LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 29th July 2008 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Apologies: Roy Griffins; Brian Huckett and Sarah Waller. Declarations of Further Interest.		
2.	Opportunity for Members of the Public to ask Questions.		
3.	Minutes of the meeting held on 20th May 2008 Part 1 and synopsis of the Part II meeting held on 20th May 2008.		Enclosure 1 & 2
4.	Matters arising		
5.	Chairman's remarks	SR	Oral
6.	Report of the Chief Executive	MF	Enclosure 3
7.	Financial Report, Month 3 2008/09	MD	Enclosure 4
8.	Auditor's report on 2008/09 Annual Accounts	MD	Enclosure 5
9.	Report of the Medical Director	FM	Enclosure 6
10.	Approve CAD 2010 Full Business Case	PB	Enclosure 7
11.	Update regarding Foundation Trust Diagnosis	MD	Oral
12.	Receive Fleet Workshop review recommendations	MF	Enclosure 8
13.	Workforce Development update:	CH	
	• Training and Development Plan update		Enclosure 9
	• Student Paramedic Pathway		Enclosure 10
	• Presentation: ECP education and future role		Enclosure 11
14.	Update regarding Service Improvement Programme 2012	PB	Enclosure 12
15.	Draft minutes of Service Development Committee, 24th June 2008	SR	Enclosure 13
16.	Draft minutes of the Audit Committee, 16th June 2008.	CS	Enclosure 14
17.	Draft minutes of Clinical Governance Committee, 2nd June 2008	BM	Enclosure 15

18.	Report of the Trust Secretary on tenders opened and use of the Seal.	CMc	Enclosure 16
19.	Opportunity for members of the public to ask question		Oral

Date of next meeting: 09.00am* on 30th September 2008, Conference room, LAS HQ, Waterloo Road, which will be followed by the Annual Public Meeting at 2.30pm.

* start time to be confirmed.

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 20th May 2008

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Roy Griffins	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Brian Huckett	Non Executive Director
	Caroline Silver	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
Apologies:		
	Ingrid Prescod	Non Executive Director
	Martin Flaherty	Director of Operations
	David Jervis	Director of Communications
In Attendance:		
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	Richard Webber	Acting Director of Operations
	Angie Patton	Head of Communications
	Malcolm Alexander	Chair, Patients' Forum
	Ashley Jones	FT Diagnostics Project Manager
	Deepak Rawal	NHS London (until 12.55)
	Chris Biggs	NHS London
	Claire Halstead	PriceWaterhouseCooper
	Christine McMahon	Trust Secretary (Minutes)

47/08 **Declarations of Further Interest**

Roy Griffins declared that he had recently been appointed a Member of the Standards Committee of the London Borough of Camden

48/08 **Opportunity for Members of the Public to ask Questions**

There were no questions from members of the public.

49/08 **Minutes of the Meeting held on 18th March 2008**

Agreed: The minutes of the meeting held on 18th March 2008.

50/08 **Synopsis of the Trust Board's Part II meeting held on 18th March 2008**

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

51/08 **Matters arising from the minutes of the meeting held on 18th March 2008**

Noted:

1. **Minute 28/08: the HR Director said that in the past year 33 members of staff who had left EOC had left the LAS altogether. Of the remaining staff who left EOC:**
   - **4 have commenced a Paramedic Science diploma course;**
   - **1 was studying to become a Paramedic via internal modules;**
   - **2 have left the full time employment of the LAS but continue to be employed as Bank Staff;**
   - **1 has become an Emergency Medical Technician.**

   The Acting Director of Operations said that EOC has a lower turnover of staff than that experienced by Call Centres in general or other similar NHS organisations.
2. **Minute 28/08: the Chief Executive said that a report regarding the handover to hospitals had been deferred to a meeting of the Service Development Committee in June as the Trust Board's May agenda was quite lengthy.**
3. **Minute 29/08: the Director of Finance said that work was being completed regarding the benefits realised of the Invest to Save Project; information was enclosed with the Month 1 Financial Report on the progress to date. The internal auditors, Bentley Jennison, will undertake an audit of the benefits realised as part of their 2008/09 programme of work.**

52/08 **Chairman's remarks**

The Chairman welcomed Deepak Rawal and Chris Biggs from NHS London and Claire Halstead from PriceWaterhouseCooper who were observing the Trust Board as part of the FT Diagnostic Pilot.

The Chairman said Dr George Greener has announced his resignation as Chairman of NHS London. He will be in post until September.

The Chairman recently attended an event for the SHA organised by McKinsey; 'Changing the role of the chairman' which was attended by Provider Trust Chairmen to prepare for Foundation Trust status. Concern had been expressed by some of the chairmen at the meeting about the lack of contact with NHS London.

David Sissling, Programme Director for Healthcare for London, attended the LAS Board's Away Day at which he spoke about the recent consultation that was undertaken concerning Healthcare for London and the different programmes of work that have commenced, e.g. stroke, trauma etc.

The Chairman attended a private meeting with David Nicholson, NHS Chief Executive, who said that although he intellectually understood the role

ambulance services could play in reducing inappropriate A&E presentations he had yet to see the evidence.

Liz Kendall has been appointed Director of the Ambulance Service Network; she was previously Special Adviser to Patricia Hewitt when she was Secretary of State for Health (2005-07). Ms Kendall has been invited to visit the LAS. The Board of the Ambulance Service Network was undertaking a review of AMBEX in light of other developments that have taken place in the ambulance service sector and the wider NHS.

The Chairman has written to Boris Johnson, the new Mayor of London, inviting him to visit the Trust. The previous Mayor, Ken Livingston, visited the LAS twice during his tenure of office. Richard Barnes, the Deputy Mayor, has also been invited to visit the LAS.

The Chairman has written to Brian Coleman, the new Chairman of the London Emergency Planning and Fire Authority, congratulating him on his appointment. In his letter, the Chairman suggested the resumption of the three way meetings of the Chief Executives and the Chairmen of the Metropolitan Police, the Fire Authority and the LAS recommence.

The Chairman was contacted by Simon Eccles, a Consultant in Emergency Medicine based at Homerton Hospital FT and a member of the British Medical Association's Central Consultants and Specialists Emergency Medicine Subcommittee. He has been charged with installing a real-time performance management system for the Homerton A&E, and was keen to be able to include a feed from the LAS showing ambulance turnaround times.

53/08 **The Chief Executive's report**

The Chief Executive presented his report, the format of which had been changed, and said he would welcome feedback from the members of the Board. He highlighted the following from his report:

The Healthcare for London (HfL) consultation had been completed and the findings will be considered by the Joint Committee of Primary Care Trusts (PCTs) on 12th June. The Trust was working with a number of PCTs on progressing various strands of work e.g. stroke, unscheduled care and trauma.

The Trust has submitted its annual declaration of full compliance to the Healthcare Commission; this year's submission included positive comments from NHS London; the Patients' Forum and seven of the London Boroughs' Overview and Scrutiny Committees. An event was held on 18th March, '247-247' to demonstrate to key stakeholders the Trust's compliance with the Standards for Better Health.

Following presentations to a panel comprising the Chief Executive and the Medical Director, Barnehurst and Chase Farm were chosen as exemplar complexes for the New Ways of Working model with a third complex being unsuccessful in its application. The Trust Board will receive regular updates on the implementation of the New Ways of Working model. **ACTION: Chief Executive**

Discussions were taking place with the Trust's Lead Commissioner regarding turnaround times at hospitals and a review of the Emergency Bed Service as part of the Commissioning Framework.

In terms of performance, 2007/8 was a very good year for the Trust, despite an increase of 3% in demand:

- 78.94% of Category A calls were reached in 8[1] minutes;
- 84.4% of Category B calls were reached in 19[2] minute;
- 93.7% of calls were answered within 5 seconds.

For 2008/09 to date, the Trust has achieved the following:

- 76.2% of Category A calls were reached within 8 minutes of Call Connect[3] (target 75%);
- 86% of Category B calls were reached in 19 minute. The Trust has been commissioned to achieve 90% for the year as a whole which will be achieved following the recruitment of additional staff in 2008/09.
- 96.2% of calls were answered within 5 seconds.

The Chief Executive said that maintaining performance in May 2008 had been challenging as demand had increased by 10% compared to May 2007. The increase in demand was due in part to the recent hot weather and the raised awareness of the implications of chest pain following the recent British Heart Foundation's poster campaign.

In regard to the LAS' Patient Transport Service, there have been improvements in quality with good performances being recorded for 2007/08. A strategic review of PTS will be presented at an upcoming Service Development Committee. **ACTION: Director of Finance**

A Clinical Support Desk has been established in EOC that has been welcomed by staff in the Control Room and by front line crews. The Board will receive further reports on the usage of the clinical support desk during the course of the year. **ACTION: Deputy Director of Operations**

The LAS will be hosting a national Emergency Preparedness conference, 'Lessons Identified', on the 8th July 2008. The purpose of the conference is to share the lessons learnt from the major incidents experienced in recent years (e.g. the flooding that took place in 2007) between the ambulance services.

The Trust was working with the Trade Unions to finalise a new agreement on partnership and consultative arrangements and the Board will be kept informed of progress. **ACTION: HR Director**

One of the projects of the Invest to Save programme was that retrospective criminal record checks were undertaken of all staff that have patient contact. A number of checks have been positive and further investigations were being undertaken.

The level of absence due to sickness has improved in recent months and the HR team was working with the Trust's Occupational Health Provider on the management of members of staff with long term sickness.

In April 2008 front line staff received a rest break on 60% of shifts. It was recognised that the allocation of rest breaks will continue to be a challenge for the Trust. Confidence was expressed that the additional staff being recruited in

[1] Category A: presenting conditions which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

[2] Category B: presenting conditions which though serious are not immediately life threatening and must receive a response within 19 minutes.

[3] Call Connect: until 1st April ambulance response times were measured from a point when 3 pieces of key information has been obtained (location, telephone number and chief complaint). From 1 April 2008, the clock started when the call is connected to the ambulance control room.

2008/09 and the embedding of the allocation system in the Control Room will further improve matters.

The Board's attention was drawn to the work undertaken by the Communications department, including the poster campaign '*Use our Service wisely*'.

The Board was informed that two members of staff had recently passed away. The first had worked as a Clinical Telephone Adviser and had died suddenly. The second had been killed in an accident whilst undertaking training to be a motor cycle responder. The Board expressed it sadness and sympathy for the families of both.

The CAD 2010 project was now at the stage where the two final tenders were being evaluated for final consideration by the CAD 2010 Project Board week commencing 27th May 2008. If matters proceed according to schedule, the Project Board will be able to make a recommendation to award the tender and a draft Full Business Case will be written for consideration by the Trust Board before it is submitted to NHS London. It will then return to the Trust Board for final approval. In order to ensure there is minimal delay in commencing work with the preferred supplier, the Trust Board was requested to delegate authority to the Service Development Committee meeting in June 2008 to selection of the preferred supplier of CAD 2010 and to approve that work should commence with the preferred supplier on the basis of a letter of intent while full approval via NHS London is finalised.

It was NOTED that:

The LAS has expressed interest in the PASA Framework Tender for Patient Transport Service (PTS) in London run by NHS London. The LAS' PTS' team was especially interested in the range and quality of the service specified in the tender. The size of the PTS market in London as outlined in the tender was estimated to be £55m.

The current overtime incentive scheme is scheduled to cease at the end of June 2008. The Chief Executive said he had concerns about the impact on performance in the summer months of removing the overtime incentive and of rolling out the training courses before the newly recruited members of operational staff are deployed in the autumn

The improvement in the allocation of rest breaks was due partly to the new management systems introduced in the Control Room. It was also due to a greater appreciation by the staff in the Control Room of the benefits of allocating rest breaks and thus avoiding a drop in the availability of front line vehicles when crews finished half an hour early at the end of their shift (as they are entitled to if they have not been allocated a break).

The number of suspended staff was less than the 12 reported in the Chief Executive's report, as eight of the cases had been resolved since the report was prepared; there were currently four 'live' suspensions and these will be resolved as soon as possible. One of the suspensions, which dated back to 10th January 2008, had been delayed until the conclusion of a Police investigation and the LAS' internal investigation; a disciplinary hearing will be held shortly to conclude the matter. The Chairman said he appreciated that there may occasionally be an issue about maintaining confidentiality but said he wished the Board to receive a fuller report than was presented at this meeting. The Chief Executive clarified that the full report presented previously was as a result of historic delays in managing length of suspensions which was no

longer an issue. The HR Director said she will review the format of the report for the next Board meeting. **ACTION: HR Director**

That the Trust had received an Innovative Information and Communications Technology Award for FREDA at the recent the London Health And Social Care Awards.

In response to the question on whether the target of an absence level of below 6% was a sufficiently challenging target, the HR Director said that given the Trust's historic data for absenteeism it will be a challenging target as it will be for 2008/09 as a whole. The HR Director said she would bring back to the Board a more ambitious target for the level of absenteeism in 2009/10. **ACTION: HR Director**

The two submitted tenders for CAD 2010 were being analysed prior to a report being presented to the Programme Board w/c 27th May 2008. Both contractors had been asked by the LAS to undertake a due diligence review of the LAS and its systems to ensure that they were comfortable with the organisation's capability to proceed with the contract. In response to a question the Finance Director said that the majority of the work undertaken to date with CAD 2010 had been treated as a revenue expense as per accounting guidance.

Agreed: **1. That authority be delegated to the Service Development Committee in June 2008 to approve:**
- **the selection of the preferred supplier of CAD 2010;**
- **that work should commence with the preferred supplier on the basis of a letter of intent while full approval via the SHA is finalised. The Trust will be liable for limited costs on a time and materials basis only if a full contract was not signed, and the LAS did not proceed with the full procurement. Given the strategic importance of this project and the detailed procurement process, the risk of this happening should be considered as low. Any financial commitment would be subject to the normal procurement guidelines and the Trust's Standing Financial Instructions.**

Noted: **2. That the Finance Director estimated that the Trust's liability for the work being undertaken on a time and materials basis will be less than £1m.**

54/08 Financial Report, Month 12, 2007/08

The Finance Director presented the Month 12 financial report 2008/09 which showed a surplus at year end of £400,000. Month 11 had been very challenging as it entailed managing the Invest to Save programme which had included 71 projects. A benefits realisation analysis was being undertaken and will be presented at the next Trust Board meeting. **ACTION: Finance Director**

The Finance Director referred the Board to the identified financial risks managed by the Trust in 2007/08:
- the failure to achieve 90% performance for Category B 14 minutes in 2007/08 resulted in the Trust paying a penalty of £1m to its Commissioners;
- the A&E overtime had been within the agreed limit;

- the Trust achieved £10.3m of the target £11.4m Cost Improvement Programme figure, which was to be applauded given the challenge of the Invest to Save Programme in Month 11;
- PTS had hit its financial targets.

The Audit Commission was currently undertaking the annual audit and its report will be presented to the Audit Committee on the 16th June.

The Balance Sheet showed the capital employed increasing by £10m during 2007/08 following increased investment in fixed assets.

It was NOTED that:

The increase in 'other debts' and prepayments in Month 12 was due to the Invest to Save Programme, Year End Cash management and the accounting for the sale of Buckhurst Hill in March 2008.

An update regarding the management of stock in the Trust will be presented to the Audit Committee in June; preparations were being made for the introduction of bar coding and hand held devices to manage stock supplies. **ACTION: Finance Director**

The summary information on page 1 reported the cost of an A&E response and this was inflated as shown by the the impact of the Invest to Save programme and the A&E incentive payments in March. The analysis will be revised to show an the underlying trend. **ACTION: Finance Director**

The Acting Director of Operations said that the increased cost of sending an A&E response reflected the additional expense incurred following the introduction of Call Connect and of needing to have sufficient resources, adequately spread out, to ensure despatching a response with a running time not exceeding 6.5 minutes.

Work was being undertaken to improve the rate of utilisation as it was currently too high; this should be addressed through the recruitment of additional front line personnel in 2008/09. The Chairman requested that the utilisation graph, which had previously been included in the Board's information pack, be included in future Chief Executive's reports. The Chief Executive said there had been problems acquiring the data for May but the information will be included in the information pack for the July meeting. **ACTION: Chief Executive.**

55/08 Financial Report, Month 1, 2008/09

The Finance Director apologised that a full financial report was not presented to the Board; this was due to the meeting being held a week earlier than normal and the Finance Team had been engaged in concluding the 2007/08 financial accounts. A full report will be produced by the end of the week (23rd May 2008).

Investigations were taking place into why PTS was showing a loss of £120,000 and the necessary adjustments will be undertaken in Month 2. The Finance Director said possible causes for the loss were an excessive usage of third party transport and not charging for all of the A&E work undertaken in Month 1.

The Audit Committee will be asked to review the Trust's financial risks which will be tracked during 2008/09; the Trust Board will receive an update on this matter in July. **ACTION: Finance Director**

The Board's attention was drawn to the £400,000 associated with Invest to Save which had been accounted for in April 2008.

Expenditure on overtime was forecast to reduce from £1.7m in July 2008.

The Cost Improvement Programme (CIP) was on track with £650,000 being saved in Month 1, mainly through vacancy management.

The Director of Finance said that:

- Income received was in line with plan;
- The income received for Emergency Care Practitioners was higher than forecast; funding was received from Newham, Ealing and Barnet PCTs;
- The Trust was now receiving funding from road traffic accidents via the NHS Litigation Authority.

It was NOTED that:

There was concern expressed regarding the phasing of the decrease in overtime particularly in the final quarter of the year when performance pressures will be high. The Finance Director said that the level of overtime was monitored on a weekly/monthly basis and adjustments will be made as necessary.

The Trust was undertaking a tendering exercise for fuel in conjunction with other public sector bodies. Rising fuel costs represented a risk for the Trust of approximately £400,000 per annum. **ACTION: Financial Director**

The Finance Director recommended that members of the Board read NHS London's report on how Brent PCT incurred a £25m deficit in 2007/08; the report was accessible on NHS London's web site. The LAS' Audit Committee will review the lessons to be learnt from the report. **ACTION: Financial Director**

56/08 **Report of the Medical Director**

The Medical Director highlighted the following from her report:

Serious Untoward Incident (SUI): the investigation into the SUI reported to the Board in March concerning a delay in attending a 36 year old female patient who was bleeding heavily had been concluded. There had been difficulties in communicating with the patient and the family, and the significance of the patient's symptoms were not appreciated. Sadly, despite the despatch of a Fast Response Car and two ambulances, the patient subsequently died in hospital. An action plan has been drawn up to ensure the lessons learnt are implemented. Following the recent death of a member of staff who was killed whilst undertaking motor cycle training, the LAS instigated a SUI level of investigation with the same level of support offered to the family and to the other trainees on the course.

Safety Cannulae: following the concerns expressed by front line crews regarding the safety cannulae introduced in 2007/08 the Trust has been trialling a new model. The new cannulae insertion pack that was being evaluated includes a label that will enable Hospitals to identify pre-hospital cannulation, a procedure that has been cited as a source of pre-hospital infection.

Increasing medical support: the Board was informed that Dr Fenella Wrigley, a Consultant in Emergency Medicine has provisionally been appointed Assistant Medical Director, Control Services (subject to references and Occupational Health clearance).

Healthcare for London (HfL): the LAS has been working with the HfL's stroke programme. To date 19 acute trusts have expressed interest in delivering stroke treatment. A decision has yet to be taken whether the choice will be the hospitals that can offer treatment 24/7 or whether there will be a 'hub and spoke' approach adopted as recently trialled in South West London.

At a workshop held by HfL on the 21st April to consider trauma care in London there were discussions as to whether the trauma strategy should focus solely on the provision of trauma care in London or whether it should be expanded to include the South East of England. The likely position is that that there will be no less than 3 and no more than 5 trauma networks established. Each network will have a Major Trauma Hospital supported by a number of Trauma Hospitals which will not have the same degree of specialist care.

Polyclinics: 29 PCTs have expressed interest in establishing a pilot polyclinic in their areas. Further developments were awaited following the conclusion of the consultation.

Clinical Newsletter: the March and April editions of the Clinical Newsletter were circulated at the meeting. The April edition contained an article on 'suspension trauma' and an article entitled 'lesson of the month' reminded crews to take the defibrillator with patients who have suffered a STEMI and were being conveyed from an ambulance to the catheter laboratory.

Clinical Audit and Research Unit: an audit was undertaken in respect of CPI completion in 2007/08 which showed that though there had been a marked improvement in the number of Clinical Performance Indicators (CPI) audits undertaken by Team Leaders the target 80% has not yet been achieved. On a positive note, the findings of the CPI audits found evidence that there was a high standard of care being documented by front line staff. The level of feedback given by Team Leaders to front crews whose Patient Record Forms (PRFs) were audited was high and in a number of complexes exceeded the set target.

Themed Risk Information Report on Obstetrics originally considered by the Clinical Governance Committee in August 2007 was presented to the Trust Board. Although there were only a small number of complaints received in respect of obstetric cases they were often problematical as they go back a long time. Many of these cases had not been flagged up by the crews as highlighting a risk through submission of an LA52. The HR Director said that Obstetrics will be one of the modules introduced in the next tranche of training and will include the lessons learnt from complaints.

Infection Control: further to her report, the Medical Director said a bulletin relating to measles had been issued by the Chief Medical Officer advising that all staff exposed to immune compromised patents should either be immunised or be able to provide evidence of immunity. The Trust was holding discussions with the Occupation Health Provider as to how this could be taken forward.

It was NOTED that:

The Trust was aware of the recent changes in the law relating to mental health patients place on Section 136 of the Medical Health Act being transported between hospitals. The HR Director said that Mental Health will be one of the training modules offered to front line crews in 2008/09.

Although there were complexes that had an excellent record of Team Leaders giving feedback to front line crews following the auditing of PRFs, there were

some complexes with poor performance that needed to be actively kept under review.

That there had not been an increase in the number of complaints received in regards to Obstetrics. The Head of PALS & Complaints said that there had been an increase in the Obstetric incidents reported by LAS staff involving other agencies.

57/08 **Annual Complaints and PALS Report**

The Chief Executive presented the Annual Complaints and PALS report which had been combined in recognition that the two work streams had been integrated. In 2008/09 the Trust will be one of the early adopter pilot sites for the Department of Health's 'Making Experience Count' which will seek to integrate the complaints system across the health and social care systems.

The level of complaints received by the Trust had fallen though the Trust continued to be vulnerable at the weekend due to poor resourcing; 539 complaints were received in 2007/08 compared to 557 in 2006/07. The Trust had responded to 81% of the complaints received within the required deadline of 25 days. The two main sources of complaints were attitude and behaviour and delays in responses. Conversely, the Trust had also received a high number of letters of appreciation citing positive attitude and behaviour.

Work was being undertaken with the two exemplar complexes for 'New Ways of Working' concerning benchmarking performance. This will include complaints received about attitude and behaviour.

The work undertaken with Frequent Callers saw a reduction of approximately 10,000 inappropriate calls to the Service. The initiative was also instrumental in putting in place more appropriate healthcare packages for the majority of the Frequent Callers and was an example of good patient outcome.

It was proposed that a further report concerning Complaints and PALS be presented to the Trust Board in November 2008. **ACTION: Chief Executive**

It was NOTED that:

The two complaints received about Voluntary Aid organisations (St John and the Red Cross) raised questions as to the training given by those organisations. The Acting Director of Operations said that the training delivered by St John and the Red Cross was assessed by the LAS as being of the required standard. A Memorandum of Understanding was being drawn up between the LAS and the Voluntary Aid organisations which will be completed in the next five months. In response to a question from the Medical Director, the Acting Director of Operations said that the training delivered by St John was part of a national package and included documentation i.e. Patient Report Forms which was delivered to the Trust's Management Information department.

Following a complaint received concerning an Emergency Medical Technician (EMT) being despatched to a patient who had experienced an epileptic seizure and was unable to administer the appropriate medication, a mechanism was introduced enabling EOC to identify the skill levels of operational crews. The Acting Director of Operations said that Ambulance Operation Manager for Islington had recently given evidence to the borough's Overview and Scrutiny Committee regarding this incident and the Trust's response.

In November 2007 the Chief Executive informed the Board that a letter had been received from the Healthcare Commission criticising the Trust for not resolving a higher percentage of complaints locally. Following a letter from

the Trust's Head of Complaints & PALS strongly refuting the comments, the Healthcare Commission reviewed its data and withdrew its criticism.

58/08 **Approve Workforce Plan**

The HR Director presented the Workforce Plan. She referred the Trust Board to previous reports, including the Longterm Workforce Plan that was approved by the Trust Board in March 2007. The Trust Board will receive the following reports in 2008/09: full scale skills escalator and associated student paramedic programme description; the finalised Training Plan and the plan to move to a Higher Education training module. **ACTION: HR Director**

The Workforce Plan outlined the recruitment that will be undertaken in 2008/09 to increase the A&E staff establishment by 108 by March 2009 through recruiting to increased establishment; filling existing vacancies and taking account of the number of anticipated leavers in the year.

The Plan also included the training of 144 Technicians to become Paramedics in 2008/09 and the recruitment of 25 additional members of staff to work in the Emergency Operations Control room.

Recruitment to the Student Paramedic programme has commenced and entailed a robust assessment process including numerical and verbal reasoning. Recruitment to the A&E Support role was continuing and going to Plan. The Trust has struggled to recruit to the full establishment of 70 for the Clinical Telephone Adviser role and efforts were continuing to raise the profile of the role, both internally and externally.

The following risks associated with achieving the Workforce Plan were identified, together with how they will be managed:

- inability to recruit to the numbers required;
- inability to train the numbers required;
- increase in number of leavers over that anticipated, either through movement within the LAS or departures.

It was NOTED that:

To date, 1,000 requests for information packs had been received in response to the recent recruitment advertising. Further advertising will be undertaken to generate a further 1,000 expressions of interest so as to get the desired number of candidates. The following publications were used for the recruitment advertising: the Evening Standard; the Metro; London Lite; the Eastern Eye; NHS Jobs; Monster and the Voice.

Appropriate measures have been put in place to ensure that recruits commence training as soon as possible; negotiations were taking place for a nearby venue that will meet the Trust's needs for an additional training facility.

the Organisation Development and People Programme has launched a project to identify an online tool that could be used to assess candidates' values, so as to help recruit staff with values and behaviours reflecting those desired by the Trust.

Clinical placements will be organised to take place in Year 3 of the Student Paramedic programme.

The risk of not achieving the Workforce Plan will be considered for inclusion on the Trust's Risk Register. The Senior Management Group will be closely monitoring the progress of the Workforce Plan during 2008/09 and the Trust Board will receive regular reports. **ACTION: HR Director**

The Chairman queried whether the up-skilling of existing staff was sufficiently ambitious. The HR Director said this had to be seen in the context of the fundamental changes that were being introduced to working practices. The Chief Executive said the Workforce Plan was ambitious as it will result in one of the biggest changes in the organisation's history with the introduction of the Student Paramedic role; the introduction of a higher education model that will affect new and existing staff, and the innovative methods being adopted to deliver training. The two exemplar complexes will be leading the way in delivering the New Ways of Working model of clinical care.

Approved: The 2008/09 Workforce Plan, which will be subject to ongoing monitoring during the course of the year.

59/08 Approve Foundation Trust (FT) Diagnostic Project Plan

The Finance Director presented the FT Diagnostic Project Plan to the Board for approval and drew the Board's attention to the LAS Diagnostic timetable that set out a number of milestones to be achieved before mid August.

The LAS and the North East Ambulance Service were chosen to pilot the ambulance service sector specific diagnostic. The Trust was working with NHS London on an accelerated programme which contained rehearsals of key aspects of the application process to become a FT.

At the conclusion of the pilot, a diagnostic report will be available which will enable the Trust to anticipate the challenges presented by the formal process and identify the actions to be undertaken to comply with Monitor's detailed review of aspirant FTs.

It was NOTED that:

A board to board meeting between members of the LAS' Trust Board and NHS London's Trust Board has been scheduled for 1pm on 7th July 2008.

John Wilkins, the Head of Governance, has been appointed the Project Lead for the FT Diagnostic Project Plan.

The FT Project team was holding weekly telephone conference calls with North East Ambulance Service to share the lessons learnt in working through the FT Diagnostic Plan.

Approved: The schedule set out in the paper to achieve the FT Diagnostic Project Plan.

60/08 Call Connect Diagnostic Visit to LAS

The Acting Director of Operations presented the report which was written by the Department of Health's Inspection Team following a visit on 8th and 9th April to verify that the LAS had robust measures in place to deliver Call Connect. The report's findings concluded that the Trust was a successful, delivering organisation.

The Senior Management Team has accepted the recommendations contained in the report. The action plan to implement the recommendations will be presented at the next Trust Board. **ACTION: Director of Operations.**

It was NOTED that:

The reference in the report to the Trust having an 'expert patient' was not something that had proved viable for Ambulance Services, though Acute

Hospital and other NHS bodies have been able to call upon that resource to a greater degree.

Noted:
1. **The contents of the report, which reflected well on the Senior Management Team as a whole.**
2. **That the findings of the report will be disseminated to members of staff via the Pulse.**

61/08 **Fleet Plan**

The Acting Deputy Director of Operations presented the Fleet Plan for the Trust Board's approval. The Plan set out the planned procurement programme for 2008-13, including the replacement of 123 LDV fleet by 123 Mercedes Sprinter vehicles. The five year fleet plan included reference to the Trust's Workforce Plan; the planned expansion of Urgent Care and the accident and emergency vehicles that will be required to support the Olympics.

It was NOTED that:

What was being proposed was essentially a five year policy and a Fleet procurement plan for 2008/09. The latter will be supported by a full business case which will be presented to the Board for approval. **ACTION: Director of Operations**

The full business case will be presented to the Trust Board for approval following agreement of the new A&E ambulance's specification by the national procurement group.

The Finance Director, in response to a question, said that the Trust's five year business plan which had been approved by the Trust Board in January 2008 had included the cost of replacing some of the fleet.

The next tranche of vehicles purchased to be Fast Response Units (FRU) will be Zafiras. The Acting Director of Operations said that the seat covers and the carpet of the existing FRU vehicles have been changed to non-absorbent material to enable them to be used to transport patients if necessary.

The reference to the vehicles being maintained by the Trust's workshops in paragraph 8.1 was an error as there was a review of the configuration of the workshops underway, as set out in paragraph 8.3.

Approved
1. **The five year fleet policy incorporating the comments made by the Trust Board;**
2. **The 2008/09 procurement plan subject to a full business case.**

62/08 **Rules on the capture, recording and calculation of LAS performance (KA34)**

The Director of IM&T presented a report which set out the rules on the capture, recording and calculation of LAS performance. The report included information on how various systems were synchronised and other general issues associated with measurement of performance standards. The LAS was compliant with the guidance issued by the Department of Health Information Centre for the KA34 annual return

Noted: **The contents of the report.**

63/08 **Estates Plan update including ratification of Chairman's Urgent Action in respect of the sale of Buckhurst Hill**

The Finance Director gave a presentation outlining the work undertaken in reviewing the Trust's Estate Strategy which included a workshop being scheduled for 2nd June attended by Operations Staff to discuss what estate the Trust will require in the future.

It was NOTED that :

Sufficient time will be set aside at a future Board meeting or Service Development Committee to discuss the proposed Estate Strategy. The Chief Executive suggested that 30-45 minutes will be required to fully discuss the implications of the Strategy**. ACTION: Director of Finance**

Approved: The Chairman's Urgent Action in respect of the sale of Buckhurst Hill; the reasons for which were set out in the Urgent Action sheet.

64/08 **LAS' approach to Corporate Social Responsibility (CSR)**

CSR is a concept which encourages organisations to consider the interests of society by taking responsibility for the impact of the organisations activities on customers, employers, shareholders, communities and the environment.

NHS London, in line with guidance from the Department of Health, has required CSR to be incorporated into all business plans and for a Board member to be nominated to lead on CSR. London Trusts have been asked to review all their major capital and revenue spend reviewed for its impact on CSR.

The LAS was working with community partners to promote public health, to reduce waste and to reduce its carbon footprint. Waste management was in line with NHS London's guidelines; the Trust complied with the Greater London Authority's Low-emission Zone requirements and there was widespread re-cycling across service. A review was being undertaken by the Procurement department to reconcile how the Trust, in line the CSR guidance to use local businesses where possible, can simultaneously obtain best Value for Money.

Further work will be undertaken in respect of a self assessment to identify what further work needs to be undertaken in relations to CSR. This will be reviewed by the Senior Management Group and presented to the Trust Board later in the year. **ACTION: Finance Director**

65/08 **Results of Board Effectiveness Review**

The Chairman presented the findings of the Board Effectiveness Review undertaken in March 2008; overall the Members of the Board rated the Board's effectiveness as being high.

There were a number of areas where Members were less satisfied and work will be undertaken to address these areas, e.g. work was being undertaken in respect of benchmarking performance against other Ambulance Services and will be presented to the Board when it is available.

It was NOTED that:

The King's Fund was reviewing the Appointments Commission's role in the delivery of training to new Board appointees. It has been suggested that NHS

London should have a more active role in training and developing Non-Executive Directors as part of the London Leadership programme.

Caroline Silver said she found the LAS' two day induction course very useful and enjoyable and that the training provided by the King's Fund's Board Leadership programme had proved to be a very good resource.

The Board will seek to undertake training to further develop a its capacity for dealing with issues of business development. The Chairman said that he will undertake to identify someone to deliver this training. The Director of Service Development said the Board may need to consider commissioning bespoke training. **ACTION: the Chairman**

In respect of the Board's involvement with staff, it was recognised that there was probably little awareness of the Board amongst front line staff and that the Chief Executive and the Senior Management had a higher profile across the Trust. It was commented that when Non-Executive Directors undertook ride-outs with front line crews questions were often asked that revealed ignorance about the role of the Board.

The board effectiveness review was felt to have been useful and a similar self-assessment will be undertaken in March 2009. **ACTION: the Chairman**

66/08 **Service Improvement Plan (SIP)**

The Director of Service Development presented the report, which included descriptions of the projects under the five Programme headings, and the milestone charts that illustrated progress.

The Board had previously requested that an exceptions report be presented for projects that were not on track and were a cause of concern. The Referral Pathways project has effectively stalled due to the long term illness of the project manager. A number of steps had been identified to get the project back on track: the recruitment of a new project manager, the completion of all training packages and a redefinition of the timescales for training of team leaders prior to cascading to front line staff, and continuing to explore the possibility of displaying available pathways via the Mobile Data Terminals (MDTs).

Work will be undertaken to demonstrate the benefits realised following the completion of projects and to verify that the necessary business changes have been embedded in the organisation.

In June 2008 the LAS will hold a conference to engage stakeholders on the future of the Emergency Bed Services (EBS). EBS was used by health professionals to access emergency bed spaces on a London-wide basis. The project to develop EBS will be managed by the Access Programme Board.

It was NOTED that:

The purpose of the report was to provide the Board with sufficient details about the progress of the SIP and individual projects. It was recognised that there was a continuing balancing act in providing too much or too little information.

67/08 **Draft minutes of the Clinical Governance Committee, 28th April 2008**

The Chairman of the Clinical Governance Committee highlighted the following from the draft minutes of the recent meeting:

Dr Anne Weaver, Consultant in Emergency Medicine and Pre-hospital care and Clinical Lead for the Helicopter Emergency Medical Service (HEMS) attended the meeting. In her presentation she referred to HEMS' impressive clinical governance arrangements, something the LAS would like to emulate despite the challenge of LAS' greater scale and busy-ness (HEMS treats approximately 5-6 very seriously ill patients a day while the LAS treats 2,500 patients a day).

The Trust's new Occupational Health Provider raised concerns regarding interpretation and application of the Department of Health's Guidance 'HIV Infected Healthcare Workers'. An interim policy has been agreed by the Committee while the Trust sought medical advice and the matter will be discussed formally by the Trust Board in due course.

A DVD jointly produced by the Metropolitan Police Service and the LAS, 'Preventing Death in Custody,' has been circulated to senior training managers for comment.

The format of the Areas' Clinical Governance Report will be reviewed to ensure that the Committee receives qualitative and not just quantitative information.

Attitude and behaviour continue to be the most common cause of complaint; the Committee considered the measures adopted to address this including the testing for values when recruiting staff and the introduction of reflective practice.

It was Noted that:

The issue surrounding HIV testing had arisen because the guidance issued by the Department of Health was considered unhelpful; further medical advice was being sought. In the interim, the Trust was interpreting the guidance locally as to what 'exposure prone practice' meant. The only members of staff who were liable to have exposure prone practice were members of staff working on HEMS and the appropriate steps have been taken .

Noted: The draft minutes of the Clinical Governance Committee, 28th April 2008.

68/08 **Draft minutes of the Remuneration Committee, 18th March 2008**

Noted: The draft minutes of the Remuneration Committee, 18th March 2008 and the error in the footnotes references.

69/08 **Draft notes of the Board Away Day, 29th April 2008**

Noted: The draft notes of the Board Away Day, 29th April 2008.

70/08 **Report from Trust Secretary on tenders opened since the last Board meeting**

Five tenders have been opened since the last Trust Board:

1. Provision and Maintenance of Stretch Trolleys

VW Limited	Stryker	Ferno

2. Security Services at LAS Headquarters

Chargecrest Security Ltd	Charter Security Services	City Security
Empire Services Plc	Legion Group Plc	OCS
Octavian Security	Mitie Security (London) Ltd	S2 Securities Ltd
Sectorguard	Vigil Security Management	

3. Consultancy re. Benefits Realisation

Sigma	PriceWaterhouseCooper

4. Provision and Maintenance of defibrillators

Laerdal	Zoll	Schiller (Amazon Medical)
Physio Control		

5. CAD 2010 Procurement

Integraph	Northrop Grumman

Use of the Trust's Seal: there have been three entries, reference 114, 115 and 116 since the last Trust Board meeting. The entries related to:

No.114 Sale of Buckhurst Hill to Aspen Healthcare Ltd. (authorised via Chairman's Urgent Action)

No. 115 Members Agreement, Health and Social Care Information Centre.

No. 116 Planning deed re. 392 Shooters Hill Road, Blackheath SE18.

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

71/08 **Any Other Business**

There was no other business.

72/08 **Opportunity for members of the public to ask questions**

There were no questions asked of the Board by members of the public.

73/08 **Date of next meeting**

Tuesday, 29th July 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 13.09

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 20th May 2008
held in the Conference Room, LAS HQ, London SE1

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

On the 20th May 2008 in Part II the Trust Board discussed the following:

How the LAS and the Patients' Forum would work together in the future to deliver excellent patient care.

An issue that had arisen concerning the Mercedes Lease which was commercially sensitive and hence not raised in Part I; the matter would be further considered by the Audit Committee on 16th June 08.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 29th JULY 2008
CHIEF EXECUTIVES REPORT

1. SERVICE DEVELOPMENT

1.1 Healthcare for London

Work continues to ensure that the ambulance service is involved in and contributes to NHS London's work on Healthcare for London. Clinical and policy staff are engaged in most of the workstreams, in particular those on unscheduled care, stroke and trauma. It has taken longer to get involved in the workstreams on polyclinics and on diabetes, but this is beginning.

Current progress includes:

Stroke
Insufficient numbers of patients were involved in the first period of the SW London pilot for a valid evaluation, so the time for that has been extended. Mark Whitbread and Nick Lawrance continue to represent the LAS on various working groups

Trauma
Hospitals were invited to propose themselves as level 1 trauma centres, as part of trauma networks. Fionna Moore was part of the process that short-listed five hospitals to develop their proposals further. An internal working party has been convened to consider the issues the LAS needs to address.

Unscheduled Care
The Healthcare for London Unscheduled Care work stream has led to a report announced at a conference attended by a number of LAS delegates. It became clear at the conference that while many people understood the role that LAS could play in coordinating appropriate urgent care in the Capital, many others were not aware of it. More work is needed on this area.

The business case for purchasing a knowledge management system that will allow access to a directory of health and social care services, and ultimately an ability to make direct referrals to other health professionals, is being prepared and will be presented to commissioners in the autumn.

Local Hospital Feasibility
A report is due out shortly that will look at the clinical and financial viability of the model for a local hospital proposed in *Healthcare for London*

Polyclinics
When PCTs were invited to propose sites for polyclinic type solutions, a large number came forward. The project has engaged only with providers so far, but Nick Lawrance has now established relations with the project manager and has been assured that we will be involved in the next phase.

Diabetes
As we now test the blood sugar levels of most patients over 40, we can play a role in early identification of diabetes. We have made the project team aware of this.

The NHS London Healthcare for London team will shortly be establishing three more workstreams: Children; Mental Health and Women's Health.

Further information on LAS involvement in HfL activities can be found in the Medical Director's report.

1.2 A&E Operations

- Overnight on Monday 21 July into Tuesday 22 July the new 999 call handling telephone system was brought live in EOC. This was the result of many months of intensive work of planning and testing a brand new system for both EOC and the fall back centre at Bow (the Bow installation was part of the pre-planning work).

  The actual task on the night involved a truly multi-agency approach – BT, Cable & Wireless, Vodafone, Avaya (system suppliers), Eco communications (system maintainers), CTS, IM&T Communications staff, IM&T Systems staff, dedicated staff from EOC as well as EOC staff who were managing the normal business. The cut-over commenced with a full briefing @ 21:40 on 21 July and through the night executed a minute by minute plan to test and progressively change 6 live telephony circuits (and associated services like CLI) from the old to new system. As always with technology changes of this complexity there were challenges, but by 06:30 on 22 July all services were transferred without a loss of service.

  This upgrade has now significantly improved the 999 telephone system in terms of facilities including number of operators that it can support. Additionally the resilience arranges with the Bow system will provide additional reassurance for the Trust.

- I am pleased to advise that after some ten months of difficult consultation the Trust has now agreed the 'Active Area Cover' policy with our Trade Unions. The new arrangements will be the subject of joint implementation from Monday 4th August and will be jointly reviewed after some six months. This will allow us to deploy resources much more effectively and will reduce patient waiting times.

- The amalgamation of Bow Resource Centre and Ilford Resource Centre took place successfully on Monday 21st July and the service is now operating on a two Resource Centre configuration at Ilford and Croydon..

- In light of the increasing demand and deteriorating staffing position the Trust has raised the REAP Level from level 2 'Concern' to Level 3 'Critical' and is implementing all the relevant actions associated with this level.

- A new and more comprehensive 'Gazeteer' has been introduced into EOC. There have been some issues as staff have learnt to navigate their way around the new gazetteer but as this settles we should see more accurate locations being identified which will result in crews being more effectively navigated to the calls and thus arriving sooner, particularly in the more difficult to identify locations such as housing estates. In addition we hope to see some improvement in the time taken to confirm addresses which in turn leads to faster activation and improved performance.

- The Control Services management re-structure has now been largely completed and staff have been promoted to the new Area Controller positions. The new post will be fully implemented on the 28th July and this will allow us to provide a team of dedicated managers to oversee the performance across an entire geographical area . Their principle focus will be on achieving performance targets , managing 'Active Area Cover' and managing rest breaks. We will also be ensuring that each of these managers has a close working relationship with their respective operational management teams in East, West and South

- A new digital telephone switch is due to be installed in EOC on Monday 21st July and will ensure greater stability for 999 call taking. The new switch will also allow us to provide more call taking positions and improve the levels of information available about all aspects of the call cycle

- The Board will be aware of the tragic road traffic collision (RTC) which occurred 4th June 2008 in which an ambulance en-route to a 999 call was involved in a collision with a motorcyclist who sadly died at the scene. We continue to co-operate with the police fatal accident enquiry and are managing the incident as though it were an SUI although it has not been declared as such due to the fact that it was an RTC. The driver concerned is currently suspended from driving until the outcome of the police investigation is known.

- June is the beginning of the summer events season in London. The Emergency Preparedness department has been busy putting bespoke plans in place for the various events including Trooping the Colour, the Nelson Mandela Birthday celebrations and many others.

- The Service has held a Major/Serious incident debrief since the last report. This was for the recent Biggin Hill air crash. The debrief was successful and useful learning from the incident will be utilised for the future management of incidents.

- The Hazardous Area Response Team (HART) has now been made a permanent resource for the service to deploy to serious incidents. Recruitment and training has now taken place to bring the team up to strength (30).

- We have now confirmed that the LAS will commence Urban Search & Rescue (USAR) training in September. The existing HART team will be expanded to 42 staff to incorporate these new skills. This will in turn give the ability for

specially trained paramedics to operate inside confined spaces and other hazardous environments delivering early definitive care to patients.

- In July the Emergency Preparedness department ran a series of sessions designed to re-train all the trainers of the London Acute Trusts in decontamination procedures. The training was well received by all with excellent feedback and this process will now be repeated annually.

- The LAS Emergency Preparedness Department hosted a national conference in July targeted at emergency planning leads UK wide. The conference was titled "Lessons Identified" and was an opportunity for all UK emergency planning leads to share experiences of large incidents and learn from each other. This is the first such conference to be held in the UK and feedback from attendees was excellent. Subjects covered included the Sussex Fireworks Factory Explosion, the Greyrigg Rail Crash, the Yorkshire & Gloustershire floods, the Glasgow Airport Bomb and the changes made to the LAS major incident plan following the 7th July 2005 London suicide bombings.

1.3 Patient Transport Services

The LAS has been advised by the Purchasing and Supply Agency that our tender to be added to the framework agreement for the provision of PTS services in London has been successful. Consequently we will be invited to participate in mini-competitions for the following contracts:

Barking, Enfield and Haringey Mental Health Trust (new business)
Barking, Havering and Redbridge Hospitals (part existing business)
Bromley Hospitals (existing business)
Great Ormond Street Hospital (new business)
Guys and St Thomas' Hospital (new business)
Lewisham Hospital (new business)
Moorfields Eye Hospital (new business)
North East London Mental Health Trust (existing business)
North West London Hospitals (new business)
Queen Mary's Sidcup Hospital (existing business)
Royal Marsden Hospital (new business)
Royal National Orthopaedic Hospitals (existing business)
South London and the Maudsley Mental Health Trust (existing business)

PASA has advised that the timetable for these tenders will be:

Advertisement of mini-competitions July 2008
Completion of tender documentation to be returned by end of August 2008
Announcement of successful bidders November 2008
Commencement of new contracts 1 April 2009.

Outside of the above process the LAS has submitted a detailed preliminary questionnaires for South West London and St George's Mental Health Trust (existing business) and Newham General Hospital NHS Trust (new business). As a result we

have been invited to submit a full tender for South West London and St George's. We are waiting for a response from Newham.

The senior management restructure has now been completed and the following individuals have now taken up post as of 1 June 2008:

Deputy Head of PTS -	John Comerford
TOC Group Manager -	Lisa Dickinson
Business Manager East -	Ann Elliott
Business Manager West -	Vacant

The PTS senior management team is now turning its attention to the restructure of the remaining management grades in line with changes to the operational model and this is due for completion by October 2008.

1.4 London Ambulance Radio Project (LARP) Project Update

The plan for the rollout of the Airwave Radio Project, to migrate the Trust from Analogue to Digital Radios, was to have the installation and testing of the system completed for service commencement on the 28th July and roll out within the Trust starting 18th August to complete by November 2008.

Due to issues in the Airwave integration testing the plan has now moved. The new plan schedule shows the service commencement to be the 19th September, therefore the Trust roll out of Airwave terminals to start 10th October. The end of rollout must be completed before December 2008 ahead of 'Winter Pressures', traditionally the busiest time of year for the Trust. The new plan dates only allow a migration period for the Trust of eight weeks, in which 4000+ Operational Staff need to be trained in addition to 444 Control Room Operational Staff. This is in addition to deploying the handsets and the Control Room upgrades.

The risk is that should any problems be encountered the Trust could be running the operation with a combination of both Analogue and Digital radios for Christmas and New Years Eve.

This plan leading up to service commencement, whilst based on a full execution of integration tests, does not;

- have allowances for dry run testing of the application by the supplier in the Trust infrastructure
- consider test failures and re-test time
- allow for reporting and review of the previous test cycle to be completed before starting work on the next testing cycle
- provide contingency for any significant failures as identified during the first cycle of testing

In light of these considerations, this plan should be considered high risk. Before communications are circulated for the rollout programme to begin, an allowance should be made for previously failed resilience tests to be completed, thereby giving the Trust confidence in the product. The project will be focussed on meeting the

service commencement for the 19th September; however, it will be wholly dependant on the quality of the software.

Current Status
The Project deliverables have been broken into seven key areas below:

Technical Integration
Connectivity of LAS IM&T infrastructure to the Airwave network is almost completed. There are two key issues which are outstanding; virtual dialling which is waiting for finalisation of the Avaya Switch upgrade in the control room, and voice recording where technical issues in the approach are being discussed with Airwave.

Integration Testing
Prior to acceptance of the system, integration testing is being carried out by the DH and the supplier. This is based on Off Air (dry runs by the supplier) and On Air testing (executed by the supplier and witnessed by the DH)

On Air is to be re-started with a new version of the software following a number of 'Level 1' failures during the first cycle of testing, in particular critical failures occurred around resilience testing. We are expecting that some of the failures from the first execution to pass especially those based on test script errors, however it is crucial to the Trust that resilience tests are passed.

For the Trust Scenario Testing the test scenarios have been created and had subsequent review by the users. The resource scheduling is on hold as significant resources are required and from a number of departments within the Trust once there is a greater degree of confidence in the software the resources will be scheduled.

Vehicles Fitting
The Project is currently averaging fitting 15 digital radio terminals into Trust vehicles per week. The key target to meet prior to the service commencement is to complete dual fitting the A&E (ambulance and FRU) fleet. Approximately 37 A&E fleet are remaining which should be completed before the end of July. In addition, some manager's cars and PTS vehicles have also been installed.

The only issue to report is that we are awaiting the supplier to perform a survey for a number of specific other vehicle types. The remaining single fit vehicles will be installed during the migration programme.

Service Level Products:
DH has supplied a draft of the SLA illustrating the service to be provided by Airwave; this is under review with the users. Service level requirements e.g. response times, resolution times, priority definition, service level reporting and measurement requirements need to be aligned with the DH product. Following on from this internal IM&T processes and procedures will be updated to support the operation.

Training
Training deliverables for 444 EOC and 4000 operational users have been approved and the order has been sent to the printers, Training will be 2 hours for front line staff and up to three days for control staff. PTS, Workshop staff and others that have not

used radios to date will need additional time to get them used to normal radio procedures.

Migration Plan

The migration plan is currently work in progress being re-planned following new plan dates. Discussions with the users have identified that migration approach should focus on key champion groups, Motorcycle, Fast and Cycle Response Units, followed by a roll out based on the analogue radio channel and the Operational Area e.g. Channel 1 and the West.

The Project is currently gathering metrics to identify the Area where the least risk exists, in terms of Radio usage, number of staff requiring training and number of vehicles requiring single fit.

Business Continuity and Disaster recovery

We are working with Airwave and in discussion with the Trust Business Continuity Manager to integrate Airwave into the Trust DR/BCP plans and procedures.

The Project will remain focussed on supporting the DH in the testing and working towards achieving the planned service commencement in September. The key focus will be on detailing the migration plan to ensure that the resources for the multiple streams of activity across the service are scheduled and have the necessary training, tools and equipment to meet the tight timeline.

However, given the amount of work required to successfully complete the software testing the current plan remains at high risk. The potential impact is that further delay would force the whole roll out to commence after Christmas (partial installation across this period would not be operationally acceptable).

2 SERVICE DELIVERY

2.1 Accident & Emergency service performance and activity (graphs 1-8)

The table below sets out the A&E performance against the key standards for the first quarter of 2008/9 and for the first 14 days of July.

	CAT A8	**CAT A19**	**CAT B19**
Standard	***75.0%***	***95.0%***	*90.%**
April 2008	76.9%	98.6%	88.4%
May 2008	74.5%	98.3%-	83.8%
June 2008	71.8%	97.7%	80.8%
1-20 July 2008	70.0%	97.7%	81.3%

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

- Category A performance held up well in April and fell to only just below target in May which was pleasing. June has proved much more difficult due to rising workload and falling staffing levels and came in at a disappointing 71.8 %

despite best efforts. July has continued to be difficult with further reductions on overtime working leading to performance falling to circa 69% in the first two weeks.

- Category B performance has also declined for similar reasons and has fallen from just over 88% in April to circa 80% in June and July.
- It is important to retain some perspective here in that Call Connect performance last June and July was 48% and 46% respectively. The levels now being achieved against a higher workload still represent a step change in performance.
- Overall workload has increased by 3.6% in the first quarter of 08/09 when compared with 07/08 and Category A workload has increased by 6.7% over the same period. This increase in Category A incidents has been in part linked with the high profile British Heart Foundation Campaign which ran throughout the month of May.
- Staffing has been a particular problem and despite continuing to offer incentives to work overtime the number of overtime hours being worked has fallen markedly in the latter part of June and through July. Whilst this was to some extent expected the fall off has been more marked than was anticipated. In total, ambulance hours have fallen to under 28,000 per week which is some 2000 hrs below that provided in April and May and FRU hours have fallen to circa 12000 hrs per week again some 2000 hours less than those provided in April and May. We are currently reviewing the incentives in place particular for FRU working to try and improve the situation.
- Control Services has continued to perform well generally although we have seen a fall off in call taking performance during the end of June and into early July. This situation has now recovered but is nonetheless disappointing given many months of excellent performance.
- Category B performance continues to be very challenging and is currently the subject of extensive discussion with commissioners. The Board will recall that we were commissioned at 90% on Category B this year which reflected the degree of performance challenge associated with meeting the Category A call connect targets for the full year, whilst at the same time improving Category B performance. We have prepared a comprehensive recovery plan for Catetgory B which is designed to deliver on the 90% commissioned target. NHSL is at present asking commissioners to work with the LAS to determine what assistance might be offered to allow the service to improve on this position.

2.2 Patient Transport Service performance and activity (graph 9-12)

Performance on the quality statistics continue to remain static even though there is an increase in activity. Figures for June 2008 were:

Arrival time:	90% - within contracted time window (+15 mins / -45mins of appointment time)
Departure time:	93% - within contracted time window (+15 mins / -45mins of appointment time)
Time on Vehicle:	95% - within contracted time window (normally < 1hr)

3. HUMAN RESOURCES

3.1 Workforce Plan implementation

The workforce plan for 2008/09 seeks to increase the number of frontline A&E staff and introduces the new Student Paramedic role resulting in a requirement to recruit c400 operational staff within the year. This is a significant challenge to the Trust and is a key priority to achieve.

A major recruitment project has been established to achieve this as early in year as possible. Progress of this work to date is as follows:

21 qualified Paramedics have been recruited to date through recruitment advertising and the University route.

The new Student Paramedic role was advertised to internal clinical staff initially resulting in 25 A&E Support staff commencing training in May and June. Further programmes for additional internal staff are scheduled for October 2008 and February 2009.

Following external advertising we received over 2000 requests for information. Of these around 400 applicants are currently at some stage of the recruitment selection process with 250 awaiting assessment or interview. We are continuing to advertise both for qualified and Student Paramedics to maintain momentum of attracting potential candidates.

In addition we are advertising for other qualified healthcare professionals (i.e. Nurses) who can APEL (Accreditation of Prior Learning) existing knowledge and skills and access “fast track” Paramedic training. This has not been tested in London before and the level of response to this has yet to be seen.

In addition to the increased recruitment activity generated by the workforce plan, the need for additional training provision for newly recruited Student Paramedics is significant. Plans are currently being progressed to increase existing training capacity. The Trust is finalising lease arrangements for a floor at Hannibal House, Elephant and Castle, which will have the capacity to train up to 54 Students at any one time. Whilst this would allow the Trust to achieve its plan in terms of recruiting the required number of staff in year, availability of further temporary facilities is also being sought to enable recruitment and training of new staff to be completed earlier in year and thus provide the workforce benefits to A&E Operations.

The Education and Training Department is fully involved in the delivery of the workforce plan implementation project, identifying adequate numbers of qualified Trainers, equipment requirements, vehicles for driver training etc. Development of the Student Paramedic training itself is reported as a separate agenda item to the Trust Board.

The scope and detail of the implementation project is considerable and is being managed through tight project management methodology.

Recruitment to other posts continues as planned and will be managed through normal management processes.

The Trust Board will be updated regularly on progress against the workforce plan.

3.2 Unions and Partnership Arrangements

The Trust's management and union colleagues have worked very closely on reaching agreement, through the Operational Consultative Forum on Active Area Cover. Arrangements under this agreement will now be introduced in early August 2008.

In late 2007 a new Partnership Agreement involving each of the 4 recognised trade unions was adopted. This was the pre-cursor to a review of the whole of the Trust's consultative arrangements. After detailed discussion a formal proposal for a new constitution for the Staff Council and other consultative committees was submitted to the Trade Union Side for consultation. The proposal is built upon national and local partnership commitments and principles, incorporating bets practice and guidance from national terms and conditions and the Social Partnership Forum. A formal response was requested by the end of March, but the unions were not at that time in a position to offer this. The Trade Union Side Secretary indicated, however, that it was hoped that the proposal could be agreed no later than the meeting of the existing Staff Council on 17 July.

At that meeting it was reported that the staff side members had debated the proposal at their side meeting on 8th July, and that it had been put to a vote and duly passed. However, those voting in favour belonged to Unison, and representatives of GMB and T&G/Unite voted against. The representative of Amicus/Unite was not present at the staff side meeting.

Consequently, although due process had been followed, at this stage only Unison was willing to sign up to the new arrangements. The offer of seats for the other recognised unions, which have been asked to reconsider their position, remains open.

3.3 Education and Development Funding

The Education and Development funding provided this year by NHS London is supporting the planned "upskilling" of the workforce with the future aim of providing a wider range of appropriate responses based on patient need.

Specific focus therefore of this funding is to provide increased Paramedic Training, ECP Training, Patient Assessment, Leadership Development and Clinical Support. Whilst the Trust is currently working with NHS London to finalise the Service Level Agreement and associated KPIs connected to the funding, work in all these areas is being implemented.

3.4 Retrospective CRB checks

This exercise is now almost complete.

At the time of this report, only 16 staff have made no effort at all to comply with the process and we are commencing investigations under the disciplinary procedure to address these cases.

To date 92 checks have been 'positive'. This includes 12 cases which have already been disclosed to the Service by the individual. Each 'positive' check has been considered by a single panel to decide what further action might be necessary. As a result 23 investigations under the disciplinary procedure have been or will be undertaken. All disciplinary hearings are heard by a single (different) panel. Thus far, three investigations have resulted in a disciplinary hearing being convened. One member of staff has been dismissed.

3.5 Workforce information

The level of staff turnover for the year as a whole to (July 2007 to June 2008) at 7.8% is 1.9% higher than the same period last year. An increase in turnover can be seen across all areas of the Trust and whilst the level of turnover is currently within acceptable levels overall, the trend will continue to be monitored to ensure this remains the case. Reported turnover within CTA however will be investigated further, though it should be noted that percentages here are based on low numbers.

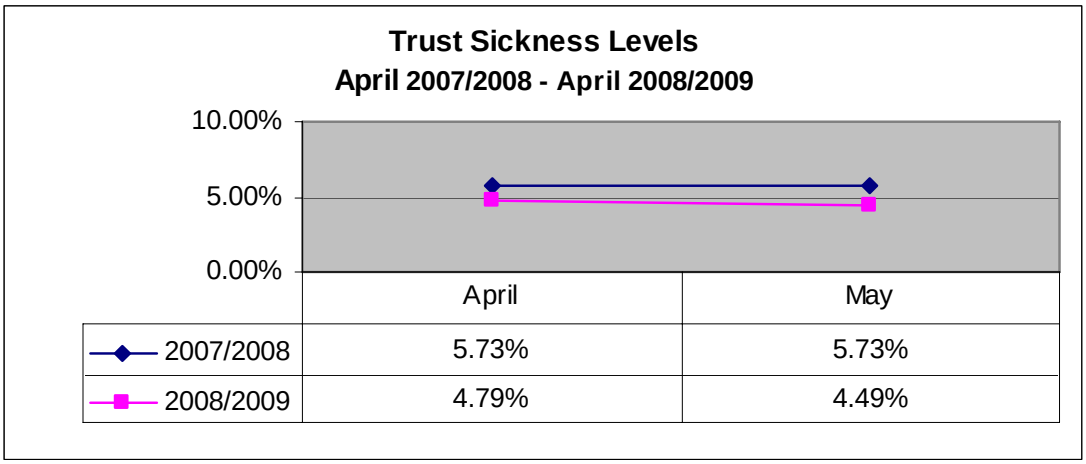
Sickness absence levels have seen a marked and continued improvement since March 2008. This is likely to be attributable in part to the overtime incentive in place for Operational staff during this period together with a clear focus on absence management.

Current vacancies within A&E Operations include the increase to establishment with planned recruitment to these vacancies contained within the workforce plan implementation project highlighted earlier in this report.

Staff Turnover		
Staff Group	July 2006/ June 2007/	July 2007/ June 2008/
A & C	11.95	14.20
A & E	4.76	5.75
CTA	0.00	10.00
EOC Watch Staff	10.51	13.57
Fleet	8.93	13.21
PTS	7.02	12.50
Resource Staff	2.00	2.08
SMP	6.28	8.12
Grand Total	**5.93**	**7.80**

A&E ESTABLISHMENT REPORT			
Position Title	Funded Establishment	Staff in post	Variance
Team Leader	175	159	16
ECP	86	50	36
Paramedic	830	808	22
EMT4)	1220	855	-113
EMT3)		478	
S Para	300	25	275
A&E Support	**232**	**153**	**79**
CTA	**70**	**45**	**25**
Total	**2913**	**2573**	**340**

Absence 2007/2008	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08
A&E Ops East	6.92%	6.64%	6.23%	5.63%	4.67%	4.18%
A&E Ops South	7.00%	7.02%	6.36%	5.91%	4.86%	4.18%
A&E Ops West	6.52%	7.78%	6.77%	6.61%	6.41%	5.69%
Control Services	6.83%	6.98%	6.79%	5.40%	4.45%	5.11%
PTS	7.13%	8.27%	9.86%	8.36%	6.80%	6.02%
Trust Total	**6.34%**	**6.61%**	**6.3%**	**5.66%**	**4.79%**	**4.49%**



SUSPENSIONS as at 29.04.08		Date of Suspension	Stage in Investigation	Hearing Date
East	1	30th June 2008	Investigation commenced	25.08.08
South	3	17.06.08	Investigation complete	30.07.08
		24.06.08	Investigation complete	August 2008
		24.06.08	Investigation complete	August 2008
West	1	16.05.08 Booked sick 2nd June 2008 – OH referral to be done	Investigation commenced 14.05.06	July 2008
Control Services	0			
HQ/Fleet/Others	1	8th February 2008	Last interview scheduled for week commencing 28th April 2008	August 2008

4. COMMUNICATIONS

4.1 Media

Stabbings: The issue of stabbings remains high on the media agenda and the Service has received numerous enquiries over the last few months relating to stabbing incidents, many of which have been covered by national as well as regional media.

CRB checks: Media enquiries were received from The Guardian and the Evening Standard about retrospective Criminal Records Bureau checks carried out on those members of staff who had never had one. Statements were provided outlining the reasons for the checks and the process involved, and the subsequent reports focused on numbers of staff who had yet to comply with the checks.

Cardiac reunions: Two reunions have taken place recently. Lee Kerry (given CPR by Air China cabin crew and defibrillated by staff) met the staff again on 4 July on his way to China; the reunion was filmed for ITV London Ambulance. Wilhelm Schleibach (given CPR and defibrillated by BA cabin crew), who is a consultant in healthcare management, met staff and cabin crew again on 15 July at Heathrow. Media coverage for both reunions is pending.

Fuel costs: There have been enquiries about the impact of increasing fuel costs on the Service. The Service's current stance on this issue is that estimated fuel price and usage increases are built into budgets each year based on price and usage trends. Commissioners are funding a limited general element to cover cost pressures, including an estimate for fuel price increases, and the Service will be continuing to monitor the fuel price situation closely throughout the year.

Ambulance collision: In early June an ambulance was involved in a collision with a motorcycle in SW4 while responding to an emergency call; sadly the motorcyclist died at the scene. A statement was issued and the story was covered by local media.

Unexploded bomb: When the largest ever unexploded bomb in London was discovered on a building site in Stratford, there was some local and national media interest as crews stood by on the scene for four days.

4.2 London Ambulance Service Awards 2008

Outstanding members of staff were praised by colleagues and thanked by patients at this year's Service awards night.

Almost 300 staff attended the event which recognised the work of exceptional members of staff, all of whom had been nominated by their colleagues for the work they do.

Over dinner, patients were reunited with the crew staff who had treated them, before taking to the stage to hand over framed certificates and engraved glass blocks to winners and runners-up.

Compere Geoff Cotton hosted proceedings and staff heard from Chairman Sigurd Reinton and Chief Executive Peter Bradley, who announced the names of those who had won and been highly commended.

This year's award winners and highly commended were:

Special award in recognition of dedication to counselling and staff support
Andrea Brain

Patient Transport Service Person of the Year

Winner:	Natalie Dutton, Cluster Planner
Highly commended:	Joanne Sarsfield, Team Leader (both based at Becontree)

Control Services Person of the Year

Winners:	Wilma Bryson, Sector Controller and Denise Clifford, Emergency Medical Dispatcher

Support Services Person of the Year

Winner:	Tracey Dawes, New Malden Station Administrator
Highly commended:	Paul Freeman, Bromley Workshop Technician

Manager of the Year

Winner: (Romford)	Steve Colhoun, Ambulance Operations Manager
High commended:	Paul Cassidy, Operations Centre Manager

Trainer of the Year

Winner:	Radford Quist, Emergency Operations Centre
Highly commended:	Kay Dark, Barnehurst

Innovation of the Year

Winner:	Mark Whitbread, Clinical Practice Manager
Highly commended:	Paul Webster, Performance Improvement Manager for Control Services

Accident & Emergency Person of the Year

Joint winners:	Dave Hyam, Paramedic (Poplar) Mark Heinsen, EMT (Romford) Neil Kendrick, Paramedic (Romford)

4.3 Patient and Public Involvement (PPI)

Public Education: A pilot development programme for public education staff is being launched in early October. This has been designed in conjunction with London South Bank University and will comprise six days' training, supported by learning sets. Once

the pilot course has been evaluated, it is planned to extend it to staff who do public education work on a more ad-hoc basis.

A new post of PPI & Public Education Co-ordinator is to be introduced over the summer. This role will be to co-ordinate PPI & Public Education activity and resources, supporting local teams to deliver effective PPI and public education, and set up reporting systems between all the teams doing public education work.

New Ways of Working: The Community Involvement Officer posts for Barnehurst and Chase Farm ambulance complexes have been advertised, with interviews being held at the end of July and early August.

Tower Hamlets project: Arrangements are being made to conduct training sessions with expectant mothers in Tower Hamlets, focusing on basic life support, choking and bleeding. The aim of these sessions is to reduce infant mortality rates, which are higher in Tower Hamlets than other boroughs.

A joint project between the LAS and Tower Hamlets PCT (Get the Right Treatment) won the London heat of the Health & Social Care awards. This project aims to provide information to residents of Tower Hamlets about health services in the area, by using interactive training sessions. A session is being arranged for LAS staff at Silvertown and in the Clinical Telephone Advice team, so they are informed about local care pathways and can disseminate the information to others. We are also considering extending the sessions to neighbouring complexes as they also attend patients in Tower Hamlets.

There are also plans, in collaboration with Tower Hamlets PCT, to introduce Get the Right Treatment into schools.

NHS Centre for Involvement: Following their review of PPI in the LAS last year, the NHS Centre for Involvement have returned to assess progress against their recommendations. They were impressed with the developments made since last year, particularly the introduction of the Community Involvement Officer role.

Picker Category C Survey: The LAS was a pilot site for a new national survey, commissioned by the Department of Health and conducted by Picker Europe, looking at the experiences of patients receiving a Category C response from the ambulance service.The findings from the pilot were that most LAS patients were very satisfied with the service received, whether or not they were taken to hospital. It was striking how many of the respondents reported having long term conditions or disabilities. There were some emerging themes around the quality of information given to patients. However, it has been decided that we should wait until the findings of the larger national survey are known, later in the autumn, before any further action is taken on this.

Enclosure 4

London Ambulance Service NHS TRUST

TRUST BOARD 29th July 2008

Finance Report for the month ending June 30th 2008

Contents:

Key points

Year to date***:***

- For the year to date, expenditure exceeds income by £360k. The budgeted position to month 3 is for expenditure to exceed income by £2,300k, hence there is a year to date favourable variance of £1,940k reported.
- The year to date loss of £360k arises due to the planned payment of incentives to work overtime to meet operational performance pressures and expenditure on Invest To Save (ITS) projects carried forward from 07/08. The loss is not as high as anticipated to month 3 since expenditure on development projects, LARP, CAD2010 and education & development initiatives were planned to occur evenly throughout the year when in fact the majority of this expenditure will now be in the latter half of the year.
- Income to date is higher than budget to date at £274k due primarily to the receipt of RTA and PTS contract income over plan.
- PTS is reporting a loss to date of £360k, against a planned surplus of £22k. The loss arises due to the use of third party providers and overtime worked.

Month:

- In the month expenditure exceeds income by £3k against the plan of £857k, resulting in a favourable variance of £854k against budget. Expenditure is down marginally compared to month 2 due to a slightly lower uptake of the overtime incentive in June compared to May.

Forecast:

- The year end forecast is a surplus of £1.193m against a planned surplus of £1.140m.
- The total operational costs forecast of £242m assumes that enhanced payments for overtime working will continue in July & August and the number of overtime hours decreases after August. Overtime hours in Apr to June were averaging 92k per month, the plan for the rest of the year brings this average down by 50%. Operational staff are assumed to be recruited in line with the agreed workforce plan which sees the recruitment of student and graduate paramedics and A&E support trainees from September.
- PTS is assumed to recover its loss and the year end forecast is to make a profit of £42k. This will be done by the full rollout of 2 new Transport Operation Centres which will manage the efficient use of resources.
- The income forecast of £255m includes £15.6m call connect, £8.3 CBRN, £2.5m HART, £8.2m Education & Development funding and £1.6m Olympics funding. The income forecast is higher than plan due to RTA, stadia and PTS contract income being higher than budget.

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board Meeting – 29 July 2008

Report on behalf of the Executive Trust Director Finance

Audited Annual Accounts for the year ending 31 March 2008

1. **Annual Accounts**

   The Audited Annual Accounts for the year ending 31 March 2008 are attached.

2. **Audit Committee**

   The Audit Committee approved the accounts on the 16th June 2008.

3. **Audit Commission**

   The Audit Commission, our external auditors, gave the accounts a clean opinion.

4. **Statutory Duties (Note 23, pages 33 & 34)**

   Performance against the four statutory duties was as follows:

   - **Breakeven performance – achieved**

     The retained surplus for the year was £398k.

   - **Capital Cost Absorption Rate – achieved**

     The Trust is required to make a 3.5% financial return on average relevant net assets. The actual rate of return in 2007/08 was 3.7%; this was within the permitted range of 3.0% to 4.0%.

   - **External Financing Limit – achieved**

     The Trust achieved its External Financial Limit (EFL) target of (£7,359k) for the year.

   - **Capital Resource Limit – achieved**

     The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend. The CRL was underspent by £2,104k against the limit agreed with the Strategic Health Authority of £8,978k.

5. **Accounts Completion**

The Annual Accounts were completed by the 1st May target date and submitted to the NHSE and the Audit Commission.

6. **Public Sector Payment Policy (PSPP) (Note7.1, page 20)**

The PSPP performance for Non-NHS trade invoices was 85% and for NHS invoices it was 84% (in numbers of invoices), the target set by the Strategic Health Authority was 95%.

7. **Auditors Local Evaluation (ALE)**

The ALE assessment for 2007-08 has not been completed at the time of this report. Last year the Trust achieved a 'Good' rating out of a possible Excellent, Good, Fair or Weak rating. The table below shows the current position, the highest score achievable for any category is 4:

ALE	2006-07	2007-08	Comments
Financial Management	3	3	To be confirmed
Internal Control	2	3	To be confirmed
Value for Money	3	3	To be confirmed
Financial Standing	4	4	To be confirmed
Financial Reporting	3	3	To be confirmed
Final Overall Score	3	3	To be confirmed

8. **Other Matters**

A verbal commentary on the annual accounts will be provided at the meeting.

9. **Recommendation**

THAT the Trust Board APPROVE the audited annual accounts for the year ended 31st March 2008.

Michael Dinan
Director of Finance
7th July 2008

Definition of Statutory Duties

External Financing Limit (EFL)

The External Financing Limit (EFL) is the means by which the Treasury via the NHSE controls public expenditure in NHS Trusts.

The EFL can broadly be defined as "a form of cash limit on net external financing". External financing can broadly be defined as the difference between agreed expenditure on capital and internally generated resources.

Each year, each individual NHS Trust is allocated an EFL as part of the national public expenditure planning process. The Trust has a statutory duty to maintain net external financing within its approved EFL.

For 2007/08 the Trust achieved its EFL.

Capital Resourcing Limit (CRL)

The introduction of Resource Accounting and Budgeting in the NHS required the introduction of a capital control – the capital resource limit (CRL), which controls capital expenditure in full accruals terms. All NHS bodies have a capital resource limits. The CRL is accruals based as opposed to the cash-based EFL in NHS Trusts.

Under spends against the CRL are permitted and overspends against the CRL are not permitted.

A capital resource limit controls the amounts of capital expenditure that a NHS body may incur in the financial year.

For 2007/08 the Trust achieved its CRL.

Capital Cost Absorption Rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £4,079,000, bears to the average relevant net assets of £109,704,000 that is 3.7%.

This was within the permitted range of 3.0% to 4.0%.

Break-even duty

The Trust is required to break-even each year. For 2007/08 the Trust exceeded this requirement and generated a surplus of £398k. (See board report for details).

Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29 July 2008

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

Ten incidents have been considered as possible SUIs since my last report to the Trust Board in May; two were considered to have met the criteria and were declared. Of the other eight incidents, the LAS co-operated with Newham Hospital (the lead agency) in the investigation into loss of ampoules of morphine in one, and the remainder which all led to investigations and, where appropriate, action plans.

The SUIs declared involved the tragic death of an LAS Paramedic undertaking a motorcycle training course, and the circumstances around the management of a baby born at home. The investigations into both incidents are nearing completion.

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

Safety Alert Broadcasting System:

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

Twenty eight alerts were received from 30th April 2008 to 18th July 2008. All alerts were acknowledged; only two required any action, both relating to electric and battery operated wheelchairs. The actions required are now complete.

Paediatric laryngoscopes

A problem was identified during a medically supervised interhospital transfer where a paediatric laryngoscope was found to have missing batteries. A bulletin was issued in May requesting that all paramedics check their PALS kit to ensure the laryngoscope functioned correctly. A bulletin was reissued last week requesting a further check. The Logistics Support Unit is coordinating the response.

The following procedures are presented for approval and are included in the Medical Directors report as appendices.

Procedure Relating to the Clinical Handover of Patients (Appendix 1)

The Procedure Relating to the Clinical Handover of Patients has been revised because ambulance crews are no longer required to perform the second 'admin' handover at hospitals. The 'admin' handover has been deemed unnecessary for ambulance crews to carry out, and the decision has been taken after extensive consultation with A&E managers. The opportunity has been taken to remove the sections relating to hospital closures and diversions which will now form a new Hospital Queuing, Divert and Closure Procedure. The procedure was approved by Clinical Governance Committee on 2nd June 2008 and the Trust Board is requested to ratify this decision.

Procedure for Ambulance Observers (Appendix 2)

The Procedure for Ambulance Observers was revised in 2007 but this revision was not formally approved by Committee at the time. Apart from some minor updates the Indemnity Form at Appendix 1 was amended. Subsequent to the 2007 revision a new section 6 to Appendix 2 has now been added. The procedure was approved by Clinical Governance Committee on 2nd June 2008 and the Trust Board is requested to ratify this decision.

Procedure for Responding to Enquiries and Giving Evidence at Coroners Inquests and Statements at Police Interviews (Appendix 3)

This procedure has been revised and apart from minor updates the Procedure now includes new sections on Providing Witness Statements (S.2.0); Interviews Under Caution (S.5.0); and Review and Monitoring (S.7.0). The procedure was approved by Clinical Governance Committee on 2nd June 2008 and the Trust Board is requested to ratify this decision.

Procedure on Actions on Scene Indirectly Related to the Patient (Appendix 4)

The Procedure on Actions on Scene Indirectly Related to the Patient has been revised to include the new arrangements for the use of patient property bags in Section 9. In Section 2 there is now further detail and clarification on forced entry by ambulance staff including action to be undertaken by EOC. The procedure was approved by Clinical Governance Committee on 2^{8th} April 2008 and the Trust Board is requested to ratify this decision.

2. Second domain – Clinical and Cost Effectiveness

Medical Support to Control Services

Dr Fenella Wrigley has accepted the post of Assistant Medical Director, with responsibility for Control Services and will join the LAS in October. Dr Wrigley who was a Consultant in Emergency Medicine at Lewisham University Hospital, is currently at the Royal London Hospital. She is a senior doctor in St John Ambulance with extensive experience in managing the clinical aspects of major planned events in

London. She has a background which includes paediatrics and is an Emeritus HEMS Consultant.

Airway management – JRCALC recommendations July 2008.

Introduction.
At the main committee meeting held in London on 9 July 2008 JRCALC members were able to study the final version of its commissioned working group report entitled " A Critical Reassessment of Ambulance Service Airway Management in Pre-Hospital Care" (the report can be seen in its entirety on the JRCALC website www.jrcalc.org.uk). JRCALC had recommended that this area of clinical practice be examined in more detail to produce guidance and recommendations for future practice, having been aware for some time of the difficulties in providing training and assuring ongoing competence in the intervention. This has already been explained in more detail in the "*Airway Management Update following committee meeting on 12 March 2008*" to be found on the JRCALC website homepage. Three main points had therefore been scrutinised: 1) a current assessment of the benefit on patient outcome of tracheal intubation without drugs, 2) an appraisal of the adequacy of current training requirements for competency in tracheal intubation and 3) an assessment of the adequacy of ensuring ongoing competency in the intervention.

After careful consideration of the document and its accompanying evidence the committee have accepted the group's conclusion that "…paramedic intubation can no longer be recommended as a mandatory component of paramedic practice and should not be continued to be practiced in its current format", and that "…for the majority of paramedics … greater emphasis should be placed on airway management using an appropriate supraglottic device (SAD)".

Recommendations.
JRCALC now recommends that much greater emphasis be placed on the establishment of a clear airway and optimum gas exchange than on achieving an assumed gold standard of endotracheal intubation (ETI) per se. The theoretical line that originally lay to the right on the airway management spectrum between ETI and cricothyroidotomy will now be moved to the left to lie between placement of a "supraglottic device" and ETI. In the same way that currently trainees are made aware of the technique of cricothyroidotomy which may in rare circumstances be life-saving but in which they receive no formal assessment, so they will have a working knowledge of laryngoscopy and endotracheal tube placement. Laryngoscopy and the use of Magill's forceps will of course remain valuable skills to deal with impacted foreign bodies in the airway. This means that trainee paramedics will continue to gain experience in the whole spectrum of airway management in the unconscious patient during their theatre attachment and where appropriate or possible observe (and even undertake) intubation under supervision, but they will no longer be required to be specifically signed off as competent in that intervention. They would however be expected to gain wide experience in the use of supraglottic airways.

Timeline.
It is appreciated that such a significant alteration in airway management cannot, and would not be expected to, take place overnight. Time will be needed for important bodies including the Health Professions Council (HPC) and the Institute of Health

Care Development (IHCD) amongst others who will need to assimilate the recommendations within their own ordinances. Ambulance Trusts will similarly require time to adjust, and in recognising this JRCALC supports the airway group's recommendation that wherever endotracheal intubation is undertaken from now on definite steps should be taken as soon as possible for a bougie and a means of carbon dioxide detection to be made available.

The Future.
Current developments in supraglottic devices make this an exciting and fast-developing way forward in prehospital care, and has the very real potential to afford patients even safer airway management in the future. It is realistic to suggest that we in the UK will be able to lead in the research that will underline the potential advantages that are achievable.

LAS position.
The LAS remains one of the services that currently expect trainee paramedics to undertake training in advanced airway management and achieve 25 intubations, under supervision, in the operating theatre environment. We will continue to do this but will emphasise the importance of becoming competent in the placement and management of supraglottic devices. We will stress the shift in anaesthetic practice and expect to see this mirrored in prehospital practice over time. We will continue to insist that for all intubations, robust governance arrangements are in place; that a bougie is available for all attempted intubations and that not only is end tidal carbon dioxide monitored but that for patients transferred to hospital, a print out is handed over to the receiving clinical staff.

Mental Health update

The Joint Agreement between LAS and MPS for conveying members of the public has now been signed off.

New Drugs:

Clopidegrel trial: awaiting ethical approval from the London Chest. Anticipated go live from September 2008.

Oral Morphine: supplies will be delivered next week and will be packed into paramedic bags from early August.

Oxygen: the LAS will implement the British Thoracic Society Guidelines for Emergency Oxygen use from 1st October. Colleagues in Emergency Medicine have been asked to bring this to the attention of staff working in their departments to ensure they are familiar with the implications of the changes.

Feasibility studies:

- Therapeutic hypothermia: LAS crews working from Fulham, Chiswick and North Kensington Ambulance Stations are trialling therapeutic hypothermia in patients with ROSC and a GCS of less than 9, in conjunction with the Emergency Departments at Hammersmith and Charing Cross Hospitals. 4 patients recruited so far, 2 of whom have survived to hospital discharge.

- CPAP: Crews working from the Whipps Cross Complex are trialling CPAP in patients presenting with acute LVF. 9 staff trained, used once in practice
- iGEL: selected staff at Pinner and Islington are trialling the iGel supra glottic device. Positive feedback in the main (75%)

Clinical Update Newsletter

The May edition (issue 8) covers issues arising around the use of the Recognition of Life Extinct (ROLE) procedure. This has now been in use for over a year and the article addresses some concerns expressed by both crews and HM Coroners.

The June edition (issue 9) deals with palliative care, introducing the concepts of the Liverpool Care Pathw

ay and the Gold Standard Framework (GSF). These set out the standards of care that should be available to patients to provide high quality care in their final months of life so that they and their relatives and carers can make an informed decision about where and how they would like their care to be provided.

Both editions contain the 'ECG of the Month'. *Copies of these bulletins will be available at the meeting.*

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

Appendix 5 provides a summary of findings from the National Ambulance Clinical Performance Indicator Pilot. This study looked at 5 CPIs developed by the National Ambulance Clinical Audit Group and included material gathered between May 2007 and March 2008. The five CPI areas selected were: stroke (including transient ischemic attack); acute myocardial infarction (STEMI); cardiac arrest; asthma, and hypoglycaemia.

These results are also presented in the form of funnel plots, or 'trombonograms.' Illustrative examples will be available at the Trust Board meeting.

3. Third Domain – Governance

Clinical Support Desk

The Clinical Support Desk, staffed 24/7 by a small group experienced Paramedics, has been running in the Control Room since 21st April 2008. Initial findings suggest that this service is valued, being accessed on average 10 times a day. The common reasons for calling are to check on guidelines and to discuss capacity and consent issues. Recognition of Life Extinct is another reason for accessing support. In addition to answering queries from staff on ambulances and cars, the advisers have an important role in 'trouble shooting' within the Room.

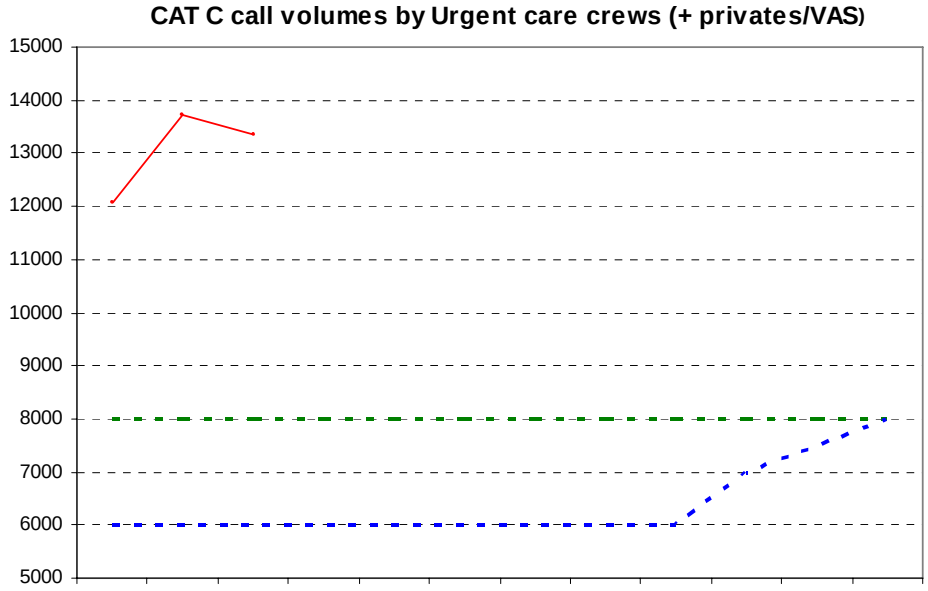
Two important areas where staff on the desk have impacted on patient care are facilitating Patient Specific Protocols and expediting the transfer of patients on the transplant register, where journeys may need to be arranged within a short time frame.

Interestingly the number of calls to the on call advisers from the Medical Directorate has dropped significantly, although this team stays in close contact with the Desk, to provide advice where necessary.

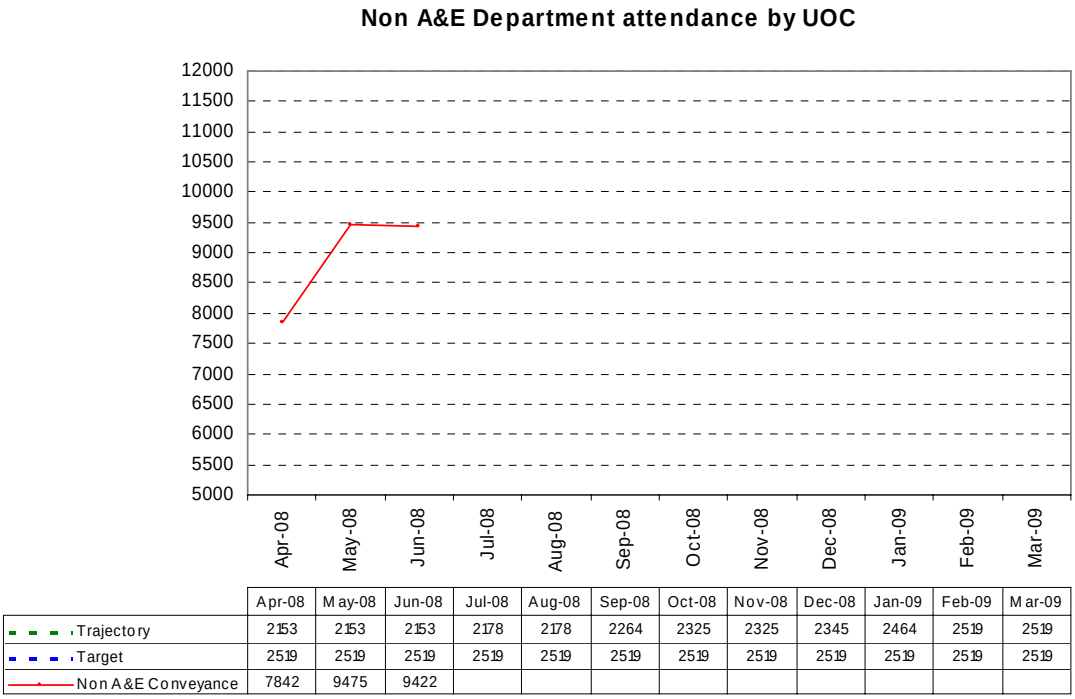
4. Fourth Domain – Patient Focus

Category C activity; (Urgent Operations Centre) Update on activity July 2008
This report is included as work in progress and considers the governance arrangements around Clinical Telephone Advice.

UOC Activity



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Trajectory	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000
Target	6000	6000	6000	6000	6000	6000	6000	6000	6000	7000	7500	8000
Cat C calls by UOC	12081	13724	13343									



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Trajectory	2153	2153	2153	2178	2178	2264	2325	2325	2345	2464	2519	2519
Target	2519	2519	2519	2519	2519	2519	2519	2519	2519	2519	2519	2519
Non A&E Conveyance	7842	9475	9422									

PTS central services undertook 225 A&E referrals from UOC in June 2008.

<u>UOC Process, technology developments and proposals for the future</u>

In order to deal more effectively with the increasing demands for Urgent Care crews and maximise their utilisation a ‘change request’ has been submitted to the IM&T department highlighting the necessity to ‘split’ the UOC desk into North and South areas. Currently staff are duplicating the filtering of the ‘Pan London’ calls and passing tickets manually between themselves, with only one printer in place. The current set-up is not fit for practice and often causes allocation and dispatch delays.

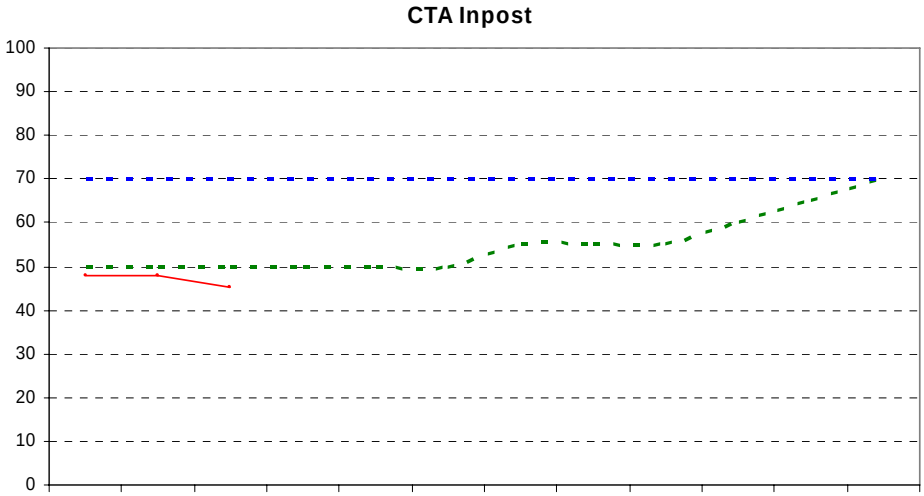
Discussions are ongoing with members of the CTAK enhancement team to highlight the use of FRED and FREDA when handling Green Calls in public places. The management team are aware of the significant delays and clinical risk potential for these patients, and are therefore exploring the dispatch criteria for these calls, and the fact that these should not be passed to CTA or UOC sectors.

A ‘change request’ has been submitted for the AS3 timeframes to be removed. Currently calls of this type are only visible 1 hour prior to the Scheduled Time of Arrival, making planning and referral to PTS more difficult. The outcome of the request is awaited.

In order to track the utilisation of the Privates and Voluntary Aid ambulances that assist UOC, it has been proposed that these resources are given specific dedicated call signs that can be tracked and audited by Management Information. Following the introduction of technology for mobilisation and tracking of the MRU and CRU’s, we are currently awaiting the outcome of the ‘trial’ to see if this process and solution can

be rolled out to these specific UOC vehicles also. This will allow the effective utilisation of these crews who do not currently appear electronically in CTAK.

CTA Staffing and Recruitment



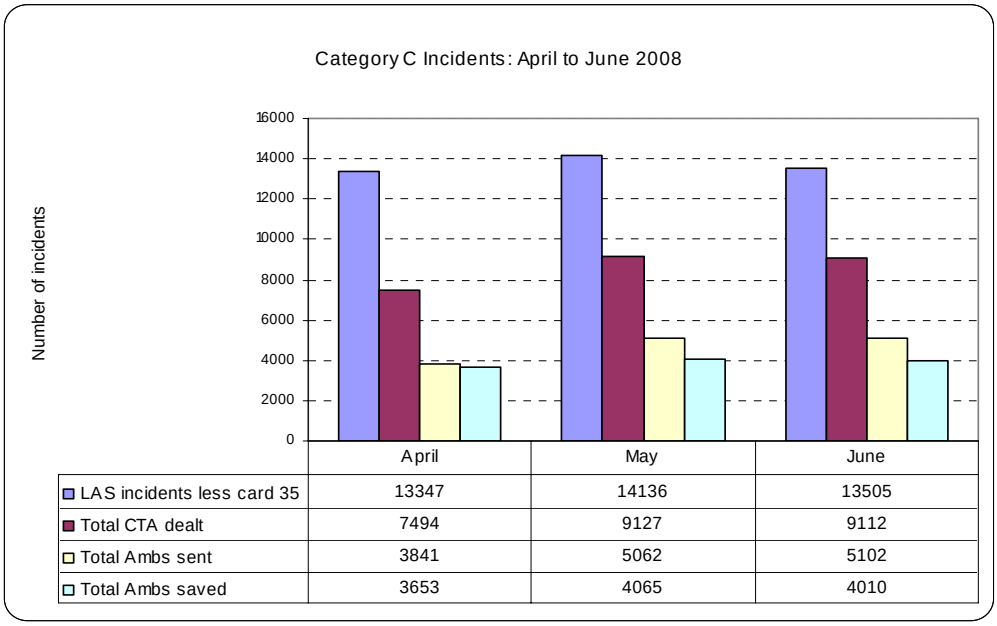
	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Trajectory	50	50	50	50	50	50	55	55	55	60	65	70
Target	70	70	70	70	70	70	70	70	70	70	70	70
CTA In-Post	48	48	45									

CTA in-post to be at 70 FTE by March 2008

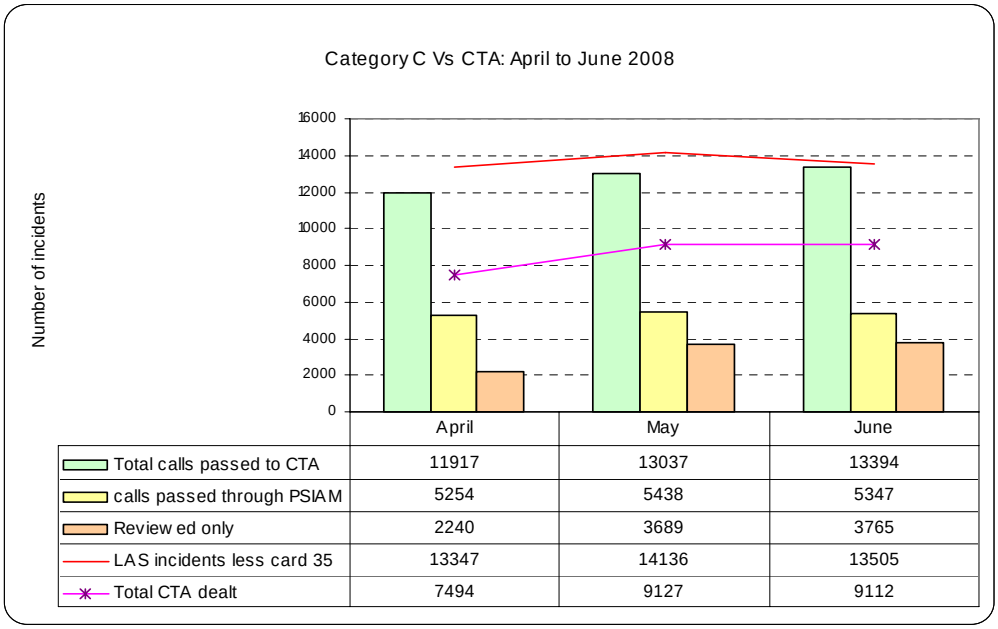
CTA staffing is currently at 45.37 WTE as it stands today.

There is a recruitment drive in progress with a slight change of direction from previous drives. An advert has gone out for 3 month secondments, with a commitment to undertake 24 hrs in CTA following this time. This is to try and encourage staff that do not necessarily want to commit full time, but are prepared to do shifts either on overtime or Bank. (The closing date is 22/07/08 and adverts and courses have been planned 3 monthly. It had been suggested that the previous aggressive fortnightly campaign may have implied that we were ‘desperate’, but evidence has shown that the attraction of the O/T bonuses in particular has not helped with the recruitment of staff into CTA.)

CTA Volumes



	April	May	June
LAS incidents less card 35	13347	14136	13505
Total CTA dealt	7494	9127	9112
Total Ambs sent	3841	5062	5102
Total Ambs saved	3653	4065	4010

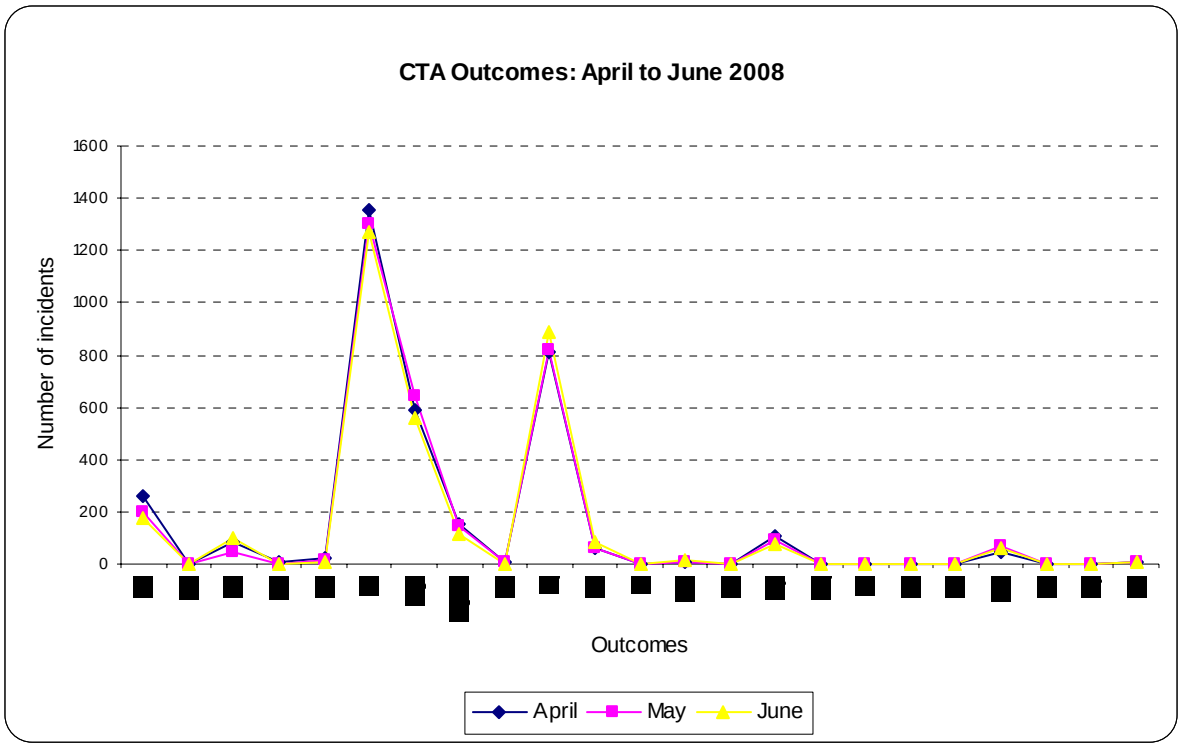


	April	May	June
Total calls passed to CTA	11917	13037	13394
calls passed through PSIAM	5254	5438	5347
Review ed only	2240	3689	3765
LAS incidents less card 35	13347	14136	13505
Total CTA dealt	7494	9127	9112

In the period reviewed CTA passed 5347 calls through PSIAM and clinically reviewed and referred 3765 on ringbacks.

This is translated as total ambulances sent and saved were 5102 and 4010 for June 2008.

CTA Outcomes



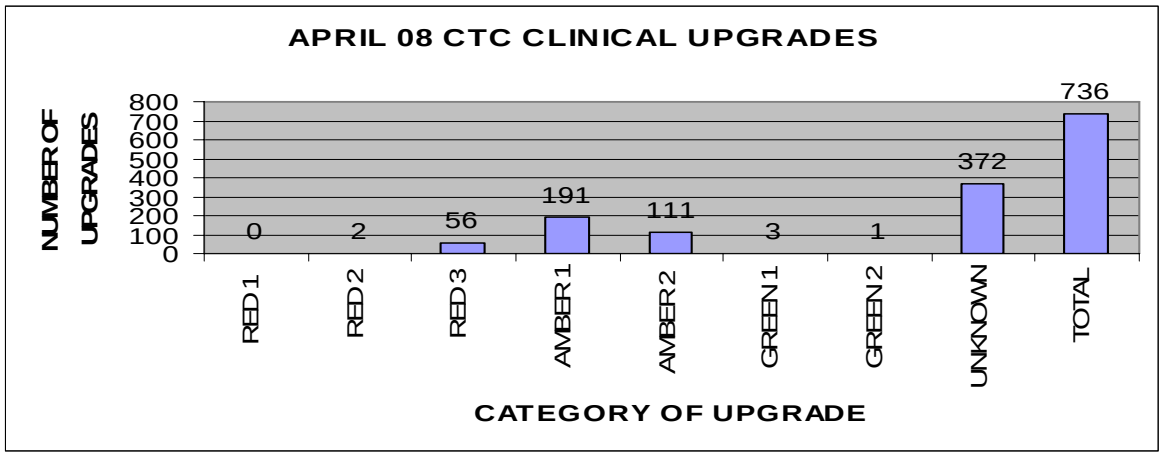
The CTA outcome codes are recorded and audited monthly. The majority of outcomes for the last few months are Ctf, Ctj and Ctg1.

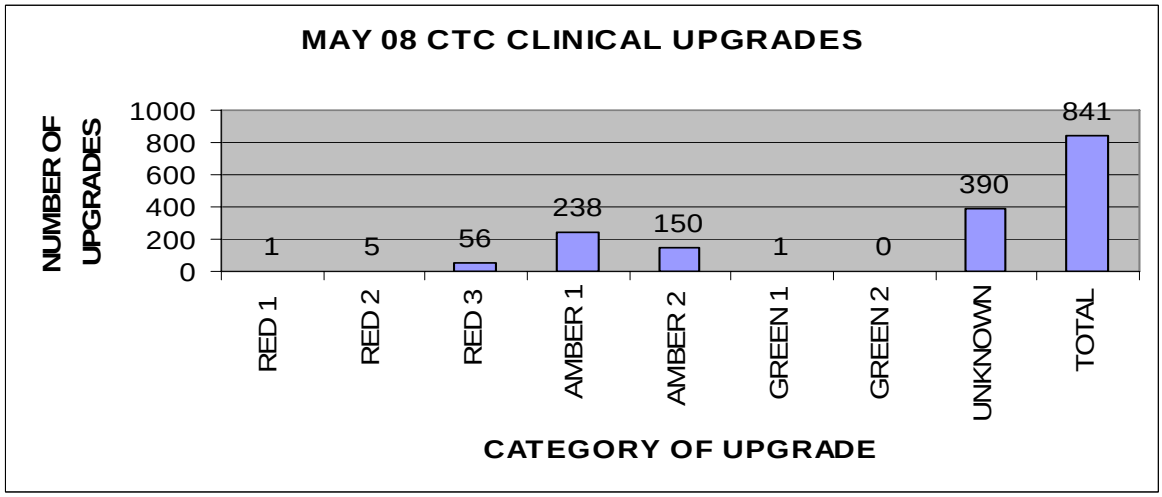
CTa - Advice given – no further action required (Self Care)
CTb - Beyond acceptable wait for call-back (1hour elapsed)
CTc - Referred back to EOC sector-Clinical Upgrades (Frontline response)
CTd - Referred to District Nursing Service
CTe - Requires ECP
CTf - Referred back to UOC/EOC Sector – Requires EMT1 level
CTg1 - To see GP (arranged by Caller/Patient)
CTg2 - To see GP (arranged by CTA Advisor)
CTh - Referred back to UOC sector-Clinical Upgrades (EMT2+)
CTj - Making own way to A&E
CTk - Other referral eg: falls team / dentist (please specify)
CTl - Patient left scene/No Trace – referred to UOC
CTm - Making own way to Minor Injuries Unit
CTn - No-Send policy invoked
CTp - Requires PTS resource
CTq - CTA assessed with no health care identified yet patient still insisting
CTr - No ring back /unacceptable time delay (30 mins elapsed/No Pt contact)
CTs - Referral to Social Services
CTt** - Clinical Reviewer called back and resolved
CTu - Unable to contact-Referred back to UOC/EOC Sector
CTw - Making own way to Walk-in-centre
CTx - Not suitable for CTA
CTy - Vehicle sent during assessment
CTz - Cancelled on Ring Back

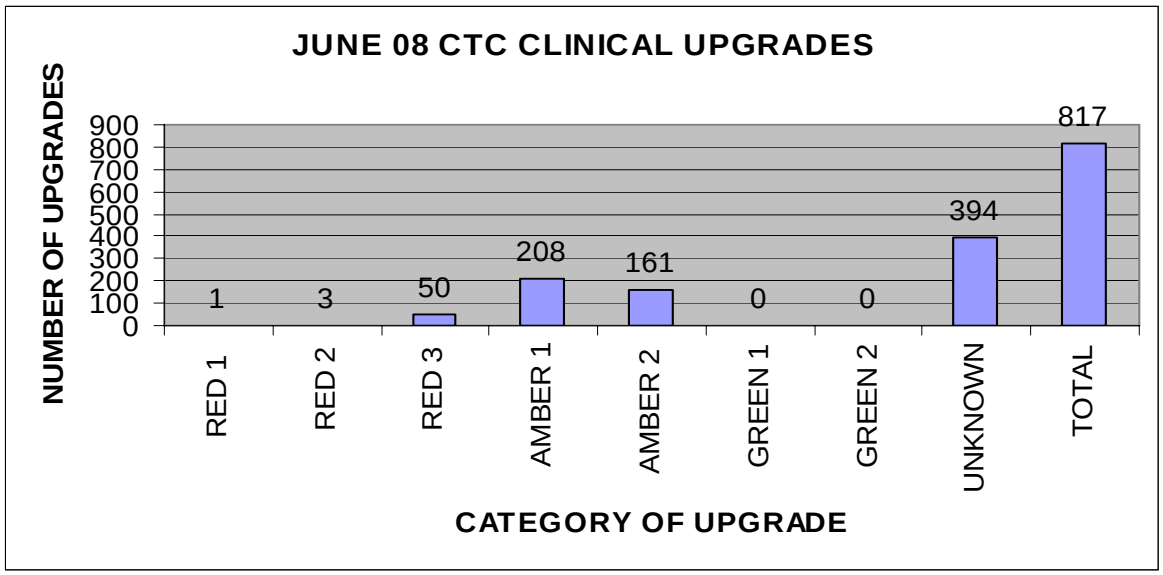
***When acting as a Clinical Reviewer, or when PSIAM is not opened and a call is resolved the CTt code is used. CTt / CTG1 (for example) actually records the complete outcome code and what decision was made for each patient. These records allow us to calculate more accurately the number of alternative care pathways accessed and will more closely reflect the success of CTA actions.*

Clinical upgrades by CTA

An increase has been apparent over recent months of CTc, the clinical upgrades requiring of CTA assessed calls, indicating the patients requiring the assistance and skills of frontline crews.







The UOC Operations Centre Manager is leading this work and is currently looking more closely into the data. He will assess the individuals using the code, the process and cross reference the data against the patients' presenting symptoms to fully explore all avenues.

The questions to be explored;

1) What percentage are CTc following full PSIAM assessment as opposed to Review?
2) Is there any correlation between particular patient group and the need for CTc?
3) Is this trend increasing for particular individuals?
4) Are there any particular training needs for staff regarding outcomes, suitability and appropriate referral pathways?
5) What does the 'unknown' represent for CTc in the above findings?

<u>The Quality Assurance of the Clinical Reviewing Process</u>

It has become apparent that there are inconsistencies in the way experienced staff perform the ringback and reviewing function in CTA. To try to circumvent this occurring in the future we have worked with the QA department to design an audit tool providing a framework for both quality and consistency.

Once approved, this will be rolled out and staff will form part of the QA process. Calls will be randomly selected and audited, and appropriate feedback if necessary delivered to staff.

<u>Ambulance Category C Service User Survey – PILOT 2008</u>

The LAS was chosen recently by the Picker Institute as part of the above pilot.

Several aspects were evaluated in relation to Category C patients, including their experience, treatment and overall satisfaction of the services they received. The call

handling aspects were included, incorporating both MPDS and CTA (PSIAM) telephone triage and assessment.

Following the successful pilot, a full audit is to be undertaken in the forthcoming months. The final findings of the full audit will be considered following its completion.

Complaints Department – Report for Quarter 1 of 08/09

The Complaints Department has received a total of 98 complaints in the first quarter of this year, showing a drop of 29% compared to the total received in the same quarter in 07/08.

There has also been a drop in the number of written complaints received. A written complaint is classed as one received by letter, fax or email. In 07/08 written complaints made up 45% (62 out of the 138) of the total complaints received and in 08/09 this percentage is 36% (35 out of the 98).

Below are two tables showing the total number of complaints received in the first quarter for both 08/09 and 07/08.

The table below shows the total number of complaints received by Service area for 08/09:

	08/09 Q1	08/09 Q2	08/09 Q3	08/09 Q4	Total
Emergency Operations Centre	34	0	0	0	34
A&E East	13	0	0	0	13
Not our service	15	0	0	0	15
Patient Transport Service	6	0	0	0	6
A&E South	18	0	0	0	18
A&E West	12	0	0	0	12
Totals:	98	0	0	0	98

The table below shows the total number of complaints received by Service area for 07/08:

	07/08 Q1	07/08 Q2	07/08 Q3	07/08 Q4	Total
Emergency Operations Centre	52	0	0	0	52
A&E East	26	0	0	0	26
Not our service	11	0	0	0	11
Patient Transport Service	5	0	0	0	5
A&E South	28	0	0	0	28
A&E West	16	0	0	0	16
Totals:	138	0	0	0	138

Although the overall number of complaints has dropped, the spread of complaints over each area remains similar in both quarters when compared with the total amount received.

- EOC receives the most complaints in both quarters making up 35% of the total complaints received in 08/09 compared to 38% in 07/08. This is because issues of

delay are attributed to EOC, when the actuality in many cases is that sufficient resources were not available for dispatch. All 'delay' responses are therefore now routinely disseminated to the relevant ADO.

- The South makes up 18% of the total complaints in 08/09 compared to 20% in 07/08
- The East makes up 13% of the complaints in 08/09 compared to 19% in 07/08.
- The West makes up 12% of the complaints in both 08/09 and 07/08.
- PTS makes up 6% of complaints in 08/09 compared to 4% in 07/08.

Complaints received are broken down into subject areas, these are also similar in both the first quarters of 07/08 and 08/09 when compared to the total amount received as the below tables show.

The table below shows the subjects received by Service area for 08/09:

	EOC	E	NOS	PTS	S	W	Total
Aggravating Factors	0	0	0	0	0	1	1
Delay	32	2	0	2	1	1	38
Non-conveyance	5	2	0	1	2	1	11
Not our service	0	0	15	0	0	0	15
Non-physical abuse	13	10	0	7	15	9	54
Road handling	0	1	0	1	3	1	6
Treatment	9	5	0	2	5	7	28
Totals:	59	20	15	13	26	20	153

The table below shows the subjects received by Service area for 07/08:

	EOC	E	NOS	PTS	S	W	Total
Aggravating Factors	0	0	0	0	1	0	1
Conveyance	0	2	0	0	0	0	2
Delay	46	2	0	1	2	0	51
Non-conveyance	4	1	0	1	1	1	8
Not our service	0	0	11	0	0	0	11
Non-physical abuse	11	16	0	4	25	12	68
Road handling	0	4	0	0	4	2	10
Treatment	10	10	0	3	6	6	35
Totals:	71	35	11	9	39	21	186

The total of the subjects is greater than the number of complaints received. The reason for this is that a complaint may not involve a single subject area, but cover a variety of issues and each one will be recorded and investigated.

'Delay', 'Non-physical abuse' and 'Treatment' are three of the main subject areas. All three of these main subjects have fallen in 08/09 when compared with the total amount received.

- 'Delay' complaints made up 27% of the total subjects received in 07/08 and this fell to 25% in 08/09.
- 'Non-physical abuse', which is the main heading for attitude/behaviour complaints, made up 37% in 07/08 and again this fell to 35% in 08/09.

- ‘Treatment’ complaints made up 19% of the total subjects in 07/08 and this fell to 18% in 08/09.

With the advent of the ‘Making Experiences Count’ programme, the regionalised structure of ‘complaints’ will be unpicked. This will enable improved equanimity of resourcing without inhibiting continued analysis by region. This will also unify PALS data so that a comprehensive analysis will be enabled, rather than the partiality of ‘complaints’ distinct from other sources of service user and stakeholder feedback. Discrepancies between subject indices recording within the different modules will also be resolved.

PALS Update on the ‘Frequent Caller’ initiative (June 2008)

All files held by PALS referring to Frequent Callers have been reviewed. All ‘Frequent Caller’ patients known to PALS have now been allocated by postcode to a complex and borough. These reviews have established whether patients are still active, have stopped calling, moved to a different address or deceased, and where our intervention has promoted a change to care provision or initiated other action.

Where it is found that the patient is a high volume caller, using CTAK facility, the patient is moved into the ‘Top 20’. The case is then reviewed and appropriate action carried out immediately.

A special project is being undertaken on homeless persons in North East London who abuse alcohol as these are the subject of numerous calls from staff at Hainault Bus Garage. This has involved liaising both with the PCT and local police.

A Social Worker (with ASW experience) has been appointed and will take up post in October 2008.

Case load

Since November 2007 the Frequent Caller Unit has closed 182 cases, of which 40 patients have died, 5 patients re-housed to nursing home, 1 person in prison. 206 cases remain open.

There are currently four boroughs which have active multi-agency forums which meet regularly to review patient care plans. These forums have considered the following case volume:

10 cases - Croydon Forum (Monthly)
12 cases - Greenwich Forum (Quarterly)
12 cases - Lewisham Forum (Bi-weekly)

Bromley has a two separate active forum for Frequent Callers and High Risk register review. (Monthly)

Over the coming months the following cases will be reviewed again. These cases are being monitored where some intervention has occurred and the patient is no longer

placing 999 calls or their call volume has fallen dramatically to no longer warrant our intervention. These cases require monitoring given that patients with complex needs often lead chaotic or dysfunctional lifestyles. The majority of these cases should however be closed by the end of the year:

25 cases - July review
9 cases - August review
21 cases - September review
15 cases - October review
22 cases - November review
9 cases – December review

'Top 20'cases - 14 further cases have persistent high volumes of calls generated by the patient and are still active. These cases are high priority. Two PALS case Managers are managing a total of 34 cases. A further 23 cases are awaiting further information or a case conference to be held.

Local Forums

Local Forums have been established in the following PCT areas:-
Greenwich
Bromley
Lewisham

Local Forums are being established and are at formation stage:-
Croydon
Enfield
Haringey
Camden
Islington
Barnet
Havering

Suspended Local forums:-
Newham
Tower Hamlets

Approaches have been made to the following PCT/Local Authorities:-
Southwark
Lambeth

The majority of complexes now have 'frequent caller' representatives with the exception of Pinner, St Johns Wood & Waterloo.

Appendix 6 gives illustrative examples

5. Fifth Domain – Accessible and Responsive Care

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

6. Sixth Domain – Care Environment and Amenities

Patient property scheme

Disappointingly, the LAS has received almost as many enquiries as before the scheme was introduced. Data has been forwarded to the Assistant Directors of Operations to indicate that from 1st August, in any case where the crew have not recorded use of the bags, the enquirer will be referred to the local AOM. We expect that initially there will be more complaints and claims. However we remain confident that once bedded in, the scheme will prove a success, evidenced by the fact that not received a single enquiry has been received in relation to the Hillingdon complex, where the scheme was piloted and crews are familiar with using the bags. We are also planning posters in every ambulance, to remind crews and alert patients. The infection control issue is apparently not a problem.

Infection Control

The post of Infection Control Co-ordinator has been advertised and suitable candidates will be interviewed at the end of July. A second Trust wide Infection Control Audit was commenced in May; returns are currently being collated.

7. Seventh Domain – Public Health

Nothing further to report

Recommendation

THAT the Trust Board NOTE the report and RATIFY the decisions of the Clinical Governance Committee in approving the four procedures attached.

Fionna Moore,
Medical Director
20th July 2008

Appendix 1

London Ambulance Service NHS
NHS Trust

Procedure Relating to the Clinical Hand Over of Patients

1. Introduction

The London Ambulance Service NHS Trust (LAS) conveys patients, using the Accident & Emergency (A&E) services fleet, to a variety of departments/units. The majority of patients are, however, conveyed to Emergency Medicine departments. It is therefore essential that a close working relationship is sustained between LAS and hospital staff to ensure the patient is handed over in a safe and timely manner. Delays may arise through difficulties in patient placement which can affect the hand over process, delaying ambulance activity.

The principles of this document should be used as guidance when patients are handed over into any other department or treatment centre. It is, however, accepted that there may be times when the transfer of patients to the designated receiving units may take longer than the LAS standard of 20 minutes. In these circumstances the respective control room should be informed so that they can appropriately record the reasons for the delay and actions taken to resolve it.

The LAS A&E service also conveys patients to other units for humanitarian reasons, e.g. a hospice. In these cases the patient's comfort and dignity will be the factors guiding hand over.

2. Objectives

1. To provide clarity for both LAS and hospital staff of their role in the hand over of a patient, ensuring the provision of seamless patient care.
2. To ensure the patient is handed over in a safe and timely manner within the 20 minutes LAS hospital handover time standard.
3. To identify when responsibility for the patient transfers from the LAS to the receiving hospital
4. To improve communication between LAS staff and receiving unit staff

3. Procedure

3.1 Clinical Hand Over

3.1.1 A clinical hand over of the patient should be given to the Emergency Medicine nurse/doctor taking responsibility for that patient using the Patient Report Form (PRF) to provide structure and clarity over the information provided. The information should include the patient's vital signs, history, injuries, name and age.

3.1.2 The patient's privacy must be maintained at all times. Ideally the handover should not take place in a public area.

3.1.3 Once the clinical hand over is complete, the receiving clinician should retain a copy of the PRF. At this point responsibility for the patient is transferred to the hospital staff.

3.1.4 Ambulance staff should also hand over any information on the patient's social circumstances to the receiving clinician which may help hospital staff with discharge planning. Any relevant medication, patient property and medical information should also be handed over at this time.

3.1.5 It is the responsibility of the hospital to ensure that their administrative process is fulfilled. Ambulance staff will leave the mini PRF with the hospital in the pre-arranged location, but should not be involved in the generation of the hospital patient record. LAS Staff should not carry out a verbal handover to reception staff, enter details on the hospital computer or source the patient's hospital notes.

3.1.6 It is critical that the copy of the PRF to be handed over is clearly legible. Staff should use a black ball point pen; press on a firm surface and sufficiently hard. If this copy is not legible, it should be over-written before being handed in.

4. Completion of Documentation

4.1 Wherever possible the PRF should be completed whilst en route with the patient to hospital, in accordance with LAS guidelines. If this cannot be achieved then the PRF should be completed as soon as possible on arrival at hospital. In the event that a FRU has attended the call prior to an ambulance, a copy of their HRF (handover report form) should be given to the crew conveying the patient so that it forms part of the overall patient record.

4.2 In some situations a clinical handover precedes completion of the PRF, particularly where patients are taken directly into the resuscitation room. If this is the case the PRF should be completed as soon as possible and then left with the receiving clinician to form part of the patient's record.

5. Reporting Availability

5.1 It is essential that ambulance staff ensure their availability is reported promptly to the control room after patient hand over by the use of the 'green mobile' status button.

5.2 After reporting their availability to the control room, the ambulance crew may request to remain on active area cover at the hospital and avail themselves of local facilities, provided they remain immediately available to respond to a call.

6. Delays due to assisting Hospital staff when necessitated by the Patient's condition

6.1 Ambulance staff should inform the control room as early as possible of any potential delays as a result of the patient's condition. Any other delays should also be reported to the control room at the time of the delay (not retrospectively) and documented on the electronic call log and the PRF. Actions taken to mitigate and reduce such delays should also be recorded.

7. Staff Welfare

7.1 If ambulance staff subsequently feel they need further support or assistance once the hand over is complete, they should contact the control room who will contact the appropriate officer.

8. Delays for Patients who are 'Not Ready for Transfer'

8.1 There are times when ambulance staff are committed to the transfer of a patient and the patient is not ready. If the delay is expected to exceed 20 minutes then the control room must be informed immediately and the crew should remain in contact with the control room. The final decision on whether ambulance staff should be re-deployed rests with the Operations Centre Manager (OCM). Effective liaison between ambulance staff and the control room is essential.

9. Hand Over of Adult Patients Where Death has Occurred

9.1 In certain circumstances, and in accordance with the National Clinical Guidelines, ambulance staff are authorised to recognise patient death. Form LA3 must be completed for all patients where death has been recognised. This constitutes legal confirmation of patient death. Copies of both the LA3 and the PRF relating to the patient must be handed to the attending police officer. In circumstances where death is expected and the ambulance crew feel able to leave the scene before the arrival of the police, this documentation must be handed to the responsible person who will remain on scene with the deceased.

9.2 The introduction of Recognition of Life Extinct (ROLE) for ambulance crews now eliminates the need for patients to be taken to Emergency Medicine Departments in order to pronounce life extinct.

9.3 When ROLE has been initiated the deceased patient then becomes the legal responsibility of the Coroner and must not be removed from scene without their authority. This authority is given via the attending police officer. In some circumstances the Coroner may permit the deceased patient to be removed to a pre-determined mortuary of the Coroner's choice.

9.4 When a deceased patient is permitted to be removed to a public mortuary, copies of the LA3 and the PRF should be handed to the police officer escorting the patient, or the mortuary attendants.

9.5 Any delays should be reported to the control room as normal.

10. LAS Equipment Taken into the Emergency Medicine Department

10.1 All non-disposable equipment and blankets taken into Emergency Medicine departments should be retrieved, where possible, before leaving. This may be achieved by a direct swap. In the event of any essential equipment being left this must be documented on the LA1 and EOC staff informed. All equipment must be identifiable to the LAS. Any equipment not retrieved by the end of the shift must be verbally reported to the oncoming crew and documented in the station Occurrence Book. Every attempt must be made to retrieve the equipment during the course of the shift.

NOTE: This procedure adheres to current JRCALC guidelines. Section 9 will be expanded when agreement is reached between Coroners' Courts and the Local Authorities concerning a common approach to Sudden Unexpected Death in Infancy (SUDI).

Appendix 2

London Ambulance Service NHS
NHS Trust

Procedure for Ambulance Observers

Introduction

This procedure relates to all requests from anyone seeking permission to undertake periods of observation on both Accident and Emergency and Patient Transport Services (PTS) vehicles.

Most requests to ride out with ambulance staff on a London Ambulance Service NHS Trust (LAS) vehicle generally come from student doctors, nurses and other healthcare agencies within the NHS including staff from LAS. Occasionally, MPs, local councillors, representatives from non-NHS or UK ambulance services, visitors from abroad, journalist and the media will request or be invited to ride out as an observer.

For the purpose of this procedure an 'ambulance observer' means; an authorised person suitably dressed who may accompany ambulance staff solely to observe operational activities and crew actions without interference or assisting in any way with patient care or treatment.

Objectives.

1. To ensure a standard approach when dealing with all requests/ invitations to observe on LAS vehicles.

2. To ensure proper scrutiny for all such requests is undertaken and that appropriate paper work and indemnity where necessary, is confirmed in writing.

Procedure

1.0 Who may ride out as an Ambulance Observer on an LAS vehicle

1.1 As a general rule no one under the age of 18 years may go out as an ambulance observer on any LAS vehicle. The only exception to this rule is for students undertaking an appropriate training course (student nurses, GNVQ Health & Social Care, etc) who may observe on A&E vehicles providing their college agrees the undertaking in 2.4 below to provide indemnity for the negligence of the student.

2.0 Processing and authorising applications for Ambulance Observers.

2.1 A person wishing to ride out as an observer will be referred to the appropriate Practice Learning Manager who will provide the necessary indemnity form.

2.2 In the case of an LAS employee whose service induction includes a period of time as an ambulance observer or where subsequently observer duties are arranged, it will not be necessary for them to sign indemnity forms.

2.3 Whenever a third party wishes to accompany LAS staff on a vehicle, the Indemnity Form (LA123) Part A (see Appendix 1), and the Observers Guidance Notes, part B (Appendix 2) must be signed and returned to the LAS prior to the period of observation.

2.4 If the third party is employed by another NHS Trust, health authority or a student at university or College of Further Education pursuing a professional health qualification, the employing authority/ university/ College of Further Education must confirm on headed letter paper that the employing authority will accept liability for the negligence of their staff in the event of personal injury, injury to patients or LAS staff or damage to LAS property.

2.5 If the third party is not employed by a NHS Trust or health authority or is not a student at university or College of Further Education pursuing a professional health qualification, the third party must be asked to provide proof of public liability and employer liability insurance to the value of:

£250,000 - if they are a student or unemployed,
£2,000,000 - if they are employed by a private company or other public body,
£5,000,000 - if they are employed by a public limited company.

2.6 Authorising applications and making final arrangements, such as name of crew time, date and place for the ambulance observer to report to accompany an A&E vehicle, will be undertaken in the first instance by AOM/DSO. PTS authorisation for an observer will be granted by a Contract Operation Manager or Site Manager. In the event of the AOM's absence, authorisation may be granted by DSO, HR Officer or Support Services Officer. In the event of the Contract Operation Manager or Site Manager's absence, authorisation may be granted by PTS Lead.

2.7 A copy of the signed indemnity form together with the proof of the insurance or letter from the NHS employer/ university or College of Further Education and other documents will be retained by the department facilitating the arrangement for a period of 4 years.

2.8 Should any injury/ loss/ damage occur whilst the third party is accompanying LAS staff as an ambulance observer, an Accident/ Incident Reporting form LA 52 must be completed.

2.9 In any event an ambulance crew have the right and responsibility to terminate the 'ambulance observation' period at any time should they believe the observer has breached or compromised these guidelines to the detriment of patients and staff.

3.0 Inviting Politicians, VIPs, guests from abroad and the media as Ambulance Observers.

3.1 Occasionally, the LAS approaches individuals from external organisations to observe on a vehicle. It would be inappropriate for the service to expect indemnification from this group of people when this has been initiated by the LAS and clearly for the benefits of the service's own interests.

3.2 In these special circumstances, managers or officers of Assistant Director of Operations level or above may allow guests to observe on vehicles without the need to provide indemnity or insurance. The group of individuals that this is most likely to apply would be politicians, VIPs, visitors from abroad and, when the LAS has made the initial approach to the press/media.

3.3 This facility must not be used to short-cut the procedure in the event of a 'guest' requesting the facility of ambulance observing at short notice, because of not having sufficient time available or due to incomplete or incorrect documentation.

Appendix 1

LA123
(Part A)
Indemnity Form

1. In consideration of you allowing me to accompany and observe your employees, independent contractors or agents during the course of their duties with the London Ambulance Service I hereby irrevocably and unconditionally undertake as follows:

    1.1 to indemnify you and keep you indemnified from and against all actions, claims, demands, costs (including legal costs), losses and expenses which may be brought or made against you by any person or incurred by you arising directly or indirectly, wholly or partly out of any act or omission by me (including my negligence) when so accompanying any such person as aforesaid;

    1.2 not to hold you responsible or make any claim against you in respect of any loss, damage or injury arising as aforesaid unless I suffer personal injury or death arising out of your negligence.

2. I agree:

    2.1 I will keep confidential and not disclose any and all information relating to you, your staff, and any of your patients or any other third parties, which I acquire or receive during the course of activities referred to in paragraph 1 or otherwise;

    2.2 I will not film, photograph or record any of your patients or any other third party without first obtaining the verbal consent of such patient or third party;

    2.3 I will not film, photograph or record any of your staff without first obtaining the verbal consent of such staff;

    2.4 I will not film, photograph or record on private property without first obtaining the verbal consent of those persons responsible for the property;

    2.5 In the event that I film ,photograph or record during the course of activities referred to in paragraph 1 above, any material I obtain and which is subsequently used by me or any third party (including in and by the media) will not identify any individual without that person's prior written permission;

    2.6 You may terminate my activities referred to in paragraph 1 above at any time, if you consider this to be necessary for the purposes of carrying out your operations, or if I do not comply with any of my obligations under this Indemnity Form.

3. I agree that:

3.1 The benefit of this undertaking shall extend not only to you but to your successors and assigns whether immediate or derivative and all and every one of your employees or agents whether now or hereafter in` your employment and for this purpose I acknowledge that in respect of this undertaking you are acting on your own behalf and as agent for your employees and agents as aforesaid.

3.2 Your rights pursuant to this undertaking are without prejudice to and in addition to any other rights or remedies provided by law and or statute for your benefit and the benefit of your employees and agents.

3.3 You reserve the right to require from me at any time evidence of appropriate insurance cover or other evidence of my ability to meet my liabilities under this undertaking.

3.4 If:

3.5 a claim is made for which I am only obliged to provide a partial indemnity by virtue of the fact that any personal injury or death is partly caused by your negligence or;

3.6 a claim is made in which legal proceedings are threatened or brought against you or against both you and me then you shall be entitled to be represented separately in respect of the conduct of any such claim or proceedings.

4 This undertaking shall be binding on my heirs, successors in title and personal representatives.

5. Any change in your constitution or your abolition or amalgamation with any other person of the acquisition of all or part of your undertaking by any other person shall not in any way prejudice or affect your rights hereunder.

6. This agreement shall be governed by and be construed in accordance with English Law and the parties hereby submit to the exclusive jurisdiction of the English Courts.

DATED the day of 20__

SIGNED by))
PRINT NAME:_____)
)
in the presence of)

WITNESS:
Signature: _____

Address: _____

_____

Occupation: _____

Appendix 2

1 LA123
2 (Part B)

London Ambulance Service NHS Trust

Notes to be read and signed by any person wishing to accompany London

Ambulance Service staff as an observer on a vehicle.

1. Due to the nature of the Ambulance Service it is difficult to predict the type of incident or locations that you will attend. With this in mind you should wear clothing that is practical and yet offers some protection from the elements etc. In particular you should wear footwear that offers protection to the feet and has a non-slip sole. In addition you will be required to wear a reflective tabard that clearly identifies you as an "observer" and appropriate safety equipment during the course of the shift.

2. At all times you must act under the instructions of the crew of the vehicle. This relates to your seating position in the vehicle and whilst at incidents or locations. Contravening these guidelines or instructions given by the crew may result in your observation period being terminated by the crew or authorising officer.

3. For your own safety, you should remain seated with seatbelt applied, whilst the vehicle is in motion and comply with the London Ambulance Service no smoking policy as well as other London Ambulance procedures and protocols

4. At the beginning of the period of observation you should acquaint yourself with the layout of the vehicle and the location of any safety equipment, fire extinguishers etc.

5. During the course of this period of observation you should not attempt to use any items of LAS equipment or offer any treatment to a patient unless asked to do so by the attendant / crew members.

6. You owe a duty of confidence to patients and must not, therefore, disclose any patient identifiable information about patients to a third party.

7. If for operational or patient care related reasons it is not possible to immediately convey you either from the scene of an incident to hospital or from hospital back to an Ambulance Station, the LAS will make every effort to do so, as soon as possible.

8. In the event of the crew being deployed to a known violent incident/ address, or a declared major incident the crew may request the observer to leave the vehicle at the nearest safe location.

Signed: _____

Name Printed: _____
Date: _____

Appendix 3

London Ambulance Service NHS Trust **LA123 (Part C)**

Observers Details Form

Name of Observer		
Address		
Age: if under 21		If over 21 years of age please enter 'over 21'
Sponsoring Organisation		

If employed by another NHS Trust the following should be attached:

- Letter from Trust confirming that the employer will accept liability for the negligence of their staff (see 2.4 in procedure) ☐
- Signed Indemnity Form (Form A) ☐
- Signed Observers Notes (Form B) ☐

If the Observer is not an employee of an NHS Trust the following should be attached:

- Copy of appropriate Insurance Certificate ☐
- Signed Indemnity Form (Form A) ☐
- Signed Observers Notes (Form B) ☐

Proposed date of observation			

Station	
Shift Time	
Crew (Name or Call Sign)	

For official use

Received:

Details Checked by

Authority is hereby given for the above named to accompany LAS Staff on the date/shift indicated above.

Signed: _____

Position:_____

Date: _____

Appendix 3

London Ambulance Service NHS
NHS Trust

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

Introduction

A Coroner's inquest is a court hearing to establish the details surrounding an individual's death. The Coroner hears evidence to assist him/her in their enquiry into the means and circumstances of the death, including who died, where, when and how they died. If an individual dies in an accident, or suspicious/unknown circumstances, an inquest is usually held. An inquest must be held if the cause of death is violent, unnatural, or remains unknown following a post mortem examination.

The ambulance staff's role in these proceedings is primarily to provide independent evidence of the circumstances surrounding the death, as witnessed by them. As ambulance staff are usually among the first people to attend the scene, they may be called on as witnesses to provide evidence of their recollections.

The statements requested by the Coroners are concerned with the condition of the patient, any interventions carried out and any pertinent information regarding the scene of death. Statements need to be produced as quickly as possible to ensure that staff can still recall detailed information about the incident in question, to enable the Coroner to set a date for the inquest. Most enquiries will be made by the Coroner's Officers but some will be conducted by the Police, e.g. RTA Investigation Units and Serious Crime Units.

If statements are provided, this may be sufficient evidence for the Coroner and the individuals may not be called to give evidence at the inquest, i.e. they will not have to be stood down from their normal duties.

In the majority of cases, there is no criticism of the London Ambulance Service NHS Trust (LAS) or the treatment provided by the crews. Occasionally, if the Coroner (or the family of the deceased) feels that the response time was too long, or there are questions about the treatment provided, the Coroner will ask for the crew and/or other representatives from LAS to attend the inquest. Staff may also be called if the statement they give does not corroborate evidence, or contains key evidence related to the death.

The Police request interviews with, and statements from, LAS staff in order to gain further evidence/insight into a particular incident the LAS was called to / attended. This may lead to LAS staff attending court to give evidence.

Objectives

1. To ensure, effective communication takes place with the Coroners/ Police and all relevant information is obtained.

2. To establish time scales for producing requested information are established.

3. To obtain clarity at the outset as to whether there is any criticism of the LAS.

4. To put in place clear mechanisms after receiving a call from the Coroner/ Police to ensure that appropriate action is taken.

5. To ensure that if statements are required, staff are notified as soon as possible.

6. To ensure that if staff are required to attend a Coroners Inquest/ Police interview they feel fully supported by the LAS NHS Trust.

Procedure

1.0 Coroner's Inquests

1.1 Any enquiries that come in from Coroner's Officers should be directed to Legal Services. Legal Services will then ascertain the nature of the information required by the Coroner's Officer, including when it is required and whether there is any criticism of the LAS.

1.2 If there is no criticism of the LAS.

1.2.1. All records relating to this case will be requested from archives and then sent to the Coroner's Officer.

1.2.2. If statements are required from staff this will be put in writing and faxed to the appropriate Station Administrator. It will be clarified whether one or both crew members are required to make statements and guidance on how to write a witness statement will be enclosed with the request (see Appendix 1). Legal Services will advise the Coroner's Officer if there are any difficulties in obtaining statements or with staff availability. When the statements have been received these are sent to the Coroner's Officer.

1.2.3. Once the inquest date is confirmed it will be established whether the crew/other LAS staff are required to attend; if so they will be notified through their Station Administrator and be given details of the date, time and place. It is the responsibility of the Complex Management Team to arrange for a suitable officer or manager to accompany staff at an inquest.

1.3 If there is any criticism of the LAS

1.3.1 Legal Services will find out from the Coroner's Officer what the line of questioning is likely to be in relation to LAS and in broad terms. The appropriate Ambulance Operations Manager (AOM) or Patient Transport Service (PTS) Operations Manager will be informed of the criticism.

1.3.2. Legal Services will then refer the case to the Medical Director, for a view on the standard of care provided and causation; and to the Education Governance Manager for a view on compliance with training and protocols. The Medical Director and Education Governance Manager will provide their views to Legal Services, subject to legal privilege.

1.3.3. Legal Services will establish whether the family are legally represented and ascertain that LAS have all relevant documents prior to the inquest, for example call records, statements and transcript. The Head of Legal Services will decide whether the Trust requires legal representation at the inquest.

1.3.4. When crews or EOC staff are required to attend an inquest, support will be provided by one or more of the following:

- AOM/ Duty Station Officer (DSO)/Team Leader/ Training Officer,
- AOM EOC/ Operations Centre Manager/ Sector Controller,
- Department of Education & Development / EOC Training Department,
- Legal Services,
- Communications Department,
- PTS Operations Manager

1.3.5. The AOM /DSO /Team leader /Training Officer /PTS Operations Manager, and where necessary, Legal Services will attend the Inquest with the staff. Managers attending the Inquest to provide support should be aware that they may be asked questions by the Coroner. The AOM Control Services will provide support and advice in respect of questions about EOC. The Department of Education & Development will provide support when issues around patient care are highlighted. Legal Services will provide support in explaining the court rules and order of proceedings, and ascertaining the line of questioning and possible concerns – in relation to the LAS - of the Inquest. Communications' role will be to support the LAS in case of any media presence at the inquest.

1.3.5. Legal representation will be obtained in accordance with best practice and advice from the NHS Litigation Authority (NHSLA).

The criteria for obtaining legal advice will be:

- when it is advised that the Inquest is being held before a jury, in which the other parties are legally represented and criticism against the LAS may be expressed,
- where there is a possibility that the Inquest will be followed by a claim against the LAS

1.3.7. Where staff are required to attend, the AOM / PTS Operations Manager will maintain on-going liaison with Legal Services, who will in turn keep the Coroner's Officer informed.

1.3.8. A meeting between all relevant staff and support services will take place prior to the inquest to ensure continuity and avoid deviance from the agreed approach.

2.0 Providing Witness Statements

2.1 Where staff are required to prepare a written statement, either for a Coroner's inquest or in response to a Police enquiry where an interview is not being held, staff will be stood down to prepare the statement at a time designated by their Management Team.

2.2 EOC will comply with the request and ensure that the operational staff are stood down from duty at the appropriate time and venue. EOC shall not interrupt the crew member unless a major incident is declared or an immediately life threatening call (RED 1) is being held in the local area.

2.3 Before the statement is forwarded to Legal Services or the police, it should be checked by a member of the Complex / Watch Management Team.

2.4 A copy of any written statement should be securely retained at the main station or on the PTS staff member's file at Sector.

3.0 Police Enquiries – Responding to Enquiries

3.1 Any information recorded about a patient may not be disclosed to the police without the patient's consent or a Declaration Form for Data User (Police) LA 414 being completed. Copies of the declaration form can be obtained from the LAS' intranet, and when completed, faxed to the Operational Information and Archives Department at Bow.

3.2 The police must contact Operational Information Dept. (Mon-Fri 09.00 to 17.00) in order to identify the ambulance staff involved and when requesting information such as incident related call records and /or audio tapes of calls (see section.5.2 'Disclosing Patient Information to the Police' in TP/009 Policy for Access to Health Records).

3.3 Operational Information Dept. will raise an Enquiry Form LA411 and provide police with a Declaration Form for Data User (Police) which must be completed and returned to the department by fax on 020 7887 6690, along with a 172 which is the police form for Patient/Next of Kin Consent.

3.4 On receipt of the completed Declaration Form for Data User (Police), Operational Information Dept. will retrieve the necessary records from archives and, pass the relevant documents and staff details to the police.

4.0 Arranging Police Interviews with Staff

4.1 For EOC staff, Operational Information will:

- contact EOC Resource Centre to ascertain the availability of the identified control staff,
- inform and submit the relevant documentation to the AOM,
- notify the police when the staff are next on duty and agree a mutually convenient date and time with the police at LAS headquarters.

4.2 The appropriate AOM, Control Services, will be responsible for:

- arranging stand down of the member of staff at the appointment time with the police
- ensuring that the member of staff is accompanied and supported by an appropriate manager if not the AOM.

4.3 For operational staff, Operational Information Dept. will:

- notify the police of the ambulance station and telephone number at which the operational staff may be contacted via the AOM / PTS Operations Manager.
- Provide a copy of the relevant patient report form for the AOM to pass to the member of staff being interviewed.

4.4 The AOM / PTS Operations Manager has responsibility for ensuring the following actions as appropriate:

- arranging through the Resource Centre an appointment time and the venue for the interview,
- notifying the operational staff of the time, date and venue of the interview,
- notifying the police and confirming the arrangements,
- ensuring ambulance staff are accompanied and supported by an appropriate member of the Complex Management Team at the interview,
- obtaining relevant call records from Operational Information Dept. using 'Operational Information & Archives Enquiry Declaration Form' (LA413 for all users) and faxing to: 020 7887 6690.

4.5 The Resource Centre will notify the EOC Loggists of the arrangements made with the police for the staff interviews.

4.6 For all staff, EOC will comply with the request and ensure that the staff are stood down from duty at the appropriate time and venue. EOC shall not interrupt the interview unless a major incident is declared. Should a crew be interrupted, EOC must arrange for the crew to complete their interview at the earliest opportunity.

4.7 At the conclusion of the interview it is the responsibility of the operational staff to report their availability directly to EOC / PTS site control.

4.8 Should the police enquire directly to an ambulance station or EOC out of hours and at weekends, an LA 414 -'Declaration Form for Data Users (Police)' – may be given to the police for completion and faxed to Operational Information (see 3.3). This form can be located on the Pulse.

4.9 At no time should Patient Report Forms (PRFs) be released to the police without a signed LA414 as this could not only jeopardise the court case but also leave the LAS member of staff open to criticism.

5.0 Interviews under caution

5.1 Where staff are interviewed under caution, they have a right to be accompanied by a legal representative. In the event that a legal representative cannot be obtained through membership of a trade union, a legal representative will either be obtained by the authority interviewing under caution or by the LAS. If the LAS is arranging a legal representative to be appointed on behalf of the member of staff, this will be done under the instruction of the Head of Legal Services.

5.2 When notification is received that a member of staff is to be interviewed under caution the AOM / DSO / PTS Operations Manager / Support Services line manager will:

5.2.1 Inform the Deputy Director of Operations / other Director as required and the Assistant Chief Ambulance Officer and recommend whether the Serious Untoward Incident Policy / Procedure should be invoked.

5.2.2 Ascertain whether the member of staff can arrange to be accompanied and supported at the interview by a legal representative.

5.2.3 Arrange for the member of staff to be stood down at the interview.

5.2.4 Request a copy of the signed witness statement from the interviewer.

5.2.5 Arrange for immediate and ongoing support to the member of staff interviewed under caution.

6.0 Miscellaneous enquiries – Solicitors, Insurance Companies and members of the public

6.1 On occasions enquiries are made direct to ambulance stations / EOC requesting ambulance staff making a statement or seeking information and records. All such enquiries must be referred to PALS, Bow. PALS will refer solicitors to ambulance stations to make the arrangements for staff to be interviewed.

7.0 Review and Monitoring

7.1 The effectiveness of the arrangements in this Procedure will be reviewed by the Head of Legal Services two years after issue or following any legislative changes that govern the conduct of Coroners Inquests, whichever is the sooner. In addition the relevance and effectiveness of the Procedure will be considered in the Round Table Reviews of

contentious Inquests and the summary results reported to the Area Governance Groups and Clinical Governance Committee at six monthly intervals. In particular staff who are called to give witness evidence at a Coroner's Inquest or when interviewed by the police, whether or not under caution, will be asked to comment on how well they felt supported, and whether and how this could be improved in the future.

Appendix 1

London Ambulance Service NHS Trust

Information to be provided in witness statement:

The following details should be included in a witness statement and are intended to guide staff who have been asked to produce a witness statement for a Coroner, the Police or following an untoward clinical incident.

- Name and Job Title
- Length of Service with the LAS and period of time in current role
- Times recorded on the Call Assignment Form, Patient Report Form e.g. time of dispatch, arrival etc.
- Any difficulty encountered in locating the patient/location
- Brief details (where known) of other people present on scene with the patient
- Details obtained about the patient's condition from the patient, relatives, friends or bystanders
- Conversations recalled with other people who were present
- Details of the treatment provided to the patient, measurements taken, and drugs, oxygen etc administered from arrival on scene until the patient was handed over to hospital staff
- Evidence of drug or alcohol abuse - comments which cannot be substantiated, e.g. he was drunk, or are speculative in nature, should not be included
- Comment on any criticisms made about personal involvement

Do's and Don'ts

- Do write the statement in chronological order.
- Do give as much detail as possible about the patient's condition, the advice and treatment given.
- Do write own statement and do not do this jointly with another witness such as a crewmember. If asked to give evidence in Court at a later stage, the evidence required will be about personal actions and observations.
- Do sign and date each page of the witness statement.

- Do not make up anything that cannot be remembered and was not recorded.

- Do not include opinions about the patient or others, keep to the facts.

- Do not include abbreviations unless these are explained in full.

Example of Draft Outline for a written statement:

On (..date..) at (..time..) I was a member of a LAS crew with (..name..). A call was passed to me / us at (..time..).

I / we attended (..address..). This was a (house/flat/street/other public place) in a part of London where traffic and parking conditions were (…give details if there was a delay in arriving). I / we had been told that (brief initial message). I / we arrived at (..time..).

I / we were faced with (..describe situation..). I / we did (..this..) and we did (..that..). Also present were (..names of people..).

We placed the injured person in our ambulance (… describe how the patient was conveyed. We arrived at (..hospital..) at (..time..) and handed over the patient to (..hospital staff..).

This statement is true to the best of my knowledge and belief.

Name (print):……..

Signature:……..

Date: …..……

Page number: …… of ……. (total number)

Appendix 4

London Ambulance Service NHS Trust

Procedure on Actions on Scene INDIRECTLY Related to the Patient

Introduction

Whilst attending the scene of a call staff frequently face many operational issues that affect but do not directly involve the patient, some of which include liaison with other agencies.

This procedure aims to capture the most common of these situations and provides direction and guidance for staff on how they should be managed.

Objectives

1. To ensure that staff are appropriately advised of the action to be taken on scene, in the most commonly occurring issues that are not directly patient related.

2. To ensure that adequate support is available for staff to call upon when working in vulnerable situations.

3. To minimise risks that can occur whilst on scene.

Procedure

1.0 Safety on Scene

1.1 When on scene it is paramount that ambulance staff first protect themselves, their colleagues, the patient and any other persons on scene. Once ambulance staff arrive at an incident, there may be instances where further Personal Protective Equipment (PPE) may be required. If the scene is for any reason considered unsafe, staff should initially withdraw and immediately contact the Emergency Operations Centre (EOC).

1.2 Close liaison must be maintained at all times with other emergency services and, where appropriate, the senior safety officer or other responsible person on scene.

2.0 Forced Entry by Ambulance Staff

2.1 In the instance of ambulance staff being unable to gain access to a property they should contact EOC to confirm the address and that full information has been received.

<u>Action to be taken by EOC</u>

2.2 Before authorising a crew to make a forced entry into a private property, EOC should carry out the following checks in:

- Listen to the tape recording and confirm that the telephone number and address are correct
- Ring the telephone number provided
- Contact the police and advise them of the potential for a collapse behind locked doors
- Ask the crew to establish from neighbours information on the occupant and the location of spare keys to the property if available
- Once EOC is satisfied that there is likely to be an occupant in the premises that requires *urgent* medical help, permission should be granted to the crew to make a forced entry, if police are not in attendance. This is in accordance with the IHCD Training Manual. The patient should be seen or heard to be in distress before an entry is forced and their consent should be sought where possible

2.3 Staff should carry out a dynamic risk assessment, balancing the need for a fast entry, with their safety. Following this assessment, an entry with the minimum amount of damage and minimum personal risk may be attempted.

2.4 In the instance of a forced entry it is critical that EOC is made aware as soon as possible. EOC staff will advise the police and unless the patient's condition is deteriorating quickly, the crew should remain on scene until arrival of the police.

2.5 Where the patient's condition requires immediate evacuation, an attempt should be made to secure the premises in the best way possible and to leave it looking visibly secure. Depending on the circumstances it may be appropriate to ask a neighbour to look after the premises until the police arrive.

2.6 Any break in to a property should be documented on the PRF including the reasons for doing so, the condition of the patient and the security state of the property on departure.

3.0 Staff Attitude and Behaviour on Scene

3.1 As representatives of the LAS, ambulance staff should ensure that they conduct themselves in a manner that reflects both their own and the Services professional standing. A professional approach includes:

- the correct wearing of uniform in accordance with the LAS Dress Code for Uniformed Staff,

- body language that imparts sympathy and understanding,

- interpersonal and clinical skills that allow ambulance staff to assess each patient in a calm, confident and methodical manner.

3.2 Staff should be aware that their actions on scene may be witnessed by third parties who may feel that an action, inaction or statement is inappropriate for the circumstances. Staff should make every effort to explain their actions to those who have reasonable cause or grounds to request such information.

3.3 A patient's behaviour may at times appear unreasonable, but despite this staff should not be drawn into arguments. Any problems should subsequently be referred to a line manager and documented on the PRF.

3.4 Disagreements between LAS staff or with other Health Care Professionals must never take place in public places or in view or hearing of the patient or public.

4.0 Road Traffic Accidents (RTAs) not previously given as RTA

4.1 If, on arrival at scene, staff discover the call falls within the remit of the Road Traffic Act (this includes incidents such as falling from a bus) they should inform EOC as soon as possible and in the case of personal injury request the attendance of police. If the police have not arrived before conveying a patient, the crew should again, inform EOC of this fact and the hospital to which they are conveying.

5.0 Manual Handling

5.1 Ambulance staff should undertake a risk assessment of the situation in which they find their patient. If they estimate any factors to be beyond their capabilities then the assistance of a second ambulance crew or other services should be sought.

5.2 The rear suspension of the vehicle should be lowered when loading and unloading patients. Walking patients should use the hand rails provided to assist themselves into and out of the vehicle. Ambulance staff will need to give additional guidance if the person is injured, disabled, hard of hearing or has impaired sight.

5.3 Ambulance staff can request assistance from responsible personnel such as police officers, nursing and porter staff and members of the public but they must give clear and concise instructions and not ask them to undertake any activity that is obviously beyond their capability or which they are reluctant to do.

5.4 Staff should use all available lifting aids that they have been trained to use. If other lifting equipment is available on scene, for example, hoists, consideration should be given to allowing only the persons trained in use of the equipment to assist in the lift.

5.5 Ambulance staff called to attend patients in Care Homes are duty bound to fully examine, assess and treat appropriately. If it is necessary to lift the patient, staff should seek alternatives to manual handling such as hoist and slides if suitably qualified persons are present.

5.6 If patients in Care Homes are found to be uninjured the responsibility for lifting should be passed back to the Care Home staff.

6.0 Criminal Offences on Scene

6.1 Everyone has a responsibility to report a suspicion of criminal offence. Ambulance staff, in common with other NHS staff, also have a duty of confidentiality towards their patients. These priorities need to be balanced to ensure that appropriate medical care is provided for all patients whilst alerting police to a crime or crime scene.

6.2 If ambulance staff believe or suspect that their patient is involved with a crime they must continue to treat that patient and, if necessary, convey to hospital. Staff must immediately tell EOC, or advise the hospital staff, to inform the police of their suspicions or evidence. In any event, EOC must always be informed so that the call record can be endorsed.

6.3 Where there are unusual or suspicious circumstances, staff should take reasonable precautions to preserve the potential crime scene, and await, if appropriate, the arrival of the police.

7.0 Delays on Scene

7.1 Ambulance staff must report all delays on scene in excess of 15 minutes to EOC by the expiry time of the delay and keep them subsequently regularly updated. Ambulance staff should record delays on the PRF and EOC will also record all delay reports on the call record.

8.0 Safeguarding of Children

8.1 If the removal of a patient to hospital will result in a child being left unsupervised, ambulance staff must either convey the child/children or contact EOC to arrange for the police to attend and assume responsibility. This action should not delay the patient's conveyance to hospital. If the patient's condition is serious and children are to be left alone, then the urgency for the police attendance must be indicated.

8.2 There is no minimum age at which a child may be left unsupervised. Legally, no offence is committed until the child comes to harm, at which point the responsible adult can be prosecuted for failing to ensure their safety. As a guide, a person is considered a child in this context until the age of eighteen.

- If a child is under fifteen years, staff should make arrangements as in 8.1,

- Children between fifteen and eighteen years may be temporarily left alone if staff are confident of the child's ability to care for themselves. If in doubt staff may make arrangements as in 8.1. If the child is left at home the receiving A&E nurse/doctor must be notified at hand over and the occurrence documented on the PRF.

8.3 If an unrelated adult, e.g. a neighbour offers to take responsibility for the children, and the patient/carer is not able to approve the arrangement then ambulance staff must inform EOC to request police attendance.

9.0 Security of Property

9.1 Wherever possible the patient's property should be left with the patient, or a person accompanying the patient (where it may reasonably be assumed that such a person may held to be acting in the interests of the patient). There may, however, be some circumstances, where the patient, or any other person, is unable to take responsibility for the patient's property and, in these instances; the items should be taken to hospital with the patient, using the designated patient property bag. The bag should be sealed in the presence of the patient, the details completed and a record of the bag number made on the PRF. The bag should be passed to hospital staff at the handover of care; the tear-off strip should be attached to the PRF copy given to the hospital, or provided to the patient, if necessary around the patient's wrist.

9.2 If, however, the property is bulky and not easily transportable, for example a bicycle, attempts should be made for it to be secured at scene and only as a last resort stored as securely as possible in the vehicle and conveyed with the patient. Arrangements should be made at the hospital site for the secure maintenance of the item, and for the patient to be notified accordingly by hospital staff. Any action should be documented on the PRF.

9.2 Ambulance staff should always check the cab/saloon of the ambulance for patient property before leaving the receiving unit. If any item is encountered, the procedure described in paragraph 9.1 should be adhered to.

9.3 The Patient Advice and Liaison Service will host enquiries relating to patient property. Where information is not documented on the PRF, the matter will be referred to the relevant complex management team to resolve matters locally. Local managers should be aware of the requirement to advise an enquirer of their right to make a formal complaint and/or a compensatory claim. In this event the matter should be referred to the appropriate department.

10.0 Safeguarding the Welfare of Animals

10.1 If it is brought to the attention of ambulance staff that a patient in need of conveying has sole responsibility for an animal, reasonable measures should be taken to ensure that the animal is subsequently cared for.

10.2 If the patient is in a public place when receiving emergency care and has an animal with them, ambulance staff should ascertain whether there is an appropriate person on scene to take short term responsibility. EOC should then be informed to contact the police. As a last resort and at the discretion of staff the animal may be conveyed with the patient. Guide dogs must be conveyed as a matter of course.

10.3 If the patient is in their own environment and a neighbour is available it may be appropriate to ask them to ensure the animal is looked after. If not, then ambulance staff should contact EOC and they will inform the police.

11.0 Removal of Equipment/Soiled Dressings/Sharps

11.1 No used equipment, soiled dressings or sharps should be left on scene. If waste is generated at any time whilst attending a patient, it must be disposed of in a healthy and safe manner. Once sharps are used they must be put into a sharps container immediately. Clinical waste must be put into a yellow bag for incineration and general waste into the appropriate receptacle. This is in accordance with the LAS Infection Control Manual.

12.0 Persons Wishing to Accompany the Patient

12.1 Patients often wish to be accompanied by their friends or relatives to hospital and this should be accommodated where possible. In allowing 'escorts' the attendant should consider the following factors:

- Maximum loading on the vehicle, including patient and ambulance staff should not exceed 6 people,

- Escorts who are themselves distressed may have an adverse effect on the patient,

- Ambulance staff safety is paramount – escorts who appear drunk/disorderly may compromise that safety (especially if two or more). Equally, refusing an escort may aggravate the situation and will require careful judgement by the crew,

- If the patient is in cardiac arrest, or arrest is imminent, a relative / close friend will be helped through the process by seeing that everything possible is being done. If the decision is taken not to convey the relative / close friend with the patient, consideration should be given to arranging alternative transport.

12.2 In general terms, the work of the attendant is best achieved with the minimum number of 'escorts' in the vehicle. If the attendant decides not to allow escorts, this message should be conveyed with sensitivity, tact and diplomacy.

13.0 Observers

13.1.1 There are frequent requests for observers to accompany ambulance crews on A&E or Patient Transport Services (PTS) vehicles. Approval for observers on either A&E or PTS vehicles can only be authorised once the procedures laid out in TP/ 014 '*Procedure for Ambulance Observers*' have been followed.

13.1.2 When such arrangements have been approved, the observer, regardless of their status, qualifications and training must not become involved in the care and treatment of patients unless specifically requested to do so by ambulance staff.

13.1.3 Observers should be clearly identified by wearing an LAS fluorescent jacket marked 'Observer'.

Appendix 5

Clinical Audit & Research Summary Reports for the Trust Board

Summary of findings from the National Ambulance Clinical Performance Indicator Pilot

Author: Dr. Rachael Donohoe

Background

In May 2007, a set of five national Clinical Performance Indicators (CPIs), based on clinical areas proposed by the Directors of Clinical Care of ambulance services, were developed by a sub-committee of the National Ambulance Clinical Audit Steering Group. These CPIs were piloted and the results have been used to inform the national ambulance CPI programme. The aim of this programme is to enable benchmarking of clinical care across ambulance services in England, to drive quality improvement and ensure consistency of care.. The five CPI areas selected were: stroke (including transient ischemic attack); acute myocardial infarction (STEMI); cardiac arrest; asthma, and hypoglycaemia.

All ambulance services in England contributed to the pilot, which concluded at the end of March 2008. Submission of data to the pilot was adopted by the Healthcare Commission as one of the 2007-2008 standards for ambulance services.

As a result of the pilot, the National Ambulance Clinical Audit Steering Group (chaired by Rachael Donohoe) refined the indicators and designed three further cycles of data collection beginning in May 2008 and ending in November 2009. Data from the first and second cycles of the National CPI programme (non-pilot) will be used by the Healthcare Commission (HCC) in the 2008-09 performance ratings. The HCC has yet to formally agree how they will collect this information.

To support the national CPI programme, and in particular the collection and reporting of data, funding has been awarded by the Department of Health under '*Clinical audit, registries and related activities'* to develop a National Ambulance Clinical Performance Indicator Registry. This initiative is being led by East Midlands Ambulance Service and the University of Lincoln, and supported by the National Ambulance Audit Steering Group.

Method

A period for data collection of one month was allocated to each CPI area. Within the set data collection periods, ambulance trusts were requested to extract data from the first 300 records (or up to 300 if there were fewer than this) for each CPI. Data were entered onto specifically developed data collection templates and submitted to a Clinical Data Analyst based at East Midlands Ambulance Service who co-ordinated the pilot process, undertook data analysis and produced the pilot CPI report.

Findings

The table below presents a comparison of the LAS's compliance scores against the national average compliance rating. Compliance scores represent the documentation of the delivery of appropriate care or a valid exception to care being delivered.

Indicator	LAS Compliance	National Average Compliance*
STEMI		
Initial pain assessment	94%	70%
Final pain assessment	92%	52%
Aspirin administration	99%	80%
GTN administration	99%	76%
Stroke		
Fast assessment	88%	76%
Blood glucose measurement	96%	73%
Blood pressure measurement	99%	95%
Cardiac Arrest		
ROSC on arrival at hospital	30%	21%
Response time between 0-3 mins	12%	10%
Response time >8 mins	19%	35%
Hypoglycaemia		
Blood glucose measured before treatment	99%	97%
Blood glucose measured after treatment	97%	82%
Treatment recorded	99%	79%
Asthma		
Respiratory rate recorded	100%	95%
Peak flow recorded	55%	27%
SpO2 recorded	77%	77%
Beta 2 agonist given	91%	85%
Oxygen administered	91%	79%

** averages are based on scores from all ambulance services*

Discussion

The LAS scored than the higher than or equal to the national average for all indicators.

A breakdown of the results by ambulance service is available in the national CPI pilot report, a copy of which can be obtained via the Clinical Audit & Research Unit. Inspection of the data contained within the report further shows that in addition to scoring higher than average, the LAS consistently scored higher than all other ambulance services on the majority of measures.

Although higher than the national average compliance score, there is room for improvement by the LAS with regards to documenting a peak flow measurement when treating asthma patients.

It is interesting to note that the clinical areas measured as part of the national CPI pilot are the same as those areas already assessed by the LAS as part of our own CPI programme. The quality improvement evidenced through our CPI programme will have contributed to the finding that the LAS's compliance scores are so much higher than those of the other services.

Note: These results are also presented in the form of funnel plots, or 'trombonograms.' Illustrative examples will be available at the Trust Board meeting.

Appendix 6

Examples of the management of 'Frequent callers'

A series of illustrative cases are attached. The first section deals with high volume callers where interventions have resulted in the LAS being able to close the investigation into a specific case (case number used as identifier); the second deals with ongoing investigations.

Closed cases – high volume callers

12681
Behavioural problems. 1194 calls since 1/1/07 to 18/02/08
Majority of the calls relate to anxiety attacks and with no need to attend hospital. Ongoing collaboration with Mental Health team and Social Services in devising 'No Send' Policy for this patient. Police now considering sanctions due to threatening behaviour to crew. Patient moved into residential warden control home. No further calls.

1275
Behavioural problems. 338 calls from 5/1/07 to 4/2/08.
'Prohibitive Activity Order' imposed by Court. Condition of order requires patient to call third party if she needs an ambulance and they will assess her needs. Call rate had has almost stopped. Arrested twice since Order established. Now deceased, no ramifications relating to Order or LAS. LAS leading review of care management with invitations to other agencies.

17800
Anxiety/panic attacks. 299 calls from 1/1/07 to 27/01/08. Patient's details provided to Lewisham PCT 'Patient At Risk' Forum. Extensive therapy now in place. No further calls.

11926
Behavioural problems – 616 calls from 1/1/07 to 18/02/08.
Ongoing monitoring. Approached Bromley police to begin legal process with the support of the PCT & GP. MH section April 2008. Now undergoing psychiatric therapy. Awaiting discharge meeting. No further calls.

16169
Behavioural problems. 654 calls from 1/1/07 to 18/02/08
'No Send' policy put in place. Frequency of attendances down but evidence used to relocate patient to nursing home in Kent. No further calls.

16850
281 calls from 1/1/07 to 30/4/08.
PCT/Social Services alerted. Patient now in hospital and awaiting discharge meeting. Patient will be offered placement in a nursing home.

16121
Relocated to nursing home - January 2007

8192
Relocated to nursing home – January 2007

19053
9/1/07 to 26/10/07 – 19 calls. No further calls . Care package put in place.

16138

Last call 16/01/07. Third party intervention arranged. No further calls

1605

Relocated to nursing home - January 2007

15272

1/1/07 to 5/5/07 – 131 calls. Relocated to residential home – May 2007

16654

Sickle cell disease patient. 62 calls from 1/1/05 to 10/9/07. Travels across London and visits every A&E for pain relief. Sickle cell centre intervention. No calls since 10/09/07.

12582

Behavioural problems. 359 calls from 1/1/07 to 9/1/08.
Family intervention. No calls since 4/7/07.

8910

508 calls from 1/1/07 to 1/2/08
Arranged meeting with Waltham Forest Social Services, case conference held on 21 February 2008. Patient moved to nursing facility. No further calls.

15463

Frequent Faller. 218 calls from 1/1/07 to 18/1/08.
Intensive care package put in place. Calls stopped until 18/1/08. Readmitted to hospital. On discharge extensive care plan now in place. No further calls.

12988

Frequent faller –160 calls from 1/1/07 to 18/02/08. Liaison with Havering PCT and Community Matrons. However, patient deceased before review assessment.

<u>Ongoing caseload – High volume callers</u>

5503

Behavioural problems – 422 calls from 1/1/07 to 18/02/08
Community matrons now refusing to visit. 'No Send' policy in place – weekly review.

17302

Frequent faller – 82 calls from 1/1/07 to 18/02/08
Liaison with Enfield PCT and case conference requested. Awaiting review outcome.

12130

Frequent Faller - 62 calls from 1/1/07 to 17/02/08.
Liaison with Lewisham PCT. Awaiting outcome of review.

7913

DIB/Chest pains - 157 calls from 1/1/07 to 18/2/08.
Contacted GP & Community Matron. - Case conference requested.

13152

210 calls from 1/1/07 to 18/02/08.
Community matron and local rep in consultation to review case, working with the GP to re-house the patient in sheltered accommodation. Case conference arranged.

19053

192 calls from 1/5/07 to 19/208
Social services referral made. - patient to be re-housed in sheltered accommodation.

3503

302 calls from 1/1/07 to 5/3/08. Mental Health history.
Police and housing officers have both talked to patient and raised the prospect of eviction or imprisonment if calls continue. Last call 14/3/08.

20596
112 calls from 1/1/07 to 30/4/08. COPD patient. Case conference requested.
1543/4072
411 calls 1/1/07 to 10/04/08. Mental health patient/substance abuse
Ongoing liaison with Community Matron/GP/Mental Health Team.
19912
153 calls 01/01/07 to 11/06/08.
Frequent faller –Community Matron intervention agreed. Last call 11/6/08.
20012
COPD patient. Patient managed by Community Matron. Existing Patient Specific Protocol (PSP), devised by ECP, does not address care requirements. Ongoing multi-agency liaison. Single responder proposed and trialled for 6 weeks period.
16714
155 calls from 1/1/05 to 6/6/07; 120 call from 1/7/07 to 10/4/08
Initial research and background being undertaken; Community Matron intervention and care plan revision proposed.
19903
124 calls from 01/01/08 to 10/03/08. Mental health patient.
Liaison with mental health service provider.
21016
110 calls from 01/01/08 to 18/4/08. DIB caller. Case investigation and research initiated.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

CAD 2010 FBC
(Part 1)

1. Sponsoring Director: Peter Bradley

2. Purpose: For Noting

3. Summary

The objective of the CAD 2010 Project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. Full details of the project have been continually reported to the Trust Board.

At the Service Development Committee on 24th June 2008 (under delegated authority from the Trust Board), the evaluation Tender Report and draft version of the Full Business Case (FBC) (V1.0) were approved. Specifically the following recommendations were accepted:

- Note the content of the Evaluated Final Tender Report, the recommendations of the Procurement Team and the CAD 2010 Project Board's selection of Northrop Grumman Information Technology Global Corp. as the preferred supplier.
- Accept the draft FBC ahead of finalisation as outlined in section 3.
- Approve the selection of Northrop Grumman Information Technology Global Corp. as the preferred supplier of CAD 2010.
- Approve work to commence with the preferred supplier on the basis of a letter of intent, in accordance with standard financial instructions capped at £750K, with an agreed reporting structure back to the Board. This would only be paid if there was a failure to agree contract terms and the procurement did not proceed.

The next stage is to gain approval from the Trust Board to submit the FBC to the Strategic Health Authority (SHA). Following their support, the Trust Board will be able to ultimately sign a contract with Northrop Grumman. For reasons of commercial confidentiality the FBC, Appendices, Gateway report and Solicitors report will be reported to the Trust Board in Part 2 of the meeting.

4. Recommendation

THAT the Trust Board NOTE this update.

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

Review of Fleet Support Services

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: For approval.

3. Summary .

A presentation was made to the Senior Management Group (SMG) on 11th June following the completion of the Review of Fleet Support Services. The SMG agreed that a submission could go forward to the Trust Board on 29th July.

The review of Fleet Support Services commenced in December 2006 and involved a comprehensive review of Workshop numbers and locations, operating hours, shift patterns, and potential additional services. A Working Group met on a regular basis and produced a report in August 2007 recommending a number of options for the future delivery of services.

Consultation was carried out in the Autumn of 2007 with Fleet Workshop staff and Operational colleagues which led to some refinement of the options and new proposals.

Following this, ORH were commissioned to produce modelling based on a number of Workshop sizes and configurations and hours of operation. KPMG were asked to prepare Business Case information around the risks, costs, and benefits of the various options.

A further round of consultation has since been carried out with fleet and operational staff following receipt of the ORH and KPMG data.

The conclusion drawn from the various strands of work is that there are significant operational benefits in establishing 2 large Workshops, supported by mobile facilities, working a 24/7 shift pattern. This will reduce Vehicle Off Road (VOR) time and assist in reducing the overall size of the vehicle fleet. In addition a number of additional services, such as bodywork repairs and MOT work can be introduced.

Further to the SMG meeting held in June, the Fleet Staff Side Committee was advised of our intention to seek the agreement of the Trust Board to implement the changes outlined in the submission. A letter was also sent to all fleet staff advising them of our proposed course of action

4. Recommendation

THAT the Trust Board APPROVE the recommendation that a two Workshop configuration be established.

Review of Fleet Support Services

Executive Summary

1. The purpose of the review was to examine a number of Workshop configurations and operating scenarios to see if additional services could be developed. The primary aim of any potential changes was to reduce vehicle downtime and provide robust support for operational developments in a cost-efficient manner.

2. The review was initiated in late 2006 with a Working Group set up to look at options to improve the efficiency of the Workshops. A report from the group identified a number of key areas that would improve the situation; these included the extension of some Workshops and fewer but larger Workshops working extended hours.

3. The following options agreed by the original Working Group formed the scope of the modelling work carried out by Operational Research in Health (ORH).

    - To examine options to extend current Workshops and identify 'Brownfield' site locations against criteria to minimise vehicle to Workshop journey times.
    - An appraisal of the relative efficiency of the Workshop configurations against vehicle off road times (VOR).
    - An appraisal of the staffing levels required for each option.
    - Assessment of the impact of the above options on the ferrying of vehicles to and from Workshops.
    - The impact of extended working hours (06.00 – 22.00) and twenty four seven working.

4. KPMG was engaged to produce a model to compare the options based on the recommendations from the ORH review. The scope of their assessment was to include all operating costs associated with Fleet and Workshops and assess these against the preferred options. Risk analysis and benefit realisation were also to be explored.

5. As part of the overall business case, KPMG also looked at the option to outsource the Fleet and Workshop function. Their approach was to assess the markets' reaction to a generic tender and measure the cost and service approach from different providers.

6. The model that was generated by KPMG from LAS inputs gave the basis for the financial assessment for the business case.

    Additional Services are a key element to improving the efficiency of the Workshops and the following areas were considered under the review process:

- Body and Paint Shop
- Electrical and Communications
- MOT testing
- Deep Cleaning and Wash facilities
- Comprehensive stores facilities
- Training Room
- A comprehensive twenty four seven Mobile Workshop Service

7. The ORH modelling (Table 1) identified that it would be difficult to extend our existing Workshops from both a planning and environmental perspective. In addition to this there were no improvements in VOR from the modelling. With this in mind we have disregarded these options. The modelling for the 'Brownfield' site options for two, three and four Workshops gave strong support for these and recognised that good improvements in VOR could be achieved. When this was examined further and twenty four seven working was introduced over extended hours we saw a further improvement in VOR.

8. When we outlined the terms of reference for KPMG we decided to remove the option to extend existing Workshops for the reason given previously; also at this stage we removed the four Workshop option because of site location difficulties in the North and there was no operational benefit from the additional site.

9. KPMG's analysis from LAS inputs has shown there are no clear financial benefits between the two and three Workshop models and when consideration is given to either extended hours or a twenty four seven operation again we saw little change in costs (Table 2).

10. Analysis of the Outsource option has proven to be a challenge with cost comparisons difficult to assess. Only two service providers responded to the tender, both with different solutions to the management of the Fleet, which has demonstrated how difficult it is to give a balanced approach to the analysis.

11. We believe the Hitachi approach to managing the Fleet is flawed and certainly their costs imply they will be no more than a management arm directing vehicles through an existing network of repairers. We feel this approach places LAS at an unacceptable risk to unreliable service and maintenance support.

12. The Venson approach is similar to that of the model from ORH, two Workshops in the East and West newly built and solely dedicated to the LAS fleet. Whilst the benefits of the outsourcing approach are expected to be significant, the current costs of this option mean that it is not cost-effective. There are additional VAT benefits which have not been considered in this assessment of costs but these have been excluded in line with NHS Guidance on production of business cases.

13. We would recommend that the outsourcing option be re-reviewed once the efficiencies of moving to the new configuration have been realised internally, rather than passing this benefit directly onto the outsourcing provider.

14. Taking account of:

    a. The size and geographical spread of the Fleet
    b. Additional services planned to be brought in-house and
    c. The risk-adjusted Equivalent Annual Cost (EAC) per weighted benefit point for each option (table 7)

    We would like to recommend to the Trust Board that two Workshops are located to support current and future LAS Fleet requirements, located in the West and East of London.

Introduction and Background

15. An internal review of Fleet Support Services commenced in the winter of 2006. Previous attempts to carry out this process had been undertaken by consultants before there was any engagement from Fleet or Operational staff. This had led to a lack of commitment to participate in the process from staff. The findings of a previous ORH study were also considered to be flawed as significant vehicle maintenance data was not effectively captured and only A&E vehicles were included in the modelling.

16. After significant effort and negotiation, Fleet Staff representatives agreed to participate in a process to review the operation of vehicle maintenance and repair services. It was agreed that a Working Group would be established under the chair of the Deputy Head of Fleet, Colin Gerald, to further this initiative. The group consisted of staff side representatives and workshop staff, and managers and administrative staff from Fleet and Operational Support. It was agreed that this group would consider existing arrangements and scope potential options for future change. Once these options were produced, operational colleagues would be consulted.

17. This approach was adopted to ensure that fleet staff took some ownership of the process, which they accepted was transparent and consistent. Previous attempts to establish a working group of Fleet and Operational staff had proved difficult to achieve. Fleet staff ultimately withdrew from this process.

18. The Working Group agreed Terms of Reference for the review. The group would consider the number and spread of vehicle workshops, hours of operation, number of staff, the use of mobile resources, and the potential for additional services. It was agreed the group would meet at regular intervals during 2007 to produce a report and recommendations.

19. The Working Group analysed existing working arrangements and considered how these might be enhanced to produce improved services. From this work a number of options emerged for further consideration; these included proposals for expansion to the existing thirteen workshop model; nine; eight; four and

two workshops. Extended working hours were considered for all options along with enhanced mobile services. There was also considerable interest in the idea of employing "ferry drivers" to move vehicles between stations and workshops.

20. An option scoring matrix was used to assess the various workshop options. The 4 and 2 options scored heavily based on the potential for new services, staffing resilience, and the establishment of a Fleet Resource Centre.

21. A report of the work covered by the working group was produced in August 2007. A number of potential options for further consideration and assessment were recommended.

Workshop Modelling

22. ORH was engaged to carry out an analysis to establish the optimum number of Workshops and their locations.

23. This report presents key findings from the analysis and modelling work over a twelve month period to December 2007. Their terms of reference and scope were agreed over a number of meetings with the Head of Operational Support and the Project Manager and are as follows:

Terms of Reference:

a. Identification of current Workshops where extension to existing buildings is feasible from both a planning and environmental perspective. To consider minimising average vehicle to Workshop journey times to those Workshop options.

b. Identification of 'Brownfield' site locations against minimising average vehicle to Workshop journey times.

c. An appraisal of the relative efficiency of Workshops based on the location analysis and configuration that will demonstrate improvements in VOR.

d. A broad appraisal of Staffing levels required for each option.

e. Assessment of the impact of the above options on the ferrying of vehicles to and from Workshops. The impact of extended and twenty four seven working and any potential for reducing journey times by moving vehicles at night.

Scope:

f. To assess the option of extended operating hours (6am to 10pm) on all options and how this impacts on VOR.

g. To assess the option of a twenty four seven operation on 'Brownfield' sites and the additional capacity for planned work and how this impacts on VOR.

13 Workshops Service Delivery

24. The number of jobs completed at the thirteen Workshops varies significantly and reflects the size and the operating challenges that are inherent, with small Workshops that are manned in some cases by two or three Technicians.

25. A summary of the Workshop performance against KPIs shows seven out of eight targets were met. The average job times that were established for the analysis **do not** reflect the times when the Workshops are closed. The usual measure of efficiency within the Workshop environment is productivity (the number of hours available against hours booked). However, there is no formal structure for recording this information within Fleet, so it is necessary to rely on VOR.

26. The KPI database also shows that average job times vary between Workshops. This is again due to small Workshops that are unable to manage unscheduled work and the impact this has on planned servicing and MOTs.

13 Workshops Staffing

27. The current actual Workshop staffing information has been analysed and results show significant differences in actual Workshop staff availability. Permanent staff availability has fallen by twenty nine per cent from fifty three point seven staff to thirty eight. The shortfall is made up by temporary staff, but this has proven difficult to achieve given the required skill sets that are needed and not usually found within this group.

28. Robust staffing levels are key to establishing improvements in productivity (VOR) and are seen as a significant risk to LAS. The issues surrounding the Trust's inability to recruit Technicians will be addressed later in this report.

Workshop Location Modelling Results

29. ORH's location optimisation software was used to generate and compare location options. The location modelling was geared to generate optimum locations based on minimising the average vehicle to Workshop travel times.

30. The results were optimised against the distribution and size of the Fleet. The frequency and distribution of vehicles was calculated based on the results from a previous ORH study (LO/95) giving a robust base for the analysis.

31. The analysis was based on optimum vehicle to Workshop journey times and the ability to extend and introduce additional shifts. The assumption was made

that it will be possible to address both environmental and planning regulations. This approach identified two configurations, utilising existing sites.

These nine and eight Workshop options are shown below:

9 Workshops	**8 Workshops**
Barnehurst	Barnehurst
Camden	Camden
Croydon	Croydon
Fulham	Fulham
New Malden	New Malden
West Ham	West Ham
Chase Farm	Park Royal
Park Royal	Waterloo
Waterloo	

Further analysis of the location modelling identified three further options (Brownfield sites):

4 Workshops (new)	**3 Workshops (new)**	**2 Workshops (new)**
Park Royal	Park Royal	Hanwell
Islington	Bow	Bow
Woolwich	Streatham	
Streatham		

The average journey to Workshop times by option, are summarised below:

	Average Travel Times	**Average Day**	**Average Night**
13 workshops	09:40	11:36	07:44
9 workshops	11:43	14:04	09:22
9 workshops	12:28	14:58	09:58
4 workshops	12:54	15:29	10:19
3 workshops	14:04	16:53	11:15
2 workshops	16:02	19:14	12:50

32. Although the options presented for two, three and four 'Brownfield' Workshops results in increased average travel times to Workshops, this increase would be mitigated by an increase in the proportion of night-time journeys made by ferry drivers.

33. There would only be a net adverse impact for the three and two Workshop configurations, and the increase in journey times would be marginal (less than one hour per vehicle per year).

34. The average speeds achieved across London were based on information collected by ITIS on behalf of Transport for London. They show that on average, speeds are fifty per cent quicker at night compared to the day time.

35. The average speed analysis implies that there is potential for thirty three per cent reduction in Ferry Driver staffing if vehicles were moved at night. This potential saving excludes the impact of higher wage costs at night compared to the day which would need to be factored in.

Resource Modelling

36. To measure Workshop activity ORH produced an individual model for each of the thirteen Workshops, dependent on factors such as the number of bays, staffing levels, opening hours and job arrival rates. Each model was validated against actual Workshop KPI performance and therefore gave a robust base for measuring the options for change.

Eight and Nine Workshop Options

37. The results of the modelling for both the eight and nine Workshop options showed the need to extend the Workshops by an additional eighteen bays across the nine Workshop option; and twenty bays across the eight. Further investigation identified that restrictions are evident from the space available in the majority of the Workshops.

38. In addition to the physical constraints, environmental issues also need to be considered. Local planning restrictions in residential areas would make it unlikely that planning permission would be granted in some cases to extend Workshop hours of operation.

39. Given the difficulties associated with these options and the need to maintain the same level of work through the Workshops, this would inevitably have an adverse effect on VOR.

Four, Three and Two Workshop Options

40. Three sets of analysis and model runs were produced for each of the 'Brownfield' site configurations.

    - Extended opening hours with untiered operations (planned work undertaken separately from unplanned work).

    - Twenty four seven opening hours with untiered operations.

    - Twenty four seven opening hours with tiered operations.

41. The 'Brownfield' site modelling shows a significant reduction in VOR times for planned and unplanned work, particularly when this is combined with twenty four seven opening hours. Furthermore, when job completion times are

excluded from the analysis there is virtually no queuing time for unplanned work.

42. For the purpose of the modelling and analysis the staffing level has remained constant throughout each configuration option. This has allowed us to draw direct comparisons with the current Workshop configuration.

43. For the purpose of the modelling we only assessed a generic tiered operating model and assumed the same level of staffing across the day and that all jobs could be evenly distributed across the Workshops. The reality would be a higher number of staff available at night to "manage" planned work (ie, servicing and MOT's)

44. The range of Workshop configurations considered through ORH modelling and appraised against the impact on VOR shows a significant reduction can be achieved particularly when combined with twenty four seven opening in the two, three and four Workshop options.

Table 1

RESOURCE MODELLING RESULTS

Workshop Configuration	Opening Hours	Number of Bays	Staffing	Average VOR (hours)
2WS	Current	58	51 (2x25.50)	22
3WS	Current	58	51 (3x17.00)	23
4WS	Current	58	51 (4x12.75	25
8WS	Current	41	Staff at 4WS removed	32
9WS	Current	44	Staff at 5WS removed	33
13WS	Current	58	51 (current)	27
8WS	Current	58	51 some redeployments	27
9WS	Current	58	51 some redeployments	27
2WS	Extended	58	51 (2x25.50)	17
3WS	Extended	58	51 (3x17.00)	19
4WS	Extended	58	51 (4x12.75)	18
8WS	Extended	41	51 some redeployments	29
9WS	Extended	44	51 some redeployments	30
2WS	24\7	58	51 (2x25.50)	12
3WS	24\7	58	51 (3x17.00)	12
4WS	24\7	58	51 (4x12.75)	12
2WS tiered	24\7	58	51 (2x25.50)	9
3WS tiered	24\7	58	51 (3x17.00)	9
4WS tiered	24\7	58	51 (4x12.75)	9

Extended Hours are defined as Monday to Friday 06.00 to 22.00

Economic and Financial Analysis

45. KPMG were engaged to model the economic impact (risk-adjusted cost-benefit) of the options reviewed by ORH. Over a fifty year period of analysis, the re-configured options present cashflow savings, resulting from reduced premium agency costs and an assumed residual value of the properties, partially offset by the initial capital investment. Assessing the costs over a shorter period makes the re-configured options more expensive than 'business as usual' as a result of the initial capital investment.

Table 2 Equivalent Annual Cost (EAC) of Options, assessed over a 50 year period

	Do Minimum	**Option 1 3 workshops 12 hours**	**Option 2 3 workshops 24 hours**	**Option 3 2 workshops 12 hours**	**Option 4 2 workshops 24 hours**	**Option 5 Outsource (Venson)**
EAC (buy) (£000)	£7,457	£7,015	£7,104	£6,933	£7,044	£10,162

46. The Weighted assessment of Benefit (Table 3) and the Assessment of Risk (Table 4) are used to compare the costs and benefits of each option.

47. The outsourcing option scores highly on benefits due mainly to its flexibility. Performance requirements would be placed on the 3rd party provider who would themselves have to overcome issues such as skill shortages and matching work to off-peak periods.

48. There are potential savings in the in-house reconfiguration options, both in reducing reliance on specialists (for example, Accident Repairs, MOT testing and CTS work) and in the ability to manage the Fleet on a reduced relief factor. As the timing and extent of these savings is not yet known, these factors have been incorporated into the benefits analysis, favouring the options in which such savings would arise.

49. The risk table (Table 4) identifies risks that may impact the effectiveness of each option and scores them according to their impact and their probability. It is considered that the reconfiguration options present more risk than business as usual due to the changes required and more risk than the outsourcing option due to the requirement to overcome issues in-house, rather than placing accountability onto a 3rd party.

50. The analysis in Table 5 brings together the costs, benefits and risks of each option. It also shows rent and buy options and a comparison of appraisal periods (10 and 50 years). It shows that Option 4 has the lowest risk-adjusted EAC per weighted benefit point under all scenarios.

51. The option to Outsource (Venson) the Fleet and Workshop operation is costly and this is reflected in the analysis. Despite significant benefits, the cost-efficiency (cost-benefit) of this option is not favourable compared to the other in-house reconfiguration options.

Table 3 Weighted Assessment of Benefit

		Options											
Benefits	**Weight**	**BAU**		**3 x 12/7**		**3 x 24/7**		**2 x 12/7**		**2 x 24/7**		**Outsource**	
		Score	WxS	Score	WxS	Score	WxS	Score	WxS	Score	WxS	Score	WxS
Matching of VOR with off-peak demand periods	20.6	2	41	6	123	8	165	6	123	8	165	9	185
Consistency of servicing provision across London	18.5	2	37	8	148	8	148	8	148	8	148	9	167
Improved servicing regime resulting in lower breakdowns etc.	16.7	3	50	7	117	9	150	7	117	9	150	9	150
Reduced VOR for regular servicing and unscheduled work	13.3	1	13	7	93	10	133	7	93	10	133	10	133
Reduced fleet size due to reduced VOR	10.7	1	11	4	43	6	64	4	43	6	64	6	64
Reduced reliance on specialist repairers	7.5	1	7	5	37	6	45	7	52	8	60	10	75
Greater flexibility with staffing levels (holiday/sickness)	5.2	1	5	5	26	6	31	6	31	9	47	10	52
Improved efficiency of admin/stock control processes	3.7	1	4	8	29	8	29	9	33	9	33	9	33
Ability to overcome skill shortages	2.6	4	10	6	15	6	15	6	15	6	15	9	23
In-house training facilities	1.3	1	1	8	10	8	10	8	10	8	10	8	10
Total	**100**		**180**		**643**		**791**		**666**		**825**		**892**

Table 4 Assessment of Risk

Risk	Impact	BAU prob	BAU Score	1 prob	1 Score	2 prob	2 Score	3 prob	3 Score	4 prob	4 Score	5 prob	5 Score
Inability to recruit substantively	2	5	10	2	4	2	4	2	4	2	4	0	0
Inability to locate large enough sites in good locations	3	0	0	3	9	3	9	3	9	3	9	0	0
Trade union engagement	5	0	0	5	25	5	25	5	25	5	25	5	25
LSS Flexible Fleet unable to provide service due to staffing issues	3	2	6	2	6	2	6	2	6	2	6	0	0
Unable to extend working day due to local restrictions	5	0	0	3	15	2	10	3	15	2	10	0	0
Unable to extend workshops to cope with increasing fleet size	3	5	15	2	6	2	6	2	6	2	6	0	0
Planned and unplanned work at risk due to sickness and holiday	2	5	10	2	4	2	4	2	4	2	4	0	0
Three or fewer workshops place LAS at risk should a disaster occur at one or more sites	5	0	0	2	10	2	10	3	15	3	15	2	10
	Totals		41		79		74		84		79		35

Table 5 **Buy vs Rent Option Analysis**

Summary of EAC and Weighted Benefit Score £K

	Appraisal Period	Do-Min EAC £K	Do-Min Weighted Benifit Score	Do-Min Risk Adjustment £K	Do-Min Risk Adjusted EAC per Weighted Benefit Score £K	Option 1 EAC £K	Option 1 Weighted Benifit Score	Option 1 Risk Adjustment £K	Option 1 Risk Adjusted EAC per Weighted Benefit Score £K	Option 2 EAC £K	Option 2 Weighted Benifit Score	Option 2 Risk Adjustment £K	Option 2 Risk Adjusted EAC per Weighted Benefit Score £K
Buy	50	7,457	180	41	41.6	7,015	643	79	11.0	7,104	791	74	9.1
Rank					6				4				2
Rent	50	7,457	180	41	41.6	7,205	643	79	11.3	7,294	791	74	9.3
Rank					6				4				2
Buy	10	5,937	180	41	33.2	5,957	643	79	9.4	6,090	791	74	7.8
Rank					6				4				2
Rent	10	5,937	180	41	33.2	6,168	643	79	9.7	6,300	791	74	8.1
Rank					6				4				2

	Appraisal Period	Option 3 EAC £K	Option 3 Weighted Benifit Score	Option 3 Risk Adjustment £K	Option 3 Risk Adjusted EAC per Weighted Benefit Score £K	Option 4 EAC £K	Option 4 Weighted Benifit Score	Option 4 Risk Adjustment £K	Option 4 Risk Adjusted EAC per Weighted Benefit Score £K	Option 5 EAC £K	Option 5 Weighted Benifit Score	Option 5 Risk Adjustment £K	Option 5 Risk Adjusted EAC per Weighted Benefit Score £K
Buy	50	6,933	666	74	10.5	7,044	825	79	8.6	10,162	892	35	11.4
Rank					3				1				5
Rent	50	7,197	666	74	10.9	7,308	825	79	8.9	10,162	892	35	11.4
Rank					3				1				5
Buy	10	5,864	666	74	8.9	6,016	825	79	7.4	9,373	892	35	10.5
Rank					3				1				5
Rent	10	6,160	666	74	9.4	6,312	825	79	7.7	9,373	892	35	10.5
Rank					3				1				5

52. It is considered that the 50 year appraisal period is more appropriate at this stage for assessing this long-term project. The most appropriate period for assessment will be determined by the availability of land and/or buildings and rental or leasehold periods associated with them.

53. Over a 50 year period, the economic analysis would suggest a purchase option is more cost-effective than a rental one. The analysis is based on estimates of land and lease costs and assumes that both options are available. It is expected to be difficult to identify land or buildings for sale freehold and thus the rental option may be the only practical option.

54. A full affordability analysis will be performed once more information is obtained concerning the availability of sites and their purchase or lease cost.

Staff Consultation

55. **Workshop and Fleet staff** consultation took place last autumn (when meetings were held at all thirteen Workshops) and at three other meetings in May. Whilst the general feeling was one of disappointment that significant changes are being considered from the ORH and KPMG modelling, we believe that there was a realisation that change was inevitable and necessary.

56. At Staff level, there have been major concerns raised over the results of the Review. The main issue raised by staff was remuneration. It has been clear from the start of this project that LAS has a problem recruiting new staff into the Workshop environment. This is a reflection of the salary on offer and is seen as a very substantial risk to the project. A senior HR Manager played an important role in addressing shift allowances and travel expenses and took the time to make it clear that LAS was looking at the salary issue and saw it as a very real concern.

57. It was brought to the attention of Workshop Staff that the additional services being proposed for the Workshops will assist with a new job description and will aid the salary review process.

58. The proposed introduction of shift working was seen by many as unnecessary, but we feel this was more to do with individuals' change in circumstances rather than a perceived requirement for the business. The general consensus was that Workshop Staff recognised the benefits that servicing and MOTs carried-out at night would bring to LAS. We feel there is still some work to be done with staff on the benefits of shift working and its impact on their work-life balance.

59. Staff meetings indicated that any decision made by the SMG on the proposed new Workshop configuration must be supported by a firm commitment to review and address the salary issue before we go back to staff. Without a proposal we are likely to run into Staff resistance to any change that is part of this review.

60. **Operational Managers** were consulted over a number of regional meetings in addition to a meeting with ADO's. The feed back was positive towards what is trying to be achieved by the review. There were fewer concerns than we expected, particularly when faced with closure of an on-site Workshop. We believe the general feeling from Operational Management was that this review was overdue and its findings are in line with how they perceive they should be supported.

61. Operational Management did question running repairs and how they would be addressed in the new model and were satisfied with the use of a well equipped mobile Workshop facility. They were sensitive to the issues surrounding Workshop staff and remuneration and understood the significant changes to work life balance that will be part of the proposed new Workshop Model.

62. Should the proposal for the New Workshop model be agreed, it was suggested by Operational Managers that a Service Level Agreement (SLA) be drawn up jointly with Fleet Management to measure the performance of the Workshops. We believe this would be advantageous for groups, identifying key responsibilities on the part of both Fleet and Operations, and measuring the performance in these areas.

Conclusions

63. Findings from the ORH and KPMG modelling analysis points us towards a two Workshop model operating twenty four seven. The efficiencies that can be gained from moving vehicles at night are proven from the analysis that ORH have produced. There is also evidence that moving vehicles at night to a fewer number of Workshops will reduce the number of ferry drivers, with a subsequent reduction in cost.

64. More efficient use of vehicles will deliver a reduced relief factor. We are not proposing a direct reduction in Fleet size but should be better positioned to absorb increases in demand.

65. The additional services that will be part of the new Workshop model, will deliver long term savings and efficiencies. Better management of accident repairs and communications systems are key to these improvements.

66. Introducing MOT testing into the new model will give a modest revenue stream, but importantly will increase the safety and the environmental management of our vehicles, through ease of access to a rolling road for brake and emission testing. In addition it will allow external agencies to audit and monitor LAS safety results. There will be the additional saving in time, with Engineers not having to take vehicles for test.

67. To support the new Workshop model there will be an increase in the number of Mobile Workshops. These will be better equipped to deal with more involved running repairs and possibly equipped to repair/ replace tyres. We expect this service to repair seventy five per cent of running repairs (except accidents).

68. The new model will have a different management structure. The Workshop Manager will have administrative assistance in addition to the Shift Managers who will be direct reports. This will give them the opportunity to focus on Workshop productivity, a key aspect to delivering a better and more efficient service.

Recommendation

69. We believe the modelling from ORH and KPMG has laid a clear path for a more productive and cost-efficient operation. The additional services that we intend to introduce into the new model are key to delivering these benefits. It is evident that this can be better achieved within two large Workshops. It

would also strengthen the position of management with a more robust work force focused at two locations. The difference in vehicle to Workshop journey times was minimal so we do not anticipate an adverse effect in this area.

70. The approach to the New Workshop Model will be phased. It is our intention upon approval of this proposal that Park Royal Workshop be moved across to the new site in the West first. As you are aware the Workshop is due for closure and staff are to be deployed across various Workshops. The phased approach maintains business continuity, gives staff the opportunity to settle into the new premises and our Operational colleagues time to adjust to the new arrangements.

71. With due consideration of the analysis that has gone into this project and with approval from the SMG we would like to recommend to the Trust Board we move to the next stage to secure funding for two Workshops positioned in the West and East of London. Up to date affordability analysis, reviewing the budgetary impacts, will be carried out as more information about potential sites is obtained. The availability of sites for freehold purchase is expected to be very limited. As more information is gained on potential sites and costs, the economic analysis should also be updated to ensure the most cost-effective option is still being pursued.

72. With approval and funding agreed, we expect to roll out the new Workshop model in approximately eighteen months.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

Training and Development Plan Update for 2007-09

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

2. Purpose: For noting

3. Summary

The Training and Development Plan 2007 – 2009 has been updated to include the provision of training for the new Student Paramedic role and Practice Placement Educators. The provision of Student Paramedic training is significant and is seen as a priority to achieve improved performance and future provision of quality services. As such it is supported by a comprehensive recruitment project. The plan also revises the detail of the current Paramedic training for existing staff to take account of requirements introduced by the validation of this training by the Health Professions Council due in September 2008.

Finally, the plan recognises the current pressures on the organisation to achieve its patient response standards and the associated recruitment time to increase staffing levels to support this. During the remainder of the period of this plan, delivery of Continuing Professional Development (CPD) has been modified in response to these challenges and will focus on those staff identified as not having accessed existing modules.

The changes to plan previously seen by the Board are highlighted in yellow.

4. Recommendation

THAT the Trust Board NOTEs the changes to the Training Plan

Training & Development Plan: July 2007-April 2009

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

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

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

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

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

i. Clinical & Technical

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

Pre Registration Courses.

Patient Transport Services

Ambulance Persons (AP) Course

This is a four week training package designed for new entrant staff; it includes all of the elements covered in the PTS Drivers course in addition to manual handling and the use of the manual handling small aids kit. At the conclusion of the course the student will be able to undertake the full range of operational PTS duties using all PTS vehicles. (During the period covered by this plan this training may be subsumed

into the A&E Support training programme, but is maintained in its current form pending future decisions).

There are non of these courses currently planned for this year

PTS Events Course

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

There are none of these courses currently planned for this year

Work Based Trainer Development Days

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

There are none of these courses currently planned for this year

PTS Conversion Course

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

None of these courses are planned during the current year.

A & E Support Courses

The A&E Support Course is designed to equip staff with the requisite skills to staff urgent care vehicles within the Trust. This course comprises of a classroom based four week theoretical & technical training. The student is then required to complete a three week driving programme and a further week of practical assessments prior to consolidating their skills in a four week period of operational training.

10 courses of either 8, 9, 12 or 15 places are planned providing **123** places.

EMT 1 to EMT 2 Bridging Courses

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

2 courses of 6 places planned providing **12** places

Student Paramedic Course

The Student Paramedic Course is designed to equip staff with the requisite skills and competencies required to become eligible for registration as a Paramedic. This 3 year course provides all the theoretical and practical elements required and allows time in practice to consolidate these skills. As the Student Paramedic progresses through the course their scope of practice will be development concomitant with their level of competency.

20 Courses of 12 or 18 are planned this year providing **294** places. This plan is subject to amendment and may therefore increase in year. Development and provision of this new programme and associated resource requirements is supported by a comprehensive Recruitment Project.

Driving Courses (1 & 2)

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

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

30 courses incorporating D1 & D2 are planned providing a total of **417** places.

FRU Driving Update

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

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

EMT 2 End of Year Assessments

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

There is no requirement for these during 2009 due to no EMT courses planned in late 2007/2008.

Paramedic pre Entry Assessments

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

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

Paramedic

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

The structure of the course has been recently updated as described above to meet the requirements of HPC validation. In respect of these requirements, further changes may take place during 2008/09.

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

5 full time courses of 10 week duration are planned providing **120** places. Additionally one modular course is planned providing **24** places.

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

Post Registration Courses

Modular CPD Courses

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

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

One day CPD modules are being delivered (avoiding times associated with increased operational demand) to those staff identified as not yet receiving relevant CPD training. Ultimate numbers of places provided will be determined by the ability to release staff together with consideration for resourcing requirements. (It should be noted that each new module provides a 10 hour training day, delivering approximately 40% more training contact time than a corresponding day in the previous model). It is anticipated that provision and access to the wider range of modules will increase significantly once the Trust's recruitment plan is achieved and this will be reflected in the training plan for April 2009 onwards.

Currently there are eight modules are available for delivery and cover the following topics:

- Patient Assessment
- Basic Life Support / Advanced Life Support
- Manual Handling
- Diversity
- Mental Health
- 12 Lead ECG
- Obstetrics
- Major Incidents

Operational Managers' Clinical Update Days

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

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

Practice Placement Educator Courses:

This one day course provides the student with the requisite skills and underpinning knowledge to provide support to both Student Paramedics (from the direct entry and Higher Education Route) and to newly qualified Paramedics in practice. This supports requirements of HPC validation for Student Paramedic and Paramedic courses, as well as significantly improving the clinical supervision provided for staff.

16 courses are planned providing **363** places

Team Leader Courses

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

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

Instructional Methods / Instructor Qualifying Courses

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

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

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

ii. University Programmes

Full-time BSc/Foundation Degrees

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

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

Part-time Certificate, Diploma and Degree in Paramedic Science

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

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

iii. Control Services

Emergency Medical Dispatcher Call Taking Course

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

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

Emergency Medical Dispatcher Dispatch Course

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

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

Work Based Trainer Course

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

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

Emergency Driving course

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

No courses planned to date.

iv. Management Development

Exploring Leadership & Self Awareness (ELSA)

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

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

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

ELSA for Senior Managers

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

Managing Disciplinaries

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

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

Managing Attendance

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

6 one day courses offering **72** places

Recruitment & Selection

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

5 one day courses offering **50** places

Managing Safety & Risk

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

5 one day courses offering **50** places

Display Screen Equipment

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

5 one day courses offering **45** places

v. Staff Development (Non-Clinical)

Applying for Promotion

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

3 one day courses offering **42** places

Assertive Communication

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

3 one day courses offering **36** places
Presentation Skills

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

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

Effective Meeting Administration

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

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

Return to Study

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

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

Participating at Meetings

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

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

Station Administration Development Programme

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

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

Excellence in Patient Care

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

11 courses offering **110** places

Monitoring

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

Exclusions

Training activities currently excluded from this plan are:

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

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

SUMMARY TABLE

Course/Module	Number of courses/modules	Total number of places
Ambulance Person Course	4	48
PTS Events Course	2	24
PTS WBT Development	3	36
PTS Conversion	3	36
A&E Support	17	144
EMT 1 Bridging	3	36
Driving Courses	30	276
FRU Driving	As required	As required
EMT 2 End of Year Assessments	14	140
Paramedic Pre-entry	2	Dependant on applications
Paramedic	9	200
Paramedic Modular	2	48
Modular CPD	636	6360
Managers' Clinical Update	15	120
Team Leader	4	60
Instructional Methods	1	12
Instructor Qualifying	1	12
EMD Dispatch	9	112
EMD Call Taking	9	112
Control WBT	1	6
Emergency Driving	2	14
ELSA (Senior)	2	20
ELSA	3	40
Managing Disciplinaries	6	72
Managing Attendance	6	72
Recruitment & Selection	5	50
Managing Safety & Risk	5	50
Display Screen Equipment	5	45
Assertive Communication	3	36
Presentation Skills	2	20
Effective Meeting Administration	2	20
Return To Study	2	20
Participating at Meetings	2	24
Station Administrator Development	4	48
Excellence In Patient Care	11	110

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

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

Student Paramedic Pathway

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

2. Purpose: For noting

3. Summary

The Trust has developed a Student Paramedic training programme to support the implementation of the Workforce Plan.

The training programme has been designed to meet the requirements of the existing awarding body (IHCD), the registering body (Health Professions Council) and the validation requirements on the programme by the HPC which is scheduled to take place in September.

Further work will be undertaken through the OD and People Programme to develop and introduce the Diploma level training programme in the future.

4. Recommendation

THAT the Trust Board NOTES the update on the Student Paramedic Pathway

LONDON AMBULANCE SERVICE

TRUST BOARD 29 July 2008

Student Paramedic Pathway

Introduction

The London Ambulance Service Student Paramedic Pathway is designed to prepare students for registration as a qualified paramedic with the Health Professions Council (HPC) and to meet the operational needs of the ambulance service.

Students will be trained over a three year period, with all input during this time designed to meet both the requirements of the current awarding body (IHCD), and the HPC as the registrant body. Development of this programme has coincided with the statutory requirement for all Paramedic training programmes to be validated by the HPC which is scheduled with the London Ambulance Service for September 2008. The programme therefore reflects the requirements contained within this national validation process.

Given the timescale available to introduce this new training programme and the specific requirements (including timescale) of the HPC validation it has not been possible at this stage to incorporate the desired development work to also introduce a Diploma level training programme. This however, remains the ultimate aim for future paramedic training and will form a specific project under the OD and People Programme.

Recruitment

The recruitment process supporting the Student Paramedic Pathway is geared to the recruitment of applicants who demonstrate the potential to achieve paramedic status. The details of the recruitment process therefore include enhanced entry and selection requirements tested through a range of checks and assessments.

Student Paramedic Level 1

This level will comprise modules providing corporate induction, statutory training such as manual handling and the first level of clinical knowledge and skills (over an eleven week period) including advanced patient assessment and 12 lead ECG. Students will also receive driver training at this stage.

Clinical training will be consolidated with a period of practice placement under the supervision of a qualified Practice Placement Educator or Associate Practice Placement Educator.

Student Paramedic Level 2

This module will consist of a work-based placement, lasting twelve months, during which time the student will work as a divisional relief for the ambulance service, undertaking the full range of duties appropriate to their level of training. During this placement the student will be allocated a qualified Practice Placement Educator who will act as a mentor throughout the placement.

An assessment based module will be completed during which the student will carry out theoretical, practical and operational components to enable them to progress to level three. This module must be completed prior to entering any Level 3 modules.

Student Paramedic Level 3

This module will consist of a work-based placement, during which time the student will work as a divisional relief for the ambulance service, undertaking the full range of duties appropriate to their extended level of training, experience and assessed competence as outlined above. The duration of this placement will be a further twelve months and will again be supported by a qualified Practice Placement Educator. During this placement the student will access additional training modules required under the new HPC validated programmes. These include:

- Ethics and Law
- Clinical Decision Making
- Clinical Audit and Research
- Sociology
- Psychology
- Health Promotion

A further assessment based module will be completed during which the student will carry out theoretical, practical and operational components to enable them to progress to level four. This module must be completed prior to entering any Level 4 modules.

Student Paramedic Level 4

This module will consist of a work-based placement, for a period of approximately sixteen weeks.

The Student Paramedic will be able to carry out 'paramedic level' skills under the direct supervision of a qualified Practice Placement Educator, with the exception of the administration of controlled. This can only be undertaken once registered at the end of the programme.

This placement will run concurrently with the other, final paramedic modular elements of Level 4 with 'extended skills' being carried out under supervision where appropriate.

Students will also access hospital based placements during which time the student will complete the requirements of the awarding body as well as working towards the

placement guidance from the College of Paramedics in regard to paramedic competencies.

During Level 4, the Student Paramedic would also be required to embark upon the Practice Placement Educator scheme.

Eligibility to Register

Upon satisfactory completion of all of the above modules, the London Ambulance Service will issue a confirmation of completion certificate and the student's IHCD Paramedic Certificate. The student would then be eligible to apply to the Health Professions Council for registration.

Upon confirmation of HPC Registration, the LAS would be in a position to offer continued employment to the student in the position of Registered Paramedic.

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

Presentation

Emergency Care Practitioner Education and Future Role

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: For noting

3. Summary

Currently 53 ECPs are in post across 12 LAS complexes, the aim is to recruit 30 new ECPs this year and to establish ECP schemes at both NWOW sites in Barnehurst and Chase Farm

Current issues

- Operational performance: resolve issues around performance management; tasking and resourcing
- Management structures: substantiate programme manager post; resolve training requirements and reporting structures
- Continued interest from PCTs in working with LAS ECPs to meet the urgent care agenda. How do we fit into the pan London urgent care agenda v. local PCT agendas? Do we need to prioritise?
- Ensuring that we get the clinical leadership programme model right as part of the New Ways of Working

4. Recommendation

THAT the Trust Board considers the issues outlined in the presentation and gives direction on the future development of an ECP strategy**.**

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 29 July 2008

Service Improvement Programme 2012 Update

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting.

3. Summary

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

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

a. Trust Board – every meeting;

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

4. Recommendation

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

London Ambulance Service NHS Trust

Trust Board Meeting, 29 July 2008

Service Improvement Programme 2012 Update

1. Purpose

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

2. Approach to Performance Management of SIP 2012

The approach to performance managing the service improvement programme is based on tracking achievement of planned milestones. Using this approach the report consists of five sections, one for each of the sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A brief description of the live projects within the sub-programme concerned;
- A graphical representation of progress for each project focusing on planned milestone achievement as at the date indicated on the chart by the vertical line.

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

3. Overview of programme structure

The service improvement programme is made up of the following five sub-programmes:

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

There is also a supporting *Stakeholder Engagement and Communications Strategy* led by the Director of Communications.

4. Exceptions

This section provides commentary on those projects (not individual milestones) identified as being of red status (i.e. not on track and cause for concern).

Improving our Response

Referral pathways
The project has been delayed following the now long term absence of the project manager. Referral pathways continue to be developed and agreed with providers but making them consistently available to front line staff is proving very difficult as is the agreement of specific milestones for delivery. Next steps are:

- Agree the way forward with HR to ensure provision of sufficient support to allow the project to continue;
- Complete all training packages and redefine timescales for training of team leaders prior to cascading to front line staff;
- Continue to explore an electronic solution to displaying available pathways via MDTs;
- Draft a project plan for the next phase.

Automatic data recording and analysis
The major exercise to bring all fleet mobile data terminals to the same build state and full functionality, referred to as MDT 'MoT' is currently suspended pending resolution of a technical problem integrating the Express-Q client software. A solution for the client software problem is currently being evaluated.

Corporate Processes and Governance

Asset Tracking
The project to roll-out a system for tracking EBME (Electro-Bio-Medical Engineering) equipment on ambulances in order to track and manage EBME servicing more efficiently is on hold due to server room capacity and power issues. There is a constraint on the capacity to provide additional electrical power in the HQ communications room impacting on the ability to deliver additional functionality. Overtures are being made to various outsource organisations to cover the capacity gap.

Access

London Ambulance Radio Project ARP

There have been significant problems in acceptance testing of the solution with the DH and the supplier. Formal testing has been suspended on a number of occasions. At present there is a new version of the software for the control terminals offered for test that will be tested under a new plan. The previous plans indicate handover of the service at the end of July 08 (this has now slipped to the beginning of September). The completion of all migration is still expected at the end of Nov 08, however this is extremely tight and considered high risk, the likelihood is that there will be some cross over of implementation into the New Year. Working practice, policy and

training planning work is progressing and policy documents are currently in draft around radio procedures and ambient listening. Senior Users have agreed the training documentation. This is to be prepared and delivered for September rollout. Train the trainer courses are scheduled for end of July.

5. Recommendation

THAT the Trust Board NOTES the progress made with the Service Improvement Programme 2012.

CAD 2010
Project Manager: Ian Pentland
The purpose of this project is to replace the core Call Taking and Dispatch capabilities within Control Services, including replacement or development of any interfaces with existing systems, applications or services.

CTAK Enhancements
Project Manager: Rony Zaman
The objective is to enhance CTAK capability as an interim measure pending its ultimate replacement by the system put in place by the CAD 2010 project.
This has been achieved through a series of software releases, incrementally delivering new functionality.

Data Warehousing
Project Manager: James Cook
Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse information. Information is not available from outside the LAS network and therefore it is not accessible to our partners and stakeholders.
To address these issues a data warehouse will be developed that stores LAS data. Eventually this data warehouse will encompass the whole of the LAS, including A&E and PTS data, resources, fleet, finance, estates, staff, recruitment and more. This project is the first step towards that goal and will limit the scope of its data to A&E data and vehicle manning and availability.

LARP (London Ambulance Radio Project)
Project Manager: Rony Zaman
As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable radios, EOC / UOC dispatcher equipment and the integration with CTAK

PTS System; Meridian Mobile Technology
Project Manger: Robert Utchanah
The intension of this project is to introduce handheld information terminals to build upon the functionality of the upgraded Meridian booking, billing and management reporting system used to support Patient Transport Services operations.
The system eliminates paper-based dispatching. The use of handheld terminals to receive and feed back operational and management

information related either to the patient or of relevance to the customer in a more timely manner and in a secure technological environment, is expected to deliver efficiency savings over time and a more flexible operation on a day-to-day basis.

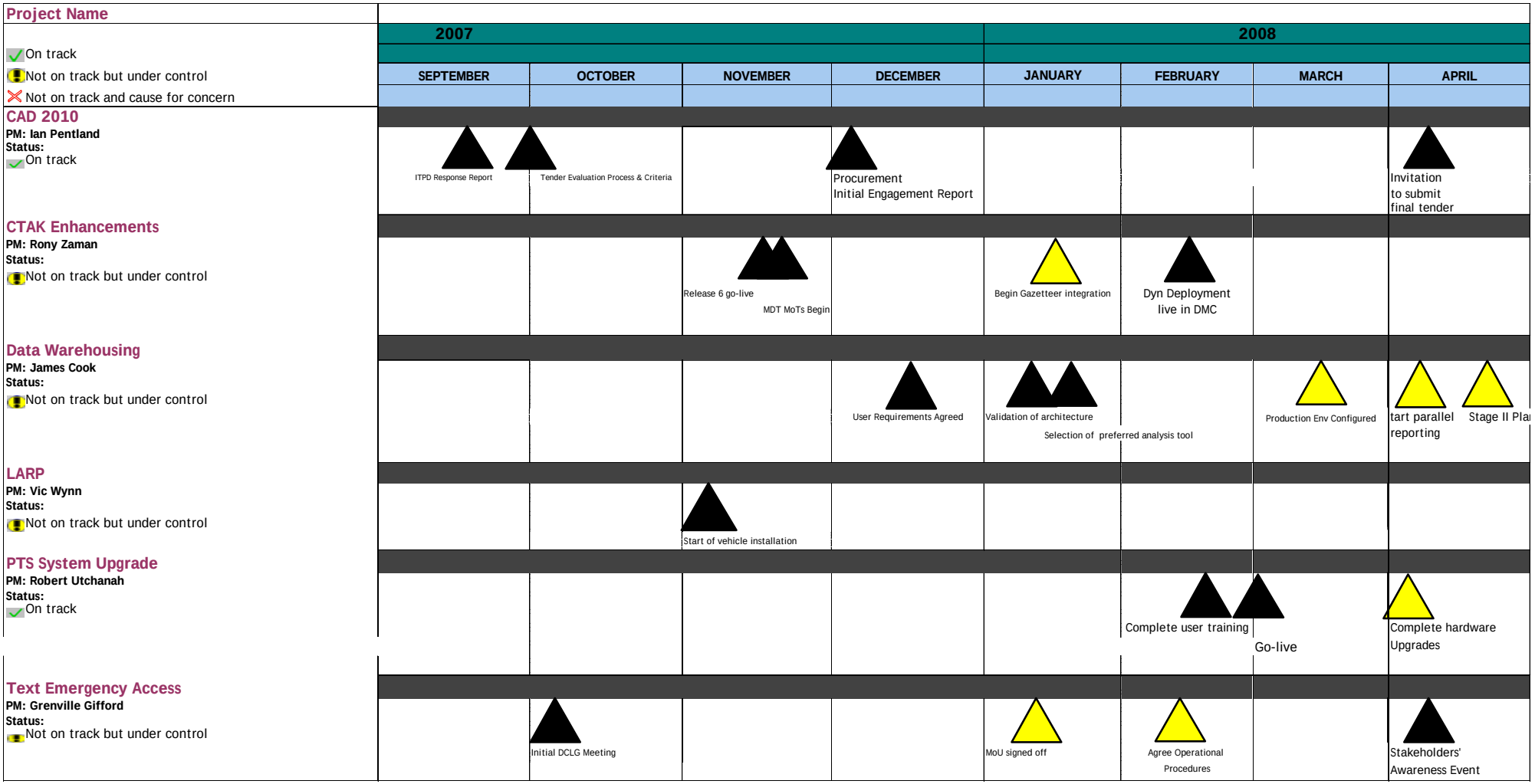
TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)
Project Manager: Grenville Gifford

The objective is to provide the capability to respond to patients or their carers who have a speech or hearing impairment that prevents use of the normal '999' facility.

A method piloted by several U.K. police services is to use texting from mobile telephones and at present this would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.

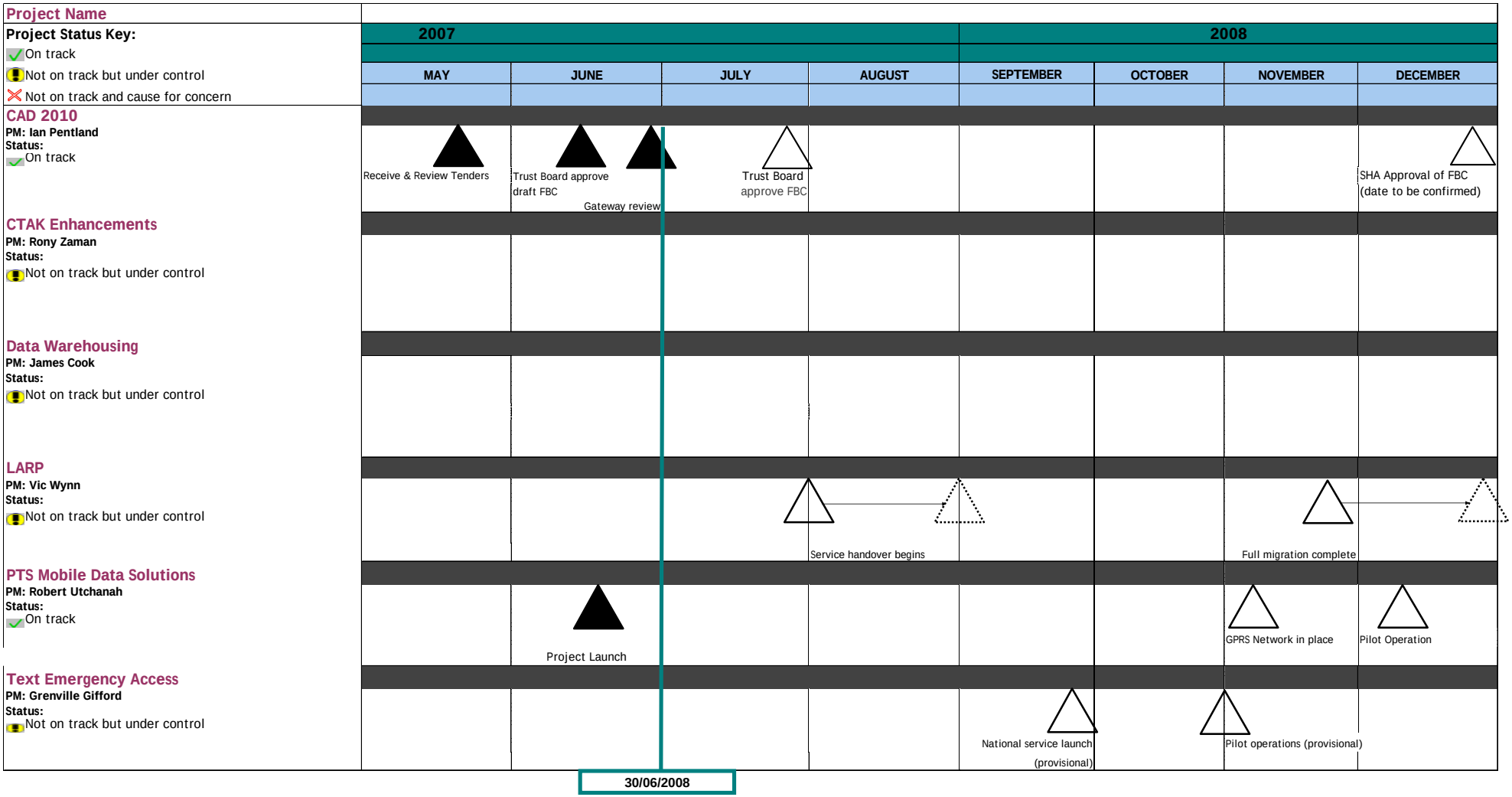
Our intention is to adopt this solution for call taking and this was initially expected to be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up during 2008.

Because of continuing delay and uncertain surrounding the national initiative the project is also investigating the feasibility of establishing an in-house solution that would deliver text messages directly to ambulance control rooms.



Legend

- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and cause for concern
2007
2008
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
CAD 2010
PM: Ian Pentland
Status:
On track
Receive & Review Tenders
Trust Board approve draft FBC
Gateway review
Trust Board approve FBC
SHA Approval of FBC (date to be confirmed)
CTAK Enhancements
PM: Rony Zaman
Status:
Not on track but under control
Data Warehousing
PM: James Cook
Status:
Not on track but under control
LARP
PM: Vic Wynn
Status:
Not on track but under control
Service handover begins
Full migration complete
PTS Mobile Data Solutions
PM: Robert Utchanah
Status:
On track
Project Launch
GPRS Network in place
Pilot Operation
Text Emergency Access
PM: Grenville Gifford
Status:
Not on track but under control
National service launch (provisional)
Pilot operations (provisional)
30/06/2008
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Clinical Support Desk
Project Manager: Stephen Hines

This project is aiming to establish as system to provide immediate clinical support to both operational clinicians and to call handlers. A desk in the Emergency Operations Centre (EOC) will be staffed by senior paramedics, who will be able to access a range of databases to assist with staff queries.

First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe

The LAS is looking to revise and expand existing responder schemes which broadly fall into one of three categories: Static defibrillator sites where staff who work in the vicinity are trained to provide Emergency Life support, Co-responders that work for established organisations and who respond to selected emergency calls as part of their work, and community responder who are groups of local people who volunteer to share the provision of a single responder within their local area.

Active Area Cover (phase 2)
Project Manager: Andy Heward

Following extensive consultation with staff and staff representatives it has been decided to implement Active Area Cover (AAC) for ambulances and FRUs with effect from 9 June 2008.
The implementation will be gradual, over a number of months, until it is routine business for the Trust. This project is tasked with establishing the steps towards initial implementation on 9th June and the subsequent steps to achieve full implementation.

Mobile Office
Project Manager: Stuart Crichton

This project is tasked with equipping DSO vehicles with laptops to enable staff to work remotely, giving them immediate access to information whilst also allowing them to spend more time out in the field. The project will establish hardware and software requirements, examine security concerns and establish the best way to transport the laptops in the vehicles.

Team Based Working
Project Manager: Gareth Hughes

This project is tasked with undertaking a review of current working patterns and providing a series of alternative options which can be piloted as part of the NWoW initiative. The aim is ultimately to introduce working patterns to each individual complex which reflect the needs of staff and provide an efficient and manageable system for the Service

Vehicle Fleet Procurement
Project Manager: Nick Pope

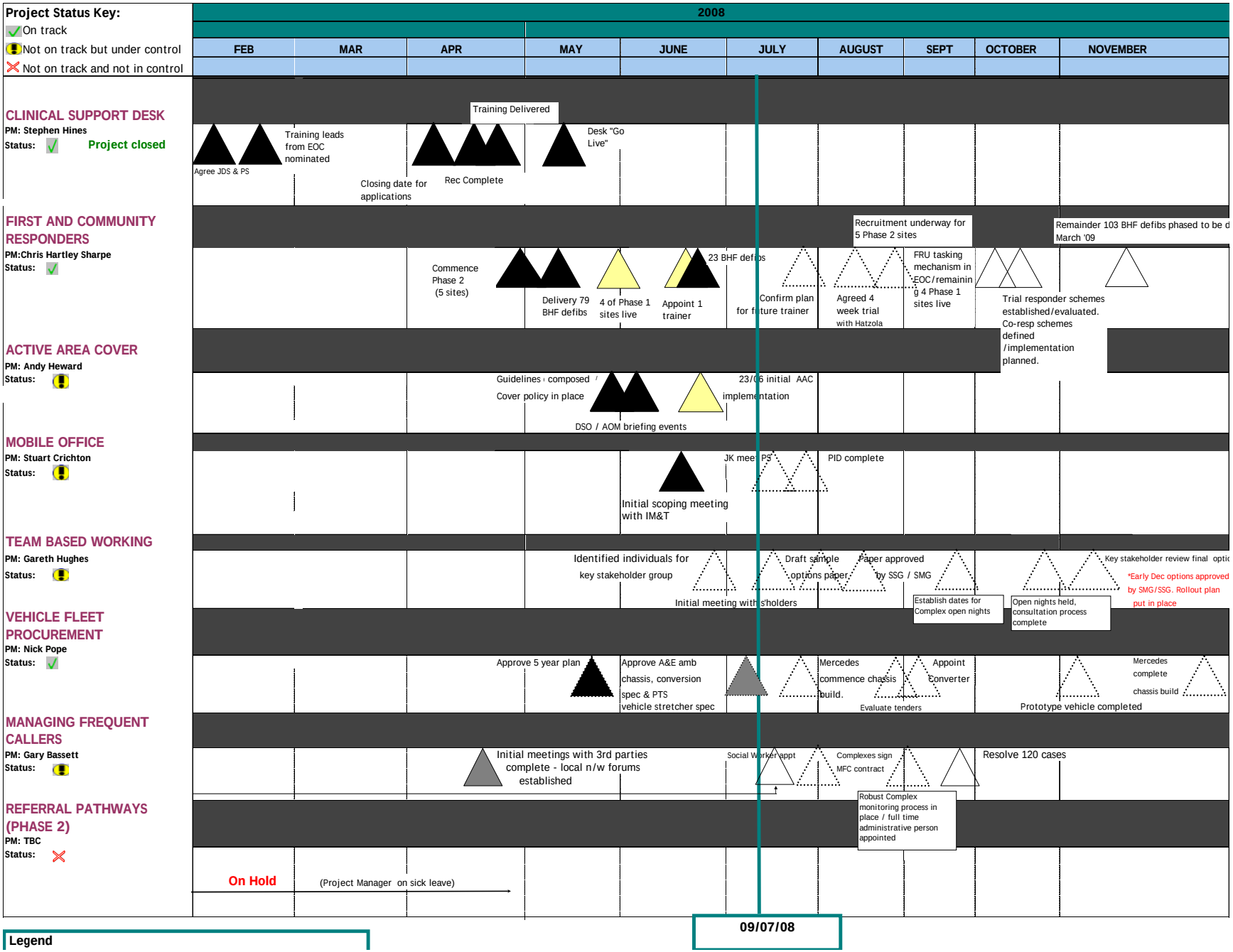
This project is responsible for delivering a 5 year fleet procurement and policy plan. This includes; ambulances, PTS, bariatric and training vehicles

Managing Frequent Callers
Project Manager: Gary Bassett

The aim of this initiative is to achieve an appropriate care pathway for service users where the deployment of an emergency ambulance resource may not be the most appropriate response. Local multi-disciplinary network forums will be created in partnership with local authority and other social and health care agencies with the objective of resolving the issues presented by this patient community. The aim is to achieve a reduction of 10,000 ambulance journeys per annum.

Referral Pathways
Project Manager: Allison Bolsover

The agreement of pathway protocols with providers, the encouragement of their use by frontline staff and evaluation to ensure that all patients receive consistently appropriate care delivered in a safe manner. This work should result in the LAS taking 200,000 fewer patients a year to A&E by 2012.


Project Status Key:
On track
Not on track but under control
Not on track and not in control
2008
FEB
MAR
APR
MAY
JUNE
JULY
AUGUST
SEPT
OCTOBER
NOVEMBER
CLINICAL SUPPORT DESK
PM: Stephen Hines
Status:
Project closed
Agree JDS & PS
Training leads from EOC nominated
Closing date for applications
Rec Complete
Training Delivered
Desk "Go Live"
FIRST AND COMMUNITY RESPONDERS
PM:Chris Hartley Sharpe
Status:
Commence Phase 2 (5 sites)
Delivery 79 BHF defibs
4 of Phase 1 sites live
Appoint 1 trainer
23 BHF defibs
Confirm plan for future trainer
Recruitment underway for 5 Phase 2 sites
Agreed 4 week trial with Hatzola
FRU tasking mechanism in EOC/remaining 4 Phase 1 sites live
Remainder 103 BHF defibs phased to be d
March '09
Trial responder schemes established/evaluated.
Co-resp schemes defined /implementation planned.
ACTIVE AREA COVER
PM: Andy Heward
Status:
Guidelines composed / Cover policy in place
DSO / AOM briefing events
23/06 initial AAC implementation
MOBILE OFFICE
PM: Stuart Crichton
Status:
Initial scoping meeting with IM&T
JK mee PS
PID complete
TEAM BASED WORKING
PM: Gareth Hughes
Status:
Identified individuals for key stakeholder group
Initial meeting with s'holders
Draft sample options paper
Paper approved by SSG / SMG
Establish dates for Complex open nights
Open nights held, consultation process complete
Key stakeholder review final optic
*Early Dec options approved by SMG/SSG. Rollout plan put in place
VEHICLE FLEET PROCUREMENT
PM: Nick Pope
Status:
Approve 5 year plan
Approve A&E amb chassis, conversion spec & PTS vehicle stretcher spec
Mercedes commence chassis build.
Appoint converter
Evaluate tenders
Mercedes complete chassis build
Prototype vehicle completed
MANAGING FREQUENT CALLERS
PM: Gary Bassett
Status:
Initial meetings with 3rd parties complete - local n/w forums established
Social Worker appt
Complexes sign MFC contract
Resolve 120 cases
Robust Complex monitoring process in place / full time administrative person appointed
REFERRAL PATHWAYS (PHASE 2)
PM: TBC
Status:
On Hold
(Project Manager on sick leave)
09/07/08
Legend

Project Name										
Project Status Key: On track Not on track but under control Not on track and not in control	2008	2009								
	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
CLINICAL SUPPORT DESK PM: Stephen Hines Status: ✓ Project closed										
FIRST AND COMMUNITY RESPONDERS PM:Chris Hartley Sharpe Status: ✓										
MOBILE FLEET (PHASE 2) PM: Andy Heward Status: !										
MOBILE OFFICE PM: Stuart Crichton Status: !										
TEAM BASED WORKING PM: Gareth Hughes Status: !										
VEHICLE FLEET PROCUREMENT PM: Nick Pope Status: ✓	△ First converted A & E ambulances delivered			△ 60 A & E ambulances delivered						
MANAGING FREQUENT CALLERS PM: Gary Bassett Status: !										
REFERRAL PATHWAYS (PHASE 2) PM: TBC Status: ✗										

OVERVIEW OF OPERATIONAL MODEL CONTROL SERVICES PROJECTS

Automated Ambulance Dispatch
Project Manager: Paul Webster

The objective is to deliver a technical capability similar to FRED used successful to dispatch FRUs. This should improve response times by anticipating the need to convey the patient and also reduce the allocators' workload in progressing AMBER calls requiring a double-crew response.

Automatic Data Reporting and Analysis
Project Manager: Sue Meehan

The project introduces changes to performance reporting in accordance with KA34 guidance providing the technical capability to capture on scene timings based upon geographical proximity (< 200 metres) of the vehicle to the patient location and subsequently of the vehicle to the hospital.
A second reporting objective is to ensure that the use of static deployed defibrillators, calls to GP surgeries and other KA34 permissible first responses are captured and reflected in performance reporting statistics.

Control Services Management Restructure
Project Manager: Alan Edmonds

The project, which is a continuation of Tranche-1 changes, seeks to restructure management broadly in line with Sector Operating Model to ensure consistency of performance through adequate managerial and supervisory support. Tasking Control Services AOMs to optimise use of resources to ensure compliance with performance targets and to facilitate closer support of CS staff; e.g. improved clinical governance, IPM, better clinical risk management. Finally to ensure appropriate skills are developed and appropriate capability available at all levels of EOC and UOC

Paperless Control Room
Project Manager: Lisa Dickinson

To facilitate the introduction of LARP into EOC and the need to economise on printing costs the project will analyse the use of paper copies, identify essential needs and formulate procedural changes to avoid making unnecessary copies.

Re-Engineering Call Handling
Project Manager: Vicky Graham

The aim of the project is to reduce call handling times to a predicable and acceptable period of time. This will include changes to consistently answer calls within 5 seconds, to capture Location and Brief Description within 50 seconds and complete the call within 2 minutes.
This will be achieved by adapting rosters and reviewing rest break arrangements to ensure that staff with the optimum skill mix are available to match the demands of call type and volume. Best practise will be established by identifying exemplary staff using IPM then replicating these practises and behaviors with all call takers.

Urgent Care Workload
Project Manager: John Hopson

The aim of the project is to increase the role of Urgent Care Services to improved urgent care to patients and reduce the use of emergency care resources to meet these requirements.

This will be achieved via a number of discrete "threads" of activity, partly by increasing the number of staff in both Clinical Telephone Advice and Urgent Care operations and partly by reviewing the skill mix and working arrangements of current staff.

Project Name

Project Status Key:

- On track
- Not on track but under control
- Not on track and not in control
- C Complete

2008

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

AUTOMATED AMBULANCE DESPATCH

PM: Paul Webster
Status:
Status: **Project complete**

Define business rules
Revise CTAK
Test revisions
Auto dispatch live

AUTOMATIC DATA REPORTING & ANALYSIS

PM: Sue Meehan
Status:
Not on track and not in control

Implement perf stds using auto status
Begin MDT update
Impler

CONTROL SERVICES MGT RESTRUCTURE

PM: Alan Edmonds
Status:
On track

Review JDs
Start Consultation
Finish consultation
All staff slotted in

PAPERLESS CONTROL ROOM

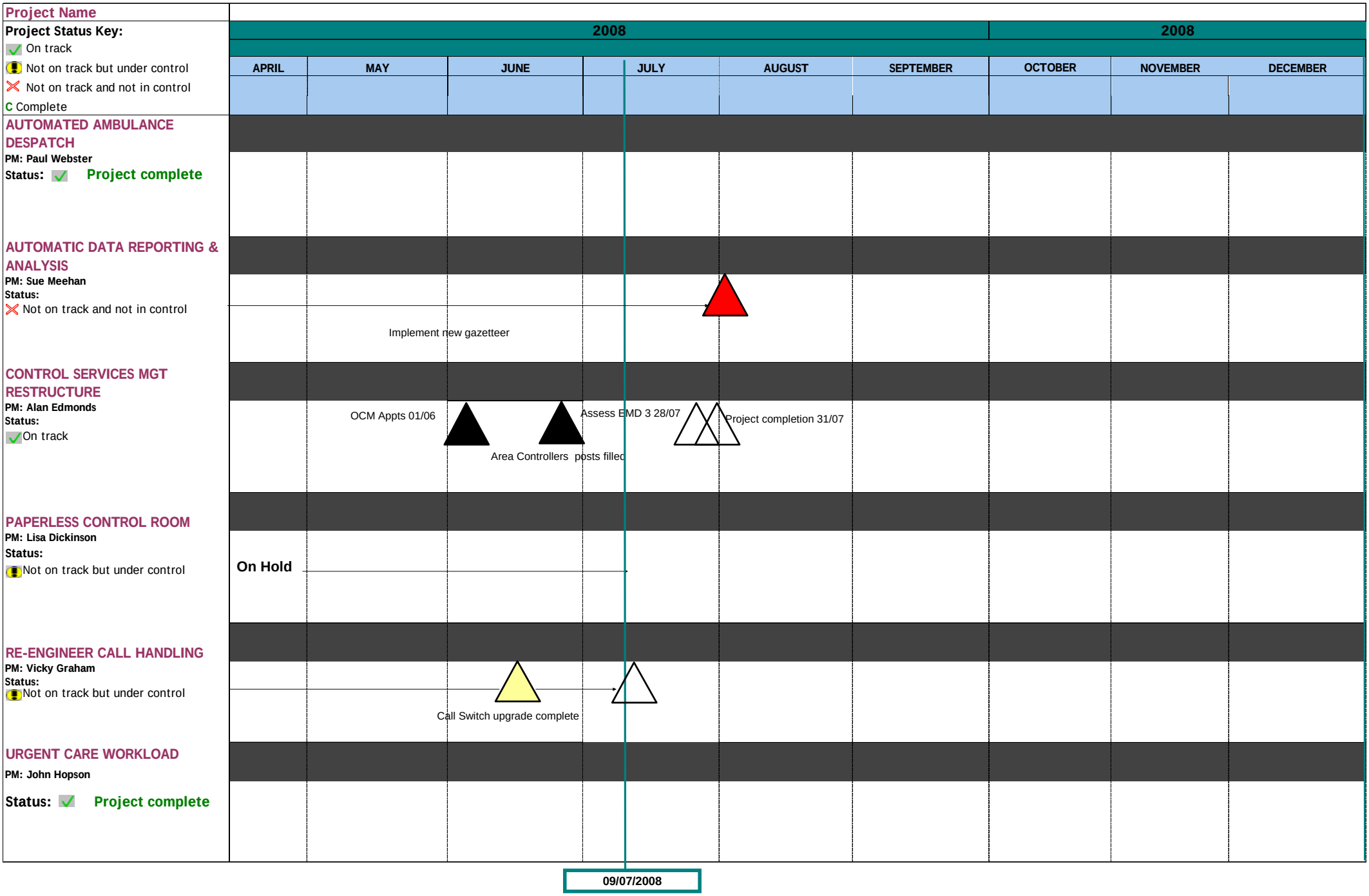
PM: Lisa Dickinson
Status:
Not on track but on hold

Gather as-is proc maps
Go/no go meeting
Mapping w / shop

RE-ENGINEER CALL HANDLING

PM: Vicky Graham

GMT Planet
Rest breaks


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
C Complete
2008
2008
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
AUTOMATED AMBULANCE DESPATCH
PM: Paul Webster
Status: Project complete
AUTOMATIC DATA REPORTING & ANALYSIS
PM: Sue Meehan
Status:
Not on track and not in control
Implement new gazetteer
CONTROL SERVICES MGT RESTRUCTURE
PM: Alan Edmonds
Status:
On track
OCM Appts 01/06
Assess EMD 3 28/07
Project completion 31/07
Area Controllers posts filled
PAPERLESS CONTROL ROOM
PM: Lisa Dickinson
Status:
Not on track but under control
On Hold
RE-ENGINEER CALL HANDLING
PM: Vicky Graham
Status:
Not on track but under control
Call Switch upgrade complete
URGENT CARE WORKLOAD
PM: John Hopson
Status: Project complete
09/07/2008

Recruitment & Induction
Project Manager: Shani Phipps

This initiative will revise the recruitment process to enable the organisation to assess and recruit candidates for values, attitudes and behaviours. This project will also help LAS to deliver diversity targets for achieving a more representative workforce and insuring fairness and equity for all candidates. The induction process will also be revised to reflect these same themes.

Leadership Development
Project Manager: Jo Anthony

This initiative is to establish and support new styles of leadership at all levels underpinned by the right skills; through continuing the current leadership programmes available and developing new leadership programmes. The programme will be comprised of a number of courses and qualifications aimed at specific groups within the organisation to support both the New Ways of Working and OD and People Programmes.

Individual Performance Management
Project Manager: Steve Sale

The aim of this initiative is to develop a comprehensive performance management process that is accepted and used by all staff members. This performance management framework will enable all staff to accept responsibility and accountability for their personal performance, rewarding and recognising good performance, whilst identifying and supporting staff with poor performance, and where necessary enabling appropriate exit strategies.

Workforce Re-Configuration
Caron Hitchen

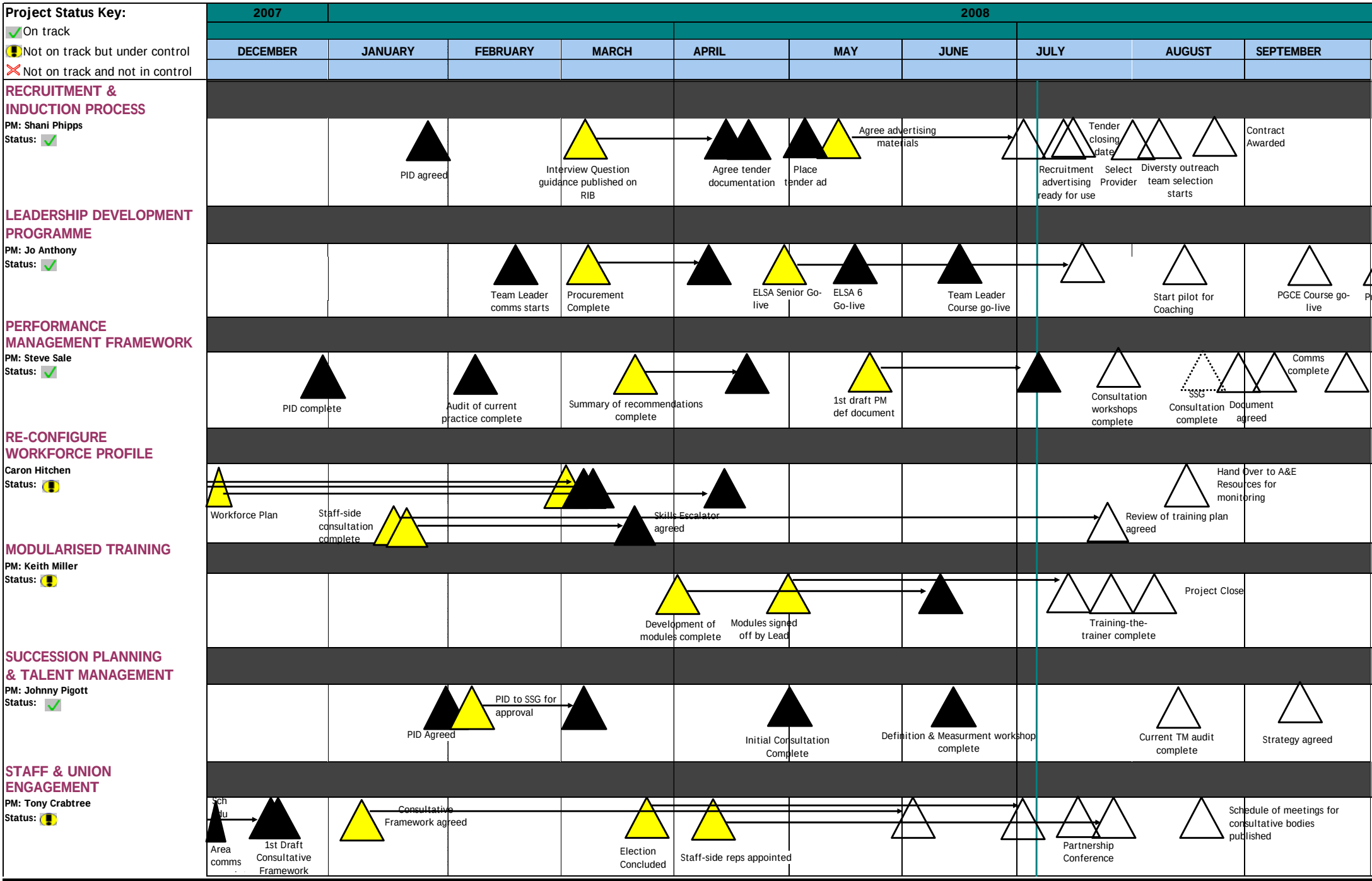
The aim of this initiative is to develop the workforce plan that supports the Operational Model and implements a staff profile that is representative of the population of London.

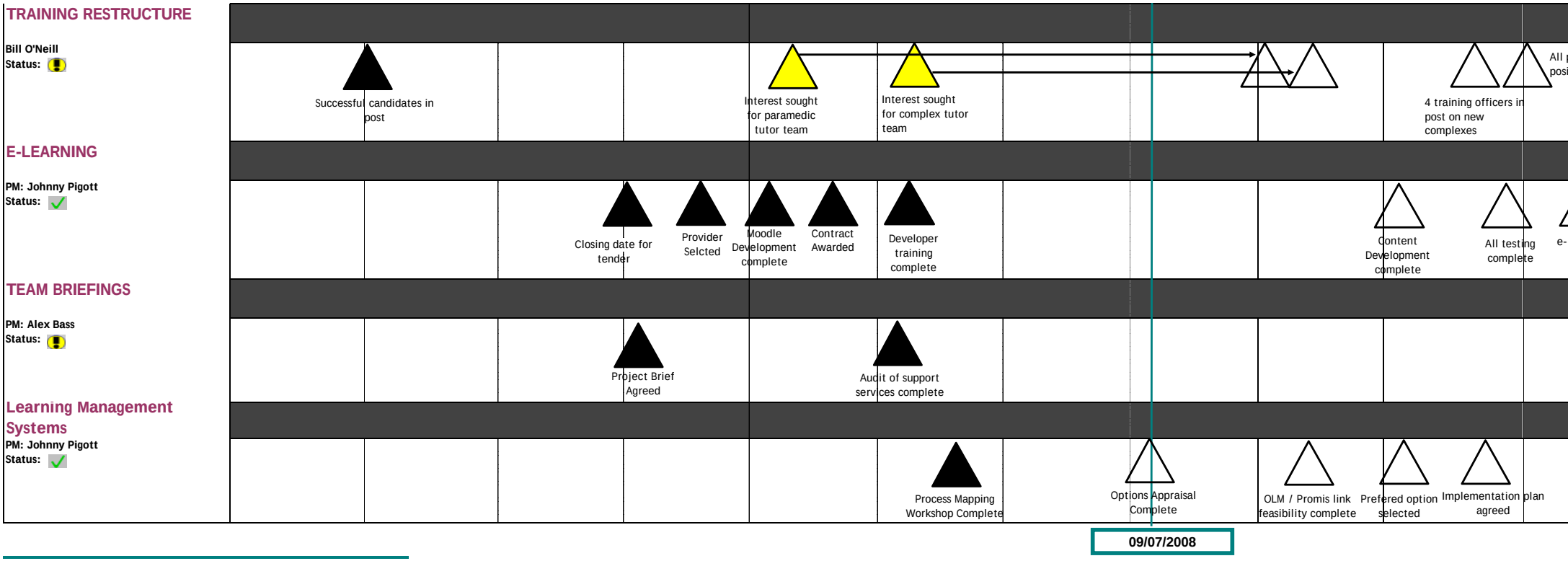
Modularised Training
Project Manager: Keith Miller

The aim of this initiative is to provide all staff with access to appropriate professional development through training and development packages delivered through a variety of media. There are currently three training modules in operation with the intention to develop a number more, prioritised by clinical need.

Talent Management
Project Manager: Johnny Pigott

The aim of this initiative is to provide a clear career development framework for all staff that allows staff to progress their career according to their choice and their own pace, whilst recognising and providing the opportunity for talented staff, anticipating and targeting opportunities for talented


Project Status Key:
On track
Not on track but under control
Not on track and not in control
2007
2008
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
RECRUITMENT & INDUCTION PROCESS
PM: Shani Phipps
Status:
PID agreed
Interview Question guidance published on RIB
Agree tender documentation
Place tender ad
Agree advertising materials
Recruitment advertising ready for use
Tender closing date
Select Provider
Diversty outreach team selection starts
Contract Awarded
LEADERSHIP DEVELOPMENT PROGRAMME
PM: Jo Anthony
Status:
Team Leader comms starts
Procurement Complete
ELSA Senior Go-live
ELSA 6 Go-live
Team Leader Course go-live
Start pilot for Coaching
PGCE Course go-live
PERFORMANCE MANAGEMENT FRAMEWORK
PM: Steve Sale
Status:
PID complete
Audit of current practice complete
Summary of recommendations complete
1st draft PM def document
Consultation workshops complete
SSG Consultation complete
Document agreed
Comms complete
RE-CONFIGURE WORKFORCE PROFILE
Caron Hitchen
Status:
Workforce Plan
Staff-side consultation complete
Skills Escalator agreed
Review of training plan agreed
Hand Over to A&E Resources for monitoring
MODULARISED TRAINING
PM: Keith Miller
Status:
Development of modules complete
Modules signed off by Lead
Training-the-trainer complete
Project Close
SUCCESSION PLANNING & TALENT MANAGEMENT
PM: Johnny Pigott
Status:
PID Agreed
PID to SSG for approval
Initial Consultation Complete
Definition & Measurment workshop complete
Current TM audit complete
Strategy agreed
STAFF & UNION ENGAGEMENT
PM: Tony Crabtree
Status:
Area comms
1st Draft Consultative Framework
Consultative Framework agreed
Election Concluded
Staff-side reps appointed
Partnership Conference
Schedule of meetings for consultative bodies published


TRAINING RESTRUCTURE
Bill O'Neill
Status:
Successful candidates in post
Interest sought for paramedic tutor team
Interest sought for complex tutor team
4 training officers in post on new complexes
E-LEARNING
PM: Johnny Pigott
Status:
Closing date for tender
Provider Selcted
Moodle Development complete
Contract Awarded
Developer training complete
Content Development complete
All testing complete
TEAM BRIEFINGS
PM: Alex Bass
Status:
Project Brief Agreed
Audit of support services complete
Learning Management Systems
PM: Johnny Pigott
Status:
Process Mapping Workshop Complete
Options Appraisal Complete
OLM / Promis link feasibility complete
Prefered option selected
Implementation plan agreed
09/07/2008

OVERVIEW OF OLYMPIC PROGRAMME PROJECTS: *to be completed once project initiation documentation signed off*

T1P1: Operations
Project Executive: Jason Killens; Project Manager: Gareth Hughes
The aim of this project is to model the human and non-human requirements for the Games, and identify an approach for command and control. The project is intended to ensure a comprehensive understanding of requirements/assets needed with regards to vehicles/equipment and staff.

T1P2: Communications
Project Executive: Peter Thorpe; Project Manager: Tim Edmonds
This project is intended to finalise the development of the Olympic Programme approach to communications, and knowledge transfer. Its objective is to ensure staff, public, media, and key stakeholders are aware of the role the Service will play during the 2012 Games.

T1P3: Mutual Aid and Volunteers
Project Executive: Peter Thorpe; Project Manager: Steve Irving
This project is intended to identify current partnership agreements and produce a framework for mutual aid/volunteers. One objective of the project is to develop a partnership agreement legacy that will enhance patient care beyond 2012 and contribute to the transfer of knowledge.

T1P4: Clinical Skills Acquisition/Training
Project Manager: *vacant*; Senior Supplier: Keith Miller
This project is intended to identify the training requirements for Games time, and produce and approve a draft timetable, the implementation of which will equip the LAS with the skills to deliver a high level of service throughout the Games. The project is intended to provide a clear awareness of how the requirements for the Olympic Programme will be assimilated into the LAS training programme.

T1P5: Procurement: Vehicles and Equipment
Project Executive: Chris Vale; Project Manager: Karen Merritt
This project will consist of the identification of Olympic procurement requirements (and how these fit within LAS procurement cycles) and an approach towards offers of goods/equipment from external organisations. An approach to maintaining awareness of environmental issues/'green' options relating to vehicles and equipment throughout the duration of Olympics Programme will be determined.

T1P6: Staff Engagement
Project Executive: Tony Crabtree; Project Manager: Anna Kilpin
This project will identify an approach to staff engagement which will subsequently underpin the Olympics Programme. The project will consist of the identification of any barriers, an understanding of staff expectations, what incentivisation may be required, and an identified approach to staff benefits.

T1P7: Financial Framework
Project Executive: Paul Cain-Renshaw; Project Manager: Michael Bartley
The objective of this project is to ensure that the Olympics Programme has adequate financial controls and management in place to successfully deliver the programme on time and within budget. The project will consist of the development of a strategic and operational approach to financial management at programme-level.

T1P8: Estates Strategy
Project Executive: Martin Nelhams; Project Manager: Steve Sellek
This project will identify estates requirements for the Olympics Programme, the development of implementation plans, and identification of cost parameters. The focus will specifically be on the Olympic Games Planning Office, an 'Olympic Station' and a central control function.

T1P9: IM&T Strategy
Project Executive: Vic Wynn; Project Manager: *vacant*
This project will consist of the identification of a strategic approach to IM&T for the duration of the Olympic Programme. Planning assumptions, interdependencies and external influences will be identified and the potential for realising legacy benefits will be explored.

Project Status Key:	2008								
✓ On track									
! Not on track but under control	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
✗ Not on track and not in control									
T1P1: OPERATIONS			Produce and test modelling tool; Model resource requirements						
Project Executive: Jason Killens									
Project Manager: Gareth Hughes				Agree command and control structure			Model workforce for central control function		Conduct post-project review
Status: ✓		Complete project initiation							
T1P2: COMMUNICATIONS		Finalise Communications and Engagement Plan							
Project Executive: Peter Thorpe									
Project Manager: Tim Edmonds			Finalise Stakeholder Management Strategy	Transfer of Knowledge Workshop		Framework for Transfer of Knowledge	Initiate knowledge capture to date		Conduct post-project review
Status: ✓	Complete project initiation								
T1P3: MUTUAL AID & VOLUNTEERS								Sign off framework	
Project Executive: Peter Thorpe									
Project Manager: Steve Irving	Complete project initiation	Identify existing partnership agreements			Produce partnership agreement framework		Share framework with existing partners		Conduct post-project review
Status: ✓									
T1P4: CLINICAL SKILLS ACQUISITION/TRAINING				Identify operational training requirements	Identify event management training requirements	Approval of training requirements: Medical Director	Approval to recruit: PLM/EPA SpR		
Senior Supplier: Keith Miller									Conduct post-project review
Project Manager: vacant		Complete project initiation	Identify clinical training requirements			Produce draft training timetable		Tabling of draft timetable: Training Services Group	
Status: !									
T1P5: PROCUREMENT					Scope/appraise options for funding/supply	Approach/process for external offers of goods/equipment			
Project Executive: Chris Vale									
Project Manager: Karen Merritt		Complete project initiation	Vehicle/equipment kit lists	Review LAS procurement cycles			Environmental statement to inform procurement		Conduct post-project review
Status: ✓									
T1P6: STAFF ENGAGEMENT						Feedback survey findings to Staff; Assessment of effectiveness, feasibility, deliverability		Options appraisal for meeting workforce requirements	
Project Executive: Tony Crabtree									
Project Manager: Anna Kilpin		Presentation at Staff Council	Workshop with Staffside to identify issues/ risks	Survey staff to identify expectations	Council of benefits	Draft staff and volunteer recognition programme	Staff welfare requirements identified		Conduct post-project review
Status: ✓	Complete project initiation								
T1P7: FINANCIAL FRAMEWORK					Programme Board agreement of strategic approach	Identify potential costs/ expenditure during Games period in relation to all stakeholders			
Project Executive: Paul Cain-Renshaw									
Project Manager: Michael Bartley				Develop a strategic approach to financial management of the programme			Develop, populate and test financial modelling tool		Conduct post-project review
Status: !	Complete project initiation								
T1P8: ESTATES STRATEGY				Implementation plan for OGPO	Estates requirements for Olympic Station	Implementation plan for Olympic Station	Implementation plan for Estates Event Control		
Project Executive: Martin Nelhams									
Project Manager: Steve Selleck			Estates requirements for Olympic Games Planning Office (OGPO)	Costing parameters for OGPO		Costing parameters for Olympic Station	requirements for Event Control facilities		Costing parameters for Event Control facilities
Status: ✓	Complete project initiation								
T1P9: IM&T STRATEGY				Workshop to identify planning assumptions, interdependencies		Scoping of IM&T		IM&T Strategy for entirety	review
Project Executive: Vic Wynn									
Project Manager: Sharon King				Workshop to scope all IM&T activity up to/during Games	and external influences	activity up to/during Games; Identification of planning assumptions, interdependencies and external influences		of Olympic Programme including legacy opportunities	Conduct post-project review
Status: ✓		Complete project initiation							

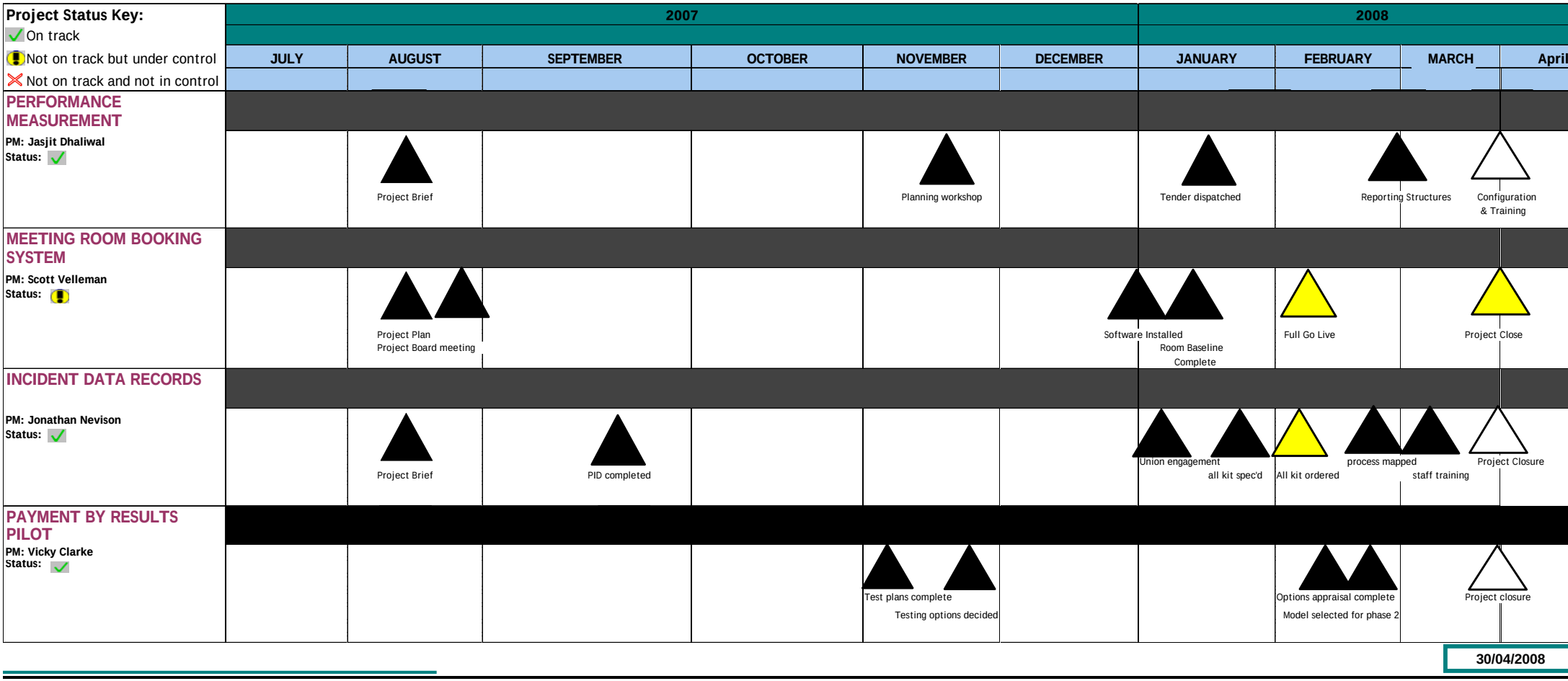
OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE - TRANCH 1 PROGRESS REPORT

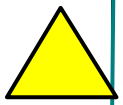
Performance Measurement
Project Manager: Jas(jit) Dhaliwal

The first phase of the Performance Measurement project will examine the Balanced Scorecard and various weekly reports in the light of the 2007/08 SMG objectives.

Meeting Room Booking System
Project Manager: Scott Velleman

This project involves the identification and implementation of software to allow the management of all room bookings across the Trust, including all training facilities and hot desks.


Project Status Key:
On track
Not on track but under control
Not on track and not in control
2007
2008
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
April
PERFORMANCE MEASUREMENT
PM: Jasjit Dhaliwal
Status:
Project Brief
Planning workshop
Tender dispatched
Reporting Structures
Configuration & Training
MEETING ROOM BOOKING SYSTEM
PM: Scott Velleman
Status:
Project Plan
Project Board meeting
Software Installed
Room Baseline Complete
Full Go Live
Project Close
INCIDENT DATA RECORDS
PM: Jonathan Nevison
Status:
Project Brief
PID completed
Union engagement
all kit spec'd
All kit ordered
process mapped
staff training
Project Closure
PAYMENT BY RESULTS PILOT
PM: Vicky Clarke
Status:
Test plans complete
Testing options decided
Options appraisal complete
Model selected for phase 2
Project closure
30/04/2008

Project Status Key:	2008					
✓ On track						
! Not on track but under control	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
✗ Not on track and not in control						
PERFORMANCE MEASUREMENT						
PM: Jasjit Dhaliwal **Status:** ✓			 Workshops preparation			
MEETING ROOM BOOKING SYSTEM						
PM: Scott Velleman **Status:** !		 Project Closure				

30/06/2008

OVERVIEW OF PROGRAMME: CORPORATE PROCESSES AND GOVERNANCE TRANCH 2 PROGRESS REPORT -

Map all Processes
Project Manager: Martyn Salter

This project involves identifying all corporate processes, producing a Process Mapping Standard for use throughout the Trust and then using the standard to map all key processes. These process maps will then be used by subsequent projects to review processes and improve upon them to deliver the programme vision. A central repository will be identified and developed so that process maps can be stored reliably and are accessible as required.

Staff Administration
Project Manager: Jonathan Nevison

The project consists of a review and redesign of staff administration processes at complex level. Previous process mapping indicates that an interface between ESR and ProMis could substantially improve efficiency by reducing duplication and hard copy paper flows and the project is tasked with exploring this further. There is also an urgent need to replace the Station Operating System, which is becoming increasingly difficult to support.

Real-Time Fleet Management Information
Project Manager: Chris Miles

The project consists of implementing TranMan across the whole of Fleet Support and ensuring that all business changes are implemented.

Re-Engineer Income Collection
Project Manager: Chizoba Okoli

This project has been set up to map and document all income streams and collection processes with a view to streamlining them to improve cashflow.

PRF Handling and Processing
Project Manager: Jonathan Nevison

This project involves reviewing the process by which the prf is recorded at complexes and transported to Management Information.

The Intelligent Trust
Project Manager: Stephen Moore

This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement SharePoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

Foundation Trust Diagnostic Project
Project Manager: Ashley Young

Carry out the diagnostic processes, which will enable the Trust to proceed to making a Foundation Trust application.

Electronic Expenses
Project Manager: Jonathan Nevison

Select and implement an electronic system for claiming and authorising staff expenses. The systems must interface with ESR to eliminate manual input of data into the payroll system.

Asset Tracking
Project Manager: Gadge Nijjar

This project is the roll-out phase of a piloted system for tracking the dozen or so pieces of EBME (Electro Bio-Medical Engineering) on each ambulance, developed in conjunction with the 'make-ready' contractor. This will also offer the facility to track and manage EBME servicing more robustly.

Inventory Management
Project Manager: David Selwood

This project is to develop electronic stock management in the Trust enabling better management of stock levels and real-time stock information. This is being done using a new module within the Trust's accounting package. The initial stage is to roll-out a paper-based stock control system which will subsequently be automated.

MAP ALL PROCESSES

PM: Martyn Salter

Status:

Identify Processes

Software Installed

Process Improvement training

Project Plan

STAFF ADMINISTRATION

PM: Jon Nevison

Status:

Payroll variation process /self-service

sickness reporting formatted

AEM1 query written in ProMis

ProMis sign-on sheet redesigned

New time and attendance entry screen

Management annual leave move to RCs

Testing of new time entry system

REAL-TIME FLEET MANAGEMENT INFO

PM: Christopher W Miles

Status:

Specification agreed

Tender documents issued

Tender Evaluation

Contract Let

Data Capture Complete

Testing

Training

Implementation

RE-ENGINEER INCOME COLLECTION

PM: Chizoba Okoli

Status:

Identify inefficient processes

Redesign processes

PRF PROCESSING

PM: tbc

Status:

Project Brief

Project Board

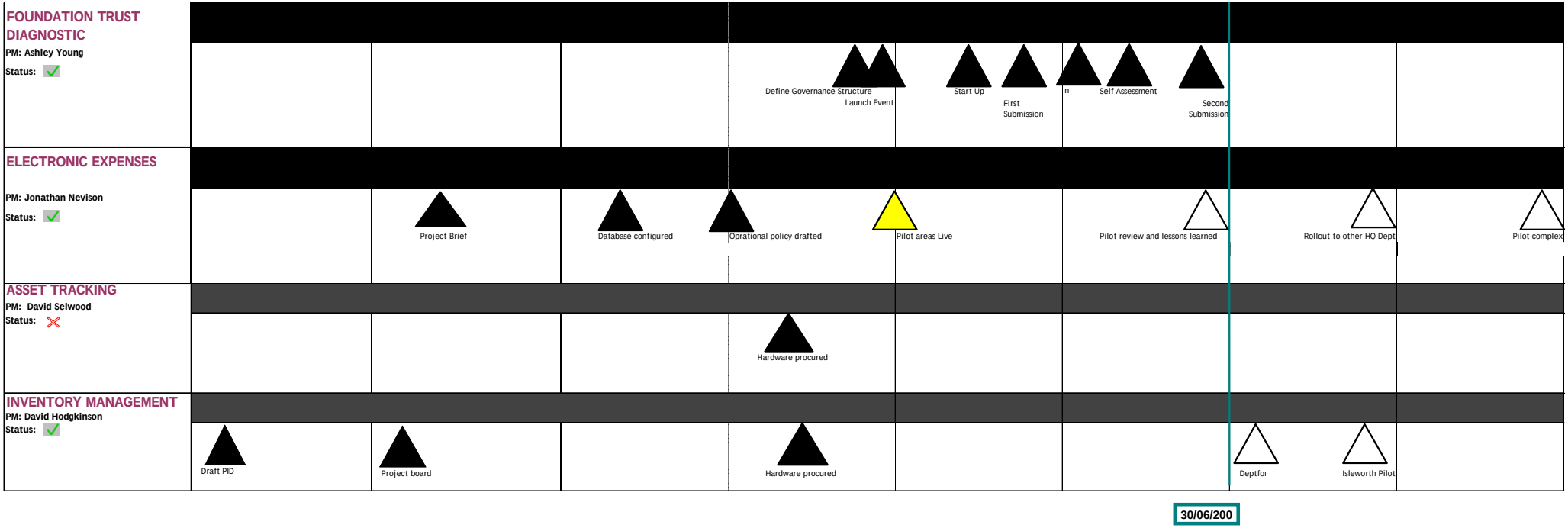
THE INTELLIGENT TRUST

PM: Stephen Moore

Status:

Project Brief

Project Board


FOUNDATION TRUST DIAGNOSTIC
PM: Ashley Young
Status:
Define Governance Structure
Launch Event
Start Up
First Submission
n
Self Assessment
Second Submission
ELECTRONIC EXPENSES
PM: Jonathan Nevison
Status:
Project Brief
Database configured
Oprational policy drafted
Pilot areas Live
Pilot review and lessons learned
Rollout to other HQ Dept
Pilot complex
ASSET TRACKING
PM: David Selwood
Status:
Hardware procured
INVENTORY MANAGEMENT
PM: David Hodgkinson
Status:
Draft PID
Project board
Hardware procured
Deptfo
Isleworth Pilot
30/06/200

Enclosure 13

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 24th June 2008 at 10:00 a.m.
Held in the Conference Room, LAS HQ

Present:	Sarah Waller	Non Executive
	Beryl Magrath	Non Executive (until 12.40)
	Caroline Silver	Non Executive (until 13.05)
	Roy Griffins	Non Executive (until 13.10)
	Brian Huckett	Non Executive
In attendance:	Mike Dinan	Director of Finance
	Martin Flaherty	Director of Operations
	Peter Suter	Director of Information Management & Technology (IM&T)
	Ann Ball	Deputy HR Director
	Angie Patton	Head of Communications
	Ian Pentland	Consultant Project Manager (CAD 2010)
	David Hodgeson	Project Officer, FT Diagnostic Project (FT Diagnostic Update)
	Vicky Clarke	Finance Manager A&E Operations (FT Diagnostic Update)
	Christine McMahon	Trust Secretary
Apologies:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Fionna Moore	Medical Director
	Ingrid Prescod	Non Executive
	Caron Hitchen	Director of Human Resources & Organisation Development
	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development

Tabled at the meeting: Update regarding patient booking-in.
Post meeting update: the above paper was circulated via email (25th June 08) to Members and attendees of the SDC who were not present at the meeting.

The Committee expressed their best wishes to the Director of Human Resources and Organisation Development and the Director of Communications, both of whom have been unwell recently.

13/08 Minutes of the last meeting of the Service Development Committee, held on 26th February 2008.

The Vice-Chairman **signed** the Minutes as a correct record of the meeting held on 26th February 2008 with a correction to minute 07/08 'to engage in Urgent Care restructure'.

Matters Arising

Minute 01/08: the Director of IM&T said that the replacement of the CD ROM drives in the vehicles with a different (and updatable) memory device will be kept under review as part of the MDT replacement over the next couple of years. **ACTION: Director of IM&T to provide an update to the Committee at a future meeting.**

14/08 Chairman's Update

The Vice Chairman said that Dr George Greener, Chairman of NHS London, recently visited the LAS and held discussions with the Chairman, the Director of IM&T and the

Director of Service Development. The Director of IM&T said that the NHS London Chairman was very supportive of the CAD 2010 project.

The Primary Care Trusts (PCTs) have been given a tight timetable to separate their provider and commissioning functions. It was suggested that it will be challenging for the PCTs to separate managerial and financial systems by 31st March 2009. The governance arrangements for the new approach to commissioning and the provision of services were under discussion and it was hoped that a clear model will emerge during the forthcoming months. Though there was little likelihood of the London PCTs merging, a number were 'clustering' so as to obtain the benefits of sharing financial and personnel resources.

James Cleverly, Greater London Assembly (GLA) Member for Bexley & Bromley, visited the LAS on the 23rd June. Mr Cleverly has been appointed the new Health Lead for the GLA. During his visit he spent time in the Emergency Operations Centre and the Urgent Operations Centre.

Lord Darzi's final report, setting out the nationwide vision for the next decade was expected on 30th June 2008, ahead of the NHS' 60th birthday celebrations on the 5th July 2008. The hope was expressed that Lord Darzi's plan will not include reference to a National Ambulance Tariff.

15/08 Performance update

The Director of Operations updated the Committee on performance. Category A 8 minute performance has fallen; it was 76.9% in April, 74.45% in May and 73% in June to date. The year to date figure for Category A 8 minute performance was 74.88%. Category B 19 minute performance has also fallen since April; it was 88.4% in April; 84% in May and 81% in June to date. The year to date figure for Category B 19 minute performance was 85%.

The reasons for the fall in performance were an increase in workload and poor staffing resourcing. Category A 8 minute demand increased by 10% in May 2008 compared to May 2007, making it the third busiest month in the Trust's history. Category A 8 minute demand in June to date was approximately 5.3% higher than June 2007, with a high level of demand being experienced at weekends.

Overall the Trust is just behind the national Category A 8 minute target at the end of the first quarter; only 5 other Ambulance Services were achieving the Category A 8 minute performance. The Director of Operations was confident that performance would be recovered in the forthcoming months.

The second British Heart Foundation (BHF) campaign was run in May 2008 and had a discernable impact with an estimated 9% increase in Category A 8 minute calls. The Director of Operations said that detailed work was being undertaken in regard to the effect on Cardiac related AMPDS determinants and the LAS will be sharing the findings internally and also with the BHF.

Another factor in the downturn in performance was that during June the Metropolitan Police Service took down the CAD link for five days to undertake maintenance. This meant call takers in EOC were answering an extra 500 calls a day instead of receiving the call electronically via the CAD link.

The Director of Operations said that the increase in demand in May was above the agreed funding threshold and this would be raised with the Commissioners at the regular meeting next week.

NHS London was urging the London PCTs to review the level at which Category B 19 minute had been commissioned for in 2008/09 which was 90% as opposed to the national target of 95%. The LAS has made it clear that when funding is made available to meet the

national target in February 2008 it was accepted that there would be a time delay before those newly funded staff were available to operations. As a result the LAS had agreed with Commissioners a 90% Category B 19 minute target for 2008/09. It was the view of the Trust that 95% performance for Category B 19 minute would be delivered in 2009/10. The Director of Operations said that the Trust Board will be kept informed as to progress of the on-going discussions with NHS London and Commissioners.

The 2008/09 Workforce Plan was being implemented and discussions were on-going to ensure that any barriers to achieving the Plan were swiftly addressed. The Director of Operations said that he expected to have 213 vacancies in March 2009; as although the extra staffing would have been recruited they would not all have completed their training and be available for deployment. The earliest he anticipated having full establishment was September 2009. **ACTION: HR Director to provide the Trust Board with a progress report in July 2008.**

In the interim, the Trust will remain heavily reliant on overtime, and in the short term the payment of bonuses, to meet current resourcing needs. The Senior Management Group had debated the matter and was in agreement that the Trust should continue the payment of bonuses until the end of August. The situation will be kept under constant review and particularly the management of the performance/financial dynamic. The Director of Operations said that despite operational pressures Paramedic training and Continuous Professional Development were being undertaken; with particular focus being placed on members of staff who have not received training over the last two years. In response to a question he said that Management had kept its promise to new members of staff who had been working the B Relief Rota (7 weekends in ten) for 18 months and they were now working a normal rota.

The Deputy HR Director said there had been a good response to the Trust's recruitment campaign. The Trust is staggering its recruitment campaigns to ensure that candidates did not experience undue delays between application, interview and training. In response to a question as to whether other ambulance services could assist by providing additional trainers the Deputy HR Director said that the Trust itself had received enquires from other ambulance services as to spare training capacity. There appeared to be little spare capacity nationally in respect of qualified trainers, nevertheless the Trust was continuing to explore the possibility.

The national target for Category B 19 minute performance had been scheduled to be phased out in 2009/10; it was now likely to remain in force until 2010/11. Eight of the twelve ambulance services were not achieving the national Category B 19 minute performance target. The Department of Health was keen that the target remain in force until it was confident that robust systems were in place to provide a workable alternative based on clinical outcomes.

16/08 **Finance update (Month 2)**

The Director of Finance presented month 2 financial update. He said that the financial risks agreed by the Audit Committee on 16th June 2008 had been included and that these will be tracked in 2008/09. The risks were as follows:

- Category B 19 minute penalty;
- Failure to manage A&E overtime within plan;
- Fuel price rise in excess of planned figures;
- Failure to meet the Trust's Cost Achieve Programme and PTS' profit less than forecast.

The Director of Finance highlighted the following from his report:

- The Trust was forecast to have £1m surplus at year end.
- The A&E cost per incident had fallen in recent months: £218 in April and £189 in May. This was due to a rise in the volume of calls which lowered the average cost per day.
- PTS had a net loss of £153,000 in Month 2; in response third party controls had been improved and measure were being taken to address some billing that had not been accrued. PTS was forecast to break even in 2008/09. The Committee will consider the PTS Strategy in October 2008. **ACTION: Director of Finance**
- The Finance Director drew the Committee's attention to the trend report on page 5 of the report, in particular to the expenditure on overtime which was tracked on a weekly basis.
- The Trust was undertaking a joint tender with the Ministry of Defence in respect of fuel and oil. The Finance Director said that, if necessary, the Trust will seek additional funding should the higher cost of fuel become a burden on the Trust.

In response to a question regarding £0.5m spent on vehicle maintenance the Director of Finance said this related to shuttle drivers being employed to transfer ambulance and other service vehicles between garages and complex stations. The Director of Finance said he would investigate why PTS staffing was shown as sharply decreasing in August 2007 (128 compared to 547 in July 07 and 457 in September 07). **ACTION: Finance Director**

The Finance Director drew the Committee's attention the Analysis by Expense Type, page 9, which included financial information for 2007/08 as a comparator to expenditure in 2008/09.

17/08 Under Delegated Authority from the Trust Board:

Approval of CAD 2010 Supplier choice and draft full business case for the SHA

The Director of IM&T presented the draft Full Business Case for CAD2010 to the Committee. The circulated pack contained: a covering paper; the evaluated final tender report; draft full business case. The supporting pack of 31 appendices included: the initial transition plan; capital charges and benefits realisation plan. The Director of IM&T said that the fundamental reason for the CAD 2010 project was that the current system (CTAK) was no longer fit for purpose, specifically in relation to long term aspirations of the LAS and providing support for the Olympics.

The process to replace the current CAD system has been complex and has involved a three stage business case process (Strategic Outline Case, Outline Business Case , and Full Business Case); using the full European tendering process and the Gateway review process. Following approval by the Service Development Committee, under delegated authority from the Trust Board, the draft FBC will be reviewed as part of a Gateway 3 that will commence on 25th June with the final FBC being presented to the Trust Board in July 2008 for authority to submit to the SHA. The FBC will then be passed to the SHA for approval; this was likely to take 3-6 months, following which the FBC will be re-presented to the Trust Board for final approval and the contract awarded.

The Director of IM&T reminded the SDC of the procurement process. When the tender was initially advertised there were 13 expressions of interest received; the first stage of the evaluation process reduced the number to 6 and then to a final 2 potential suppliers, Intergraph and Northrop Grumman. Both companies were invited to participate in the competitive dialogue process. This involved very detailed discussions with the Trust's Officers being in constant dialogue with the two companies. Following extensive evaluation of both bidders' final submissions, the procurement team recommend to the

CAD 2010 Project Board that Northrop Grumman should be selected as the preferred bidder, and subject to final contract clarification selected as the CAD 2010 supplier. This recommendation was accepted and was being put forward within the FBC.

The Director of IM&T said the Project Team had been consistently impressed with the professionalism and the responsiveness of Northrop Grumman. The Finance Director said that both Suppliers were asked to perform a due diligence review of CTAK to ensure they understood the interface requirements for the transition process. The LAS' service level requirements were higher than those of other UK ambulance services and that, although the existing CTAK system was out of date, its core functionality was quite sophisticated.

The following is a summary of the answers provided by the Directors of IM&T and Finance to the questions posed by the Non Executive Directors concerning the draft FBC:

- The Trust's Intellectual Property rights over developments undertaken by Northrop Grumman will be discussed as part of the contract negotiations;
- There will be sanctions in the contract for non-performance; these were outlined in schedule 2.2. The contract will include performance indicators that will be closely monitored. There will also be a framework for response times should problems arise with the new system to ensure minimum disruption to Operations.
- Schedule 6.1, the financial component of the FBC, included an overall project programme with key activities/milestone. Schedule 6.1 and 7.1 included details of the 200+ elements with associated costs. Schedule 7.4 outlined the labour rates that will be charged should a contract not be agreed. The Finance Director said he would forward the detailed breakdown of the schedule to Brian Huckett. **ACTION: Finance Director**
- The phased transition from CTAK to CAD 20010 and the costs involved were included in the stated overall cost. The two systems were expected to co-exist for approximately nine months.
- Schedule 4.1 outlined the scope of the support and maintenance that will be provided; this will be 'basic' with an option for a fully managed service.
- There was an on-going discussion as to when would be optimum time to engage a Contract Manager to oversee the contract. The Head of Procurement has been working full time on CAD 2010 and will remain involved until the contract is signed. The Trust Board will receive regular updates on the progress of CAD 2010. **ACTION: Director of IM&T**
- Discussions will be held with Commissioners on the funding of the CAD 2010; the Director of Finance said a detailed plan will be put in place to cover any gaps in funding.
- Following a risk assessment of the cost profile of the current project plan a risk contingency of £1.1m was included. In addition an optimism bias of £794k was added by the Project Board. In view of the concerns voiced by the Non Executive Directors that this was a potentially low figure the Director of Finance undertook to review the contingency figure prior to the Trust Board considering the final draft of the FBC. **ACTION: Finance Director**
- As per treasury guidelines the FBC does not include inflation as the Trust receives inflationary uplift every year for both pay and non-pay which would be applied to CAD2010 costs.
- The difference between the costings set out in the Strategic Outline Case (£22.8m) and the FBC (£23.2m) was due to: the costs now being spread over 10 years rather than the original 15 years; greater knowledge of the actual costings following the tender exercise being undertaken and the
decision to reduce revenue costs and increase capital costs reflecting how the CAD 2010 Programme will be managed.

- The Finance Director said he was comfortable with the proposed £16.1m capital spend. The Trust Board in July 2008 will receive a multi-year report on the proposed capital spend. **ACTION: Finance Director**
- The duration of the contract will be for 7 years with a potential extension of 5 years bringing it up to a maximum of 12 years. This will be made explicit in the contract.
- All concerned were keen that CAD 2010 be in place and fully operational prior to the Olympics being held in London in 2012.
- The Trust will not be required to update the system on an annual basis but will be able to choose which new releases it wishes to incorporate. If, however, individual components of the new system (e.g. Oracle) issue new releases that the Trust wishes to incorporate additional costs will be incurred

Roy Griffins undertook to share the FBC with Carrie Armitage, the Consultant engaged to independently advise the Board on the CAD 2010. She will be asked for her views prior to the Trust Board in July 08. **ACTION: Roy Griffins**

In the interim, between the Trust Board approving the final FBC in July and the SHA approving the FBC, work will be undertaken with the preferred Suppliers whilst contract negotiations were being undertaken. The work on a time and money basis, for which the SDC was asked to approve a total of £750k, will be subject to a Letter of Intent for specific pieces of costed work. If, for any reason, more than £750k was committed the Trust Board's approval would be sought.

The Vice-Chairman asked the Non-Executive Directors and Executive Directors if they felt they had has sufficient information to make a decision or whether they wished for the matter to be deferred to the Trust Board meeting in July. The consensus was that the members present felt they had sufficient information to make a decision, that the questions raised had been answered and it was recognised that the Trust was not actually being committed to anything at this point except for £750k. The Trust's legal advisers will be asked to provide the Board with a summary of potentially contentious areas identified in the proposed contract with Northrop Grumman. **ACTION: Finance Director.**

Approved

1. **The selection of Northrop Grumman Information Technology Global Corp. as the preferred supplier of CAD 2010 subject to Terms and Conditions and Full Business Case.**
2. **Work to commence with the preferred supplier on the basis of a letter of intent, in accordance with standard financial instructions capped at £750K, with an agreed reporting structure back to the Board. This would only be paid if there was a failure to agree contract terms and the procurement did not proceed.**
3. **The draft FBC ahead of finalisation as outlined in section 3**

Noted:

4. **The content of the Evaluated Final Tender Report, the recommendations of the Procurement Team and the CAD 2010 Project Board's selection of Northrop Grumman Information Technology Global Corp. as the preferred supplier.**
5. **That further work would be undertaken in respect of reviewing the level of contingency included in the costings.**

18/08 FT diagnostic update

The Finance Director presented the draft Integrated Business Plan (IBP) that was submitted to NHS London's FT Diagnostic team on 16th June; the 95 page Plan had been produced to a very tight deadline and the errors identified in the draft would be addressed.

The format of the IBP was based on South West London & Maudsley NHS Trust IBP. It included material from the existing Service Improvement Programme; the existing NHS London/London Provider Agency returns; the Trust Board and Service Development Committee papers; market assessment based on diagnostic team review and the financial

model based on existing LPA plan. The feedback received from the NHS London team was generally positive with suggestions that the narrative linking facts and figures be made more explicit and that a more detailed market assessment is included as well as explanations for the position taken. The following concern/risks were flagged up: additional detail concerning the delivery of the Cost Improvement Programme in particular the use of overtime and vacancy management; the percentage of the Trust's income that is not secured and that the Trust Board and SDC papers needed to describe how decisions were arrived at.

The Board to Board meeting will be held at 1pm on 7th July at the Trust's headquarters. It was suggested that the following may be participating in the Board to Board meeting: the Chief Executive of the London Provider Agency; two NHS London Non Executives; NHS London Finance Director and the LPA's FT lead. The format of the meeting will be a ten minute presentation by the LAS' Chief Executive followed by 60 minutes of questions on the IBP. At the conclusion of the meeting there will be initial feedback from the NHS London team on what areas need to be developed further. Detailed feedback will be received at the conclusion of the Pilot. The Finance Director said that time has been put aside for the Senior Management Team to receive briefings prior to the Board to Board which the Non-Executives were welcome to join. The times and dates were circulated via email. In addition, specific briefings for Board members were available as required from the FT Diagnostic Team.

The Finance Director said he would welcome comments about how the IBP could be improved, in particular the section on market assessment. He asked that any comments be forwarded to him by the close of business on 25th June. One suggestion was that further work be undertaken around sensitivity analysis with a number of different scenarios considered and included in the Plan. A follow up draft IBP will be circulated prior to the Board to Board on 7th July 08. **ACTION: Finance Director.**

The LAS was one of two ambulance services piloting the FT Diagnostic for Ambulance Services. The Finance Director said that by participating in the pilot the Trust will move more confidently through the FT application process as lessons learnt at this stage would be implemented prior to assessment by Monitor. Sarah Waller requested that a flow chart be produced, comparing what the LAS has undertaken to date in respect of the FT Diagnostic and the normal schedule of an application, so as to demonstrate the benefit of undertaking the FT diagnostic pilot. **ACTION: Finance Director.**

The earliest that Ambulance Services will be able to apply for FT status is April 2009. Other areas of work that will need to be undertaken in preparation for the FT application were three month public consultation period and the recruitment and management of a membership. In terms of managing the process it was anticipated that the FT Project Group will be replaced by a FT Programme board with effect from the autumn.

Noted:

1. **The contents of the Draft Integrated Business Plan**
2. **That the financial section of the IBP had been redrafted by the Development Accountant and will be circulated to SDC members. ACTION: Financial Manager A&E Operations**

19/08 **Receive 2007 Staff Survey Results**

Ann Ball, the Deputy HR Director, presented a summary of the results of the 2007 Staff Survey. This survey was undertaken by the Picker Institute on behalf of the Trust; the majority of the questions asked were standard across the NHS although each Trust was able to include 7 questions specific to that Trust. A random sample of 833 members of staff was pre-selected to complete the Healthcare Commission National NSH staff survey. The annual survey is carried out nationally allowing for comparison to be made with all other NHS trust across the country.

The survey was conducted between October and December 2007; the response rate of the sample surveyed was 45% was the best recorded since 2004.
The following areas were highlighted as being of significance/interest:

- General 'feel good' factor: there were no major changes from last year to the statements 'I am proud to work for the LAS'; 'taking everything into account, I feel positive about working for the LAS' and 'the LAS NHS Trust is a good employer to work for.'
- Appraisal: the LAS continues to compare well to other Ambulance Trusts with 61% of staff receiving appraisal last year and 44% having a Personal Development Plan in place. There was a reduction from 23% to 15% of responses saying the appraisal was well structured and helpful.

  The Director of Operations said that despite the operational pressures experienced in 2007/08 appraisals and PDPs were undertaken and that the LAS compared well when benchmarked against other NHS trusts.
- Consultation: there was a slight reduction of 4% in positive perception of unions and management working well together and on consultation in the development of policies and procedures. This was viewed as evidence that there was a reduced dependence on the Trade Unions for information and what is going on in the LAS.
- Safety and well being: the Trust compared equally with other Ambulance Trusts on staff experiencing physical/verbal abuse from patients and relatives. There was no change from last year. There was a general level of satisfaction expressed in the effective action taken by the Trust following such incidents. There was a reported decrease in staff accessing Health and Safety Training. This would be followed up as part of the action plan.
- Communications: there was a reduction in satisfaction to 'communication in my part of the LAS is good' and 'on the whole communication in my organisation is effective'. The responses to the following questions was significantly better than the national average in 'communication between senior management and staff'; 'communication between different parts of the Trust' and 'receiving feedback on 'how well am I doing my job'.

The Chief Executive's annual consultation meetings were an effective means of communicating directly with members of staff. The Head of Communications said that staff engagement was a key part of New Ways of Working; local audits will be undertaken to ascertain the level of communication on stations which will include looking at the feedback loop discussed by the Audit and Clinical Governance meetings.

Noted:

1. **The staff survey results**
2. **That local action plans will be drawn up to address key areas. ACTION: Local Managers**
3. **That localised details were available from the HR Department for Areas and Departments to view.**
4. **That the local Area Operations Managers have been tasked to review the responses for their respective complexes and identify areas of concern which will be followed up by a local action plan.**
5. **That the staff survey results and response rates will be part of the annual assessment undertaken by the Healthcare Commission.**

20/08 <u>For discussion: Information Management & Technology (IM&T) Strategy</u>

The Director of IM&T presented the Strategy for SDC's consideration prior to it being presented to the Trust Board in September 2008 for approval.

The Audit Committee and the Clinical Governance Committee had expressed concern that there was no demonstrable feedback loop in place to ensure that front line members of staff received and acted upon disseminated information, particularly in regard to changes in clinical practice. The Director of IM&T said that the introduction of web based training was supported by the Strategy; if the introduction of web-based training was considered to be a priority for the Trust it could be delivered in a shorter time frame than was currently planned.

The Vice-Chairman requested that an executive summary be included at the beginning of the Strategy. **ACTION: The Director of IM&T.**

The reference to home working in Section 7 would be considered further by the Senior Management Group and amended as appropriate as Members felt it was a strategic and not simply a policy decision. **ACTION: The Director of IM&T**

Noted:

1. **That the appropriately amended IM&T Strategy will be presented to the Trust Board in September. ACTION: The Director of IM&T**
2. **That members of the Committee were invited to forward any further comments regarding the Strategy to the Director of IM&T.**

21/08 SIP 2012 Update: Access

Due to the extended discussion of the draft Full Business Case for CAD 2010 the update regarding the Access Programme was deferred to the SDC's next meeting in October 2008.

22/08 Patient Booking-in

The Director of Operations tabled a paper that reported on the changes to the handover of patients to A&E members of staff which was introduced in order to meet the DH standard for an ambulance average hospital turnaround time of 15 minutes. Turnaround times in London were amongst the highest reported in the country and the Trust examined its own internal procedures to identify whether there were weaknesses in the existing practices being carried out by ambulance crews at A&E units. It was found that there was no single standard procedure pan London. Various local arrangements had been implemented; these were amalgamated to form the London A&E co-ordination protocol.

At the beginning of 2008 the Trust decided to alter its hospital handover procedure to eliminate the administration handover in an effort to help reduce the hospital turnaround times. In removing this element it was recognised that it was also an ideal opportunity to implement a more robust clinical handover.

A 3 phase consultative programme with A&E partners was adopted which included: the Medical Director meeting with A&E Consultants to engage at senior level; the Assistant Directors of Operations (ADOs) writing to each hospital's Chief Executive and A&E Manager requesting further strategic collaboration and Operational Area Management teams holding summit meetings with their respective A&E departments to discuss what changes would need to be made.

In March 2008 the Trust made changes to its handover procedure to eliminate the administration handover performed at many A&E units. To assist with the new process local management teams were placed at each hospital to help manage any concerns. Many units offered to place an administrative function at the point of triage to help with ambulance admissions and reduce the time spent on handover. An audit to determine the effectiveness of the revised handover procedure was undertaken in May 2008. Areas of best practice were identified at the following hospitals: St Mary's, the Homerton and St Hellier and were shared with other A&E departments. A follow up audit of the handover procedure will be undertaken in August/September 2008.

The Director of Operations said that further work was taking place with PCTs and NHS London to agree a pan London Divert and Closure policy.

It was recognised that a strategic solution would be for the national 4 hour A&E target to be adapted to start the clock when the ambulance service arrives at the hospital rather than when the Acute hospital locally determines.

23/08 **Date of future meetings:**

The Trust Board meets on 29th July and 30th September 2008 at 10.00am in the conference room at the LAS, Waterloo Road, SE1.

The Service Development Committee meets again at 10.00am on 28th October 2008 in the conference room at the LAS, Waterloo Road, SE1.

The meeting concluded at 13.20

Enclosure 14

London Ambulance Service NHS TRUST

Trust Board 29th July 2008

SUMMARY OF THE MINUTES
Audit Committee 16th June 2008

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

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

3. ❑ **Agreed:**

The Annual Accounts, subject to the Mercedes Lease Chassis provision being agreed with the Audit Commission. The Statement of Internal Control was said to be consistent with assurance reports received by the Trust Board in 2007/08.

That the following financial risks will be tracked in the monthly financial report received by the Trust Board and SDC: Category B penalty (£2.1m); Achieve Trust CIP (£7.2m); Overtime Control (£9.7m); PTS profitability (£0.3m) and Fuel Price (£0.7m).

❑ **Noted:**

The recommendations made by the Audit Commission: reaching a full and final settlement on the subsistence provision with the HRMC; the adjustment of Balance should be stated in line with the Manual for Accounts Guidance; the Trust adhering to the Better Payment Practice Code and that all PCT Agreements be signed at the beginning of the financial year.

That the Finance Director had reviewed Senior Manager's expenses, nothing untoward was found and a formal report will be presented to the Audit Committee in September.

That the Internal Auditors will undertake an audit to verify the implementation of a change in practice. The Finance Director will seek the Medical Director's advice as to which change in practice to audit.

That the audit of the Asset Register by the Internal Auditors provided substantial assurance with no significant weaknesses identified.

That good progress had been reported via the Auditors' Recommendations database; with 13 recommendations implemented since the Committee's meeting in March 2008.

The 2007/08 annual report from the Local Counter Fraud Specialist and the 2007/08 Compound Indicator Declaration Form. Additional resources were allocated to counter fraud work in 2007/08, including the production of a DVD that is used at induction to promote an anti-fraud culture in the Trust.

The primary and secondary causes for the £25m deficit incurred by Brent PCT in 2007/08. The Committee will review the Trust's external financial reporting process at its meeting in November 2008.

That the annual declaration of full compliance with the Standards for Better Health had been submitted; the Healthcare Commission will publish its findings in October 2008.

That in October 2008 the Trust will be assessed by the NHSLA at Level 1 of the new Risk Management Standards for Ambulance Services. An action plan was in place to ensure that the Trust successfully meets the requirements of Level 1.

- **Standing items**:

1. Hospitality declared by the Chairman and the Director of IM&T.
2. That there was one waiver of Standing orders since the last Audit Committee meeting in regard to the use of electronic tendering system to open submitted tenders. The Internal Auditors will be asked to verify the audit trail of the electronic tendering system.

Minutes Received:

Minutes of the Clinical Governance Committee (April and June 2008) and Risk Compliance & Assurance Group (May 2008)

4. **Recommendation** **That the Trust Board NOTE the draft minutes of the Audit Committee**

LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE
2.30pm, Conference Room, LAS HQ

Monday, 16th June 2008

Present:	Caroline Silver	Non-Executive Director (Chair)	
	Roy Griffins	Non-Executive Director *	
	Sarah Waller	Non-Executive Director	
	Brian Huckett	Non-Executive Director	
In Attendance:	Mike Dinan	Director of Finance	
	Christine McMahon	Trust Secretary (Minutes)	
	Peter Bradley	Chief Executive	(left at 4.40pm)
	Chris Vale	Head of Operational Support	"
	Kelly Jupp	Audit Commission	"
	Robert Brooker	Local Counter Fraud Specialist	"
	Jasjit Dhaliwal	Compliance Officer	(left at 5.30pm)
	Michael John	Financial Controller	"
	Nicola Foad	Head of Legal Services	"
	Chris Rising	Bentley Jennison	"
	Sue Exton	Audit Commission	"
	Dominic Bradley	Audit Commission	"

***** Roy Griffins left the meeting at 4pm to be interviewed as part of the FT Diagnostic Project, rejoining at 5pm.

Circulated at the meeting: Annual Governance Report addendum – Mercedes Lease Chassis Provision by Audit Commission.

The Audit Committee held a private meeting with the internal and external auditors prior to the start of the meeting at 3pm.

16/08 Minutes of the last Audit Committee meeting held 3rd March 2008 and Matters Arising

Agreed:

1. **The minutes of the last Audit Committee meeting held on 3rd March 2008.**

Noted:

2. **Minute 01/08 (2): the Director of Finance said a review had been undertaken of Senior Managers' expenses and nothing untoward had been found. The guidance regarding expenses and hospitality will be reviewed and updated. A formal report will be presented to the Audit Committee in September 2008. ACTION: Director of Finance.**

3. **Minute 01/08 (4): the Director of Finance said that work was continuing to ensure that front line staff acted on bulletins informing them of changes in practice. At the Team Leaders' Conference on 20th June, one of the messages will be the need for Team Leaders to ensure the implementation of changes in practice when they undertake ride outs with front line staff. Another area of improvement in terms of communication with staff will be the redesign of the Trust's intranet.**

   Sarah Waller said an audit should be undertaken six months following a change in practice to ascertain its successful implementation. ACTION: Director of Finance to consult Medical Director prior to an audit being undertaken in 2008/09.

4. **Minute 02/08 (4): the Government has deferred introduction of the IFRS; an update will be presented to the Audit Committee in November. ACTION: Finance Director**
5. **Minute 03/08: the Director of Finance will circulate to the Audit Committee for approval the proposed scope of the Audit Commission's review of the CAD 2010 procurement process, which will verify that the technical and legal process undertaken were correct. ACTION: Director of Finance**
6. **Minute 04/08 (3): the Clinical Governance Committee (April 2008) received the Internal Auditor's report concerning drug control – morphine. The Internal Auditor said the scope of the briefs for future clinical audits would be shared with the Medical Director and the findings of such audits will be shared with the Clinical Governance Committee.**
7. **Minute 06/08 (2): it was confirmed that although the Foundation Trust legislation does not specifically require a Trust Secretary the role is recognised in model constitutions.**
8. **Minute 08/08: Sarah Waller said that the King's Fund will continue to provide training for members of Audit Committees as it has proved to be a very popular course.**

17/08 Audit Commission

Dominic Bradley, Audit Commission presented the Progress Report Audit 2007/08 and drew the Committee's attention to the Provisional Interim Auditors Local Evaluation (ALE) score:

- Financial management remained at 3 though two sub areas (sound planning and strategic links and managing the asset base) had increased their scores.
- The internal control scores had increased to level 3 with three of the sub area improving.
- The score for value for money remained at 3 with no changes in the sub areas' scores.

The Finance Director said he had been disappointed that the Trust had not achieved 4, particularly in regard to Value for Money, given that a lot of work had been undertaken during the year. The Director of Finance said that the Trust was undertaking benchmarking with other Ambulance Services and Acute Trusts. Dominic Bradley said that although the scores had not moved, there had been improvement (i.e. from a "weak 3 to a strong 3"). He suggested that the Trust might consider undertaking a self-assessment in 2008/09 which the Audit Commission could review against the criteria of the ALE.

The Chairman of the Audit Committee said she had also been disappointed that the Trust had not improved its overall score from 3 to 4.

Annual Governance report - audit 2008/08

Kelly Jupp, Principal Auditor, who undertook the on-site audit, referred the Committee to the recommendations contained in the Annual Governance report:

1. Reach a full and final settlement on the subsistence provision with HRMC in 2008/09. The Trust was awaiting a decision by HRMC as regards the subsistence provision.

2. Adjustment of Balance should be stated in line with the Manual for Accounts Guidance

The Trust disclosed £217k of debtors in TRU33 adjustment to balances in line, which included invoices dated prior to 01 April 2008. The Financial Controller said that the debtors were recorded in this manner as they were debts that were being disputed by other

Trusts. The Trust has provided for some of the older debts by way of a bad debt provision. The Financial Controller was confident that a portion of these debts would be paid when the disputes have been settled.

3 The Trust should adhere to the Better Payment Practice Code

The DH's better payment practice target for 95% of invoices should be paid within 30 days. The Trust did not achieve this target for either NHS (84%) or non NHS invoices (85%) although there was a small improvement on the 2006/07 performance.

3. All PCT Agreements should be signed at the beginning of the financial year
The Finance Director said that he had signed all 31 PCT Agreements. **ACTION: Financial Director to undertake that the outstanding 13 Agreements be signed by the counter party signatories.**

4. Develop the fixed asset system to produce a breakdown of assets under construction
A transaction listing for Assets under Construction was not available during the audit as the current fixed asset system cannot produce such a breakdown. The Finance Director said this was being reviewed as part of the Corporate Processes and Governance Programme.

In closing, Kelly Jupp thanked the Finance Director and the Finance team for their co-operation with the annual audit. A post audit meeting will be held to discuss a few issues that arose during the audit. **ACTION: Financial Controller and Audit Commission.** The Financial Controller said that the earlier scheduling of the audit had been challenging for the Finance Team as it coincided with the preparation of Month 1 financial accounts. Sue Exton, Audit Commission, said that the timetable for the 2008/09 audit would be even earlier than this year.

Audit and Inspection Plan 2008/09

The Audit Commission's fee had been reduced to reflect the delay in introducing IFRS.

Noted:

1. **The issues raised in the Annual Governance audit:**
2. **The progress made on the interim ALE scores with two of the three scores remaining at 3 (with improvements in the sub areas) and one area improving from 2 to 3. There are two remaining areas to be scored following the completion of the 2007/08 annual audit: financial standing and financial reporting.**
3. **The final version of the 2008/09 work plan subject to agreement of the scope of the review of the CAD 2010.**

18/08 Report re. Mercedes Lease provision

The Audit Committee considered the question of whether the Trust in its 2007/08 accounts should provide for the remounting work that will be undertaken in October 2008 under the terms of the leasing agreements taken out between October 2003 and September 2006.

Under each lease agreement, there is a mid-tem date at which the chassis must be replaced. The cost of this replacement was to be paid by the lessor at an amount agreed in the lease. In 2007/08 the LAS began to obtain up to date estimates of the costs of remounting as the first remounts were due to take place in 2009. It was discovered that the amount provided by the lessor in each lease would not cover the cost of the new chassis and the costs of remount. In particular, the Trust learned that Mercedes had changed the size and shape of the chassis and that the existing cab could no longer simply be remounted onto a new chassis. The current contract does not allow for this.

Under accounting rules (FRS 12) an entity should make a provision if: a legal or constructive obligation exists as a result of a past event; a resulting cost is probable or a realistic estimate of the obligation is possible. The Finance Director said a legal obligation exists to remount the vehicle and the past event, Mercedes changing their chassis had

caused a resulting cost. An estimate of the cost can be recalculated using estimates from suppliers. The Trust proposed to make provision of £1.764k in 2007/08; this reflected the costs under each lease being spread over the life of the leases and all costs from 2003/04 until 2007/08 being provided for.

The Audit Commission said that there was no clear commitment as of 31st March 2008; that there was no contractual obligation at 31st March 2008, based on their review of the master lease agreement, individual lease and supporting schedules so far. It was argued that the trigger point for obligation for each batch of leases would be the 1 year notice period to activate the lease break clause which would be October 2008 and it is at this point the total amount of expenditure for the chassis replacement for that lease batch could be provided for. Finally, that as there is no enhancement of the economic benefit by replacing the chassis, so the expenditure should be included as it is incurred.

The Finance Director said that if the Trust terminates the leasing agreements at the mid-point it will incur an estimated cost of £6.1m as well as the additional costs incurred in re-tendering and negotiating new leases.

The Finance Director said that there was anecdotal evidence that the provisions of the original lease had been discussed with the Audit Commission at the time the original lease agreement was signed and further investigation was taking place to locate documentation.

The Committee was of the view that a constructiven, if not a stated obligation existed at the 31st of March 08 and was minded therefore to believe that a provision would be required, but agreed with the Audit Commission that there needed to be greater clarity concerning the basis for such a provision and a discussion as to whether this would require the leases to be treated as "onerous" under FRS 12..

The Finance Director said that the figure was based on estimates received from suppliers regarding the remounting of vehicles in October 2008. Further discussions will be held with the Leasing Companies to share the incurred additional costs and a tendering exercise will be undertaken for the remounting work.

In response to a question from the Finance Director, Sue Exton, Audit Commission, said that whilst time was short, the key thing was to reach the correct conclusion, and therefore the Trust would be not penalised for any delays in finalising its accounts due to the on-going discussions concerning the proposed provision of £1.7m.

Agreed: **1. That, following further discussions between the Finance Director and the Audit Commission confirming the obligation on the Trust to replace the chassis in Year 6, the matter will be included in the agenda for the Service Development Committee meeting on 24th June and the Finance Director will update the SDC as to the outcome of the discussions as to whether a provision of £1.7m should be made in the 2007/08**

Noted: **2. That the Audit Commission, whilst recognising that the figure of £1.7m was arguably below the materiality levels for 2007/8, nevertheless felt that the principle had to be upheld that, unless evidence could be provided to the contrary, there was no obligation as at 31 March 08.**

19/08 Annual Accounts 2007/08

The Committee reviewed the 2007/08 Annual Accounts.

The Internal Auditor, Chris Rising, said that he had reviewed the Statement of Internal Control contained in the Annual Accounts and had found it to be consistent with assurance reports received by the Trust Board in 2007/08.

Members of the Audit Committee concurred that the Statement was consistent with reports that the Trust Board had received. The Statement included reference to Information Governance and Serious Untoward Incidents as per DH guidance.

In response to Brian Huckett's question the Finance Director said that the 'public dividend capital repaid' referred to a capital charge applied by a rate set by the Treasury.

Approved: The Annual Accounts subject to the provision for the Mercedes Leases being resolved; the Audited Annual Accounts will be presented to the Trust Board in July 2008.

20/08 Internal Auditor's report

The Internal Auditor presented the findings of the audit completed since the last meeting of the Audit Committee, an internal audit of the Trust's Asset Register. There was substantial assurance given with only 'one merits attention' recommendation and no significant weaknesses identified. This represents a very positive outcome for the Trust.

The Internal Auditors will be re-auditing Medical Records Management which will include the transport of Patient Record Forms (PRF) to Management Information (MI). The findings of the audit will be shared with the PRF Project and the Clinical Governance Committee as well as reported to the Audit Committee. The Finance Director said that the management and transport of PRF documentation was one of the projects overseen by the Governance and Corporate Processes Programme. The Head of Operational Support Services said that the merged tendering service should have addressed the issue of delays in transport of PRF documentation to MI in the previous audit.

Noted:

1. **The assurances provided in the Internal Auditor's report.**
2. **That the following audits, which were at draft stage, will be reported later in the year: Records Management; Debtors; CTak Resilience; Standards for Better Health; Procurement and Supplier Administration.**
3. **That the following audits were work in progress: Urgent Care, CTA and EOC; PTS; Business Continuity; Payroll and Expenses; Strategic Planning and Distribution Reporting and Analysis.**
4. **That the consultancy division of Bentley Jennison was providing advice to the Trust under a separate letter of engagement in respect of the long term financial model as part of the FT Diagnostic.**
5. **The Client Briefings including: Foundation Trust Update (Nos 7 & 8); NHS Breaking News which included an update regarding the delays in implementing IFRS and HMRC Compliance regarding Construction Contracts in the Public Sector.**

21/08 Audit Recommendations Database

The Committee reviewed the Audit Recommendations Database.

Clinical Telephone Advisers (July 2006): Sarah Waller said that the recommendation for a Risk Assessment of Clinical Telephone Advice has been on the database since 2006 and had a completion date of September 2008.

Drug Controls (February 2008): The Chairman said that there was a lot of duplication of wording in the 'current status' column which gave little comfort.[4] It was noted that the actions were reported as being implemented.

[4] 'Emails/bulletins to Team Leaders etc reinforcing procedures, all of which were reported as being complete. A follow-up audit will be undertaken in 2008/09 to ensure that the lessons have been learnt and local management was taking responsibility for following the Trust's polices and procedures'.

In the proposed follow-up audit of Drug Controls as part of the 2008/09 Internal Audit, Sarah Waller said the Medical Director should be consulted as to what were the outlying stations in regards to the administration of drugs.

The Head of Operational Support said that a daily audit of the morphine drug cupboard, and a weekly audit of the controlled drug stocks, is undertaken at Deptford Stores. Compliance with formal policies at the store and on station is measured by the annual audit. On occasions when local stations discover a discrepancy e.g. when an audit of the controlled drugs is undertaken, a lock down is implemented, the Police are alerted and a thorough investigation is undertaken. In many cases the matter is quickly resolved with the missing ampoules found.

Business continuity Planning (February 2007): The Finance Director said that the IM&T Directorate held table top exercises at its quarterly conference held on 12/06/08.

Emergency Care Practitioner (ECP) (November 2005): The Chief Executive said Lizzy Bovill, Assistant Director of Operations, was developing a revised handbook for all ECP specific operational, administrative and clinical polices and procedures. The completion date is June 2008.

Noted:

1. **That there has been significant progress with the recommendations since the last meeting in March with 13 shown as being completed and work started on 5 recommendations that were previously reported as 'not started'.**
2. **That there is one recommendation where work has not started, detailed polices and procedures for Patient Transport Service (June 2006); the draft policy is due to be published in June 2008.**

22/08 Report of the Local Counter Fraud Specialist (LCFS)

Annual Report 2007/08

Robert Brooker (LCFS) presented the Annual Report 2007/08 in accordance with the Secretary of State's Directions for countering fraud in the NHS. The work undertaken during the year included: a review of a number of polices (e.g. Whistle blowing; Authorised Signatory Procedure; Travel Time Policy) and completion of a CFSMS[5] Local Risk Management Exercise that looked at the procurement of supplies and good that was forwarded to the CFSMS. In response, the CFSMS requested a review of five tenders, looking at the process and evidence to support this through the whole tendering process from the Expressions of Interest to invoices being paid in respect of the supplies/goods received by the Trust.

The number of days allocated to LCF work was increased by 40 days during the course of the year, bringing the total to 70.5 days which fell short of the CFSMS recommendation of 133.5 days for an organisation of a similar size and budget as the LAS. The number of agreed days was based on a number of factors. These included an informed assessment of counter fraud needs, based on the a determination of perceived and/or known fraud risks to the health body, and consideration of both historical and ongoing counter fraud measures an activities in place at the Trust.

Compound Indicator Declaration Form 2007/08

Although the form has been amended in response to feedback received in 2007/08, the same rating criteria has been used as last year to enable like for like comparisons to be made. The Compound Indicator Declaration required NHS organisations to submit work

[5] CFSMS: Counter Fraud and Security Management Service, is a division of the NHS Business Services Authority and has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service.

they have completed and to provide evidence of effective outcomes. The declaration for 2007/08 focused on the importance of demonstrating effectiveness and the correlation between task, output and impact.

The Trust achieved a rating of 1 in 2006/07 and expected to achieve 2 in 2007/08. The Finance Director said that benchmarking work will be undertaken with other Ambulance Trusts; particularly those who have achieved scored 3 and 4. The Finance Director said that the Trust's score could be improved by counter fraud being placed directly on the

Trust Board's busy agenda. He was reluctant to do this as he felt it was a matter for the Audit Committee whose minutes are presented to the Trust Board.[6]

Annual Work plan for 2008/09

The LCFS's 2008/09 work plan will include the following: creating an Anti-Fraud Culture; Deterring Fraud; Detecting Fraud and Investigations. The CFSMS minimum number of days is 91.5; the LCFS recommended number of days is 64.

Noted:
1. **The contents of the LCFS's 2007/08 annual report;**
2. **The completed Compound Indicator Declaration Form;**
3. **The summary of the workplan areas for 2008/09;**
4. **That a DVD has been produced to promote a counter fraud culture in the Trust and was being used as part of the Induction Process.**

23/08 Lessons to be learnt from Brent PCT's deficit of £25m.

The Finance Director outlined the lessons that had been learnt from Brent PCT's deficit of £25m in 2007/08. He recommended that the members of the Committee review the full report available from NHS London's website.

In November 2008 the Audit Committee will receive a report on FIMS, the monthly report submitted by the Trust to NHS London, and will review the presentation of financial information to external bodies. The Internal Auditors carry out a reconciliation between the FIMS, the General Ledger and the monthly financial accounts.

The Committee discussed the need to have firm agreements in place in respect of funding for additional work such as CBRN or the Olympics. It was recognised that Foundation Trust status would require firm funding contracts to be in place. The Finance Director said that CBRN funding had been received early in 2007/08 and he was confident that funding would shortly be received in respect of 2008/09. Funding of the work being undertaken in respect of the Olympics continues to be under discussion with the Department of Health.

The Financial Director said that he would include the use of cash forecasts and reporting in his regular financial reports to the Trust Board. **ACTION: Financial Director**

Noted:
1. **The primary and secondary causes for the £25m deficit incurred by Brent PCT in 2007/8.**
2. **That finance reports were linked to other performance reports or service/capital planning reports so as to provide a level of assurance to the Trust Board.**

24/08 Review of Financial Risks 2008/09

The Committee reviewed a list of potential financial risks and grades.

Agreed:
1. **That the Finance Director would track the following financial risks as part of his monthly report to the Trust Board:**

[6] The Service Development Committee received a presentation on counter fraud at its meeting in February 2008.

- **Category B penalty (£2.1m);** **Overtime control (£9.7m);**
- **Achieve Trust CIP (£7.2m);** **PTS profitability (£0.3m)**
- **Fuel price (£0.7m).**

Noted: **2. That, if necessary, the Trust will approach the PCTs for additional funding if the cost of fuel continues to rise as the recent rate of inflation was much higher than that anticipated when the 2008/09 budget was drawn up.**

25/08 Update re. HCC/NHSLA

Noted:
1. **That the Trust declared itself to be fully compliant with the Standards for Better Health; the Healthcare Commission (HCC) will publish its annual report in October 2008.**
2. **That the NHS Litigation Authority will undertake a two day assessment visit in October 2008. The Trust will be assessed at Level 1 against five standards (each containing 10 criteria) of the Risk Management Standards for Ambulance Services, demonstrating it has the requisite polices and procedures. An action plan is in place to ensure that the Trust successfully meets the Level 1 assessment.**
3. **That the Department of Health was consulting on a new regularity framework, to be called Care Quality Commission, which will replace the current HCC and may include the regulation of Patient Transport Services.**
4. **That the Trust was currently receiving a discount of 20% as it had been assessed at Level 2 under the previous assessment process.**
5. **That the Internal Auditor had been impressed with the framework the Trust had in place to demonstrate compliance with the Standards for Better Health framework.**

26/08 Standing Committee Items

Noted:
1. **The declarations of hospitality by the Chairman and the IM&T Director.**
2. **That there was one waiver of the Standing Orders since the Committee met in March 2008; this was in connection with the introduction of electronic tendering process which will enable all tender activities to be conducted on-line. The Finance Director said that the Internal Auditors would be asked to verify the audit trail. ACTION: Finance Director**
3. **That the guidance around the giving and receiving of hospitality will be reviewed as part of the annual review of the Standing Orders and Financial Instructions.**

27/08 Draft minutes of the Clinical Governance Committee

Sarah Waller presented the draft minutes and highlighted the fall in workload reported by the PALS & Complaints Manager following the introduction of Lost Property Bags. The Financial Director said that the impact of the Lost Property Bags will be tracked and a benefits realisation exercise undertaken. **ACTION: Finance Director**

A Working Party met in June to review how the Clinical Governance Committee would function in the future; a revised Terms of Reference and future workplan would be considered by the full membership of the Committee when it meets in August 2008. .

Noted: **1. The draft minutes of the Clinical Governance Committee, held 28th April 2008**

2. **The draft minutes of the Clinical Governance Committee's Working Party, 2nd June 2008.**

28/08 Draft minutes of the Risk Compliance and Assurance Group (RCAG)

In the Chief Executive's absence, the Finance Director presented the draft minutes of the RCAG. He highlighted the new risks added and the risks deleted from the Risk Register. At its meeting on 11th June the Senior Management Group discussed the serious issue of power capacity at HQ; immediate remedial action was being undertaken by the Director of IM&T with medium/long term actions being planned. The Director of IM&T and the Estates Team were working closely to address this issue.

The Director of Finance said there was a discussion as to whether the Vehicle Equipment Working Group (VEWG) was the appropriate forum for evaluation of the EZ-Intraosseous Infusion device. It was recognised that the Trust had procedures in place concerning the introduction of new equipment and the VEWG was the main forum for implementing these procedures.

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

29/08 Audit Committee work plan and timetable for meetings in 2008.

Noted:

1. **The contents of the 2008 workplan**
2. **That in September the Committee will receive the following reports:**
   - **An update on the FT diagnostic plan, if there are areas that the Audit Committee should discuss;**
   - **Formal report following the review of Senior Management Expenses;**
   - **Annual review of Standing Orders and Financial Regulations.**
3. **That in November the Committee will :**
   - **Review the Trust's External financial reporting process (e.g. FIMS);**
   - **Receive the revised Accounting Policy, depending on the outstanding issues associated with the IFRS being clarified.**

30/08 Any Other Business

In camera, the Finance Director reported the results of the recent tendering of the Internal Audit function. Five accountancy firms, including the existing provider, were invited to tender for the work. Only one tender was received by the deadline; the Procurement Manager had contacted the other tenderers to ascertain if there was a problem with the electronic tendering system or whether they were simply not interested in tendering for the work. The submitted tender will be reviewed and the Committee will be kept informed of progress. **ACTION: Finance Director.**

Date of next Audit Committee meeting : 2.30pm, 8th September 2008

Meeting finished at 5.40pm

Enclosure 15

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 2nd June 08

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

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

3. **Agreed:**

- Procedure relating to the clinical handover of patients;
- Procedure for ambulance observers
- Procedure for responding to enquiries and giving evidence at Coroner's Inquest and Statements at Police Interviews.

That a small working group would investigate how the reporting of the Areas' governance could be improved so as to enable the Committee to be assured that high quality patient care was being delivered throughout the organisation. The Risk Information Report will include commentaries that focus on identifying trends both from each contributing author and corporately; on what changes have resulted following PALS enquiries /Complaints and will report on areas where performance has improved/deteriorated and actions taken since the previous report was presented. The Risk Information Report will be used by the Area Governance groups to identify local governance issues and to report on how these where being managed. The intention is that the Area Clinical Governance report will be shorter in length and will be more focussed on clinical outcomes.

Noted:

The initial findings of a self assessment that was undertaken by members of the Committee (response rate 74%); the Chairman and the Medical Director will review the feedback and take on board the comments to direct the future working of the Committee.

A number of changes were proposed to the Committee's terms of reference. Revised terms of reference will be which will be presented for approval to a full meeting of the Committee in August, and will be subsequently presented to the Audit Committee and the Trust Board. Amongst the proposed changes were that the quorum be amended to include the Deputy Director of Operations as well as one Non-Executive Director and the Medical Director and that there will be four meetings of the Committee per annum as opposed to the current six.

Minutes/oral reports received from:

No minutes were receiving by the Working Party.

Recommendation: THAT the Trust Board NOTE the draft minutes of the Clinical Governance Committee's Working Party 2nd June 2008.

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee working party
11.00am, 2nd June 2008, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director
Nicola Foad	Head of Legal Services
John Wilkins	Head of Governance
Stephen Moore	Head of Records Management & Business Continuity
Gary Bassett	Complaints/ PALS Manager
Jenny Goodridge	Interim Head of Governance
Paul Gates	Performance Improvement Manager (East)
Heather Ransom	Staff Officer to Deputy Director of Operations
Christine McMahon	Trust Secretary (minutes)

Welcome to Jenny Goodridge, Interim Head of Governance while John Wilkins is seconded to lleading the Trust's FT Project.

The meeting replaced the normal core meeting of the Committee with a small working party to explore reviewing the Terms of Reference and working practices of the Clinical Governance Committee.

34/08 Clinical policies/procedures for approval

1. *Procedure relating to the clinical handover of patients – AGREED*

NOTED: that an advisory note will be added stating that the procedure adhered to current JRCALC guidelines and that the Trust awaited agreement between Coroners' Courts and the Local Authorities concerning a common protocol relating to the sudden death/unexpected death in infants. **ACTION: Head of Records Management & Business Continuity**

NOTED: that the following amendments be made – section 3: copy of PRF (number/colour to be unspecified) and mini-PRF to be given to the hospital and section 9 title to be changed to Handover of Adult Patients where Death has Occurred. **ACTION: Head of Records Management & Business Continuity**

2. *TP/014 Procedure for ambulance observers – AGREED*

NOTED: that Practice Learning Managers have taken on responsibility for the co-ordination of ambulance observers doing ride-outs.

3. *P/015 Procedure for responding to enquiries and giving evidence at Coroner's Inquests and Statements at Police Interviews.- AGREED*

NOTED: that the use of 2nd person pronoun should be used as standard in appendix 1, 'information to be provided in witness statement'. **ACTION: Head of Records Management & Business Continuity**

NB: the Chairman commended the document control/classification as excellent. Future revisions to policies/procedures to be highlighted using italics/underlining etc. **ACTION: Head of Records Management & Business Continuity**

35/08 Review the format and content of the area governance report and the risk information reports

The Working Party reviewed the current guidance for producing Areas' Clinical Governance Reports and the Risk Information Report. To date the Committee has received alternate Areas' Clinical Governance that focussed on an Area e.g. East and a general Clinical Governance report that collated the findings of all the areas including UOC/EOC.

Following discussion it was AGREED that a small Working Group comprising of PIM, East; PALS/Complaints Manager; Staff Officer to Deputy Director of Operations; the interim Head of Governance and the Head of Legal Services will consider how the new process for producing Area's Clinical Governance reports will work. The recommendations of this working group will be presented to the Deputy Director of Operations, the Senior Management Group and the Clinical Governance

Committee for endorsement/approval. The intention is that the Area Clinical Governance reports will be shorter in length and will be more focussed on clinical outcomes.

The Clinical Governance Committee will receive a report on the clinical governance activity taking place in the Areas, what trends have been identified in respect of complaints/PALS enquiries or CPI/PRF feedback from team leaders to front line staff. Duplication of reports is to be avoided i.e. performance reports considered by the Trust Board/SMG will not be considered by the Clinical Governance Committee. Reports should focus on outcomes, i.e. what changes have been made as a result of trends being identified. In addition to the topics included in the current framework it was suggested that the following might also be useful indicators e.g. the management of frequent callers and high risk address register as they reflect the level of local liaison taking place.

It was suggested that the Areas' Clinical Governance meetings may wish to consider adopting the HEMS practice of undertaking longitudinal audits of 1-2 calls per meeting in order to identify what went well or what lessons could be learnt.

It was proposed that the Committee receive quarterly General Areas' Clinical Governance reports, with each quarterly report containing contributions from two complexes per Area, highlighting the clinical governance issues identified by those two complexes.

The Head of Governance said that Performance Accelerator, the new web based system that was being introduced, will facilitate the proposed new process but will need 'buy-in' from Operations, with a nominated person per Area being tasked to up load the information on a regular basis.

Work will be undertaken at the Area and Complex level to promote a feedback loop whereby information flows from the centre to the local area governance forums (via the Risk Information Report), enabling them to individually identify the pertinent clinical governance issues which they will then report to the Clinical Governance Report that will in turn feedback on the information to the Area Governance Forum (via the 1 page synopsis of the Committee's minutes).

In order for the new process to work there will need to be a commitment from Operations that the Complex and Area Governance meetings take place regularly and evidence good clinical governance practice. The Working Party said that ownership of the Area Clinical Governance process had to rest with the ADOs under the supervision of the Deputy Director of Operations.

Risk Information Report:

The current guidance notes were reviewed and amendments suggested. **ACTION: interim Head of Governance to amend the guidance notes.**

The commentaries included in the Risk Information Report will focus on identifying trends both from each contributing author and corporately; on what changes have resulted of PALS/Complaints etc since the last report and reporting on areas where performance has improved/deteriorated and actions taken since the previous report was presented.

36/08 Review effective working of Clinical Governance Committee

Prior to the meeting a self assessment questionnaire was circulated to each member of the full committee. The Working Party received the initial findings; the response rate was 74%.

The Chairman and the Medical Director will review the feedback and take on board the comments to direct the future working of the Committee.

It was AGREED that an aide memoire will be drafted, which will serve as training/induction for new

members of the Committee, following the review of the Committee's Terms of Reference and the recommendations from the working group as to the future reporting of Areas' Clinical Governance. ACTION: this will be considered at a future meeting of the Committee.

37/08 **Review committee's terms of reference**

The Working Party reviewed the Committee's Terms of Reference and suggested a number of amendments. The revised terms of reference will be presented for approval to the full Committee in August; to the Audit Committee in September for comment, and the Trust Board in September for ratification.

AGREED: that the quorum be amended to include an ADO/Deputy Director of Operations.

NOTED: that the Committee will review the Clinical Governance Strategy in August. **ACTION: Medical Director/interim Head of Governance**

NOTED: that as/when the Trust was not abiding by JRCALC guidelines the matter would be initially discussed by the Committee and reported to the Trust Board via the Committee's minutes.

ACTION: Trust Secretary will circulate the Clinical Governance Development Plan & Strategy to the Chairman, the Medical Director and the Director of Service Development for their comments. ACTION: Committee to review the clinical strategic goals.

38/08 **Programme for High Level themed risk information report:**

AGREED: that there will be 2 risk information reports produced per annum with a themed report being produced for the fourth meeting.

39/08 **NHSLA update**

There was no update given at the meeting though the need to meet the external assessor's requirements ready for the assessment in October 2008 with evidence of improvement and responsiveness to complaints, incidents etc was acknowledged.

40/08 **Review of 2008 forward planner**

AGREED: that consideration will be given to reducing the number of meetings in 2009 to four per annum, with two 'core' and two 'full' meetings.

The 'core' committee's agenda will focus on clinical governance issues whilst the agenda of the full meeting will focus on new strategies, receive presentations and receive Areas' Governance reports. The forward planner will be updated to include the activities arising from the revised terms of reference of the CGC following approval by Audit Committee/Trust Board. **ACTION: Chair/Trust Secretary.**

Meeting concluded at 12.10

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 29th July 2008

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

1. Purpose of Report

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

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

2. Tenders Received

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

Conversion of Vauxhall Movano: PTS Stretcher Vehicles

Oughtred & Harrison (Facilities) Ltd	U V Modular Limited
Wilkes UK Limited	

Internal Audit & Counter Fraud

RSM Bentley Jennison

Web Based Psychometric test

Criterion	Previsor	SHL
Kenexa	Selby & Mills	Calibrand
Gloabal Technologies	IDN Ltd	Stuart Robertson & Assoc
OPP	Montpellier	t-three consulting
Assergent Technologies Solutions		

Replacement of asbestos roof: Friern Barnet

Advanced roofing services ltd	RKC Industrial Rfg and Cldg Ltd
Brandclad Ltd	Westfield Roofing Co. Ltd

3. Use of Seal

There have been two entries, reference 117 and 118 since the last Trust Board meeting. The entries related to:

No.117	Lease of Unit 4, Lea Bridge Industrial Centre
No. 118	Lease of Unit 2, Lower Hook Farm, Shire Lane, Down, Kent.

4. Recommendations

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

Christine McMahon
Trust Secretary