coordination of information and storage systems.

All NHS records are Public Records under the Public Records Acts and must be kept in accordance with following statutory and NHS guidelines:

- Public Records Acts 1958 and 1967
- Data Protection Act 1998
- Freedom of Information Act 2000
- HSC 1999/053 For the Record
- Standards for Better Health, 2004
- Caldicott Review of Patient Identifiable information, 1997
- Audit Commission, Setting the Record Straight, 1995

This policy relates to all records held by the Trust relating to information, created or received in the course of business, and captured in a readable form in any medium, providing evidence of the functions, activities and transactions of the organisation. They include:

- Administrative records (including personnel, estates, financial and accounting records, contract records, litigation and records associated with complaint-handling),
- Patient health records,
- Photographs, slides, and other images,

- Microform (i.e. fiche/film),
- Audio and video tapes, cassettes,
- Records in all electronic formats,
- Personal data as defined by the Data Protection Act 1998.

They do not include copies of documents created by other organisations such as the Department of Health, kept for reference and information only.

All records created in the course of the business of the trust are corporate records and are public records under the terms of the Public Records Acts 1958 and 1967. This includes email messages and other electronic records.

Objectives

The main objectives of this policy are:

1. Accountability – that adequate records are maintained to account fully and transparently for all actions and decisions in particular:
    - To protect legal and other rights of staff or those affected by those actions
    - To facilitate audit or examination
    - To provide credible and authoritative evidence

2. Quality – that records are complete and accurate and the information they contain is reliable and its authenticity can be guaranteed

3. Accessibility – that records and the information within them can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation

4. Security – that records will be secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled and audit trails will track all use and changes. Records will be held in a robust format which remains readable for as long as records are required

5. Retention and Disposal – that there is a consistent and documented approach to retention and disposal which will include retention and disposal schedules, managed storage, and provisions for permanent preservation of archival records.

6. Systems – that a system or systems are put in place to ensure that Objectives 1-5 are achieved in a fully auditable controlled management environment.

7. Training – that all staff are made aware of their record-keeping responsibilities through generic and specific training programmes and guidance and where significant new systems are introduced, tailored training programmes are put in place to guide staff through the process of change.

8. Performance measurement – that the application of records management systems and procedures are regularly monitored against agreed indicators and action taken to improve standards as necessary

Implementation

This policy will be implemented by a Records Management Strategy which will set out the Programme of work required to achieve the objectives of this policy.

Responsibilities

1. The **Chief Executive** has overall responsibility for ensuring that records are managed responsibly within the Trust.

2. The **Head of Records Management** is responsible for co-ordinating records management **(RM**) in the organisation and identifying key corporate records and providing guidance and advice on their management and retention.

3. **The Senior Management Group** and **Heads** of corporate and clinical departments are responsible for ensuring that the policy is implemented in their directorates and individual departments. They will nominate departmental representatives, who will liaise with the Head of Records Management on the management of records in each directorate.

4. Records management responsibilities will be written into all accountable individuals job descriptions and clear procedures for retention of key records issued. It is the responsibility of **all staff** to ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and with any guidance subsequently produced by the Head of Records Management.

References: Public Records Acts 1958 and 1967
Data Protection Act 1998
Freedom of Information Act 2000
HSC 1999/053 For the Record
Standards for Better Health, 2004
Caldicott Review of Patient Identifiable information, 1997
Audit Commission, Setting the Record Straight, 1995.

Signature:

Peter Bradley CBE
Chief Executive Officer

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

CLAIMS POLICY AND PROCEDURE UPDATE.

1. Sponsoring Executive Directors: Fionna Moore / Michael Dinan

2. Purpose: For approval.

3. Summary

The Claims Policy and Procedure has been updated to incorporate the feedback of the NHS Litigation Authority Assessor that the guidance is required to clearly detail when external agencies are involved in the investigation process and not simply informed.

This requirement has been satisfied by adding section 1.9, the fifth bullet point in Appendix 1 and "When external agencies need to be involved" in Appendix 2.

Two other factual amendments have been added in section 1.1 to reflect the additional service provided by the NHS Litigation Authority on the handling of equal pay claims, and in section 2.1.4 on the excess under the motor insurance.

4. Recommendation

THAT the Trust Board is asked to:

1. To note the factual amendments.
2. To approve the amended policy and procedure.

	London Ambulance Service NHS Trust **Claims Policy and Procedure for Clinical Negligence, Personal Injury, Property and Other Liability Claims** **Circulated To: LAS Departments, All Stations, EOC, PTS, Resource and Training Centres.** **For Use By: All Staff**

Introduction

This policy sets out the revised arrangements for the handling of clinical negligence, personal injury, property damage, and other liability claims against the London Ambulance NHS Trust to comply with the rules and practices for civil litigation. The principal changes arise from the addition of the Appendices outlining the roles and responsibilities for the handling of claims, NHS indemnity and insurance, and the procedure for the handling of claims in clinical negligence, employer / public liability, and property expenses.

The arrangements are modelled specifically on the Clinical Negligence Scheme for Trusts (CNST) Reporting Guidelines Second Edition – April 2002, the NHS Litigation Authority's Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service, April 2004, the rules of the CNST, the Liabilities to Third Parties and the Property Expenses Scheme administered by the NHS Litigation Authority, and the requirements of the Trust's commercial insurers.

The policy will be subject to further review when the outcome of the changes arising from the introduction of the Redress Scheme proposed in the Chief Medical Officer's Report "Making Amends" and the NHS Redress Bill have been determined, and / or other changes to the rules and cover in the NHS Litigation Authority's indemnity schemes are announced.

Definitions

The NHS Litigation Authority define a claim as "allegations of clinical negligence and/or a demand for compensation made following an adverse clinical incident resulting in personal injury, or any clinical incident which carries a significant litigation risk for the Trust. This includes complaints leading to claims, notification of serious adverse events, untoward incidents or accidents, requests for disclosure of records or witness statements, which represent a significant litigation risk. However, defining an incident as a 'claim' in the absence of a demand for compensation does not of itself imply that the NHS Litigation Authority or the Trust accepts that compensation will ultimately be paid. It simply means that a preliminary analysis should be carried out and the matter may need to be reported." (CNST Reporting Guidelines, Second Edition - April 2002).

The NHS Litigation Authority's definition of a claim however, can also be adapted to encompass other claims in negligence and under contract and statute by deleting the word "clinical".

Objectives

The objectives of the Trust Board in the handling of clinical negligence, personal injury, and other liability claims are as follows:

1. To promote higher standards of patient care.

2. To ensure that the right payments are made to the right claimants.

4. To minimise the cost of litigation arising from clinical negligence, personal injury, and other liability claims over time.

5. To initiate a series of improvements, through effective claims handling arrangements and the risk management programme, to reduce the incidents which give rise to claims.

6. To comply with the legal and good practice requirements for NHS bodies in respect of claims and risk management.

1. 0 Board level and other responsibility

1.1 Claims handling

Aside from claims heard by Employment Advisory Tribunals, for which the Director of Human Resources and Organisation Development is responsible, the Director of Finance and Business Planning is responsible for the handling of liability and property expenses claims and through the Risk Management Committee will keep the Trust Board informed on major developments and progress. The Trust has informed the NHS Litigation Authority that advice and assistance with the conduct of equal pay claims will be sought from the Authority. The Head of Legal Services, who manages liability claims, reports directly to the Director of Finance and Business Planning and supports the Director of Human Resources and Organisation Development and the senior managers in the handling of Tribunal claims. The Head of Estates also reports to the Director of Finance and Business Planning and manages claims relating to the LAS estate. The claims handling responsibilities for the Head of Legal Services and the Head of Estates are summarised in Appendix 1.

All claims for compensation arising from allegations of clinical negligence are passed to the NHS Litigation Authority. The Trust has a nil excess for claims that fall within the Clinical Negligence Scheme for Trusts and authorisation from the NHS Litigation Authority is required before admissions are made or monetary compensation may be offered. The Head of Legal Services is the Trust's nominated representative for managing clinical negligence claims and is responsible for ensuring that the NHS Litigation Authority's guidance on conducting a preliminary analysis and reporting of clinical negligence claims is followed when there is a significant litigation risk.

A significant litigation risk may arise:

- Where an untoward incident or obstetric emergency has been assessed as high priority.

- Where the possible breach of duty may lead to a potential large value claim with damages of over £250,000 that is likely to generate substantial media interest.

- Where there has been an allegation of professional misconduct.

- Where the preliminary analysis to a report for disclosure of records indicates that a claim may be pursued.

- Where following a complaint investigation the response indicates that an admission of liability has been implied.

- When a Rule 43 Report is received from a Coroner, following an Inquest, recommending action to be taken by the Trust to prevent fatality.

Where the litigation risk is not covered by the NHS Litigation Authority indemnity schemes or by commercial insurance the conduct of the claim will be managed in accordance with the delegation of authority in 2.0 below.

After reporting a claim to the NHS Litigation Authority or commercial insurer the Head of Legal Services will maintain close liaison to assist with future conduct including keeping interested parties informed about the key stages reached, the selection of experts, and advice on the Trust's position on the admission on breach of duty and liability. The procedure for the management of clinical negligence, liability, and property expenses claims is described further in Appendix 2.

1.2 Links to other policies and procedures

The arrangements for effective claims handling require potential claims to be identified as early as possible to permit a thorough investigation before a letter of claim is received. In this the following play a vital role:

- The Risk Management Framework and associated documents including the Accident / Incident Reporting Policy and the Procedure for Rapid Follow-up of Serious Untoward Incidents

- The Complaints Procedure

- The Policy for Access to Health Records, Disclosure of Patient Information, Protection and Use of Patient Information

- Procedure for Responding to Enquiries and Giving Evidence at Coroners Inquests and Police Interviews

- The Information Management and Technology Security Policy.

- Memorandum of Understanding Investigating patient safety incidents (unexpected death or serious untoward harm) : a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive

1.3 Risk Management

The responsibilities for risk management, and Clinical governance are set out in the Risk Management Framework, the Clinical Governance Development Plan, and the Clinical Governance Annual Report. In these documents the Chief Executive Officer together with all other Board members have overall responsibility for the risk management process.

The Risk Management Framework states that a root cause analysis will be conducted on all accidents / incidents and complaints assessed as high priority. The root cause analysis report will provide a factual account of the investigation with recommendations based on evidence and will be passed to the NHS Litigation Authority by the Head of Legal Services where it is concluded that there is a significant litigation risk.

The Incident Reporting Procedure sets out the requirements for the reporting and investigation of untoward incidents and accidents including the reporting to external agencies such the Police, Health and Safety Executive, National Patient Safety Agency, Medical Devices Agency and the South West London Strategic Health Authority.

1.4 Complaints

The Complaints Procedure sets out the arrangements to investigate and respond to complaints in accordance with the NHS Executive's requirements and good practice. The Head of Legal Services is alerted where there is an intimation that a claim may be received and will liaise with the NHS Litigation Authority or motor insurer over the response.

1.5 Access to Health Records and assistance / attendance at Coroners' Inquests

The Policy for Access to Health Records, Disclosure of Patient Information; Protection and Use of Patient Information details the arrangements for providing access to health records in accordance with the Data Protection Act 1998 and Access to Health Records Act 1990.

The Procedure on Responding to Enquiries and Giving Evidence at Coroners' Inquests and Police Interviews details the arrangements for obtaining witness evidence from staff sought by Coroners, the police and others.

1.6 The Information Management and Technology Security Policy

The Information Management and Technology Security Policy sets out the responsibilities for promoting and maintaining information security throughout the LAS estate.

1.7 The Role of the Medical Director

The Medical Director provides the initial medical assessment on whether the duty of care may have been breached and causation established of all notified potential and actual claims for clinical negligence. The Medical Director's advice also identifies what further medical expert advice may be required.

The Medical Director has a key role in determining the extent to which LAS employees may have caused or contributed to a particular injury or loss to enable the claim to be managed in accordance with the civil litigation rules and NHS Litigation Authority's CNST Reporting Guidelines. The Medical Director's report will state when it is made in response to actual or contemplated litigation.

1.8 The Head of Education and Development

The Head of Education and Development provides an assessment on the care and assistance provided by staff and whether this was in accordance with the Trust's protocols, procedures, training, or with National Clinical Guidelines and whether the care provided fell below an acceptable standard leading to the allegations made. The Head of Education and Development's report will state when it is made in response to actual or contemplated litigation.

1.9 Memorandum of Understanding and the involvement of external agencies

The Memorandum of Understanding Investigating patient safety incidents (unexpected death or serious untoward harm): a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive was issued for consultation between July and September 2004 by the Department of Health. The Trust fully supports the Protocol and will work with the Police, Health and Safety Executive, HM Coroners, other NHS Trusts, Foundation Trusts, and Primary Care Trusts in compliance with the Protocol to ensure that all relevant organisations are involved in the investigation process.

2. 0 Delegated Authority

2.1 Delegated Authority to the Trust

NHS Trust Boards delegated authority to make special payments is determined by the nature of the claim, the date of the incident from which the claim arose, and the insurance / NHS Litigation Authority indemnity in place at the time. The following apply to the LAS:

2.1.1 Employer and public liability claims (excluding motor claims) up to 31/5/99

Under the commercial insurance arrangements the LAS has a liability to pay up to the excess of £10,000. The LAS has delegated authority to pay up to level of excess.

2.1.2 Employer and public liability claims (excluding motor claims) after 31/5/99

Under the Risk Pooling Scheme for Trusts (which includes the Liabilities to Third Parties Scheme and the Property Expenses Scheme) the LAS has delegated authority to settle claims up to the excess (£3,000 for public liability, £10,000 for employer liability, and £20,000 in respect of claims concerning plant, machinery, contents, and buildings) provided that this authority has not been relinquished to the NHS Litigation's Sub Excess Claims Handling Service. For claims above the excess similar rules apply to the settlement of clinical negligence claims.

2.1.3 Claims under contract and statute after 31/5/99

The Liabilities to Third Party Scheme does not provide cover for claims made under contract or statute including claims heard by an Employment Advisory Tribunal and the Trust is not permitted to obtain commercial insurance. The LAS has delegated authority to make payments in respect of these claims as follows:

- Under legal obligation — IN FULL
- Ex-gratia payments following legal advice — £1,000,000
- Ex-gratia payments without legal advice — £50,000

2.1.4 Motor claims

The LAS has a liability to pay up to £50,000 for each and every claim involving the main fleet from 1 August 2005. Claims against the motor insurance above the excess are the liability of the motor insurer, who holds the authority to negotiate settlement, once approval has been given by the Trust to make an admission of liability.

3.0 Delegated Authority to Directors and Officers within the Trust

Within the limits under 2.0 the LAS Trust Board has delegated authority to:

- Directors to make ex-gratia payments up to £1,000 subject to a report to the Director of Finance and Business Planning.

- The Head of Legal Services to admit liability and / or agree to settle personal injury and other liability claims under contract and statute up to £10,000 where legal advice or advice from the NHS Litigation Authority has been obtained or the insurers have made a recommendation.

- The Director of Finance and Business Planning and Director of Human Resources and Organisation Development to admit liability and / or agree to settle personal injury claims and other liability claims under contract and statute over £10,000 up to £50,000 where legal advice has been obtained and the case is not covered by insurance.

- The Chief Executive Officer and Director of Finance and Business Planning to admit liability and / or agree to settle personal injury claims over £50,000 up to £1,000,000 including costs where this is not covered by insurance or the Liabilities to Third Parties Scheme when legal advice has been obtained.

- The Director of Human Resources and Organisation Development to settle Tribunal claims up to £10,000 where legal advice has not been obtained and up to £50,000 where legal advice has been obtained.

- The Chief Executive Officer and Director of Finance and Business Planning to settle Tribunal claims up to £1,000,000 subject to legal advice and a report from the Director of Human Resources and Organisation Development.

- The Director of Finance and Business Planning to settle claims that would fall within the terms of the Property Expenses Scheme up to the current level of excess (£20,000).

All special payments above the limit delegated to the Trust Board will require written approval from the NHS Litigation Authority. Payments in excess of £2,000,000 also require the approval of the Treasury.

4.0. Obtaining legal advice

Legal advice will be obtained from Panel Solicitors in accordance with the Scheme of Delegation for Legal Services and Standing Orders approved by the Trust Board.

The Head of Legal Services will obtain legal advice on claims against the LAS when necessary and advice is not available through the NHS Litigation Authority. Generally legal advice will only be obtained in respect of claims subject to the fast track or multi track procedures which are below the excess for the Liabilities for Third Parties, or are not covered by insurance, or for Coroners' Inquests or a public inquiry where it is advised that criticism may be expressed and / or there is a requirement for the Trust to be legally represented for equality of arms.

When it is necessary to obtain legal advice on conducting a detailed investigation or root cause analysis of a potential large value clinical negligence claim with damages of over £250,000 the Head of Legal Services will ascertain whether this may be treated as a cost of the claim by the NHS Litigation Authority or an expense to the Trust.

When legal advice is sought in respect of a claim the adviser will be asked to give clear advice upon:

- liability and causation;

- the strength of the defence and the probability of successfully defending the claim;
    - the likely assessment on the award of quantum damages;
    - the forecast legal costs of defending the claim including the claimant' s costs;
    - the future conduct of the claim including the use of mediation, Alternative Dispute Resolution and the initiation of Third Party proceedings.

5.0. The Rules for Civil Litigation

The rules for civil litigation, which came into effect on 26 April 1999, introduced protocols for clinical negligence and personal injury claims. The protocols require inter alia:

- Records to be disclosed within 40 days in accordance with the Data Protection Act 1998.

- A letter of claim to be acknowledged within 14 days.

- A detailed and binding response to a letter of claim to be given within 3 months.

- Disclosure statements certifying that the search for documents has been carried out to the best of the signatory's ability.

- Statements of Truth to be signed on all documents submitted in connection with the claim including the Defence and witness statements.

The responsibility for complying with the civil litigation procedures lies with the Director and manager responsible for dealing with the claim, the NHS Litigation Authority, and with the LAS's commercial insurers.

Disclosure statements may be signed by:

- All Directors
- The Head of Legal Services
- Senior Managers in Human Resources
- The Head of Estates
- Other senior managers selected by Directors or the Head of Legal Services

Statements of Truth may be signed by the above, aside from witness statements which must be signed by the individual making the statement.

6.0 Reports to the LAS Trust Board

The LAS Trust Board and Directors through the Risk Management Committee and the Risk Management Group, will receive a report every 6 months which provide:

- the number, classification, and aggregate value of clinical negligence, personal injury and other liability claims against the Trust;

- summary information on the final outcome of clinical negligence, personal injury, and other liability claims against the Trust and remedial actions taken or proposed as a consequence of those claims.

7.0 Reports to the NHS Litigation Authority

When a significant litigation risk is established for which indemnity is available by the NHS Litigation Authority Clinical Negligence Scheme for Trusts, Liabilities to Third

Parties or Property Expenses Schemes and the valuation of the possible claim is above the Trust's excess limits the matter becomes reportable to the NHS Litigation Authority.

8.0 Review

This policy will be reviewed two-years after approval by the Trust Board or following the publication of the new Rules for the NHS Litigation Authority indemnity Schemes and / or legislative changes pertinent to the handling of claims within these Schemes. Amendments to the policy will be submitted to the Trust Board for approval.

References:

Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Services , NHSLA, April 2004
Access to Health Records Act 1990
Data Protection Act 1998
Pre-action Protocols for Personal Injuries and the Resolution of Clinical Disputes,
CNST Reporting Guidelines Second Edition – April 2002, NHSLA
Rules for the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties and the Property Expenses Scheme
HSC 1998 /183 Handling Clinical Negligence Claims
HSC 1999/021 Insurance in the NHS : Employers / Public Liability and Miscellaneous Risk Pooling
Memorandum of Understanding, DOH, July 2004
TP/004 - Complaints Procedure
TP/005 – Risk Assessment Framework
TP/009 – Policy for Access to Health Records, Disclosure of Patient Information; Protection and Use of Patient Information.
TP/015 - Responding to Enquiries and giving evidence at Coroners' Inquests
Information Management and Technology Security Policy
H&S / 011 – Incident Reporting Procedure

Signature:

Peter Bradley CBE
Chief Executive Officer

Appendix 1

Roles and Responsibilities for the Handling of Claims, Indemnity and Insurance

1. Claims

The Head of Legal Services supported by the Claims Co-ordinators and Road Traffic Accident Claims Assessor and Administrator Incidents / Claims is responsible for managing litigation in clinical negligence, employer / public liability, and motor liability in accordance with the Trust's Policy and Procedures for such claims. This will include:

- Receiving, assessing, acknowledging receipt of all new claims and identifying the relevant liability insurer / indemnity provider.

- Providing disclosure of health records to Claimants' solicitors in accordance with the requirements of the Data Protection Act 1998 and Access to Health Records Act 1990 for deceased patients, the Pre-action Protocol for the Resolution of Clinical Disputes, and the Trust's Policy for Access to Health Records, Disclosure of Patient Information, Protection and Use of Patient Information.

- Investigating whether there are or may be grounds for a claim against the Trust, including obtaining detailed factual witness statements, identifying relevant protocols / procedures / guidelines, obtaining the opinions of the Head of Clinical Training and Development (or other relevant Head) on the standard of care provided and the Medical Director on causation where there are / may be grounds for allegations of clinical negligence.

- Producing a Preliminary Analysis, Claim Report Form and paginated bundle of documents for submission to the NHS Litigation Authority where it is concluded there are grounds for reporting an incident or claim, in accordance with the reporting requirements of the Clinical Negligence Scheme for Trusts and Liabilities to Third Parties Scheme, now part of the Risk Pooling Scheme for Trusts.

- Liaising with external agencies including the Police, Primary Care Trusts, NHS Trusts, and Foundation Trusts, Strategic Health Authorities, in connection with the investigation of claims involving the Trust as a potential co-defendant, including representing the Trust at "Gold Meetings" or meetings of an Incident Co-ordination Group. Typically "Gold Meetings" may be convened following the declaration of a Serious Untoward Incident involving NHS bodies and the police to ensure that there is a forum for communicating, exchanging information and co-ordinating multiple investigations.

- Reporting claims under the Trust's motor insurances to the motor insurer where a third party is involved or the accident damage is above the excess level. The Claims Guidelines under the current motor insurances provide that the insurer must be notified *as soon as you become aware of a claim or a circumstance or event which could give rise to a claim.* To encourage prompt

reporting Key Performance Indicators are reported quarterly to Ambulance Operations Managers and Patient Transport Service Managers.

- Establishing and maintaining contact with Trust staff (and former staff) assisting with the conduct of a claim in clinical negligence, employer / public / motor liability to ensure that they are updated on progress and outcome, are supported as necessary, and involved in the review of risk management action at file closure.

- Liaising with the NHS Litigation Authority Case Managers for the Clinical Negligence Scheme for Trusts and Liabilities to Third Parties Scheme, Panel Solicitors and instructed Counsel, the motor insurer and instructed solicitors / Counsel, and the former employer / public liability insurer and instructed solicitors (on claims arising from incidents before 1 June 1999) on the further investigation and strategy for the conduct of the claims, including the instruction of experts and assessment of witness evidence.

- Receiving quarterly and ad hoc reports on the reserves for employer / public and motor liability claims and advising the Financial Controller of the sums to be included in accounting provisions.

- Receiving, reviewing and authorising the payment of legal fees invoiced by panel solicitors, the NHS Litigation Authority for below excess costs incurred under the Liabilities to Third Parties Scheme, and invoices from the motor insurer for below excess motor liability payments.

- Using the integrated risk management data base to produce reports on the management of claims and risk management action taken / proposed as stated in paragraph 6 of the Policy.

- Conducting multi-disciplinary round table reviews on the risk management action taken and proposed and presenting a report to the Clinical Risk Group (on closed clinical negligence claims / incidents), the Corporate Health and Safety Group (on closed employer / public liability) claims, and the Motor Risk Group and Vehicle and Equipment Working Group (on closed motor liability claims).

- Conducting a quarterly joint review with the Trust's motor insurer of claims with an estimated reserve of over £10,000 under the Trust's motor insurance and an audit of 10% of all closed claim files.

- Advising the Head of Professional Standards Unit and others on the investigation of and response to complaints and serious untoward incidents where there may be grounds for a claim or an inquest or public inquiry may be held or other parallel investigations undertaken in accordance with the Memorandum of Understanding issued by the Department of Health.

- Meeting the Head of Professional Standards Unit monthly to review complaints where parallel investigations may be / are being undertaken.

- Attending round table meetings with the Trust's Medical Director and other senior managers to explain to Claimants and their legal advisers of the risk management action taken following the incident that gave rise to a claim.

The Head of Estates is responsible for the handling of claims under the Property Expenses Scheme for damage, loss, or destruction of the Trust's property or estate and will report and investigate such claims in accordance with the rules of the Scheme.

The Financial Controller, supported by the Senior Financial Accountant, is responsible for submitting a summary loss report, which includes below excess losses to the Trust property and estate under the Property Expenses Scheme.

2. Indemnity and Insurance

The NHS (Clinical Negligence Scheme) Regulations 1996 which established the Clinical Negligence Scheme for Trusts, defined clinical negligence as " a liability in tort owed by a member to a third party in respect of or consequent upon personal injury or loss arising out of or in connection with any breach of duty of care owed by that body to any person in connection with the diagnosis of any illness, or the care or treatment of any patient, in consequence of any act or omission to act on the part of a person employed or engaged by a member in connection with any relevant function of that member".

Heath Service Guidelines HSG 96/48 set out the NHS Indemnity Arrangements for clinical negligence claims in the NHS. An executive summary with questions and answers about the applicability of NHS indemnity is available from the NHS Litigation Authority website at www.nhlsa.com

The Head of Legal Services is the nominated representative for the Trust to liaise with the NHS Litigation Authority on enquiries about NHS indemnity and coverage by the Clinical Negligence Scheme for Trusts.

The Financial Controller is responsible for providing financial information to the NHS Litigation Authority for the assessment of the annual contribution to the Clinical Negligence Scheme for Trusts.

Health Service Circular HSC (1998) 174 announced that NHS Trusts could not obtain commercial insurance except for specialist areas including the motor fleet, motor traders, airside liability, engineering inspection, income generation, and Public Finance Initiative Schemes.

The Head of Legal Services and Financial Controller are responsible for advising the Director of Finance and Business Planning on the appropriate level of specialist insurance to hold and answering enquiries about such insurances. The Head of Legal Services and Financial Controller are assisted by the Trust's broker Marsh UK Ltd.

The Head of Legal Services and Financial Controller hold the Summary of Insurances and insurance policies since Trust status was achieved in April 1996. These documents contain the excess levels and other conditions which apply for the term of insurance.

Health Service Circular HSC (1999) 021 announced the provisions of the Liabilities to Third Parties Scheme and the Property Expenses Scheme. The Membership Rules can be obtained from the NHSLA web site or alternatively from the Head of Legal Services.

The Head of Legal Services and Financial Controller seek the advice of the Willis Helpdesk on enquiries about the administration and indemnity cover provided under the Liabilities to Third Parties Scheme and the Property Expenses Scheme.

The LAS Patient Advice and Liaison Service (PALS) operates to advise and support service users, their families or carers, the general public and health and social care professionals in their respective care journeys and contacts with Trust services.

The LAS affords equal value to PALS, Professional Standards Unit (PSU) and Legal Services as mechanisms for achieving organisational change and improving patient care by creating learning opportunities arising from concerns brought to the Trust.

It is the choice of the individual whether to use PALS or the formal NHS Complaint procedure. Enquirers maintain the right to pursue a complaint at any stage – most usually if they remain dissatisfied at the conclusion of PALS enquiries.

Appendix 2

Procedures for Handling Claims in Clinical Negligence, Liability, and under the Property Expenses Scheme

1. Clinical Negligence

Identifying a claim or potential claim

A claim is defined under definitions in the Policy, and is generally received as a Letter of Claim, but may also be by issue of a Claim Form and Particulars of Claim.

A potential claim is distinguished from a claim by an indication that a claim is being considered by a Claimant or following the investigation of an untoward incident in which a patient suffered harm or loss which may have been caused by a negligent act or omission by Trust staff and a claim may follow. Potential claims may be received as a request for records about the treatment of the patient, a complaint under the NHS Complaints Procedure, a communication with a Coroner's Officer indicating that the family of the deceased will be legally represented at the Inquest and may be critical of the Trust and / or the death occurred in custody.

A claim may also arise from an enquiry to PALS in the same manner as a complaint to Professional Standards Unit (PSU). Close collaboration between PALS, PSU and Legal Services works to ensure a coherent and seamless approach to resolving issues of concern brought to the LAS by service users, members of the public, professional colleagues, etc, and by using the appropriate mechanisms as described in this policy.

Claims and potential claims are recorded on the claims module of the integrated data base for risk management.

Investigating a claim or potential claim

Obtain all available information that may be pertinent, including the call records, contemporaneous treatment protocols and clinical guidelines, witness statements, and the opinions of the Head of Education and Development on the duty of care owed and Medical Director on whether the duty of care may have been breached and causation is likely to be established. To establish a claim in negligence it is necessary to show that:

- the Defendant owed a duty of care to the person treated;
- the standard of care appropriate to the duty was not attained and therefore the duty was breached by action, inaction, advice or failure to advise;
- the breach must be demonstrated to have caused the injury and the resulting loss complained about;
- any loss sustained as a result of the injury and complained about is recognised by the courts as compensatable; and

- the injury and resulting loss complained about was reasonably foreseeable as a consequence of the breach.

When external agencies need to be involved

When investigating a claim or potential claim it becomes apparent that there may be allegations concerning another NHS body, a copy of the untoward incident investigation and other relevant documents will be requested to enable the Medical Director give a rounded judgement on breach of duty and causation.

When an Inquest is opened following the death of a person in custody and the Trust is an interested party, the Trust will conduct its own investigation and provide assistance to the Police and HM Coroner Inquiries, including but not limited to contributing to the pre- Inquest meetings and Gold Meetings, and facilitating investigations by the Police.

When investigating a patient safety incident involving death or serious untoward harm the Memorandum of Understanding will be followed as stated in section 1.9.

Reporting a claim or potential claim

- All claims must be reported to the NHS Litigation Authority (Croydon Office for claims up to £25,000 and the London Office for claims over £25,000) in accordance with the CNST Reporting Guidelines. This will include:

- untoward incidents involving the treatment of patients which have been assessed as having a high priority risk by application of the LAS Risk Prompt and Scoring Matrix;

- claims arising from a complaints investigation and response that may be interpreted to have implied an admission of liability;

- requests for the disclosure of records which have triggered the requirement to undertake a Preliminary Analysis investigation which in turn has indicated that it is possible a claim may follow with a significant litigation risk;

- letters of claim or Proceedings which are the first indication of action.

Prior to reporting a potential claim advice may be sought from the Team Leader at the NHS Litigation Authority on whether the incident should be reported.

A Preliminary Analysis will be prepared for all claims and potential claims reported to the NHS Litigation Authority. Where possible the Preliminary Analysis will be submitted within 40 days of the notification / identification of a claim. The Preliminary Analysis Report written in contemplation of litigation will include:

- a synopsis and chronology,
- an outline of the care management problems,
- the Trust's opinion on breach of duty,
- the opinion of the Trust's Medical Director on causation,

- an estimate of quantum,
- a suggested strategy for future conduct and assessment of the litigation risk,

All as required in the CNST Reporting Guidelines.

Responding to a claim or potential claim

A letter of claim will be acknowledged within 3 days of receipt and forwarded to the NHS Litigation Authority within one working day. Any additional information to the Preliminary Analysis Report that is relevant will be provided to the Case Manager / instructed Panel Solicitor with the Letter of Claim or an indication of what is being sought and will follow.

The Trust's response to the allegations of breach of duty and causation will usually be provided in the Preliminary Analysis Report. Where there has been a late notification or identification of the claim, for example when protective proceedings are issued near to limitation, the Trust's position will be given separately as agreed with the Case Manager / instructed Panel Solicitor.

A draft detailed response to a letter which is not a letter of claim commenting on the allegations of negligence and Medical Director's opinion on breach of duty and causation may be prepared and discussed with the Case Manager at the Litigation Authority when it is appropriate for the response to come from the Trust.

The management and conduct of the claim

The CNST Reporting Guidelines state that if it is proposed to make an admission of liability agreement will be obtained from the Trust first and the Trust will be advised if settlement is to be negotiated. The authority to make an admission of liability is stated in 3.0 Delegated Authority to Directors and Officers within the Trust.

The Trust will provide every assistance to the NHS Litigation Authority / instructed Panel Solicitor in obtaining timely opinions and conducting further investigations in support of the conduct of the claim.

Keeping interested parties informed and supported

When staff are asked to prepare a witness statement for a claim they will be supported by one or more of the following:

- Legal Services,
- Line manager / team leader / duty officer,
- Emergency Operations Centre (EOC) Sector Operations Officer / nominee,
- PTS Manager,
- Education and Development.

Staff who give witness statements will be kept informed of the key stages in the claim.

Where expert reports on breach of duty and / or causation are provided these may be shared with the Medical Director, Head of Education and Development, or other

senior manager who has contributed to the Preliminary Analysis, for comment or where there are criticisms of the Trust.

When a claim proceeds to trial staff giving witness evidence will receive support through line management and Legal Services both in the conferences before trial and at trial. Additionally if staff so wish they may choose to be accompanied by their union representative. It has been identified in round table review that staff may feel unsupported if line management are not aware / in attendance at key meetings before trial and that it is not sufficient to ensure that staff understand their role as a witness and the legal process.

All staff have access to the Employee Assistance Programme providing confidential information, advice, and support on a 24 hour year round basis.

Mediation / Alternative Dispute Resolution

Mediation and other forms of alternative dispute resolution are actively promoted by the NHS Litigation Authority in suitable cases. Mediation involves the use of a trained mediator, who is a neutral third party, to assist the parties to a dispute to find a mutually satisfactory outcome. Claims of relatively limited financial value, but possessing other major emotional elements, such as the death of a child, might be suitable for mediation. Potentially however, all cases may benefit from mediation or alternative dispute resolution at any stage up to trial.

"The Clinical Disputes Forum's Guide to Mediating Clinical Negligence Claims" July 2001, available from the NHS Litigation's website www.nhsla.com provides more detailed guidance on what mediation is, when it should be considered, and how the process should be used to reach a satisfactory outcome for all concerned in a clinical dispute.

Closure and round table review

A quarterly round table review of closed claims and potential claims is conducted to review the outcome action plans and determine the recommendations to be submitted in the quarterly report to the Clinical Risk Group. The outcome action plan identifies what feedback has been given / is planned to individuals / their teams / Trust wide, together with any recommendations about training, procedures or protocols, or new equipment.

2. Liability Claims

There is an obligation under the Liabilities to Third Parties Scheme to report to the NHS Litigation Authority:

- All incidents where a Letter of Claim is received and the estimated value of damages and costs exceeds £3,000 for claims under Public Liability and £10,000 for claims under Employer Liability.

- All incidents which have or are likely to result in any of the following:
  - death
  - amputation of a limb
  - major head injury
  - absence of work of more than 10 consecutive days
  - Health and Safety Executive prosecution
  - Involvement of the media or politician
  - Multiple claims from a common or single cause
  - Novel, contentious, or repercussive claims.
  - Part 36 Offers.

As caseload and other workload permit claims with an initial estimated value, inclusive of costs, within 20% of the excess sums above may be managed by Legal Services in accordance with the delegated authority by the Trust Board. Where claims are passed to the NHS Litigation Authority Legal Services will work with the Case Manager appointed by the NHS Litigation Authority to ensure that all relevant documentation is obtained including, the incident report and investigation, a schedule of pre and post accident earnings, training records, risk assessments, equipment inspection and repair records, premises inspection reports, policies and procedures, Occupational Health and personnel records. In addition Legal Services will assist the Case Manager to obtain witness statements.

Personal injury claims are governed by the Protocol for Personal Injury Claims. Under the Protocol for Personal Injury Claims a Claimant is required to send a Letter of Claim providing a summary of the facts, the allegations, and details of injury or loss. The Letter of Claim should also identify which documents are sought for disclosure.

The Defendant has 21 days to acknowledge the Letter of Claim and three months to provide a Letter of Response. The Letter of Response should include an admission of liability or denial (with reasons), together with the documentation requested to be disclosed that is held and available.

The Pre-Action Protocol for Personal Injury Claims encourages the use of jointly appointed experts and the disclosure of the Claimant's expert Medical Report to the Defendant. The Defendant may submit questions to the Claimant's medical expert, accept the Report, or obtain a Medical Report from another medical expert in accordance with the Civil Procedure Rules on the instruction and appointment of expert witnesses.

A Claimant's Offer to settle is known as a Part 36 Offer and can be made with the Letter of Claim, supported by the Medical Report, Schedule of Loss and other relevant documentation. A Response to a Part 36 Offer is required within 21 days. If a Part 36 Offer is rejected but is later successful punitive costs may be awarded against the party who rejected the Part 36 Offer.

Similar arrangements to keeping interested parties informed and supported will be followed to those described above for clinical negligence claims apply to liability claims.

Mediation /Alternative Dispute Resolution will be considered in appropriate cases as outlined for clinical negligence claims.

The Corporate Health and Safety Group, Motor Risk Group, and Risk Management Group will receive quarterly multi disciplinary reports on the review of closed claims identifying the risk management actions taken and proposed. In addition these Groups will receive analyses of the claims data to inform on the progress in managing the Trust's Risk Register.

3. Property Expenses

There is an obligation for all member Trusts to report to the NHS Litigation Authority under the Property Expenses Scheme:

- All claims where the estimated value will exceed the delegated excess of £20,000 for buildings and £20,000 for contents.

- All claims that are within 20% of the delegated excess levels.

All claims with a potential value above the delegated excess and for which indemnity is sought must be handled by the NHS Litigation Authority. Where the potential value subsequently reduces to a level within the delegated excess the claim will continue to be handled by the NHS Litigation Authority until conclusion without the levy of a handling fee for the Loss Adjuster's work.

Claims below the delegated excess may incur a Loss Adjuster's fee.

Enclosure 13

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

CAD 2010 USER REQUIREMENT & THE WAY FORWARD.

1. Sponsoring Executive Director: Peter Bradley
2. Purpose: For approval.
3. Summary

On 22 February 2005 the SDC (Service Development Committee) approved a paper entitled "CAD – The Way Forward". The paper proposed a two-phased approach to the problems and frustrations experienced with the existing CAD environment over recent years. Phase 1 was referred to as dealing with the "Immediate Requirements". Phase 2 referred to a new CAD environment, identifying where the Trust needs to be by 2010. This paper refers to the second of those initiatives, known as the CAD 2010 Phase 2 Project.

Stage 1 of this project was described in that initial paper as "Procurement Preparation" with the intention to …

"define the user requirement, conduct market research (including looking at the existing Ambulance CAD products) and produce a business options report recommending how the new environment should best be provided …".

The objective of this paper is to deliver to the Trust Board against these intentions, and set out the plans for proceeding.

The results of the analysis are encouraging, indicating a comprehensive approach to requirements capture. It has however undermined the original concept of being able to implement an existing Ambulance CAD solution. Initial research of the existing Ambulance CAD market place does not identify a product that would meet the needs (even adopting the 80-20 rule) of the LAS. Indeed, there are indications that some products would provide less functionality that the current system.

The Business Options Report identifies that at this stage of analysis the best solution for a new CAD is by a commercial procurement, seeking to engage suppliers to work with the LAS to adapt (potentially with some development) and integrate existing products. Given the complexity and potential scale of what is required, the project is proceeding on the assumption that the business case will require approval by the SHA. Plans next year therefore include provisions for the Strategic Outline Case and the Combined Business Case that will require appropriate SHA approval.

Recommendation: THAT the Trust Board:

1. Note the delivery of the project against the plan and the progress to date.
2. Note the scale and complexity of project (being far greater than that first envisaged).
3. Approve the project approach for the period December 2005 to July 2006.
4. Approve the user requirements, noting there is yet work to do to refine these further.
5. Approve that the project should proceed assuming that its scope will require SHA authority

The report regarding CAD is on the LAS web site as a separate document along with 3 accompanying supporting documents.

➢

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 29 November 2005

SERVICE IMPROVEMENT PROGRAMME UPDATE

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

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

4. Recommendation

THAT the Trust Board note the progress made with the Service Improvement Programme.

SERVICE IMPROVEMENT PROGRAMME UPDATE

1. Purpose

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

2. Overall progress

Currently there are 283 items within the SIP of which 56 are live. Overall 19 Outcomes are green, 12 amber and 9 red to be achieved at the end of the SIP in March 2006.

3. SIP Outcomes

Assessment of the effectiveness of the SIP is demonstrated through progress in achieving the 40 Outcomes identified for People, Patients and Performance. The Senior Management Group review progress towards achieving these Outcomes on a monthly basis using a traffic lights reporting system where red indicates significant risk to target achievement at the end of March 2006, amber indicates a lower level risk to target achievement and green indicates being on track. The report for November 2005 can be found at Annex 1 (Part A) with an exceptions report for amber and red status Outcomes (Part B). The 9 red Outcomes are:

No. 5 - Reduction in sickness absence levels
No. 21 - Regular availability of information about the delivery of patient care throughout the Service
No. 26 - Category B14 minute performance target achieved;
No. 27 - AS2 – Doctors' urgent performance at 95% within 15 minutes of agreed arrival time;
No. 29 - Percentage of the week when utilisation rates exceed 70%;
No 30 - Reduced non-staff (vehicle) related downtime;
No. 32 - Resource demand/match compliance significantly improved on sectors;
No. 35 - Activation times of 95% within 2 minutes (Category B);
No. 36 - 95% of Doctors' calls answered in 30 seconds.

Since the last Trust Board meeting 3 Outcomes have changed colour to red:

Outcome 30- The manual system of Vehicle Off Road (VOR) reporting via CAC is not producing reliable information. An automated system is being developed for the mid – long term, however this is not likely to be achievable in the short term and given other priorities it is thought unlikely that reliable data will be available before year end. In the interim CAC have agreed to amend the LA16 report form and additional categories of reasons for VOR have been added. It should be noted however that manual trawling of the data

by Logistics indicates that actual levels of vehicle related VOR are very low (below the target 2%).

Outcome 35 - Category B activations are significantly below target. There is slight improvement, however it needs to be more sustained. Sector controllers have been focussing on Category A calls and performance is ambulance resource dependant. With the new dispatch procedures in place Fast Response Units (FRU) could be dispatched to Category B calls which they can't do under the present procedures Arrangements are being made to re-incorporate FRU under the sector desk.

Outcome 36 - The target of 95% of Doctors' calls answered in 30 seconds is at risk, however new procedures in CAC have started to show improvement. These procedures need to be continually reviewed. Work continues with the opening of the Urgent Operations Centre and the integration of the Emergency Bed Service (see below). Consideration will be given to look at their process to see if doctor calls should present in CAC and there is work underway to review the message sent to GPs and hospitals as to how to access emergency transportation. Achievement of the 95% target is expected in July 2006 in accordance with current performance trajectories.

4. Progress on significant improvement programme initiatives

Patients

Fully integrate Emergency Bed Service (EBS) staff into the LAS Trust: In the last few months, attention has been concentrated on transferring the EBS and its operations from Fielden House to the new Urgent Operations Centre at headquarters, with a projected date for the move of 29 November. The move is being organised on the basis that there will be no immediate change in operational arrangements, so all present EBS services will be maintained, as will service development work already underway, even though some of those services may not at this point be seen as traditional, core LAS work. With the emphasis on integration, rather than assimilation, the intention is for this move to lead to an expanded, better supported EBS, providing services that aim to ease access to care for patients and making sure that its specialised expertise and experience remain available to the wider NHS as well as playing a full part in the development of LAS Urgent Care Services.

Make Ready: Make Ready is now live on 16 Complexes. All remaining complexes are now programmed for roll out by 30 March 2006 when the project phase will be complete. A deep cleaning exercise for A&E ambulances on complexes where Make Ready has not yet been rolled out has been undertaken. The scheme continues to perform well against Key Performance Indicators and feedback from operational staff and managers remains generally positive. Two pilot schemes are due to commence in November/December. Flexible Fleet Management will seek to achieve better utilisation of spare vehicles. A further pilot will also be undertaken aimed at improved stores management and reductions in stock holdings.

Increased use of Emergency Care Practioners (ECPs). (Part 1) - ECP teams are operating in the Croydon, Wandsworth, Havering, Bromley and Hounslow areas with Barnet, Redbridge, Hillingdon,, Brent, Harrow, Ealing and Sutton (funding unsure) going live when the new ECP cars become available (December onwards – initial tranche of 13). Additionally there is pressure from 9 other Primary Care Trusts to have ECP teams operational in their areas as soon as possible.

People

Increased use of ECPs.(Part 2) – there are 69 ECPs in practice or training., 12 Trainers are also undertaking the education programme. Funding for the ECP and Trainers' education at St Georges is secured until August 2006 and the ECP programme is being re-validated at St Georges in February based on feedback and input from ECPs and the Medical Directorate. There will be six core modules to the programme that will be mandatory (physical assessment, clinical decision making, minor illness, long term condition, minor injury and pharmacology) and then an element of choice for the final two modules to complete the ECP Diploma. All new ECPs are now being recruited on a permanent basis to reduce pressure on Ambulance Operations Managers with current ECPs being made permanent as they finish their first year of the programme (first batch completed).

Performance

Specialist Ambulances: These ambulance vehicles are larger than the current front line ambulances and are specifically designed to convey those patients that for many reasons cannot be carried safely on a front line vehicle. These patients include ITU patients with associated equipments; obese patients; Intra-aortic Balloon pump patients; wheel chair patients etc. Due to problems of being able to procure ambulance patient trolleys for obese patients this has caused a delay in the final interior design layout and fixtures. Therefore delivery of these vehicles is now expected to be completed at the end of the fourth quarter of the 2005/2006 financial year or early in the first quarter of the 2006/07 financial year.

Fast Response Vehicles: The additional 11 Rapid Response Units (RRUs) were delivered into service in June 2005 and all are in use as first response vehicles. The first tranche of replacement vehicles have been delivered by Vauxhall to the vehicle converter and the first of these vehicles is expected to be delivered to service just prior to Christmas. Both the RRU equipment and ECP equipment carried in these vehicles has been reviewed and reduced. This has led to an improved design of equipment rack to be fitted into the slightly smaller space envelope in the rear of the Zafira.

Fleet Computer System Implementation: Fleet Plan is available in 10 vehicle workshops with roll out required to a further three sites. An updated version of

Fleet Plan software has been agreed and will be rolled out to all vehicle workshops at a date yet to be confirmed. Problems with the server at a number of sites have been identified and need to be addressed. There will be a requirement for some further training of workshop staff and refresher training for all staff that use the system. Once the new software package is available, training will be provided. The target date for project completion remains the end of March 2006.

5. Communication

Over the autumn and winter period (October to February) the Chief Executive's consultation meetings provides the main internal communication vehicle for developments within the Trust including SIP initiatives. Approximately a third of these meetings have been undertaken to date and an update is contained in the Chief Executives report.

6. Recommendation

THAT the Trust Board note the progress made with the Service Improvement Programme.

Martin Brand
Head of Planning and Programme Management
17 November 2005

SERVICE IMPROVEMENT PROGRAMME OUTCOMES (Part A) November 2005

1. People Outcomes

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported (updated statistics given, any new comments in Part B)	Expected Outturn Position End March 2006
1	CH	Annual staff survey shows more staff feel positive about working for the LAS	3.0 (on revised basis, previously 66% on old measure)		Green
2	CH	Annual appraisals and personal development plans in place for all staff	System in place, with all staff having an annual appraisal and a personal development plan		Green
3	MF	Reduction in staff incidents at work	446 reported incidents per 1000 staff per year		Green
4	MF	Reduction in assaults on staff	107 reported assaults per 1000 staff per year		Green
5	CH	Reduction in sickness absence levels	5.5% (average for the year) .		Red
6	DJ	Alternative reward and recognition systems in place	Systems in place which recognise qualification attainments, long service, outstanding performance, and retirement. These systems will include an annual awards ceremony		Green
7	FM	Range of Career paths/ development opportunities	Standard systems in place and used as part of the appraisal/PDR processes.		Green
8	DJ	Annual staff survey shows that more staff feel that communication in the LAS is good	66%		Amber
9	CH	Improved staff support systems	Implementation of the Staff Support Project recommendations. Monitoring of satisfaction & usage levels		Green

			& reports to Trust Board/SMG bi-annually. Substantial improvement in staff survey results on this issue.		
10	CH	Staff more involved in the decisions that affect them	Partnership Agreement in place and working effectively. Staff Survey results demonstrate that staff feel more involved in the decisions that affect them		Amber

2. Patient Outcomes

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported	Expected Outturn Position End March 2006
11	FM	Improved cardiac arrest survival rates (to discharge)	8%		Green
12	MF	Coronary Heart Disease National Service Framework call to door times achieved	30 minutes	04 Data 41 mins Average	Amber
13	KJ	A proportion of demand diverted to more appropriate care, thus freeing up ambulances for serious & potentially life threatening calls.	30% of all Green Calls;	12.7%	Amber
14	MF	'Centre of Excellence' achievement for call taking in CAC (compliance with pro QA)	95% "Centre of Excellence" status achieved & maintained	Maintain CoE March 05	Green
15	MF	A comprehensive ambulance cleaning and equipping system in place. Improved pride & professionalism in the Service	Make Ready in place in all complexes	Live at 16 complexes	Green

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported	Expected Outturn Position End March 2006
16	MD	(Formerly Clinical Negligence Scheme for Trusts Level 3 achieved) Revised june 2004 to: To comply with the new combined Risk Management Standard for Ambulance Trusts, at the next equivalent level to CNST 2 (for clinical risks) and RPST 1 (for non-clinical risks).	Level 3		Amber
17	M F	Clinical supervision in place across the LAS - Team Leaders, Complex Trainers; Delivering training at local level e.g. Epinephrine 1:1000 National guidelines, Protecting Children / Vulnerable Adults	175 Team Leaders and 25 Sector Trainers in post		Green
18	MF	Reduce all patient care related complaints A&E	1.0 complaint per 10,000 calls per month	1.24	Amber
19	MF	Reduce all patient care related complaints PTS	1.0 complaint per 10,000 journeys per month	0.4	Green
20	MF	Reduce all patient care related complaints CAC	1.0 complaint per 10,000 journeys per month	0.95	Green

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported	Expected Outturn Position End March 2006
21	KJ	Regular availability of information about the delivery of patient care throughout the Service	60% completion of CPI every month by Team Leaders. Audit reports available on intranet. Data on patient views available (derived from patient involvement, PALS and complaints) and used for improvement. Data available to demonstrate performance against National Service Framework targets.	9% CPI completion rate for whole LAS in September	Red
22	DJ	Regular comprehensive information about user views/levels of satisfaction	- Patient involvement in all significant Service developments. - Annual patient survey – evidence of actions as a result of survey. - Other means of gaining patient views, e.g. Focus groups		Green
23	MF	A robust, well controlled system is in place to minimize clinical risk and improve patient care through the efficient management of drugs	Drug Management System rolled out and fully embedded in the service	Complete	Green

3. Performance Outcomes

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported	Expected Outturn Position End March 2006
24	MF	Category A performance targets achieved		73.4% YTD	Amber
25	MF	Category A 14-min performance targets achieved.	95%	94.5% YTD	Green
26	MF	Category B 14 min performance targets achieved	95%	54% YTD	Red
27	MF	AS2 –Doctors' urgent performance at 95% within 15 minutes of agreed arrival time	95%	53.4%	Red
28	MF	95% of 999 calls answered within 5 seconds	95%	70.6% YTD	Amber
29	MF	Percentage of the week when utilisation rates exceeds 70%.	15%	Unreportable	Red
30	MF	Reduce non-staff (vehicle) related downtime	2%	No Change	Red
31	MF	Reduce staff related downtime	3%	4.8%	Amber
32	MF	Resource demand/ match compliance significantly improved on sectors	100% Compliance with LO50 (34164 Amb hrs per week)	90.69%	Red

No.	Lead	Outcome	Target (March 2006)	Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green)	
				Last Results Reported	Expected Outturn Position End March 2006
33	MF	Resource/demand match compliance significantly improved in CAC	97%	99.22 July 05	Green
34	MF	Activation times of 95% within 2 minutes (Cat A)	95%	85.5% YTD	Amber
35	MF	Activation times of 95% within 2 minutes (Cat B)	95%	54% YTD	Turns red
36	MF	95% of Doctors calls answered in 30 secs	95%	63.7% YTD	Red
37	MD	Achieve financial savings to fund ISONs	£3m (£1m increase each year)		Green
38	MF	Vehicle accidents per 10,000 ACTIVATIONS reduced by 33% for A&E	9.7 per 10,000	12.71 to Jan 05	Amber
39	MF	Vehicle accidents per 10,000 journeys reduced by 33% for PTS	2.04 per 10,000	2.2	Green
40	MF	Reduce job cycle time	55 minutes	62.27 YTD	Amber

See over for commentary on Outcomes identified as RED/AMBER i.e. will not be achieved or at risk to be achieved by end March 2006

Service Improvement Programme Outcomes Part B - Exceptions Report (Red/Amber) Nov 2005

Outcome No. 5 Description: Reduced sickness absence levels **Lead**: CH
Reason For RED status Given the sickness absence level at this point in the year it is virtually impossible to achieve an average of 5.5% for the year. At best we may achieve 5.5% at outturn i.e. for the month of March.
Remedial Action To Be Taken To Achieve Outcome Continue to manage sickness absence proactively and introduce revised sickness absence policy. This will not however achieve the target average for the year. **If this action is taken will the outcome be achieved NO**

Outcome No. 8 Description: Annual staff survey shows that more staff feel that communication in the LAS is good **Lead**: DJ
Reason For AMBER status Risk due to current climate/IR situation in relation to Agenda For Change
Remedial Action To Be Taken To Achieve Outcome **If this action is taken will the outcome be achieved NO**

Outcome No. 10 Description: Staff more involved in decisions that affect them **Lead**: CH
Reason For AMBER status If staff align this question on the staff survey to discussions relating to agenda for change we may see an increase in dissatisfaction.
Remedial Action To Be Taken To Achieve Outcome Proactive communication aimed at positive AfC messages supported. Chief Exec consultation will be a useful forum to respond during period of staff survey. **If this action is taken will the outcome be achieved YES/NO?** Not definitive!

Outcome No. 12 Description: Coronary Heart Disease National Service Framework call to door times achieved **Lead**: MF
Reason For AMBER status The NSF CHF calls for a call to needle time of 60 minutes, a figure of 30 minutes to respond to scene, examine and transport may not be suitable. Data gathering is a long process and the measure reported is at least four months old, which makes this measure awkward to manage.
Remedial Action To Be Taken To Achieve Outcome 12 lead refresher courses, direct admission to cath labs, crew education are all ongoing **If this action is taken will the outcome be achieved YES/NO?**

Outcome No. 13 Description: A proportion of demand diverted to more appropriate care, thus freeing up ambulances for serious & potentially life threatening calls. – target 30% **Lead**: KJ
Reason For AMBER status Although the figure has risen as high as 15%, it has been consistently at around 12.5% throughout the period being measured (see table below). The reasons are: ECP attended calls have not increased as might have been expected by the fact that total ECP numbers have increased. Efforts by senior operational officers to increase utilisation were briefly successful, but the figures have settled back to earlier levels after the increased intention. At the same time, the number of green responders has gone down. Calls resolved through CTA have not increased, largely due to the staffing problems experienced in that service. (Urgent calls and whitebase calls have increased however)
Remedial Action To Be Taken To Achieve Outcome Co-location of PTS central services, whitebase/greenbase, CTA and EBS is expected to have a major impact on these figures **If this action is taken will the outcome be achieved YES?**

Accident and Emergency Service

Green calls receiving an alternative response & not a front line crew

	ECP	EMT1	Green responder	White Base	Total alternative crews (ECP + EMT1 + GR + WB)	% GREEN calls by alternative crews (excl CTA)	Vehicles saved by CTA	% GREEN calls saved a vehicle by CTA	Total alternative crews & CTA	% GREEN calls sent alternative vehicle OR vehicle saved by CTA	Total green calls
Jun-04	222	125	351	115	813	5.4%	1,146	*7.7%*	1,959	13.1%	14967
Jul-04	177	149	349	137	812	5.4%	1,172	*7.9%*	1,984	13.3%	14920
Aug-04	285	150	280	135	850	5.8%	1,236	*8.5%*	2,086	14.3%	14569
Sep-04	208	95	184	101	588	4.2%	1,110	*7.9%*	1,698	12.1%	14053
Oct-04	175	114	119	42	450	3.1%	1,090	*7.4%*	1,540	10.5%	14638
Nov-04	137	164	74	73	448	3.1%	1,064	*7.4%*	1,512	10.5%	14426
Dec-04	175	367	84	129	755	4.7%	1,164	*7.3%*	1,919	12.0%	15956
Jan-05	237	547	87	181	1052	6.8%	1,243	*8.0%*	2,295	14.8%	15537
Feb-05	230	574	71	187	1062	7.6%	1,097	*7.8%*	2,159	15.4%	14024
Mar-05	229	470	100	145	944	6.0%	1,094	*7.0%*	2,038	13.0%	15713
Apr-05	241	421	77	111	850	5.5%	979	*6.3%*	1,829	11.8%	15440
May-05	262	556	93	198	1109	6.7%	1,027	*6.2%*	2,136	12.9%	16544
Jun-05	244	497	122	188	1051	6.5%	875	*5.4%*	1,926	11.9%	16207
Jul-05	222	340	105	168	835	5.4%	1,019	*6.6%*	1,854	12.1%	15371
Aug-05	258	479	128	206	1071	6.8%	1,092	*7.0%*	2,163	13.8%	15636
Sep-05	220	247	142	114	723	4.6%	1,118	*7.2%*	1,841	11.8%	15627
Total Jun 04- Sep 05	**3,522**	**5,295**	**2,366**	**2,230**	**13,413**	**5.5%**	**17,526**	***7.2%***	**30,939**	**12.7%**	**243,628**

Outcome No. 16 Description: Comply with the new combined Risk Management Standard for Ambulance Trusts **Lead**: MD
Reason For AMBER status Level 2 achieved 2005
Remedial Action To Be Taken To Achieve Outcome Action plan is being developed to secure green result. This plan is being finalised following October meeting with the NHSLA. **If this action is taken will the outcome be achieved YES**

Outcome No. 18 Description: Patient Care related complaints **Lead**: MF
Reason For AMBER status Last reported data for a four month period indicated that this measure at the time had been met by receiving 31 complaints for 380749 calls equivalent to 0.81. Last monthly results reported 1.24.
Remedial Action To Be Taken To Achieve Outcome. Future actions involve a review of the role of PSU, ensuring lessons learnt are passed on, and ultimately improved patient assessment skills delivered through revised training. **If this action is taken will the outcome be achieved YES**

Outcome No. 21 Description: Regular availability of information about the delivery of patient care throughout the service **Lead:** KJ
Reason For RED status As reported to last SSG meeting – all items are on track except CPI completion rates, which have actually decreased since recording started,
Remedial Action To Be Taken To Achieve Outcome Plans are in train to make CPI completion easier (by making the tool web-based, and removing a number of the indicators). However, the figures will not improve unless this area receives the same attention as other key deliverables in operations. **If this action is taken will the outcome be achieved NO**

Outcome No 24 Category A performance targets achieved **Lead:** MF
Reason For AMBER status. It has become increasingly difficult to ensure adequate resourcing is operationally maintained, and available for deployment by CAC.
Remedial Action To Be Taken To Achieve. Ongoing monitoring of abstractions and sickness that has occurred. Overall recruitment numbers have been reviewed, forecasting full establishment by September 06. Completion of UOC expected to alleviate some pressures on A&E provide sufficient resources can be employed and technology supports call transferring. Innovative software is being developed in house to allow proactive monitoring of critical staffing levels directly from ProMis. UOC will go live by month end with full technological support expected by April 06 **If this action is taken will the outcome be achieved YES**

Outcome No. 26 Description: Category B 14 min performance targets achieved **Lead:** MF
Reason For RED status Category B 14 minute performance is in the red category as being significantly at risk. 2005/6 YTD is at 54% and it is unrealistic to expect to achieve this target this year. It is currently anticipated that we will achieve circa 80% for the full year. Significant changes to AMPDS during the first two weeks of April have effected the volume of CAT B calls reported. Prior to April FRUs attended a proportion of CAT B as Red calls, the amount of this work has now changed, hence the identified drop in performance for this area. B14 will be changed in April 2006 to measure the UK standard of B19.
Remedial Action To Be Taken To Achieve Outcome This can only be done by maximising ambulance staffing and by introducing a distribution regime which allows ambulances to respond more often from a mobile status rather than from station. ACAOs and AOMs need to focus on achieving this target as well as the CAT A targets. Significantly more emphasis needs to be given at PPGs and Complex Review Meetings to this area. Work being undertaken on revisions to the workforce plan following the publication of LO77, and the Urgent Care Control becoming fully operational are all areas that are expected to improve this indicator. The opening of UOC in November, the recruitment of CTA staff will remove some further workload from A&E. **If this action is taken will the outcome be achieved** YES

Outcome No. 27 Description: AS2 –Doctors' urgent performance at 95% within 15 minutes of agreed arrival time **Lead**: MF
Reason For RED status Urgent performance is at 53.4% for the YTD and remains significantly behind where we need to be. The performance has also deteriorated in recent months for a variety of reasons. Urgent performance measurement will change in April 2006 in line with National guidelines to reflect arrival at patient.
Remedial Action To Be Taken To Achieve Outcome Changing operational priorities within the Trust may indicate that resources will be engaged achieving other response time targets for Cat A&B calls, to the detriment of AS2 performance. However, considerable progress will be achieved by initiatives planned already. These may be summarised as 1) dedicated call takers to AS2 lines in CAC (achieved), 2) immediate dispatch of call when one hour remaining on STA (progressing), 3) a system of AS2 triage which results in more even spread of workload over a three hour period, 4) blue light response to one-hour AS2s. Operational resources within the Urgent Care Service now has around 104 staff in post, primarily responding to AS2 & 3s, and some stations continue to support unfunded AS2 vehicles. A system for triaging AS2s is currently being developed; National changes to the definition may also assist in achieving this outcome by year end. As in SIP26 UOC and other call handling changes will make this new standard more readily achievable. **If this action is taken will the outcome be achieved** YES

Outcome No. 28 Description: 95% of 999 calls answered in 5 secs **Lead**: MF
Reason For AMBER status Call demand on some days is outstripping the positions available. Pressures on staffing levels and long call handling times is impacting on call answering performance
Remedial Action To Be Taken To Achieve Outcome There will be a review of the ideal staffing levels, proactive recruitment, continued robust management attendance system increase call taking facilities, and a review of how AMPDS works in certain calls **If this action is taken will the outcome be achieved YES/NO?**

Outcome No. 29 Description: Percentage of the week when utilisation rates exceeds 70%. **Lead**: MF
Reason For RED status Last year we converted our performance databases from FoxPro to SQL. As part of the process we had to rewrite all of the performance reports. The only one not changed was the utilisation report. This was because the utilisation report depends on information from two areas, performance and manning and is therefore not straight forward to do. The manning system is still in FoxPro and is well overdue for a major overhaul and needs converting to SQL. This area has not been updated since July 2004.
Remedial Action To Be Taken To Achieve Outcome We are hoping to develop a new manning system using the data generated by the MDTs and work with Systems and Networks should identify in the next few weeks whether this can be done and the issue for IM&T is to develop necessary protocols and reporting abilities. The current manning system is not flexible enough to provide information to reflect the new service structure and has been adapted over and over again to try and accommodate numerous service changes such as the introduction of FRUs and “unusual” rotas. A new system that can monitor the manning for all types of vehicles using information generated by MDTs needs to be developed. Time scales for rectification are uncertain at this stage; MI needs to see the data that could be provided from the CAC systems. The SIP item should be shown as Currently Unreportable **If this action is taken will the outcome be achieved YES/NO?** YES

Outcome No. 30 **Description:** Reduce VOR to 2% **Lead**: MF
Reason For RED status It was explained at the last 4 SSGs that the manual system of VOR reporting via CAC is not producing usable information. An automated system is being developed for the mid – long term. Logistics have led a review of the manual system as MI has not had the resources to do so. Manual trawling of the data by Logistics indicates that actual levels of vehicle related VOR are very low (sub 2%). However as at 12th October no reliable manual information is available. This is the same position that has been reported at the previous 4 SSGs. Given other priorities it is thought unlikely that reliable data will be available before year end. This outcome has been re-graded as RED.
Remedial Action To Be Taken To Achieve Outcome MI work on automated and manual data systems. Manual system was due for completion by 30/09/05. However MI don't think it is something they can solve on their own or progress from their end. They already produce regular reports on downtime by station and by any period required, but Logistics have explained to MI that some more detailed reasons for downtime would be required to be able to tackle vehicle related unavailability of cover. The problem is that the current manual system operated in CAC, i.e. the LA16 form, is not suitable in the current format to supply all the detailed information that Logistics require. There are currently 16 reasons listed on the form and it wouldn't be a problem for MI if that list were extended. However, on the basis of experience even the current form is not always filled in properly and a longer list may just make this worse. CAC don't really need such detailed information to do their work and so may be reluctant to fill the forms in properly, because they will see it as even more unnecessary paperwork slowing them down. The real solution to this would be a list of reasons on the MDT to be selected when the unavailable button is pressed. MI would then get this data and could produce reports automatically. However this is not likely to be achievable in the short term and CAC have agreed to amend the LA16 form. Additional categories required have been added. A meeting is to be held between the Director of Information Management and Technology and the Head of Operational Support to discuss the way forward. **If this action is taken will the outcome be achieved YES/NO?** Yes providing reliable data is not at wide variance with current unreliable data.

Outcome No. 31 Description: Staff related downtime **Lead**: MF
Reason For AMBER status Data issues over basis of calculation.
Remedial Action To Be Taken To Achieve Outcome Data issues being reviewed. **If this action is taken will the outcome be achieved YES/NO?**

Outcome No. 32 Description: Resource demand/ match compliance significantly improved on sectors **Lead**: MF
Reason For RED status With no growth in front line establishment other than that which is associated with Agenda for Change our ability to impact on this measure is very limited and it remains at 90.69% compliant.
Remedial Action To Be Taken To Achieve Outcome AOMs need to continue to work at making changes to Complex rosters but in reality only an injection of additional staffing will allow this target to be achieved. ORH commissioned to look at how all targets could be met within existing resources or with a modest increase. This work LO77 is nearing completion and will essentially recommend a radical change to our response regime which assumes that 80% of Green workload is managed by the Urgent Care Tier and the remaining CAT A and CAT B workload is managed by a much increased number of rapid response units with a reduced ambulance fleet being held back until a definite need for transport has been identified. This will lead to a revised ideal covering both the FRU component and the ambulance component for each operational area. If this is adopted as the way forward then we will work towards achieving full compliance over the period April 06 to April 08. **If this action is taken will the outcome be achieved YES/NO? NO** the ORIGINAL Outcome will not be achieved

Outcome No. 34 Description: Activation times of 95% within 2 mins (Cat A) **Lead**: MF
Reason For AMBER status Activations is approximately 9.5% lower than what is required.
Remedial Action To Be Taken To Achieve Outcome Changing operational procedures in the control room is planned. Call handlers need to identify the chief complaint quicker than the process allows and dispatch needs to have the ability to activate all emergency vehicles from a single point. This is also ambulance / FRU resource dependant, and the opening of the UOC. Recent trials in the room have contributed to improvements in the time taken to record the call, this is leading to earlier presentation to sector controllers to enable earlier dispatch and hence activation times **If this action is taken will the outcome be achieved YES/NO?**

Outcome No. 35 Description: Activation times of 95% within 2 mins (Cat B) **Lead**: MF
Reason For RED status CAT B activations are significantly below target. There is slight improvement, however it needs to be more sustained.
Remedial Action To Be Taken To Achieve Outcome Sector controllers have been focussing on CAT A calls and again this is ambulance resource dependant. With the new dispatch procedures in place FRU could be dispatched to CAT B calls which they can't do under the present procedures Arrangements are being made to re-incorporate FRU under the sector desk, action will support item 34 **If this action is taken will the outcome be achieved YES/NO?**

Outcome No. 36 Description: 95% of Doctors calls answered in 30 secs **Lead:** MF
Reason For RED status This target is at risk, however new procedures in CAC have started to show improvement. These procedures need to be continually reviewed.
Remedial Action To Be Taken To Achieve Outcome Work continues with the opening of UOC and the integration of EBS. Consideration will be given to look at their process to see if doctor calls should present in CAC there is work underway to review the message sent to GPs and hospitals as to how to access emergency transportation. Expected outturn at 95% expected July 2006 according to trajectories. **If this action is taken will the outcome be achieved YES/NO?** No

Outcome No. 38 Description: A&E Vehicle collisions **Lead**: MF
Reason For AMBER status Current status of 11.5% for A&E.
Remedial Action To Be Taken To Achieve Outcome Motor Risk Management group has been reconstituted, revised and updated reporting procedures to be issued in the near future. Guidelines for reporting to be made available to managers. Serious investigation into what can be achieved by installation of a 'black box' data recorder into the fleet to improve reporting, aid investigation and defend malicious claims. Decision has been reached to trial a number of vehicle recorders on response units across an Area. **If this action is taken will the outcome be achieved YES/NO?**

Outcome No 40 Reduce job cycle time **Lead:** MF
Reason For AMBER status. It has become increasingly difficult to ensure adequate resourcing which has led to increased workload pressures on crews.
Remedial Action To Be Taken To Achieve. New operating regimes within CAC are being introduced to maintain the fleet as a mobile resource, to improve mobilisation. From the 24th October the Assistant Directors for the new areas have been in post and will be focused on ensuring that JCT will be consistently and actively targeted, as part of an overall performance management system. **If this action is taken will the outcome be achieved YES**

Enclosure 15

London Ambulance Service NHS Trust Board

27th September 2005

Report of the Trust Secretary

TENDERS RECEIVED

1. Purpose of Report

1. 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.

2. 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

Register no.	Details of tender:	Tenders Received From
16/05	The provision and supply maintenance of photocopiers	Canon UK Imagistics NRG Group Danwood Group Xerox
17/05	Extension works at Hayses AS	Axis Europe plc Griffiths Construction Diamon Build Ltd Neilcott Special Works Mitie Property Services
18/05	Provision of CRAMM Risk Assessment	Mott McDonald (Vega) Insight Consulting Tribal Yale

It is proposed that the tenders listed above be analysed by the appropriate department and the results of that analysis be reported in due course to this Board.

4. Recommendations

THAT the Board note this report regarding tenders received.

Christine McMahon
Trust Secretary

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday 25th October 2005 at 10:00 a.m.
Held in the Conference Room LAS Headquarters
220 Waterloo Road, London SE1 8SD

Present:	Sigurd Reinton	Chairman
	Barry MacDonald	Non Executive
	Sarah Waller	Non Executive
	Toby Harris	Non Executive (arrived 10.25 am)
	Colin Douglas	Non Executive
	Beryl Magrath	Non Executive
	Martin Flaherty	Director of Operations
	Mike Dinan	Director of Finance
	Caron Hitchen	Director of Human Resources & Organisation Development
In attendance:	Peter Suter	Director of Information Management and Technology
	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development
	Tony Rowe	Business continuity project co-ordinator
	Paul Carswell	Diversity Manager
	Marilyn Cameron	Minutes (until 10.30)
	Christine McMahon	Trust Secretary – minutes (from 10.30)
Apologies	Peter Bradley	Chief Executive
	Fionna Moore	Medical Director

28/05 Minutes of the Meeting held on 28th June 2005

The Chairman **signed** the Minutes as a correct record of the meeting held on 28th June 2005 with no amendments.

29/05 Matters Arising

Minute 16.5: the Chairman confirmed that he had met Ian Dodge from 10 Downing Street; he thought it had been a very fruitful meeting and had taken Mr Dodge on a tour of CAC.

30/05 Chairman's Update

Following the launch of 'Commissioning a Patient Led NHS' the Chairman reported that there has been little progress to date. Although it is clear that there will be one London-wide SHA the number of Primary Care Trusts (PCTs) remains in doubt.

The Chairman, with the Board of the Ambulance Service Association, recently met with Lord Warner and advised him that more flexibility will be required for Ambulance Trusts in dealing with overtime and Agenda for Change.

31/05 Finance Report – Month 6

The Director of Finance reported that in Month 6 the Trust had received £17.2 million and spent £17 million. The year to date surplus is £1.6m.

The report shows that there has been increased expenditure on overtime and A&E has been forecast as paying double time for additional work through the bank of temporary staff until Christmas**.**

The Committee was informed that PTS has made a loss of £100,000 in the month. Hammersmith Hospital Trust has asked for a credit note which is annoying considering the extra time and money we have spent on handover to the new transport provider. The Finance Director reported that a review of PTS's West sector is near completion and the review of the East Sector will be completed by the next Trust Board. He said that more work is required with regard to controlling costs incurred by PTS Central Services.

It was commented that the ECP abstractions on page 5 is incorrect and will be revised. **ACTION: Director of Finance**

The Service Development Committee was informed that the Trust is planning to pay out £23-26m in three months for Agenda for Change (AfC), which should be reimbursed by the Department of Health.

The Director of Finance was pleased to report that, with the exception of Hounslow PCT, PCTs have been making payments.

In reply to Barry McDonald's question regarding CBRN funding the Director of Finance reported that he had been assured by Julie Dent that CBRN funding will be recurrent given that London continues to be in a state of high alert; of the original £9m, £8m has been claimed as recurrent. Barry Macdonald felt that given that financial climate in the Department of Health is changing we should not be sanguine about future income streams.

Barry Macdonald was informed that savings of £1.5m have been identified from management vacancies in the year to date.

Barry Macdonald queried the discrepancy in the report regarding overtime - on page 4 overtime is shown as being within budget which is contradicted in the commentary. The Director of Finance said that the commentary was incorrect and he will clarify the issue at the Trust Board meeting in November. **ACTION: Director of Finance**

Beryl Magrath asked about the expenditure for repair damage exceeding budget. The Director of Finance reported that the matter was being monitored and managed by the Motor Risk Group. Two stations in particular have been responsible for high levels of expenditure on repairs. The Director of Operations said that work is being done to devolve budgets to complex level which will include managing costs of repairs to vehicles. The Director of Finance thought that more needs to be done to understand why there are so many incidents.

There was a lengthy discussion regarding the payment of arrears to front line crews – the HR Director reported that every effort is being made to assimilate staff and pay arrears. A number of options are being considered as to how the task can be accomplished. The Director of Operations recognised that regardless of when arrears are paid to front line crews the Service will take a hit in the amount of overtime staff will be willing to work. Once staff are assimilated on to the AfC terms and conditions double time for overtime ceases and a new rate of time and half is paid. The HR Director commented that, in the long term the aim is to have full establishment, thereby decreasing reliance on overtime.

In response to a question from Colin Douglas the Director of Operations said that there was no specific plan for winter pressures but planning is undertaken for the year in total. There is specific planning being done with the South West London Strategic Health Authority (SWLSHA) regarding a possible flu pandemic. He assured the Committee that planning has been undertaken with regard to various 'what if' scenarios and how the Service would respond. He said that he had some concerns about the level of service provision during the Christmas period. The Chairman suggested that it would be useful for a summary of these options to be discussed at the November Trust Board. **ACTION: the Director of Operations.**

32/05 Draft Statement of compliance with Standards for Better Health

The Director of Finance presented the draft statement regarding the Trust's compliance with Standards for Better Health. With the exception of some minor typos this was the definitive version. Beryl Magrath suggested that e.g. C11B could have more detail added about the mandatory training programmes – the Director of Finance undertook to forward her comments to the Head of Governance.

On the 31st October 2005 the draft statement will be submitted electronically to the Healthcare Commission. A hard copy will then be printed off for signature. The Executive Directors will be signing the draft statement and it was hoped that the Non-Executive Directors will also sign.

Noted:
1. **The draft statement of compliance with the Standards for Better Health**
2. **That routine reports regarding statement of compliance will be submitted to the Trust Board and the Service Development Committee.**

33/05 London's response to 'Commissioning a patient led NHS

The Service Development Committee considered the response of the LAS and the strategic health authorities to the 'Commissioning a patient led NHS'. The Director of Service Development reported that the expert group's findings will be in the public domain in December 2005.

Toby Harris reported that there has been a lot of political pressure regarding the proposed reduction in the number of Primary Care Trusts (PCTs). There is now some doubt as to whether any reconfiguration will take place which will result in a reduction in the number of PCTs. There is also some doubt as to whether the PCTs will cease being providers of services which was also suggested in Sir Nigel Crisp's original paper.

The Director of Finance stated that the LAS has been consistent in its message to the SWLSHA that the LAS will not be contributing to the proposed £250m cost savings expected from the reconfiguration of PCTS and SHAs in London. It was commented that if the savings are not realised through PCT mergers they may be by reducing front line services.

The Director of Service Development pointed out that the LAS's response to the consultation undertaken by the Office of Public Management had been based on the premise that there would be fewer PCTs, which had been viewed as a positive move in terms of the commissioning relationship and working together on a more strategic basis.

34/05 Agenda for Change - update

The HR Director reported that paramedics and team leaders will be assimilated in October and will receive their arrears in November.

She was pleased to report that agreement has been reached regarding the Emergency Medical Technician (EMT) role. A number of EMTs will be eligible to become EMT 4s based on their length of service and undertaking additional training. The enhanced role will include an initial payment of a recruitment and retention premium which is allowable under Agenda for Change (AfC); the pan London AfC group recently endorsed the proposal. During the next couple of weeks representatives of staff and management side will work together on banding EMTs. It is hoped that EMTs will be assimilated in November 2005. Every effort will be made to pay arrears as soon as possible. Measures have been put in place to bolster payroll capacity, through the use of additional staff and changes to the process.

The HR Director reported that the national requirements for AfC implementation have changed. Trusts have been put into Three categories reflecting progress to date, with the LAS falling into Category 3. Category 3 contains trusts that have assimilated less than 65% of their staff. Once EMTs are assimilated the LAS will have 68% assimilated. Along with

30 other Trusts (7 of whom are Ambulance Services) the LAS is required to have a recovery plan in place by 1st November 2005 as to how it will assimilate 100% of staff by 31st December 2005 and pay all arrears by 31st March 2006.

In response to a question from Beryl Magrath the HR Director confirmed that meeting the 31st December deadline for the assimilation of all staff will be a challenge.

In response to a question from Sarah Waller the HR Director confirmed that a significant number of staff groups other than EMTs still need to be assimilated.

Sarah Waller requested a breakdown of major job categories in terms of the basic pay – she was assured this will be contained in the recovery plan which will be presented to the Trust Board in November. **ACTION: HR Director**

35/05 Update on Business Continuity Planning

The Business Continuity Project (BCP) Co-ordinator gave a presentation regarding business continuity planning and the work that has been done to date. He outlined the requirements of the Civil Contingency Act which comes into force on 14th November 2005. He has consulted with key personnel and a draft plan has been completed. The Executive Director responsible for business continuity planning is the Finance Director. A steering group will be set up to monitor the process and a co-ordinator for that steering group appointed. The BCP Co-ordinator reported that he was reassured to find that the Trust's plan broadly agrees with the recently published NHS' business continuity plan.

The Committee were assured that there are plans in place to test the Trust's business continuity plans. The Director of Information Management and Technology reported that the technology system will be tested in a 3 stage process including table top exercise, a dry run at the weekend and then an unscheduled test. The Director of Operations said that his senior team will be working with the BCP Co-ordinator on a table top exercise on the possible impact of a flu epidemic this winter. An ongoing discussion is taking place regarding the necessity of a back up for Bow.

The Director of Finance said that the Internal Auditors will be asked to review individual department's preparedness for business continuity.

In response to a question from Colin Douglas the BCP Co-ordinator felt that Trust was at 'awareness' stage. As part of the ongoing work to raise awareness an article will be published in the LAS News. The BCP Co-ordinator recently gave a presentation on contingency business planning to the Trust's top 100 managers. Every department will be expected to have business continuity plans with individuals in the departments being made aware of the plan. With sufficient preparedness it is hoped to remove the drama of any incident by having a plan in place to ensure that the Trust is able to continue to provide an emergency service in London.

Noted: The report

36/05 Focus Group Feedback

The Director of Service Development introduced Paul Carswell, the Diversity Manager, who presented the findings from research carried out for the LAS by The 1990 Trust. The 1990 Trust had been asked to undertake qualitative research amongst Black and Minority Ethnic (BME) communities to enable the LAS to understand why BME patients and their families expressed less satisfaction with the service they received than White patients and their families. This was in response to a national patient survey conducted by the Commission for Health Improvement in 2002 which found high levels of satisfaction among LAS service users but less so among service users from the black and other ethnic minorities. This is mirrored in the Commission's survey results for other NHS services and, indeed, for public services generally.

The 1990 Trust interviewed 74 people from a number of communities in London – Chinese, West African, Turkish, Somalian, Mental Health service users and sickle cell sufferers.

The Director of Service Development offered to share the full report from the 1990 Trust which she said made for interesting reading.

The 1990 Trust made a number of recommendations as to how the Trust could be more responsive to BME patients. The report presented to the Committee outlined the recommendations and the Trusts' response, initially in June 2005, with an update on progress in October 2005. Although some of the recommendations were considered impractical, e.g. asking people who ring 999 their ethnicity, other recommendations have been implemented. The Trust has introduced ethnicity monitoring in the majority of relevant LAS departments and the results will be performance managed by the SWLSHA.

The Diversity Manger reported that a survey, recently conducted by the LAS Patients' Forum of 276 LAS service users and staff, had similar findings as that of the 1990 Trust in the feedback received from BME patients.

The Director of Service Development confirmed that recommendations in the report which had been agreed but not yet actioned will be included in the Trust's Seven Year plan.

Recruitment: the HR Director reported that in partnership with the Ambulance Service Association research is being undertaken to understand why efforts to increase recruitment from BME communities has been not been more successful. Following the research's completion in February 2006 an action plan will be drafted for targeting recruitment from BME communities. It was commented that it was important that realistic, achievable targets are set for recruitment from BME communities. It was recognised that one of the advantages of the Trust's workforce reflecting the multitude of communities in London is that it will reinforce the message that the LAS's mission is to provide clinical care to all Londoners.

37/05 Seven year plan

The Director of Service Development outlined progress to date. A Gantt chart is being drafted which will outline the programme for 2006/07 and subsequent years. Work is also being done to cost the 2006/07 programme; the budgetary process will formally commence on 2nd November when the Deputy Director of Finance will give a presentation to key personnel. A further progress report will be presented to the Service Development Committee in December 2005 and a first draft of the seven year plan will be presented to the Trust Board in January 2006. **ACTION: Director of Service Development**

In response to a comment from Colin Douglas the Director of Service Development explained that themes such as access, diversity and information technology will permeate the Seven Year Plan rather than being stand alone strategies. The Director of Finance is working on identifying performance measurements to support a balanced scorecard approach to measuring progress with the seven year plan.

38/05 Workforce Strategy – 1st thoughts

The HR Director reported that the LAS is undertaking a comprehensive review of the Trust's long term workforce planning taking into account different drivers for the Ambulance Service nationally.

The Trust is biding to participate in a national long term workforce planning project which will be completed by February 2006. The work will include: a robust workforce strategy to support the Seven Year Plan; a review of the Patient Transport Service; consideration of the skills that Service may need in seven years time; understanding the interdependencies

of the different staff groups and the external labour market. The work undertaken by Operational Research Health (ORH) will also be included in the review. The Chairman commented that the skills composition required of staff in seven years time will be different from that of the traditional two person ambulance.

Sarah Waller queried whether the work programme outlined by the HR Director can be achieved in four months and thought the ambulance service was unusual in that it trains staff in-house. She suggested that there were health service professionals with transferable skills who could be encouraged to transfer to the Ambulance Service.

The Director of Finance thought that in some ways the Seven Year Plan was an aspirational document. A gap analysis will reveal what is outstanding and work will be done to identify the ways and means by which the gap will be closed. The HR Director and Service Development Director undertook to present an action plan to the Committee in December which will include identified milestones. **ACTION: HR Director and Director of Service Development.**

39/05 A&E and PTS restructure

The Director of Operations reported that the new A&E structure went live yesterday (24th October 2005) with the new Assistant Directors of Operations in post. An announcement was posted on the Pulse; biographical information and pictures of each appointee were included in the article.

PTS – the Director of Operations informed SDC that there has been a change in line accountability for the two senior PTS mangers; they will now be reporting to the Deputy Director of Operations. The Director of Finance is continuing to closely monitor PTS finances.

40/05 Update on Cardiac Care

The Assistant Head of Training/Cardiac Lead presented a DVD on Cardiac Care which had been produced by the LAS's Communications Department. The DVD contains facts and figures on cardiac care in London, the role of the LAS and includes a dramatisation of what happens when the LAS receive a call for assistance when someone suffers a heart attack. In 1997 the survival rate was 1.9%, in 2004/05 this has improved to 8.1%. The Communications team and the Cardiac team were congratulated on the DVD, which the Committee thought was an excellent piece of public relations for the Trust. The Non Executive Directors requested copies of the DVD. **ACTION: Assistant Head of Training/Cardiac Lead**

41/05 Any other Business

7th July 2005: The Director of Operations outlined the contents of the Emergency Planning Unit's debrief following the bombings in London on 7th July 2005. A number of lessons have been learnt; one of which was the over-reliance on mobile phones which has been addressed by the reintroduction of pagers. It was recognised that some things could have been handled better, e.g. the dispersing of patients to hospitals around London. Some things require further work, in particular the management of information in the round and how the deluge of information that is received following an incident can be better managed. An action plan is being drafted and the Assistant Director of Operations will be responsible for implementation.

Anu Miah Case: the Service Development Committee was informed that the Healthcare Commission is to hold its own investigation into the death of Anu Miah, in particular the crew's assessment and treatment of Anu Miah.

London First: the Chairman had spoken to other NHS members of London First and was informed that they had either already resigned or were about to resign as members of that forum. The LAS will not be renewing its membership as London First has not delivered the hoped for benefits.

42/05 Date of next meeting

The next meeting of the Service Development Committee will be held on 20th December 2005 at 10.00am in the conference room at LAS HQ.

The meeting concluded at 13.00

Enclosure 17

London Ambulance Service NHS TRUST

TRUST BOARD 29th November 2005

SUMMARY OF THE MINUTES
CLINICAL GOVERNANCE COMMITTEE - 31ST OCTOBER 2005

1. Chairman of the Committee Beryl Magrath

2. Purpose: To provide the Trust Board with a summary of the proceedings of the Clinical Governance Committee

3. The Committee agreed the broad principles of introducing a framework for the recognition of advanced directives. The Senior Clinical Adviser to the Medical Director will be taking this project forward and a report will be presented to the Committee in 6-9 months time.

   The Committee agreed the training needs analysis. It was noted that only 68% of booked places were taken up. The reasons for this will be investigated and reported back and looked forward to receiving a report on the gaps between the training schedule and what actually takes place.

   The Committee noted that:
   - Only 4 Borough Scrutiny & Overview committees had written to support LAS' draft declaration for the Healthcare Commission. Work is being done to develop Borough links
   - A Diversity Group is to be reconstituted
   - A Policy for non English speakers to access LAS services is being developed
   - The Medical Director will highlight pain management, ethnic monitoring & acute coronary syndrome in her presentation at CEO's Consultation meetings
   - The Records Manager is working towards developing an EDRMS across the Trust involving all staff & a major cultural change

   The Committee received a progress reports on:
   - the NHSLA level 3 workplan;
   - a presentation on the findings of the evaluation of ECPs. Evaluation and;
   - from the ADO Urgent Care and Clinical Development with regard to establishing the Urgent Operations Centre due to which will be opening fully on 30th November.

   The Committee received regular reports from the PPI Manager and the PALs Manager with regard to their respective areas and from the Medical Director regarding the Services Training Committee.

4. Recommendation That the Trust Board note the minutes of the Clinical Governance Committee (full set attached).

LONDON AMBULANCE SERVICE NHS TRUST

Draft Minutes of the Clinical Governance Committee
31st October 2005 LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Barry Mc Donald	Non-Executive Director
Fionna Moore	Medical Director
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
John Wilkins	Head of Governance
Bill O Neill	Head of Education & Development (until 12.30)
Tony Crabtree	HR Manager
Jason Challen	Senior Training Officer-PTS
Julian Redhead	Consultant in Emergency Medicine, St Mary's, Paddington
Malcolm Alexander	Patients' Forum (Chairman)

In attendance

Henry Gillard	Member of Patients' Forum
Sue Carr	On behalf of Joesf Kane (until 11.30)
Ralph Morris	ACAO on behalf of Martin Flaherty
Christine McMahon	Trust Secretary (minutes)
Stephen Moore	Records Manager
David Whitmore	Senior Clinical advisor to Medical Director
Gary Bassett	PALs Manager (from 10.25)
Paul Carswell	Diversity Manager
Ian Todd	ADO Urgent Care and Clinical Development
Margaret Vander	PPI Manager (from 10.50)
Julie Dahlstrom	Management Trainee shadowing Director of Service Development

Apologies

Martin Flaherty	Director of Operations
Sarah Waller	Non-Executive Director
Josef Kane	PSU Manager (Acting)
Laverne Harris	Governance Manager

36 Minutes of the meeting held on Monday 15th August

Agreed The minutes of the Clinical Governance Committee meeting held on 15th August 2005

37 Matters Arising

Minute 27 – the Chairman of the Patients Forum reported that he continues to have problem accessing the LAS website. The Director of Communications suggested that he contact the Trust's IT department who might be able to help resolve the matter. With regard to access to the LAS intranet this is work in progress.

Minute 29 – Clinical Governance annual report near completion and work is being done to remove any acronyms.

Minute 30 – the Head of Governance reported that he had met with the London Borough Scrutiny and Overview Committees Network and given a presentation based on the evidence of compliance with the core standards. This evidence was set out as the basis for the Trust's decision to submit the Draft Declaration stating full compliance with the 24 core standards. Disappointingly only 4 of the Borough Committees have responded with comments to be included in the Draft declaration to the Healthcare Commission. The Head of Governance will be encouraging the Borough Overview and Scrutiny Network to develop their submission as a pan – London approach to the Trust's Final Declaration in March 2006.

Work is ongoing to develop local links between Ambulance complexes and their local Borough's Overview and Scrutiny Committees.

Minute 31 – the Diversity Manager reported that following his meeting with the Assistant Head of HR, the Diversity Strategy Group has been re-constituted. The purpose of the Group is to monitor implementation of the Trust's diversity strategy. He will report back on progress. ACTION: Diversity Manager

The Chairman of the Patients' Forum enquired about the policy that was being drafted by the Head of Communications on how different non-English speaking communities access the services of the LAS. The Director of Communications said that the work had not been completed and he undertook to share it with the Patients' Forum as soon as possible.

Minute 31 – the Director of Service Development confirmed that ethnic monitoring has been added to the Clinical Performance indicators; a progress report will be presented in January as data is not currently available. As part of the Chief Executive's annual consultation the Medical Director will be highlighting pain management, the importance of ethnic monitoring and acute coronary syndrome.

The Head of Education and Training informed the Committee that a bulletin with dedicated themes is to be produced. An example of the bulletin will be shared with the Committee in due course. ACTION: Head of Education & Development

Noted: The matters arising

38 NHSLA level 3 workplan progress report

The Head of Governance reported that the NHSLA assessor visited the Trust on 10th October 2005; she was presented with evidence that the Trust had implemented the actions outstanding from the Level 2 assessment report. She was also presented with evidence on work the Trust has done for assessment at level 3 in January 2006. She has undertaken to give detailed feedback to the Head of Governance by mid November, so that a workplan can be produced to prepare for the two day assessment visit by the NHSLA assessment team in January 2006. A potential vulnerability for the achievement of level 3 by the Trust is evidencing lessons learned and improvements resulting from complaints.

It is clear that the NHSLA assessment has been developed from an original acute trust assessment approach without a detailed knowledge of the clinical procedures undertaken by ambulance crews; for example the requirement to demonstrate that staff are trained in Basic Life Support, a core clinical procedure for front line ambulance crews.

Barry McDonald asked about training records for all front line staff and it was confirmed that there is now a full audit trail for courses. There is a paper trail showing the management of non-attendance and the re-booking of staff onto other training courses.

Noted: The report

39 Evaluation of Emergency Care Practitioners

The Director of Service Development presented work undertaken by Mary Halter and Tom Marlow evaluating Emergency Care Practitioners (ECPs)which was published in July 2005.

The evaluation showed that although initially ECPs were being sent to predominantly green calls they are now responding to all categories of calls. The job cycle is longer than that of an average ambulance crew (average 82 minutes) but this is still cost effective given that it is a single staff response. Utilisation remains low at 41% but has recently started to show an improvement. There is a lower rate of conveyance to hospitals which becomes marked with increased experience and confidence of individual ECPs. The patients left at home do access other health care pathways. In particular, the time spent in Hounslow PCT building relationships and identifying alternate care pathways has been extremely worthwhile. The

ECP programme has included work with patients on setting quality standards, which has been very useful in setting qualitative as well as quantitative targets. In Bromley PCT the ECP provides out of hours service for the local GP service at weekends and on bank holidays.

A comparative survey was undertaken of patients treated by ECPs and A&E Ambulance crews. There was a good response rate (53%) and a high level of satisfaction reported. The higher satisfaction expressed about ECPs was probably due to the thoroughness of assessment undertaken and the explanation given as to what would happen next which relates to the longer job cycle. Greater dissatisfaction was expressed by patients in the younger age groups and amongst some ethnic groups, which needs to be better understood.

Semi-structured interviews were undertaken with the ECPs followed by an analysis of theme/content. The results were generally positive with some dissatisfaction expressed about the variable quality and focus of lectures. They thought the programme was exciting if a bit daunting, wanted clarity about their role, felt their practice was influenced by education, placements, clinical and peer support. Frustration was expressed with the system in particular the tasking of jobs.

There were a number of recommendations from the evaluation which included: that good practice should be shared across the PCTS (currently numbering 5), that issues regarding tasking need to be addressed; the use and continued collection of patient feedback; the need for further clarity regarding the role of ECP and that further work be done modelling costs.

With regard to examination of a person of the opposite sex without the presence of a chaperone the ECPs follow General Medical Council guidelines that no form of intimate examination is undertaken.

The ECP who is providing Out of Hours cover in Bromley is tasked to that service for the day. It may be that the arrangement needs to be amended so that the ECP is available to be tasked by CAC unless otherwise engaged – this would help the Trust meet its performance targets in Bromley PCT.

It was important that ECPs attend all categories of calls to maintain their level of skills. With completion of the relevant modules the ECPs are allowed to carry an additional 9 drugs bringing the total of drugs they can administer to 18. They are able to identify alternate care pathways for patients other than being taken to hospital.

Software is being written which will make the tasking of ECPs easier by CAC, at the moment it is down to the ability of individual dispatchers on the degree of utilisation.

Further research is being undertaken by Mary Halter, currently on secondment to St Georges/Kingston University, into the outcomes for patients following their interaction with ECPs.

It was recognised that there are approximately twelve other ECP programmes running in the country, each of which is different. An ECP at the LAS has a two year training programme; in another Ambulance Service an ECP will have a 9 week training programme. The Director of Service Development reported that as part of her continuing research Mary Halter will also be looking at ECPs on a national basis, contrasting the experiences of ECPs in two Ambulance Services.

Currently the ECPs are geographically dispersed around London in 5 different PCTs. Due to the need for pump priming funding the LAS is dependent on PCTs being willing to pay for ECPs. Though the introduction of ECPs means savings for local healthcare economy it is too costly for the LAS to introduce without guaranteed funding. The Committee were informed that there are plans in place to introduce ECPs in North West London.

Due to the dispersed number of the ECPs there has not been the critical mass present in any one PCT by which evidence could be obtained as to their impact on A&E despatch. The Director of Service Development thought it might be possible to experiment and perhaps have 5 cars operating in one PCT on a single day and review the data.

With regard to the lower satisfaction ratings by age/ethnic groups this is being addressed by the Continuing Professional Development programme; it is an issue for the Service as a whole not just ECPs.

Noted: The report.

40 Presentation re. Urgent Care

Ian Todd, the Assistant Director of Operations (ADO), Urgent Care and Clinical Development gave a brief presentation on the Urgent Care Service outlining the significant changes that are being implemented. He outlined the component parts of the Urgent Operations Centre (UOC), which from the 30th November will be located in one room. These are 'white work', Patient Transport Service Central Services, Emergency Bed Service, and Clinical Telephone Advisers. The different parts of UOC will be technically fully integrated by 30th April 2006, by which time it was anticipated that technology will address inefficiencies in the current system.

UOC's purpose is to take 80% of all green calls, where clinically appropriate, so as to save A&E resources for those that are in need of that emergency service. The roles of the "White work" staff (which is supposed to be a step down from A&E work) and EMT1s are being reviewed. Clinical Telephone Advisers, with the support of GPs and Consultants, are expected to hear/treat more patients – there is evidence that GPs have great expertise in triaging calls over the telephone.

During the next six months work will be undertaken to build a more integrated clinical governance framework, and integrate the service with the other parts of the LAS.

The Chairman of the Patients' Forum was assured that there is a rigorous quality assessment undertaken of the advice given by CTA, which looks at a range of factors including quality of clinical advice and tone of voice used.

The Head of PPI asked about the complexity of some Category C calls and how this will be handled. The ADO Urgent Care and Clinical Development felt that this is an area where ECPs will be most utilised in conjunction with CTA. The Medical Director thought that the new system of care would be much safer for patients as it will identify the best pathway of care for patients.

The Chairman requested that a progress report be presented in six months time. The Head of Governance suggested that the report identify the outcome improvements delivered by the new Urgent Operations Centre. **ACTION: ADO Urgent Care and Clinical Development**

Noted: The report

41 Advance Directives

The Senior Clinical Adviser to the Medical Director presented a briefing note on the use of Advance Directives to the Committee for comment. It is proposed that a framework be established by which members of the public with advance directives can make them available to the LAS staff who treat them. The proposal has been undertaken jointly with Mr Henry Gillard, who has been acting on behalf of the Voluntary Euthanasia Society (VES).

Further work will be done on how identification and registration of members of the public with advanced directives will be undertaken, the updating and amendment of such advance directives, a periodic review of the any procedures that the LAS might put in place and the cost of the proposed scheme. The Head of Governance asked that a detailed project plan should now be produced to take this important work forward. **ACTION: Senior Clinical Adviser to Medical Director**

In reply to a query from Barry McDonald it was confirmed that no such system is in place at the moment; that if such a system is put in place the lines of communication will already be in place with an individual's GP. It was recognised that if the framework is introduced it will be necessary to ensure that hospital staff are able to recognised whatever method of identification is used.

The adaptation of the Medicalert system ('battenburgh' style wristband with a PIN) is being considered as a means of identifying patients with advance directives as is 'message in a vital' in the patient's fridge. Information would be stored on the CAD system in CAC. It was acknowledge that this will need to be carefully considered in terms of preserving patients' confidentiality.

Further work will be undertaken with VES who are in partnership with National Death Society and the Terrence Higgins Trust. The Committee

Agreed: **1. That the broad principles of introducing framework for the recognition of patients with advance directives be adopted**

Noted: **2. That a further report would be presented to the Committee in 6-9 months time, when further research has been undertaken and viable method identified.**

42 Draft Declaration re. SfBH

The Head of Governance reported that the Trust's Draft Declaration on the Standards for Better Health will be despatched electronically to the Healthcare Commission by the deadline of 31st October 2005. The Trust is stating that it is fully compliant with all the Standards. A hard copy of the Draft Declaration will be produced and the Trust Board will be asked to sign so that it can be sent to the Healthcare Commission by 3rd November 2005.

The Trust will be required to make a Final Declaration in March 2006 regarding Standards for Better Health. The Committee will receive regular progress reports on compliance with the standards.

Noted: **The report.**

43 Clinical Governance development plan/annual report

The Committee considered the progress report of the Clinical Governance Development Plan which included an update on some of the main service developments eg diversity and equality; patient, public involvement; providing feedback to crew members; complaints handling and statement writing; records management; the NHSLA assessment and learning form the outcomes of Serious Untoward Incidents.

The Head of Education and Development assured Barry McDonald that all operational staff attend the Continuing Professional Development course. Courses were not held in August due to operational pressures but resumed again in September.

Noted: **The report**

43 Training needs assessment

The Head of Education and Development presented the training needs analysis which focused on training and development delivered against performance targets in the following areas: provision of recruitment/basic training and development; provision of training and development to meet other state specific organisational performance targets; provision of refresher and update training and development, including mandatory professional recertification development courses and provision of specific mandatory risk management training and development.

In reply to a question from the Chairman the Head of Education and Development estimated that for a variety of reasons approximately 68% of places on training courses were taken up. It was recognised that this needs to be improved.

It has been agreed that all front line staff will have six training days a year; this is a significant improvement on previous years. It was recognised that there are occasions when operational pressures require training courses to be rescheduled.

In January 2006 the Committee will receive a report which reveals where the gaps are between what is scheduled and what takes place; and what action is being taken to reduce them.

Agreed: 1. The training needs analysis
Noted: 2. That the Services Training Committee will receive regular updates on progress of the training programme.

44 Records Management

The Head of Records Management, who has been in post 4 months, gave a very comprehensive review of records management at the LAS. His presentation included the importance of effective records management to ensure compliance with legislation and standards, and to maintain business efficiency.

He presented his initial findings on records management in the Trust and the proposed way forward which will include a records management team representing all parts of the organisation, and a Records Management Strategy which will outline the programme of work which will be necessary.

This programme will need to be part of the Seven Year plan and will include records preparation work, the development of a business classification scheme and the introduction of an Electronic Document Records Management System (EDRMS) across the Trust. He emphasised the need for a corporate trust-wide solution, the involvement of all staff and the culture changes that would be necessary in order to implement this solution successfully. As a first step a Records Management Policy will be presented to the Trust Board for approval in November 2005.

Noted: The report

45 Patient Public Involvement update

The Head of Patient Public Involvement (PPI) reported on the different areas of activities she has been working on during recent months. She has visited a number of external groups (Local authorities and community groups) and shown the Cardiac Care DVD. Internally she has been supporting colleagues with their PPI work and has been pleased at the level of PPI work being undertaken – approximately 70 different pieces of work being undertaken. Examples include visits to schools whereby 40,000 school children ranging from 5 year – 18 years received information regarding how to call 999 to careers in the NHS. The Community Resuscitation team, between April and September, delivered BLS training to 195 different community groups.

In addition she has been working closely with the Head of Diversity reviewing the Trusts' recruitment policies and procedures. She has also been working with the Head of Governance

on how complaints are responded to and how patients' comments are fed back into the organisation. .

In response to a question from the Chairman the Head of PPI said that the PPI Committee is chaired by the Director of Communications, attended by the Chairman of the Patients' Forum as well as two other Forum members and has approximately 12/14 members in total.

With regard to the preparation for Foundation Trust Status in 2008 the Head of PPI thought that the membership's nucleus could be formed from members of existing web of groups that the LAS interacts with, in a hub/spoke type of arrangement, with local groups feeding into a main membership group.

The Chairman of the Patients' Forum asked what happens to information received externally – from the school visits, the Annual Public Meeting, the Patient Care Conference etc. The Director of Service Development thought the Trust was quite good at learning from feedback received from stakeholders. The Records Management Manager though that the changes that will be introduced as part of the Records Management Strategy will improve information sharing across the organisation and with external organisations.

The issue of overshoes was discussed and it was agreed that the LAS will fund overshoes. The PALs Manager pointed out that the issue was originally being raised two years ago by a patient. The Chairman was assured that the action will be implemented by January 2006. **ACTION: PPI Manager & ACAO.**

Agreed: **1. That the LAS will fund the cost of overshoes (approximately £600), that they will be stored on ambulances and circulated to mosques.**

Noted: **2. The report**

46 PALs update

The PALs Manager gave a brief update on activities since the last Clinical Governance Committee. The service continues to be very busy (April – September received 2110 calls), an

increase of 15% compared to same time in 2004. A review is taking place on how existing resources might more efficiently utilised.

In order to address the issue of lost property a bag has been designed (an example of which was circulated); the lost property bags will be trialled for six weeks by Hillingdon AS.

Patient tracking has greatly improved with the access to CTAK system though there still remains some difficulty obtaining information that is more than six hours old.

The Chairman of the Patients' Forum commented that he found the inclusion of case studies to be very useful.

Barry McDonald was assured that the collapse of CTAK mentioned on page 43 was an unusual occurrence and that CTAK was quickly restored on the day.

Noted: **The report**

47 Reports from Groups/Committees

1 *Clinical Risk Group –*

A summary of the recent meeting was not available for the meeting.

Noted: **That the Trust Secretary will circulate a summary of the minutes of the Clinical Risk Group by email to the members of the Clinical Governance Committee today.**

2 *Training services Committee*

The Medical Director reported that the Training Services Committee has met twice since the last Clinical Governance Committee meeting; it reviewed the training programme against the plan. The Committee sought to balance the operational needs of the Trust with the provision of training programmes for staff.

Noted: The report.

3 *Complaints panel*

The Head of Governance reported that the Complaints Panel has met twice, that its terms of reference were being finalised and should be agreed when the Panel met again in December 2005. The purpose of the Complaints Panel is to demonstrate how the Trust has learnt from complaints, Serious Untoward Incidents etc.

Noted: The report.

4 *Clinical Steering Committee*

Noted: That this Committee has not met since May 2005 and is scheduled to meet again in December 2005.

48 Dates of next meeting:

Monday, 23rd January 2006 at 9.30 in the Conference Room, HQ.

Meeting concluded at 12.50