**LONDON AMBULANCE SERVICE NHS TRUST**

**MEETING OF THE TRUST BOARD**

**Tuesday 29th March 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 24th January 2005. Part 1 and II | Enclosure 1& 2 |
| 4. | Matters arising | |
| 5. | Chairman's remarks | |
| 6. | Report of the Chief Executive | Enclosure 3 |
| 7. | Month 11 Financial Report. | Enclosure 4 |
| 8. | Report of the Medical Director | Enclosure 5 |
| 9. | 2005/06 Service Plan and Budget for approval | Enclosure 6 |
| 10. | Assurance Framework | Enclosure 7 |
| 11. | Registration of Professional Clinical Staff | Enclosure 8 |
| 12. | Report on risk data sharing project | Enclosure 9 |
| 13. | Service Improvement Programme Update | Enclosure 10 |
| 14. | Emergency Care Practitioners update | Enclosure 11 |
| 15. | Presentation - Fleet Review | |
| 16. | Report of the Trust Secretary – Tenders opened since last board meeting. | Enclosure 12 |
| 17. | Report of the Trust Secretary – Sealings | Enclosure 13 |
| 18. | Minutes of the Clinical Governance Committee – January 2005 | Enclosure 14 |
| 19. | Minutes of the February Service Development Committee | Enclosure 15 |

20. Any Other Business.

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

22. Date and Venue of the Next Trust Board Meeting.
31st May 2005, 10.00am at 220 Waterloo Road, London SE1

Enclosure 1

**LONDON AMBULANCE SERVICE**

# TRUST BOARD

**Monday 24th January 2005**

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

**Present:**

| | | |
|---|---|---|
| Sigurd Reinton | Chairman | |
| Peter Bradley | Chief Executive | (10.35-11.55 presentation to SHA CEO re. ECPs) |

Non Executive Directors

| | |
|---|---|
| Barry MacDonald | Non Executive Director |
| Colin Douglas | Non Executive Director |
| Toby Harris | Non Executive Director |
| Sarah Waller | Non Executive Director |

Associate Non Executive Director

| | |
|---|---|
| Beryl Magrath | Associate Non Executive Director |

Executive Directors

| | |
|---|---|
| Mike Dinan | Director of Finance |
| Fionna Moore | Medical Director |
| Wendy Foers | Director of Human Resources & Organisation Development |

**In Attendance:**

| | |
|---|---|
| Martin Flaherty | Director of Ambulance Services (East) |
| Philip Selwood | Director of Ambulance Services (West) |
| Peter Suter | Director of Information Management & Technology |
| Keith Andrews | Director of PTS |
| David Jervis | Director of Communications |
| Mike Boyne | Head of Operational Support |
| Kathy Jones | Director of Service Development |
| John Hopson | Asst. Chief Ambulance Officer - CAC |
| Vishy Harihara | Patients' Forum Representative |
| Angie Patton | Communications Manager |
| Martin Brand | Head of Planning & Programme Mgt. |
| John Wilkins | Head of Governance |
| Gary Bassett | PALS Manager |
| Christine McMahon | Trust Secretary (Minutes) |

**01/05** **Declarations of Further Interests**

There was no declaration of further interests

**02/05** **Opportunity for Members of the Public to ask Questions**

There were no questions.

**03/05** **Minutes of the Meeting held on 30th November 2004**

**Agreed:** **1. The minutes of the Board meeting held on 30th November as a true and accurate record with the exception of the correction noted below.**

**Noted:** **2. Minute 107/04: Colin Douglas asked that the minutes be amended to reflect that the crew involved in the Reaston Street incident had not done everything possible for their patient whereas it was accepted that the crew who had treated Anu Miah had shown diligence in their treatment.**

**3. Minute 104/04 – Barry McDonald wished it noted that there were two approaches being taken to improve "Doctors' Urgents" performance: one of which is focussing on utilising EMT 1s and the other is negotiating Ambulance arrival times with GPs.**

**04/05** **Matters Arising**

There were no matters arising that were not covered in the agenda.

**05/05** **Report of the Chairman**

The Chairman congratulated the Chief Executive, Peter Bradley, on the CBE he had been awarded in the New Year's Honours List. The Chairman felt the award was proper recognition Peter's achievements, and also reflected what the LAS had accomplished in recent years.

The Trust was in the process of recruiting two Non-Executive Directors; the Chairman hoped the appointments would be made by mid-March 2005. Prospective candidates had been invited to an open event to be held on 25th January 2005.

The recent NHS Confederation Council meeting had, again, highlighted the high levels of dissatisfaction with the Appointments Commission among its 'customers'. There was some hope that it had now been persuaded to conduct a user satisfaction survey to which the LAS would be contributing.

NHS Employers was consulting employees on proposed changes to the NHS pension scheme, including a move from being a final salary scheme to one based on average salary. Employees would also be asked their views on extending the pension age to 65years. The Chairman welcomed the NHS Pension Scheme's attempt to introduce a more flexible approach to older employees working flexible/part time hours pre/post retirement age.

It was noted that, with the exception of elective surgery, the implementation of Payment By Results has been put back for the time being.

Integrated Emergency & Urgent Care project: following the failure to obtain funding from the Treasury there was a joint meeting of the Reference Group and Steering Group last week. A set of outline draft recommendations were presented; it was recognised that further work would be necessary before deciding how to proceed next.

**06/05** **Report of the Chief Executive**

The Chief Executive thanked the Board for their congratulations and wished to express his gratitude to the Senior Management Team for their support during the last few years. He highlighted the following from his report:
*Performance:* in December Category A 14 calls increased by 7% - this was experienced by the LAS and nationwide. In December there were approximately 700 such calls being received on a daily basis; the numbers have decreased in January.

Category A 8 minute performance is below 70% in 4 PCT areas - measures were being put in place to try and address this shortfall in performance.

It was reported that the Department of Health's performance criteria for Category A 14 minutes and Category B 14 minutes now included cars responding to calls**.** This meant the LAS should achieve a performance figure of 95% for Category A14 for the year and is therefore on track to secure its two star rating. Further work was being done to improve performance relating to Category B 14 and Doctors' Urgents.

*31st December 2004* went very well; the Trust has received some good feedback from British Telecom regarding call handling. It was the first year since 2000 they had not received any complaints regarding delays in call answering.

*Tsunami* – the Chief Executive praised the work of the LAS crews and volunteers who had provided medical assistance to British holiday makers returning from South East Asia, some of whom were still in shock on arrival at Heathrow.

*London's Olympic bid* – the Chief Executive and the Director of Ambulance Services (West) would be making a presentation in support of London's bid to host the Olympics in 2008 to the International Olympic Committee in February 2005.

The *Chief Executive's Consultation meetings* continue – there are 4 meetings with CAC, 10 with PTS and 1 with the Logistics team scheduled for January and February 05. The Trust Board will received feedback in due course.

The *Improving Working Lives* validation process for "Practice Plus" will commence on 28th January 2005. This is important to the Trust as it contributes to the Trust's star rating.

The *National Health Service Litigation Assessment* will be taking place on 25th January 2005; the Trust is being assessed at level three.

*Communications:* two LAS staff won NHS Champions awards courtesy of the Evening Standard/King's Fund/London Tonight – Kevin Marshall and Ian Stuart-Maitland.

*Change in Licensing Hours* – the impact of the recent changes to the licensing laws is being monitored.

*Agenda for Change* – the Director of HR confirmed that the LAS was awaiting national resolution regarding the Emergency Medical Technician banding and also guidance on the management of meal breaks. It was noted that, although the timescales for implementation of Agenda for Change have been reviewed, they remained challenging.

An Executive Search Agency has been engaged to recruit a new HR Director following the disappointing response to the advertisement/interviews held in October 2004. The Chief Executive reported that he was consulting with the HR Director about her remaining in post until June 2005.

Beryl Magrath commended PTS on the excellent results shown in their patient survey; PTS should be proud of their achievement.
Beryl Magrath queried the poor performance figures for the PCTs in North Central. The Director of Ambulance Service (East) apologised for the graph as it was North East sector and not North Central where the problems with performance were being experienced. He felt the poor performance was due to a mismatch between resources and demand and that there was an action plan in place to address the problem.

The Director of Ambulance Service (East) and the Chief Executive had met with representatives from the North East London Strategic Health Authority to discuss the situation.

The Chief Executive confirmed that the North East sector would be receiving additional staff, ECPs and CTA to enable that sector to meet the high demand.

The Chairman had been surprised to learn recently that in a year the LAS receives around 1.1m calls to 770,000 incidences to which we had sent over a million responses. 10% of incidents receive a second ambulance, and a Fast Responder Vehicle was dispatched in 29% of all cases. This is necessary to meet performance targets but is expensive. It would be more efficient to use single response vehicles with experienced and qualified staff to respond to most calls, to be followed by an ambulance where a patient assessment had taken place and determined that ambulance transport is needed.

Newham is one of the PCTs where performance is unsatisfactory – a number of contributory factors were identified. It is the busiest ambulance complex in the UK (taking more calls than some county services), a mismatch between resources/demand and that the fact ambulances are often dragged into NE London. In November and December demand in both Newham and Haringey increased to very high levels. It was planned to make better use ECPs in the North East sector.

Bounds Green: the Board were informed of the circumstances which had led to the murder of a young man who was beaten to death by a gang of 10 youths whilst he was in ambulance. The member of staff had not been attacked and was unharmed but he was very shaken by what he had witnessed. The Police are investigating the case and have a number of suspects in custody.

There was a brief discussion regarding uniforms; historically EBS staff do not wear uniform and there are no plans to alter this. The Director of Service Development pointed out that of the 4 staff groups that would be working in the new Green base room, 3 of them do not wear uniform and it is a sensitive issue.

The Director of Ambulance Service (East) pointed out that when AfC was implemented there might be a knock on effect in staff being less willing to work overtime; the Trust has a young workforce who might wish to have more personal time.

Toby Harris reported that at a recent meeting with the Metropolitan Police at Heathrow following the Tsunami disaster they had been unstinting in their praise of the LAS crews for the support that was offered to the returning victims and holiday makers.

Sarah Waller was informed that the outcomes of the Hammersmith and St Helier PTS contract negotiations would be known in February 05.

The Director of HR confirmed that PDR was being rolled out over the next few months and that major progress would be achieved.

**Noted: The report**

**07/05** **<u>Report of the Director of Finance and Business Planning – Month 9 Financial Report</u>**

The Director of Finance presented the Month 9 financial report. The year end forecast was that the Trust would have a surplus of £947,000. The Board's attention was drawn to the performance of individual departments.

The Board was informed that some of the expected surplus for the year would be spent on funding additional overtime in CAC and A&E in an effort to boost performance in the final quarter of 2004/05.

The Trust was pursing outstanding debtors including the three Strategic Health Authorities who had yet to make any contribution to the cost of ECPs – this was estimated to be approx £300,000.

*PTS* – the trend is reasonably positive and awaiting decision on contract disputes that have gone to arbitration.

*Agenda for Change* – Interest received this year on the AfC funding is shown in the management accounts as £54,000.

Accounts receivable within 90 days has decreased to £233,000 to 4% of debtor balance. This is due to excellent work by the Finance team.

The Board discussed the proposal to broker most of the forecast surplus with the expectation that the money would be returned to the LAS in April 2005. Sarah Waller felt that the Trust needed to be clear why the surplus had occurred this year in case the LAS's level of funding was challenged. The surplus has arisen due to the slow implementation of AfC.

Barry McDonald queried why the East sector was not only over budget but also had poor performance in many PCT areas. The Director of Finance pointed out that both the budget and actual analysis by A&E sector was skewed by the impact of both CBRN funding and ECP costs. In the 2005/06 budget, cost, resources and performance would be better aligned.

Beryl Magrath asked if we had received all of the expected funding from the Changing Workforce Programme. The Director of Finance replied that we were chasing all the expected funding (£200k) with some urgency.

**Noted:**
1. **The report**
2. **That there was a positive variance- forecast for end of year is £947,000.**

**08/05** **Report of the Medical Director**

Clinical governance – the Trust is to be assessed in two areas. Firstly, by the NHS Litigation Authority (NHSLA) on 25th January 05 on its risk management arrangements and whether they are effectively embedded from Trust Board level through to front line staff. The NHS LA assessment has combined clinical and non-clinical standards; the Trust has asked to be assessed at level three which is the highest level that can be assessed. The LAS is the first Ambulance Trust to apply for level three assessments. There has been a significant amount of work done by the Governance Department Unit preparing for the Assessment. The focus of the visit on the 25th January will be to interview staff and review the LAS's progress in achieving the recommendations by previous assessments CNST (level 2 May 2002) and RPST (level 1, May 2003).

Secondly, it was reported that a report would be presented to the South West London Strategic Health Authority on 9th February 2005 regarding the Trust's substantial progress in achieving the recommendations that had arisen from the 2004 CHI review.

The Medical Director drew Members' attention to a report from the SE Ambulance Clinical Audit Group examining the treatment of patients with hypoglycaemia. One of the recommendations was that crews should be encouraged to improvement documentation of blood glucose values post treatment and report valid exceptions for not measuring blood glucose. The Clinical Audit & Research Group have recommended routine blood sugar screening of all patient over the age of 40, who may unknowingly have Type 2 diabetes.

The Board was asked to agree to the Medical Director and Clinical Effectiveness Manager travelling to Seattle to learn from the initiative being undertaken to improve out of hospital cardiac arrest survival in general and the implementation of the Despatch Assisted Respiratory Trial in particular.

Sarah Waller queried one of the key findings of the Clinical Audit Report which was that the crews should be informing the patient's GP that hypoglycaemia had been diagnosed. The Medical Director felt that there were issues regarding confidentially and practicality. It was confirmed that when patients have been diagnosed as hypoglycaemic and left at home, they are given a pink form and advised to inform their GP.

In reply to a question from Beryl Magrath the Medical Director said she felt that the NHS LA assessment would be a challenge for the LAS. She felt that one area where the Trust might be vulnerable would be proving that basic life support training has been given to all EMTs. However it was recognised that EMTs are called to approximately 7,000 cardiac cases each year and carry out cardiac respiration on approximately 3,500 patients. EMTs are supported by Team Leaders, Paramedics and there is an active training programme.

The Chairman requested that the Board receive a future report concerning ECP training programme, who does it and how is it funded.

**Agreed:**
1. **That permission be given to the Medical Director and Clinical Effectiveness Manager to travel to Seattle**
2. **That thanks be expressed to the LAS staff, Basic London, Basic UK and other volunteers who worked so tirelessly at Heathrow to help returnees from South East Asia who had been caught up in the Tsunami disaster.**
3. **That a report regarding ECP's training programme and funding would be presented at a future meeting.**

**Noted:**
4. **The Medical Director's report**

## 09/05 Freedom of Information Act Policy

The Director of Information Management & Technology presented the Freedom of Information Act Policy to the Board for approval. The Policy sets out the basis on which the Trust will respond to enquires made under the Freedom of Information Act (FoI). The Trust's basic approach will be to provide information when properly requested rather than finding reasons not to. The Trust will be also publishing as much information as possible on the web site, to keep the cost of responding to individual requests down.

There was some discussion regarding the request under the Act for information contained in email. Although it is illegal to dispose of material once a request has been received, it was recognised that although someone deletes email from their computer the same email will be saved on the server's back up system. The Director of Information Management & Technology undertook to investigate this aspect further. **ACTION: The Director of Information Management & Technology**

The Board thought the Policy was sensible, consistent with the Act and in line with the Trust's policy of being as open and accessible as possible.

The Finance Director reported that he had recently attended a meeting of the Chief Executives of the SWLHA at which FoI had been discussed. It was clear that there were some subtle differences in the legal advice received by each of the Trusts. The Department of Health had therefore undertaken to provide a standard set of advice regarding the FoI Act.

The Chairman felt that the more information that is published on the website the less cost there will be to the LAS – and this is also consistent with the Trust's policy of openness. He observed that the LAS was more likely to be inclined to openness than other areas of the NHS as it was involved in fewer potentially controversial decisions.

**Agreed:** **1. To approve the Freedom of Information Act Policy**

**Noted:**
**2. That the Policy would be reviewed in July 2005**
**3. That when the policy was reviewed a detailed annex regarding exemptions would be attached.**
**4. That should an Information Requestor be dissatisfied with the outcome of the internal complaints procedure he/she may appeal. The appeal will be heard by a panel consisting of NEDs who would consider the complaint**
**5. That to date only five emails have been received on the Trust's FoI email address – of these only one was deemed to be a true FoI enquiry, the other four were misdirected (one of them was an electronic Christmas Card).**
**6. That the Medical Director is the Caldecott Guardian.**
**7. That an ethnic monitoring form will be sent to requestors of information and they will be asked to return the form to the Trust for its records.**

## 10/05 Estate Matters for approval

*Combined business case for Brixton AS* – the Board was asked for approval to purchase a new Ambulance Station in the Brixton area with a total capital budget of £950,612 which includes a property value of £500,000. The Board recognised that a new station would ease pressure at the Oval AS, improve response times to Category A calls and release resources for deployment elsewhere in the Service.

*Purchase of Feltham & Chase Farm AS* –the Board was informed that the two ambulance stations had not been transferred when the LAS was established in 1996 as they had been thought to be surplus to the Trust's long term requirements. The Board was asked to approve the transfer and purchase of the two ambulance stations from the Secretary of State.

The Trust will receive additional funding to cover the cost of the two Ambulance Stations (effectively a nil effect on the balance sheet). However the Trust will incur a small additional revenue cost as it would be liable for depreciation and dividend contribution.

**Agreed:**
**1. To approve the purchase of Unit 25, Bessemer Park Industrial Estate, SE24 for use as an Ambulance Station in Brixton.**
**2. To The transfer and purchase of Feltham and Chase Farm AS from the Secretary of State to the LAS NHS Trust.**

## 11/05 Audit Commission Annual Audit Letter

The Chairman of the Audit Committee presented the Audit Commission's Annual Audit Letter to the Board for information. The Board were pleased that although the Audit Commission made a number of recommendations it was a very positive Audit Letter.

The Board discussed the subsidisation of PTS by A&E; the situation has improved (at one point it was £2.6m, it was now £1.7m and would be decreased next year by £300,000). The Finance Director assured the Board that the matter was in hand. It would be part of the 2005/06 budgeting process to decrease the cross-subsidisation and eliminate it before reference costs were introduced.

**Noted:** **With satisfaction the contents of the Audit Commissioner's Annual Audit Letter and the following recommendations:**

- **That the subsidisation of PTS by A&E cease**
- **That the Trust should aim to break even in 2004/05**
- **That the Trust should not be concentrating on achieving Category A 8 minutes to exclusion of its other targets**

**12/05** **Service Improvement Programme Update including a presentation regarding Make Ready.**

The Service Improvement Programme Manager presented the traffic light report which highlighted the progress of the Service Improvement Programme.

Toby Harris requested update on the replacement of digital radio which has been a national procurement project for the last fifteen years. The Director of Information Management and Technology confirmed that the Project Team is evaluating final offers and the intention is to go with one supplier.

The following outcomes have been identified as at risk of not being achieved by March 2006.

*Outcome 2 Regular availability of information about the delivery of patient care throughout the Service.* The Director of Service Development reported although the number of Clinical Performance Indicators checks had increased since the Sector Operating Model had been introduced, it still fell short of 100% of the required checks. Discussions were currently going forward about developing challenging but achievable milestones towards the 100% target.

*Outcome 26 & 27 – Category B 14min performance of 95% achieved & AS2-Doctors' urgent performance at 95% within15 minutes of agreed arrival time*. The Director of Ambulance Service (West) reported Outcomes 24 to 27 were concerned with changing the method of holding AOMs to account using balanced score card approach.

The four outcomes related to key performance indicators. Category B 14 minutes performance was felt to present the biggest challenge; this was being tackled by different use of single responders and the aim was to achieve 10% activation for Category A and Category B calls. The two Directors of Ambulance Services were reinforcing with their AOMs the need to focus on Doctors' Urgents. One area that is being explored is the possibility of PTS providing assistance when they have downtime or alternatively A&E buying time from PTS.

*Outcome 32 – Resource demand/match complaint significantly improved on sectors.* The Director of Ambulance Service (East) reported that the problem with achieving this outcome was that it was difficult to get the Commissioners to pay for the additional 300/400 front line ambulance staff that have been shown to be required. He is reviewing how ECPs could be better utilised to address the shortfall between demand and resources.

*Outcome 36 – 95% of Doctors calls answered in 30 secs.* The Assistant Chief Ambulance Officer – CAC (ACAO-CAC) reported that the following measures were in place to meet the target: staff were being trained on AMPDS Version 11 which would deal with new call time triage, there had been a separation of Doctors' calls and 999 calls and there would be dedicated staff answering Doctors' calls. With the addition of new staff, assistance from the IT and Training department the ACAO – CAC was confident that the target of 95% of Doctors' Calls would be achieved by March 2006.

*Presentation: Make Ready*

The Head of Operational Support gave a presentation on the Make Ready scheme, the reasons for introducing it and the lessons learnt from the roll out to five complexes to date. Ten complexes would have Make Ready introduced in 2004/05 and the remainder of the programme would be rolled out in 2006/07 and 2007/08.

The benefits to the Trust from the introduction of Make Ready are greater efficiency in the use fleet, better stock management, 'saved' crew hours and improved infection control. The Director of Operations felt the challenges for the future would be (1) getting the basics right, (2) benefits realisation of the programme and (3) funding the programme.

The Board was informed that as part of the Key Performance Indicators an analysis is done of random ambulances that have undergone the Make Ready process. This analysis is undertaken both before/after an ambulance is cleaned – the results to date suggest that there is a significant decrease in bacteria. There has been no MRSA found in the ambulances either pre/post a Make Ready.

**Noted**

1. **That five outcomes were deemed to be red (at risk) – four related to performance issues and one related to a patient issue.**
2. **That twenty-two were deemed to be amber**
3. **That thirty-two were deemed to be green**
4. **The progress of Make Ready to date.**
5. **That the format for presenting the results of the swab tests would be reviewed to improve comprehension.**

**13/05** **<u>Summary of PALS annual report</u>**

The Summary of the Patient Advisory Liaison Service (PALS) Annual Report was presented to the Board by the PALS Manager. The report contained detailed analysis of enquiries received by PALS since September 2002 to December 2004. An average of 300 enquires were received each month; a snapshot of the sort of enquires were included in an annex to the report.

Toby Harris had been impressed that Ambulance crew met with the families of young people that had been killed in a road accident. He thought it would be very helpful for bereaved families if the LAS could offer this service in special circumstances. The PALS Manager felt that this had been a unique event requested by the two families involved in the tragedy. He felt that Ambulance Crews would not be comfortable meeting with relatives of deceased patients on a regular basis

The Chief Executive highlighted the work that had been done with frequent callers, whereby Social Services had been contacted and were able to offer assistance.

**Noted: The report and the excellent work undertaken by the PALS unit.**

**14/05** **<u>Report from the Trust Board Secretary – tenders opened since the previous board meeting</u>**

Two tenders have been received since the November Trust Board meeting:

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

**Noted: The report**

**15/05** **Report from the Trust Board Secretary – sealings that have taken place since the previous board meeting**

Four sealings have been undertaken since the November Trust Board meeting:

- Draft memorandum of understanding between the LAS and Ziqitza Health Care Ltd
- Transfer of Chase Farm AS from the Secretary of State for Health and the LAS
- Transfer of Feltham AS from the Secretary of State for Health to the LAS
- Contract for redevelopment of Streatham AS between Coniston Ltd and the LAS

**Noted:**
1. **The report**
2. **That two of the sealings were premature in that the Board had not given their approval to the transfer of Chase Farm AS and Feltham AS from the Secretary of State to the LAS.**

**16/05** **Minutes of the December Service Development Committee**

**Noted:** **The Minutes of the December Service Development Committee**

**17/05** **Minutes of the Risk Management Committee – 6th December 2004**

The Chairman of the Risk Management Committee, Barry McDonald, commented that the trend of claims were downward with the exception of slips and trips.

**Noted:** **The Minutes of the Audit Committee Meeting held on 6th December 2004.**

**18/05** **Minutes of the Audit Meeting December 2004**

The Chairman of the Audit Committee, Barry McDonald, reported that the Director of Information Management and Technology had presented a work programme to address the issues raised by the Internal Auditors. There had been a number of reports presented for the Committee's review.

There had been one significant recommendation which related to policies and procedures not being followed consistently at station level. The Committee thought it would be worthwhile carrying out the same audit in a year or two as AOMs had been introduced since the audit was undertaken and there had been a strengthening of the management structure across the LAS.

**Noted:** **The Minutes of the Risk Management Committee Meeting held on December 6th 2004.**

**19/05** **Any Other Business**

1. Noted that a summary of the discussions held in Part II of the Trust Board meeting on 30th November had been included in the Part I agenda to comply with the spirit of the FoI Act.
2. The Trust Board discussed the potential cost of the 24 hour licensing hours to the general health economy. It was suggested that as responsibility for granting licences is being moved from magistrates to Local Authorities it might be easier to raise any concerns about individual licenses or clustering of licensees. It was reported that work was being undertaken by the Chief Executives of Primary Care Trusts to collate information on the impact of the change in licensing hours.

3. Colin Douglas wondered what the LAS's state of preparedness was for the predicted flu pandemic. The Medical Director confirmed that although LAS staff had been offered flu vaccination the take up had been disappointing. GPs were carrying out a programme of flu vaccination for their practices and for patients who were 60 years plus.

   The Director of Ambulance Services (West) reported that a table top exercise concerning the possibility of a flu pandemic had taken place in the Autumn 2004 and he would present the information to the SDC meeting in February 2005.

**20/05** **Opportunity for Members of the Public to ask Questions**

**Noted: That there were no questions from the Members of the Public.**

**21/05** **Date and Venue of the next Trust Board Meeting**

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

Enclosure 2

# LONDON AMBULANCE SERVICE NHS TRUST

## TRUST BOARD
## Part II

### Summary of discussions held on 24th January 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 24th January 2005 in Part II the Trust Board discussed the ongoing negotiations concerning Agenda for Change.

Enclosure 3

**LONDON AMBULANCE SERVICE NHS TRUST**

**TRUST BOARD MEETING 29th March 2005**

**CHIEF EXECUTIVE'S REPORT**

## 1. ACCIDENT & EMERGENCY SERVICE

### 1.1 999 Response Performance

The table below sets out the A&E performance against the key standards for the year to date. A detailed position is available in the attached graphs.

| | CAT A 8 | CAT A 14 | CAT B 14 | Urgent within 15 mins of STA |
|---|---|---|---|---|
| Standard | 75% | 95% | 95% | 95% |
| 04/05 year to date* | 76.4% | 95.8% | 79.6% | 58.2% |
| 03/04 year | 76% | 89.3% | 77.6% | 50% |

* year to date figures, management information data up to 17th March 2005

Key highlights:

- We remain on track to deliver the A8 and A14 targets for the year as a whole despite an overall rise in Emergency responses of 7.6%.
- Category A volumes for the year are up some 5-6% overall but February 05 data shows a 14.5% increase in Cat A volumes compared to February 04. In addition there remains considerable variation in Category A growth across PCT areas.
- We will now achieve the individual PCT target of no less than 70% CAT A 8 performance in 27 out 31 PCTs. Considerable efforts in February and March have now brought Waltham Forest PCT within target and we also believe that we will recover the position in Newham PCT by year end. This leaves three areas outside the target namely Barnet, Havering and Bromley. Work continues to deliver the best possible year end figure for these areas.
- Commissioners are keen to see more equity in performance across PCT areas and further modelling work is to be commissioned in April to understand how best this might be achieved.
- It should be noted that recent changes in H guidance have now allowed us to include FRU responses to B calls in our overall response time data. Whilst FRUs are not routinely tasked to B Calls at present this has nevertheless allowed us to show a slight improvement over the ambulance only figures. We therefore now anticipate a B14 figure of circa 80% for the full 2004/5 year.
- We are currently planning for the imminent changes in CAT A definitions in April and in particular for the decision to no longer automatically include children under two as a CAT A response. It is difficult to assess the overall impact of these changes at this stage particularly as we are changing to the

latest version of AMPDS (version 11.2) at the same time and we will be closely monitoring Cat A volumes during April and May

## 1.2 Central Ambulance Control

During January and February more than 250 staff have received 2 days training on AMPDS Version 11.2 ready for the launch of the new software and protocols in April. This intensive period of training has inevitably had some effect on our call answering performance which fell slightly in February to 78% in ten seconds. Three minute activation for January was 94.3% and for February it was 94.5%. It is the intention from April 05 to measure activation against a two minute target of 95% rather than three.

CAC management teams continue to be especially focused on all aspects of attendance management. Sickness figures continue to improve with January at 8.2% and February at 7.5%.

On the 21st March, Fifteen new staff started their training to fill the current vacancies, Plans are in hand to recruit circa 30 additional staff during 2005/6 to bring CAC staffing in line with the growth in overall demand.

ACAO John Hopson is working on a CAC plan for 2005/6 with the CAC Senior Management team, to ensure that the improvements made during 04/5 are sustained and built upon. There are now increasingly strong links between CAC and the IM&T Directorate with regular meeting aimed at progressing and implementing windows based technology within the new financial year whilst also making progress towards 'CAD 2010'.

## 1.3 Resourcing – January & February 2005

Despite a slight increase in seasonal levels of sickness in January, some of the highest average daily hours for ambulance and FRU were produced, compared with the last twelve months. In the main this was due to increased overtime working which returned to normal levels following the drop-off in December. Staffing as a percentage of plan for ambulances was 98.5% and 109% for FRU

February saw a further increase in FRU staffing (115% of plan) and a further increase in the number of average daily hours produced as challenged PCT areas increased FRU cover to maintain performance. This in part resulted in a slight reduction in ambulance cover (95.5% of plan).

## 1.4 Emergency Planning

### Exercise Atlantic Blue

Work continues to prepare for the worlds largest emergency planning exercise. Entitled Atlantic Blue this will be played out between the UK, Canada and the USA with many thousands of players and hundred's of organizations involved internationally. The LAS element of the exercise is will now no longer involve any 'Live Play' but will instead involve our full participation at Strategic and Tactical levels in a complex table top scenario. LAS will take a full and

pivotal role along side our NHS partners, the DOH and other Emergency Services. It will take place over five days in April often running 24 hrs a day. This will be an exacting test of our ability, both to respond to and resource a catastrophic incident.

**The 2012 Olympic bid.**

The IOC Commissioners visit was successful from an LAS and Health perspective and we are given to understand that all the presentations we were involved in were well received. We clearly now await the outcome of their decision in the summer and should the capital be successful at winning the games then planning will begin in earnest from that point on.

**Event Planning**

We are currently planning for the Mayday demonstrations and for the VE and VJ events in July. We will also be assisting other services in the planning for Royal Ascot in Yorkshire later this year and the G 8 Summit in Scotland.

**National Co-ordination Centre.**

During the recent Asian Tsunami disaster we assembled a National Ambulance Co-ordination Centre at our fall back control room in Bow . This proved successful and the model is currently being considered as a blueprint for a potential permanent arrangement which could be implemented quickly in the event of a similar emergency in the future.

## 1.5 Urgent Care Service

The Operational element of the Urgent Care Service currently has an establishment of 129. There are 104 in post, with twenty-five vacancies that comprise EMT1s and white work staff. Recruitment is ongoing and training courses for EMT1s are planned for May 2005. CTA staffing remains a challenge with around twelve vacancies from their establishment of thirty, although recruitment is at an advanced stage to rectify this.

Difficulties continue with the dispatch of Urgent Care crews primarily due to a lack of MDT Technology within the Green Base environment. This is at present resulting in a lower level of workload than originally anticipated. It is still uncertain whether we will initially be able to provide that MDT Technology in the new Urgent Operations Centre when it opens later this year. If this proves to be the case then we will need to explore alternatives which address the dispatching issues and raise the workload to acceptable levels.

The Doctor's Urgent Call triage system should be implemented over the next month, and training continues to be delivered to CAC staff on the new system. This will allow urgent call workload to be spread more evenly, based on agreeing an at-hospital time which is truly based on the clinical needs of the patient. It is anticipated that this will reduce the overall numbers of 'within the hour' calls.

The Emergency Bed Service have commenced a trial in the Richmond & Twickenham PCT area that will provide a single point of contact for all health care professionals, including urgent call taking function. Called 'EBS First' the trial also aims to provide a higher quality service to GPs by assisting the placement of patients at more appropriate places of care.

### 1.6 Sector Operating Model Evaluation

The Trust is undertaking a review of the Sector Operating Model which was implemented February 2004 after much consideration and consultation. A report will be compiled following the review and key learning points and any recommendations will be shared with the board in due course.

## 2. PATIENT TRANSPORT SERVICE

### PTS Training

Defibrillator training has now been completed to support the introduction of the first 35 defibs. Additional training sessions are also scheduled, for PTS Out of Hours and in Central Services staff.

### PTS Hospital arrival time

Overall performance has remained stable at 75.67%.

The arrivals time project group have identified a small number of contracts where we need to work with the trust to ensure that realistic booking times are submitted for all patients. For example, in some trust, patients attending a particular clinic are currently all given the same appointment time. This is unachievable for LAS PTS, impossible for the hospital administration to deal with. and unnecessary with the clinics operating a first come first served regime. A list of relevant trusts has been compiled, and we are liaising with them to investigate options for spreading appointment times, as a matter of urgency.

### PTS Hospital Departure time

Percentages continue around 83%, with a slight reduction in performance in February 2005 (82.7%) vs. January 2005 (84.5%). However, February was a slightly busier month overall, and particular challenges were faced, including a 16% increase in stretcher patients compared to January 2005.

Stringent cost control measures are still in place, and operational managers continue to monitor the impact on quality of this ongoing cost focus.

### Patient time on PTS vehicle

Performance continues to improve. February 2005 showed a 92.16% compliance, which is the third consecutive month to show an improvement.

## Operations

PTS Vehicles

Stretcher Vehicles - All 20 base vehicles have been delivered to the converter (Wilker), and all have undergone ramp fitment. Following a final stage inspection by the team on the 15/16th February, various cosmetic changes are being implemented. The current production schedule indicates that 15 will be delivered by 31st March 2005, with the remaining 5 (with blue lights) during April 2005.

R-reg Renault lease extension - Following further discussions with the lease company, we have tentative agreement for a minimum lease extension for all 49 R-regs for a 6 month period, with an option to extend selectively up to 2yrs. This will give us flexibility until the outcomes of the Hammersmith, Epsom & St. Helier, and Chase Farm & Barnet tenders are known.

## Contracts Update

### Hammersmith Hospitals NHS Trust

The uncertainty caused by the continuing delay in tender award is causing staffing problems, with people searching for other opportunities, and increased absence rates. We have highlighted our concerns and issues to the tender team regarding the impact of the delays.

We continue to maintain good relationships with the trust managers. Even though the hospital was obliged to close the transport lounge for two weeks, due to flooding from the renal unit above, the operations team successfully maintained a normal service. This was gratefully acknowledged by the trust.

### Wandsworth PCT

Although LAS lost the overall PTS contract for Wandsworth PCT earlier this year, we continue to provide their non-local patient transport. Over-activity on this work continues at 60%+ with invoices being paid in full. We expect to meet our original contribution target at year end. This is a huge success for the local LAS PTS operation, and we continue to talk to the trust with a view to formalising this additional activity in a revised contract.

### RNO Stanmore

Following a meeting with RNO Chief Executive, it has been agreed that LAS will re-establish an on-site control in Stanmore, and our SLA will increase by April 2005. RNO Stanmore staff also indicated that they would like LAS to undertake London stretcher journeys as soon as possible. A revised SLA is to be put forward to Stanmore with increased activity. Our ability to deliver a flexible and responsive service has resulted in increased demand for our services, with increased revenue for 2005-06.

**Tenders & New Business**

**Hammersmith Hospitals NHS Trust**

Additional data has been received from HHNT for the renal patients currently undertaken by St. Mary's Paddington. A price for this work has been submitted. Our advice from the trust is that they will be making their final award before end March 2005.

**Epsom & St. Helier Hospitals NHS Trust**

We were unsuccessful with our tender for this contract. It was awarded to Group 4.

**Chase Farm & Barnet/Barnet, Enfield & Haringey Mental Health**

We submitted a tender for Chase Farm & Barnet Trust in January 2005. No formal communication has been received to date.

BEH Mental Health is not included in this tender. We have no agreement with this trust to continue beyond 31 March 2005, and we are having difficulties communicating with anybody in the trust to clarify their needs. We continue to make every effort to progress this.

**North West London Hospitals NHS Trust**

We have submitted a proposal to undertake PTS for the limb-fitting centre run by this trust at Stanmore. This work ties in with our existing contract at RNO Stanmore, and is located on the same site. NWLH started using our PTS Central Services for on-the-day PTS bookings and evening PTS journeys. The trust has 24-hour coverage from two existing contractors, but LAS is picking up a small number of journeys which their on-site providers cannot meet. We are confident that, with the flexibility and fast response we are showing, that this work will continue to grow.

## 3. PATIENT AND PUBLIC INVOLVEMENT (PPI)

An appointment to the newly-introduced post of LAS Patient and Public Involvement Manager has been made and it is hoped the successful candidate will join the Service towards the end of May. This will give added impetus to the development of greater engagement between the LAS and the many communities across London.

Meanwhile work is progressing with the LAS Patients Forum in developing a model for PPI in the Camden area and a number of local community and patient representative organisations have expressed support for our plans.

The PPI Committee has met twice since the last Board meeting and continues to be very well attended. A range of issues around PPI have been discussed and at the last meeting a presentation was made on the focus groups held with patients treated by emergency care practitioners.

A LAS Patients Day is being held at a central London location on May 10th at which representatives of patient organisations will be invited to give their views of the ambulance service and its future development. The event will be facilitated by Barrie Taylor, chair of Westminster Council's health scrutiny committee and a commissioner with the Commission for Patient and Patient and Public Involvement in Health, and David Gilbert, PPI lead at the NHSU.

**Communications**

The Communications Department has handled media interest in a number of high profile incidents, including the murder of a man in the back of an ambulance in Bounds Green and the crush that occurred at the opening of the new Ikea store in Edmonton.

There has also been continuing interest in the case of two members of staff charged with theft from two patients.

On a more positive note, the department also helped arrange for a crew from Shoreditch to fly out to South Africa for a special edition of the BBC1 programme Trauma.

Martin Bomford and Tim Burnett rode out with paramedics in Johannesburg to learn more about the city's ambulance service and the types of pressures they face.
The programme is scheduled to be broadcast later in the year as part of a series of BBC programmes about Africa. A new series of Trauma, based again at the Royal London Hospital, will also be shown on BBC1 and BBC3 in the summer.

London Tonight and the Evening Standard both covered the NHS Champion's Awards ceremony in January. Kevin Marshall, a Friern Barnet duty station officer, received this year's 'Ambulance Crew' award after being nominated for developing a specific patient protocol for Gina Steels, who suffers from five serious forms of epilepsy and is allergic to anti-convulsive drugs. Kevin's win was also covered by local newspapers and ambulance magazines. Runner-up Ian Stuart-Maitland was nominated for his part in responding to four teenage girls who had been struck by lightning in Hyde Park.

Service vehicles are now sporting the 'NHS backs the bid' message. Stickers provided by the North East London Strategic Health Authority have been placed on the side panels of ambulances, and window stickers are being displayed on rapid response units. Chief Executive Peter Bradley and former Deputy Chief Ambulance Officer Philip Selwood attended presentations given to IOC members in February;

Peter sat on the expert panel for medical services, and Philip on the panel for security issues.

Minister of State for Health Rosie Winterton visited Barnehurst ambulance station at the beginning of February. Together with local MP Nigel Beard she met and spoke to a range of staff and learnt more about the introduction of emergency care practitioners in nearby Bromley.

Other work has included the organising of two mini-films featuring the Service, to be shown at this year's European Forum on Quality Improvement in Healthcare in London in April. The work of emergency care practitioners is the focus for one of the films to be shown during the opening session of the three day event; the Service's role in taking patients suffering a heart attack directly for primary angioplasty at specialist units is highlighted in the second film.

Also for the future, the March/April edition of the national specialist magazine, The Emergency Services Times, will feature a London Ambulance Service supplement. Opening with an introduction from Chief Executive Peter Bradley, the pull-out will profile issues including emergency planning, the 'make-ready' scheme, staff safety and mobile phone caller-location technology.

**Chief Executive Consultation meetings**

As well as the 1,500 hundred people who attended the Chief Executive consultation meetings before Christmas, a further 330 members of staff met with Peter Bradley, directors and senior managers at meeting specifically held for fleet and logistics, CAC and PTS staff.

A wide variety of issues were raised and discussed, as outlined in the current issue of LAS News (issue 113).

For fleet staff, the issues included the need for more personal responsibility towards Service vehicles. Those working in CAC reiterated the need for more staff and improved technology while PTS staff expressed concerns over job security because of the constant uncertainty over the status of contracts.

## 4. OVERSEAS TRAVEL

Andy Heward, Priority Dispatch Development Officer and James Gummett, Quality Assurance Adviser have made a request to attend the Annual International Academy of Emergency Dispatch (IAED) Educational Summit and Conference in USA in April 2005. Due to the members of staff being involved both locally and nationally, attendance of this conference would improve their knowledge on the service and bring that back to the LAS and the UK.

Andy Heward and James Gummett have also been invited to visit Richmond EMS in Virginia, USA by the CEO Jerry Overton. Both Andy and the CEO sit on the same standards council, representing the users needs and looking at how AMPDS can best

be adapted to identify emergency calls that are suitable for alternative and appropriate responses. This visit will allow Andy to spend more time with the CEO and understand his approach to this and develop allies in the way we, as the LAS and UK need to move forward. James Gummett will also take this opportunity to see an American Ambulance control in operation.

**Recommendation:**

THAT the TRUST BOARD:

Approve overseas travel by Andy Heward and James Gummett

## 5. HUMAN RESOURCES

### Improving Working Lives -Practice Plus Validation

As reported at the January Trust Board, the Service underwent validation for 'Improving Working lives – Practice Plus Status' during week commencing 21st February 2005. A draft report has been produced by the validation team, which the Trust was invited to comment upon, and this is now subject to external moderation. A decision on whether practice plus status has been awarded is expected towards the end of March.

### 2004 NHS National Staff Survey

The initial results of the 2004 staff survey have now been received which are, overall, very positive. The Healthcare Commission required the Service to sample a specified 848 staff although in fact all staff were surveyed. The response rate for the Healthcare Commission was 48% and 46% across all staff compared to an average NHS response rate of 52%.

The positive messages included

- The quality of senior management within the LAS was found to be the best across all ambulance services (for the second year).
- Very positive feelings about working for the Service.
- Few staff said that they intended to leave the LAS
- Staff reported that they work in well structured teams.
- Improvements have been achieved in the reporting of incidents.
- Staff reported increased levels of job satisfaction.
- Perceptions of effective action by the Service towards violence and harassment.

Areas of concern and which require further attention include:-

- Harassment and bullying
- The need for more health and safety training

- Pressure to work additional hours and concerns relating to the existence of work related stress.
- Concerns were expressed relating to objective setting and feedback on performance although the percentage of staff with Personal Development Plans is the same as in other ambulance services.

Work is currently underway to analyse the data in greater detail and further details will be provided to the Trust Board.

**Workforce Information**

**(1) A&E Frontline Staff**

The tables shown over the page set out the 2004 – 2005 A&E Resource Plan and provide information on recruitment and retention activity and its impact on the provision of trained operational frontline staff.

**Key Points**

- There have been 25 technicians recruited in the current financial year and 25 direct entrants have been employed.
- The number of trained staff leaving the Service as at 28th February 2005 was 110 against a plan of 108. (See table 2).
- The number of operational vacancies as at 28th February is 76 WTE with a forecast position at year end of 86 WTE, see table 6
- Of the 2372 front line staff (in WTE) 915 are registered paramedics. The total number of new paramedics trained this year is 106.
- Team Leaders are included in the frontline establishment. The position at 28th February 2005 was as follows:
- Of the 169 team leaders in post there are 16.5 WTE's on secondment.

| Team leader establishment | In post | Variance |
|---|---|---|
| 175 | 169 | (6) |

**(ii) <u>CAC Operations</u>**

**Establishment and In-post figures as at 28th February 2005**

| | Establishment | In-Post | Variance |
|---|---|---|---|
| Emergency Medical Dispatchers | 245.6 | 225.2 | (20.4) |
| Operational Managers | 56 | 54 | (2) |

**CAC Resourcing Plan 2004-2005**

| | Recruitment | | | Leavers | | |
|---|---|---|---|---|---|---|
| | **Plan** | **Actual** | **Variance** | **Plan** | **Actual** | **Variance** |
| Apr | 12 | 7 | (5) | 3 | 4 | 1 |
| May | 0 | 0 | 0 | 3 | 2 | (1) |
| Jun | 0 | 0 | 0 | 3 | 1 | (2) |
| Jul | 12 | 8 | (4) | 3 | 2 | (1) |
| Aug | 0 | 0 | 0 | 3 | 2 | (1) |
| Sep | 0 | 0 | 0 | 3 | 0 | (3) |
| Oct | 12 | 23 | 11 | 3 | 1 | (2) |
| Nov | 0 | 0 | 0 | 3 | 3 | (0) |
| Dec | 0 | 0 | 0 | 3 | 2 | (1) |
| Jan | 12 | 0 | (12) | 3 | 3 | (0) |
| Feb | 0 | 0 | 0 | 3 | 1 | (2) |
| March | 0 | | | 3 | | |
| Total | 48 | 38 | (22) | 36 | 21 | (12) |

**Key Points**

- The number of EMDs leaving the Service as at 28th February was 21 against a plan of 33
- The next EMD Training Course (of 14 WTE) started on 21st March 2005.

**(iii) Training Officers**

***Establishment and In-Post figures as at 28th February 2005***

| Establishment | In-Post | Variance |
|---|---|---|
| 78 | 74 | (4) |

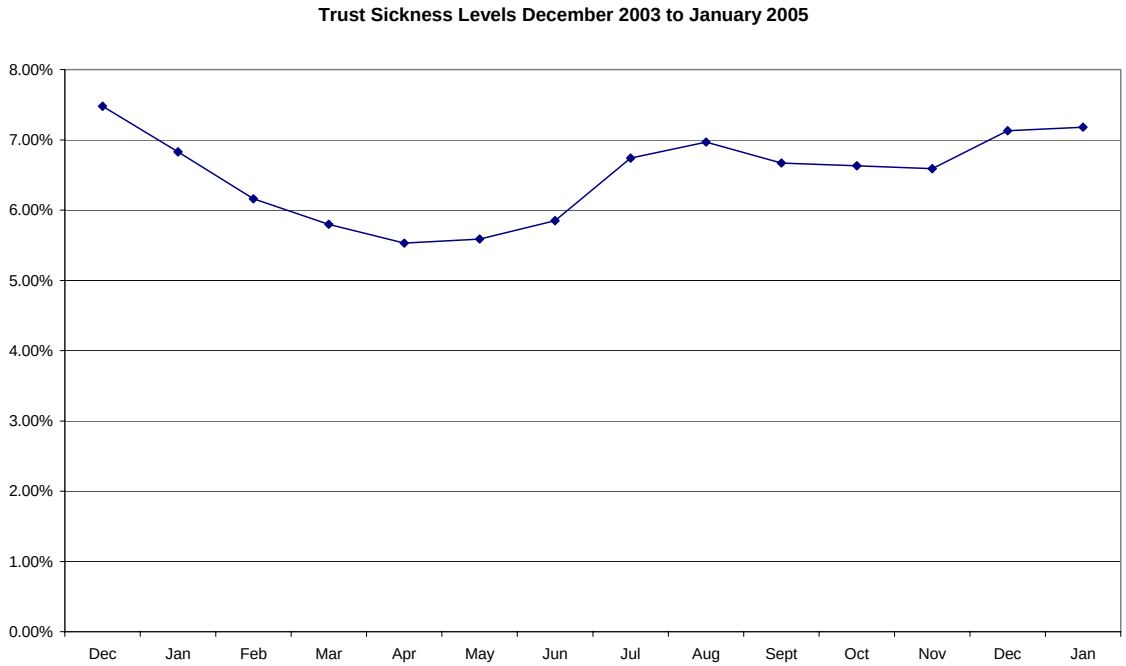
Key Point

- In addition to the 4 vacancies, there are an additional 4 training officers who are seconded out of the training directorate.

## (iv) Attendance Management

***Trust sickness levels – December 2003 to January 2005***

| Month | % Absence |
|---|---|
| Dec 03 | 7.48% |
| Jan 04 | 6.83% |
| Feb 04 | 6.16% |
| Mar 04 | 5.80% |
| Apr 04 | 5.53% |
| May 04 | 5.59% |
| June 04 | 5.85% |
| July 04 | 6.74% |
| Aug 04 | 6.97% |
| Sept 04 | 6.67% |
| Oct 04 | 6.63% |
| Nov 04 | 6.59% |
| Dec 04 | 7.13% |
| Jan 05 | 7.18% |



**Sickness levels, by staff group, for January 2005 are shown below:**

.

| Staff Group | % Total Absence |
|---|---|
| A & E | 7.16% |
| CAC (Watch Staff) | 9.86% |
| PTS | 6.53% |
| A & C | 5.87% |
| SMP | 3.95% |
| Fleet | 7.26% |
| **Trust** | **7.18%** |

**Peter Bradley CBE**
**CHIEF EXECUTIVE OFFICER**

March 2005

# A&E Crew Staff Numbers

## Table 1

| Training Course Start Date | Training Funded Plan | Into Training Actual | Variance from Plan |
|---|---|---|---|
| Apr-04 | 0 | 0 | 0 |
| May-04 | 0 | 0 | 0 |
| Jun-04 | 0 | 0 | 0 |
| Jul-04 | 0 | 0 | 0 |
| Aug-04 | 0 | 0 | 0 |
| Oct-04 | 30 | 25 | (5) |
| Nov-04 | 0 | 0 | 0 |
| Dec-04 | 0 | 0 | 0 |
| Jan-05 | 0 | 0 | 0 |
| Feb-05 | 0 | 0 | 0 |
| Mar-05 | 0 | 0 | 0 |
| Total | 30 | 25 | |

## Table 2

| Date | Leavers (Plan) | Leavers (Actual) | Variance from Plan |
|---|---|---|---|
| Apr-04 | (9) | (7) | 2 |
| May-04 | (9) | (9) | 0 |
| Jun-04 | (9) | (11) | (2) |
| Jul-04 | (9) | (4) | 5 |
| Aug-04 | (9) | (13) | (4) |
| Sep-04 | (9) | (16) | (7) |
| Oct-04 | (9) | (8) | 1 |
| Nov-04 | (9) | (11) | (2) |
| Dec-04 | (9) | (8) | 1 |
| Jan-05 | (9) | (10) | (1) |
| Feb-05 | (9) | (15) | (6) |
| Mar-05 | (9) | 0 | |
| | (108) | (112) | (13) |

## Table 3

| Date | Promoted (Plan) | Promoted (Actual) | Variance from Plan |
|---|---|---|---|
| Apr-04 | (1) | (8) | (7) |
| May-04 | (2) | 0 | 2 |
| Jun-04 | (1) | 0 | 1 |
| Jul-04 | (2) | 0 | 2 |
| Aug-04 | (1) | 0 | 1 |
| Sep-04 | (2) | 0 | 2 |
| Oct-04 | (1) | 0 | 1 |
| Nov-04 | (2) | 0 | 2 |
| Dec-04 | (1) | 0 | 1 |
| Jan-05 | (2) | 0 | |
| Feb-05 | (1) | (1) | 0 |
| Mar-05 | (2) | 0 | |
| | (18) | (9) | 5 |

## Table 4

| Date | Posted to Ops Training (Plan) | Posted to Ops Training (Actual) | Variance from Plan |
|---|---|---|---|
| Apr-04 | 0 | 0 | |
| May-04 | 6 | 6 | 0 |
| Jun-04 | 12 | 12 | 0 |
| Jul-04 | 0 | | |
| Aug-04 | 0 | | |
| Sep-04 | 0 | 0 | |
| Oct-04 | 0 | 0 | |
| Nov-04 | 0 | | |
| Dec-04 | 0 | | |
| Jan-05 | 18 | 14 | (4) |
| Feb-05 | 12 | 11 | |
| Mar-05 | 0 | | |
| | 48 | 43 | (4) |

## Table 5

| Date | Direct Recruits (Plan) | Direct Recruits (Actual) | Variance from Plan |
|---|---|---|---|
| Apr-04 | 1 | 0 | (1) |
| May-04 | 1 | 0 | (1) |
| Jun-04 | 1 | 0 | (1) |
| Jul-04 | 1 | 0 | (1) |
| Aug-04 | 1 | 0 | (1) |
| Sep-04 | 1 | 10 | 9 |
| Oct-04 | 24 | 13 | (11) |
| Nov-04 | 1 | 1 | 0 |
| Dec-04 | 1 | 1 | 0 |
| Jan-05 | 1 | 0 | (1) |
| Feb-05 | 1 | 0 | |
| Mar-05 | 1 | 0 | |
| | 35 | 25 | (8) |

## Table 6

| Date | In Post at Start of Month | Actual or Forecast Change | In Post Month End | Budgeted Establishment | Variance against Establishment |
|---|---|---|---|---|---|
| Mar-04 | | | | 2,405 | |
| Apr-04 | 2,416 | (11) | 2,405 | 2,405 | (1) |
| May-04 | 2,405 | (3) | 2,402 | 2,405 | (4) |
| Jun-04 | 2,402 | 1 | 2,403 | 2,405 | (3) |
| Jul-04 | 2,403 | (4) | 2,399 | 2,405 | (7) |
| Aug-04 | 2,399 | (13) | 2,386 | 2,405 | (20) |
| Sep-04 | 2,386 | (6) | 2,379 | 2,405 | (26) |
| Oct-04 | 2,379 | 13 | 2,392 | 2,450 | (13) |
| Nov-04 | 2,392 | (10) | 2,382 | 2,450 | (68) |
| Dec-04 | 2,382 | (7) | 2,375 | 2,450 | (75) |
| Jan-05 | 2,375 | 4 | 2,379 | 2,450 | (71) |
| Feb-05 | 2,379 | (5) | 2,374 | 2,450 | (76) |
| Mar-05 | 2,374 | (10) | 2,364 | 2,450 | (86) |

The "Actual or Forecast Change" column is calculated by subtracting the results of Tables 2 & 3 and adding Tables 4 & 5.

The difference between the figures shown above and those in Appendix 1 of the Finance Report relate to secondments.

Enclosure 5

**LONDON AMBULANCE SERVICE NHS TRUST**

**TRUST BOARD MEETING 29th March 2005**

# Report of the Medical Director

## 1. NHSLA Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service

Following the recent review of the Trust's risk management arrangements by the NHS Litigation Authority an improvement period notice has been served offering an additional three months in order to address certain areas of non-compliance at Levels one and two of the new Risk Management Standard. Evidence demonstrating compliance with the above features should be submitted by 23rd May 2005. A programme of work is underway to ensure that the Trust achieves this standard.

## 2. Progress in Cardiac care

Chapter 8 of the Coronary Heart Disease National Service Framework was released this month and relates to Arrhythmias and Sudden Cardiac Death in young people. These new areas provide an exciting time for ambulance services with the opportunity to raise their profile and contribute to research evidence. The chapter gives a clear introduction to the problems faced in this area along with 'Markers of good practice' which will affect practice in the LAS.

Within a short period patient pathways will be available which give greater details on how patients should be managed – these will apply to all professionals within the Health Service including front line ambulance staff. In particular the assessment of patients who suffer a transient loss of consciousness (T-LOC) or collapse will require acquisition and interpretation of a 12 lead ECG.

Additional Interventional Cardiology Units have expressed interest in direct admission of patients shown to have a ST elevation myocardial infarction (STEMI).

- The London Chest Hospital will offer a 24/7 service from April and now accepts patients from as far as Romford.
- Harefield Hospital is extending its catchment area to include patients from the Pinner complex.
- King's College Hospital will also start a 24/7 service from April which will initially include patients from both the local catchment area and Lewisham, but will roll out in time, to include the South East Sector.
- St George's is also offering primary angioplasty, initially on a limited hour's basis, covering the local catchment area and that of St Helier.

## 3. Continuing professional development course

The Education and Development Department will deliver a Continuing Professional Development to all front line staff commencing 11th April. This five day programme will be delivered over a period of two years and will cover the following areas; patient assessment, 12 lead ECG refresher, mental health, protection of children and vulnerable adults, diversity (providing best practice in the workplace), manual handling, major incident management, updates in CBRN and complaints management.

## 4. New drugs

Morphine

In accordance with the group authority issued under The Misuse of Drugs Regulations 2001, Morphine sulphate was recently been added to the list of drugs authorised for use by registered paramedics. Morphine is a Class A Controlled Drug under schedule 2 of the Misuse of Drugs Act 1985, and is therefore subject to full controlled drug requirements relating to prescriptions, safe custody and the need to keep registers.

The London Ambulance Service NHS Trust (LAS) will allow the administration of morphine sulphate by Registered Paramedics only. LAS registered paramedics may only draw morphine sulphate for the duration of their shift period. Under no circumstances will morphine sulphate be retained whilst staff are off duty. Guidance with regard to whom and at what dose morphine sulphate may administered is provided in the National Clinical Guidelines for use in UK Ambulance Services (2004 Edition), and the LAS will adhere to this guideline.

Following discussions with the Home Office an operating procedure has been agreed and a policy is being drawn up to formalise the procedures for the ordering, storage usage and return of out of date stocks of morphine within the LAS. The new Logistics premises at Deptford will require to be licensed by the Home Office. This application is in hand. On station, morphine will be stored in its own controlled drugs safe accessed by a digital keypad. The maximum scale of issue per paramedic, per shift will be two pre-filled syringes of morphine sulphate each containing 10mg in 10mls of solution. By agreement with the Home Office the syringes will be carried in the main compartment of the paramedic bag, which will be locked with a padlock that will be individually issued to each paramedic. The LAS is having the required Controlled Drugs registers and order / return books printed to reflect the nomenclature and circumstances of an ambulance service. (The registers available on the market are all geared to hospital / clinic use).

Education and training materials are being prepared by the Education and Training Department and these have been preceded by articles in LAS News. The target date for introduction is April / May 2005.

Amiodarone,

Amiodarone is an anti arrhythmic agent has recently been added to the list of drugs on the Prescriptions Only Medications (POMS) list. It is now the preferred drug in the

management of patients with shock resistant ventricular fibrillation as well as ventricular tachycardia. The LAS is exploring .its introduction for use by paramedics.

## 5. Update on progress in Clinical Audit and Research

To ensure the systematic reporting of clinical issues to the Board the items in Appendix 1 are presented for information.

## 6. Recommendation

THAT the Board note the report

Fionna Moore
Medical Director
March 2005

**Appendix 1**

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

**Clinical Audit & Research Summary Reports for the Trust Board**

- Summary of the findings from the ASA/JRCALC 2003 National Clinical Audit Report – Patients identified as having ST Segment Elevation

  Copies of the full ASA/JRCALC National Clinical Audit Report are available on request from the Clinical Audit & Research Unit or can be found on the LAS Common Server (x:/A&E Development/Clinical Audit & Research Unit/Clinical Audit Reports/Annual Reports).

## Summary findings of the ASA/JRCALC 2003 National Clinical Audit Report – Patients identified as having ST Segment Elevation

**Dr Rachael Donohoe; Head of Clinical Audit & Research.**

---

This report summarises the findings of the 2nd ASA/JRCALC national clinical audit, which assessed the care of patients identified as having ST Segment Elevation Myocardial Infarction (STEMI) during the 12-month period from 1st January 2003 – 31st December 2003. 31 Ambulance Trusts took part in the audit, submitting data on a total of 13,023 patients. The LAS contributed data on 244 patients who had a STEMI diagnosed by crews using a 12-Lead ECG.

This summary report also compares the LAS's performance figures for 2003 with the LAS figures published in the 2002 ASA/JRACALC national clinical audit report.

The percentage figures reported in the table below are a calculation of the number of times a treatment or performance standard was met plus exceptions or contra-indications.

| | 2002 | 2003 | 2003 |
|---|---|---|---|
| **Indicator** | **LAS Patients (n=63)** | **LAS Patients (n=244)** | **National Average (n=13,023)** |
| Aspirin administration | 92% | 80% | 81% |
| GTN administration | 92% | 76% | 67% |
| Pain score decreased | 11% | 50% | 63% |
| Analgesia administration | 10% | 18% | 27% |
| Oxygen administration | 92% | 80% | 90% |
| Call to on-scene time within 8 minutes | 74% | 62% | 62% |
| Call to door time within 30 minutes | 14% | 20% | 18% |

In the 2002 national audit report, the LAS's results were generally higher than national average. However, this time the findings are less favourable. For a number of indicators (namely pain management, analgesia and oxygen administration) the LAS's scores are lower than the 2003 national average. The notable exceptions are GTN administration and the 30 minutes call - door targets where performance is

higher than the national average. Both aspirin administration and performance against the 8 minute call – scene target are equivalent to the national average.

When the LAS's 2003 figures are compared with those for the previous year, a pattern of decline further emerges where scores against the majority of indicators have decreased. The exceptions are pain scoring, analgesia administration and the 30 minute call - door target where performance has increased.

While it is encouraging that pain scoring and analgesia administration have both improved over the last year, these scores still fall short of the national average.

These figures are of significant concern to the LAS and further decline must be prevented. The quarterly STEMI reports and the CPI reports produced by CARU will provide regular information against which the care of STEMI patients can be continuously monitored.

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 29th March 2005

# 2005/06 Service Plan and Budget

## 1. Purpose

To present the Trust Board with the Service Plan and Budget for 2005/06 and obtain endorsement.

## 2. Recommendation

THAT the Trust Board agree:

- the Service Plan 2005/06
- the Budget 2005/06

**Peter Bradley**
**Chief Executive**
**March 2005**

# Service Plan 2005-06

## Contents

## 1. Introduction

This plan outlines what the London Ambulance Service (LAS) will strive to deliver for its patients and the public of London, for the year 2005/06. This builds on the 2004/05 achievement of a forecast 76% response rate in eight minutes to Category A calls against a target of 75% and an increase in damand of 5-6% (7.6% overall) . This plan is also a step on the way to achieving the LAS Vision, Purpose and 'CRITICAL' Values (Appendix 1).

**Vision:** *A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.*

**Purpose:** *The purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement.*

*We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London.*

The development of this Service Plan was linked to the processes of budget setting and commissioning, along with direction and feedback from various stakeholder groups, meaning that service planning was almost continuous throughout the year.

The plan is driven in part by the NHS Planning Framework containing the new *Standards for Better Health* and what the organisation as an ambulance service can contribute to the achievement of targets and priorities within that. It is also driven by a range of internal sources – the Service Improvement Programme which has been extended to a fifth year to end in March 2006, Initial Statements of Need, Diversity and Clinical Governance plans, the Trust's Risk Register, and feedback from staff.

In the coming year, as in 2004-05, LAS priorities are increasingly influenced by feedback from patients and the public about their experiences and what they wish to see happening differently. The Chief Executive's consultation meetings with staff take place between September and February each year, and the feedback received during these meetings was influential in planning for the forthcoming year.

This Service Plan is a one year plan, but there is an intention to move during 2005 to a longer planning cycle in line with the NHS Planning Framework. The creation of a Strategic Plan based on wide stakeholder input and building on the success of the Service Improvement Programme will drive forward service improvement after March 2006.

A Strategic Plan will set direction for the organisation in the wider context of developments in the NHS in the fields of emergency and out of hours care. It will be the vehicle for further translating the Vision and Purpose into tangible outcomes and programmes of work to deliver them.

## 2. LAS Aspirations

2.1 *To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, with particular attention to*:

- National priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology;
- National performance targets, e.g. financial balance, response time performance and call answering targets, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt;
- Responding to recommendations of reviews that took place in 2004/5 by implementing recommendations;
- Supporting partnership working with other organisations, to input and improve Urgent and out of hours care;
- Providing more consistent training to existing members of staff.

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

- Following up on changes to LAS structure, including the new A&E operations structure, integration of the Patient Transport Service and the Emergency Bed Service, instituting the Urgent Control Room and embedding the Urgent Care Service;
- Providing a high quality working and supportive environment for staff with good logistical support;
- Developing a culture in which information is readily, openly shared and all staff are listened to and heard;
- Ensuring behaviour is consistent with LAS Values.

## 3. Key actions in support of the aspirations

The financial position for 2005/06 means that very limited funding is available for new projects. As in previous years, bids for developments have been requested using the 'Initial Statement of Needs' process. This year there is only a small amount of funding for Initial Statement of Needs projects from the internal savings that have been identified and the capital allocation (Capital Resource Limit).

The Trust is continuing with those Service Improvement initiatives that began in 2004/05 or that are funded from existing budgets. These are:

- Agenda for Change;
- Make Ready Scheme;
- Introducing and equipping replacement ambulances;
- Maintaining staffing levels in sectors and CAC;
- Implementing the Organisation Development Programme;
- Work to respond more appropriately to non life-threatening calls;
- Development of PTS;
- Implementing the Diversity Plan;
- Ensuring that the Trust is meeting the Core Standards specified by Standards for Better Health so as to be able to make a public declaration to this effect by September 2005;
- Complete modernisation and new role for the Emergency Bed Service;
- Implement the Patient and Public Involvement strategy;

- Continue the implementation of the Urgent Care Service and Urgent Control Room;
- Expand the roll of Emergency Care Practioners.

## 4. External drivers

As for last year, 3-year Local Delivery Plans are being co-ordinated for their PCTs by the Strategic Health Authorities, detailing how the NHS targets set out in the NHS Planning Framework will be achieved.

The LAS has a key role to play in supporting the NHS in achieving these targets, many of which depend on taking a whole system approach, with each organisation – including the LAS - playing its part in delivery, with local sharing of performance and financial data and involving front-line staff.

As an NHS Trust, the LAS sees itself as an active contributor to principles such as designing services around the people who use them, involving patients and the public, meeting national priorities and achieving cultural change. The emphasis is on:

- making measurable progress in high priority areas;
- developing capacity by increasing staffing numbers, facilities and equipment;
- changing the way the whole system works, particularly ensuring greater choice for patients and users.

Every organisation needs to:

- ensure the safety of service users, including developing clinical governance arrangements;
- ensure people are fully informed and involved;
- take into account the working time directive;
- take part in emergency planning;
- continue to modernise service delivery (including sharing good practice);
- provide new skills and competencies;
- introduce new information and communication systems.

The health and social care priorities are:

- improving access to all services through better emergency care, reduced waiting and more choice for patients;
- focusing on improving services and outcomes in cancer, coronary heart disease, mental health, older people and improving life chances for children;
- improving the overall experience of patients;
- reducing health inequalities;
- contributing to the cross-government drive to reduce drug misuse.

The key national target for LAS remains maintaining our response time performance of reaching 75% of patients with conditions prioritised as Category A in eight minutes. Having now reached the Category A target, the LAS must concentrate on other national targets (Category B, 14 minutes and GP Urgent calls) as well as improve performance against clinically focused indicators.

The Service Improvement Programme, and many core activities, link to these targets and principles, being essential in the delivery of the core service or in supporting staff to modernise.

A number of emerging themes have been identified which will shape the the Strategic Plan being put together for the period 2006-20011. In addition to those things mentioned above these are:

1. stakeholders telling us what they want the Trust to deliver to them over the forthcoming years expressed through Stakeholder Goals and targets;
2. developing new measures and delivering on them in response to Government announcement that there will no longer be a national response time target for Category C patients, particularly a new focus on outcome measures for specific disease groups;
3. greater contribution to meeting NHS system-wide objectives;
4. Implementation and working through the implications of Agenda for Change;
5. responding to population growth, particularly in the Thames Gateway area;
6. co-location with PCT facilities when they consider new builds;
7. re-location of central administrative functions;
8. focus on organisation development and modernisation.

## 5. Staff consultation

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

The LAS believes that its success depends on staff feeling informed, listened to, involved and valued. A number of communication tools have been enhanced – intranet, internal magazine, routine bulletins – and much attention has been given to face to face communication.

The fifth annual series of Chief Executive meetings were attended by almost 2,000 staff and provided a huge amount of feedback from the 45 events held across the LAS. Key issues raised were around:

- Agenda for Change – the new NHS pay system;
- Desire for more training and development throughout the Service
- Development of the new Urgent Care Service
- Staff support, especially regarding alternative posts for older staff

Other issues raised included: call prioritisation; reducing the retirement age; need for more staff in CAC and on station complexes; need for more space throughout the Service; more management cover, especially out of hours and better communication.

Regular internal conferences for managers and team leaders are used to share key messages and information and to reiterate the importance of the LAS values. The introduction of an induction programme and the development of staff recognition processes have also helped improve communication.

*The (number) annual staff survey again showing increasing levels of satisfaction in all key areas and included the following results:*

- *Are you proud to work for the Service ? – 87% said yes compared to 83% in 2002;*
- *I feel positive about working for the LAS – 74% + (70%);*
- *The LAS is good to work for – 81% (73%).*

*However the survey revealed there are still concerns over a number of issues including:*

- *working conditions;*
- *local management communication;*
- *training and development opportunities.*

Much attention is being given to improving local management communication and the creation of stronger management teams following the A&E Service restructure which is currently being evaluated.

Acting on feedback and continuing to improve the way it communicates and consults with staff will remain a high priority for the LAS and is one of the guiding principles of its ambitious and challenging Organisation Development strategy.

## 6. Achievement against the 2004/05 Service Plan

High levels of demand continued throughout 2004/05 ending at circa 7.6% above the overall demand for 2003/04 and with some 5-6% growth in Category A demand. Despite these significant increases the Service achieved the 8 minute Category A response target with a full year figure of 76%. The Category A14 minute target was also achieved with a full year figure of 96% overall.

Supplementary targets for Category A 8 minute performance by PCT area were partially achieved in that 28 out of 31 PCTs were above their 70% Category A 8 minute performance floor for 2004/05. The remaining three PCT areas were only 1-2% off target and work will continue in 2005/06 to improve performance in these areas.

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

The above performance achievements were obtained simultaneously with a high level of operational distractions and challenges. The most significant of these was the introduction of the new management arrangements in A&E, the Sector Operating Model. Introduced in February 2004 these new arrangements have taken time to bed in and the teams are still growing in operational capacity and capability. The introduction went smoothly and one year on is currently being evaluated to see what further enhancements if any can be made.

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

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

Achievement against key objectives in 2004/05 for this aspiration:

| | **Objective** |
|---|---|
| Key objectives achieved | Ensure the business case process for new ambulances goes quickly and smoothly |
| | Roll out the Make Ready Scheme to 10 complexes |
| | Maintain 75% Category A 8 performance |
| | Improve performance against 95% Category A14 target |
| | Redevelop the Emergency Medical Technician course to reflect the changes of moving to the Guidelines and to improve patient assessment skills and techniques |
| | Finalise the corporate LAS Patient and Public Involvement strategy, to include a model for developing local PPI initiatives which should be implemented in at least one sector by March 2005 |

| | |
|---|---|
| Key objectives achieved and ongoing | Make significant progress on care development strategies:<br>- Cardiac Care<br>- Older People<br>- Mental Health<br>- Chronic Conditions |
| | Lead on OOH/ECP developments |
| | Maintain good working relationships with the PCT commissioners and the SWLHA, maximising the funding available |
| | Raise the profile of patient care within the LAS |
| | Develop clinical indicators as a means of regular performance assessment |
| | Update the PTS planning and scheduling computer system |
| Key objectives partially achieved | Improve the PTS "arrival times" performance and responsiveness for patient care |
| | Achieve an average Category A performance of 70% in each PCT area (achieved in 28 out of 31 PCT areas) |
| | Improve performance against Category B 14 and Doctors Urgents |
| | Develop savings ideas generated in 2003/04 into viable plans across the service to deliver cash savings in 2004/05 |

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

Achievement against key objectives in 2004/05 for this aspiration:

| | **Objective** |
|---|---|
| Key objectives achieved | Achieve improvements in staff survey results in key areas against 2003 results with the 2004 survey |
| | Ensure the Commission for Health Improvement action plan is project managed successfully |
| | Achieving Practice Plus status in respect of IWL |
| | Reorganise the Chief Executive consultation meetings – including the PTS meetings – to ensure that this face-to-face communication remains effective and credible |

| | |
|---|---|
| Key objectives achieved and ongoing | Continue to roll out the introduction of the Personal Development and Review Process for staff in accordance with agreed timescales |
| | Make demonstrable progress on the implementation of the Organisation Development work programme. This includes a range of interventions aimed at moving the Trust towards its long term vision of being a world-class ambulance service |
| | Ensure robust arrangements are in place in readiness for the implementation of 'Agenda for Change' from October 2004 |
| | Progress all assigned SIP items sufficiently to ensure that the overall SIP programme can be completed by 31 March 2006 |
| | Develop effective internal communications at local level in all areas of the LAS |
| Key objectives partially achieved | Achieve closer integration of PTS within the LAS |
| | Implement the diversity plan and demonstrate significant progress in the recruitment of black and ethnic minority staff |

## 7. Action to achieve aspirations for 2005/06

Overview

Category A demand has increased by 5-6% on the same period last year with total demand up 7.6%. The focus for 2005/06 remains on sustaining Category A performance while achieving the other key government targets. The LAS continues to operate in a more challenging environment given the need to maintain Category A8 and A14 performance whilst making ground on Category B 14 and Doctors' Urgent calls. This is a year where money is particularly tight with PCT Commissioners having no funding available for any development initiatives in any Trusts.

Other challenges include delivering the final year of the Service Improvement Programme, and achieving the Core Standards of the NHS *Standards for Better Health* framework (the Trust has to make a public statement that it is compliant with these in September 2005 which will be verified by Stakeholders and inform the Healthcare Commission's assessment of Trust performance). Emergency Preparedness (an agenda which shows no sign of abating), Agenda for Change, Diversity issues and the overarching Organisation Development programme all require major effort if progress is to continue to be made.

The forecast outturn performance baseline for 05/06 is as follows:

| Category | A8 | A14 | B14 | Urgents |
|---|---|---|---|---|
| | | | | |
| **Target** | 75% | 95% | 95% | 95% |
| **2004/05** | 76% | 96% | 80% | 58% |

**Note:** A8 performance criteria 04/05 in descending order of priority:
i) to maintain 75% for the year
ii) to achieve 70% average for each PCT for the year
iii) Category B14 includes Green 1and 2 but excludes "Category C" calls

Future demand management

A number of national changes announced by Government in 2004/05 assist in performance in 2005/06:

- decision to remove national targets for Category C work from October 2004;
- agreement that a car response could be counted towards achievement of Category B targets;
- the revised policy regarding response to calls for patients under two years old, whom it will no longer be obligatory to classify automatically as Category A even if the condition presented does not warrant it. Patients under two years old have accounted for 10% of Category A calls.

However as indicated in the table overleaf performance challenges going forward remain significant. In an effort to address this the Trust is engaged in initiatives which seek to remove all but serious emergencies from frontline resources, for example:

- **The Urgent Care Service** - has been formed to respond to patient medical needs which are not immediately life-threatening in a more appropriate way through a dedicated dispatch centre managing its own resources. The Urgent Care Service has 104 operational staff in post with twenty five vacancies. Recruitment continues and training courses for Emergency Medical Technicans 1 (EMT1) are planned for May 2005. The ultimate intention is to manage this work through a range of more appropriate alternative care pathways which seek to avoid sending a frontline ambulance to calls with resulting presentation at A&E. LAS will be working closely with the SHA to fully integrate this programme of activities in South West London.

  Work is underway on developing an Urgent Care Operations Centre which is anticipated to be operational in summer 2005. Clinical Telephone Advisors, Central Ambulance Control, Green Base staff, the Emergency Bed Service team and PTS Central Services are working together to define processes, scope workload and identify links between their work. It is anticipated that with new levels of staffing, the Urgent Care Service will deal with around 45% of green calls, urgent and non-urgent calls;

- **Emergency Care Practitioners** - the London Ambulance Service in partnership with Primary Care Trusts and St. Georges Medical School has developed the new role of Emergency Care Practitioners (ECPs) and there is now increased demand by PCTs, Strategic Health Authorities and the Department of Health for the roll-out of this role across London. The programme's aim is to develop and implement the principle of 'see and treat' in the pre-hospital setting. It is a community role integrated with the local health and social care service providing prompt high quality assessment, treatment and referral, where necessary, for people in crisis situations.

  Research by the Modernisation Agency, the University of Sheffield and the London Ambulance Service A&E Development team has shown significant whole system gains from the programme and the role can have a significant impact on the way 999 calls are managed. Based on modelling projections, there is a minimum demand for over 420 ECPs across London in the future. There are currently 34 ECPs and it is important for a phased approach to be taken to the delivery of such volumes, not only to maintain high quality recruitment but also to match funding availability.

<u>Key objectives for 2005/06</u>

The items that follow are the key objectives that have been set in order to meet our aspirations. Many of these have a series of activities contained within them that may be part of the LAS Service Improvement Programme and / or directorate level annual plans, or are on the LAS Risk Register.

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

Key objectives designed to achieve this aspiration:

| Objective | Lead directorate |
|---|---|
| Achieve financial balance | Finance |
| Achieve performance targets listed (A&E):<br>• 75% Category A8 performance for the year as a whole<br>• Ensure that Category A8 performance in each London PCT does not fall below 70% for the year as a whole<br>• 95% Category A14 performance for the year as a whole<br>• 95% Category B14 performance by March 2006<br>• 95% of Doctors urgent performance by March 2006<br>• 95% of 999 calls answered within 5 seconds<br>• Reduce span of performance achievement for the above measures across PCTs | A&E Operations |
| Achieve performance targets listed (PTS):<br>• PTS waiting time performance improvement to achieve 90% within specified time<br>• PTS arrival time performance improvement to achieve 90% within specified time | PTS |
| Successfully complete year 5 of the Service Improvement Programme (SIP) with the exceptions indicated in the 29 March Trust Board paper. Among key SIP deliverables are:<br>• Successfully introduce new ways of responding to urgent and non-urgent calls, including modernisation and a new role for EBS, an Urgent Operations Centre and ECPs;<br>• Implement the PPI strategy;<br>• Roll-out Make Ready to 8 complexes. | Service Development<br>A&E Operations/ Service Development Communications A&E Operational Support |
| Achieve the People, Patient and Performance SIP Outcomes | All departments |
| Ensure the savings programme delivers | Finance |
| Ensure the Trust state of emergency preparedness continues to develop to meet the scale of the threat faced by the capital post 09/11 | A&E Operations |
| Establish 10 satellite station sites during 2005/06 | Finance |
| Recruit and train as operationally effective additional staff in CAC to reduce call waiting times | A&E Operations (CAC) |
| Achieve CAD Phase 1: implement Windows Ctak | Information management and technology |
| Achieve CAD Phase 2 Stage 1: define the user requirement for a new CAD system, recommend how a solution should be provided (development v commercial product) | Information management and technology |

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

Key objectives designed to achieve this aspiration:

| Objective | Lead directorate |
|---|---|
| Develop a five year business plan (2006/7 to 2010/11) as a successor to the Service Improvement Programme (SIP) to focus and integrate activity across the LAS, drive service improvement and deliver the Vision | Service Development |
| Successfully implement Agenda for Change; | Human Resources |
| Progress organisational development work in three areas, SMG, 100 senior managers, management teams; | Human Resources |
| Implement the diversity plan and demonstrate significant progress in the recruitment of BME staff; | Human Resources |
| Roll-out Personal Development and Review process; | Human Resources |
| Achieve Level 3 of the NHS Litigation Authority Risk Management Standard for Ambulance Trusts | Finance |

## 8. Risk

There are very significant risks reflecting the size and scope of the London Ambulance Service (LAS) NHS Trust and the scale of improvement planned. At the same time, NHS organisations have made significant progress over recent years, through the work of clinical governance, the implementation of controls assurance and the development of governance roles of boards to address risks at an appropriate level.

Regulatory and inspectorial roles with regard to risk management are carried out by a range of legislative and advisory bodies, including the Healthcare Commission and the NHS Litigation Authority (NHSLA). In addition, independent inspection of controls assurance and finance is provided by internal auditors.

The LAS is accountable for its performance and must create a coherent strategic framework within which service improvement can be delivered. The Assurance Framework brings together strategic objectives, risks and performance measurement and is used to keep the Board informed of these issues.

It undertakes its performance role through identifying risks which may threaten the achievement of strategic objectives, for example the risk information provided by Datix (the integrated risk management system) or in trust-wide risk assessment workshops.

Once a risk is identified it is entered onto the trust-wide Risk Register where it becomes part of the risk reporting structure. Action plans are then put in place to reduce or eliminate these risks.

Using this model, the following principal risks and their associated action plans which relate to the proposed development activity in 2005/06 have been identified*:*

| **Principal Risks** | **Development Activity** |
|---|---|
| **High Risks** | |
| Inability to implement Agenda for Change within timescale and subsequent consequences of implementation expected to impact on operational performance due to staff retention, sickness & absence, staff satisfaction, weekend/flexible working, meal breaks etc. | Agenda for Change |
| Risk of technicians failing to meet requirements for mandatory refresher and update elements of risk management training. | Staff concerned with all aspects and provision of healthcare participate in mandatory training programmes |
| Failing to appreciate the significance and urgency of psychiatric illnesses, and to provide the appropriate response/assistance/treatment. | Review management of mental health patients and implement change as required. |

| Principal Risks | Development Activity |
|---|---|
| **High Risks** | |
| Risk of injury due to not being able to maintain vehicles due to asset tracking issues. | Asset Tracking |
| Risk of injury to operational staff and/or patient through issues relating to manual handling. This can occur when using equipment, including trolley beds and carry chairs, or when lifting or assisting patients without equipment. Staff can also incur injury when lifting inanimate heavy loads. | Improve techniques and equipment for manual handling |
| Delay in activating vehicles due to human error in CAC when call taking and allocating vehicles. | QA of Dispatch |
| Delay in activating vehicles due to inability to answer calls promptly before the recorded message is played. | Implement 999 call taking in dispatch part of CAC |
| Failure to meet responsibilities under the Race Relations (Amendment) Act 2000 in the monitoring of patient ethnicity. | Development of a system of ethnic monitoring of patient complaints to be able to:<br>• demonstrate equality of access to the complaints procedure<br>• Identify differences in the quality of patient experience by ethnicity |
| Risk of not learning and changing practice, as appropriate, as a result of complaints. | Overhaul complaints investigation process including defining management responsibilities |

| Principal Risks | Development Activity |
|---|---|
| **Medium Risks** | |
| Risk of employing staff with a criminal record due to not conducting criminal records bureau checks | All appropriate employment checks are undertaken and professional registration checked |
| Staff expectations not met due to inability to sustain implementation of PDR service-wide. | PDR |
| Risk of insufficient resources to implement the Patient and Public Involvement plan resulting in staff being unaware of responsibilities and service delivery not being responsive to Patient and Public need. | Develop and implement patient and public involvement strategy |
| Delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones as a result of factors including negative attitudes, lack of education and variable local NHS service provision. | Develop and introduce older person's strategy |
| The management of medical devices and ability to identify recurrent faults is not consistent throughout the organisation due to the lack of a policy on deployment, monitoring and control of medical devices. | All risks associates with the acquisition and use of medical devices are minimised |
| Carry chairs are not being presented with A&E vehicles for servicing. This represents a risk to patients, staff and to the LAS in not being able to demonstrate that equipment has been properly serviced if legal claims or HSE audits are made. | Carry Chair Replacement |
| Risk of potential legal action and negative publicity due to staff being unaware of how to report suspected abuse of children and vulnerable adults through the appropriate channels, which may lead to the continuation of abuse. | Children & Vulnerable Adults |

| Principal Risks | Development Activity |
|---|---|
| **Low Risks** | |
| Risk of staff not knowing their accountabilities for internal control and the principles of the Code of Conduct. | Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice |
| Risk of research being stopped due to failing to conform to Research Governance framework. | Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied |
| Wrong vehicles for purpose due to age/design/new legislation, leading to inability to meet patient/customer/staff expectations/requirements within PTS contracts. | Develop and agree strategic PTS vehicle support strategy with the fleet department |
| Risk of PTS objectives NOT being prioritised within the service. | Identify, develop and implement initiatives for PTS re-integration within LAS |

These risks are challenging but the LAS is confident that these risks are manageable on the basis of its risk management process allowing the prioritisation of work necessary to manage the risks identified.

In order to reduce the level of risk, the LAS prioritises its actions by;

- Being clear about what the risks are, and the ones we can actually do something meaningful about.
- Gaining a focus from staff on the things that really make a difference so that people's efforts are maximised not diffused.
- Making sure that decision making and action is taking place in the specialist risk management groups so that risks are being focussed on by the right people so that progress can be made and reported up to the Board.
- Using the Risk Register to help prioritise the allocation of requests for funding. All Initial Statements of Need (ISONs) should reference risk and therefore will form one of the elements of how a decision will be made.
- Getting good quality data and information across the Trust and maintaining an informed view of what is actually happening.
- Actively and appropriately intervening where issues are escalating outside the control of a single group or identified lead.
- Working with other agencies and trusts where we can to manage risks which cross the boundaries of our organisation.

## 9. Financial plan

The Service Plan and Budget for 2005/06 have been developed through one integrated planning process over autumn 2004 and winter 2005. The Service Plan identifies what the London Ambulance Service intends to do during the year and the Budget identifies the resource requirements to do it in the context of the imperative of achieving financial balance. The Budget paper presented to the Trust Board on 29 March 2005 constitutes the financial plan for the Service in 2005/06.

**Appendix 1**

## London Ambulance Service Values

### Clinical excellence

We will demonstrate total commitment to the provision of the highest standard of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to the patients' needs.

### Respect and courtesy

We will value all colleagues and the public, treating everyone, as they would wish to be treated, with respect and courtesy.

### Integrity

We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.

### Teamwork

We will promote teamwork by taking the views of others into account. We will take a genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.

### Innovation and flexibility

We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.

### Communication

We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

### Accept responsibility

We will be responsible for our own decisions and actions as we strive to constantly improve.

### Leadership and direction

We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

Enclosure 7

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Assurance Framework

## 1. Purpose

To inform the Board of the principal risks that are threatening the achievement of the LAS objectives, as highlighted by the Assurance Framework.

## 2. Recommendation

1. THAT the Board consider the attached report and endorse the actions which the Assurance Framework process has highlighted.
2. THAT the Board agree that further updates on the Assurance Framework are routinely received by the Board as part of its continuous risk management function.

Mike Dinan
Director of Finance
March 2005

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# ASSURANCE FRAMEWORK

## 1. Introduction

The Assurance Framework was first developed for the reporting year 2003/04, since then the Board has noted that it would be developed and refined further year on year. Work is currently underway to format the document so that it supports the Standards for Better Health which will be launched by the Healthcare Commission in April 2005.

The Framework provides a functional tool for the Board to use and through its revision over the course of this financial year the information from it will give an assurance to Board members, that risks threatening the achievement of our objectives and compliance with the Standards for Better Health are being adequately managed. It is hoped that this approach will embed the Assurance Framework into a mechanism that the Board can use as part of its regular monitoring role.

It is expected that this important communication mechanism will be supplemented by the Framework's contribution to designing the internal audit programme; specifically, that internal audit work is planned to be undertaken where there are gaps in the assurances recorded in the Assurance Framework. This proposal is being considered by the Audit Committee on the 21st March.

## 2. Risks that have Increased/Threaten the Achievement of Principal Objectives

These risks on the Framework must be considered by the Board as a priority. The following recommendations refer to areas of risk that we are not managing adequately, either because there is a lack of controls/ robustness of controls or where there is limited assurance available to evidence how well we are managing.

i Records Management

It is essential that the LAS have an integrated records management system in place in order to comply with the Freedom of Information Act which came into force on the 1st January 2005. A recent internal audit made the following recommendations to address this;

- Produce and implement a Records Management Strategy that links to existing policies and procedures.
- Formal links between the Caldicott Guardian and local records managers should be made.

- A Records Manager should be appointed to oversee the work required to manage this risk, interim arrangements have been made but long term arrangements need to be considered.

Actions.

A draft Records Management Strategy has been produced which is currently out for consultation. The recruitment process is underway and interviews for A Head of Records Management will take place in April. After the Head of Records Management has been appointed the other actions recommended by internal audit can be progressed.

ii Lack of crewed ambulances on Saturday/Sunday nights

The ability to maintain control of this risk may be threatened by the implementation of Agenda for Change. Current controls involve the application of enhanced rates and the use of targeted overtime between 2300 and 0300 at weekends together with improved use of Bank Staff and had largely resolved this issue. The new Agenda for Change pay arrangements may have a negative effect as they do not allow the service to continue to pay double time for overtime worked in this particularly unsocial time period, consequently making it difficult to maintain the levels of cover currently provided.

Actions:

A solution is currently being sought to mitigate this risk through the Agenda for Change negotiations.

iii Delay in activating vehicles due to inability to answer calls promptly

This is predominantly an issue of CAC call taking performance which has lead to unacceptable delays in call answering times. This also impacts at times on vehicle activation when CAC staff are moved from the despatch area to call taking in order to improve call taking performance which in turn leaves less than optimal staffing in despatch. It should be noted however that this is only one component of the reason for delays in activation of vehicles the most substantial of which are periodic lack of vehicle availability and peaks of workload outstripping the supply of available vehicles.

Actions:

In order to address this situation there has been continued focus on attendance management in CAC coupled with careful monitoring of overall resource levels and call taking performance. In addition recruitment has been ongoing not only to reach current establishment levels but also to plan for an increase in establishment of circa 30 staff during 2005/6. These measures coupled with some technology enhancements will resolve the problem during the year.

iv Delays in responding to urgent calls

Urgent Call performance is currently at circa 58% ytd against a target of 95%. This represents an increased clinical risk for patients.

Actions:

CAC staff are being trained in the use of a new Health Professionals questioning protocol. This tool will provide prioritisation for calls from Doctors and Hospitals, resulting in CAC being able to prioritise urgent calls relatively alongside emergency calls. The aim will be to arrive at an agreed time at hospital which is based more accurately on the patient's clinical needs. A service-wide group is working on this and new operating regimes are being introduced to ensure more rapid dispatch of urgent calls. We will also be introducing a team of call takers who are dedicated to taking calls from Doctors.

## 3. Board is asked to note that assurances tell us are under control

The risk of failure to reduce reported risks through incident information not being systematically shared with all relevant departments and committees etc. thus limiting the scope of the investigation, or the identified investigation actions, not being implemented has recently been assured by an internal audit report on Incident Reporting. The report produced 3 recommendations, 2 of which have been dealt with and the remaining action is minor.

## 4. Conclusion

The Board is asked to consider the above update and endorse the actions which the Assurance Framework process has highlighted.

The Board is asked to agree that further updates on the Assurance Framework are routinely received by the Board as part of its continuous risk management function.

Michael Dinan
Director of Finance
March 2005

Enclosure 8

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Registration of Professional Clinical Staff

## 1. Purpose of the Report

It is a requirement of the NHS Litigation Authority that the Trust Board notes and approves the Trust's policy on the Registration of Professional Clinical Staff. The policy sets out the management arrangements for ensuring that staff hold and maintain their professional registration.

## 2. Recommendation

THAT the Trust Board note and approve the Registration of Professional Clinical Staff policy.

**Wendy Foers**
**Director of Human Resources and Organisation Development**

**March 2005**

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Policy on the Registration of Professional Clinical Staff

## Background

The following categories of staff are required to maintain registration with a professional body while employed in the NHS. It is illegal to employ a person in any of these categories if they are unregistered.

| **Grade** | **Professional Registration Body** |
|---|---|
| Doctors (including GP's) | General Medical Council |
| Dentists | General Dental Council |
| Nurses/Midwives/Health Visitors | Nursing & Midwifery Council |
| Pharmacists | Royal Pharmaceutical Society of Great Britain.<br>The Pharmaceutical Society of Northern Ireland |
| Paramedics | Health Professions Council |
| Chiropodists/ Podiatrists | Health Professions Council |
| Art, Music & Drama Therapist | |
| Dietitians | |
| Occupational Therapists | |
| Orthoptists | |
| Physiotherapists | |
| Prosthetists & Orthotists | |
| Operating Department Practitioners | |
| Therapetic Radiographers<br>Diagnostic Radiographers | |
| Biomedical Scientists<br>Clinical Scientists | |
| Speech & Language Therapist | |
| Dental Hygienists | General Dental Council |
| Dental Therapist | General Dental Council |
| Opticians | General Optical Council |

In order to safeguard patients, all NHS Trusts are required to take reasonable steps to ensure that staff in these categories do maintain registration while employed in the NHS.

For the purposes of this document, in the vast majority of cases the "manager" will be the Ambulance Operations Manager.

## 1 Commencing Work

1.1 Interview letters should ask applicants to bring with them to interview Professional Documents including proof of Professional Registration, certificates of qualifications and proof of identification e.g. passport, driving licence (pictorial where possible).

1.2 At interview, or prior to an offer of appointment being made, the qualifications and registration of a prospective member of staff must be verified. The Manager/Professional Head of Service or Chair of the Interview Panel should see proof of qualifications, identification and current registration number. The registration number together with date of birth should be recorded on the interview documentation and provided to Recruitment Department. The Recruitment Department will then verify the information with the appropriate registration body and ensure that the details are entered on the HR Database. The line manager will be informed immediately if there are any problems with verification of the information.

1.3 If an applicant fails to bring documents to the interview, it is the responsibility of the Chair of the Interview Panel to ensure the original documentation is seen within four working days of the interview, enter the information on the interview documentation and return to the Recruitment Department.

1.4 Newly qualified members of staff are required to register with the appropriate registration body as soon as possible after qualifying.

1.5 Contracts of employment for posts that are subject to having professional registration will state:

**"**If it is a requirement for you to be registered with an appropriate professional registration authority, your employment is conditional upon continuing registration throughout your employment with the Trust and you following the appropriate codes of professional conduct, competence and ethics, and any other such standards that are required to be maintained as a condition of your continuing registration. Proof of renewal must be produced and failure to do so within a specified period may lead to dismissal".

1.6 On the first day of employment a new member of staff (new joiner) must provide to their manager the following information before starting work:

i) Documentary evidence of <u>current</u> registration.

ii) Birth certificate or passport as a means of identification.

It is the managers' responsibility to place a copy of this information on the individual's personal file and ensure that the information provided tallies with that provided at the interview stage and that it has been verified with the relevant authorising body.

**The employee cannot start working with patients until the Manager is satisfied that valid identification and current registration with the relevant regulatory body has been provided.**

**It is the Line Manager's responsibility to ensure Registration details are correct before an employee is allowed to treat patients.**

1.7 It is also the manager's responsibility to ensure that confirmation of the registration is entered on to a local register. At this stage, the manager needs to make the employee aware that he/she must renew the registration at the correct time.

1.8 It is the responsibility of the employee to ensure that their registration is kept up to date.

Each employee should undertake to notify his or her Line Manager each time his/her registration is renewed.

1.9 Managers should arrange for renewal to be monitored locally.

1.10 The procedure for bank staff will be the same as for permanent staff.

## 2. Annual Verification of Registration

2.1 The annual date of registration for paramedics is 1st September.

2.2 Once verification of renewed registration has taken place the manager will ensure that details are sent to Management Information (M.I.) to enable the HR database to be updated.

2.3 Exception reports will be produced by M.I. for circulation to managers in October each year

## 3. Failure to Register by the Registration Renewal Date

3.1 Where a lapsed registration has been identified, the line manager should ensure that the individual concerned is seen immediately and ascertain what steps have been taken to renew the registration.

3.2 Where registration has been allowed to elapse, the following will apply:

3.3 The individual will be downgraded to an emergency medical technician post and pay and required to renew registration within the quickest timeframe possible. (N.B. Restoration to a register can take several days and may require a re-registration fee over and above the normal fee). For this reason employees are urged to pay their registration fees by direct-debit from their bank account.

3.2 Employees will not return to their original grade until proof of renewal has been received by the Trust and no backdating of payment will be made to the employee.

3.3 Employees must be aware that continued failure to renew registration could become the subject of disciplinary action.

3.4 Alternatively, if an individual chooses to no longer practice as a State Registered Paramedic, they will be allowed to permanently re-grade to an available emergency medical technician post.

## 4 Agency Staff

4.1 Temporary/ Locum /Agency staff should have their details verified before starting. It is the manager's responsibility on contacting the agency to ascertain the registration details of the employee to be placed. This information should be recorded in the local register.

4.2 On the first day of work the manager needs to see the proof of registration and identification. They need to ensure that this tallies with that provided by the agency.

4.3 The original documentation must be seen and should state "certificate or other proof of registration". Agencies used by the Trust must show evidence that they regularly check professional registration status of the staff they provide.

# Appendix 1

**Professional Bodies Contact Details**

**General Medical Council**

| | |
|---|---|
| Tel | 020 7915 3630 |
| Web | www.gmc-uk.org |
| Email | registrationhelp@gmc-uk.org |

**Health Professions Council**

| | |
|---|---|
| Tel | 020 7582 0866 |
| Address | HPC, Park House, 184 Kennington Park Road, London, SE11 4BU |
| Web | www.hpc-uk.org |

Enclosure 9

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Risk data sharing project

## 1. Purpose

To update the Trust Board on the risk data sharing project which was undertaken between April and September 2004. The Trust Board previously gave its permission for the LAS to participate in the project which was set up in response to the Dixon inquiry recommendations for more effective multi-agency working and better information sharing.

## 3. Recommendation

The Board is asked to note the report and endorse the Project Group's recommendations.

Peter Bradley
Chief Executive

March 2005

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Risk Data Sharing Service

## 1 Background and Pilot

1.1 The Risk Data Sharing Service was set up in response to the Dixon inquiry recommendations for more effective multi-agency working and better information-sharing. Between April and September 2004, the Metropolitan Police, London Probation Area, London Ambulance Service and mental health services in Camden, Islington and Westminster jointly piloted a method of sharing risk-related information about mental health service users in urgent circumstances.

1.2 A formal information-sharing agreement, supported by the Information Commissioner and signed by all the parties, underpinned the operation of the service. The project was overseen by the London Development Centre for Mental Health

1.3 The LAS hosted the contact point for the service.

1.4 When asked to approve LAS involvement, the Board raised a number of questions, particularly in respect of the data protection and human rights issues raised by the service. There were also questions about the resource implications, particularly for the Information Technology Directorate. For this reason it is appropriate to return to the Board with a report on how the pilot went, and the proposed next steps.

## 2. The Pilot Results

2.1 APPENDIX 1 is a description of how the service operated, what information was held about patients, what the evaluation showed, and what was discussed at an event designed to discuss and seek views on the evaluation.

2.2 In summary:

- The limited time and geographical coverage meant that the service was used relatively little, and no "matches" were found between the requests and the database held by the service. The service was, however, able to pass information held by police and probation to mental health professionals, and this was well received and reported as useful.

- Users were, and remained, concerned about the project. They feared that inaccurate information might be held, and that services to them might be delayed or prejudiced as a result of the information being shared. However, the legal framework can support information-sharing as well as protecting

service users' rights. This has been confirmed by the Information Commissioner.

- Two-thirds of service users referred to the database were not notified about the referral. It was clear that risk assessments are not routinely discussed with, or shown to, service users.

- Holding information about patients such as who to contact in an emergency (friends, family, health workers) can improve the response to them when they are in crisis.

- While the evaluation exposed a number of limitations related to the limited geographical coverage and the quality of information held by mental health teams, the model works.

## 3. Proposal for London roll-out of the service

3.1 The project team have therefore decided to set up a similar service, but expanded to cover the whole of London. The service will provide 24 hour access to risk and crisis plan information about mental health service users who pose a significant risk to themselves or to others.

3.2 The scope of the service, in terms of the client groups involved and links to related services, will be reviewed in some detail. The future service will be open to more frontline staff, including those working in forensics, inpatient settings and CMHTs, and will be particularly helpful in allowing them and others access to up-to-date and accurate risk / crisis plan information.

3.3 A London-wide service will potentially contribute to multi-agency working arrangements and enhance out-of-hours and emergency services. It will deal with some of the difficulties arising from geographical and organisational boundaries, and will also formalise arrangements for sharing information across agencies within a complex legal framework.

3.4 Given the large area and number of organisations involved, the project team is developing a plan to roll the service out across London, area by area, over 3 years from April 2005. They will be working closely with NPfIT and local implementation of electronic CPA.

3.5 Following the evaluation report's publication, the project steering group agreed that plans to roll out the service should continue. However, attention will need to be paid to:

- The criteria for referring service users to the database
- Service user involvement and engagement
- Demonstrating the potential value of the service

3.6 Whilst a Cost Benefit Analysis might be useful, the group felt it would not be possible to do this in time for the 2005 / 06 funding discussions.

3.7 The future of the service is to be discussed at the SHA Chief Executives' meeting at the end of March. At a previous meeting, this group had suggested commissioning a piece of work looking at information-sharing across London, which is now underway.

**4. Issues for the London Ambulance Service**

4.1 The initial concerns raised by the LAS Board have been addressed by the attention to appropriateness of information sharing. Also, the project intends to base at a location other than the LAS. Therefore there are no extra resource implications other than an estimated £15,000 for the financial year 2005 / 06, recurring over future years of the service's existence. APPENDIX 2 shows broad costings from which this figure has been derived.

4.2 SMG has considered the issue whether the expenditure of £15,000 be justified, given the conclusion of the pilot that the model works, but that it has not, as yet, produced tangible benefits in terms of reduction of risk to staff or patients? The Board is invited to discuss the balance of expenditure and risk involved. SMG concluded that the expense involved was low compared to the potential risks to staff.

**5. Conclusion**

5.1 SMG has agreed that

- The LAS maintains involvement in the steering group.
- Makes a £15,000 contribution to the roll-out of the project, making contributions in future years conditional on progress against the project plan and appropriate evidence of benefit.
- Plays its part in ensuring the concerns of service users, and the issues about appropriate referrals to the database, are given high priority in the roll-out plans.
- Maximises the benefits of the partnerships within the project; in staff training, expert advice about information-sharing, and links with service users. Continued involvement in the project would be likely to present opportunities for obtaining staff training and expert advice, both of which are features of the forthcoming mental health strategy.
- Considers its 'at risk' information, and whether this should be shared with other agencies.

**6. Recommendation:**

THAT the Board endorse this approach.

Kathy Jones
Director of Service Development
March 22, 2005

**What did the pilot service look like?**

A 24-hour Single Contact Point (SCP) was staffed by mental health professionals and based in Central Ambulance Control. The team maintained a central secure database of risk and crisis plan information, which was by staff in community mental health teams (CMHTs). Information was only passed on to the SCP if a team judged that an individual posed a significant risk to themselves and / or to others.

Staff from the organisations involved could request information from the SCP. They included mental health staff based in A&E departments, ambulance crews, the police, duty social workers, community mental health staff and probation staff.

Once the SCP staff had verified the identity of the caller and judged the reason for requesting information as valid within the legal framework, they provided the information held on the database. When dealing with requests from mental health staff they also checked for any related information held by other organisations, including the probation service, the police and the ambulance service.

Over the 6 month pilot, 160 service users were referred to the central, secure database. Of the requests for disclosure, 40% came from mental health professionals, 38% from ambulance staff and the remainder from the police. The service was particularly successful in obtaining information from the police for mental health professionals working in duty, crisis and A&E liaison teams.

**What sort of information was held on the database?**

The information held was the minimum necessary to manage a crisis situation safely for both service users and professionals. It consisted of key risk and crisis plan information, which came from the Care Programme Approach (CPA) and formal risk assessment.

**Evaluation**

The service was evaluated by Imperial College London. In summary, their findings were:

- The service received 65 requests for information and 58% of these requests were assessed as justifying disclosure. However, there were no matches between the requests made and the service users referred to the service.

- On several occasions the SCP was able to obtain information from the police and probation services and pass it on to mental health professionals. The professionals who received information from the SCP found the service valuable, efficient and relevant.

- Service users did not support the concept of information-sharing, nor the specific model of the Risk Data Sharing Service. They were concerned about stigma from

the association between mental health and violence, and potential discrimination by police, ambulance staff and others. They expressed a view that aid might be delayed to a patient with a life threatening medical condition.

- Two-thirds of service users referred to the database were not notified about the referral. It was clear that risk assessments are not routinely discussed with, or shown to, service users.

The evaluation report concluded that:

- The limited scope of the pilot (geography, time, and limitation of responding only to urgent requests) affected the capacity of the evaluation. The low number of enquiries was attributed to the difficulties of achieving cultural change and communication in large organisations.

- The model developed for sharing information was viable, and would generate greater benefits if used across a wider geographical area. The pilot showed that the legal framework can support information-sharing as well as protecting service users' rights.

- The pilot highlighted the poor quality or lack of information available about service users' previous contact with the criminal justice system. Future development of the service could help mental health professionals to access this information and enhance risk management.

- Any additional workload for CMHTs could be reduced by incorporating the process of referral into the CPA, where it could aid both crisis planning and risk management.

- Suggestions for reducing risk relating to communication, non-threatening behaviour and the involvement of people known to the service user (such as family members or friends) could be incorporated into training for police and ambulance staff. The need for better training to make effective use of the information shared was emphasised by all stakeholders.

- Ignorance of the legal framework governing information-sharing contributed to professionals' reservations about the service. The balance between preserving confidentiality and public protection was highlighted. Mental health professionals, citing the importance of confidentiality in relation to the information they held, were keen to gain easier access to police data.

- Mental health professionals working with people they did not know (in duty, crisis and A&E liaison teams) were particularly supportive of the service.

The evaluation team regarded the potential of the Risk Data Sharing Service as follows:

- The service could contribute to a broad range of circumstances by expanding its scope to include non-urgent situations, forensic and prison services and inpatient

facilities. Further expansion would also provide opportunities for the police to protect people in custody and manage pre-planned operations more safely.

- The LAS is currently working on improving its approach to mental health issues, and service could support changes in staff understanding and handling of people with mental health problems, as well as contributing to the development of alternative care pathways for them.

- Many lessons have been learned from this groundbreaking pilot which are relevant to a wider mental health agenda, as well as to future developments of this specific service.

**Discussion at the evaluation event**

An event to launch the evaluation was held in mid-January, and was followed by a general discussion. Some of the key points are listed below:

- The service had been presented as a way to prevent homicide, but the advantages for the service user should also be highlighted and may help change their perception of the service.

- It was imperative to involve service users in the risk assessment process, and it was a cause for concern that so few of them knew they were being placed on the database.

- Concern was expressed about how CMHTs had decided which service users to refer to the database. They had not necessarily used robust criteria, and the criteria used may have varied between teams. Of particular concern was the fact that some of the information included was likely to have been anecdotal (e.g. that a service user may have committed a violent crime in the past, but with no supporting information).

- Potential advantages had emerged strongly during the pilot. It was noted that people often move between areas and a pan-London service would address some of the boundary issues.

- The evaluation showed this type of service was feasible. There was no actual evidence in terms of reduced risk, as there had been no matches on the database during the pilot. The service would become more cost-effective, the larger it became. However, a way of showing the service's value in terms of investing public money was needed.

- The evaluation highlighted issues about ambulance staff training, both in comments made by service users and in terms of the general lack of understanding about information-sharing.

**Margaret Vander**
**Development Manager (Policy & Partnerships)**
**1st February 2005**

**Running costs and set-up costs for London Risk Data Sharing Service, 2005/06 - 2007/08**

| Item | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| | **Running costs (£000)** | | |
| Service Manager | 50 | 50 | 50 |
| Admin support | 20 | 20 | 20 |
| Senior practitioner | 42 | 42 | 42 |
| SCP staff (G Grade equivalent x 8) | 150 | 360 | 360 |
| 5% corporate overhead charge | 13 | 24 | 24 |
| IT (advice, maintenance & support) | 20 | 35 | 35 |
| Telecoms | 0 | 5 | 5 |
| Premises | 25 | 25 | 25 |
| Staff recruitment and training | 0 | 10 | 10 |
| Communications (advice & materials) | 0 | 10 | 10 |
| Development work | 0 | 3 | 3 |
| Misc (expenses, Steering Group, etc) | 5 | 5 | 5 |
| **Total** | **325** | **589** | **589** |
| Cost per each of 47 organisations | 6.9 | 12.5 | 12.5 |
| | **Set-up costs (£000)** | | |
| Project (roll-out) Manager | 50 | 50 | 50 |
| Liaison leads (G Grade equivalent x 4) | 76 | 152 | 152 |
| IT (database software, website) | 75 | 0 | 0 |
| Telecoms | 25 | 0 | 0 |
| Premises | 30 | 5 | 5 |
| Staff recruitment | 25 | 0 | 0 |
| Communications (advice & materials) | 30 | 30 | 30 |
| Legal advice | 30 | 0 | 0 |
| Development work | 10 | 0 | 0 |
| **Total** | **351** | **237** | **237** |

Enclosure 10

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Service Improvement Programme Update

## 1. Purpose

To update the Trust Board with progress in implementing the Service Improvement Programme (SIP) since the last update in January 2005.

## 4. Recommendation

THAT the Board:

1. Agree the reporting arrangements outlined in Section 4.

2. Note the progress made with the Service Improvement Programme;

3. Note that the initiatives identified in Section 4 will not be completed by March 2006, thereby rolling forward into a successor modernisation programme to the SIP;

**Peter Bradley**
**Chief Executive**

**March 2005**

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# 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 312 items within the SIP of which 99 are live and 25 are yet to start including eight which it is known will not be completed by the end of the SIP in March 2006 as reported in January (see section 4 overleaf). Delivery of the remaining SIP items and Outcomes are a key focus for development of the 2005/06 Service Plan. Work is in train to develop the framework for identifying the successor modernisation programme to the current SIP. It is intended that the approach to the development of this framework will be discussed at the SDC awayday in April.

## 3. SIP Outcomes

Crucial to assessing the effectiveness of the SIP are the 40 outcomes identified for People, Patients and Performance. The Senior Management Group are now reviewing progress towards achieving these Outcomes on a monthly basis using a traffic lights reporting system where red indicates significant risk to target achievement by March 2006, amber indicates a lower level risk to target achievement and green indicates being on track. The report for March 2005 can be found at Annex 1 (Part A) with an exceptions report for the five Outcomes identified as being of red status (Part B).

These five Outcomes are:

| | |
|---|---|
| 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. 32 | Resource demand/match compliance significantly improved on sectors |
| No. 36 | 95% of Doctors calls answered in 30 seconds. |

Of these number 32 is at greatest risk. These Outcomes will continue to be a focus of Senior Management Group attention over the forthcoming months. In addition to the traffic light reports the SMG have received presentations on

three to four Outcomes per month and discussed them in detail. To date thirty out of the forty Outcomes have been considered in this way and the remaining 10 will be presented by the end of June 2005.

## 4. SIP Initiatives which will not be completed by March 2006

Following recognition at previous SMG meetings and as reported to the 24 January Trust Board meeting, there are several projects which will not be completed by March 2006 when the SIP comes to an end, primarily due to dependency on the National Programme for IT and therefore outside the Trust's control:

| | |
|---|---|
| SIP 48 | Implement pooled dispatchers in CAC |
| SIP 97 | Introduce a long term digital solution which will give effective away from vehicle communication; |
| SIP 117 | Evaluate Electronic Patient Report Form; |
| SIP 118 | o Evaluate data link with A&E departments (access to Electronic Patient<br>o Records and Electronic Health Records; |
| SIP 140 | Acquire a new CAD system and implement it if a review of the need (SIP no. 139) indicates such; |
| SIP 186i | Implement pan London arrangements for an integrated information management system to provide a one stop shop for primary care professionals including a supporting IT system (EBS); |
| SIP 186j | Provide an integrated national and local information system for the National Intensive Care Bed Register including a supporting IT system; |
| SIP 244/244a | Investigate and implement PTS radio communications (linked to SIP item 97) |

It has been decided to re-cast SIP items 139 and 140 to fit with decisions made as to the approach to developing the replacement CAD system. Item 140 has become "CAD plan Phase 1:implement Windows Ctak" while item 139 has become "CAD plan Phase 2 Stage 1: define the user requirement for a new CAD system, recommend how a new solution should be provided (development v commercial product)"

There are also several projects where resource constraints signify material risk to project completion by March 2006:

| | |
|---|---|
| SIP 49 | Implement 999 call taking in despatch part of CAC |
| SIP 113ea | Asset tracking phase 2 (computer based); |
| SIP 154b | Implement cleaning vehicles and Make Ready |
| SIP 130b | Introduce 3 fixed standby sites per annum (toward a total of 25). |

SMG have agreed and it is proposed to the Trust Board that the items which it is known will not be delivered (and probably won't be started) by March 2006 are listed at the foot of the SIP Gantt Chart as carry over items into the next modernisation programme. In this way they remain on record but will not be the subject of reporting as exceptions during 2005/06. These items are: 48, 97, 113ea, 117,118, 186i,186j, 244/244a as described above.

## 5. Service Improvement Programme initiatives completed during 2004/05

During the past year 26 SIP initiatives have been completed, a list of which can be found at Annex 2.

## 6. Initiatives for 2005/06

In the context of PCT Commissioners having no funds for development activity in any Trusts, a key determinant of the scope of service improvement activity during 2005/06 will be resource availability. Discussion with Commissioners has focused on initiatives which will help manage demand and support performance target achievement looking to 2005/06 and beyond, such as:

*Urgent Care Service*

62 staff have now been assigned to sector, with recruitment progressing for the remaining 12 vacancies. All sectors have now received EMT1s, who are undertaking urgent, non-urgent and green calls. Work is progressing to provide a dedicated Urgent Care Operations Centre which is due to open in Spring although it is likely that this date may need to be deferred until later in the year.

*Fixed Satellite sites*

The programme envisages the introduction of three fixed standby sites per annum on the way towards a total of 25, one per Complex, however as part of the Service Plan development process consideration is being given to accelerating this rate of roll-out.

*Increased use of ECPs.*

There are 36 ECPs in post operating in the Croydon, Wandsworth, Havering, Bromley and Hounslow areas, growth in numbers is dependent on funding being made available.

Significant initiatives due to start (subject to funding) in 2005/06 are:

- Implementation of an appropriate resource distribution model;
- Implement 999 call taking in despatch part of CAC;
- Management development to support the SOM;
- Implementation of Windows Ctak in CAC as Phase 1 of CAD development;
- Defining user requirements for the CAD replacement as Phase 2 of CAD development and recommend a solution;
- Implementation of the Electronic Staff Record (including payroll) on the national system;
- Carry chair replacement;
- Acquisition and implementation of a replacement PTS scheduling system.

## 7. Benefits Realisation

Evaluation of the Sector Operating Model is underway and scheduled to be the subject of report in mid-April. The Audit Manager has been asked to focus his attentions on verifying that a number of initiatives which have been completed

are being implemented out in the field, for example the Children and Vulnerable Adults policy.

## 8. Recommendation

THAT the Trust Board

1. Agree the reporting arrangements outlined.
2. Note the progress made with the Service Improvement Programme
3. Note that the initiatives identified in section 4 above will not be completed by March 2006, thereby rolling forward into the successor modernisation programme to the SIP, and

**Martin Brand**
**Head of Planning and Programme Management**
**17 March 2005**

## SERVICE IMPROVEMENT PROGRAMME OUTCOMES (Part A) March 2005

## 1. People Outcomes

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position ) |
| 1 | WF | Annual staff survey shows more staff feel positive about working for the LAS | 3.0 (on revised basis, previously 66% on old measure) | | Score of 2.9 on the 1 to 5 scale. This exceeds our target of 2.8 and places LAS in top 20% compared with other ambulance trusts |
| 2 | WF | 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 | | PDR "reviewer" training currently under way and due to complete by July 05. The 2005 staff survey reported that 26% of staff have a PDP. PDR process now compatible with KSF |
| 3 | MF | Reduction in staff incidents at work | 446 reported incidents per 1000 staff per year | | 435 per 1000 |
| 4 | MF | Reduction in assaults on staff | 107 reported assaults per 1000 staff per year | | 102 per 1000 |
| 5 | WF | Reduction in sickness absence levels | 5.5% (average for the year) . | | The average sickness from Jan 04 to Dec 04 is 6.3%. To achieve the target of 5.5% will require sustained effort during the next 12 months |

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position ) |
| 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 | | |
| 7 | FM | Range of Career paths/ development opportunities | Standard systems in place and used as part of the appraisal/PDR processes. | | LAS have provided info. on difference between LAS EMTs and those elsewhere- EMT 4 is scoped and education modules being developed by Kingston Uni / LAS Education Department<br><br>Pay linked to EMT 4 can only be sorted out once AFC is agreed |
| 8 | DJ | Annual staff survey shows that more staff feel that communication in the LAS is good | 66% | | Actual score of 51% against 50%.target (March 05) |
| 9 | WF | Improved staff support systems | Implementation of the Staff Support Project recommendations. Monitoring of satisfaction & usage levels & reports to Trust Board/SMG bi-annually. Substantial improvement in staff survey results on this issue. | | 95% (March 2004 actual score of 96% against a target of 95%.) |
| 10 | WF | 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 | | Actual score of 49% against a target of 45%. (March 05) |

## 2. Patient Outcomes

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position ) |
| 11 | FM | Improved cardiac arrest survival rates (to discharge) | 8% | | Still awaiting hospital outcomes data before writing 03/04 report |
| 12 | MF | Coronary Heart Disease National Service Framework call to door times achieved | 30 minutes | | Average 40 mins (range 22-101 for 73 pats) May to Sep 04 |
| 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; | | 12.5% of Green Calls responded to other than by ambulances |
| 14 | JH | 'Centre of Excellence' achievement for call taking in CAC (compliance with pro QA) | 95% "Centre of Excellence" status achieved & maintained | | |
| 15 | MB | A comprehensive ambulance cleaning and equipping system in place. Improved pride & professionalism in the Service | Make Ready in place in all complexes | | Make Ready is now live on 8 complexes and will be live on 10 by 31st March 05. A further 8 complexes will be live by 31st March 06 |

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position) |
| 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 | | Currently working towards meeting the requirements set out in an improvement period in order to attain level 2. |
| 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 | | 18 candidates, if all successful 178 substantive by May 05 |
| 18 | MF | Reduce all patient care related complaints A&E | 1.0 complaint per 10,000 calls per month | | May – Dec 04 reported as 1.4 |
| 19 | KA | Reduce all patient care related complaints PTS | 1.0 complaint per 10,000 journeys per month | | 0.46 |
| 20 | JH | Reduce all patient care related complaints CAC | 1.0 complaint per 10,000 journeys per month | | 0.95 |

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position) |
| 21 | KJ | Regular availability of information about the delivery of patient care throughout the Service | 100% 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. | | Target under review See Note (Part B) |
| 22 | DJ | Regular comprehensive information about user views/levels of satisfaction | - Patient involvement in all significant Service developments.<br>- Annual patient survey – evidence of actions as a result of survey.<br>- Other means of gaining patient views, e.g. Focus groups | | PPI strategy approved and PPI manager being appointed |
| 23 | MB | 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 |

## 3. Performance Outcomes

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position) |
| 24 | MF | Category A performance targets achieved | 75% in 8 minutes (any response) | | 76.4% |
| 25 | MF | Category A 14-min performance targets achieved. | 95% | | 95.8% |
| 26 | MF | Category B 14 min performance targets achieved | 95% | | 79.6% See Note (Part B) |
| 27 | MF | AS2 –Doctors' urgent performance at 95% within 15 minutes of agreed arrival time | 95% | | 58.2% See Note (Part B) |
| 28 | JH | 95% of 999 calls answered within 5 seconds | 95% | | 71.4% |
| 29 | MF | Percentage of the week when utilisation rates exceeds 70%. | 15% | | No figures available to provide update |
| 30 | MB | Reduce non-staff (vehicle) related downtime | 2% | | 3.1% YTD as at 31 Jan 05 (see Footnote) |
| 31 | MF | Reduce staff related downtime | 3% | | 4.6% |
| 32 | MF | Resource demand/ match compliance significantly improved on sectors | 100% Compliance with LO50 (34164 Amb hrs per week) | | 89.9% Compliance See Note (Part B) |

| No. | Lead | Outcome | Target (March 2006) | Traffic Light Status For Target Achievement March 2006 (Red/Amber/Green) | |
|---|---|---|---|---|---|
| | | | | Last Results Reported (Board) | Current YTD ( Latest known position) |
| 33 | JH | Resource/demand match compliance significantly improved in CAC | - | | 96.7% |
| 34 | JH | Activation times of 95% within 2 minutes (Cat A) | 95% | | 89.6% |
| 35 | JH | Activation times of 95% within 3 minutes (Cat B) | 95% | | 71% |
| 36 | JH | 95% of Doctors calls answered in 30 secs | 95% | | 58.4% |
| 37 | MD | Achieve financial savings to fund ISONs | £3m (£1m increase each year) | | Baseline to be determined before this is categorised as Red |
| 38 | MF | Vehicle accidents per 10,000 ACTIVATIONS reduced by 33% for A&E | 9.7% per 10,000 | | 12.05 per 10,000 Apr 04 to Jan 05 |
| 39 | KA | Vehicle accidents per 10,000 journeys reduced by 33% for PTS | 2.04 per 10,000 | | All accidents 2.3 per 10,000 journeys (April 04 – Jan 05) |
| 40 | MF | Reduce job cycle time | 55 minutes | | 50 mins |

**Footnote: Outcome 30 - Reduce non staff (vehicle) related downtime**

This target has seen a steady decline over this reporting period. The end of year position is likely to improve marginally once figures from 1st February – 31st March are included which should smooth out the peak of vehicle off road activity during the winter pressures period. The reasons for the decline are being subjected to further analysis. The principal tool for improving vehicle off road is the Make Ready Scheme which will be live on 18 complexes by 31st March 2006 so it is still anticipated that the SIP target will be met. In addition the measures will be reviewed as they currently include non vehicle related downtime such as dirty uniform and officer request.

**See over for commentary on Outcomes identified as RED i.e. at serious risk to be achieved by March 2006**

## Commentary on SIP Outcomes Identified as RED (Part B)

**Outcome No.** **21** **Description:** Regular availability of information about the delivery of patient care throughout the Service
**Lead:** KJ

**Reason For RED status**

Risk around 100% completion of CPI every month by team leaders. Data for August shows no. of CPIs increasing but still low, great variation between complexes. Incomplete teams coupled with high levels of secondment and lack of Make Ready on all complexes also contribute negatively to this indicator.

**Remedial Action To Be Taken To Achieve Outcome**

Percentage completion of CPI checks to be included by Directors of Ambulance Services (DoAS) in their complex performance reviews (CPI reports have been revised to assist DoAS in this). The fall-back position is to agree a new (lower) target e.g. 100% achievement in one or two weeks per month of general checks, plus 100% of risk related checks. Remedial action:

- Recruit to full TL Establishment
- Controlled ECP recruitment with planned backfill for any Team Leader establishment depletion.
- Continued roll out of Make-Ready
- Increased focus from Complex management Teams

Work now in hand to reduce the target to a more realistically achievable figure and introduce intermediate yearly targets rising to 100% completion. In addition we now accept that some of the CPI's are too complex and too time consuming to complete. These will now be simplified as part of the review process.

**If this action is taken will the outcome be achieved YES/NO? YES against the newly revised target.**

**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 . 2004/5 YTD is at 79.6 %. It is unrealistic to expect to achieve this target this year but we simply must improve on the 2003/4 figure of 77.6%. It is currently anticipated that we will achieve circa 80% for the full year.

**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.

**If this action is taken will the outcome be achieved YES/NO? Yes**

| | |
|---|---|
| **Outcome No.** **27** **Description:** AS2 –Doctors' urgent performance at 95% within 15 minutes of agreed arrival time<br>**Lead**: MF | |
| **Reason For RED status**<br>Urgent performance is at 58.2 % for the YTD which is an improvement of +8.2% on last year but still remains significantly behind where we need to be. The performance has also deteriorated in recent months for a variety of reasons. Small improvements achieved since last reported | |
| **Remedial Action To Be Taken To Achieve Outcome**<br>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 calltakers 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 unfounded AS2 vehicles.<br><br>The SIP item should now be amended to show **75%** of AS2s within 15 minutes of STAs<br><br>**If this action is taken will the outcome be achieved YES/NO? YES** | |

| | |
|---|---|
| **Outcome No.** **32** **Description:** Resource demand/ match compliance significantly improved on sectors<br>**Lead**: MF | |
| **Reason For RED status**<br>With no growth in front line establishment being funded by commissioners this year our ability to impact on this area is limited and it remains at 89.9% compliant. Small unsustainable improvements gained through winter pressures measures. | |
| **Remedial Action To Be Taken To Achieve Outcome**<br>AOMs need to continue to work at making changes to complex rosters to move towards greater compliance but in reality only an injection of additional staffing will allow this target to be fully achieved.<br><br>**If this action is taken will the outcome be achieved YES/NO? NO** | |

| | | | |
|---|---|---|---|
| **Outcome No.** | **36** | **Description:** | 95% of Doctors calls answered in 30 secs |
| **Lead:** | JH | | |

**Reason For RED status**

This target is at risk, however new procedures in CAC have started to show some improvement.

**Remedial Action To Be Taken To Achieve Outcome**

There is now an active recovery plan being established for CAC and ACAOs and AOMs need to support this fully.
Plans for the New Non Urgent control may also allow a different approach to answering GP calls. During times of high demand, there are dedicated staff now answering GP calls. This is also Staff and IT dependent**.**

**If this action is taken will the outcome be achieved YES/NO? YES**

**Annex 2**

## SIP Initiatives Completed During 2004/05 AS At 17 March 2005

| SIP No. | Description |
|---|---|
| 5 | Introduce statement of duties |
| 14 | Implement improvements outlined in Clinical Governance strategy and caldicott Implementation |
| 15b | Review operational management of fleet resources and fleet size and implement changes |
| 79 | Review uniform supplier, quality and supply – tender with existing uniform |
| 82 | Introduce health promotion scheme for staff including voluntary medical assessments |
| 106 | Review and if appropriate implement a changed role for Whitebase, in the context of managing green demand |
| 107c | Participate in partnership projects about reforming Emergency Care |
| 113a | Implement action plan following Commission for Health Improvement report |
| 113b | Implement revised paramedic re-certification course |
| 116 | Replacement defibrillator programme |
| 164 | Join NHS Net |
| 172 | Undertake annual Chief Executive's consultation programme 2004/05 |
| 174a | Implement NHS Plan |
| 179 | Implement improvements outlined in controls assurance |
| 181 | Implement Health and safety Executive report recommendations |
| 183a | Continuing management of Clinical Risk |
| 187b | Review and ensure all PTS staff have access to a computer and PTS e-mail facilities |
| 232b | Evaluate the EBS pilot Bonus Scheme, and adjust as necessary |
| 229 | Develop operating procedures for ECJ and long distance PTS journeys |
| 229a | Develop pricing strategy for ECJ and long distance PTS journeys |
| 187o | Implement proposals for a centralised PTS car service |
| 239 | Compile and use a competitor database to analyse industry best practice |
| 187f | Investigate feasibility and case for defibrillators on PYS vehicles |
| 218 | Update SSL system to solve existing problems and enhancements |
| 199 | Revise content of basic training for Aps and Cas |
| 301 | Review and seek to improve PTS accommodation in LAS premises |

Enclosure 11

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Emergency Care Practitioner Update

## 1. Purpose

To update the Board on the current progress with the ECP scheme including current deployments, activity levels, education and governance arrangements. The report also summarises some of the key challenges which we still face in terms of optimising and rolling out the scheme across London.

## 2. Recommendation

THAT the Trust Board note this report.

**Peter Bradley**
**Chief Executive Officer**

**March 2005**

**LONDON AMBULANCE SERVICE NHS TRUST**

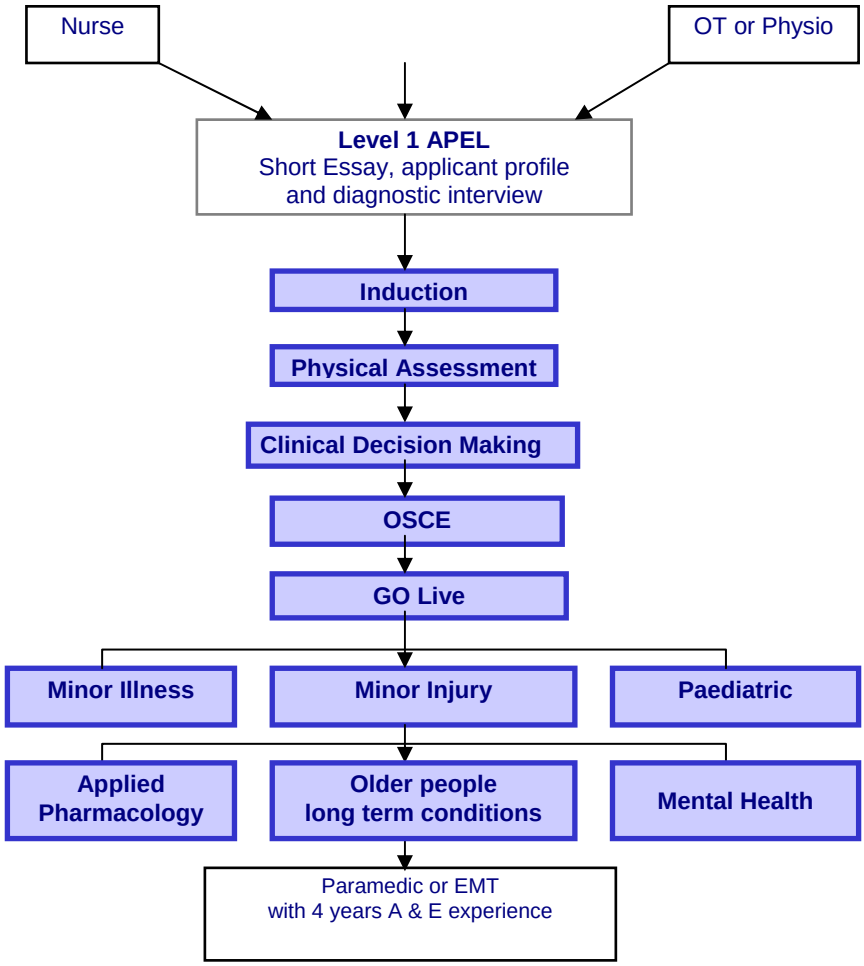
TRUST BOARD MEETING 29th March 200

# Emergency Care Practitioner Update

*Current deployment*: There are currently 34 Emergency Care Practitioners. Teams are Primary Care Trust based and are responding to 999 calls in:
Bromley, Havering (2 cars),Wandsworth, Croydon and Hounslow

The scheme has also committed to manning the Physician Response Car at the Royal London from April onwards. In addition there is a small pilot in Bromley where ECPs are responding to GP Out of Hours calls on Saturday and Sunday. These staff also rotate through the 999 work.

*Education:* This is continuing with St Georges Hospital Medical School. 178 modules of 150 hours each have been delivered over the last year. All trainee ECPs are working towards a Diploma, which takes on average two years on a day release basis, and the first fully qualified ECPs will emerge in the autumn of 2005. Modules have also been made available to LAS Training Officers, funded by the programme. 10-12 trainers have taken up the opportunity so far and 3 places are now allocated on each intake for trainers. The education is structured as follows:



*Finance:* To be addressed in finance paper separately

*Activity:* In January & February 2005 ECPs were dispatched to 1527 calls, of which 153 were cancelled.[1] 16% were categorised as red, 38% amber and 46% green. Table 1 shows the number of calls attended in each participating PCT and main outcome/destination groups.

ECP attendances by PCT, month and outcome/destination
(Source: LAS ECP Database)

| PCT | Total calls attended | | Percentages by outcome/destination | |
|---|---|---|---|---|
| | Jan | Feb | Jan | Feb |
| BROMLEY | 93 | 115 | | |
| Treat & Leave | | | *15* | *30* |
| Care Pathway – Referred | | | *4* | *6* |
| Care Pathway – Conveyed | | | *6* | *3* |
| Taken to A&E | | | *65* | *47* |
| CROYDON | 165 | 128 | | |
| Treat & Leave | | | *25* | *25* |
| Care Pathway – Referred | | | *7* | *10* |
| Care Pathway – Conveyed | | | *5* | *4* |
| Taken to A&E | | | *51* | *48* |
| HAVERING | 197 | 141 | | |
| Treat & Leave | | | *18* | *14* |
| Care Pathway – Referred | | | *10* | *8* |
| Care Pathway – Conveyed | | | *1* | *1* |
| Taken to A&E | | | *49* | *57* |
| HOUNSLOW | 104 | 145 | | |
| Treat & Leave | | | *24* | *20* |
| Care Pathway – Referred | | | *10* | *21* |
| Care Pathway – Conveyed | | | *4* | *3* |
| Taken to A&E | | | *56* | *43* |
| WANDSWORTH | 155 | 131 | 7 | |
| Treat & Leave | | | *32* | *25* |
| Care Pathway – Referred | | | *12* | *10* |
| Care Pathway – Conveyed | | | *1* | *4* |
| Taken to A&E | | | *46* | *48* |

[1] Cancelled calls have been excluded from analysis of statistical outcomes for the first time this month, because this information has now been provided by MI. This has resulted in a slight apparent increase in both the A&E & non A&E take rates, though in practice it is a tightening in reporting categories. The 'other' category is also being currently tightened.

*Roll out:* 14 new ECPs will commence their training on April 11th. Subject to funding and Board agreement there will be a total of 25 new ECPs in the next financial year (inclusive of the 14). A uniform pricing model has been agreed. Intakes are possible in July, September and January. There is widespread interest from PCTs and Strategic Health Authorities in ECPs, particularly in the North East and North West Sectors. Management: Mainstreaming management of ECPs under AOMs is proceeding well in 'live areas'. ECP Co-ordinators have now been formally appointed in Croydon, Wandsworth and Hounslow and they report to AOMs. Development areas are being supported by the ECP Project Manager. There is also an ECP Operational Group chaired by an ECP Co-ordinator - Croydon.

*ECP Clinical Governance:* The ECPs also have a Clinical Development Group which is co-chaired by Dr Daryl Mohammed & Emma Williams (ECP Co-ordinator - Hounslow). All sites have a representative on the group. The group reports to Fionna Moore. Key areas of work include developing:

- Clinical performance indicators framework
- Competency framework
- Patient Group Directives to extend drug formulary

Clinical review sessions are being held every 2-3 weeks and are being led by Dr Daryl Mohammed and Fionna Moore. In addition the scheme is trialling a 'trainee ECP Consultant role'. This is a joint practitioner/trainee consultant role. The aim is to produce a layer of staff who will lead on clinical issues for ECPs and more broadly in the Trust who will report to Fionna Moore. These staff would be clinical leads for an SHA area and also have specific clinical portfolios.

*Patient Involvement:* A patient satisfaction survey was sent to all ECP attended cases (n=774) and a matched sample of ambulance cases (n=884) for three months (October to December 2004). A 54% response rate was achieved. Key findings include high satisfaction ratings (77% very good, 15% good and ECP cases rated more highly on thoroughness of examinations, information given, the explanation of what was going to happen next and patient satisfaction with outcomes.

Patients were asked on the survey if they would be willing to be contacted again. If yes, they were then either sent:

- A health outcome survey (n = 403) including a quality of life measure (analysis not yet complete)
- An invitation to attend a focus group aiming to set quality standards for the scheme (n=30 each in Havering [aged 65 and over] and in Wandsworth/Croydon [aged 18 to 65]).

18 patients attended focus groups. Transport was provided where required and venues were fully accessible. A payment of £30 plus travel expenses was offered to all participants. Participants were invited to talk about their experiences and expectations and also to design quality standards for the ECP service. Headline findings were as follows:

- Participants praised ambulance staff and were pleased to have been invited to give feedback.
- Their first choice would always be to stay at home if well enough
- The quality standards they would expect to be met were to be provided with an individualised response from courteous, calm and positive staff who reassure, listen, are sensitive to their needs, fears and comfort, checking the patient understands how, and is able, to meet their needs, handing over to the relevant people and contacting them the following day if left at home
- Explanation and information, offering choice whenever possible on destination and the sharing of personal information.

Patient involvement will continue as a core part of developing the ECP scheme.

Key Project Challenges

- Increasing utilisation rates and targeting ECPs at the calls where face to face assessment is required and they can give maximum patient and operational gain
- Increasing the number of ECPs whilst ensuring we retain the quality of candidates
- Managing the tension between operational delivery and developing clinically confident and competent practitioners
- Logistical and IT support to underpin successful delivery of the programme
- Embedding learning about success factors from the programme into wider reform, This may be particularly pertinent for the control / call management function where consideration should be given to:
- Predicting demand more accurately
- Ensuring resources are correctly temporally and geographically located
- Inserting higher levels of clinical knowledge into the call management process and enabling professional judgements to be made. Multi-disciplinary and multi-agency partnerships will be necessary to deliver this.
- Creating robust alternative care pathways directly available to CAC to deliver care appropriate to need.

Martin Flaherty
Director of Operations

March 2005

Enclosure 12

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Part I

# Tenders Received

# Report of the Trust Secretary

## 1. Purpose of Report

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. Tenders Received

| Register no. and details of tender: | Tenders Received From |
|---|---|
| 02/05 Patient monitoring devices | G E Healthcare<br>Artemis<br>Philips<br>Welch Allyn UK Ltd<br>Ortivus UK Ltd<br>Huntleigh Healthcare<br>Drager Medical |
| 03/05 Refurbishment of Croydon AS | Burt & Travica<br>Squire Building Contractors<br>TCL Granby<br>Axis Europe Plc |
| 04/05 A&E Ambulance conversion tender | MacNellie & Son Ltd<br>U V Modular Ltd<br>Wilber Ltd |
| 05/05 Barnehurst AS | Maguire Brothers<br>Weatherproof Roofing Contractors<br>Russell Trew Roofing Ltd |
| 06/05 Edmonton AS | Maguire Brothers<br>Weatherproof Roofing Contractors<br>Russell Trew Roofing Ltd |
| 07/05 PTS Vehicle lease tender | ILC (Bank of Scotland)<br>Automotive Leasing<br>Alliance & Leicester |

**3. Proposals**

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.

**Christine McMahon**
**Trust Secretary**

**March 2005**

**LONDON AMBULANCE SERVICE NHS TRUST**

TRUST BOARD MEETING 29th March 200

# Part I

# Register of Sealings

# Report of the Trust Secretary

## 1. Purpose of Report

1.1. To advise the Trust Board of new applications of the Trust seal that have taken place since the last meeting of the Board.

## 2. Background

2.1. It is a requirement of Standing Order 32 that all sealings entered into the Sealings Register are reported to the next meeting of the Trust Board.

2.2. There have been 3 entries, reference 87, 88 and 89, since the last Board meeting. These entries relates to:

- Contract document for the new extension at Whipps Cross Ambulance Station between Coniston & the LAS
- Lease of premises at Rotherhithe Ambulance Station between Southwark PCT and the LAS.
- Contract for the provision of additional office space and toilet accommodation and other associated works at St Andrew's House, Bow between TCL Granby Ltd and the LAS.

2.3. Board Members may inspect the register after this meeting should they so wish.

## 3. Recommendations

3.1. THAT the Trust Board notes this report and the entries to the Sealings Register.

**Christine McMahon**
**Trust Secretary**
**March 2005**

Enclosure 14

**LONDON AMBULANCE SERVICE NHS TRUST**

**Draft Minutes of the Clinical Governance Committee**

31st January 2005 LAS HQ

**Present:**

| | |
|---|---|
| Beryl Magrath (Chair) | Associate Non-Executive Director |
| Barry Mc Donald | Non-Executive Director |
| Fionna Moore | Medical Director |
| David Jervis | Director of Communication |
| Martin Flaherty | Director Ambulance Officer (East) |
| Bill O'Neill | Head of Education and Development |
| John Wilkins | Head of Governance |
| Jason Challen | Senior Training Officer-PTS |
| Kathy Jones | Head of A&E Development |
| Tony Crabtree | HR Manager |
| Gary Bassett | PALS Manager (departed 104.5) |
| Paul Carswell | Diversity Manager |
| Julian Redhead | Consultant in Emergency Medicine, St Marys- Paddington |

*In attendance*

| | |
|---|---|
| Vishy Harirhara | Representative of Patients' Forum |
| Dr Lena Wanford | Representative of Patients' Forum |
| Peter Suter | Director of Information Management & Technology (departed 10.45) |

**Apologies**

| | |
|---|---|
| Sarah Waller | Non- Executive Director |
| Claire Glover | Governance Manager |

The Chairman welcomed Julian Redhead from St Mary's Hospital and also Mr Vishy Harihara and Dr Lena Wanford, Patient's Forum representatives in attendance.

## 1 Minutes of the meeting held on Monday 4th October 2004

**Agreed:** **The minutes of the Clinical Governance Committee meeting held on 4th October 2004.**

## 2 Matters Arising

Minute 21 – The Director Ambulance Service (East) reported that he had discussed the issue of paper overshoes with the Camden DSOs and it was felt that this was not an issue for the Service.

Minute 32.2 – Julian Redhead was in agreement with the suggestion of a pilot being done to formalise feedback to the LAS. **ACTION:Julian Redhead/Martin Flaherty**

Minute 32.6 – The Director of Communications reported that it will be a key task of the Patient Public Involvement Manager to progress the establishment of a database of patients/public who have expressed an interest in being actively involved with the LAS. It was reported the Diversity Team was working with the Camden AOM and the Patients' Forum; the LAS were continuing to develop its links with local communities. **ACTION: DJ - progress report would be given at the next meeting**

Minute 36.3 – The Medical Director reported that during the Chief Executive's

Consultation meetings crews had raised the issue of having one day off the road for training purposes- the Service cannot guarantee two days off the road.

The Training Services Committee has complied a long list of training items it would like to see delivered to staff and it is reviewing how the various elements of training could be delivered ie classroom, via the Pulse, through team leaders/sector trainers. The training needs of PTS staff are also being considered.

It was thought that the training programme may have to be rolled out over a two year period. **ACTION: Training Services Committee**

**Noted:**
1. **The matters arising**
2. **That the Patients' Forum would be having a discussion regarding diversity on 7th February 2005.**

## 3 Update CHI Action Plan

The Committee were informed that an update on the CHI Action Plan would be reviewed by the Strategic Health Authority on 9th February 2005. The LAS has made considerable progress on achieving the CHI action plan; the outstanding items will be merged into the new Development plan due from the Health Authorities in February 05.

It was recognised that the Patient Forum and PPI have been actively involved in various aspects of the LAS' work. In particular, Malcolm Alexander, Chairman of the Patients' Forum, has been involved with the sector model in Camden.

**Noted:**
1. **That the Strategic Health Authority would be reviewing the progress the LAS has made against the CHI Action Plan on 9th February 2005.**
2. **That the outstanding CHI Actions would be merged into the new Development Plan in 2005/06.**

## 4 New Clinical Governance Development Plan - Draft

The Committee considered the draft Clinical Governance Development plan which outlined the 24 standard range of domains and the work that will be necessary for the LAS to meet new healthcare standards.

Complaints – the December Trust Board agreed the revised Complaints Policy which included reference to how the Trust could learn from complaints and avoid re-occurrence. Julian Redhead commented that hospitals have a system whereby there is a review body which considers complaints to ensure that where possible lessons could be learnt.

The Diversity Manager reported that the Trust is legally required to undertake a risk assessment whereby it monitors service delivery on an ethnic basis.

**Agreed:**
1. **The new Clinical Governance Development Plan**

**Noted:**
2. **That the Committee would receive quarterly reports on progress of the plan.**
3. **That the core healthcare standards will replace the current star rating system.**
4. **That the LAS is required by law to undertake an Impact assessment on an annual basis**

## **5** Update on NHSLA risk management assessment

The Medical Director reported that the NHSLA risk management assessment took place on 25th January; due to a second visit being necessary the assessors are with the Trust today (31st January 2005). Previously the LAS had achieved level 2 when assessed by the CNST in May 2002 and level 1 when assessed by RPST in 2003. The LAS has asked to be assessed at level three. Feedback would be received following the assessment.

Training Needs Analysis: The Chairman queried the training needs analysis (TNA) report that had previously been presented to the Committee. The Head of Education and Development confirmed that the document had not been an analysis but a plan. **ACTION: the Head of Education and Development to ensure a proper assessment of TNA is undertaken.**

The Committee were informed that it would not be possible for the Trust to ensure that all Technicians had a record of Basic Life Saving refresher training this year. The Medical Director commented that in total there were approximate 2,400 staff who should be given BLS relevant training. It was recognised that although Team Leaders in their ride-outs with crews were undertaking training these sessions were not currently documented. There has been a 2 day training package on cardiac care delivered to all front line staff. Over 400 PTS staff had been trained in BLS. The Director of Ambulance Service (East) was in agreement that the assessment be undertaken and a realistic time frame for delivery of training agreed.

**Noted:**

1. **That the next CGC meeting would receive a report back on the outcome from the NHSLA with management assessment**
2. **That an assessment of the TNA would be undertaken and its findings presented to the Committee.**

## 6 Summary of PALS Annual Report

The Committee considered the summary of the PALS annual report; it was suggested that the graphs be reviewed prior to publication and their presentation improved. The report would be included in the Trust's publication scheme. Gary Bassett, the PALS Manger, presented the report which included on requests received to date under the Freedom of Information Act.

Frequent callers – the Committee was pleased with the case study of the frequent caller and the assistance that was able to be offered to the individual. The PALS Manager confirmed that there is no set figure for determining a frequent caller; PALS relies on local AOM to identify.

Lost property – the Committee were informed that of the reports of lost property about 20% are located and up to 80% found elsewhere. Locating lost property is a very time consuming activity for the PALS team. A number of solutions were suggested and it was agreed that the Director of Ambulance Service (East) would come back in due course with a plan following some trials. **ACTION: Director of Ambulance Service (East)**

**Noted:**

1. **The Summary of the PALS Annual Report**
2. **That there have few requests received under the Freedom of Information Act; the Trust will review its FoI policy after six months.**

## 7 Frontline clinical governance communication

An example of frontline clinical governance communication was presented to the Committee – 'Heartbeat' produced by the Fulham and North Kensington complex. The Committee were informed that New Malden also has a magazine which is of a high standard.

The Director of Communication commented that the Senior Management Group were keen to monitor and encourage these initiatives which relied on local trainers/management/staff on station to contribute ideas for the magazines. The Director of Ambulance Service (East) undertook to raise the issue of newsletters and their usefulness in terms of clinical governance with PPG

**Noted:** **That there were approximately 6 frontline communications highlighting clinical governance issues.**

## 8 Review of the Department of Education and Training

The Head of Education and Development circulated a report which outlined the re Organisation that is taking place at the Department of Education & Training. The re-organisation took place following consultation across the department and other stakeholders in the LAS. The growth of the department during the last ten years had led to a dilution of management of clinical education.

From April 2005 the Head of Education & Training will report to the HR Director and will be responsible for management development and clinical staff development. The Department will have 4 distinct areas –(1) development, (2) quality, standards and logistics; (3) clinical education who will be responsible for delivery of clinical education training and (4) delivery of education.. The Clinical Development Manager will report directly to the Medical Director; the Community Defibrillation Officer will report directly to the Clinical Development Manager. Two clinical education posts have been advertised to oversee the delivery of training – closing date 9th February 05. This concludes the first phase of the reorganisation; the second phase will focus on the next tier and meetings will be held in February to discuss future roles.

The role of the Learning & Development Manager is being reviewed; the Head of Education and Development is drafting a job description for Leadership Development Manager who will be responsible for non-clinical staff development. Following Claire de la Roque's resignation the Resuscitation Team's function is being reviewed.

The Chairman thanked the Head of Education and Development for his report and wished him luck as she recognised there would be a lot of work involved.

**Noted:** **The report**

## 9 Review of the Clinical Governance Committee

The Head of Governance presented a review of the Clinical Governance Committee. Proposals for change were last discussed at the CGC meeting on 26th January 04 which was approved by the Trust Board in March 2004.

The Committee considered the various recommendations which included:

i. that the CGC direct and seek action relating to reports it received that propose evidence of outcomes leading to improvement in patient care;
ii. that the CGC make decisions concerning the quality of clinical governance so as to ensure that the domains and standards of the Standards for Better Health are achieved
iii. that the Complaints Panel provide routine reports to the CGC specially concerning evidence of recommendations made and fully implemented.

The Director of Ambulance Service (East) felt the Committee's terms of reference should be reviewed and queried the Committee's role to task/direct – the Committee could ask members to provide evidence but the tasking of managers could become confusing.

The Medical Director thought that the report from the Complaints Panel would be most useful in terms of the LAS learning lessons – a meeting of the Complaints Panel needs to be set up.

**Agreed:** **That the Head of Governance would circulate the CGC s terms of reference and the Healthcare standards for information to the Members of the Committee.**

## 10 Reports from Groups/Committees

### 1 Clinical Audit & Research Update + Minutes of the CARSG

**Noted:**

1. **That the Clinical Audit and Research Steering Group had agreed the preliminary finding of the Anaphylaxis Clinical Audit, approved a new cardiac research project (Dispatcher-Assisted Resuscitation Trial) and discussed the difficulties being experienced in recruiting for the Activated Charcoal research project.**
2. **That a final draft of the 'Fit to be left' research project was expected the end of January 05.**
3. **That Lena Wanford of the Patient Forum had observer status on the CRSG and she was happy with how the Committee conducted itself.**

### 2 Summary of the Clinical Risk Group

**Noted:**

1. **The contents of the report and the work that the CRG was undertaking:**
2. **Complaints against external agencies - Datix would be utilised to record these complaints offering better case management and the ability to take action on emerging trends.**
3. **CPI checks – fallen by 10% (Apr-Sep) though the number of calls relating to the CPI topics increased by 13%. It was recognised that the quality of information has improved. Team Leader training in 2005 will include highlighting the 70:30 split being a priority.**
4. **A previously identified skill gap was being addressed through a 2 day refresher programme held in December 04 which included intermediate staff**
5. **Two risks were recommended for change in grading – failing to appreciate the significance and urgency of psychiatric illness, and to provide the**

**appropriate response/assistance/treatment was upgraded to high from medium + risks of paramedics failing to qualify for registration and not being able to practice due to the cancellation of, or non-attendance, at recertification audits was downgraded from high to medium.**

6. **The risks posed by FRU drivers were discussed and their training needs reviewed. To address concerns regarding clinical competency it was suggested that FRU drivers should work at least one day a month on an ambulance. This was to be taken to PPG. MF commented that many FRUs probably do overtime on an ambulance and that there may be practical difficulties ie staff rosters.**

3 **NPSA Update**

**Noted:**

1. **That since December 04 the LAS are contributing to the National Reporting and Learning System.**
2. **That this is an important step in improving the practical use of information from the Incident Report System as outlined in the Clinical Governance Development Plan.**

4 **Complaints Panel**

**Noted:** **That a meeting would of the Complaints Panel would be convened.**

11 Date of next meeting: 9th May 2005 TBC

**LONDON AMBULANCE SERVICE NHS TRUST**

# Draft Minutes of SERVICE DEVELOPMENT COMMITTEE

**Tuesday, 22nd February 2005 at 10:00 a.m.**

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

| | | |
|---|---|---|
| **Present:** | Sigurd Reinton | Chairman |
| | Peter Bradley | Chief Executive (departed 11.50am) |
| | Barry MacDonald | Non Executive (departed 12.25) |
| | Sarah Waller | Non Executive |
| | Toby Harris | Non Executive (arrived 10.20am) |
| | Colin Douglas | Non Executive |
| | Wendy Foers | Director of Human Resources |
| | Fionna Moore | Medical Director (departed 11am) |
| | Mike Dinan | Director of Finance |
| | Beryl Magrath | Associate Non Executive Director |
| **In attendance:** | Peter Suter | Director of Information Management & Technology |
| | David Jervis | Director of Communications |
| | Martin Flaherty | Director of Ambulance Services (East) |
| | Philip Selwood | Director of Ambulance Services (West) |
| | John Hopson | ACAO CAC |
| | Christine McMahon | Trust Secretary (minutes) |
| | Mark Whitbread | Assistant Head of Training, Cardiac Lead |
| | Greg Masters | Project Manager, Agenda for Change |

## 01/05 Minutes of the Meeting held on 21st December 2004

The Chairman **signed** the Minutes as a correct record of the meeting held on 21st December 2004 with the exception of the amendments noted below:

Minute 43.04 Sarah Waller thought it important that the Minutes reflect the SDC's views that the negotiations taking place regarding Agenda for Change (AfC) be treated as part of a single package.

Minute 46.04 The Director of Information Management and Technology suggested that the reference to NHS guidelines be deleted and replaced by 'as set out in Legislation'.

## 02/05 Matters Arising

Minute 44.04 – in response to a question from Sarah Waller the Chairman was unable to confirm when the Strategy for Integrated Emergency Care would be published. He reported that Pippa Bagnall would be meeting with Emergency Care networks to discuss the draft recommendations for Integrated Emergency Care in London.

The Chairman and the Chief Executive are giving a series of presentations to the Chief Executives and Chairmen of the five London Strategic Health Authorities concerning Emergency Care Practitioners (ECPs); these presentations will include reference to integrated emergency care.

## 03/05 Chairman's Update

The Chairman reported that eighty-seven applications had been received for the two Non-Executive Director vacancies; interviews will take place on 2nd March 2005.

The Chairman informed the SDC that the Director of Ambulance Services (West) had been appointed Chief Executive of the Wiltshire and Gloucester Ambulance Service. The Chairman praised the efforts of the Director of Ambulance Services (West) who during his time with the LAS took responsibility for introducing Mobile Data Terminals (MDTs) with Ian Tighe (former LAS IT Director), Emergency Preparedness and Emergency Bed Service. Following the introduction of the Sector Operating Model in 2004 the Director of Ambulance Services (West) became responsible for West London. The Chairman considered the degree to which the two Directors of Ambulance Services have worked together to be a model of collaboration.

The Director of Ambulance Services (West) thanked the Chairman for his kind words. He felt he had been privileged to have had two careers, first with the Metropolitan Police, from which he retired as Divisional Commander in 1997 and secondly with the LAS Trust. He said that he had greatly enjoyed working with the Senior Management Group and the Trust Board. He thought that the close relationship between himself, the Director of Ambulance Services (East) and the Chief Executive had ensured consistent leadership across the Trust.

## 04/05 Cardiac Care Update

The Cardiac Lead (Mark Whitbread) presented an update on cardiac care, including progress on a number of initiatives intended to improve performance.

*Community Resuscitation, Education and Training* - the Community Resuscitation team has been very active. The team provided training to 185 communities; 105 public courses at training schools; 35 Mother and Baby talks and 21 LAS inductions. The SDC were reminded of the "Live or Let Die" poster campaign launched in October 2003 with the aim of promoting CPR, chest pain awareness and the need for action. It was a very successful campaign and led to over 3000 people receiving training in 2003. In 2004, however, the number of people trained fell to below 2000. Sustaining an advertising campaign such as the "Live or Let Die" poster campaign is very expensive. The team is currently targeting Asian communities as members of that community have high incidences of heart attacks.

*Defibrillators in Public Places* – from February 2005 the LAS became responsible for the continued development; training and use of the 298 defibrillators distributed around 32 London locations. Funding has been secured for the appointment of two full time training officers. Jo Smith has recently been appointed as the LAS's Community Defibrillation Officer. She will be responsible for the Defibrillators in Public Places, liaising with the Department of Health project manager.

*Cardiac arrest* – the SDC was informed that there are approximately 8,000 cardiac arrests reported in London per annum (more than any other city in the world). The LAS monitors the outcomes from these incidents and is actively involved in research and audit projects looking to improve the management and survival of these patients. The LAS is contributing data to End-Tidal CO2 audit/research project.

*Dispatcher Assist Resuscitation Trial* (ARRT study) involves compression only resuscitation – this project is being jointly undertaken with Seattle**.** It was reported that Seattle has the highest survival rate for people suffering cardiac arrest in the world – 20%. The LAS has made some progress; in 2000 the survival rate was 2%, in 2004 it was 6.4%.

As part of the presentation the Cardiac Lead presented data concerning pre-hospital thrombolysis "clot-busting" drugs. Although in some ambulance services it is becoming the standard therapy for heart attack patients, it is thought to be effective for only 60-70% patients. The LAS considered the evidence for primary angioplasty and it suggested that this may be superior to the "clot-busting" drugs. When feasible, patients with ST elevation

myocardial infarction are transported to one of the ten heart attack centres in London where they receive angioplasty treatment.

*Heart attack centres* – There is a clinical window of three hours for primary angioplasty from the onset of pain. The Department of Health's target's is one hour for a patient to be assessed and thrombolyis administered. The Cardiac Lead confirmed that 1% of patients with heart attacks are currently taken to the heart attack centres. The process needs to be carefully managed to ensure that the heart attack centres are not overloaded and that their internal management of waiting lists for elective cases hampered.

Primary Care Trusts and Strategic Health Authorities will be urged to support the use of the heart attack centres for the care of patients with myocardial infarction as this is the right way forward clinically and in the long term it may be the cheaper option.

In reply to a question from Colin Douglas as to why there are not more defibrillators in public places it was pointed out that, to be of value, a defibrillator needs to be no more than 2 minutes away from the victim. As approximately 75% of heart attacks take place in the home, only public places where there is significant footfall are candidates for the programme. There are 298 defibrillators distributed around London at airports, railway and underground stations and other public venues, 98 of them at Heathrow Airport.

The Defibrillators in Public Places scheme was taken over by the LAS in February 2005 and the team has yet to receive data about usage prior to that date. The survival rate following use of defibrillators is 29% for patients in a shockable rhythm. Ambulance Services in rural areas use clot busting drugs as they are often unable to transport patients to heart attack centres within an hour – the LAS prefers to transport patients to a heart attack centre for angioplasty.

The Director of Ambulance Services (West) suggested that British Airways be approached to fund pedal paramedics given the difficulties of accessing medical help at Heathrow Airport. **ACTION: AOM Hillingdon**

The Chief Executive commented that the Senior Management Group had recently discussed defibrillators. There had been some doubt expressed as to whether the expenditure in ensuring every LAS and PTS vehicle carried a defibrillator was one that delivered real value for money. There was anecdotal evidence that most A&E crews do not take the defibrillators to every call. It was confirmed that the Emergency Care Practitioners' bag contains a defibrillator and that the primary response bag also contains a defibrillator.

The Cardiac Lead confirmed that time and the use of defibrillators were the most important elements in delivering further improvements in the cardiac survival rate. It was commented that not all Ambulance Services record data in a standardised manner – if this could be addressed useful data might be obtained.

The Chairman undertook to write to Ruth Kelly (Secretary of State for Education and Skills) in support of resuscitation training being included in the national curriculum. This was recently introduced in Northern Ireland where 11-12 year olds were being taught Cardiac Pulmonary Resuscitation (CPR). **ACTION The Chairman**

**Noted: That the SDC would receive a further progress on cardiac care report in 2006**

**05/05 <u>Format of SDC meetings</u>**

The Chairman invited views on the format of the Service Development Committee (SDC) meetings. The original idea for SDC was that it would be an informal forum where the Members of the Board received in-depth briefings. A number of views were expressed and the consensus was that there should be a move towards monthly Trust Board meetings with an SDC meeting following on from some meetings of the Trust Board – perhaps four times

a year. The Chairman undertook to review what extended discussions the SDC has had in the past in order to guide what time should be allocated in future. **ACTION: Chairman**

*Reports* - the Non-Executives wish to receive full financial reports on a monthly basis, including an exceptions report highlighting any areas of concern. It was agreed that performance reports would be produced in a phased fashion – one month focussing on HR issues, another month on performance etc. It was suggested that all the reports presented to the Board contain an executive summary.

*Public attendance* - in order that the LAS' endeavours receive greater recognition it was felt that the public and the media should receive greater encouragement to attend Trust Board meetings. If more people were to attend Trust Board meetings an alternative venue would need to be identified as the conference room at LAS headquarters would be unsuitable.

*Format of the meetings* - it was suggested that the meeting should ideally last no more than two hours and that the agenda should not be unduly lengthy. Fewer items on the agenda would permit more in-depth discussion. It was proposed that operational and routine reports could be dealt with in the first forty-five minutes and that the Board could then consider two or three "big" items during the remainder of the meeting.

**Agreed:**

1. **That the Chairman would sketch out what the future format of meetings would look like and circulate to the Members for comment.**
2. **That the Chairman would analyse how the SDC has used its time at previous SDC meetings and report back to the Board.**
3. **That the matter would be further discussed at the Board Away Day on the 18th and 19th April 2005.**

## 06/05 Performance update

The Chief Executive stated there was nothing further he wished to add to the briefing delivered to the Non-Executives at the Breakfast meeting held just prior to the SDC meeting.

## 07/05 Financial Report – Month 10

The Month 10 financial report showed that expenses exceeded income by £754k for the month with a positive variance of £758k for the year to date.

The Finance Director reported that the year end figure has been re-forecast to a £380,000 underspend. Three factors led to the forecast being revised downwards by £566,000:
(1) MDTs had not been depreciated (a root cause analysis is being undertaken to ensure there is no repeat of such an oversight); (2) provision had now been included for additional staff overtime to be worked in February and March to maintain operation performance and included enhanced hours element paid at Easter and (3) the interest being earned on high cash balance had been included.

The Finance Team has been asked to ensure that the financial reports are produced within 5 days of month end so as to ensure there are 5-10 days for analysis.

The Trust's Debtors has decreased by £6.4m due largely to receipt of the CBRN funding. The balance in excess of 90 days overdue has been adjusted for the impact of the £430,000 overpayment by Camden. The in excess of 90 days debtors balance is now 24% of the total debtors balance; the disputed PTS balance in arbitration accounts for 19% of this measurement.

In response to a question from Barry McDonald, the Finance Director confirmed that the 2005/06 budget will be presented to the Trust Board on 29th March 2005.

The draft budget will contain standard items of expenditure and items "at risk" (e.g. increase in the number of ECPs) until the Commissioners confirm what funding the LAS will receive in 2005/06

**Noted:**
1. **That the format of the finance report is being reviewed to include updates on trends etc.**
2. **That the LAS has physically received the CBRN funding of £6.9 million.**

## 08/05 Agenda for Change - update

The Director of Human Relations gave a brief update to the SDC on the progress regarding the implementation of Agenda for Change (AfC) and highlighted that there were some areas of concern. She advised the Committee that little progress had been made at a national level concerning the job profiles for Emergency Medical Technicians and Paramedics. In addition to this there had been no national guidance issued regarding meal breaks which had a direct link to the length of working week. The Committee accepted that further delay at national level in respect of these two issues could seriously delay the assimilation of staff on to their new terms and conditions of service.

The Project Manager for AfC reported that the traffic light reporting arrangements to the Strategic Health Authority on individual trust progress with the implementation of AfC had been abolished. There would however remain a requirement to provide a monthly progress report to the SHA. Sarah Waller questioned whether the risks associated with AfC had been properly assessed and recorded on the Trust's risk register. The Director of Human Relations confirmed that although a risk assessment had been carried out, the risks had not been included on the register. It was agreed that the risks should be reviewed and the appropriate entries made to the risk register. **ACTION The Director of Human Relations.**

The Director of Ambulance Services (East) reassured the SDC that the Senior Management Group had considered the operational risks associated with AfC and work was being undertaken to mitigate the identified risks.

**Noted:**
1. **The progress report on the implementation of Agenda for Change**
2. **That the risks associated with Agenda for Change would be reviewed and included in the risk register.**

## 09/05 Infection Control - update

The Head of Operational Support gave a brief presentation to the SDC regarding Infection Control. He outlined a number of initiatives that the LAS has introduced to manage the risk of infection control, including the Make Ready scheme which was presented to the Trust Board in December 2004. To date, Make Ready has been rolled out to 5 complexes and it has been very successful in ensuring a clean patient environment.

Two working groups have been established, both of which should help with infection control (the Infection Control Steering Group and the Vehicle and Equipment Working Group). They review products and procedures to ensure that risk is managed. The Head of Operational Support is the chairman of both of these working groups.

The Head of the Governance Development Unit is to undertake an Audit of Infection Control in February 2005; the results of which will be reported to the Board as part of the Assurance Framework Report in March 2005.

Sarah Waller asked whether the Make Ready scheme includes PTS vehicles. The Head of Operational Support confirmed that although there were no plans as yet to include PTS as part of the Make Ready Scheme, PTS vehicles could be included in the Audit programme being undertaken in February 2005.

In response to Sarah Waller's second question regarding hand washing he confirmed that friends and relatives accompanying patients are not asked to wash their hands.

It was recognised that there needs to be ongoing education and training with front line crews to ensure that hands are properly washed and that gloves are used appropriately.

**Noted: The report.**

## 10/05 The way forward for CAD

The Director of Information Management and Technology presented a report which set out a two phased approach as the way forward for CAD (computer aided despatch).

Phase 1 will focus on the existing system in line with the pre-existing planned Windows CTAK proposals and Phase 2 will endeavour to identify where the Trust needs to be by 2010 and to implement a completely new CAD system. It is intended that the two phases will run in tandem. How the current CAD system will be replaced has not yet been decided – there are a number of options to be investigated and evaluated. The expectation is that Phase I will go live in March 06 and Phase II will go live in April 2008.

The SDC supported the approach outlined in the presentation, especially the necessity of a high calibre internal user group. The Director of Information Management and Technology reported that he had done some preliminary research and had been surprised to learn that there are relatively few suppliers of CAD systems. He had also realised that in comparison to the Police or the Fire Brigade the LAS requires a system capable of supporting more complex decision making processes.

In response to a question from Sarah Waller regarding the exposure of the LAS due to only one member of staff having full knowledge of the current CAD system, the Director of Information Management and Technology confirmed that he has appointed someone whose start date is 29/2/05.

The Director of Information Management and Technology undertook to provide the Board with an update in due course when there is progress to report.

The Assistant Chief Ambulance Officer - CAC reported that he was meeting with the Director of Information Management and Technology on a monthly basis to discuss short term fixes to the CTAK system.

The Director of Ambulance Services (West) reported that he had discussed with the Director of Information Management and Technology the "big ticket" items (e.g. the deployment of emergency care service CAD) which are acting as a constraint on the development of Green Base urgent care and could be achieved in the short term.

**Noted: The report.**

## 11/05 Any Other Business

The Chief Executive reported that interviews for a new Human Resources Director will be taking place on 4th March 2005.

In reply to a question from Sarah Waller, the Director of Ambulance Services (West) reported that he and the Chief Executive had given two presentations concerning security and the provision of medical services to the International Olympic Committee during its recent inspection visit.

## 12/05 Date of Next Meeting

The next meeting of the SDC would be on Tuesday 28th June 2005 at 10:00 am in the Conference Room, LAS Headquarters.

The meeting concluded at 1.15