LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 20th May 2008 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Apologies & Declarations of Further Interest.		
2.	Opportunity for Members of the Public to ask Questions.		
3.	Minutes of the meeting held on 18th March 2008 Part 1 and synopsis of the Part II meeting held on 18th March 2008.		Enclosure 1 & 2
4.	Matters arising		
5.	Chairman's remarks	SR	Oral
6.	Report of the Chief Executive	PB	Enclosure 3
7.	Financial Report, Month 12 2007/08	MD	Enclosure 4
8.	Financial Report, Month 1 2008/09	MD	Enclosure 5
9.	Report of the Medical Director	FM	Enclosure 6
10.	Receive Annual Complaints and PALS Report	PB	Enclosure 7
	Refreshments		
11.	Approve Workforce Plan	CH	Enclosure 8
12.	Approve FT Project Plan	MD	Enclosure 9
13.	Receive report regarding Call Connect Diagnostic Visit to LAS	RW	Enclosure 10
14.	Approve Fleet Plan	RW	Enclosure 11
15.	Rules on the capture, recording and calculation of LAS performance (KA34)	PS	Enclosure 12
16.	Estates Plan Update including ratification of Chairman's Urgent Action in respect of the sale of Buckhurst Hill.	MD	Presentation Enclosure 13
17.	Discuss LAS approach to Corporate Social Responsibility	MD	Presentation
18.	Note results of Board Effectiveness Review	SR	Presentation
19.	Service Improvement Programme 2012 Update	PB	Enclosure 14

20	Draft Minutes of Clinical Governance Committee, 28th April 2008	BM	Enclosure 15
21	Draft minutes of the Remuneration Committee, 18th March 2008	SR	Enclosure 16
22.	Draft notes of the Board's Away Day 29th April 2008	SR	Enclosure 17
23.	Report from Trust Secretary on tenders opened since the last Board meeting	CMc	Enclosure 18
24.	Opportunity for members of the public to ask question		Oral
25.	Date of next meeting: 10.00am on 29th July 2008, Conference room, LAS HQ, Waterloo Road.		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 18th March 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	
Ingrid Prescod	Non Executive Director
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
Martin Flaherty	Director of Operations
Caron Hitchen	Director of Human Resources & Organisation Development

In Attendance:

David Jervis	Director of Communications
Kathy Jones	Director of Service Development
Peter Suter	Director of Information Management & Technology
George Shaw	LAS Patients' Forum
Angie Patton	Head of Communications
Christine McMahon	Trust Secretary (Minutes)

22/08 Declarations of Further Interest

There were no declarations of further interest.

23/08 Opportunity for Members of the Public to ask Questions

There were no questions from members of the public.

24/08 Minutes of the Meeting held on 29th January 2008

Agreed: The minutes of the meeting held on 29th January 2008 with the correction to minute 14/08, 'Category A were the most expensive calls due to the despatch of multiple responses, which included fast response cars and ambulances, to ensure the achievement of the Category A8 minute response time.

25/08 Synopsis of the Trust Board's Part II meeting held on 29th January 2008

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

26/08 Matters arising from the minutes of the meeting held on 29th January 2008

Noted:

1. **Minute 06/08: That the Chairman will write to the Mayor of London, pointing out that one of Mayor's responsibilities was the reduction in health inequalities and highlight how Emergency Life Support training fell into that category. ACTION: The Chairman**
2. **Minute 09/08: That the Trust Board in May will receive a report on the benefits realised from the Invest to Save Programme. The report will include the benefits realised from the Frequent Callers Project. ACTION: Finance Director**
3. **Minute 10/08: That in regard to Left Bundle Branch Block (LBBB), the Medical Director said that the exact number of patients conveyed to 'Heart Attack Centres' since the change in the procedure was very small, and the number of patients in the community with asymptomatic LBBB was approximately 0.45% (men) and 0.2% (women).**

27/08 Chairman's remarks

The Chairman said that the arrangements for the Board's Away Day in April were progressing well. Three NHS Foundation Trust Chairmen were attending the morning session to talk about their respective Trust's experience of becoming a foundation trust. In the afternoon David Sissling, Programme Director of Healthcare for London, will be attending to discuss the future implementation of the Healthcare for London programme.

28/08 The Chief Executive's report

The Chief Executive presented his regular report to the Board. The Trust had achieved its best performance to date in terms of call answering and its response to Category A[1] and Category B[2] calls. Preparations were in place to ensure that the Trust is in a good position to respond to the new Call Connect[3] target commencing April 2008.

Achieving the required 75% 'Call Connect' Category A performance target in April would be a significant challenge given that the Trust had achieved 65% Call Connect Category A performance in March. Amongst the number of initiatives being considered to ensure that this performance target is achieved was Active Area Cover[4]. Negotiations were taking place with Staff Side regarding Active Area Cover and it was anticipated that once agreement had been reached front line staff would be activated from a mobile start rather than, as is the current practice, from their ambulance stations.

Despite the recent disruption caused by refurbishment of the call taking area in the main Control Room, call taking had remained consistently high. The refurbishment has improved the working environment and will ultimately provide 36 call taking
positions which is an increase of 10 over and above that provided by the old layout.

The Chief Executive said that the take-up of overtime was disappointing and the Trust currently has a number of vacancies among front line crews. The Workforce Plan was being re-worked in light of the additional investment secured from Commissioners to achieve the new Call Connect standards. The Trust would be recruiting 100 paramedics and student

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[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: Call Connect: ambulance response times are currently 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 will start earlier - when the call is connected to the ambulance control room.
[4] Active Area Cover – previously known as dynamic deployment.

paramedics and 100 A&E support workers in early 2008/09. A more detailed report will be presented to the Trust Board in May 2008. **ACTION: HR Director.**

The Director of Information Management and Technology spoke about the recent problems experienced with the Trust's email system; the cause and the remedial action taken. The Board was assured that 999 call handling was not affected.

The Patient Transport Service (PTS) had a good year financially, was meeting its performance targets and had won a number of additional contracts e.g. Whipps Cross.

Efforts were continuing to ensure that sickness absence was actively managed as this had risen in recent months. The Chief Executive expressed particular concern at the increased level of sickness absence reported by PTS.

The allocation of rest breaks was also a concern; the Director of Operations said there would be a renewed focus in the Control Room, despite the current performance pressures, to ensure that the number of crews receiving breaks was improved. Management and staff side representatives were currently undertaking a joint review of the Rest Break Agreement.

The Chief Executive said that the Director of Communications was preparing a public education campaign that would be launched at the end of the March, asking the public to use the ambulance service thoughtfully.

The ending of administrative handover at hospitals took place as planned on 10th March and has been generally well received by members of staff. Management presence has been increased at hospitals throughout the two weeks following 10th March and local teething problems were being addressed, both with our own members of staff and the hospitals themselves. The next Chief Executive's report will provide some further detail on the changes and the impact on overall job cycle times. **ACTION: Director of Operations.**

The LAS has recently assisted other ambulance trusts. Ten ambulances were lent to the Great Western Ambulance Service, who had a particularly acute vehicle problem, and more recently six control room members of staff were provided to assist South Central Ambulance Service.

It was Noted that:

A&E Departments in North East London in particular had experienced significant capacity issues in recent weeks leading to an unacceptable level of diverts and closures. The Service was working closely with the trusts concerned to try and broker sensible diverts across the area and so help alleviate potentially capacity problems.

The Trust had reached 75% of Category A calls in every Primary Care Trust (PCT) area but two (Richmond and Twickenham) and had met the target of not falling below 70% in any PCT area.

The recent national review of Agenda for Change had not altered the framework for ambulance trusts in respect of unsocial hours payment.

The LAS' Patients' Forum will officially cease to exist as a statutory body with effect from 31st March and will be replaced by LINks[5]. The LAS' Patients' Forum has set itself up as an independent charity. A proposal to enter into a formal Memorandum of Understanding has been received from the Forum and is under consideration.

The deployment of additional resources, such as motorcycle and bicycles, has improved performance times by 1-2% in Tower Hamlets and Newham.

A strategic review was being undertaken of Emergency Bed Service (EBS) and will be presented to the Trust Board in July. **ACTION: Director of Operations.**

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[5] LINks: Local Involvement Networks, whose role will be to find out what people want, monitor local health and social care services and se their powers to hold local authorities and other service providers to account.

Although EOC has a higher staff turnover than A&E operations, this was normal for this area of work. The HR Director confirmed that the EOC staff receive the same incentives as front line operational staff as they are considered to be operational staff. She also pointed out that a proportion of those who leave EOC do not leave the Trust but do so to train as front line staff. A detailed breakdown of EOC leavers will be presented to the Trust Board in May 2008. **ACTION: HR Director.** The HR Director said that the Trust had been successful in recruiting to EOC.

The 'Insight into Management' Scheme, which was undertaken in East London, had been a very worthwhile project. Although the five young participants in the Scheme had not expressed interest in joining the LAS as operational members of staff, there was interest expressed in the work of the IT department.

Agreed:

1. **To express its appreciation of the contribution that the LAS Patients' Forum had made to the work of the Trust.**
2. **To congratulate the staff of EOC in maintaining the service under challenging circumstances and also to the support provided by the Estates and the IM&T departments which enable the refurbishment to proceed smoothly.**
3. **To congratulate the A&E service, both staff and management teams, in achieving the best ever annual operational performance against a background of rising demand and the challenges of preparing for Call Connect.**

29/08 Financial Report, Month 11

The Director of Finance apologised that the normal financial report had not been presented; this was due to the Board meeting taking place earlier than normal in the month because of Easter falling in March. A full financial report would be circulated to Board members. **ACTION: Director of Finance.**

The forecast year end position is £1.2m surplus. There has been a lot of activity in procurement and other departments to ensure that the Invest to Save programme was delivered this financial year. The Invest to Save Programme comprised 110 projects and a review of the benefits realised would be undertaken to ensure that value for money had been obtained. The findings will be presented to the Trust Board in May 2008. **ACTION: Director of Finance.**

The Director of Finance was undertaking a review of the balance sheet, which will include a review of the vehicle leasing arrangements. The outcome of the review will be reported to the Audit Committee in April and to the Trust Board in May 2008.

The Trust has reached a settlement of £1m with the Commissioners in respect of the various penalties inherent in the 2007/08 A&E contract.

The Trust was currently forecasting £13m cash at the end of the financial year. Guidance was awaited from the Department of Health as to the amount of cash the Trust would be permitted to retain. The cash would be used to fund the 2008/09 capital programme.

Caroline Silver, Chairman of the Audit Committee, requested that the Internal Auditors, Bentley Jennison, audit the benefits realisation review. **ACTION: Director of Finance**

30/08 Report of the Medical Director

The Medical Director reported that a Serious Untoward Incident (SUI) had been declared since the last Trust Board meeting. It had been declared following a delay in attending a 36 year old female patient who was bleeding heavily. 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 attendance of a Fast Response Car and two ambulances, the patient later died in hospital.

The inquest into the death of a patient in April 2007, which was investigated under the SUI policy, was held on 26th February. This case involved a death in police custody of a patient requiring restraint. No blame was attached to the ambulance staff involved in the case and the Coroner was sympathetic to the suggestion that the LAS pursue an alternative method of restraint (perhaps chemical) in the unusual and infrequent circumstances of this kind.

Procedure on the Transportation of Persons to Hospital: an Agreement has been reached with the Metropolitan Police Service (MPS) regarding the transport of persons to hospital. The LAS has written a procedure with the MPS to ensure a consistent approach to the transportation of patients to hospital in circumstances where ambulance transport is not appropriate. The Procedure was approved by the Clinical Governance Committee on 4th February 2008 together with a corresponding MPS procedure that was currently in draft. The Agreement between the LAS and the MPS was presented to the Trust Board for ratification.

Feasibility study into the provision of therapeutic hypothermia commenced on 4th February 2008. To date two patients have received therapeutic cooling. One has survived to admission to the Intensive Care Unit.

Patient Specific Protocols (PSP) & Out of Hours (OOH) Palliative Care Handover Forms continues to be a well utilised resource. We are currently processing on average four PSPs per month and five OOH forms per day. With regard to the PSPs the trend is for "Preferred Place of Care" requests, and "Do Not Attempt Resuscitate" information. The OOH form system is being rolled out slowly across all London PCTs.

Equipment purchased via the Invest to Save (ITS) Programme has included the following equipment:

- Tourniquets for major haemorrhage control: scale of issue is to be one tourniquet per Primary Response Bag
- EZ-IO Intra Osseous (IO) device for providing both adult and paediatric vascular access: this is the end result of an evaluation of suitable (IO) devices for pre-hospital use. The scale of issue will initially be one device for each FRU.

- Sandell Paediatric Tape for providing information on drug dosage and equipment sizing to paramedics dealing with paediatric cardiac arrest / life threatening paediatric illness: scale of issue is to be personal issue to all Paramedics
- 8 Faretech CT6 Traction Splint & 8 Kendrick Traction Device: these are being evaluated as a possible replacement for the Sager Traction Splint currently in use by LAS. Each device on evaluation is a third of the cost of a Sager Splint and is designed to carry out the same function as the Sager. Design improvements to both the Faretech and the Kendrick device now make an evaluation a viable exercise

Feasibility study into the use of Continuous Positive Airway Pressure (CPAP) Training for staff at Whipps Cross starts on 25th March to assess the suitability of using a CPAP system on LAS ambulances. This is primarily for the management of patients suffering acute left ventricular failure.

Introduction of Oromorph - the smallest bottles of oral morphine available for LAS to purchase were 100ml, following a change in presentation by the manufacturer. Fortunately Frimley Park Hospital Pharmacy has agreed to decant the drug into 20ml bottles. It is intended that two 20ml bottles will be placed into the paramedic drug pack along with 5ml oral syringes and bungs, over the forthcoming months.

The Clinical Audit & Research Unit provided a summary of the report examining the factors associated with survival from cardiac arrest for patients treated by staff from the Waterloo Complex. Previous reports have highlighted the increased survival to hospital discharge of

patients suffering an out of hospital cardiac arrest achieved by this complex. This report included the role of the motorcycle response unit and points to some areas for potential improvement.

The Risk Management Policy has been updated and amended in accordance with the Trust's Policy and Procedural requirements for an annual review of key governance documents. Guidance is awaited from the NHS Litigation Authority before the document is finalised.

'Making Improvements Count'. The LAS has been chosen to act as an 'Early Adopter' Trust for 'Making Improvements Count.' This is the Department of Health Consultation document that sets out proposals to review and revise the NHS Complaints procedure. It is envisaged that Patients Advice Liaison Service (PALS) is likely to be brought into the complaints structure. The LAS has been selected along with two local authorities, two PCTs, local acute and mental health Trusts in Westminster and Barking. This will give the Trust the opportunity to influence what the model will eventually look like. The inclusion of ambulance services in this process was as a result of lobbying by the Head of Complaints to the Consultation team

Measles: there have been outbreaks of measles in several London boroughs. The percentage of patients that were routinely inoculated against measles has fallen in the last ten years due to concerns relating to the MMR vaccine. There has been an increase in the number of reported cases with approximately 900 reports of incidents measles in the UK in 2007. Recently two members of staff were suspected of contracting measles and the Trust liaised with the Health Protection Agency (HPA) and the Occupational Health Service.

HART (Hazardous Area Response Team, which is now part of the Incident Response Unit, IRU) participated in the recent Exercise Orpheus[6]. There were significant number of lessons learnt and the team presented itself very positively.

It was Noted that:

The Trust was considering its position in respect of introducing screening for measles for both recruits and existing front line staff. The Director of Operations said that the suspicion of exposure to measles has a potentially serious impact on staffing resources as staff that had come into contact with someone who had been diagnosed as having measles had to be tested and in the interim were unavailable for work. In answer to a question the Medical Director said that she did not think the use of immunoglobulin would be a viable alternative to screening due to its limited availability.

The Trust has not yet appointed an Infection Control Manager but efforts to recruit to this post were continuing.

The Chairman suggested the team undertaking the Hypothermia Pilot should liaise with South East Coast Ambulance Service (SECAmb) which was also undertaking a pilot, as it would enlarge the number of patients. The Medical Director said she would share the suggestion with the team. **ACTION: Medical Director**

POST MEETING NOTE: SECAmb has not yet implemented therapeutic hypothermia, although it is considering so doing.

Agreed: To ratify the agreement with the Metropolitan Police Service, and the procedure, concerning the transportation of patients to hospital

31/08 Update re. submission of 2008/09 Budget and three year plan

The Finance Director said that the final 2008/09 budget and three year plan had been submitted to the London Provider Agency (LPA) following approval at the recent Service Development

[6] Exercise Orpheus: a training exercise that was part of the programme of Health Protection Agency exercises run on behalf of the Department of Health.

Committee in February[7]. Although queries were received asking for clarification no negative feedback has been received.

It was Noted that:

There has been an internal restructure at the LPA with the number of performance managers cut from three to one.

The 2008/09 agreement with Commissioners included a penalty if the Trust failed to achieve 90% Category B performance target; there was no penalty attached to failing to achieve 75% Category A performance target.

32/08 Final Assurance Framework for the Annual Healthcheck 07/08

The Director of Finance presented the Final Assurance Framework for the Annual Healthcheck 2007/08. An event was held on the 13th March, "247247" at which the Trust demonstrated its compliance with the Healthcheck standards. The event was attended by representatives from 13 of the Overview and Scrutiny Committees of the 32 London Boroughs; the LAS' Patients' Forum and the Healthcare

Commission. Questions were asked by attendees concerning the potential impact of hospital closures and the implications of the Trust becoming a foundation trust.

As part of the Assurance Framework the Board received a report that set out the Trust's top 25 risks on the Risk Register cross referenced to the Trust's principal objectives, with the highest scoring risks at the start of the document. These risks and their controls were mapped against the domains and healthcare standards of the Annual Health Check.

It was Noted that:

In the column reporting the control systems in place there appeared to be the inclusion of future action points rather than current controls in place. The Finance
Director said he would review this, perhaps by amending the column's title. **ACTION: Finance Director**

Risk 273 and 274 highlighted there was currently no fall back control for Urgent Operations Centre or the Incident Control Room although there is one for Emergency Operations Centre. These two risks were being managed through the Business Continuity Steering Group.

Agreed:
1. **That the Final Assurance Framework provided evidence of full compliance for the Annual Health Check**
2. **That the Final Declaration be submitted stating that the Trust is fully compliant with the core standards of the Annual Health Check 2007/08.**

33/08 Foundation Trust Application

The Director of Finance presented a brief overview regarding foundation trust status which described NHS Foundation Trusts:

- a new type of NHS organisation, established as independent public benefit corporation similar to mutual organisations such as the Co-op or building
societies; providers of healthcare according to core NHS principles – free care, based on need and not ability to pay;
- required to meet the Department of Health's national standards on service quality and effectiveness;
- authorised and monitored by Monitor, the independent Regulator of NHS Foundation Trusts.

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[7] In January 2008, the Trust Board delegated authority to the Service Development Committee to approve the 2008/09 budget and three year plan in order to meet the LPA's deadline of 28th February 2008 (Minute 11/08).

The paper set out the benefits and disadvantages of the LAS becoming a foundation trust. The benefits included: an opportunity for a more meaningful connection with the public, our patients and our staff by becoming a true 'membership organisation'; financial flexibility to facilitate delivery of our strategic plan and greater strategic freedom to engage effectively with other NHS partners in delivering better quality healthcare for London. The disadvantages included the cost of preparing an application and of a significant investment in management time at a challenging time for the LAS and the lack of support from the local Unison representative.

In discussion it was Noted that:

In making the argument for foundation trust status, specific examples should be given of what would be the benefits for patients and staff.

The benefits to the Ambulance Service were less obvious than for Acute Trusts, as ambulance services have historically suffered less interference than that experienced by other parts of the NHS.

The Unison Branch Secretary had reservations concerning the LAS becoming a foundation trust. These were outlined in an email to the Director of Finance and a copy of this was circulated with the agenda. Discussions would take place with Staffside representatives, reassuring them that becoming a foundation trust would not affect the current Partnership Agreement.

A report detailing the proposed project plan, budget and governance arrangements to progress the foundation trust application would be presented to the Trust Board in May 2008. **ACTION: Finance Director.**

Agreed: That the LAS should progress a foundation trust application.

34/08 Communication and Engagement Strategy

The Director of Communications presented the Communications and Engagement Strategy that had been amended to reflect the comments made when the document was considered by the Service Development Committee in February 2008.

The objectives of the strategy included:

- increasing Londoners' understanding of our role and future plans;
- involving the public and patients in shaping the way the Trust delivers its service and building relations with those people who are key stakeholders in our Service Improvement Programme;
- improving our reputation among black and minority ethnic (BME) communities;
- developing our public affairs activity and develop an environment where members of staff feel valued, are proud to work for the Service and actively contribute to improving patient care.

The research undertaken by MORI in 2006 informed the strategy, particularly the need to provide the public with more information about the role of the ambulance service and to investigate why those in black and minority ethnic communities tended to speak less highly of the Service than others. The Director of Communications said that the findings of the MORI research could be found on the Trust's web site.

The strategy comprised both long term objectives (as set out above) and specific pieces of work which would be undertaken in 2008/09, such as supporting the Service Improvement Programme (Call Connect, New Ways of Working, CAD 2010 and the Olympics). Other work would include involving and informing patients and the public, developing key messages, adding to communication tools (for example by introducing a new web site) and demonstrating learning from feedback received, for example from PALS' enquiries or complaints. Work would also continue to implement strong internal communications and to ensure that there was an infrastructure in place to ensure the Trust can instil confidence in times of crisis. The Board

will receive an annual report on the implementation of the Communications and Engagement Strategy. **ACTION: Director of Communications**

It was Noted that:

The strategy, which was felt to be well written, would be placed on the Trust's web site for a wider audience than the Trust Board to read. **ACTION: Director of Communications**

It is planned that the Trust would have the facility to recruit via its web site in the next 12 months although this function was not yet in place. The HR Director said she expected to have the necessary interface with NHS Jobs on the Trust's web site within the next 12 months.
In the section that refers to BME communities being less satisfied with the service than the population at large it was proposed that the phrase 'as with many public bodies' be removed from the document as it might convey the impression that the lower satisfaction was, therefore, OK.

The Director of Service Development reminded the board that, following the Patients' Surveys undertaken by Commission for Health Improvement (CHI) in 2003 and 2004, the Trust had requested that the data be analysed to identify differences in the responses on the basis of ethnicity. This showed that although the level of satisfaction was very high it was less so amongst patients from BME communities. Focus groups were then organised to better understand why this occurred and although the Trust was not able to resolve all the concerns that were raised it has endeavoured to respond to them. For example, front line crews on vehicles can now access LanguageLine to help communication with patients and their carers when there is a language barrier. The Director of Communications said that the Patient Public Involvement (PPI) work currently being undertaken in Tower Hamlets was as a direct result of the findings from the focus groups. The Director of Service Development undertook to share the findings of the focus group with Ingrid Prescod. **ACTION: The Director of Service Development**

In a discussion around raising the profile of the organisation as a employer with various sixth form and higher education establishments it was recognised that trends indicated that the average age that staff join the Service was thought to be in their mid '20s rather than 16 or 18 when they leave school. The HR Director said whilst there was no lower age limit for recruiting staff, the necessity of having a driving licence with C1 category generally meant recruits were over 21 years.

Although the Trust would like to reach out to younger members of the population (and particularly in the BME communities) to encourage them to consider a career in the ambulance service, it was not in a position to offer work experience on the front line due to the nature of the work undertaken. There was, however, a work experience programme in place in support services. The HR Director reminded the Board that the Trust had no difficulty recruiting and that it continued to strive to improve the diversity of its workforce.

Approved: The Communications and Engagement Strategy, 2008-13 which will be reviewed annually by the Trust Board.

35/08 Presentation: Estates Plan Update

The Director of Finance gave a presentation updating the Board on the work being undertaken in respect of the Estates Strategy that will be presented to the Trust Board in July 2008. The Director of Finance proposed that the strategy be a 'live' document, reviewed annually by the Board. **ACTION: Director of Finance**

Work undertaken in 2007/08 included: updating the strategic plan for estates in line with SIP 2102; implementing a workshop project; the sale of Buckhurst Hill and evaluating the fixed satellite options. Links were made with the London Fire Brigade, the Metropolitan Police Service, Transport for London, the Greater London Assembly and NHS London. Work was also undertaken in respect of the Olympics and what additional estates provision would be

necessary, if any. An options analysis in respect of the HQ building was also being undertaken.

The review of the Estates Strategy included exploration of current and future service delivery; evaluation of the existing estate against potential requirements and consideration of options for change and their implications. The strategic considerations included: the requirements of the new Operating Model and Healthcare for London; Emergency Planning; Business Continuity; CAD2010 and the 2012 Olympics.

36/08 Delivery of 2007/08 Training Plan

The HR Director presented a report showing activity against the 2007/08 training plan. The report included details of the core clinical and technical training programmes, modular training, station-based training together with non-clinical management and staff development. The activity data gathered from station-based training was being developed to ensure that all activity data was reported.

The introduction of modular training has gone well with over 1,800 attendances in 2007/08; 94-96% of those booked on to training there had attended which was considered to be excellent. The HR Director said that efforts would continue to improve the booking of staff onto training programmes. From May 2008 the following additional Continuing Professional Development (CPD) modules would be introduced: diversity; obstetrics; mental health; 12 Lead ECG (intermediate and advanced); major incidents; advanced patient assessment and referral pathways.

It was Noted that:

44 staff had failed to attend the Patient Assessment module. This module was crucial given the changes in practice that were being introduced across the Trust. The HR Director said that the 7% non-attendance (of those booked on a course) was in line with the Trust's sickness levels and was not therefore thought to be a cause for concern.

Although only 95 of the 106 places on the University of Hertfordshire's BSc course were filled this was not considered by the Executive Directors to reflect negatively on the popularity of the course. The Medical Director said that there was a different cohort of students studying for the BSc four year sandwich degree than on the other further education courses. The Director of Operations said that the course was generally well subscribed and that the Trust was satisfied with the calibre of graduates joining the Trusts on completion of their degree.

37/08 Final draft of the Trust's submission to the Healthcare for London consultation

Following the comments and feedback received when the Service Development Committee considered the draft submission to the Healthcare for London, the final response was submitted to NHS London by the required deadline of 7th March 2008.

The Director of Service Development said that the submission would be used, both internally and externally, as a briefing document on the Trust's position regarding Healthcare for London. A key element of the Trust's response has been advocating the introduction of integrated response hubs.

The Trust was working with the Senior Responsible Owners and/or Project Managers of the six workstreams of Healthcare for London: Unscheduled Care; Polyclinics; Stroke; Local Hospital Feasibility; Trauma; Chronic Disease Management. The Medical Director was a member of the Clinical Advisory Group to the 'Healthcare for London' project.

It was Noted that:

Sarah Waller requested a copy of the template concerning polyclinics and a copy of the submission to the Healthcare for London. **ACTION: Medical Director and Director of Service Development.**

The Chronic Diseases Management workstream was initially focussing on diabetes rather then end of life. It was recognised that patients with chronic diseases, which included COPD[8] as well as cancer, often found it very difficult to co-ordinate their care with different NHS providers. The Director of Service Development said the Trust's submission to Healthcare for London included the suggestion that the LAS introduce a register containing information that terminally ill patients wished the Trust to have. This would facilitate a co-ordinated response between the patient's healthcare providers and ensure that the patient's wishes regarding their end of life care was respected.

Two potential bidders to manage polyclinics have expressed interest in working closely with the LAS in preparing their bids.

Lord Darzi had been invited to speak at the LAS' Patients Care Conference in June 2008.

In addition to being submitted to the Healthcare for London consultation the document had been sent to the Senior Responsible Owners, Project Managers and senior figures at NHS London. The document will be shared with Lord Darzi and the Chief Executives and Chairmen of the London PCTs. **ACTION: Chief Executive and the Chairman.**

Noted:
1. **The contents of the submission to the Healthcare for London consultation.**
2. **That the Trust Board will receive updates on a quarterly basis concerning Healthcare for London. ACTION: Director of Service Development**

38/08 CAD 2010 update and migration options

Procurement: The Director of IM&T presented the report outlining the progress of the CAD 2010 Project. The Project was currently in Stage 3 – Procurement. Following the completion of the European Tendering exercise a defined supplier(s), product(s) and costs will be set out in the Full Business Case (FBC). Extensive negotiations were taking place with two suppliers concerning all aspects of the CAD 2010 contract. The paper set out two options for approving the FBC. The Director of IM&T stated that the preferred option was to submit a draft FBC to the Board for approval on 24th June 2008, with approval of the final FBC and contract being signed in October-December 2008.

Transition (migration) issues: The Director of IM&T said that a number of options were being explored but the current preference was for operating both CTAK and the new CAD system in parallel, with an appropriate level of data synchronisation between them. This will allow a progressive period of roll out into the live control room environment. This will be a very complex process and there was an element of risk involved - as there would be regardless of which migration option was chosen.

Gateway Review: the Gateway 3 Review was scheduled to take place on 23rd June 2008.

Work on the FBC was making good progress and the Director of IM&T was confident that once the procurement had been concluded the FBC could be compiled in a timely manner. Roy Griffins, who was tasked by the Board with keeping an eye on CAD 2010, referred the Board to the recent report from the Consultant engaged to independently advise the Board in regard to CAD 2010. Mr Griffins said he supported the Director of IM&T's recommendations in respect of a gradual transition as it can be closely monitored. He drew the Board's attention to the procurement and project challenges within the report.

The Director of IM&T said the Consultant's report had been helpful but disagreed with her statement that there had been a delay to the project caused by the management approach adopted. In regard to the leadership of the project, he had discussed the report with the Director of Finance and though both would continue to be closely involved, the Director of IM&T had responsibility as Senior Responsible Owner of the project. He said that there was a misunderstanding by the Consultant in respect of the FBC as there was a definite plan in place.

[8] COPD: Chronic Obstructive Pulmonary Disease

The draft FBC will be presented to the Board in June 2008. **ACTION: Director of IM&T**

It was Noted that:

The Director of Finance said he would like the Consultant to focus on providing more detailed technical advice regarding the various options on CAD 2010. The Director of Finance said that when the Trust negotiated with Commissioners regarding 2008/09 funding it had been made clear that CAD 2010 was not included in that arrangement and that once the cost of the project was confirmed, further separate discussions would be held with the Commissioners.

The request for time and material will be specific to the work being undertaken by the preferred supplier during the time between approval of the draft FBC and the final FBC. The contract that will be signed will include the time and material provision. The Chairman suggested that given Brian Huckett's experience with similar large projects at Visa he might work with Roy Griffins in advising his Board colleagues in respect of the CAD 2010 project.

A number of ambulance services in England were procuring CAD systems of a similar size and complexity to that being procured by the LAS. The Director of IM&T was liaising closely with his colleagues in the other ambulance services.

The approval of the draft FBC in June 2008 will be a crucial decision by the Trust Board as it will set out the case for choosing the preferred supplier of the CAD 2010.

Noted:

1. **The progress of the project;**
2. **The preferred approach regarding the transition process;**
3. **The outline timetable, particularly the timeline required for Strategic Health Authority approval;**
4. **That the Trust Board will be asked to consider allowing the project to proceed on a time and material basis following the presentation of the draft FBC; which will be within strict parameters set by the Trust Board.**

39/08 SIP 2012 Update

The Director of Service Development presented the SIP 2012 update which included a description of each project currently included in the five programmes and a milestone chart for each programme showing progress as of early February.

It was Noted that:

The Board was satisfied with the reporting format but would like to receive, on an exceptions basis, a report concerning projects that were not on track.

Although a few projects were reported as not being on track or not under control this did not always reflect the reality.; There was a timing issue as the milestone chart had been prepared early March. The Director of Operations pointed out that one of the projects, 'Re-Engineer Call Handling', had slipped due to a wish to bed down the new management arrangements before introducing new rostering. The Director of Service Development said that the term 'control' in the context of Project Management was a specific technical term that meant a slippage in delivering the project had not been resolved rather than the project was 'out of control'.

The Project 'Paperless Control Room' was on hold at the moment as the Director of IM&T wished to ensure there was an adequate back up in place should the new 'paperless' system fail. He said the system currently in place had demonstrated it was needed when, recently, there had been a need to resort to a paper based system because of technical difficulties.

Progress with the Referral Pathway Project had slipped due a member of staff being on long term sick leave. The Director of Service Development said that 200 referral pathways had been established but work was needed to ensure they were fully utilised locally.

During 2008/09 the report format will be modified to concentrate on the delivery of benefits as well as the progress of projects. **ACTION: Director of Service Development.**

40/08 Draft minutes of the Clinical Governance Committee, 4th February 2008

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

Lost property bags (one of which was circulated at the meeting) will be introduced on all ambulances with effect from April 2008. The Head of Complaints estimated that 50% of the enquiries or complaints received by the PALS office were concerned with lost property. A benefits realisation report will be presented to the Clinical Governance Committee in due course.

Work was continuing to ascertain the ethnicity of 999 callers. The Service was working closely with NHS Direct and the Ambulance Leadership Forum to introduce an ethnic monitoring for this group of users.

There had been discussion as to how the Service could be sure that communications, such as the monthly Clinical Update were received; read by individual front line members of staff and the required changes in practice implemented. It was proposed that Station Administrators be asked to post copies of the Clinical Update on the Stations' information boards. In due course an audit will be undertaken to determine the level of awareness amongst staff of the Clinical update. Although all members of staff have individual email accounts, a more mobile fleet meant front line crews were less likely to have access to email on a regular basis.

Noted: The draft minutes of the Clinical Governance Committee, 4th February 2008.

41/08 Draft minutes of the Service Development Committee, 26th February 2008

Noted: The draft minutes of the Service Development Committee, 28th February 2008, with the amendment that Brian Huckett be added to the list of atendees.

42/08 Draft minutes of the Audit Committee, 3rd March 2008

Caroline Silver, Chairman of the Audit Committee, presented the draft minutes to the Trust Board. She said there had been a lively debate concerning the proposal that the Audit Commission review CAD 2010. It had been agreed that the Audit Commission's remit would be precisely defined so as not to duplicate work being undertaken by the Consultant to the Board or the Gateway Review process. This audit would comprise 5% of the total audit work being undertaken by the Audit Commission in 2008/09.

The Committee reviewed the Assurance Framework, which had been presented to the Board today for approval. The Committee approved approaching the Inland Revenue to make final settlement with regard to the outstanding liability on the Trust's balance sheet in respect of subsistence.

The Committee received a report regarding the introduction of IFRS[9] and the preparatory work being undertaken by the Trust in respect of the 2007/08 and 2008/09 financial accounts. The Director of Finance said that the requirement to produce the accounts in the IFRS format may be deferred until 2009.

[9] International Financial Reporting Standards

The Chairman drew the Board's attention to two audits undertaken by Bentley Jennison, the Internal Auditors, concerning annual leave management and drug control. Significant recommendations were made by the Internal Auditors in respect of the two audits and assurances were received that these were being implemented. The Committee requested that both of these areas be re-audited in 2008/09.

The report concerning drug control would be presented to the Clinical Governance Committee in April 2008. The Medical Director said she was disappointed that the Internal Auditors had not spoken to her when they undertook the drug control audit.

Noted: The draft minutes of the Audit Committee, 3rd March 2008.

43/08 <u>Report from Trust Secretary on tenders opened since the last Board meeting</u>

Eight tenders have been opened since the last Trust Board:

Leadership Development Programme
Rightrack, Carter Carson; Fletcher Consultancy; Cullen Schofield; Montpellier; The Development Co.; Management Futures; Leadership Trust; MDP; The Work Foundation; University of Leeds; Vector Group; The Morton Partnership; 3L Group Ltd; Quadrant 1 International; Cameron Consulting; University of Lincoln; TSO Consulting; RIGHT Management; Real World Group; First Ascent; University of Herts.; Pera; Now That's Different; Frankham Consultancy; CCC Inspirations; Birkbeck University of London; Oakleigh Consulting.

New lifts at HQ
Jackson Lift Group; Otis Limited and Kone

Integrated Governance and Reporting System
Dynamic Change;

Fleet Management Software System
Civica UK Ltd; Jama Fleet Solutions; CFC Solutions; Trace Systems; Chevin Computer Systems Ltd

Units 2 & 3 Falcon Park Industrial Estate
Consiton Limited; Building Associates; TCL Granby/Crispin Borst; Russell Crawberry Ltd; Lakehouse Constructs Ltd

Replacement of the generator, UPS system and associated works at Bow
Gratte Brothers; Norland Managed Services; Haw Systems London Ltd; Lunar Electrical

E-learning
Harbinger Knowledge Products; Trainer 1

Supply & Maintenance of Pneumatic Patient Lifting Device
Manger International

Following analysis of the above tenders by the appropriate department a report would be presented to the Board on the awarding of the tenders.

In respect of the use of the Trust Seal, there have been 2 entries relating to the use of the seal:

No. 112 Counterpart lease, car parking spaces, 1-11 Blackfriars Road
No. 113 Reference for Ian Todd, requested by Nursing Midwifery Council

Noted:

1. **The report of the Trust Secretary on tenders received**
2. **That only tenders subject to European Union tender regulations were reported to the Trust Board; these were tenders whose value exceeded £90,000 over the duration of the contract.**
3. **That the Trust's seal had been used twice since the last Trust Board meeting.**

44/08 Any Other Business

There was no other business.

45/08 Opportunity for members of the public to ask questions

George Shaw, LAS Patient's Forum, had a number of questions for the Trust Board:

1. *The timeline for responding to the Memorandum of Understanding between the LAS and the Patients' Forum.* The Chairman said he did not think it was necessary to have a Memorandum of Understanding between the two organisations; he was happy for representatives of the Forum to continue attending the Board meeting and working with the Trust. The Chairman said there would be a meeting with the Chairman of the Patients' Forum to discuss this matter further. In the event that the LAS becomes a foundation trust members of the forum could become members of the foundation trust and stand for election to the Board of Governors.
2. *The Forum was concerned at the decline in Category B19 performance in recent months and asked what remedial action was being taken.* The Director of Operations said that Category B19 performance had been 86.8% in January 2008; it had fallen in the succeeding months due to an increase in workload and the availability of staffing but had recovered in March and was now 84.4%. He said that performance was generally good mid week but fell at the weekends; this was being addressed by a review of the rosters to increase the number of staff available at weekends. He added that the Trust would have a performance target of 90% Category B19 in 2008/09 and a number of initiatives were being considered to ensure that this was achieved.
3. *What advice and support was available to front line staff when they were transporting mentally ill patients.* The Medical Director said that although she shared the concern expressed by the Patients' Forum there were a number of mechanisms in place to support and advise staff when they were transporting mentally ill patients. Support was available from local management teams; the Control Room; the Clinical Support Desk (which will be in operation from the end of April) and the On Call Clinical Advisers. In addition, training on mental health will be one of the modules being introduced from May 2008.
4. *What has been the impact of the recent increase in fuel costs?* The Finance Director said that the Trust was managing that risk by switching from petrol to diesel as it was cheaper, being a more efficient fuel. In addition, the Trust, in partnership with the NHS and the Ministry of Defence, will be participating in a re-tendering exercise for fuel that should mitigate increase in fuel costs.

46/08 Date of next meeting

Tuesday, 20th May 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 13.37

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 29th January 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 29th January 2008 in Part II the Trust Board received updates:

- Regarding London Airwave Radio Project (LARP) and the difficulties experienced on New Year's Eve. The IM&T Director undertook to keep the Trust Board informed of progress.

- On the progress being made in implementing the action plan to achieve 'Call Connect' performance targets with effect from April 2008. Discussions were being held with staff side on such things as dynamic deployment.

- On the preparations for the Trust Board's Away Day in April. The Chairman said he was collating information about the governance arrangements of Foundation Trusts and would be seeking to identify what were the pitfalls and how other Trusts had resolved them.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 20 MAY 2008
CHIEF EXECUTIVE'S REPORT

1. SERVICE DEVELOPMENT

Healthcare For London

The consultation on healthcare for London finished on March 7th. The responses have been collated and are available on the HfL website at http://www.healthcareforlondon.nhs.uk/ConsultationDocs/FinalH4LCtCreport.pdf. After consideration by a number of committees, including the Clinical Advisory Group on which Fionna Moore sits, there will be a meeting of the Joint Committee of PCTs on June 12th which will agree the next steps.

The consultation demonstrated broad support for the concepts within Healthcare for London. Each PCT will need to decide how to take the proposals forward in their areas and will need to consult separately on any changes. In many cases the involvement of the LAS will be important, locally as well as, up until now, centrally.

The central involvement has included the submission of an LAS response as agreed by the Board in February and subsequent meetings with David Sissling, the Healthcare for London Programme Director, who also attended the Board awayday in April. The LAS is represented on the Clinical Advisory Group, as mentioned above and also in panels and working groups for the HfL workstreams on stroke and trauma. Further information on LAS involvement in HfL activities can be found in the Medical Director's report.

Annual Health check 07/08

The Trust has completed the submission of the final declaration for the annual health check 07/08. The declaration is now available on the Trust's website in compliance with the Healthcare Commission's requirements for providing access to the public. Positive commentaries on our self assessment of full compliance with the core standards for the second year in succession were received from NHS London and the Patients Forum. 8 overview and scrutiny committees commented.

All executive directors were involved in providing assurance to the Board of our compliance with the standards and this work was detailed in the Assurance Framework received by the Board on March 18th. The outcome will be announced by the Healthcare Commission in October. For the Annual Health check 08/09 attention will need to be given to the challenge of building relationships with the new borough-based LINK acquisitions. The standards for better health group led by the Finance Director will continue to provide assurance and review controls and risks to ensure compliance in 2008/2009.

Foundation Trust preparations

As the Board will be aware, the LAS is one of the two Ambulance Trusts piloting the assessment process prior to Ambulance Trusts being able to apply to become a Foundation Trust. John Wilkins has been appointed to Project Manager to take us through the assessment phase

New Ways of Working

I am pleased to announce that Barnehurst complex and Chase Farm complex have been selected as the first two example complexes. The implementation support team is now being recruited to assist both the station management teams through the initial diagnostic phase. A further more detailed update on progress will be provided at the next Board meeting.

2. SERVICE DELIVERY

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

The tables below set out the A&E performance against the key standards for March and April of 2008 and for the 2007/08 year. Please note that call connect was not a cumulative target for last year and has therefore been omitted in terms of ytd values. Category B figures below for April and May are against the new clock start time.

	CAT A8 (current)	CAT A8 (call connect)**	CAT B19	CAT B19 (call connect)**
Standard	75.0%	75.0%	90.0%	90.0%
March 2008	78.1%	63.9%	86.8%	-
2007-08	78.94%	n/a	84.4%	-
April 2008	n/a	76.9%	-	88.4%
May 2008*	n/a	76.2%	-	85.6%

* Accurate as at 11th May 2008
** Applicable from April 2008

- I am pleased to report that the Trust exceeded the 2007/08 Category A target of 75% and attained 78.94% across the year. This is the best performance the Trust has ever attained and is a considerable achievement.
- Call Connect performance for 2008/09 has started well with the Trust achieving 76.9% in April. The first few days of May have seen an increase in workload due to the hot weather, however the Trust has continued to deliver performance in excess of 76%. This is a very positive start to this year, particularly when considering the progress made towards the new target in the last quarter, and compares well to other Trusts across the UK.
- It is important to provide some perspective here in that Call Connect performance last April was 56% with broadly similar levels of workload

and staffing. At 76% this year we have therefore shown an improvement of 20% over the same period last year.

- Control Services has continued to perform well and call answering has remained very resilient with the percentage of call taking within 5 seconds at 96.2% for April with some weeks achieving 98%.
- Category B performance for the year was 84.4%. Whilst this is some way off the target, it is an improvement of about 4% over the previous year. The target is now measured against the new Call Connect standard and there is still some work to be done to ensure that this target is achieved this year.
- Workload in April fell slightly compared to the previous 3 months. In April we responded to 2538 (842 Cat A) calls per day as compared to March when we responded to 2590 (891 Cat A), February to 2580 (891 Cat A) per day and in January we responded to 2542 (887 Cat A) calls. Compared to last year March and April activity was up by about 1%.
- In April CTA handled 7,494 calls with 3,653 calls resulting in care being delivered other than by sending an Ambulance. This was a good achievement and resulted in 121 Ambulance journeys a day being saved.

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

A more comprehensive update on activity and performance will be provided at the next Board meeting.

Performance on the quality statistics have improved in April to:

- Arrival time: 90%
- Departure time: 91%
- Time on Vehicle: 95%

The new contracts for Lambeth PCT, South London and the Maudsley NHS Trust and Whipps Cross University Hospital all commenced operation on 1 May 2008. Initial feedback from the customers has been good and there have been few issues on start-up.

The NHS Purchasing and Supply Agency have issued a tender notice to establish a framework agreement for PTS services across London. They have estimated that the potential value of this business could be up to £55 million. The deadline for expressions of interest is 12:00 noon on 14th May 2008 and the LAS is currently putting its submission together in response.

2.3 Operational Developments

- The amalgamation of Bow Resource Centre and Ilford Resource Centre has been deferred until the end of May. This was a planned deferral due to the operational pressures put upon the Resource Centres to improve staffing levels during April. It seemed prudent not to disrupt them during this busy time.

- The Trust was at REAP level 3 'Severe Pressure' until late April, but was reduced to REAP level 2 'Concern' following the performance improvement noted.
- The administrative handover across London ceased on the 10th March. This has settled down quite well with issues only reported at a small number of Trusts, where further work is now underway. This has resulted in further reductions in crew time at hospital; although not quite to the levels desired but we are confident that this will be rectified in the forthcoming months as the changes become embedded.
- The second phase of the Control Services reorganisation was formally agreed with staffside in mid April. Work is now underway to implement the new structure and the posts are currently being filled.
- The Clinical Support desk in EOC commenced its Trial on the 21st April following the appointment and training of 6 experienced Paramedics. The desk is used to provide clinical support to both operational crews on the road as well as Control room staff and there have already been several cases where the Clinical Care delivered to patients has been enhanced by the input received.
- On March 30th the service attended a serious incident when a Cessna light aircraft crashed near Biggin Hill airport. The aircraft had 5 persons on board when it crashed into a house, short of the airfield. All persons on board were unfortunately killed. The Service although not 'declaring' the incident, followed major incident procedures with our multi-agency partners, which worked well.

- In March, HART (Hazardous Area Response Team) plus several LAS managers took part in a national HART / USaR (Urban Search & Rescue) exercise at the Fire Service College. This exercise was on a national scale and was attended by several ministers. Initial feedback to the LAS is positive towards our input.

- On 6th April the Emergency Planning Unit put plans in place to cover the Olympic Torch relay through London. This plan proved its worth. The event was tightly managed by the police and relatively quiet from our

point of view with only 8 persons being treated and 1 taken to hospital. This was however an event which was under the international spotlight and had great potential to be more difficult.

- On 13th April once again the Emergency Planning Unit put in place its well exercised plans for the covering of the Flora London Marathon. This event was managed successfully with our partners St. John Ambulance, with 4293 persons treated and 64 persons taken to hospital.

- Several exercises have been attended during this reporting period. Three of note are: Live tunnel exercise in Rotherhithe Tunnel; Live military exercise with the Tactical Response Force: and CBRN victim recovery exercise at Winterbourne Gunner training centre.

- Plans are well underway for delivering a national Emergency Preparedness ‘Lessons Identified’ conference in July, hosted by the Trust. This event is focussed on Emergency Planners and Directors of Operations from around the country and is aimed at sharing lessons from recent major incidents, as suggested by the Civil Contingency audit last year.

3. HUMAN RESOURCES

Employee Relations

The following provides an update on progress and activity related to developing new partnership and consultative arrangements within the LAS.

In 2007 a new Partnership Agreement was signed between the Trust and the recognised Trade Unions (Unison, GMB, Amicus, TGWU). It should be noted that the merger of the latter two unions to form “Unite” has been agreed formally at national level and is expected to be completed by November 2008.

A Trust-wide Partnership Conference was held in the autumn of 2007, followed in November by the establishment of the Operational Consultation Forum, comprising senior staff representatives and senior managers from the Trust. As a sub-group of the long-established Staff Council, this has become the key consultative group for operational staff within the Trust.

In view of this, the current review of the overall consultative arrangements will confirm the Operational Consultation Forum as a standing sub-committee of the new Staff Council, which will have an enhanced corporate and strategic role with membership extended to include the Directors of Finance and IM&T. It is also intended to establish a specific and separate joint terms and conditions/policy group primarily to consider corporate matters affecting all staff groups. The proposals for the new constitution are currently with Staff side and agreement is expected at the next meeting of the existing Staff Council in July.

The Operational Consultation Forum has met regularly (every three weeks) to discuss the many issues facing the Trust at a time of unprecedented change. The management and staff side representatives are jointly committed to work in partnership, through the forum, to achieve the changes required to attain the new performance standards and other quality improvements.. A number of agreements have already been reached and frameworks agreed through the Consultative Forum, including:

- Area and local updates and presentations have been delivered jointly by Assistant Directors of Operations and senior staff side representatives.
- The administrative handover at hospital has been ended.
- A framework has been agreed for the future arrangements for any review of working patterns, linking any change to evidence that it is needed.
- The framework has already been used successfully to facilitate joint agreement on revisions to working patterns in EOC, achieving a better spread of cover, more equitable workload and hence improved patient care.
- A framework for "step-down" arrangements has been agreed, allowing consideration of requests for permanent redeployment to alternative duties based upon personal need.
- Consultation on career progression including the introduction of the student paramedic programme, providing the opportunity for staff to progress their professional career.
- A joint review of mileage rates and travel expenses arrangements has begun.
- A framework for active area cover has been agreed, and the formal arrangements have been the subject of further extensive consultation.
- Regular discussion on New Ways of Working.

Transfer of PTS staff

Apart from one of the Site Managers, all staff who requested to remain with the LAS following the loss of the UCLH and Kingston Hospital NHS Trusts, have been redeployed onto other contracts. The Site Manager concerned transferred under TUPE across to Door to Door who were successful in wining part of the UCLH contract.

With the commencement of the Lambeth PCT contract on 1 May 2008; 13 Ambulance Persons transferred into the LAS under TUPE. These staff previously worked for the PCT and consequently transferred across on their existing NHS terms and conditions of service. They have been receiving both familiarisation and clinical training during their first 2 weeks with the LAS

Retrospective CRB checks

The Trust is currently undertaking CRB checks for all existing staff who have patient contact and thus meet the criteria of the Criminal Records Bureau. This exercise commenced in mid February. Almost 2000 staff were required to undergo the process and to date almost 75% have complied. A final reminder for returns has been sent to all those staff whose check is still outstanding. This reminder will warn of the potentially serious consequences of continued non-compliance.

From the returns received to date, 61 checks have been 'positive'. This will include offences 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 11 investigations under the disciplinary procedure have been or will be undertaken. Any disciplinary hearing which is convened will also be heard by a single (different) panel. The process is being managed extremely tightly both in order to comply with the Trust's and CRB requirements for confidentiality and to ensure that Trust wide consistency is maintained.

Introduction of the Student Paramedic role

The Trust Board are receiving the report on the Workforce Plan for 2008/09 at this meeting. The recruitment and training activity associated with this plan is extensive and recruitment to the new Student Paramedic role has begun with the first cohort of recruits having commenced training on 12 May 2008. The Workforce plan provides more detail on the Trust's plans to meet its challenging objective of filling all existing vacancies and recruiting to an increased A&E establishment.

NHS London

The Director of Human Resources continues to work closely with the SHA in developing a joint understanding of workforce issues related to the plans contained within "Healthcare for London".

The LAS recently participated in a London wide event, *Staffscope,* organised by the SHA and will work with the facilitators of that event and the SHA at a further LAS specific event on 23 May 2008.

Funding for Education and Development, recently agreed with the SHA is linked to this joint strategic aim of developing a more highly skilled workforce with the ability to deliver services which reflect the aspirations of both the LAS and Healthcare for London.

Sickness Absence (graph 13)

Absence levels for February and March have shown a downward trend. Levels of absence in March are the lowest for the year. Whilst this is encouraging, it should be noted that an overtime incentive scheme was introduced in March to support the Trust in achieving its "call connect" standard and it is likely this has made an impact on staff attendance.

The Trust has set a target of absence levels below 6% for the year as a whole in 2008/09. HR Managers will be closely monitoring local levels and ensuring robust application by managers of the Trust's Managing Attendance Policy. The existing HR audit of policy application will be strengthened and conducted routinely on monthly basis. Current practice allows for quarterly auditing for good performing areas but it is recognised this has the potential to allow a loss of focus during intermittent months.

In addition we will work with Atos, our Occupational Health providers at developing a specific project plan for reducing long term absence. Supporting information is currently being gathered to inform the focus of this work.

Rest Breaks (graph 14)

There has been an increased focus on rest breaks during April. The net effect has seen over 60% of crews getting rest breaks and a reduction in the number of crews ending their shift early. This has contributed to more stable performance and a reduction in performance fall at shift change-over time thus ensuring a more consistent level of care delivery across the day.

Resourcing (graphs 15-19)

Resourcing has significantly improved during March and April, assisted by an incentive scheme. Ambulance hours produced were similar for the same period last year (1st March – 22nd April) at circa 220,000 hrs however we have seen an increase of FRU hours by circa 1,000 hours to 79,000hrs for the period. There is still a good appetite for overtime as we go into May and we have seen some excellent resourcing.

EOC resourcing

EOC staffing continues to run at over plan since the beginning of March. This has supported the consistent and sustained levels of call taking performance. Changes to the existing core and relief rotas from 14 April have resulted in more consistent call answering performance at the weekends.

Suspensions

As of 29 April 2008 there were 12 suspensions, the oldest shown below:-

East: (21 February 2008)

South: (14 March 2008)

West: (30 January 2008)

HQ/Fleet/Others: (10 January 2008)

WORKFORCE INFORMATION

Table 1

A&E ESTABLISHMENT REPORT - March 2008				
Position Title	Funded Establishment	Staff in post	Variance	Leavers
Team Leader	169.50	161.19	8.31	0.00
ECP	56.00	52.56	3.44	0.00
Paramedic	910.89	818.18	92.71	4.00
EMT4	713.48	851.69	-138.21	6.00
EMT3	682.75	460.35	222.40	1.00
EMT2	0.00	99.11	-99.11	0.00
Total	**2532.62**	**2443.08**	**89.54**	**11.00**

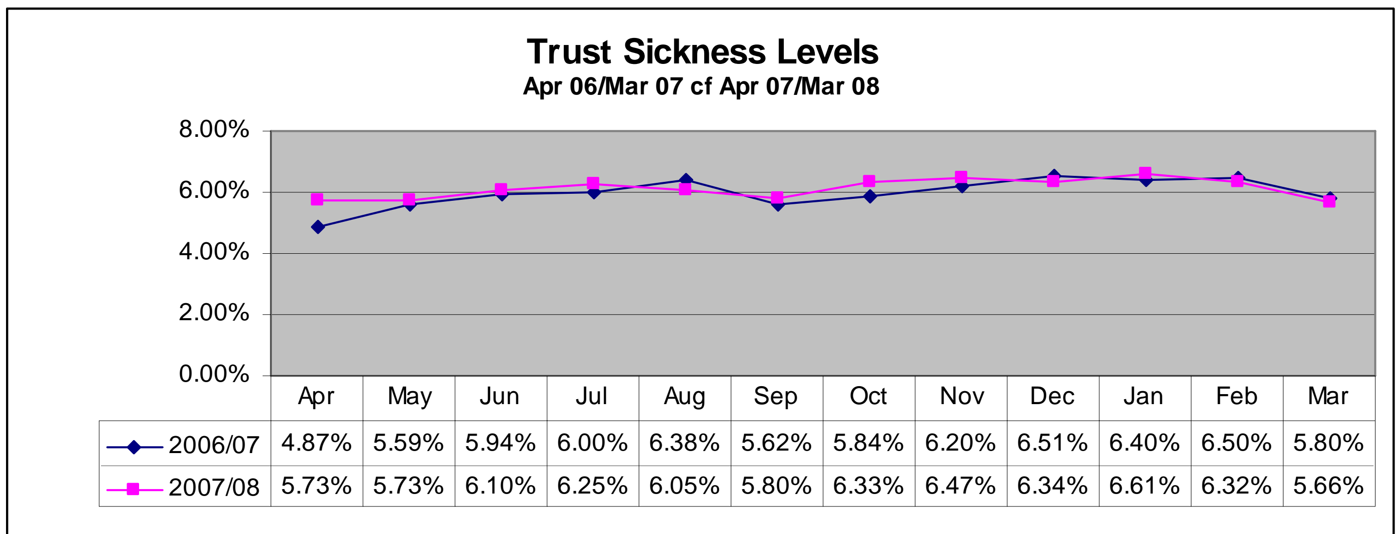
Table 2

Staff Turnover		
Staff Group	Apr 06/ Mar 07	Apr 07/ Mar 08
A & C	11.04	13.13
A & E	4.64	5.13
CTA	0.00	5.13
EOC Watch Staff	11.04	11.70
Fleet	5.08	10.91
PTS	6.16	11.02
Resource Staff	1.96	2.04
SMP	6.72	6.74
Grand Total	**5.87**	**6.83**

Table 3

Absence 2007/08	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08
A & E Ops East	7.03%	6.92%	6.64%	6.23%	5.63%
A&E Ops South	6.58%	7.00%	7.02%	6.36%	5.91%
A&E Ops West	6.23%	6.52%	7.78%	6.77%	6.61%
Control Services	7.27%	6.83%	6.98%	6.79%	5.40%
PTS	8.24%	7.13%	8.27%	9.86%	8.36%
Trust Total	**6.47%**	**6.34%**	**6.61%**	**6.32%**	**5.66%**

Graph 13



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2006/07	4.87%	5.59%	5.94%	6.00%	6.38%	5.62%	5.84%	6.20%	6.51%	6.40%	6.50%	5.80%
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%

4. COMMUNICATIONS

Campaigns

Use your ambulance service wisely: The completion of the Service's best ever year, including the achievement of the Government's Category A performance standards, was recognised by coverage in a number of local newspapers, as well as in a short news report on ITV London.

At the same time at the beginning of April – and to coincide with the introduction of the new Call Connect target - an advertising campaign was launched to encourage the public only to call 999 in the event of a genuine emergency.

Adverts featuring the image of an ambulance in a fire alarm box were placed in the Metro, London Lite and the London Paper, and also for two consecutive weeks in more than 50 weekly papers across London. As well as encouraging the public to 'use your ambulance service wisely', the adverts also outlined the range of other healthcare options available to those with less serious illnesses or injuries. Adapted version of the adverts will be running across the London Underground during the first two weeks of June, while poster versions are being distributed to stations for display in ambulances and local public buildings.

British Heart Foundation: The BHF launched a four-week London version of 'Doubt Kills' in May to raise awareness about the symptoms of heart attacks and what to do when they occur. The Service is supporting the BHF in communicating the campaign and will also be measuring the impact it has on the number of 999 calls received relating to chest pain.

The BHF has also launched a year-long campaign to raise £100,000 to fund more defibrillators for the Service's community defibrillation project and the ambulance community responder scheme. Community Defibrillation Officer Jo Smith and CRU Matt Chute assisted in launching the campaign at a charity jog at the Tower of London.

Media

Harrow building collapse: Multiple calls were received from national, regional and local media following the collapse of a building in Harrow after a reported explosion. One man who was trapped in the building died, and two other patients were treated and taken to hospital by crews in the incident.

Chelsea firearms incident: The department dealt with a number of calls from national media about a firearms incident at a residential address in Chelsea in which a man died after shots were fired after armed police arrived on the scene.

Filming – London Ambulance: Filming has begun for a second six-part series of London Ambulance which will be broadcast on ITV London later in the summer. Last year's series which followed crews at work in the capital attracted up to 360,000 viewers on a Friday evening.

Patient and public involvement

Strategic plan: A successful public event, ‘It’s your call’, was held on 26 March to obtain views from Londoners about our future plans and about the equality impact assessments that have been carried out. Over 80 people attended, including a number of people with learning disabilities, who are traditionally very hard to engage. The results are currently being written up and will be used to inform future developments.

Meetings were held with two groups for deaf people run by the Enfield Deaf Project to discuss the Access Programme and specifically the project to improve access to the Service for deaf people. The feedback will be used in the project's development.

Public Education: A development programme is being designed for staff involved in public education, in collaboration with South Bank University. Due to start in September, this will include some skills training (e.g. presentation skills, instructional methods) and will use a learning set/reflective practice approach. It is hoped the course will be accredited by the university.

A public education co-ordinator is to be appointed to co-ordinate the staff involved in public education activity and the materials and resources they need to carry out this role effectively.

Risk Assessments for public events: Concern has been expressed that the current LA168 risk assessment forms, for the Service’s attendance at public events, are not always being completed. As a result, the form is being revised; the new form will also include information about how staff will be paid for working at the event (ie overtime, time in lieu, swapping shifts etc), which should encourage them to complete it.

New Ways of Working: Two community involvement officers are to be appointed to work closely with community groups, partner organisations, patients and the public on the two complexes that have been identified to adopt the New Ways of Working model. The post holders will also have a role in the management of frequent callers and the high risk register.

Tower Hamlets Project: As one of a number of initiatives led by Tower Hamlets PCT, a health education pack and training programme, ‘Get the Right Treatment’, has been selected for the national finals of the Health & Social Care Awards. The training programme, which is currently being delivered to NHS staff and members of the public in Tower Hamlets, highlights the range of local NHS services that people should access in a variety of circumstances. The supporting DVD was produced by the Service’s Media Resources Unit.

5. INFORMATION MANAGEMENT & TECHNOLOGY

CAD 2010 Update

At the March Trust Board a full report was given on the progress of CAD 2010. I am pleased to report that in line with the timetable provided, negotiations were completed with the two suppliers for formal invitations to submit final tenders on 17 April. This marked a significant milestone in a long and complex procurement process. Responses were received back on 9 May, and we are currently on track for the evaluation report to be ready for consideration by the CAD 2010 Project Board w/c 27 May. Provided the evaluation report is able to make a clear recommendation, then data from this will be used to complete a draft FBC (Full Business Case) for consideration by the Trust Board before it is submitted to the SHA before returning to the Trust Board for final approval.

As previously discussed, in order to ensure there is minimal delay in commencing work with the preferred supplier, the Trust Board is invited to delegate authority to the Service Development Committee to:

1: Approve the recommendation of the preferred supplier

2. Approve 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 would 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.

Peter Bradley CBE
Chief Executive Officer
May 13th 2008

Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 20 May 2008

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

No new SUIs have been declared since my last report to the Trust Board in March. The investigation of an existing SUI, into the care provided to a 36 year old woman who was bleeding heavily, has been completed, an action plan drawn up and approved by the Senior Management Group.

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 six alerts were received from 4th March to 30th April 2008. All alerts were acknowledged; only one required any action; this involved alerting staff to pen torches where the bulb is incorrectly sited. This issue has been circulated throughout the Service with a photograph illustrating the faulty pen torch and instructions on returning any identified to the Logistics Department.

Safety Cannulae

Following concerns expressed by staff about the performance of the current safety cannulae a potentially more suitable model is now on trial with the Health and Safety reps in each of the old sectors. 6 Sectors have reported back indicating a preference for the new design. The Purchasing Department are liaising with the supplier to establish what training materials are available to support its introduction. This new cannulae could be available from June and the training implications are under discussion.

2. Second domain – Clinical and Cost Effectiveness

Medical Support to Control Services

The post of Assistant Medical Director, with responsibility for Control Services has been advertised. Short listed candidates will be interviewed on 12th May. It is anticipated that this appointment will strengthen the Medical Directorate and provide clinical support to both Control Rooms.

Mental Health update

The Secretary of State for Health has laid a revised Mental Health Act 1983 Code of Practice before Parliament. Subject to Parliamentary review, this will come into force on Monday 3 November 2008, at the same time as the majority of the main changes made in the Mental Health Act 2007 to the previous Mental Health Act (1983).

The Head of Policy, Evaluation and Development will develop the LAS Mental Health Strategy and relevant policies over the summer to meet the requirements of the new Code of Practice. One change came into effect on 30th April 2007: Section 44 of the 2007 Act amends sections 135 and 136 of the 1983 Act to allow a person to be taken from one place of safety to one or more other places of safety, during the 72 hour maximum overall period during which they may be detained under either of these two sections. The next edition of Patient Care News section in the LAS News and the next clinical update will carry advice for crews on this.

Work has commenced around updating the Mental Health CPD module and investigating the LAS's role in transporting patients back to secure units if they break the terms of their Supervised Community Treatment Order.

The recent change in the procedure for booking Assessments under Section 135 of the Act from EOC to UOC will be evaluated at the end of May.

The Joint Agreement between LAS and MPS for conveying members of the public will be signed off shortly.

Healthcare for London Update

Unscheduled Care

Healthcare for London have engaged PA Consulting to project manage this work stream, initially focusing on collecting in-depth data from six PCTs. The Head of Policy, Evaluation and Development attends workshops on behalf of LAS.

This data suggested 8 key areas of improvement:

1. Supporting patients in improving self care and management.
2. More effective chronic disease management in the community.
3. Single telephone number – urgent care by phone
4. Better use of pharmacies
5. Improved access to GPs
6. Better provision of generalist urgent care centres aligned to A&E departments
7. Better provision of specialist unscheduled care centres e.g. for the elderly and paediatrics
8. Improving the current models of unscheduled care provision

The LAS focus has been on two main areas:

- To encourage better links between LAS, NHSD and Out Of Hours providers so that patients can be easily transferred to the most appropriate team, without having to resubmit their details. It has been pointed out that NHSD does already provide a second number and the fact that this is not used as an urgent care telephone service (as originally envisaged) should be addressed before another service is introduced, potentially at great expense.
- As well as providing LAS with additional options for resource deployment, the possibility of positioning vehicles at Urgent Care Centres (polyclinics?) might reassure the public that in the event of an emergency speedy transfer, by experienced staff, to an A&E environment is available.

Major Trauma

Healthcare for London held a workshop, chaired by Professor Matt Thompson, Clinical Director of the project, on 22nd April. Many of the Acute Trusts were represented. The Medical Director presented on the pre hospital phase of the major trauma pathway. Acute trusts were encouraged to consider setting up networks where several trauma units would support a Major Trauma unit, and the US model for accrediting Major Trauma centres was covered in some detail.

A Clinical Expert Panel has been formed and held its first meeting.

Implications for LAS (identifying suitable cases, initial management and triage and managing the implications for job cycle times) are being investigated by a short life working group, chaired by the Director of Service Development.

Stroke

This project (again, project managed by PA Consulting) is the most developed of the work streams, both at Healthcare for London and local level. The Head of Policy, Evaluation and Development and the Clinical Practice Manager represent LAS on the Stroke Clinical Expert Panel.

An acute pathway model for FAST positive patients is being scoped to care for those patients eligible and not eligible for thrombolysis. A drive to provide gold standard care has led to the development of performance standards for the pathway, with full and interim targets developed for each. Those standards of particular relevance for the LAS include the time from call to the emergency services to admission to the Emergency Department, percentage of patients admitted to the Emergency Department within 2 hours of the onset of symptoms and the percentage of patients receiving thrombolysis within 3 hours of symptoms onset.

The precise model to be advocated by Healthcare for London (eg. all 24/7 centres, a hub and spoke model, local networks supporting telemedicine) is yet to be decided. The position preferred by the LAS is that only those centres offering 24/7 care can deliver similar benefits to those delivered by the primary angioplasty model.

However, given the potential difficulty of implementing this, the next best option is for one 24/7 centre (a hub) to be supported by several centres accepting patients 12 hours per day. LAS will support this approach, not simply to coincide with shift changes, but to ensure patients (and resources) are not forced to travel long distances to central hubs during the rush hour (eg 0700-0900 and 1700-1900).

South West London
The hub and spoke model trial is into its third month and is due to be evaluated mid June. Volumes have been low but several successes have been recorded. (24/7 care provided by St George's, supported by 0830-1630, 5 days per week centres at Kingston, St Helier and Mayday Hospitals).

North Central London
The LAS has worked closely with commissioners to inform the type of service they should develop.

North West London
LAS have just begun working with their Clinical Reference Group to assist in the design of a pathway.

Enthusiasm to implement improved acute care is such that 19 units have committed to deliver either 24/7 or 12 hour thrombolysis. Therefore, the LAS are proposing to divert all patients except those on the western and eastern fringes of London to their nearest acute stroke centre from1st September and have requested support from NHS London to implement this.

Clinical Update Newsletter

The April edition (issue 7) of the Clinical Update Newsletter covers the management of so called 'suspension trauma.' The 'Lesson of the Month' reminds crews to take the defibrillator with patients who have suffered a STEMI and are being conveyed from the ambulance to the cardiac catheter laboratory.

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.

Both editions contain the 'ECG of the Month'.

Copies of this bulletin will be available at the meeting.

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

Appendix 1 provides a summary of the Clinical Performance Indicator (CPI) figures for 2007/2008. It demonstrates a very significant increase in the CPI completion rate and highlights the importance of the feedback given to crews. The Service is still however having difficulty in reaching the target of 80 % CPI completion.

3. Third Domain – Governance

Risk Information Report

The Clinical Governance Committee regularly receives information on risks identified through reporting of incidents, complaints, problematic inquests, potential claims and enquiries to the PALS Department. This information is collated and presented as a risk information report to identify emerging themes and trends. Twice a year a themed report is produced where a particular area of potential risk to the Trust is identified and clinical incidents relating to this risk are gathered to identify lessons. To date two themed reports have been considered, covering obstetrics and non conveyed patients. The lessons identified from these reports are then communicated through the Area Governance network, through the Department of Education and Development and through the Medical Directorate.

An example of a themed report, featuring obstetrics, is included under Appendix 2.

4. Fourth Domain – Patient Focus

Nothing further to report.

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

Infection Control

The next Trust wide Infection Control Audit will be undertaken in May.

Measles

No further cases of measles have been identified within the Service and no hospitals have reported further outbreaks in their areas.

Identification of cannulae sited outside hospital

Discussions are ongoing with the Department of Health on the introduction of a 'cannula kit' comprising a sterile pack which provides the following: Sterile towel, cannula sticker (Date/Time), Chlorhexidine applicator, cannula securing plaster which is transparent to identify the early stages of infection, and gauze. We are investigating how quickly these could be introduced.

7. Seventh Domain – Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director
12th May 2008

Appendix 1.

Clinical Audit & Research Summary Reports for the Trust Board

Summary of Clinical Performance Indicator (CPI) Figures 2007/08

Author: Brendan Bradley

To ensure that patient care is of the highest quality, the LAS routinely audits Patient Report Forms (PRFs) using the Clinical Performance Indicators (CPIs) process. The CPIs focus on six areas of care: cardiac arrest; acute coronary syndromes; difficulty in breathing; glycaemic emergencies; obstetric emergencies; and non-conveyance. A seventh CPI monitors basic documentation and is undertaken on 5% of all PRFs completed in the LAS. For each CPI, Team Leaders use a database to audit the documented care as it appears on the PRF against accepted best practice protocols. Team Leaders then undertake feedback sessions with their frontline staff, where they offer praise for good practice and highlight any areas for improvement.

The Clinical Audit Facilitator produces a monthly report which monitors the completion of CPI audits, compliance to clinical care standards by staff and the number of feedback sessions being undertaken. This document summarises the findings from the Clinical Performance Indicator process between April 2007 and March 2008.

CPI Completion

CPI completion is a percentage figure used to monitor how many PRFs were audited by Team Leaders compared to the expected number of PRFs that were eligible for audit. The LAS has set incremental targets to encourage the completion of CPI audits; in 2007/08 the target was 80% and this increased to 95% in March 2008.

The LAS achieved an overall completion rate of 66%, indicating that a third of the expected number of PRFs were not audited. Average completion rates across the different CPI indicators ranged from 82% for the Difficulty in Breathing CPI to 30% for the Obstetric Emergencies CPI.

Team Leaders reported that they were unable to undertake CPI audits for almost a third of the time available to them. The main reason given for this was that they were unable to undertake CPI duties as they were staffing vehicles.

CPI Compliance

CPI compliance is a percentage figure used to measure the quality of care provided to the patient as documented on the PRF. Each CPI comprises of various standards of clinical care that should be provided to the patient. Team Leaders use their clinical judgement to determine whether each standard has been met or not, or whether there was a clinically justifiable exception to providing an element of treatment. The target for CPI compliance is 100% (i.e. that all relevant elements of care were delivered to the patient or an exception applied).

The table below displays the compliance rates achieved by the LAS in 2007/08. Overall, LAS staff complied with 91% of clinical care standards; thus indicating that a high standard of care is being provided to patients.

Clinical Performance Indicator (CPI)	Average LAS Compliance
1 in 20 (Basic documentation audit)	92%
Acute Coronary Syndrome	93%
Cardiac Arrest	92%
Difficulty in Breathing	91%
Glycaemic Emergencies	94%
Obstetric Emergencies	90%
Not-Conveyed Patients	88%
Overall	**91%**

CPI Feedback

Team Leaders use information generated from the CPI audits to provide feedback sessions to staff on areas of good practice and concern. To ensure that each member of staff receives feedback twice a year, a target number of 5160 feedback sessions was set for 2007/08. Team Leaders exceeded this target and provided a total of 5207 feedback sessions to staff, which demonstrates that the Service has made excellent progress in ensuring crew staff are regularly updated on their individual clinical performance.

In addition to the feedback given by Team Leaders, a new facility was added to the CPI database in December 2007 to allow frontline staff to view data to monitor their own clinical performance.

Summary

The LAS has demonstrated a vast improvement in the number of CPI audits being undertaken. The overall completion rate of 66% in 2007/08 was almost double that of 2006/07, which was 37%. The increase in the number of audits being undertaken has resulted in Team Leaders being able to provide more reliable and meaningful feedback to staff on the quality of care provided to patients.

The overall compliance rate of 91% demonstrates that a high standard of clinical care is being delivered to patients. It is expected that the increased levels of feedback given to staff, coupled with an increase in the number of audits being undertaken in each CPI area, will help the LAS move closer towards the 100% compliance target.

Appendix 2 (annexed to Trust Board papers).

Themed Risk Information report on Obstetrics

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Annual Complaints & PALS Report

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

The enclosed report sets out:

- The restructuring of the process for capturing service user feedback through a variety of routes, i.e. PALS, complaints, incident reporting etc.
- That the Trust has been selected as a pilot site for the 'Making Experiences Count' programme, unifying the complaints process across health and social care.
- The activity and workload of PALS and Complaints
- The reduction of calls achieved through the Frequent Callers Project
- Summary of case histories illustrating both individual and organisational learning

4. Recommendation

THAT the Trust Board NOTE the contents of the report

Introduction

In October 2007, the Head of Patient Services was charged with creating a new department, unifying the differing ways the LAS receives service user and stakeholder feedback. This includes the following work streams:

- Adult Protection referrals
- Complaints
- Freedom of Information
- 'Frequent Callers' project
- High Risk Register referrals
- Incident Reporting (internally and externally)
- PALS
- Safeguarding Children Referrals

Complaints Management

The review described was prompted by recent reports from the Department of Health and other agencies, with particular emphasis on the problems faced by patients in achieving a satisfactory response to complaints and the failure of the NHS to use lessons from complaints to improve services.

The Health Service Ombudsman's report *Making things better? A report on reform of the NHS complaints procedure in England* describes some of the problems caused by the fragmentation of complaints systems which are mirrored by the historic structure and methodology utilised by the Trust. The Ombudsman concluded that this consideration, combined with a failure to focus on patient needs and a lack of capacity and competence in complaint handling, has led to a system which fails to achieve meaningful outcomes aimed at change and improvement and in many cases, to address the deep rooted culture of defensiveness and apprehension of staff who are subject to a complaint.

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Similarly, *Developing the Patient Advice & Liaison Service: Key Messages for NHS organisations from the National Evaluation of PALS* highlighted the core messages from the national evaluation of PALS, emphasising the success of PALS but drawing attention to a two tiered system with PALS as the poor relative in relation to resourcing and profile.

Drawing on these reports and *The NHS Plan, 'Making Experiences Count'* (MEC) announced the government's intention to reform complaints management and advocated *"a comprehensive single complaints system across health and social care",* focusing on a less adversarial and a more patient-centred and unified approach. This will be achieved by 2009, with the implicit intention to combine the PALS complaints functions.

The Trust has been chosen as a pilot sight for the MEC programme. This will operate between April and October 2008 and a DH support team will be made available to provide guidance and assistance. This will also enable the Trust to have an

influencing role in shaping the eventual model to be rolled out across the NHS and social care.

We are also to work closely with the NPSA to achieve a core application of Root Cause Analysis (RCA).

Revised structure and methodology

We are working to unify the role of PALS and Complaints Officers. A gradual approach will also be taken to unpick the existing area-based structure of complaints management, to enable optimum resourcing and skill acquisition.

Complaints Officers are responsible for deciding what information is required and for accessing that information. Local managers may be asked to approach staff as required but they are no longer required to produce reports. Information is collated by the Complaints Officer and where learning points are identified the Complaints Officer will liaise with the AOM/DSO regarding the action to be taken. Complaints Officers facilitate draft complaint responses which we aim to share with all those involved prior to release to enable comment and collective ownership.

Complaints data is regularly made available which can be accessed at the Trust xdrive; this includes details for each area, 'open' complaints and the 'closed' complaints awaiting further action. Information is similarly available as to performance of each area in relation to the 25 working days target. It is also proposed to extend this to include PALS data.

Activity 2007/08

Complaints (Figures in parenthesis are 2006/2007)

• Total number of complaints received – 539 (557)
• Written number of complaints received – 231 (290)
• 267 complaints were categorised as involving 'Non-Physical Abuse' 94 of the 231 being written complaints, this is the main subject heading in relation to 'attitude & behaviour' issues. These do however include a number of sub-subject variants. (138 for the previous year))
• 134 complaints involved a delay in an ambulance response and 37 related to conveyance issues. (192 and 16)
• 123 complaints involved the clinical care provided. (98)
• 43 complaints involved driving related issues. (23)

The Trust provided final responses to 81% of complainants within 25 days against its target of 80%.

PALS

• Total number of enquiries received - 4712
• 87 cases were categorised under 'communication - attitude & behaviour'
19 cases were referred as formal complaints with the complainant advised of ICAS

NB: 13 cases involved poor attitude towards LAS staff by external health and social care agencies.
• 72 cases involved delay in an ambulance response and 69 related to conveyance issues.
• 130 cases involved the clinical care provided, 720 cases involved the provision of medical records and 209 cases some explanation of the chronology of events.
• 125 incident report referrals were received from LAS staff

NB: It is proposed to unify the subject categorisations and take the opportunity to review sub-categorisations.

PALS by Subjects and Received by quarter from 01 April 2007 to 31 March 2008

	2007 Q2	2007 Q3	2007 Q4	2008 Q1	Total
Access	7	9	10	9	35
Aggravating Factors	0	1	0	0	1
Appreciation	214	271	205	163	853
Physical Violence	1	0	1	0	2
Clinical Equipment	7	5	5	1	18
Clinical	50	40	32	19	141
Communication	46	26	28	26	126
Conveyance	21	17	13	20	71
Delay	38	18	15	7	78
Non-physical abuse	3	0	1	0	4
Dignity and Privacy	1	2	2	0	5
Non - Clinical Equipment	5	4	1	1	11
Frequent Callers	35	31	22	39	127
Information/Enquiries	504	563	662	642	2371
Lost Property	124	125	130	146	525
Non-conveyance	4	3	3	1	11
Other	6	4	6	2	18
Policy/ Procedure	48	44	18	25	135
Road Traffic Accident	4	2	2	0	8
Social Services	14	38	43	31	126
Totals:	1132	1203	1199	1132	4666

PALS by Subjects and Received by quarter between 01 April 2006 to 31 March 2007

	2006 Q2	2006 Q3	2006 Q4	2007 Q1	Total
Access	17	16	23	8	64
Aggravating Factors	1	0	3	1	5
Appreciation	161	182	173	199	715
Physical Violence	3	1	1	0	5
Clinical Equipment	10	9	11	3	33
Clinical	29	46	52	38	165
Communication	45	50	55	31	181
Conveyance	23	34	18	25	100
Delay	39	32	30	27	128
Non-physical abuse	1	1	1	0	3
Dignity and Privacy	1	1	7	0	9

Non - Clinical Equipment	5	9	5	1	20
Frequent Callers	27	37	18	20	102
Information/Enquiries	472	475	521	497	1965
Lost Property	109	94	120	127	450
Non-conveyance	8	1	0	2	11
Other	12	8	5	7	32
Policy/ Procedure	57	56	62	56	231
Road Traffic Accident	1	5	1	8	15
Social Services	30	25	35	22	112
Totals:	1051	1082	1141	1072	4346

Attitude & Behaviour

This issue continues to be the subject of poor patient and stakeholder experience and the concept of 'reflective practice' has been introduced as the principal method to enable learning. For example, in relation to EOC/UOC, these exercises are facilitated by EOC Training Managers. We also record the identity of the staff involved so that we can realise any repeat incidents involving the same staff and/or emerging local or departmental trends. Unless appropriate, disciplinary action is no longer initiated as a routine action measure, in keeping with accepted clinical governance practice.

We are also preparing case examples and data for an agency the LAS have engaged to facilitate *'Excellence in Patient Communications'* training; on some occasions, we recommend that the member of staff involved is allocated a place on this course.

Delay

This issue continues to be the subject of poor patient and stakeholder experience. In particular, a sub-category involving calls categorised as a low priority, or non-urgent/GP referrals/intra-hospital transfers continued to feature throughout the year.
Individual cases included an excessive delay to an 84YOF with a fracture, a patient awaiting surgery to re-adhere an ear torn off in an attack and a patient scheduled for urgent angioplasty.

Using a Root Cause Analysis framework, the following re-occurring factors have been identified:
• The non- triage of ETA calls. A Team Brief has been issued reminding EOC staff of the protocol in this respect.
• Less than optimum resourcing. Each individual case has been brought to the attention of the relevant ADO.
• Performance problems at shift change-over, being considered by SMG.
• Inappropriate deployment of voluntary aid society (VAS) resources. My understanding is that LAS have no means of verifying the training afforded to voluntary agency staff. Difficulties in accessing PRFs completed by VAS remains a related issue.

Other measures that have been implemented to address this issue:
• EOC reorganisation
• Increased resourcing
• FRED/FREDA automatic dispatch

• Changes to the manner in which GP urgent referrals etc are triaged and resources allocated
• The introduction of the Vehicle Resource Centre to source spare vehicles across the Trust
• Pilot scheme to accommodate ASW MHA 'Section' referrals.

We will of course continue to report back on developments in relation to this particular issue, especially in the light of the 'Call Connect' programme.

Lost Property

PALS received 518 enquiries of which only 98 (19%) were resolved. One case in now the subject of an investigation by the Health Service Ombudsman.

Funding has been given to enable the implementation of a new system, utilising *The Smart Evidence & Baggage System* (SEBS) – see www.smartmci.com - which was been introduced on 9th April.

A communications strategy was devised which has enabled information and guidance to be made available across the Trust and to all London hospital A&E departments. Trust policy (OP/17) has also been revised to reflect staff responsibilities accordingly. An evaluation and monitoring scheme is being devised.

Frequent Callers Project

Staffing
It had been agreed that the project would require dedicated resourcing including two full time Officers and a part time Community Social Work Liaison post. Both Officers are now in post and an advertisement for the social work post will be placed in *Community Care* in the next few weeks.

Structure
One of the core objectives of the project is to embed a mechanism whereby local liaison forums are established, involving local health and social care agencies, according to geographic PCT/local authority area. Each ambulance complex has an existing responsibility for a specific PCT/local authority and thus it has been a relatively simple task to align each complex accordingly. This mechanism dovetails with the review of policy and practice in relation to the High Risk Register and is in keeping with cross agency working envisaged in the *Clinical Leadership model.*

The existing liaison arrangements are however variable across each complex and significant input will be almost universally required to progress the aims and objectives of the project. Similarly, the number and extent of engagement of local complex representatives is sporadic. In order to achieve a systemic approach, AOMs will be required to assume lead responsibility for local action and it is proposed that this consideration be included in AOM/ADO performance assessment criteria.

As an interim measure, PALS have been working with various complexes and the following liaison forums have been established, although it should be noted that

further input will be required to enable all of these forums to become embedded and fully operational in terms of the project objectives:

Bromley
Enfield
Greenwich
Haringey
Havering
Lewisham
Newham
Tower Hamlets

The following PCTs/local authorities have also expressed interest

Barking & Dagenham
Barnet
Bexley
Redbridge
Waltham Forest
Westminster

Caseload Methodology

Case load is determined by reference to cases referred by each complex, using Datix case management system, although work has had to be undertaken to produce a patient list in keeping with aligning each complex with a specific PCT/local authority, given that multiple complexes often serve an individual patient.

Case Data

- Estimated calls reduction: 10,838
- Following a review, 178 cases have been closed where the issue has been resolved, or identified as no longer for inclusion within the project.
- 297 ‘open’ cases remain on file.

The 20 most frequent users have been identified and some form of action has been undertaken. Each patient is being monitored to establish if a reduction in calls is being achieved and whether interventions have therefore been effective.

Our involvement has most usually been in prompting case conferences involving all relevant agencies across the health ands social care economy. Typical solutions include re-location to supported accommodation or residential or nursing care and enhanced community care packages, with lead care responsibilities being coordinated by a named GP, Community Matron or Social Worker.

Following a precedent case in Greenwich (see below) we are now actively pursuing 3 further cases in terms of legal action towards achieving Prohibitive Activity Orders or Acceptable Behaviour Contracts. We have met with NHS CFSMS and MPS accordingly towards establishing a pan-London approach.

Case examples

LC1275: Suspended sentence and 'Prohibitive Activity Order' imposed. Condition of Order requires patient to arrange third party contact with the 999 service. Significant media coverage.

JC8192: evidence of call volume used to influence placement to nursing home.

RC19053: evidence of call volume used to influence revised care package.

CG16138: evidence of call volume used to influence family intervention.

MM15272: evidence of call volume used to influence placement to residential care.

AE16654: Patient travels across London to achieve conveyance to multiple A&E sites to achieve pain relief. Evidence of call volume used to influence Sickle Cell Centre intervention.

Pending outcome:

BP12681: CPS considering court action; evidence of call volume submitted as supporting evidence.

MT15463: evidence of call volume used to influence revised intensive care package now put into place. Patient now readmitted to hospital.

WM16169: 'No send' policy put in place. Frequency of attendances reduced. Situation under review pending possible ABC application.

AM12988: evidence of call volume used to influence revised care package. Patient currently admitted to hospital and awaiting discharge planning meeting.

RC9053: evidence of call volume used to influence application for sheltered housing. Awaiting outcome.

Case examples from Complaints and PALS

1. Following a complaint where an EMT was dispatched to a patient who had experienced an epileptic seizure and was unable to administer the appropriate medication, a mechanism was introduced enabling EOC skill level indication for all operational vehicles.

2. Following a separate incident to the above, the highlighting mechanism indicating that *'Status Epilepticus'* calls required an automatic paramedic attendance was extended to all calls involving seizures, for example febrile convulsion.

3. The patient was under the impression that if she self-harmed she would be seen more quickly at hospital. The patient produced a Stanley knife while the ambulance staff were on scene; they interpreted this as a threat which resulted in the police being requested to attend. The matter was passed to Training Directorate to consider using this incident as a case example within the metal health training module.

4. The patient was given the impression that she had only two options, to stay at home or go to hospital. The incident is to be made available to the *'Excellence in Patient Communication'* training as an example of how some staff are interpreting corporate messages about reducing demand. Numerous other examples are to be similarly made available.

5. The attending staff did not recognise that a patient was in the final stages of renal failure. The Medical Director is to highlight the clinical symptoms to improve recognition and awareness in an article in *LAS News.*

6. The attending ambulance staff left an elderly patient having re-filled the hot water bottle she was using as relief for back pain. The patient later incurred burns. Service Development are working on proposals to produce a 'good practice checklist' as part of the Strategy for Older People.

7. Following identification of an emerging trend from complaints and PALS enquiries, an EOC Team Brief was issued reminding EOC staff of the importance of re-triaging ‘ETA’ calls that had originally been afforded a low priority categorisation, to enable possible priority upgrade.

8. Following identification of an emerging trend from complaints and PALS enquiries, an EOC Team Brief was issued reminding EOC staff of the 20 minutes call back protocol.

9. Liaison was affected with a mental health Trust to enable an agreed care pathway following a complaint where the attending staff had been unable to convey a patient with mental health difficulties to the hospital responsible for his care.

10. Feedback from complaints and PALS enquiries contributed to UOC introducing a procedure to accommodate mental health patients awaiting inter-unit transfer or MHA assessment; historically, such requests fell outwith MPDS and long delays often resulted in an ambulance being dispatched.

11. A Canadian family were visiting the UK to attend the funeral of a relative. The family were seeking clarification of the circumstances leading to the patient’s death and wished to lay flowers at the scene. PALS made contact with origin 999 caller and in view of the limited period in which the family were in the UK, met the family at their hotel to provide copies of the records held by LAS. The PALS officer also accompanied the family to the location where the patient had died.

12. PALS provided a comprehensive report following an apparent significant delay in LAS accommodating a hospital transfer. It transpired that LAS had dispatched but that the patient was not sufficiently stable to be transferred. The importance of

ensuring a patient is clinically stable at the time of the transfer request was emphasised to the hospital.

13. PALS facilitated a report at the behest of a hospital midwifery unit about the care provided to a patient and her unborn baby. PALS identified that the call should have been afforded a higher priority. It was recommended that the EMD involved undertake a reflective practice exercise with an EOC manager. It was further recommended that midwives be made aware of the importance of stressing the potential life-threatening situation to the unborn child in these circumstances.

14. A sickle cell patient had placed 168 emergency calls over two years. It transpired that the patient had also independently attended a very high proportion of the A&E units throughout London. It appeared that the patient may have developed a dependence on pain relief. The local Social Services department to the patient's home address were made aware of the situation and after assessment, a referral was made to the mental health provider.

15. Arrangements were put in place to pre-plan conveyance in relation to a patient who requires an urgent lung transplant and is awaiting a donor.

16. A totality of care review was undertaken following concerns being raised by a hospital at the apparent delay in transferring a patient and the equipment carried by LAS. The evidence supported a view that the attending crew took the most expedient route to the hospital and that the ambulance staff acted appropriately in terms of monitoring of the patient, given the facilities available. The hospital agreed to action a requirement for the provision of an accompanying clinician and advanced monitoring equipment in future cases nature.

17. A GP contacted PALS as he had been unable to ascertain the outcome of arrangements of a patient who had died at his home. Following enquiries, PALS were able to identify that the attending crew had not complied with the relevant protocol. With the support of the GP, PALS liaised with a local manager to ensure the crew concerned were able to use the incident as a learning opportunity and to ensure awareness of the relevant procedures.

18. PALS received an approach from a Social Services department who were planning the relocation of a patient liable to emergency care requirements to supported accommodation. PALS arranged for a local DSO to visit the facility to ensure ease of access and egress.

19. A Resuscitation Training Officer at NHS London sought PALS assistance in reviewing an incident at a mental health facility. The Training Officer agreed to use the evidence produced to support the training of staff at the facility.

20. Following lengthy liaison with health and social care professionals, PALS were able to enlist the support of the Medical Directorate to arrange a PSP in relation to a frequent caller with multiple complex medical problems. Matters had become exacerbated as following an incident where the patient had exhibited challenging behaviour, the patient had been placed on the High Risk Register. However, the patient had subsequently developed a terminal illness and delays were ensuing prior to

conveyance whilst the attending ambulance staff awaited the arrival of the police. PALS were able to confirm that the patient posed very little risk. The HRR entry was removed and replaced with an agreed care plan.

21. PALS were contacted by the wife of deceased pt that LAS attended 2 years previously. The lady was still unsure of exactly what happened to her husband immediately before his death in a hostel as the Coroner had recorded an open verdict. PALS provided the PRF etc and made contact with the Coroners Office who were able to clarify the circumstances surrounding the patient's death.

22. PALS contacted the RSPCA after a report from an ambulance crew who had attended a patient who had collapsed behind locked doors. The patient had no relatives or neighbours who were available to care for a numbers of pets. The RSPCA subsequently agreed care arrangements of the animals with the patient.

23. PALS received an Incident Report completed by the attending crew and a telephone call from the GP involved; both parties were concerned at the management of an incident by the other. With the support of the Medical Directorate, PALS were able to arrange a reflective practice meeting so that all those involved could improve their respective understanding of the role played by each other and work towards improved collaboration in the future.

24. Following a Quality Assurance report regarding the poor attitude and compliance with protocols by an EMD, PALS were able to identify that the same EMD had previously been the subject of seven complaints about the same matters. PALS alerted EOC senior managers accordingly.

25. PALS received three incident reports involving the same hospital within the same month. With the support of the Medical Director, a meeting was subsequently arranged with hospital senior managers to improve the LAS – A&E interface and thus promote improved patient care.

Gary Bassett
PALS / Complaints Manager
10 May 2008

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Workforce Plan

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

2. Purpose: For approval

3. Summary

The A&E Workforce Plan sets out the ambitions for the Trust within 2008/09 to recruit and train additional staff aimed at meeting the long term aspirations contained within the LAS Strategic Plan and the current requirements of the national response standards.

The growth in workforce numbers is identified and the challenges in achieving a full workforce by the end of March 2009.

The plan shows the introduction of the Student Paramedic role and success of achieving the plan is particularly reliant on the Trust's ability to recruit and train sufficient numbers of these staff in year.

Key risks are identified within the document.

This plan forms part of a wider package of work relating to workforce development within the LAS. Other aspects to be finalised and to follow are:

- Skills escalator and associated student paramedic programme description
- Finalised training plan
- Plan to move to a Higher Education training model

Progress against the workforce plan will be monitored through the A&E Resources group and reported to SMG monthly from June 2008. The Trust Board will receive regular updates on progress.

4. Recommendation

THAT the Trust Board APPROVE the A&E Workforce Plan for 2008/09

LONDON AMBULANCE SERVICE

Trust Board Meeting, 20 May 2008

A&E WORKFORCE PLAN 2008 / 09

Introduction

The long term Workforce Plan for the London Ambulance Service states the desired move from 2007 to 2013 to a more highly skilled frontline workforce providing a wider range of responses to the population of London which are more appropriate to their needs. The continuing development of this workforce plan also takes account of the changing face of healthcare provision generally in London such as the proposals contained within "Healthcare for London" together with the national expectation on improved response times for Ambulance Trusts.

Further work has therefore been undertaken through a multidisciplinary workforce planning group and the SMG to ensure the workforce plan for 2008/09 reflects the current requirements and prepares adequately for the longer term aspirations of the Trust within the wider London context.

This paper forms part of a wider package of work relating to workforce development within the LAS. Other aspects to be finalised are:

- Skills escalator and associated student paramedic programme description
- Finalised training plan
- Plan to move to a Higher Education training model

Revision to A&E workforce establishment

The following sets out the proposed skill mix and workforce numbers for 2008/09. These numbers incorporate one HART (Hazardous Area Response Team) team of 42 staff within the funded establishment. The revised establishment accounts for assumptions on staff movements, such as:

- Move of paramedics to Team Leader, ECP or exit from the LAS
- Move of EMT to Paramedic or exit the LAS
- Move of A&E Support staff to Student Paramedic or exit the LAS

These movements are based on historic trends and current expectations. However, we will monitor these closely in year, and will make adjustments if trends change.

The A&E workforce establishment for 2008/09 is set out below:

	In Post March 08	2007/08 establishment	**2008/09 plan**
Team Leader	161	170	**175**
ECP	53	56	**86**
Paramedic	818	911	**830**
Student Paramedic			**300**
EMTs	1411	1396	**1220**
A&E Support	196	202	**232**
CTA	49	70	**70**
	2688	2805	**2913**

The A&E staff establishment will increase to 2913 and constitutes a workforce growth of 108 staff on the previous year.

Staff in post at the beginning of the year against this increased establishment shows a vacancy factor of 225. This, together with the anticipated leavers throughout the year of around 180 identifies an overall recruitment requirement of 405 staff by the end of March 2009.

Student Paramedic

The introduction of the Student Paramedic role will significantly support this annual workforce plan by providing the opportunity through which the Trust can develop the careers of existing staff to become qualified Registered Paramedics. In addition, it will allow the Trust to enhance its direct recruitment of staff who will, under the Student Paramedic programme, train to become Registered Paramedics.

In addition, the Trust will continue to train existing Technician staff to qualified Paramedic. This training is discreet from the Student Paramedic Programme and these staff will continue to transfer direct from EMT to Paramedic once qualified.

The Trust will continue to support and further develop links with Universities both to receive qualified Paramedics as recruits to the LAS and to develop an LAS diploma level Paramedic programme for both the above routes of progression.

Recruitment Training Plan

The training plan to support the recruitment of additional staff to the revised skill mix is currently being finalised and involves the creation of additional training resources. This is with the aim to have recruited to full establishment by the end of March 2009.

Student Paramedic Programmes are being delivered from May 2008 aimed at both internal and external candidates. These planned programmes will deliver a total of 132 places. Work is ongoing to secure an additional dedicated training location at Hannibal House in Elephant and Castle together with additional Trainers. This resource is expected to be able to provide three Paramedic training programmes concurrently with 54 participants in total. Dependant on time of completion of this work, this facility will deliver between 108 and 162 places by March 2009. The Training Department are also considering the potential for increasing existing provision should this facility not be completed in time to deliver the maximum capacity anticipated.

This training activity will also be complimented by 144 places planned for 2008/09 for the training of Technician staff to Paramedic.

Existing plans for A&E Support training are felt to be sufficient to meet requirements and may offer the opportunity for conversion to Student Paramedic places should the movement of A&E Support staff remain consistent with initial indications.

Recruitment of additional ECPs will be in line with the introduction of the "New Ways of Working" early implementer sites.

Once these plans (particularly in relation to the additional resource) have been finalised, a workforce recruitment profile for the year will be presented and used to monitor progress against the plan. This is expected to be in place by the end of May 2008.

Recruitment

Recruitment to the Student Paramedic programme is underway and entails a robust assessment process which includes numerical and verbal reasoning. This is to ensure the Trust recruits candidates with the ability to successfully complete the required training and qualify as a Registered Paramedic.

The recruitment plan aims to have adequate numbers of successful candidates ready to place within training programmes in sufficient numbers to achieve this workforce plan.

Recruitment to A&E Support roles is ongoing and continues to meet the requirements of the plan.

The Trust struggles to exceed 50 CTA staff and will continue to raise the profile of this role both internally and externally. Opportunities through NHS Professionals are currently being explored though to date progress has been slow.

Risks

The following key risks to achieving the workforce plan fully by the end of March 2009 have been identified:

- Inability to recruit to the numbers required: –
  - The Student Paramedic role is previously untested and whilst we anticipate it will prove to be popular, this has yet to be evidenced.
  - To mitigate the barrier associated with the requirement to hold a C1 driving licence, the Trust will offer financial support to successful candidates to obtain this prior to commencing employment with a "payback" agreement once employed.

- Inability to train the numbers required: –
  - It is hoped that the additional training resources can be secured in time to meet the full requirements of the plan for Student Paramedics.
  - If this is not the case and sufficient increases to existing in-house training cannot be achieved, this will result in slippage of one month into the month of April 2009.

- Increase in number of leavers to those anticipated, either through movement within or exit out: –
  - The workforce plan is premised on assumptions of movement of staff based on historic trends. If the actual numbers of staff moving or leaving are significantly greater than these assumptions, this will place more pressure both on the recruitment and training demands.
  - Plans for A&E Support staff can accommodate higher numbers. If, however, we experience greater movement of existing Paramedics and EMT staff, the plan may not be fully achieved by March 2009.
  - We will continue to have access to the additional facilities at Hannibal House to continue to provide additional training in to the year 2009/10 should the need arise.

Monitoring

Progress against this workforce plan will be monitored through the A&E Resources Group with monthly reporting to SMG and through the balanced scorecard.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 20th May 2008

FT Project Plan

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

The attached paper seeks to inform the Board of the first stage of the pilot FT Project Programme and a timetable for implementation is enclosed.

The Trust has been chosen as one of two ambulance service trust to pilot the ambulance service sector specific diagnostic. This involves us working with NHS London on an accelerated programme containing rehearsals of key aspects of the application process to become a FT. The output from this pilot will be a diagnostic report. This will enable us to anticipate the challenges presented by the formal process and identify what is to be done in order to comply with Monitor's detailed reviewing for aspirant foundation trusts.

This work is being co-ordinated through the mechanism of our internal team led by the Head of Governance.

The following abbreviations are used in the timetable:

a. IBP Integrated Business Plan
b. LTFM Long Term Financial Model
c. SDS Service Development Strategy

4. Recommendation

THAT the Trust Board APPROVE the schedule set out in the report.

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Call Connect Diagnostic Visit to LAS by Department of Health Team

1. Sponsoring Executive Director: Martin Flaherty
(Paper presented by Richard Webber- Acting Deputy Director of Operations)

2. Purpose: For noting

3. Summary

The Department of Health undertook diagnostic visits to each of the UK Ambulance Services earlier this year. The LAS visit took place in early April 2008.

The purpose of the visit was to ascertain the robustness of the Trust's Performance Improvement Plan and the anticipated ability of the LAS to deliver Call Connect. The subsequent report identified several Areas of Best Practice within the LAS and also made Recommendations for the Executive Team to further consider.

4. Recommendation

THAT hat the Trust Board NOTE notes the positive nature of the report and that an Action Plan will be produced and promulgated in due course.

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Fleet procurement and policy plan 2008/13

1. Sponsoring Executive Director: Martin Flaherty (Richard Webber presenting paper as Acting Director of Operations).

2. Purpose: For approval.

3. Summary

In 2004 the Trust approved a three year vehicle acquisition policy which has now expired.

The new Fleet Procurement Plan document sets out the revised vehicle acquisition programme for all front line ambulances, Urgent Care Vehicles, Rapid Response Cars, Duty Station Officer Vehicle, Motor Bike Response Units, Education and Development vehicles, PTS Vehicles, support and other specialist vehicles. It covers the period 2008/2013.

The Plan takes account of replacement cycles for existing vehicles. It also anticipates the number and type of vehicles required under the New Front End Model to maintain Call Connect Targets. The Plan takes account of the expansion of the Urgent Care Service and the requirement for vehicles to be provided for the Olympic Games in 2012.

A recommendation of this plan is that a Vehicle Procurement Unit team be established.

4. Recommendation

THAT the Trust Board APPROVE the five year plan for front line A&E, PTS, emergency preparedness and support vehicles. This programme would:

1. Be the basis for future vehicle acquisition
2. Enable the Fleet to be better managed through a scheduled replacement of all vehicles to avoid the premature replacement and disposal of vehicles or retaining vehicles beyond their effective life.
3. Allow flexibility of replacement arrangements which also take account of any reductions or increases in the size of the fleet.
4. Enable the Trust to plan future financial commitments in respect of vehicle acquisition
5. Enable the Trust to achieve better value for money in planning future acquisitions and maintenance arrangements etc.

London Ambulance Service NHS Trust

Fleet Procurement Policy and Plan

2008/13

Christopher Vale

Head of Operational Support

May 2008

1. PURPOSE OF THE PLAN

1.1 The Trust in 2004 approved a three year vehicle acquisition policy which has now expired.

1.2 This Fleet Procurement Plan document sets out the revised vehicle acquisition programme for all front line A&E vehicles, Urgent Care Vehicles, Rapid Response Cars, Duty Station Officer Vehicle, Motor Bike Response Units, Education and Development Vehicles, PTS Vehicles, support and other specialist vehicles. It covers the period 2008/2013.

1.3 The Plan takes account of replacement cycles for existing vehicles. It also anticipates the number and type of vehicles required under the New Front End Model to meet Call Connect Targets from April 2008. The Plan takes account of the expansion of the Urgent Care Service and the requirement for vehicles to be provided for the Olympic Games in 2012.

2. BACKGROUND

2.1 The Trust must ensure that sufficient road worthy vehicles of the correct specification are available to meet operational requirements and targets, and provide robust and consistent patient care. The fleet must be of sufficient size to maintain A&E Peak Vehicle Requirement and PTS contractual obligations. Through the work of the Vehicle Resource Centre, Flexible Fleet Scheme, and improved maintenance and service regimes, the Trust will seek to reduce the size of the fleet by means of improved utilisation and availability. The Trust will work towards a reduction in the vehicle relief factor to 10% by 2010.

2.2 The Trust is aware that vehicle reliability / availability is a major factor in providing the level of patient care required and this deteriorates as the vehicle age profile increases. In this respect the Trust will aim to ensure that it has no vehicles more than six years old in the fleet and that replacements will be purchased or leased on a regular basis.

2.3 The Plan will cover specialist vehicles such as those used for bariatric patients, BETS, control services and CBRN/HAZMAT.

2.4 Vehicles required for station management support and other support functions will also be covered by the Plan. This includes Training, Complex based Corsa's, Equipment Support Vehicles and Fleet Support Services.

2.5 The Trust will seek to achieve the best possible value for money when acquiring and replacing vehicles. This will include considerations on buying and leasing vehicles to produce the most economic whole life cost.

2.6 The requirement to procure environmentally friendly vehicles to reduce carbon emission will form part of all specifications. All future vehicles will need to comply with the requirements of the London Emission Zone where necessary.

2.7 A summary of vehicle fleet sizes and how these will be replaced during the life of the plan is attached at annex 1. A comprehensive plan will be held on the Operational Support Department areas of the London Ambulance Service NHS Trust (LAS) X drive. This will be updated at regular intervals.

3. VEHICLE EQUIPMENT WORKING GROUP

3.1 All vehicle types purchased or leased by the LAS have individual specifications which are used for tendering and vehicle build acceptance. These specifications are compiled by a User Group under the guidance of the Operational Support Department and the Vehicle and Equipment Working Group (VEWG).

3.2 The function of the VEWG forum is to bring together management and staff side representatives to define the operational needs for base vehicle purchase and conversion. The Group contains representatives from Fleet, Purchasing, Health and Safety, the Medical Directorate and Operations.

3.3 The group defines, researches and trials new vehicles and major equipment to ensure they are both safe and viable for the LAS to use with patients. The trials sometimes generate changes to the original vehicle and or equipment specification to make it acceptable to the LAS. When these are agreed they are converted into a practicable specification for base vehicle procurement and conversion.

4. FINANCIAL AFFORDABILITY

4.1 Depending upon the full value of the vehicle(s) either an Application for Financial Approval (AFA) or Business Case be raised. If the value is under £250k an AFA is raised and for values over £250k a Business Case is required.

4.2 Both the AFA and Business Case will ensure that:

- Vehicle option selection is robust
- Financial funding paths and selection is robust
- The preferred option for Value for Money (VFM) has been fully tested
- The preferred option is affordable to the LAS
- Reliability of the replacement vehicle is higher that the current vehicle (if appropriate).

4.3 The AFA or Business Case will ensure that all other costs for items affected by the acquisition of vehicles are also covered including: estates; additional workshop staff and equipment; technology staff and equipment; clinical equipment; fuel etc.

5. COMMITTEE FOR EUROPEAN NORMALISATION (CEN)

5.1 It is now incumbent upon the Trust to ensure where practicable, all newly purchased patient carrying vehicles comply with the latest Committee for European Normalisation (CEN) guidance. The Trust has agreed that alternatives to CEN can be considered if the standards and quality proposed are of an equivalent nature.

5.2 The LAS ambulance body conversion specifications are centred on this guidance as the standard for meeting good practice and thereby reducing the LAS exposure to litigation.

6. ENVIRONMENTAL STANDARDS

6.1 The LAS supports environment controls for the atmosphere and uses diesel engine vehicles specified to the latest emission standards as far as possible. Currently

London has a Low Emissions Zone and all but five of our vehicles comply. As new technologies for vehicles become available the Trust will carry out research and assess their impacts on vehicle operations. This will enable the Trust to make a positive contribution to environmental improvements.

7. PROCUREMENT POLICY

7.1 The LAS uses the NHS National procurement policies produced by The NHS Procurement and Supplies Agency (PASA); LAS Standing Financial Instructions (SFI's) and Trust Standing Orders (SO's) for the procurement of vehicles,

7.2 Where the accrued cost is under the Official Journal of European Union (OJEU) limit then procurement is conducted via the LAS SFI's and SO's using a minimum of three tenders.

7.3 Where the accrued cost of vehicle purchase over the three year period is estimated to be in excess of the OJEU limit then the procurement must be in line with the OJEU ruling. PASA have selected companies and vehicle types through the OJEU route and these are registered in their Vehicle and Vehicle Conversion Framework Agreements for use by any NHS organisation. LAS where possible will procure and convert vehicles using the PASA Frame Work Agreements and contractual documents.

7.4 The LAS also has the right to separately tender through OJEU. In this case the formal OJEU tender submission action and the full process have to be adhered to.

7.5 The Trust will seek to purchase or lease vehicles consistently from the same manufacturer whenever financial and engineering considerations allow. This encourages the development of long term supplier relationships which will result in collaborative working and potential for future financial savings. It also provides for potential savings to be made on generic vehicle spare parts. This policy also assists the training and development of maintenance staff and the provision of diagnostic tools.

7.6 Vehicle specifications will be reviewed for multi-role functionality where possible thereby minimising the number of vehicles whilst retaining efficiency and effectiveness

7.7 The Trust is working with other Ambulance Services to develop a national specification for front line A&E vehicles. This has involved consideration and development of a generic ambulance specification. This has significant potential to standardise ambulance design with the resulting cost savings this could bring.

7.8 The work of the National Specification Group has produced a number of potential specifications which are still under consideration.

8. MAINTENANCE

8.1 All vehicles procured or leased by the LAS will wherever possible be maintained by the Fleet Workshops. This ensures priority to vehicle repairs, maintenance and preparation for MOT's etc which is not offered by commercial organisations

8.2 Given the fleet size and diversity of vehicles it is essential the LAS workshops employ adequate sized work forces who are:

- qualified
- multi-skilled
- trained in appropriate new technologies

8.3 The Trust is currently in the process of reviewing the delivery of Fleet Support Services. As a result of this exercise, changes will be made to the vehicle maintenance regime aimed at improving throughput and reducing downtime.

9. VEHICLE ACQUISITION/REPLACEMENT PROGRAMME

9.1 Each vehicle type in use by the LAS has a specification covering the user and support services defined requirements. This is agreed before the procurement of the base vehicle and body conversion.

9.2 Vehicle manufacturers change design and specification of vehicle without consultation, therefore it may not be possible to continue to procure or lease the same style or manufacturer of vehicles for replacements purposes.

9.3 At the outset of each replacement cycle the specification is reviewed against:

- The current user requirement.
- Vehicle types available for procurement through the current PASA Framework
- Agreements for A&E and PTS vehicles
- Approved PASA A&E and PTS vehicle converters. Where there is not a PASA Framework agreement for vehicle conversion i.e. non-ambulance vehicles, the work may be tendered through OJEU.

9.4 The Trust authorises the acquisition of all vehicles through approval of the AFA or Business Case as briefly described in section 4.

10. AMBULANCE VEHICLES

10.1 The LAS A&E fleet is currently made up of 260 Mercedes and 123 LDV ambulances which are between 3 and 11 years old.

10.2 The LDV Fleet now requires replacement. The purchase of 123 Mercedes Sprinter Ambulances during 2008 has been agreed to facilitate this objective. These vehicles are now unlikely to be delivered until early 2009.

10.3 The future size of the combined A&E and Urgent Care Fleet has been considered in light of the establishment of the Vehicle Resource Centre (VRC). The VRC has improved the utilisation of the fleet and the management of spare capacity on a daily basis. In addition, the implementation of the review of Fleet Support Services will provide improved efficiency in the maintenance and repair process. This will allow the fleet relief factor to be reduced to 10% by 2010. These initiatives will allow additional demand to be absorbed without the need to purchase additional vehicles.

10.4 Should there be a requirement to increase the fleet size there is sufficient flexibility within the life of the plan to acquire additional vehicles.

10.5 The remainder of the A&E Fleet are Mercedes Sprinters which require replacement at the following intervals :-

2009/10 – 130

2010/11 – 65

2011/12 – 65

10.6 Replacement of these vehicles is tied to leasing agreements. The agreements allow for new chassis's to be acquired at the intervals mentioned above, and for the existing bodies/saloon to be refurbished and remounted on the new chassis. Alternatively, new chassis and bodies can be acquired.

10.7 The financial aspects of these options are being fully considered, but this will not affect the timescale of the replacement programme.

10.8 The Trust will have a responsibility to provide ambulance vehicles to support the 2012 Olympic Games. The replacement programme in 2012 may therefore be varied to allow for vehicles to be made available for this purpose.

11. URGENT CARE

11.1 For the purpose of vehicle acquisition, Urgent Care requirements have been included in the A&E acquisition section above. A generic A&E vehicle specification can be utilised by Urgent Care staff with appropriate equipment removed during their utilisation of the vehicle. This enables the maintenance of maximum vehicle flexibility with the A&E area of work.

11.2 The current 11 Movano van conversion used by Urgent Care will be removed from service or redeployed when the LDV fleet has been replaced.

12. A&E RAPID RESPONSE AND ECP VEHICLES

12.1 Following delivery of 83 FRU cars during 2008, the Fleet is now of the required size (197). Over the next five years a regular replacement programme will be implemented to ensure the car fleet remains of the correct age.

12.2 An increase in ECP vehicles (Zafiras) is anticipated in 2009 and 2010 which will bring the Fleet up to 40 vehicles.

13. MOTOR BIKES

New motor bikes have been procured this year bringing the Fleet size to 23. To meet Call Connect performance targets, 12 further motor bikes may be procured over the course of the plan.

14. DUTY STATION OFICER VEHICLES

The Duty Station Officer Zafira's are due for replacement in 2009. The Galaxy vehicles are now past their due date for replacement. A User Group is considering the specification of a new vehicle.

15. PTS VEHICLES

15.1 The PTS Fleet will be enlarged or renewed in accordance with contract obligations over the period of the plan. If new contracts are awarded, additional vehicles may be required. A clear focus will be given on improving the age profile of the Fleet which will support bids for new contracts. Strategies to reduce the time scales for acquisition of new vehicles will be considered and developed.

15.2 During the early years of the plan, replacement stretcher and sitting vehicles will be acquired. Vehicles with a bariatric carrying capability will also be acquired as will replacement vehicles that can transport patients in wheelchairs.

16. EMERGENCY SUPPORT VEHICLES

16.1 There are a number of vehicles under this umbrella including Emergency Support Vehicles (ESV), Emergency Control Vehicles (ECV), and those used for HAZMAT and CBRN.

16.2 A number of replacements for these vehicles are planned for the early years of the plan including ESV's and ECV's. Of particular concern is the replacement programme for Emergency Pod Vehicles which are funded by the Department of Health. Early confirmation will be sought to assess the timescales for this work.

16.3 These vehicles will be regularly reviewed during their operational life. Ultimately replacements will be based on mileage and changing operational need. Opportunities will be taken wherever possible to provide dual purpose vehicles to maximise potential use.

17. TRAINING AND SUPPORT VEHICLES

17.1 A number of Training and Support Vehicles will be maintained as part of this plan. This will include Driving Training Vehicles, Equipment Support Vehicles, Fleet Support Vehicles and Station Corsa Cars.

17.2 It is considered a vital element of this plan that "Support Service" vehicles are not neglected in terms of age and suitability for purpose.

18. VEHICLE PROCUREMENT PLAN

18.1 A recommendation of this plan is that a Vehicle Procurement Plan be established. This would enable a clearer focus on the acquisition of vehicles to be achieved in a timely fashion and promote further expertise

18.2 The OSD has absorbed vehicle project work formally carried out by the Project Support Office and also elements of the procurement function. It is suggested that the Fleet engineers working in this area are supported directly by a Procurement Officer and Project Manager/Administrator.

18.3 The Unit would manage all aspects of vehicle procurement, and maintain a detailed plan.

Chris Vale
Head of Operational Support
May 2008

ANNEX 1 - VEHICLE FLEET ACQUISITION/REPLACEMENT PROGRAMME 2008/13

VEHICLE	FLEET SIZE	2008/09	2009/10	2010/11
A&E AMBULANCE AND URGENT CARE	394 (current) 361(planned)	123 (replacement)	108(replacement)	65 (replacemen
RAPID RESPONSE CARS (INC. ESP and DSO)	230 (present) 258 (planned)	25(replacement)	89(replacement) 14 (new)	83 (replacemen 14 (new)
MOTORBIKES	23 (current) 35 (planned)		11 (replacement) 12 (new)	
EMERGENCY/SPECIAL VEHICLES	25(current) 30 (planned)	10 (replacement) 1 (new)	15 (replacement) 4 (new)	
PTS STRETCHER VEHICLES	40	20 (replacement)	20 (replacement)	
PTS MINI-BUS	86	43 (replacement)	43 (replacement)	
PTS – WHEEL CHAIR CARRIER	14	14 (replacement)		
PTS VANS/CARS	28	15 (replacement)		13 (replacemen
PTS BARIATRIC	3	3 (new)		
TRAINING VEHICLES	48 (current) 52 (planned)	14 (replacement) 4 (new)	32 (replacement)	

VEHICLE	FLEET SIZE	2008/09	2009/10	2010/11	2011/12	2012/13
CORSA CARS	40		32 (replacement)			8 (replacement)
EQUIPMENT SUPPORT/FLEET VEHICLES	28		22 (replacement)	6 (replacement)		
RESUS. UNIT VANS	7			7 (replacement)		

TOTAL FLEET SIZE – 966 (current)
982 (planned)

AVERAGE AGE (YEARS) OF FLEET IN EACH FINANCIAL YEAR (FOLLOWING ACQUISITION OF VEHICLES)

VEHICLE TYPE	2008/09	2009/10	2010/11	2011/12	2012/13
A&E/URGENT CARE AMBULANCES	3.4	2.3	2	1.8	2.8
A&E CARS	1	1.7	2.7	2.2	3.2
EMERGENCY/SPECIAL VEHICLES	3.6	0.4	1.4	2.4	3.4
PTS VEHICLES	2.7	1.4	1.5	2.5	3.5
TRAINING VEHICLES	3.9	1.7	1.5	2.5	3.2

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Compliance with DH Response Time Data Reporting Requirements (KA34 2008/9)

1. Sponsoring Director: Peter Bradley

2. Purpose: For approval

3. Summary

This paper describes the rules on how the LAS capture, record and calculate performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with the guidance issued by the DH Information Centre for the KA34 yearly return (version 08-09 final guidance).

It is presented to the Trust Board as a record of compliance.

4. Recommendations

THAT the Trust Board NOTE the contents of the report.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 20 May 2008

Compliance with DH Response Time Data Reporting Requirements (KA34 2008/9)

1. Background

This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. This paper incorporates LAS compliance with the guidance issued by the DoH Information Centre for the KA34 yearly return (version 08-09 final guidance).

2. Clock synchronisation

The Computer Aided Despatch System (CTAK) uses NTP* (Network Time Protocol) to synchronise its internal clock to public time servers on the Internet. The precision is between 15 and 3 microseconds. This is a constant procedure (i.e. not a scheduled process) as the servers have permanent access to the Internet for this protocol.

The current Satellite Navigation software allows the MDT clock to be set accurately down to milliseconds. The MDT synchronises the clock every time it starts up, this is every time it has been switched off manually or when it switches off automatically because it hasn't been used for more than 30 minutes. It also synchronises every hour on the hour.

3. Call Connect Time

The Call Connect Time is taken from when the call is presented at the telephone switch. CTAK detects the call arrival and timestamps it instantly. This process is an accepted industry standard. The timestamp is stored by the CLI (Calling Line Identity Process) process.

Approximately 2% of calls do not go through the main incoming 999 lines (hence the CLI process) or are not public calls. These calls do not have a call connect time so the start time (call answer time) is used where necessary. Further investigations are taking place to identify whether the call connect time could be collected for some of these calls, however, there will always be a small percentage of calls where the call connect time is not recordable.

Compliance in capturing call connect times was recently audited by DH representatives in 2007 and the service was deemed compliant.

4. Clock Start Times (Call Connect)

- **Calls generated by a 999 call**

  The clock start time (Call Connect) is when the call is presented to the control room telephone switch. This is time stamped in CTAK.

  This is the start time used for Category A, B and C calls.

- **Running calls**

  The clock start time for running calls is when the call is answered either from telephone or radio. The time is taken from the clocks on the EOC wall synchronised to the national time standard currently broadcast from Anthorn in Cumbria (formerly Rugby). There are no seconds displayed.

- **Calls taken during CTAK downtime**

  As running calls above.

5. Arrival times

Arrival times for all categories of calls are generated from automatic status reporting at scene, based on a vehicle being within 200m of the original incident location. This complies with a best practice set of guidelines agreed by the National Directors of Operations Group.

If the automatic status reporting time is not available, the MDT "red at scene" button press time is used. If neither of these times is available the PRF time is used.

PRF times are used for those calls which are not generated from a 999 call. This also applies to calls that are generated within an operational "footprint" (e.g. New Years Eve). These calls will be added into the database manually within Management Information, based entirely on data from the PRF.

At the time of this report KA34 guidance states the following:

"Category A : …….Presenting conditions, which require a fully equipped ambulance vehicle to attend the incident, must have an ambulance vehicle arrive within 19 minutes of the request for transport being made in 95% of cases, unless the control room decides that an ambulance is not required."

Currently the LAS does not operate the front end model where they wait for confirmation from the initial responder that an ambulance is required. An ambulance routinely forms part of the initial response and is not requested as described in the guidance.

6. Technical Details

Time stamp	Definition	CTAK database field	Clock used	How synchronised	Confirmed by	KA34 Compliant
Call connected	When the call hits the telephone switch	cti_eisec.time_arrived	CTAK server	CTAK servers are using NTP protocol to synchronise their internal clock to public time servers on the internet. The precision is between 15 and 3 microseconds.	George Dervis	Yes
Call answered	When the call is answered by the call taker	Incidents.recv_start_time	CTAK server	Same as above	George Dervis	Not applicable
Arrived at scene (Auto status)	When the vehicle arrives within 200m of the incident using AVLS	Log record	CTAK server	Same as below	Vic Wynn	Yes
Arrived at scene (MDT)	This is when the crew press the MDT button to indicate the resource has arrived at the patient's location	log_entry.param1 where record_type=6 and param=3	MDT	MDTs synchronise with the SatNav clock when they start up and then every hour on the hour. The accuracy is within milliseconds. The SatNav uses GPS time.	Vic Wynn	Yes

Sources of data

UTC

Universal Time Co-ordinated - the internationally agreed time standard set by synchronised atomic clocks run by several countries.

MSF ("Rugby time")

UK national time standard transmitted by the atomic clock run by the National Physical Laboratory in Teddington, but transmitted from a site near Anthorn, Cumbria. This clock is one of the synchronised official UTC clocks. The wall clocks in EOC are synchronised using this signal.

***NTP**

Network Time Protocol - this is the system by which internet servers synchronise each other to UTC. Every computer connected to the internet can synchronise its clock with this signal, using a number of public time servers run by the American military. All LAS servers are using this method to maintain synchronisation with each other.

7. Categorisation of calls during CTAK downtime or where AMPDS is not used.

Calls taken during CTAK downtime are manually allocated an AMPDS code. However, this code is not entered into the performance database and all manual calls are categorised as Category B and Amber 1.

Running calls do not go through AMPDS; all running calls are categorised as Category A.

8. MPS calls

Incidents received through the MPS link are time stamped when the call hits the LAS server. The call is categorised with a red, amber or green category by the system used by MP but there is no AMPDS code, so the calls are categorised as Category B in the performance database.

9. Changing incident attributes such as AMPDS code, category or system generated time stamps

There are no facilities in the CTAK software to make any changes to the record once the call taker completes the call. This has been confirmed by the System Manager, George Dervis. A call can be upgraded or downgraded if further information is supplied regarding a call. This up/down grading is recorded and doesn't overwrite the original categorisation. If a call is up/down graded in EOC/UOC, the categorisation used for performance calculations remains at the original category awarded.

The opportunity exists within Management Information to amend anything in the database, however, AMPDS codes, categories and time stamps are never changed.

10. Cross border calls

The KA34 return states the following:

"Each NHS Ambulance Service is responsible for reporting on the performance of all emergency calls for which it receives the initial call. This includes calls received by a Service that relate to incidents occurring outside its recognised boundary and calls relating to incidents within or outside its boundary that are subsequently transferred to another Service for response.

An Ambulance Service should not report or report on the performance relating to any incident where another Ambulance Service received the initial call, even if the call was transferred to and dealt with by that Ambulance Service. Trusts responsible for dealing with any cross-border calls should advise the trusts who received the initial call of all appropriate clock start times for performance reporting purposes."

Calls transferred to the LAS from other ambulance services are excluded from the performance calculations. Work is currently underway to share information with other ambulance services for calls received by the LAS but transferred to other ambulance services for a response.

11. Calls to a hospital or GP surgery or location where a defibrillator is available

Calls to a Hospital or GP surgery or location where a defibrillator is available (e.g. Heathrow airport, some railway stations etc.) are treated as a zero response in line with KA34 guidance.

Peter Suter
Director of IM&T
13 May 2008

Enclosure 13

London Ambulance Service NHS TRUST

Trust Board – 20 May 2008

Chairman's Urgent Action authorising sale of Buckhurst Hill

1.	Director	Mike Dinan
2.	Purpose:	Ratification of Chairman's Urgent Action

3. Summary

A copy of the Chairman's Urgent Action and the executive summary of the Full Business Case relating to the sale of Buckhurst Hill is attached for information, and explains the reason for the Urgent Action.

4. Recommendation

THAT the Trust Board RATIFY the Chairman's Urgent Action in relation to the sale of Buckhurst Hill.

Urgent Action Sheet

Date: 27th March 2008 No. 01/08

Standing Orders state that:

41.1.1 Where an urgent decision is required on a matter which would normally be reserved to the Trust Board in advance of a meeting of the Trust Board, the matter will normally be raised by the Chief Executive, or a Board Director with the Chairman, or in his absence the Vice Chairman, with a recommended course of action. The Chairman, or in his absence the Vice Chairman, shall be authorised to act on behalf of the Board where time is of the essence.

41.1.2 Where the Chief Executive, or in his absence, one of the Board Directors other than the Board Director directly involved in the issue, authorises urgent action after consulting with the Chairman of the Board, or in his absence, the Vice-Chairman, in respect of a matter on behalf of the Trust which would normally have been considered by the Board itself, such action shall be reported to the next appropriate meeting of the Board.

It is requested that the Chairman, on behalf of Trust Board, agree to the disposal of Buckhurst Hill Ambulance Station for the sum of £3.9m.

The Outline Business Case relating to the disposal of Buckhurst Hill Ambulance Station was agreed by the Trust Board in March 2006. Due to other commitments i.e. the Invest to Save Programme it was not possible to finalise the Full Business Case until this week. The Finance Director has kept the Trust Board informed of the progress of the sale of Buckhurst Hill Ambulance Station, e.g. in March 2008 when the Board received an update regarding Estates.

The planned exchange of documents to complete the sale is due to take place on 28th March 2008 which is the reason for the Chairman's Urgent Action being requested. The Full Business Case will be presented to the Trust Board in May 2008.

The Executive Summary of the Final Business Case relating to the disposal of Buckhurst Hill Ambulance Station is attached for information.

The Chairman is requested to sign, with the Chief Executive, the Land Registry transfer forms relating to the sale of Buckhurst Hill Ambulance Station in order that the sale can proceed.

The proposed Urgent Action is: agreed ☐ not agreed ☐

Signature of Chairman/Vice Chairman ………………………………………..
Date:

Signature of Executive Director ……………………………………….
Date:

The Urgent Action will be reported to the Trust Board on 20th May 2008

EXECUTIVE SUMMARY

1.1 Strategic Case

1.1.1 The current Buckhurst Hill station is part of the Whipps Cross complex within the East area of the London Ambulance Service NHS Trust (LAS). Geographically, it is located outside the Trust's operational boundary in the borough of Epping Forest, Essex and serves the areas of Buckhurst Hill, Woodford Green, South Woodford and Chingford.

1.1.2 The station's location means that it has difficulty in meeting the required performance targets for Category A calls of 75% within 8 minutes. It has been calculated that a 6.3% improvement in response times could be achieved across the sector by relocating the station closer to its area of greatest demand in the Woodford Green and South Woodford areas.

1.1.3 The station is also under-utilised, with only 2 emergency vehicles now based there. The site covers an area of 2885m² and provides internal garage and accommodation of 950m². There are also 11 Patient Transport Vehicles located at Buckhurst Hill.

1.1.4 The station is located in a mainly residential area. Planning permission to build 16 flats on the site of the existing station was recently granted.

1.1.5 The site has been valued at £3.9m with the benefit of the planning permission for residential development. The realisation of the sale proceeds will be an important component of the Trust's Capital Programme for reinvestment in other assets.

1.2 Economic Case

1.2.1 The requirement for the new ambulance station site is approximately 400m². The space requirement for separate Patient Transport Service accommodation is 700m². If a combined accommodation is provided then a site of approximately 1100m² would be required.

1.2.2 The shortlisted options considered at OBC were:

1. Do nothing: Remain at Buckhurst Hill
2. Combined Station: Acquire land and build
3. Combined Station: Acquire building and refurbish
4 Two separate stations for A&E and PTS vehicles: Acquire land and build
5. Two separate stations for A&E and PTS vehicles: Acquire buildings and refurbish

1.2.3 The preferred option at OBC was Option 4. However, since publication, 2 existing sites have been identified that are available on a leased basis. The first, for A&E vehicles, is a site owned by Transport for London upon which a suitable ambulance station can be constructed. The second, for PTS vehicles, is a commercial unit on a local industrial estate.

1.2.4 This effectively creates a hybrid of OBC Options 4 and 5, but on the basis of leased rather than purchased sites. This new option has been labelled Option 6 and can be tested

against the Do Nothing option and the other options shortlisted at OBC.

1.2.5 The table below summarises the results of the latest economic appraisal, updated for this FBC, using a 3.5% discount rate:

	Option 1 **Do nothing**	**Option 2** **Acquire 1 site**	**Option 3** **Purchase 1 building & refurb**	**Option 4** **Acquire 2 sites**	**Option 5** **Purchase 2 buildings & refurb**	**Option 6** **Lease 2 sites**
EAC	61.7	18.4	21.9	5.9	12.8	-14.1
Weighted benefit score (WBS)	100	870	850	948	918	933
EAC per WBS	**0.62**	**0.02**	**0.03**	**0.01**	**0.01**	**-0.02**
Risk adjusted EAC	62.6	23.0	26.4	10.2	17.1	-10.1
Risk adjusted EAC per WBS	**0.63**	**0.03**	**0.03**	**0.01**	**0.02**	**-0.01**
Ranking	**6**	**4**	**5**	**2**	**3**	**1**

1.2.6 The updated analysis shows that the preferred option is the new Option 6.

1.3 Financial Case

1.3.1 The capital cost of the preferred option is relatively minor as the sites will be leased under operating leases and therefore remain off balance sheet. £350k capital (£404k including VAT) will be required for construction and refurbishment works. This will be funded by the sale proceeds of the current Buckhurst Hill site, estimated at £3.9 million.

1.3.2 The annual revenue costs of the preferred option are £146k, an increase of £81k compared with the existing costs.

1.4 Commercial Case

1.4.1 The land housing the current Buckhurst Hill station was sold on the open market. The sale process is nearing completion and the capital receipt of £3.9m is almost certain.

1.4.2 Leases for the 2 new facilities are also nearing agreement, pending final legal opinions, and no significant further issues are anticipated in agreeing these within the economic and financial parameters set out in this FBC.

1.5 Management Case

1.5.1 The project will be managed by the LAS Estates Department supported by specialist advisors as required.

1.5.2 The project is generally low risk and the arrangements for benefits realisation and post-project evaluation have been agreed.

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 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:

- Trust Board – every meeting;
- 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

TRUST BOARD MEETING, 20 May 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 identified as being of red status (i.e. not on track and cause for concern).

Improving our Response

Referral pathways

The project has effectively stalled 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. The deliverable of a comprehensive set of referral pathways in each PCT area which are routinely used by staff has moved into 2008/09. It should be noted however that the Trust met its target to take 21000 fewer patients to A&E in 2007/08 although this was predominantly achieved by increasing CTA volumes. Next steps are to:

- Recruit a new project manager to ensue this initiative doesn't fall further behind schedule;
- 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.

5. Recommendation

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

Kathy Jones
Director of Service Development

OVERVIEW OF ACCESS / CONNECTING for HEALTH PROGRAMME

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: Vic Wynn
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

Project Name

Project Status Key:

- On track
- Not on track but under control
- Not on track and cause for concern

Project	2007 SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	2008 JANUARY	FEBRUARY	MARCH	APRIL
CAD 2010 PM: Ian Pentland Status: On track	ITPD Response Report	Tender Evaluation Process & Criteria		Procurement Initial Engagement Report				Invitation to submit final tender
CTAK Enhancements PM: Rony Zaman Status: Not on track but under control			Release 6 go-live MDT MoTs Begin		Begin Gazetteer integration	Dyn Deployment live in DMC		
Data Warehousing PM: James Cook Status: Not on track but under control				User Requirements Agreed	Validation of architecture Selection of preferred analysis tool		Production Env Configured	tart parallel reporting Stage II Pl
LARP PM: Vic Wynn Status: Not on track but under control			Start of vehicle installation					
PTS System Upgrade PM: Robert Utchanah Status: On track						Complete user training	Go-live	Complete hardware Upgrades
Text Emergency Access PM: Grenville Gifford Status: Not on track but under control		Initial DCLG Meeting			MoU signed off	Agree Operational Procedures		Stakeholders' Awareness Event

30/04/

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	2008							
	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
CAD 2010 PM: Ian Pentland Status: On track	Receive and review Tenders	Trust Board approve draft FBC Gateway Review 26Jun / 1July	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	
Text Emergency Access PM: Grenville Gifford Status: Not on track but under control					National service launch (provisional)		Pilot Operation (provisional)	

30/04/2008

Legend

- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Additional Complex Response
Project Manager: Steve Irving

The aim of this initiative is to provide two sets of resource to staff FRUs to respond to both CAT-A and CAT-B calls. nineteen DSO vehicles need to provide operational cover using managers between 1100 - 1400 daily and the twenty-six team leaders need to be available to staff additional cars between 1400-2000 daily (times stated above may be subject to change).
An additional element to this project requires scoping of mobile office tools that can be utilised by Service personnel whilst on the move.

Increasing Solo Response Capacity
Project Manager: Terry Williamson

To revisit the existing roll-out plan to ensure that the new FRUs (being delivered from an existing order) are distributed one per complex and to ensure that additional cars over and above this (c15 cars) are deployed for maximum benefit. Phase 2 of this initiative is investigating the expansion of the current MRU / CRU operation.

Mobile Fleet
Project Manager: Andy Heward

The specification, procurement and implementation of a full computer based system for dynamic deployment model, compatible with Systems Status Management where possible.

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.

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.

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.

Project Name	

Project Status Key:
- On track
- Not on track but under control
- Not on track and not in control

2007: JULY, AUGUST, SEPTEMBER, OCTOBER, NOVEMBER, DECEMBER; 2008: JANUARY, FEBRUARY, MARCH

ADDITIONAL COMPLEX RESPONSE
PM: Steve Irving
Status: Project closed

Training produced; Full DSO provision; Full TL provision; Quick wins for mobile office scoped; P&P sign-off; Russell Smith provide update; Mobile mapping for managers in cars

MOBILE FLEET
PM: Andy Heward
Status: Project closed

Identify business req; Release tender; Complete tender and evaluate product; Comms plan; Tool procured; Start regression testing; CTAK interface complete; Start training; Live in DMC

INCREASE SOLO RESPONSE CAPACITY
PM: Terry Williamson
Status: Project closed

Analysis for additional responders complete; Robust comms plan issued / actioned; MRU/CRU proposal to SMG; FRUs deployed; Advertise MRU & CRU staff/ draft PID; Rotas finalised for CRU; Assessed applic; Rotas finalised for CRUs; MRU training commences/ Rec complete; CRU training commences; 7 MRU/ 23 CRU response units operational; Additio

REFERRAL PATHWAYS
PM: Allison Bolsover
Status: ✕

Agreed template design; Met all PCTs; Create trng EOC/UOC; Revisit contacts with all PCTs; Training proposal to Martin F; Revisit PCT's; Have 50 ref pathways; Start creating trng for PTS A&E support & CTA live; Vehicles equipped with folders; On Hold

MANAGING FREQUENT CALLERS
PM: Gary Bassett
Status:

Submit JDs to HR; SMG authorise recruitment; Sign-off funding; First PALS appt / Two posts in RIB; MI analysis tool delivered; Disseminate guidelines to third parties / agree comms; 2ne PALS Social Worker; Social Worker Appt; Resolve 50 cases

COMMUNITY AND FIRST RESPONDERS
PM: Chris Hartley-Sharpe
Status:

Preliminary meeting with St John Ambulance; Trial EOC 1st responder desk; Training Biggin Hill/ meeting BHF; Submit BHF bid/ SPPPs submitted; 1st responder desk in EOC; Funding AEDs secured; Administrator in post

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Not on track but under control
- Not on track and cause for concern

Project Name									
Project Status Key: On track / Not on track but under control / Not on track and not in control	2008								
	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
ADDITIONAL COMPLEX RESPONSE PM: Steve Irving Status: Project Closed		Mobile mapping released w/c 5/05/08							
MOBILE FLEET PM: Andy Heward Status: Project Closed									
INCREASE SOLO RESPONSE CAPACITY PM: Terry Williamson Status: Project Closed		Additional 4 MRUs							
REFERRAL PATHWAYS PM: Allison Bolsover Status: Not on track and not in control	Training starts? On Hold	Have 93 guidelines active across the PCTs							
MANAGING FREQUENT CALLERS PM: Gary Bassett Status: Not on track but under control			Initial meetings with 3rd parties complete - local n/w forums established	Social Worker Appt			Resolve 120 cases		
COMMUNITY AND FIRST RESPONDERS Status: Not on track but under control	Trial resp schemes established/evaluated & Co-resp schemes identified/implementation planned								

(Reference Tranche 3 Schedule)

14/05//08

Legend

- Awaiting approval
- Planned milestone
- Milestone achieved
- Not on track but under control
- Not on track, and cause for concern

Project Name	2008: FEBRUARY – NOVEMBER
Project Status Key: On track Not on track but under control Not on track and not in control	FEBRUARY, MARCH, APRIL, MAY, JUNE, JULY, AUGUST, SEPTEMBER, OCTOBER, NOVEMBER
MOBILE FLEET (PHASE3) PM: TBC Status: Not on track but under control	Milestones to be submitted to the Programme Board by end May 2008
VEHICLE FLEET RE-CONFIGURATION PM:TBC Status: Not on track but under control	Milestones to be submitted to post May SMG
CLINICAL SUPPORT DESK & GUYS PHYSICAN SUPPORT PM: TBC Status: On track	Agree JDS & PS (achieved); Training leads from EOC nominated (achieved); Closing date for applications (achieved); Rec Complete (achieved); Training Delivered (achieved); Desk "Go Live" (planned)
REFERRAL PATHWAYS (PHASE 2) PM: TBC Status: Not on track and not in control	On Hold (Project Manager on sick leave)
MOBILE OFFICE PM:TBC Status: Not on track and not in control	On Hold (Project Manager - On prolonged leave of abscence)
TEAM BASED WORKING PM:TBC Status: Not on track but under control	PID/ Milestones due mid May 2008
FIRST AND COMMUNITY RESPONDERS PM:TBC Status: Not on track but under control	Commence Phase 2 (5 sites) (achieved); Delivery 102 BHF defibs (awaiting approval); 4 of Phase 1 sites live (planned); Appoint trainers (planned); FRU tasking mechanism in EOC/remaining 4 Phase 1 sites live (planned); Trial responder schemes established/evaluated. Co-resp schemes defined /implementation planned. (planned)

14/05/08

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Not on track but under control
- Not on track and cause for concern

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	2007						2008		
Project Status Key: On track; Not on track but under control; Not on track and not in control; C Complete	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
AUTOMATED AMBULANCE DESPATCH PM: Paul Webster Status: Project complete	Define business rules			Revise CTAK	Test revisions	Auto dispatch live			
AUTOMATIC DATA REPORTING & ANALYSIS PM: Sue Meehan Status: Not on track but under control	Implement perf stds using auto status			Begin MDT update			Implement new gazetteer		Complete MDT update; See overleaf
CONTROL SERVICES MGT RESTRUCTURE PM: Alan Edmonds Status: Not on track but under control	Review JDs	Start Consultation		Finish consultation	All staff slotted in				See overleaf
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				Go/no go meeting		On Hold
RE-ENGINEER CALL HANDLING PM: Vicky Graham Status: Not on track but under control	Train EBS on CTAK	Start IPM trials; GMT Planet go live; Roll out IPM	Rest breaks		C&W CLI	Call Switch upgrade	Complete IPM review	95% of call answering within 5 secs for the week	See overleaf
URGENT CARE WORKLOAD PM: John Hopson Status: Project complete		Review staff roles	Senior mgt restructure complete	Skill mix agreement			CTA incr to 50 wte		CTA incr to 70 wte; A&E Sup incr to 162 wte

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 not in control; C Complete	2007						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 but under control		Implement new gazetteer							
CONTROL SERVICES MGT RESTRUCTURE PM: Alan Edmonds Status: Not on track but under control		OCM Appts 01/06	Interviews Area Controllers 16/06	Assess EMD 3 28/07; Project completion 31/07					
PAPERLESS CONTROL ROOM PM: Lisa Dickinson Status: Not on track and not 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									

14/05/2008

Legend

- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

OVERVIEW OF OD & PEOPLE PROJECTS

New Ways of Working; Clinical Leadership
Bill O'Neill

This programme of work corresponds with many of the projects within service improvement programmes that are already underway, and in particular has many links into both the Operational Model and Organisation Development and People programmes. There are also areas that overlap with the Corporate Processes and Access programmes. However, there is a sense in which this work has a very clear identity of its own, focusing attention on life on our station complexes and how that can be improved to the benefit of the organisation, its staff and its patients, partners and the wider community as a whole.

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 individuals and ensuring equality of access.

Staff & Union Engagement
Project Manager: Tony Crabtree

The aim of this initiative is to gain general staff and union understanding of, and constructive engagement with, the management of LAS. The project will deliver the principles of partnership working as well as the consultative framework in which management and the unions will work together.

Training Restructure
Bill O'Neill

The aim of this initiative is to restructure the clinical education part of the department to meet the following requirements:

- greater emphasis on front-line staff's clinical development and continuing professional development than is currently the case
- facilitating the proposed changes to the workforce profile and skill mix; the main focus will move to paramedic development
- an enhanced internal capacity for upskilling EMTs, and developing existing EMTs to Paramedic level (bearing in mind the anticipated increase in the academic standing of the paramedic award from certificate to diploma), and in upskilling existing paramedics to the new standards of proficiency.

E-Learning
Project Manager: Johnny Pigott

The aim of this project is to develop e-learning modules that complement the modularised training modules currently being developed for class room delivery, enabling the training department to offer a blended approach to delivery of these modules. The project will also develop an appropriate platform from which these modules can be accessed and delivered. Modules include;

- 12 – Lead ECG
- Obstetrics
- Mental Heath
- Diversity
- Major Incidents

Team Briefings
Project Manager: Alex Bass

The aim of this initiative is to explore the use of a team briefing system within the corporate services department. The system would be a face-to-face briefing from the senior manager to staff, to disseminate corporate information, discuss local issues, and feedback any issues centrally. The intention of the project is to provide a flexible framework for individual services to adopt and tailor for best fit.

Learning Management Systems
Project Manager: Johnny Pigott

The aim of this initiative is to develop a learning management system solution to enable both clinical and corporate training to be captured and managed through an electronic learning management system. This system will record, manage and flag up training / professional certification needs.

Project Name

Project Status Key:
- On track
- Not on track but under control
- Not on track and not in control

2007			2008							
NOVEMBER	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
- Diversty outreach team selection starts
- Tender closing date
- Select Provider
- Contract Awarded

LEADERSHIP DEVELOPMENT PROGRAMME
PM: Jo Anthony
Status:
- Team Leader comms starts
- Procurement Complete
- ELSA Senior Go-live
- ELSA 6 Go-live
- Start pilot for Coaching
- Team Leader Course go-live
- 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
- 2nd draft PM def document
- SSG Consultation complete
- Document agreed
- Comms complete
- Training schedule & BC handover

RE-CONFIGURE WORKFORCE PROFILE
Caron Hitchen
Status:
- Fleet Modelling agreed
- Workforce Modelling agreed
- Workforce Plan agreed
- Staff-side consultation complete
- Skills Escalator agreed
- Review of training plan agreed
- Hand Over to AD resources for monitoring

MODULARISED TRAINING
PM: Keith Miller
Status:
- Development of modules complete
- Modules signed off by Lead
- Modules ready for use
- Training-the-trainer complete

SUCCESSION PLANNING & TALENT MANAGEMENT
PM: Johnny Pigott
Status:
- PID Agreed
- PID to SSG for approval
- Initial Consultation Complete
- Definition & Measurment workshop complete

STAFF & UNION ENGAGEMENT
PM: Tony Crabtree
Status:
- Partnership Agreement
- Schedule of work agreed
- Area comms complete
- 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:
- Consultation
- Start of SMT selection process
- Successful candidates in post
- Interest sought for paramedic tutor team
- Interest sought for complex tutor team
- 6 training officers in post on new complexes
- All paramedic positions filled

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
- IT training complete for users
- Comms
- system link activated on Pulse

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

14/05/2008

Legend
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

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: Jenny Palmer; 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: Nick Pope
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: Chizoba Okoli
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: Sharon King
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.

LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

Project Status Key:
- On track
- Not on track but under control
- Not on track and not in control

2008

Project	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
T1P1: OPERATIONS Project Executive: Jason Killens Project Manager: Gareth Hughes Status:		Complete project initiation; Produce and test modelling tool	Model resource requirements	Agree command and control structure			Model workforce for central control function	Conduct post-project review	
T1P2: COMMUNICATIONS Project Executive: Peter Thorpe Project Manager: Tim Edmonds Status:	Complete project initiation	Finalise Communications and Engagement Plan	Finalise Stakeholder Management Strategy	Transfer of Knowledge Workshop		Framework for Transfer of Knowledge	Initiate knowledge capture to date	Conduct post-project review	
T1P3: MUTUAL AID & VOLUNTEERS Project Executive: Peter Thorpe Project Manager: Steve Irving Status:	Complete project initiation	Identify existing partnership agreements			Produce partnership agreement framework		Share framework with existing partners	Sign off framework; Conduct post-project review	
T1P4: CLINICAL SKILLS ACQUISITION/TRAINING Senior Supplier: Keith Miller Project Manager: Jenny Palmer Status:		Complete project initiation	Identify clinical training requirements	Identify operational training requirements	Identify event management training requirements; Approval of training requirements: Medical Director	Produce draft training timetable	Approval to recruit: PLM/EPA SpR; Tabling of draft timetable: Training Services Group	Conduct post-project review	
T1P5: PROCUREMENT Project Executive: Chris Vale Project Manager: Nick Pope Status:		Complete project initiation	Vehicle/equipment kit lists	Review LAS procurement cycles	Scope/appraise options for funding/supply	Approach/process for external offers of goods/equipment	Environmental statement to inform procurement	Conduct post-project review	
T1P6: STAFF ENGAGEMENT Project Executive: Tony Crabtree Project Manager: Anna Kilpin Status:	Complete project initiation	Presentation at Staff Council	Workshop with Staffside to identify issues/risks	Survey staff to identify expectations	Feedback survey findings to Staff Council; Assessment of effectiveness, feasibility, deliverability of benefits	Draft staff and volunteer recognition programme	Staff welfare requirements identified	Options appraisal for meeting workforce requirements; Conduct post-project review	
T1P7: FINANCIAL FRAMEWORK Project Executive: Paul Cain-Renshaw Project Manager: Chizoba Okoli Status:	Complete project initiation			Develop a strategic approach to financial management of the programme	Programme Board agreement of strategic approach	Identify potential costs/expenditure during Games period in relation to all stakeholders	Develop, populate and test financial modelling tool	Conduct post-project review	
T1P8: ESTATES STRATEGY Project Executive: Martin Nelhams Project Manager: Steve Selleck Status:	Complete project initiation		Estates requirements for Olympic Games Planning Office (OGPO)	Implementation plan for OGPO; Costing parameters for OGPO	Estates requirements for Olympic Station	Implementation plan for Olympic Station; Costing parameters for Olympic Station	Estates requirements for Event Control facilities; Implementation plan for Event Control facilities	Costing parameters for Event Control facilities	Conduct post-project review
T1P9: IM&T STRATEGY Project Executive: Vic Wynn Project Manager: Sharon King Status:		Complete project initiation		Workshop to scope all IM&T activity up to/during Games; Workshop to identify planning assumptions, interdependencies and external influences		Scoping of IM&T activity up to/during Games; Identification of planning assumptions, interdependencies and external influences		IM&T Strategy for entirety of Olympic Programme including legacy opportunities	Conduct post-project review

Legend
- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

Enclosure 15

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 28th April 2008

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. **<u>Agreed:</u>**

- The procedure on 'Action on scene indirectly related to the patient'.
- That the interim position put forward in the brief (HIV Infected Healthcare Workers) and considered by the Committee be adopted until such time as the Trust Board makes a decision to change the Trust's current policy. The interim position is that a local definition of exposure prone practice would effect HEMS paramedics only and the DH policy would be adopted in regard to these staff. Further advice was being sought from a Consultant in HIV and Sexual Health.
- The proposed rewording of Risk 133 concerning the reporting of suspected abuse of children, this will be considered by RCAG on 21st May 208.

<u>Noted:</u>

- That the procedure for the 'clinical handover of patients would be re-presented to the Committee in June 2008.
- That Lost Property Bags have been introduced with a reported drop of 70-80% fall in enquiries received by the PALS team.
- That the post of the Infection Control Manager has been re-banded and will be re-advertised.
- An infection control audit was scheduled to take place in May 2008; its findings will be presented to the Committee in June 2008.
- That a draft copy of the Metropolitan Police/LAS DVD 'Preventing death in custody' has been received and was being circulated amongst operational members of staff for comment.
- The contents of the General Governance Area report, the format of which was under discussion so as to ensure the Committee received qualitative information on outcomes.
- The response to the recommendations of the Internal Auditors in regard to the drug management control – morphine. A further audit of this area will be undertaken in 2008/09.
- That the Trust had declared itself to be fully compliant in its annual submission to the Healthcare Commission.
- That work would be undertaken by AOMs as part of their local liaising as/when the borough based LINk organisations, replacing the Patients' Forum, are set up.
- The contents of the draft Annual Complaints & PALS Report 2007/08.
- In April-October the Trust will be piloting 'Making Experience Count' as part of a Department of Health initiative to reform complaints management for the health and social care.
- That the Trust will be assessed in October 2008 at Level 1 under the new NHSLA risk management criteria.
- The contents of the PPI report and the work being undertaken by the PPI Manager.

- The findings and recommendations of two audits undertaken by CARU: an analysis of the factors associated with survival from cardiac arrest for patients treated by Waterloo complex and the documentation of patient ethnicity in the LAS.
- The contents of the Risk Information Report.

Minutes/oral reports received from:

Infection Control Group (27th February 08); Update from the SfBH (22nd January 07); Training Services Group (17th March 08); RCAG (18th February 08); CARSG (14th March 08).

Minutes of the Clinical Steering Group (11th February 08) to be circulated between meetings.

Recommendation: THAT the Trust Board NOTE the minutes of the Clinical Governance Committee, 28th April 2008.

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee (full)
9.00am, 28th April 2008, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director (until 10.30)
Sarah Waller	Non Executive Director (until 11.50)
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
Nicola Foad	Head of Legal Services
Ian Todd	Assistant Director of Operations, Urgent Care & Clinical Development
John Wilkins	Head of Governance
Stephen Moore	Head of Records Management & Business Continuity
Pat Billups	Education Standards Manager (for Keith Miller)
Annie Shillingford	Diversity Manager (until 11.50)
Gary Bassett	Complaints/ PALS Manager
John Selby	Senior Health & Safety Adviser (from 10.40)
Chris Vale	Head of Operational Support
Malcolm Alexander	Chairman, LAS Patients' Forum
Margaret Vander	PPI Manager
Rachael Donohoe	Head of Clinical Audit & Research
Tony Crabtree	Assistant Director, Employee Support Services
Christine McMahon	Trust Secretary (minutes)

In attendance:

Anne Weaver	Consultant in Emergency Medicine and Pre-hospital care & Clinical Lead, HEMS

Apologies

Russell Smith	Deputy Director of Operations
Ingrid Prescod	Non-Executive Director
Paul Tattam	Ambulance Operations Manager - D Watch
Benjamin Jones	EMT
Stephen Silverson	EMD
Dr Julian Redhead	Consultant, St Mary's

16/08 Minutes of the Clinical Governance meeting held on Monday 4th February 2008

Agreed **The minutes of the previous meeting**

17/08 Matters Arising

Noted: **Minute 59/07** The Consultant Midwife gave a presentation to RCAG in February 2008 and will attend Clinical Governance Committee in August 2008.

Minute 02/08 Lost property bags have been introduced and within a week there was a fall in enquiries received by PALS of 70-80%. The Committee will receive a report in October 2008 concerning the introduction of the lost property bags. **ACTION: Complaints/PALS Manager**

Minute 02/08 The Head of Information Management & Business Continuity said that work was in hand regarding revisions to the PRF; the project group was scheduled to meet in May 2008.

Minute 03/08 Safeguarding Children & Vulnerable Adults (SCVP), the PALS/Complaints Manager said that to support this area of work additional administrative resource had been provisionally agreed as well as an ECP working with the PALS team 12 hours a week. PALS will take on full responsible for the management of SCVP by the end of June.

Minute 04/08 The post of Infection Control Manager has been re-banded and will be re-advertised. Arrangements were in place for the quarterly infection control audit in May 2008.

Minute 04/08 The Medical Director said that there was a lack of interest from London hospitals in regard to a proposal to audit MRSA even thought the average patient was not swabbed until 48 hours after admission to hospital.

Minute 06/08 That the Procedure for the Transportation of Patients to hospital was ratified at the Trust Board in March 208.
Minute 08/08 It was confirmed that training in Root Cause Analysis was undertaken and that efforts were on-going to work with the National Patient Safety Agency (NPSA).
Minute 10/08 An event was held on 13th March 08, '247-247' to promote understanding of the LAS' compliance with the Healthcare Standards for representatives from the 31 Scrutiny & Overview Committees in London. The event was attended by representatives from other stakeholders including the Patients' Forum.
Minute 13/08 The reconstitution of the Race Equality Strategy Group was under consideration.

18/08 Report from Helicopter Emergency Medical Service (HEMS)

Anne Weaver, Consultant in Emergency Medicine and Pre-hospital care & Clinical Lead for HEMS, gave a presentation that explained the role of HEMS, its governance arrangements and its relationship with the LAS and the Department of Health. The Service was funded by charitable donation (£1.7m) and by public funding from the Department of Health. It was tasked by the LAS and operated from the Royal London NHS Trust.

During the day the helicopter was despatched by the LAS to serious emergency accidents where time was of the essence; in the evening five HEMS cars were despatched to calls situated within a three mile radius. HEMS was a protocol led organisation that emphases keeping equipment and procedures simple. The HEMS team undertake risky procedures and the survival rate of 12% was amongst the best in the world. There was a strong emphasis on training, good team work and constant monitoring of the treatment given to patients.

The Head of CARU said that the long audit undertaken of a sample of jobs by HEMS was something the LAS could consider at the bi-monthly seminar when attending paramedics and technicians could be asked to nominate a job for the group to review on a quarterly basis.

The Complaints/PALS Manager said he was impressed by the innovative approach adopted to training and learning lessons. He said that in the past there had been an occasion when the LAS had difficulty accessing HEMS records; it was agreed that a way forward would be sought whereby HEMS could share details of calls they respond to as/when necessary.

Post meeting note: a Memorandum of Understanding will be drawn up between the two organisations concerning the sharing of information. **ACTION: Head of Records Information and Business Continuity/Senior Clinical Adviser.**

Noted:
1. **The impressive governance arrangements HEMS has in place including the regular pan London meetings and the detailed long audit that reviewed every aspect of a job, from the time the call was received to when the patient was admitted to hospital.**
2. **That work was being undertaken with regards to a Service Level Agreement between HEMS and LAS.**

19/08 Clinical procedures for approval

The Committee reviewed the procedures relating to 'The clinical handover of patients' and 'Action on scene indirectly related to the patient'.

Agreed
1. **The procedure on 'Action on scene indirectly related to the patient'.**

Noted:
2. **That the procedure for 'The clinical handover of patients would be amended to reflect comments made at the meeting and re-presented to the Committee in June. ACTION: Head of Records Management & Business Continuity.**
3. **That an Equality Impact Assessment had yet to be undertaken of the above procedures.**

20/08 Medical Directorate Update

The Medical Director said that a draft of the DVD produced by the Metropolitan Police and the LAS, 'Preventing death in custody', had been received. The Senior Clinical Adviser was co-ordinating the feedback on the DVD from SMG and other members of staff. The Head of Legal Services said she

had seen the DVD and regarded it as ‘essential viewing’ for front line staff. Copies of the DVD will be shared with the Trust Board in due course. **ACTION: Medical Director**

Noted:

1. **That a draft copy of the Metropolitan Police/LAS DVD, ‘Preventing death in custody’, has been received and was being circulated for comment.**
2. **That there has been no recent guidance issued by NICE relevant to the LAS.**
3. **That the Healthcare Commission’s investigation into Staffordshire AS Trust had been recently published; a summary of the recommendations will be presented to the Committee in June. ACTION: Medical Director.**

21/08 Infection Control Update

The quarterly infection control audit will be undertaken in May 2008; the results will be presented to the Committee in June. **ACTION: Head of Operational Support**

The new provider of Occupational Health medicine to the Trust was anxious that the LAS adopt the Department of Health (DH) guidance (HIV Infected Care Workers: Guidance on Management and Patient Notification, 2005) regarding the employment of HIV+ individuals and AIDs sufferers.

The Medical Director set out the Trust’s position in regards to the DH guidance, referring the Committee to a briefing paper drafted by the Assistant Director, Employee Support Services, which was tabled at the meeting. The paper set out the Trust’s current HIV Policy; applicants are not required to take a HIV test nor will they be refused an offer of work just because they are HIV positive. Existing staff are not required to take an HIV antibody test and only those workers with AIDS will be considered for reasonable adjustments including suitable alternative employment and/or retraining. The key difference with DH guidance was that all new applicants are not tested for HIV and existing staff that would be precluded from performing exposure prone practice (EPPs) because of the HIV status should also not perform pre-hospital trauma care.

The adoption of the DH guidance would present a number of potential issues for the Trust including the risk of rejected applicants bringing claims of direct and indirect discrimination against LAS and the possibility that existing staff would effectively be no longer be able to practice at all, given that ‘pre hospital trauma care’ is an extremely broad term.

The Medical Director said the risk of infection was very unlikely to occur for ambulance staff except in the rare occurrence of ‘bleedback’. It was recognised that in a hospital setting there was a higher number of exposure prone procedures undertaken. The Trust had sought legal advice which indicated that the Trust would be exposing itself to the risk of discriminating either directly/indirectly members of staff who were HIV+.

The different options were considered and the interim options of agreeing a local definition of which staff undertake EPP. It was likely that this would extend, on current practice and arrangements, to HEMS paramedics only and the DH policy would be adopted in regard to these staff.

Agreed

1. **That the interim position put forward in the brief be adopted until such time as the Trust Board makes a decision. ACTION: Medical Director.**

Noted:

2. **That a submission regarding this risk would be presented to the RCAG when it met on 21st May. ACTION: Assistant Director, Employee Support Services.**
3. **That advice would be sought from the Consultant in HIV & Sexual Health UKAP. ACTION: Assistant Director, Employee Support Services.**
4. **That there was no report or evidence of patients treated by LAS staff having occurrences of ‘bleedback’ in the wound.**

22/08 General Area Governance Report

The Assistant Director, UOC and Development, presented the general Area Governance Report. Following discussion it was suggested that the format of the report be changed so as to emphasis quality rather than quantity of information and include trend analysis rather than raw data concerning

PDR etc. Outcomes were absent from the reports. The content and structure of this report needed to be revised for the next committee meeting. Future area governance reports need to be up to the standard of the reports presented at previous meetings of the Committee.

Discussions will take place between the Medical Director, the Chairman and the Deputy Director of Operations concerning the content of the Area Governance Reports. A new net based reporting system is being introduced and there is an opportunity for area officers to be given licences and training to use the system as it is rolled out.

Noted

1. **That the Trust had achieved Call Connect performance 75% Category A8 Minute target in April 2008 and Category B19 performance had also improved. Call answering remained high with 95% of calls being answered within five seconds.**
2. **That a clinical audit was being undertaken of CTA calls. ACTION: Head of Clinical Audit & Research**
3. **That rest break allocation had improved in recent months and there was continued focus in the Control Room to allocate rest breaks.**
4. **That the level of CPI completion had remained consistent despite the operational pressures in March and April.**
5. **That disappointingly attitude and behaviour continued to be the main cause of complaints received by the Trust.**
6. **That a proposal regarding the format of the Area Governance report will be presented to the Clinical Governance Committee in June. ACTION: Deputy Director of Operations/Head of Governance**

23/08 Internal Auditor's report: drug management control

The Committee received the summary report written by the Internal Auditors, Bentley Jennison, following the audit of three ambulance stations' management of the drug morphine. The seven significant recommendations made by the Internal Auditors in connection with the management of morphine have been accepted by the Trust. It was recognised that although the Corporate Logistics Manager was the nominated responsible lead the implementation of the recommendations rested with Operational staff to ensure adherence of the Trust's policies and procedures.

Noted:

1. **That the Trust's existing policies and procedures were not criticised by the Internal Auditors; adherence to the laid down policies and procedures would have addressed the majority of the shortcomings identified by the Internal Auditors. This area will be further audited in 2008/09 to ensure that the lessons have been learnt. ACTION: Head of Governance to liaise with the Internal Auditors.**
2. **That the monthly Clinical Update will include a reminder to staff about the necessity of following the Trust's policy and procedures particularly in reference to the management and control of morphine. ACTION: Medical Director**
3. **That a progress report on the implementation of the recommendations will be presented to RCAG on 21st May. ACTION: Deputy Director of Operations/Head of Operational Support.**
4. **The comments made by the Senior Clinical Adviser in response to the audit, specifically that neither the Senior Clinical Adviser or the Medical Director were contacted by the internal auditors when the drug management control audit was undertaken.**
5. **That periodically stations were 'locked down' if ampoules of morphine were found to be missing due to the stations following the laid down protocols which also included the Police being informed and a full investigation being undertaken.**

24/08 HCC – 2007/08 Final Declaration

The Head of Governance said that the Trust had declared itself to be fully compliant in its annual submission to the Healthcare Commission. An event was held on 13th March, '247-247' to actively engage with the 31 overview and scrutiny committees in London; eight felt sufficiently informed to

make a contribution to the submission that they were satisfied the Trust was fully compliant. Representatives from other stakeholders including Healthcare Commission and the Patients' Forum also attended the event.

Relationships will be built with the borough based LINk organisations that will be established to replace the Patients' Forums. It was recognised that the Trust as part of its preparations for foundation trust status and recruiting a membership will need to forge links with these new organisations. The Chairman of the Patients' Forum said that many of the LINk organisations would not be established until September. The Complaints/PALS Manager said AOMs, as part of their local liaison work, will be encouraged to engage with the 31 London Borough Leads who will be setting up the LINk organisations.

25/08 **PALS and Complaints – Draft Annual Report 2007/08**

Gary Bassett, PALS/Complaints Manager, presented the draft annual report for 2007/08; he highlighted that the number of enquiries received by PALS had increased by 12% while the number of complaints remained the same.

The Trust has been chosen as a pilot site for 'Make Experience Count'; as part of the Government's plan to reform complaints management, advocating a comprehensive single complaints system across health and social care. The pilot will operate between April and October 2008 and a Department of Health support team will be made available to provide guidance and assistance.

Noted:

1. **The contents of the draft annual report prior to its submission to the Trust Board in May 2008.**
2. **That attitude and behaviour and delays in sending a response were the main topics of complaints received by the Trust.**
3. **The examples given of the outcomes of enquires and complaints received by PALS.**
4. **That the work undertaken in relation to benefits realised for the Frequent Callers Project will be reported to the Trust Board as part of the benefits realised of the Invest to Save report. ACTION: Director of Finance**

26/08 **Update regarding new NHSLA standards**

The Head of Governance said that the Trust will be assessed against five standards. The Trust will be assessed at Level 1, demonstrating that it has policies and procedures in place to manage risk.

Noted:

1. **That the NHSLA assessment will take place in October 2008.**
2. **That monthly meetings were taking place to consolidate the quality or evidence required to achieve compliance with the requirements of Level 1.**

27/08 **Patient and Public Involvement Update**

The PPI Manager highlight the following from her report:

The Trust held an event on 26th March 2008 that was attended by 80 members of the public who represented various stakeholders (PCTs, people with learning disabilities, patients and carers) who were asked for their views on the Service Improvement Programme. The Project Manager for the Access Programme has met with representatives of the deaf community to determine how the Trust can improve access for people who are deaf.

The Public Education Group was developing a public education programme, which will be accredited by South Bank University and will be rolled out to events and school teams as/when required.

The Risk Assessment form used by all staff who arrange and attend events was being updated to make it more user-friendly and it will be a web based document.

The PPI Manager was drafting a reimbursement and payment policy which will enable the Trust to pay members of the pubic when they are invited to attend LAS events. This was a NHS wide practice.

It was recognised that the recruiting members for the LAS Foundation Trust will be quite challenging given that the composition of the membership is expected to reflect London's demographics in terms of age, gender, social grade etc.

The report included details of the local PPI activity undertaken at complex level.

28/08 **Clinical Audit & Research Unit (CARU) Update**

The Head of CARU highlighted two audits undertaken by CARU.

1. *An analysis of the factors associated with survival from cardiac arrest for patients treated by Waterloo complex was undertake*n and the following recommendations made:

- Explore why motorcycles are not being dispatched/prioritised more frequently to cardiac arrests during their hours of operation.
- Consider dispatching motorcycle responders more readily to patients that collapse in the home (in light of the fact that just under half of all cardiac arrests (44%) in Waterloo occurred in a private location).
- Consider expanding the motorcycle response to other areas of London, particularly those where response times are longer.
- Consider adopting a cardiac-specific motorcycle response.

2 *Documentation of patient ethnicity in the London Ambulance Service.*

The purpose of the audit was to assess the documentation of ethnicity codes on a sample of 400 Patient Report Forms selected from a six week period in August and September 2007. The audit found that 77% of PRFs recorded ethnicity;

- 73% described the patient's ethnicity
- 27% reported a 'z' code identifying that the patient's ethnicity was unobtainable.

The following recommendations were made:

- that the LAS continue to employ monitoring and feedback methods (such at the CPI audits) to encourage the documentation of ethnicity codes
- that crew staff reminded to use 'z' codes for children where it is not possible to obtain ethnicity.

29/08 **Clinical Risk**

The Committee reviewed each of the Clinical Risks on the Trust's Risk Register

Agreed:

1. **That the title and controls in place to mitigate risk 133 (risk of potential legal action/negative publicity due to staff being unaware of how to report suspected abuse of children) be amended. This will be presented to RCAG approval in May 2008.**
Post meeting note: Medical Director agreed with the recommendation.

Noted:

2. **That the following risks would be considered for re-grading when the Clinical Governance Committee meets in June: 20 (PRF completion), 22 (failure to undertake clinical assessments) and 207 (risk of staff not being able to download information from defibrillators and the service failing to gain the data for analysis).**
3. **That the Head of Clinical Audit's name should be listed as the leading manager for risk 207**

4. **That a report regarding the Older Persons' strategy (risk 165) will be presented to the Committee in June. ACTION: Director of Service Development**
5. **That the notes for risk 179 (failure to meet responsibility under the Race Relations Act) will be updated. ACTION: Diversity Officer**

30/08 <u>**Full Risk Information Report**</u>

The requirements for the Risk Information Report previously agreed at the Committee's meeting on 11th June 2007 were circulated at the meeting by the Head of Governance. This was to confirm requirements for the future production of the report with contributors.

Incident reporting: The report outlined the total number of clinical incidents reported to the Safety and Risk Department based on LA52 completion. In total 576 clinical incidents were reported, with 14 of these recorded as having an impact on the patient. Overall, despite the increase in quarter 4, the report shows a decline in the reporting of clinical incidents for the first quarter of 2008.

A query was raised as to how many of the LA52s concerned vehicles managed by Make Ready. The Head of Operational Support said that any issues with Make Ready should be reported to the DSO and the appropriate action taken. **ACTION: Senior Health & Safety Adviser to review the LA52s and provide a post meeting update.**

Clinical Negligence Claims, Potential Claims and Contentious Inquests: identified the caseload opened and the emerging themes in quarters 3 and 4 2007/08. The review of clinical negligence claims, incidents, and contentious inquests was conducted on 15 April 2008. Owing to the performance pressures on Operations it was not possible to conduct the usual round table reviews with Operational Staff, and these therefore took place by telephone. The output from the discussions will be included in the reports to the Area Governance Groups when they next meet. The procedure that is directly relevant to staff making or requesting the police to force entry to premises was revised by the Deputy Director of Operations March 2008 in response to the learning from earlier claims.

Equality and Diversity: the Diversity Manager said that following the baseline enquiry, carried out by the previous Diversity Manager, into the work on Equality, Diversity and Human Rights at the LAS a number of recommendations and actions were planned for the 3rd quarter. A progress report on these recommendations and actions was presented as part of the Risk Information Report.

Sarah Waller asked who authorised the LAS joining Stonewall, a campaigning organisation, as it may have unintended consequences for the Trust. **ACTION: Diversity Manager to report back at the next meeting.**

Post meeting note: the Committee was informed that the Trust was in discussion regarding the LAS joining Stonewall's Diversity Champions Programme.

The Committee will receive an update on progress concerning CTA undertaking ethnicity monitoring at its meeting in June 2008. **ACTION: Deputy Director of Operations.**

Noted **That the Head of Complaints/PALS did not have anything to add to his submitted report and the draft Annual Complaints Report discussed earlier in the meeting.**

31/08 <u>**Reports from Groups/Committees**</u>

1 <u>*Update from the SfBH Group 22nd January 2008*</u>

Noted: **That the Group met to confirm the quality of compliance with the requirement of the Annual Healthcheck for 2007/08 and will be re-convened in October 2008 when**

the Healthcare Commission publishes its findings including performance ratings of all NHS Trust.

2 *Clinical Steering Group, 11th February 2008 (?)*

Noted: The minutes of the Clinical Steering Group were not available for the meeting and will be circulated by the Trust Secretary. ACTION: Trust Secretary

2 *Risk Compliance & Assurance Group – 18th February 2008*

Noted:
1. **The minutes of the RCAG meeting that took place in February 2008.**
2. **That there was concern expressed about the quality of service received from LanguageLine which was used by the Trust to communicate with callers/patients who do not speak English.**

3 *Infection Control Group – 27th February 2008*

Noted:
1. **That an infection control audit was being undertaken in May 2008**
2. **That a deep clean had been undertaken of PTS and Fast Response Vehicles :**

4 *CARSG – 14th March 2008*

Noted: The minutes of the meeting held in March 2008.

5 *Training Services Group – 17th March 2008*

Noted: The summary of the discussions held at the Training Services Group's meeting on the 17th March 08.

32/08 Draft 2008 Forward Planner

Noted: The forward planner.

33//08 Dates of next meeting:

Core: Monday, 2nd June 2008, at 9.00am in the Conference Room, HQ
Full: Monday, 4th August 2008 at 9.00am in the Conference Room, HQ

Meeting concluded at 12.10

Enclosure 16

London Ambulance Service NHS Trust

Remuneration Committee Meeting

LAS HQ, Conference Room
18 March 2008 at 0900 hours

Present:	Sigurd Reinton	Chairman
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Roy Griffins	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Brian Huckett	Non Executive Director
	Caroline Silver	Non Executive Director

In attendance: Peter Bradley, Chief Executive

1. **Apologies**

There were no apologies

2. **Previous minutes**

Ingrid Prescod asked for an insertion on page 4 of the minutes of the previous meeting, to read "IP said, to secure her retention, it was important that she receive support from the Service". The minutes were then approved and signed by the Chairman.

3. **Matters arising**

There were no matters arising.

4. **Car leasing**

Peter Bradley presented a paper on car leasing and said that progress had not been as fast as he had hoped and the leasing policy had not yet been finalised, but would be presented to the Trust Board in May. Guidance from the Inland Revenue had not yet been issued. PB had also spoken to other ambulance services but there was obviously no scheme standardisation.

Beryl Magrath said there was too much detail in the paper for the committee to make a decision on what category of staff needed leased cars and that the environment should also be considered. She felt strongly that people who had accidents should pay for the repair themselves. Sarah Waller said the conclusions were sensible. There might also be a resultant cost saving; however, tax issues might complicate matters.

The Chairman said that there were potentially three categories:

1. Those needing a blue light car
2. Those needing a car in order to do their job – definition required.
3. Those people to whom we may wish to offer a pay and benefits package which included a car, provided it was tax efficient. The paper provided to the Remuneration Committee did not help much on this.

Brian Huckett said that his former company abolished company cars entirely. They moved to a cash alternative which then became a problem about whether it was pensionable or not. The company paid business mileage rates for personal cars. This alternative did not seem to have been covered in the paper presented by the Chief Executive.

Roy Griffins said that he thought categories 1 and 2 were fine. Running a perk system, even tax efficiently, was complicated and he thought it best to simply increase salaries.

The Chairman summarised the definition of categories: Category 1, blue light cars was not a problem. Category 2 should be more clearly defined about who would be included and what the criteria for inclusion were.

Peter Bradley reminded the committee that it dealt with the Board's pay and benefits, rather than the wider LAS. It was agreed that the committee would reconvene once a proper analysis had been completed to determine whether a car benefit for people not falling into Categories 1 or 2 was still a tax efficient way to deliver benefits to the relevant groups, taking account of the cost to the LAS of administering the scheme and of any changes resulting from recent budget announcements. Consideration would also need to be given to transition arrangements for staff not falling into categories 1 and 2, as it would be a difficult change. Peter Bradley said a paper would be prepared and brought to the Trust Board.

Beryl Magrath said she was uncomfortable with the present arrangement of paying extra for the car of choice rather than having a standard make and model of blue light cars throughout the Service. Peter Bradley said this had previously been suggested and there had been vociferous discussion and dissention on the subject. Caroline Silver asked why hybrid cars were not used.

The Chairman said that most of the cars concerned were used as family cars most of the time; the blue light facility was there to enable the user to respond when needed. He said that depending on what the new policy is, transition arrangements will be needed in many cases.

4. **Director performance and remuneration**

The Chief Executive said he had held preliminary end of year meetings with all the SMG members and that the submitted paper reflected their conversations. He would hold formal appraisal meetings with all SMG members during April but did not expect the substance of what he said to the Committee to change as a result of these meetings.

It had been the LAS' most successful year, with the best ever response time performance and best Healthcare Commission rating.

He had been able to get some pay benchmarking information but it was less useful than in the past because of the introduction of the VSM pay framework. The information obtained would indicate that there was still quite a variation in pay across the country, especially as Acute Trusts and Foundation Trusts were not covered by the VSM framework.

The Chief Executive had taken the unusual step of asking members of SMG what they thought of their own pay levels and said he would feed this back to the Remuneration Committee.

He presented the individual performance assessments and, following discussion, these were agreed

Bonus Payments

The VSM allows for one off bonus payments for staff whose performance for that year has been either outstanding or has exceeded expectations. Last year the remuneration committee awarded one off bonus payments to the Medical Director, Chief Executive and Director of IM&T on that basis. There were three options for the remuneration committee to consider - recognising that option three does not strictly fall within the VSM guidelines.

1. Do nothing
2. Pay a one-off percentage bonus of between 5% and 10% to those SMG members whose performance has been either above standard or outstanding
3. Pay a team one-off bonus payment of, say, £5,000 to all SMG members.

Pay and bonus recommendations

The Chief Executive recommended:

- That the general inflationary uplift, once known, is applied to the salaries of David Jervis, Caron Hitchen and Kathy Jones (from 1 April 2008)

- That Mike Dinan's salary is increased to the VSM guideline salary of £108,705 with effect from 1 April 2008 and that any inflationary uplift is retrospectively applied from that date.

- That Martin Flaherty's salary is increased to the same as Mike Dinan's - £108,705, with effect from 1 April 2008 and that any inflationary uplift is retrospectively applied to that date

- That Peter Suter's salary is increased to £95,000 from 1 April 2008 and that any inflationary uplift is retrospectively applied to that date.

- That a team one-off bonus payment is made to all SMG members in recognition of the very successful year the Service has enjoyed.

The committee agreed with these recommendations but suggested after discussion that the team bonus should be set at approximately this level but as a percentage of salary.

The Chairman presented his appraisal of Peter Bradley, which reflected comments and suggestions from non executive directors and from the London SHA Provider Agency

The Chairman recommended that Peter should receive the same team bonus (as a percentage of salary) as the rest of the team, and a salary of £170,000 from 1st April 2008 and the committee agreed this. In addition, he receives a 10% responsibility allowance for his work for the DH as National Ambulance Advisor. (Note: the LAS receives £90,000 a year from the DH for Peter's work.)

The resulting pay structure is set out in Appendix 1 below.

Appendix 1

SENIOR MANAGEMENT TEAM
REMUNERATION FOR THE YEAR ENDING 31 MARCH 2009
(As agreed by the Remuneration Committee on 18 March 2008)

VSM Scale	**Executive Directors**	**Salary from 1 April 2008**	**Recruitment & Retention Premium**	**Extra responsibility payment**	**Leasing car allowance**	**Bonus payment**
144,940	Peter Bradley	170,000	25,060[10]	17,000	5,550	9,421
86,964	Caron Hitchen	TBC[11]	-	-	5,034[12]	5,456
108,705	Mike Dinan	[108,705] [13]	-	-	5,034[14]	6,281
N/A	Fionna Moore	N/A[15]	-	-	5,290	6,200
101,458	Martin Flaherty	[108,705] [16]	7,247[17]	-	5,550	6,281

VSM Scale	**Directors**	**Salary from 1 April 2008**	**RRP payment**	**Extra responsibility payment**	**Leasing car allowance**	**Bonus payment**
N/A	Kathy Jones	TBC[18]	-	-	5,034	5,053
N/A	David Jervis	TBC[19]	-	-	5,386	5,056
N/A	Peter Suter	95,000	-	-	5,034*	5,401

[10] Included in salary
[11] VSM salary uplift not yet published. When it is, CH KJ, DJ, PS, MF and MD will receive the uplift as agreed at the remuneration committee. This schedule will then be updated and attached to the minutes.
[12] Leasing car allowance for MD, PS and CH is paid as part of the salary (salary shown plus the car allowance equals total salary paid)
[13] See 2 above
[14] See 3 above
[15] Fionna Moore is paid by the Hammersmith Hospitals NHS Trust
[16] See 2 above
[17] Included in salary
[18] See 2 above
[19] See 2 above

Enclosure 17

Chairman's Away Day

9.00am, 30th April 2008, the Ravenswood, West Sussex

Present:

Sigurd Reinton (Chairman)	Peter Bradley	Sarah Waller
Beryl Magrath	Roy Griffins	Fionna Moore
Caroline Silver	Caron Hitchen	Mike Dinan
Martin Flaherty	Kathy Jones	Peter Suter
David Jervis	Christine McMahon (minutes)	

Apologies:

Ingrid Prescod — Brian Huckett

Guest Speakers:

Stephen Hay	Chief Operating Officer Monitor
David Mellish	Chairman, Oxleas NHS Foundation Trust
Michael Parker	Chairman, Kings College Hospital NHS Foundation Trust
Patricia Moberly	Chairman, Guy's and St Thomas' NHS Foundation Trust
David Sissling	Programme Director for Healthcare for London

1. Reflections on Foundation Trust Status

Stephen Hay (Chief Operating Officer, Monitor) spoke briefly about the benefits of NHS foundation trust (FT) status. These included:

- freedom to provide more responsive innovative patient care,
- ability to reinvest surpluses in improved patient services,
- ability to borrow commercially to finance capital investment,
- strengthening contractual arrangements with commissioners (legally binding contracts),
- be independent and autonomous organisations operations operating in a regulatory environment.

He outlined the reasons why NHS Trusts have failed to achieve authorisation:

- the inexperience of the Board,
- the quality of the NEDs,
- the lack of transparency in regards to financial information,
- the lack of robust business planning and financial projects,
- the lack of sound financial management and investment decision;
- local health economy deficits,
- historic debt,
- failure to meet key national standards.

To support ambulance services obtaining authorisation to become FTs the following action has been identified:

- review skill set and composition of the Board, to ensure the appropriate financial and commercial challenge of the executive team;
- consider progress on financial reporting procedures
- address concerns regarding key national target performance
- secure a representative membership which will be particularly challenging as ambulance trusts cover large catchments areas.
- mitigate against any potential competitive risks on income streams (i.e. Patient Transport Service)
- mitigate the impact of activity fluctuations without tariff based systems.

The following points were made during the ensuing discussion:

- Although FTs have legally binding contracts with their Commissioners, this was as yet untested in a Court of Law.
- New model contracts for Mental Health Trusts and the Acute Trusts were being drafted and would be published later this year.
- Applicants will not be required to have three year contracts signed by the time of authorisation though they should be in the process of being finalised. Monitor will require the contracts to be signed off by one of the four major accountancy firms.
- To date there is no provision in place should a FT become insolvent. The NHS was currently in surplus, with £1.9billion on the collective balance sheet; a large amount of uncommitted working capital and the majority of the FTs have a risk rating of less than 3.
- Although there was no empirical evidence demonstrating improved clinical performance by FTs there was greater transparency in regard to financial performance. Monitor was seeking to devise a number of clinical Key Performance Indicators that would be reflected in the regulatory framework. With the exception of MRSA, FTs have performed better as measured against the current Key Performance Indicators.
- The Trust's retention of surpluses for reinvestment in services and building increase the Trust's asset base. It will be necessary to negotiation with Commissioners to avoid future funding top sliced by Commissioners. As part of the Trust's application for FT status, funding for a three year period will need to be negotiated with Commissioners.
- Although Monitor did not set a minimum number in regards to a FT's membership it did require membership to reflect the Trust's catchment area. This will be a major challenge for the LAS as it is a pan-London organisation. Members will need to be recruited during the preparation for FT authorisation and will be measured at the point of Authorisation. FT membership was, on average, 9,000-12,000, with established FTs' membership growing on average by 9% per annum. Monitor did not have a formal position on the proposal that the membership of acute FTs be co-opted as members of ambulance trusts.
- Monitor was considering whether to continue with self certification by FTs in regards to Governance or to request a third party certify the FT's governance submissions.
- Monitor's review of the applications for FT included: assurance that the business plan was grounded in reality; that it reflected negotiations with local Commissioners and testing key assumptions such as forecasted income and activity.
- Monitor did not actively involve itself in the routine business of a FT unless there was a breach of the Trust's Authorisation. In such circumstances it was empowered to step in and remove the Board of Directors and/or Governors if need be. In the event that a dispute arose between a FT and its Commissioners Monitor would encourage dialogue and negotiation but would not seek to active involvement.
- Monitor has written to the Department of Health on 15th April raising the following concerns about ambulance trusts becoming FTs: the requirement to have a nurse/doctor on the Board of Directors; the implications of the Civil Contingency Act 2004 and the challenge of recruiting membership from a much greater catchment area. A response to the letter was awaited.
- Monitor anticipated receiving the first wave of applications from ambulance trusts in the autumn of 2009.

2. The experience of three Foundation Trusts: Oxleas; Guy's & St Thomas' and Kings College

The Chairmen of the following FTs, Oxleas Mental Health Foundation Trust; Guy's & St Thomas' NHS Foundation Trust and Kings College NSH Foundation Trust shared their Trust's experiences of recruiting Members and establishing a Board of Governors, or in the case of Guy's & St Thomas', Members' Council.

Oxleas: it had improved involvement in the Trust by users/carers and it was a genuine exercise of accountability.

Guy's & St Thomas': it had entailed additional work for the Chairman, which would need to be shared with the NEDs and Executive Directors. In recruiting members, consideration should be given as to why a member of the public would wish to be Member and what value does it add to the organisation. The Members' Council comprised Members from a variety of backgrounds; stakeholder representatives and staff representatives.

Kings: emphasis was placed on the opportunity to retain surpluses that can be reinvested in the services provided. The process of becoming a FT meant a greater degree of openness and transparency across the Trust, with an emphasis on performance management leading to improved services. The recruitment of Members and the activity of the Board of Governors had led to real engagement with the public which was reflected in an improvement in the services and the patient's experience. Members played an invaluable role in King's campaign regarding Denmark Hill BR Station.

It was Noted that:

- The size of three FT's Membership (excluding staff) was: Oxleas 1,334; Guys & St Thomas'7,000; King's 7,500. The size of the Board of Governors/Members' Council was: Oxleas 45; Guy's & St Thomas' 38; King's 38.
- Members received newsletters keeping them informed about the Trust, planned open days, health seminars, elections and meeting dates.
- The cost of maintaining the membership, which included holding elections and supporting the quarterly meetings of the Board of Governors/Members Council, was approximately £10,000 per annum.

3. Discussion Groups

Members of the Committee, attendants and the three Chairmen broke away to form three discussion groups and considered the following questions:

1. How can we create a membership?
2. What should be the role, size and makeup of the Members' Council/Board of Governors?
3. What should our business model look like?

4. Healthcare for London

David Sissling, Programme Director, Healthcare for London, joined the meeting to brief the Committee as to the progress of the implementation of Lord Ara Darzi's 'Framework for Action'. PCTs had undertaken consultation on the proposals contained in the Healthcare for London and a report containing recommendations will be formally presented to the Joint Committees of PCTs on June 12th 2008. The report, which is expected to be broadly in line with Lord Darzi's vision for an improved healthcare service in London, will be owned by the 31 London PCTs and will direct the local commissioning process, reflecting the different healthcare

needs of the PCTs' catchment areas. It was anticipated that commissioning work will take place both on an individual PCT basis or in clusters, with PCTs commissioning as a group or on a pan London basis as is appropriate.

In the interim, HfL was undertaking the following six programmes of work: Stroke, Trauma, Local Hospital Feasibility, Diabetes, Unscheduled Care and Polyclinics.

- HfL anticipated tangible results being achieved by March 2009 and improvements in service delivery in the following areas: stroke, trauma, polyclinics, new ways of delivering care and a review of unscheduled care.
- An evaluation framework was being drawn up which would support the commissioning process and will include the following five domains: access, clinical outcome, health and well being, use of resources and patient experience.

The following risks have been identified in achieving the desired integrated clinical healthcare in London:

- adequate information technology to support access to patient care records,
- a workforce with the appropriate skills and supportive of change,
- having the continued support of the mainstream political bodies,
- improving the capabilities of the commissioning service, to take forward the process and implement new model commissioning arrangements.

David Sissling said that Lord Darzi's appointment as Minister for Health is a strong indicator that there is the political will to the implementing of the Framework for Action.

During the ensuing discussion the following points were made:

- Although commissioning would remain with the individual 31 PCTs, NHS London will play an active role in overseeing the process. The Chief Executives of the PCTs have been actively involved in driving forward the consultation process and the various Programmes.
- The financial assumptions underlying Lord Darzi's 'Framework for Action' were being revised as specific proposals were being developed. Detailed financial analysis was being undertaken to identify any areas of concern in respect of the affordability of the various Programmes.
- Lord Darzi recognised the pivotal role the ambulance service has to play in implementing an integrated care delivery model and be an agent of change.
- The PCTs' commissioning function would undoubtedly need to change over the next few years and it was possible that it would divest itself of the provision of other services and focus solely on commissioning. It was recognised that Service Providers would need to have confidence in the Commissioning process to ensure they are willing to invest in developing new services to implement an integrated care model in London.
- There were a number of areas where technological development would be invaluable in delivering a more integrated service, e.g. electronic patient records to allow access to patient's records. Another developmental area will support patients remaining at home and not having to visit polyclinics or hospitals.
- There was an acceptance that further work was needed in respect of tariffs to ensure that there was no mismatch in the financial regime; that funding followed the patient and there were incentives in respect of good clinical outcomes that reflected the quality of care and the patient experience.
- As part of the LAS' application for FT status in 2009 a three year business plan will be submitted to Monitor. In preparing the business plan the Trust

will actively engage with its Commissioners concerning the developmental work and the transitional investment required to implement the wider HfL agenda.

- In terms of political support for HfL, the appointment of Lord Darzi as Minster for Health was a clear indication of the Government's commitment to the process. It was recognised that there may be opposition from individual Members of Parliament should proposed changes affect their local hospitals. It was suggested that one way of addressing this opposition would be to have alternative provision in place helping people to have confidence in the proposed new system; it was recognised this would have cost implications.

5. Implications of Healthcare for London for the LAS

Kathy Jones, the Director of Service Development, presented an update to the briefing regarding the implications of HfL previously given to the Trust Board in March 2008.

The following work was being undertaken in respect of the six HfL Programmes:

Unscheduled Care, early discussions were being held with NHS Direct on having technical links between the two organisations. A project to introduce a capacity managed system had been initiated.

Polyclinics: HfL has received applications from 29 PCTs to establish 50 polyclinics. The Medical Director said that the specification for polyclinics was quite exciting. It was anticipated that there would eventually be 150 polyclinics established. A pilot, involving 5-10 polyclinics, will enable facilitate variation in terms of location and organisational structure, and for the cost/benefit of the proposal to be fully evaluated. Following the conclusion of the pilots a tender exercise will be undertaken to appoint providers to manage the polyclinics. The Chairman said that the LAS had been approached by two/three large acute hospitals with a view to submitting joint bids to HfL to run polyclinics. `

Estates. HfL was undertaking a major exercise reviewing NHS estate in London, including consideration of the commercial options available.

Stroke. In January 2008 a pilot commenced in South West London in respect of stroke; an evaluation will be concluded in June 2008. The Director of Service Development said there was evidence from other countries to support the proposed changes to the treatment of patients who have suffered a stroke. The LAS' Stroke Care co-ordinator had been approached by North London and North Central London PCTs to set up pilots in their areas. HfL was undertaking work in respect of the tariff for the treatment of stroke.

Local Hospital Feasibility. Work was being undertaken to fully understand the ramifications for District General Hospitals if patients who may need surgery are taken to specialist hospitals.

Diabetes. The Director of Service Development said that a sizeable number of members of the public have undiagnosed diabetes and the Trust could, via a very simple test, routinely screen patients to identify diabetics and refer them to their GPs. There was also recognition that the Trust was often used by long term diabetics to manage their condition i.e. in cases of hypoglycaemia.

Trauma. The Medical Director said that the consensus following the recent Trauma Conference organised by HfL was that there would need to be more than the three trauma centres. It was proposed that there should be a major trauma centre within each network with a number of trauma centres, situated in general hospitals, to treat less serous trauma cases.

Workforce. The HR Director said the Trust had been represented on the NHS London's Strategic Steering Group for Workforce & Education; the Group was undertaking work in relation to the future educational requirement and the commissioning implications of the HfL proposal. NHS London will be launching its workforce strategy on 16th September 2008. The LAS' has shared the New Ways of Working: Clinical Leadership Model and the Service Improvement Programme with NHS London, which together with the HfL details, will inform a joint strategy with NHS London. Further events to develop the LAS/NHS London strategy were scheduled.

The funding received following the successful Education and Development bid will be used to:

- recruit and train additional Paramedics; Student Paramedics and Emergency Care Practitioners,
- provide additional clinical support,
- improve leadership development
- further enhance patient assessment and other training for Paramedics.

The Chief Executive said that in addition to the development work being undertaken by the LAS there was continued focus on getting the basics right. Within the next 24 months a new radio system will be introduced; 700 staff recruited and 100 new ambulances purchased. There would also be challenges concerning the introduction of Student Paramedics as well as the proposed new AfC banding of Paramedics.

The Chief Executive said that unscheduled care was very complicated and fragmented and it was possible that there was some duplication of effort in the system. The Chief Executive said a clinical leadership model for London was crucial and in that respect the LAS was undertaking a review of its clinical leadership structure.

In recognition of the above challenges, additional support was being recruited and developed so as to strengthen the capacity of the senior management team to deliver the Service Improvement Programme and to progress the Foundation Trust application.

6. The Chairman concluded the meeting by thanking the guest speakers for attending the meeting and sharing their experiences.

   The Chairman congratulated the Executive team on achieving 75% Call Connect Category A8 minute response target in April, which he said was a considerable achievement.

   The Chairman said he was pleased that LAS' potentially central role in implementing Lord Darzi's Framework for Action had been recognised.

Meeting finished at 4.00pm

Enclosure 18

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 20th May 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 5 tenders received since the last Trust Board meeting.

Provision and Maintenance of Stretch Trolleys
- VW Limited
- Stryker
- Ferno

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

Consultancy re. Benefits Realisation
- PriceWaterhouseCooper
- Sigma

Provision and Maintenace of defibillators
- Zoll
- Schiller (Amazon Medical)
- Physio Control
- Laerdal

CAD 2010 Procurement
- Integraph
- Northrop Grumman

3. Use of 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.

4. Recommendations

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

Christine McMahon
Trust Secretary