London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 30th March 2010
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

****

AGENDA

			Tab
1.	**Welcome and Apologies** To note the apologies from		
2.	**Minutes of the Part I meeting held on 26th January 2010** To approve the minutes of the meeting held on 26th January 2010		1 (A)
3.	**Matters Arising** **3.1 Actions from previous meetings**		2 (A)
4.	**Formal reports from sub-committees** **4.1 Audit Committee 8th March 2010**	CS	Oral
5.	**Chairman's Update**	RH	Oral
6.	**Report of Chief Executive Officer**	PB	3 (A)
7.	**Report of Finance Director**	MD	4 (A)
8.	**Clinical Quality and Patient Safety Report** Incorporating a report on progress with compliance against the core standard for medicine management	FM	5 (A/B)
	STRATEGIC AND BUSINESS PLANNING		
9.	**Annual Business Plan and Budget 2010/11** For approval	MD	6 (A)
10.	**Procurement Strategy** For approval	MD	7 (A)
	BUSINESS CASES FOR APPROVAL		
11.	**ECS Business Case (EPRF)**	PS	8 (A/B)
12.	**West London Workshop**	MD	9 (A/B)
13.	**West London HART**	MD	10 (A/B)
14.	**Vehicle Leasing**	MD	11 (A)

SERVICE IMPROVEMENT

15.	**CommandPoint Update**	PS	12 (A)
16.	**Rota Change Project Update**	RW	13 (A)

GOVERNANCE

17.	**Full update on core standards compliance 2009/10** ▪ **Mandatory training**	CH	14 (A)
18.	**Risk Management Structure including terms of reference for Quality Committee** For approval	SA	15 (A)
19.	**Interim Risk Management Policy and Strategy** For approval	SA	16 (A/B)
20.	**Board Assurance Framework and Risk Register** For approval	SA	17 (A/B)
21.	**Annual review of Standing Orders** For approval	SA	18 (A/B)
22.	**Expenses Policy** For approval	MD	19 (A)
23.	**Carbon Reduction Policy** For Approval	MD	20 (A)
24.	**Taking it On Trust** For noting	SA	21 (A/B)
25.	**Quality Account 2009/10** To note the development of the Quality Accounts 2009/10	KJ	Oral
26.	**Trust Secretary Report** To note the report from the Trust Secretary	SA	22 (A)
27.	**Forward planner** For noting	SA	23 (A)
28.	**Questions from Members of the Public**		
29.	**Any Other Business**		
30.	**Date of next meeting**		

The next meeting of the Trust Board of Directors will be held on Tuesday 25th May 2010

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 26th January 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

****

Present:

Richard Hunt	Chair
Peter Bradley	Chief Executive
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Beryl Magrath	Non-Executive Director
Caroline Silver	Non-Executive Director
Sarah Waller	Non-Executive Director (Vice Chair)

In Attendance:

Laila Abraham	Interim Head of Governance
Sandra Adams	Director of Corporate Services
Malcolm Alexander	Chair of Patients Forum
Gary Bassett	Head of Patient Experience
Francesca Guy	Committee Secretary (minutes)
Kathy Jones	Director of Service Development
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Richard Webber	Director of Operations
John Wilkins	LAS Foundation Trust Project Lead
Fenella Wrigley	Assistant Medical Director

****

1. Welcome and Apologies

The Chairman welcomed Fenella Wrigley and Francesca Guy to the meeting. Fenella was attending on behalf of Fionna Moore. Francesca had recently joined the Trust in the role of Committee Secretary.

It was noted that apologies had been received from Fionna Moore.

2. Minutes of the Part I meeting held on 24th November 2009

Subject to a few minor amendments, it was resolved that Part 1 of the minutes of the Trust Board meeting held on 24th November 2009 be approved as a true and accurate record of the meeting and that they be signed by the Chair.

3. Matters Arising

3.1 Silvertown Olympic Site
Mike Dinan reported that this was on track.

3.2 Audit Committee minutes and annual report
Sandra Adams reported that these minutes had now been confirmed and could be circulated to the Board.

Action: Sandra Adams

3.3 Service improvement programme
Kathy Jones reported that the remainder of the annual leave project had been re-scoped and was now amber. However, it was expected to be rated as green in the near future.

The project board for the Referral Pathways project would be meeting later this week.

3.4 CommandPoint progress report
This was covered in the Chief Executive Officer's report (agenda item 6).

4. Formal Reports from the sub-committees

4.1 Clinical Governance Committee
Beryl Magrath provided the Trust Board with a summary of the discussion points at the Clinical Governance Committee meeting on 25th January 2010. She raised the following points:

- The Clinical Telephone Advice (CTA) Service was using a taxi firm to transport patients who require medical attention at a minor injury unit or accident and emergency department but who had no financial means to make their own way. A query was raised about whether this should be funded by LAS or the PCTs;
- The Clinical Support Desk had experienced an increase in workload;
- CTA was dealing with a record number of safeguarding referrals;
- Communication between complexes was improving with the introduction of quarterly newsletters, an electronic rolling notice board and local accident hotspot briefings;
- Changes were being made to policies and procedures for the management of controlled drugs. In particular, this would lead to changes in the practicalities of carrying and disposing morphine. It was expected that the new procedures would be in place by 31st March 2010;
- Clinical Performance Indicator completion was averaging at 43 per cent. This remained a long way from the 95 per cent target;
- It was noted that attitude and behaviour continued to be the cause of the majority of complaints received by LAS. This was being addressed in the South Area by a piece of research which would analyse complaints of this nature against measures such as length of shift, staff group and length of service;
- It was noted that there were large discrepancies across London in the Infection Prevention and Control audit findings. The highest rating risk was associated with the use of linen. A one-to-one exchange pilot was being trialled at Chase Farm with a view to addressing this problem;
- The Committee reviewed the Care Quality Commission registration process. The Committee had recommended that LAS consider non-compliance in two areas (supporting workers and management of medicines) but support this with a detailed workplan on how the Trust would address these areas going forward to ensure compliance in the future;
- The Committee agreed the proposed risk management committee structure;
- The policies for the Statement of Duties to Patients, the Use of BASICS (London) Doctors and for Identifying and Acting Upon National Clinical Guidance were approved subject to minor amendments;
- The Committee received minutes of the groups reporting to the Clinical Governance Committee. The Committee noted that the LAS claims frequency based on the number of road traffic accidents was 143 per cent. This was much higher than other ambulance trusts.

In response, Peter Bradley stated that management of medicine had been discussed by both the Trust Board and the Senior Management Group and an action plan would be put in place to address this issue.

Caron Hitchen reported that systems had been put in place to support staff and the results of the most

recent staff survey showed improvements in this area. However it was not possible to use these results at the moment externally to support the CQC registration as they were subject to validation.

5. Chairman's update

The Chair reported the following:

- There had been a good response to the advertised vacancy for a Non-Executive Director and six candidates would be interviewed on 2nd February 2010. Candidates had expertise in the areas of general communications, commercial property and general legal as had been agreed by the Trust Board;
- There remained a vacancy for the Director of Health Promotion as the Trust had not been able to appoint during the last round of interviews;
- Operational performance over the Christmas and New Year period had been the highest on record. The Chair expressed his gratitude to staff for such good performance during a high-demand period;
- The Chair had been visiting the chairs of sector Primary Care Trusts to develop relationships with the sectors. He had also met with James Cleverly, the Chair of the GLA Health and Public Services Committee;
- The Chair and Peter Bradley had met with representatives from the Metropolitan Police and the Fire Brigade. Meetings between the three services would be held quarterly going forward;
- The director of the Ambulance Service Network had resigned and discussions were underway on how to fill this vacancy on an interim basis.

6. Chief Executive Officer's report

The Chief Executive Officer reported the following:

- All operational staff were undergoing specialist stroke and trauma training in preparation for April 2010;
- LAS was currently achieving 74.7 per cent against the CAT A target. It was expected that this would reach 75 per cent by the end of February 2010, although it would be a challenge to maintain this level of performance. The achievement of the CAT B target still remained a challenge, despite this being LAS' best-performing year to date;
- LAS received its 1 millionth call of the year on 31st December 2009. Peter expressed his gratitude to Richard Webber and the operational team for the level of performance achieved over this busy period;
- With regards to Human Resources, recruitment was on track to achieve targets; the sickness level was good and turnover was low;
- Peter drew attention to the balanced scorecard which was attached as an annex to his report. Peter stated that he would like to see this being used in the future to facilitate discussions and to highlight performance issues;
- ORH was undertaking a piece of work jointly commissioned by the LAS and NWLCP to ascertain why LAS performance was not has high as it might be;
- The priorities for SMG were to finalise the discussions on the penalty, the Foundation Trust Project Board, feedback to staff on the consultation meeting, the staff training and development plan and to finalise next year's objectives.

Beryl Magrath referred to the closure of Whipps Cross emergency department and asked whether this was indicative of a more general problem. Richard Webber responded that the hospital had experienced an outbreak of norovirus and had taken the decision to close the hospital to allow for a deep clean. However this was representative of a wider problem. Richard referred the Trust Board to graph 11 of the Information Pack for Trust Board which demonstrated that the average hospital turnaround time had improved.

The Chair summarised the discussion by stating that performance had improved, but that further improvements needed to be made. Performance remained at the top of the Trust's agenda.

7. Report of Director of Finance

7.1 To receive a report on financial performance for month 9 and the projected year end position
Mike Dinan made the following points:

- The result for the month was a deficit of £663k, however the year to date result showed a surplus of £336k;
- The full year result was forecast to be a surplus of £1.4 million. This was a reduction from the previous forecast surplus of £1.6 million which was due to additional expenditure brought on by winter pressures;
- CAD 2010 was likely to slip into next year from a cash perspective.

Mike Dinan reported that the key financial risk facing the organisation was the payment of the penalty for not achieving CAT A and CAT B targets. The payment of the penalty could only be achieved by reducing the surplus and cutting overtime.

Peter Bradley was currently in negotiations on the payment of the penalty and was seeking specialist legal advice on this matter. He should know the outcome of these discussions by the end of the week. The Board commented that the payment of the penalty should be disputed on the grounds that it would have a detrimental affect on performance. The Board supported arbitration as a last resort.

7.2 CIP development
Mike Dinan reported that the 2009/09 Cost Improvement Programme was on track to deliver.

7.3 Fleet Update and business cases for approval
Mike Dinan reported that UVM had been put into administration. He was in discussions with both the administrators and alternative suppliers to resolve to get to get the remaining 24 vehicles converted and delivered as soon as possible. A new contract for a further 65 ambulances would be awarded to a different supplier within the next couple of days.

8. Clinical Quality and Patient Safety Report

Fenella Wrigley reported the following:

- The Serious Untoward Incident policy had been updated with input from NHS London and would soon be ready for approval The revised policy emphasised analysis of SUIs with importance placed on learning from each incident;
- The Controlled Drugs policy had been updated which would lead to changes in the practicalities of carrying and disposing morphine. It was expected that the new procedures would be in place by 31st March 2010;
- Clinical Performance Indictor completion had shown an increase from 30 per cent to 43 per cent. However, more work needed to be done to reach the target of 95 per cent.

8.1 Safeguarding declaration
Gary Bassett clarified that currently safeguarding was focussed on children, however there was a move to put vulnerable adults on the same legal footing in the future. Gary added that local safeguarding boards were working with LAS on this issue, particularly as the number of referrals from LAS was increasing.

The Board noted the Safeguarding declaration.

8.2 Infection prevention and control
The Board noted progress against the action plan and requested a further update at the next meeting.

Action: Fionna Moore

8.3 Patient safety
This was covered in agenda item 9.

8.4 Medicines management/controlled drugs management
The Board noted progress against the action plan.

8.5 Patient experience report
With regards to attitude and behaviour complaints, Martin Flaherty was asked whether there were any plans to review how other organisations had addressed this issue eg South West Trains. There followed a discussion about handover of patients and whether this had a negative impact on patients' opinion of LAS. In particular, it should be made clear to callers when they are being transferred to NHS Direct. Martin Flaherty confirmed that there was no intention to withdraw the referral policy, but that LAS needed to look at ways in which to improve the system.

9. Care Quality Commission registration requirements

Sandra Adams introduced the item, explaining that the Health and Social Care Act 2008 required healthcare providers to register to provide a range of activities. Once legislation had been passed (thought to be in March 2010) all providers would have to be registered. She explained that there were different levels of registration and we would be seeking this 'without conditions'. Applications for registration had to be submitted to the CQC by Friday 29th January 2010.

We had undertaken a thorough process of reviewing evidence, primarily that collected for the core standards declaration, and assessing compliance levels. As reported earlier in the meeting, the Clinical Governance Committee had reviewed the evidence and had expressed concern about the levels of compliance for regulations 13 (management of medicines) and 23 (supporting workers). The Committee had had then recommended to the Trust Board that consideration should be given to a declaration of non-compliance in these two areas.

The Trust Board considered the evidence available and the areas of potential concern. It was agreed that the executive team would review the regulatory requirements again and consider the evidence available as well as the plans already in place, and would make a recommendation via email to the full Board. Board members would need to confirm their view by no later than early Friday morning. The Chair would then take a final view on the compliance submission.

The Trust Board noted that regulation 14 (meeting nutritional needs) had to be declared as non-compliant before we could then state that it was not applicable to an ambulance trust. This was on the advice of the CQC.

Action: Sandra Adam/Board members/Chair

[DN: On 29th January 2010, the Trust Board approved the submission of an application for registration to provide 'transport services, triage and medical advice provided remotely, with just one area of non-compliance: regulation 14].

10. Risk management arrangements

10.1 To receive an update on the development of the Strategic Risk Register and Assurance Framework
Sandra explained that the strategic risks would be confirmed at the session following today's Board

meeting. The assurance framework would be updated on completion of the strategic risk register.

10.2 To note the updated risk register
The Board noted the updated risk register.

10.3 To discuss and approve the revised committee structure
Sandra Adams explained that this proposal formed part of the Board effectiveness review which was discussed at the Board away day in October 2009. In the proposed structure, the Clinical Governance Committee would cease to exist and a Quality, Safety and Risk Committee would become the Board sub-committee alongside the Audit Committee and Senior Management Group, which would ensure the appropriate level of assurance to the Board. The role of the Audit Committee would be to focus on the effectiveness and appropriateness of the organisation's internal control system. The Quality, Safety and Risk Committee would focus on clinical, information and corporate governance and compliance matters and risk management.

A point was made about the need to clarify where there were reporting lines between committees and where committees exchanged a flow of information.

It was noted that the Public and Patient Involvement Committee and the Training Strategy Group had been omitted from this structure chart. Sandra Adams responded that the Public and Patient Involvement Committee would report to the Learning from Experience Group and the Training Strategy Group would report to the Risk, Compliance and Assurance Group.

Sandra explained that the next steps would be to draft the terms of reference and proposed composition and chairmanship.
CS expressed the need to see the membership for each board committee prior to final approval. The Board agreed that the new structure should be reviewed in 12 months' time after implementation.

Action: Sandra Adams to update the structure chart and clarify membership of committees.

11. Strategy and Planning

11.1 Strategic goals and objectives
Kathy Jones reported that this was work in progress and work was being undertaken to relate strategic goals and objectives to annual objectives.

11.2 Corporate Objectives
The Board noted the Corporate Objectives.

11.3 Draft business plan 2010/11 including the first cut submission to NHS London
The Chair commented that it would be useful to have a data sheet with information such as the number of calls received on average by front line staff.

Mike commented that the penalty payment should be clearer next year and it was important to get the resourcing level right in order to achieve the targets.

The Chair questioned whether it was possible to increase the scale of operations and maintain efficiency. LAS would need to re-evaluate how it delivered high-level services.

11.4 Estates strategy
Mike Dinan reported that he would provide more information to the Service Development Committee in February and then bring the strategy back to the March Trust Board for approval.

Action: Mike Dinan

12. Application process for becoming an NHS Foundation Trust

12.1 Membership strategy
Sandra Adams reported that she and Caron Hitchen had met with Eric Roberts to discuss the option of a staff-side partnership governor on the Council of Governors. Other Foundation Trusts had opted for this approach which had proved successful.

12.2 Integrated business plan
Work in developing the integrated business plan was ongoing.

12.3 Long term financial model
There were some issues around the long term financial model to be resolved. The first project board meeting had taken place yesterday.

13. Service improvement programme update

13.1 Progress report
Kathy Jones tabled the report and asked Board members to pass their comments to herself, Caron Hitchen or Martin Flaherty.

There followed a discussion about the level of information that the Board would receive in the future. The Board preferred having the full report separate from the Board papers, but asked that a one-page summary document be included in the Board pack.

13.2 Olympic and Paralympic games
This programme was on track and funding for 2009/10 and 2010/11 had been secured.

Clinical education – developing a new pathway
Caron Hitchen explained that work had progressed to identify potential approaches to clinical training, education and career progression in line with the move to a higher education model, which would include diploma-level training and an increasing number of degree-level routes. Peter Bradley was of the opinion that recognisable qualifications were crucial to the professionalisation of the workforce. The Human Resources team was currently working on how this would be delivered.

The Chair commented that it would be beneficial to receive an update on this twice a year.

14. Quarter 3 integrated governance and finance declaration

The Board noted the Quarter 3 integrated governance and finance declaration that had been submitted to NHS London.

15. ALE 2009/10

15.1 To receive and discuss 'Taking it on Trust'
Sandra Adams requested the Board to note the requirements within 'Taking it on Trust'. The executive team would complete the form for review and discussion at the Risk Compliance and Assurance Group, the Service Development Committee and Audit Committee meetings before final review by the Board on 30th March 2010.

15.2 To nominate Board responsibilities for Security Management: a) Executive Director (voting) and b) Non-Executive Director
The Board approved the nominations of Mike Dinan as Executive Director and Sarah Waller as Non-Executive Director with responsibilities for Security Management.

[DN: The executive lead has since been confirmed as Caron Hitchen.]

16. Report of the Trust Secretary

16.1 To note the use of the Trust Seal and tenders received
The Board noted the use of the Trust Seal and tenders received.

16.2 To note the Trust Board and Service Development Committee forward planner from January to December 2010
It was noted that external communications was not included in the forward planner. The Chair requested an external communications plan with key messages and lessons learnt from the holiday season, New Year's Eve and the recent bad weather.

Action: Angie Patton

17. Presentation on Out of Hospital Cardiac Survival Figures 2008/09

Lynne Watson gave a presentation on out of hospital cardiac survival figures for 2008/09. The data showed that survival rates had increased and this was largely due to crews receiving better training on cardiac care and crews arriving on the scene on average one minute earlier.

Martin Flaherty added that moving towards 2012, we would want to achieve the best cardiac arrest survival rate of any capital city.

18. Presentation to Joan Mager, CEO, Richmond and Twickenham Primary Care Trust

A presentation was made to Ms Mager on behalf of the Trust Board in recognition of her support to the LAS during the period when the PCT were lead commissioners for the service.

19. Questions from Members of the Public

There were no questions from the members of the public.

20. Any Other Business

There being no further questions from the members of the public and no further business, the Chairman thanked everybody for their attendance and declared the meeting closed at 1:15 pm.

21. Next meeting

The next Trust Board meeting would be held at 10:00 am on Tuesday 30th March in the Conference Room at LAS HQ.

……
Chairman

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 26 January 2010

MINUTE NO.	PART I MEETING	RESPONSIBILITY	DATE
8/09	**Infection prevention and control** To provide the Trust Board with an update on the infection prevention and control action plan	**Fionna Moore**	**30th March 2010**
9/09	**Care Quality Commission registration requirements** To review the regulatory requirements and consider the evidence available and make a recommendation to the Trust Board via email. Board members to confirm their view by Friday morning and the Chair to take a final view on the compliance submission.	**Sandra Adams/Board members/Chair**	**29th January 2010**
10/09	**Risk Management Committee Structure** To update the risk management committee structure chart following comments received by the Trust Board.	**Sandra Adams**	**8th February 2010 (RCAG Committee)**
11/09	**Estates Strategy** Estates Strategy for approval by Trust Board on 30th March 2010.	**Mike Dinan**	**30th March 2010**
16/09	**Trust Board and Service Development Committee forward planner** Add a) External communications plan with key messages b) Lessons learnt from the holiday season, New Year's Eve and the recent bad weather.	 **Angie Patton** **Richard Webber**	 **25th May 2010** **25th May 2010**

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 20 March 2010

Document Title	**Chief Executive's Report**
Report Author(s)	**Peter Bradley**
Lead Director	**Peter Bradley**
Contact Details	**CEO Office**
Aim	**To Update Trust Board**

Key Issues for the Board

This report details activities across the trust of interest to the Board.

- Commissioning negotiations for the 2010/11 contract have now been completed at a contract value of £251.5 million . Full details of the agreement have been circulated separately to the Board. Reaching agreement has required some very detailed and protracted negotiations and both the LAS teams and the lead Commissioners have worked hard to achieve an agreeable settlement against very tight time constraints.
- We will be ready to begin transporting patients with major trauma to designated Major Trauma centres as planned from April and continue to transport stroke patients to hyper acute stroke centres across London.
- The Board is asked to note that two of the three national targets Cat A8 and Cat A 19 will be achieved in full for the 2009/10 financial year and the service will also achieve its best ever performance on Cat B at 86.4%. Work is in hand to improve Category B performance throughout 2010/11 and we anticipate achieving and maintaining 95% by Sept 10.
- Demand on the Service continues to rise with a YTD increase in overall activity of circa 4% and an increase in incoming call demand of circa 6%.
- Hospital turnaround times continue to be a focus for improvement and work is ongoing with hospitals to reduce all delays. We have also worked closely with colleagues across the NHS in London to manage the consequence of delays and closures across the winter period and the pivotal role played by the trust has been recognised by both NHSL and PCTS across London..
- The LAS component of the hospital turnaround time is continuing to fall and is now at just over 19 minutes. Plans are in hand to drive this down to 15 minutes by end March 2011. Unfortunately the portion of the hospital turnaround time in the control of acute trusts has deteriorated across the winter. We are working with commissioners to secure improvements in the hospital component.
- The rollout of the Airwave radio system across front line services is now complete and the VHF radio system remains only as a fall back option.
- A review of operations within Urgent Care is underway to identify efficiencies leading to increased utilisation and productivity.
- More senior staff have now received Gold level incident command training thus enhancing resilience within the LAS
- A variety of PTS contracts are currently being tendered and LAS has varying levels of

confidence in successful outcomes.

- The numbers of staff in post continues to improve and we are now expecting only a small shortfall of around 15 wte against the funded establishment by end March 2010. many of these staff are still in training and will continue to be posted to operations across the summer.
- The YTD sickness level is within target at 4.54% across the trust which is below the target level of 5% and staff turnover is currently 4.99%
- MPET funding for 2009/10 has finally been agreed therefore removing a £1m risk for the trust.
- Staff survey results just published by the CQC show improvements across several indicators and detailed results will be reported to a future Board meeting along with a fully developed action plan to address areas of concern.
- Following the formal inspection visit undertaken by a team from the Health and Safety Executive between 2 and 5 March, the Trust has been issued with an Improvement Notice relating to manual handling training arrangements, and specifically to refresher training for staff. HSE has recognised and acknowledged that staff are trained initially, but requires assurance as to the formal delivery of a programme of refresher and update training. Work is now in hand to provide a comprehensive action plan to address the issues raised.
- The current anticipated time lines for achieving Foundation Trust status is detailed in the report with a view to achieving SHA approval to go forward by year end
- CQC registration confirmation is expected soon and will consider the LAS under three separate categories rather than one.

Mitigating Actions (Controls)

Recommendations to the Board

To note the report

Equality Impact Assessment

Has an EIA been carried out?

n/a

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate Objectives that the report links to

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 30 MARCH 2010
CHIEF EXECUTIVES REPORT

1. SERVICE DEVELOPMENT

Strategic Goals and annual objectives

Following the Service Development Committee, final revisions have been made to the strategic goals of the organisation and the 2010/11 objectives are being finalised. Following this, a short description of the goals and objectives will be prepared for communication to staff.

Commissioning

The negotiations for the 2010/11 contract for the A&E service have concluded. The maximum amount payable will be £251,448 million, of which c. £20 million is dependent on the achievement of a number of targets, measures and improvements. Details of the contract have been circulated to the Board.

Healthcare for London

Staff are now routinely taking stroke patients with onset of symptoms within the last two hours to hyper acute stroke units. There have been some teething problems in some of the units, but figures for February show that 65% of all stroke patients were taken to such units. Extension of the change to cover all stroke patients, regardless of the time of onset of symptoms, has been delayed until July, due to readiness of the units.

As of April, all major trauma patients will be taken to one of the three major trauma units that will be up and running. Training in the use of the trauma decision tree is taking place. The Clinical Coordination desk in the Emergency Operations Centre has been set up in shadow form and will provide extra support and advice to crews in making decisions about the appropriate destination of patients.

Service Improvement Programme

The service improvement programme (SIP) board report has been circulated alongside the main board papers. Key points to note are:

- Progress is steady, with most project milestones being delivered on time or within acceptable tolerances.
- Three projects are graded “red”: e-learning; real-time fleet management; and vehicle procurement. Corrective actions for these projects are outlined in the SIP Board report
- Progress is being made on identifying the benefits that are expected to come out of the business changes enabled by projects. Reporting to the Board on these will start in the next couple of months.

2. SERVICE DELIVERY

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for the year to date (2009/10), the complete validated performance for January and February and the un-validated performance for the first 16 days of March.

	CAT A8	**CAT A19**	**CAT B19**
Standard	**75%**	**95%**	**95%**
2009/10 YTD	75.2%	98.6%	86.4%
January 2010	80.0%	98.9%	90.5%
February 2010	79.0%	99.1%	87.7%
March 2010 (to 16th)*	77.6%	99.2%	86.6%

**** Estimated prior to data validation***

Demand on the LAS continues to rise with overall activity up. The incoming call demand is about 6% above the previous year and responses up about 3.9%. Activity rose by 1.6% in January and 5.4% in February, as compared to the previous year. Year to date there has been an increase in Category A8 activity of 2.7% and Category B activity of 3.1%. Resource utilisation fell to 67% in January and rose slightly to 69.1% in February (following a peak at 75% in December) which is closer to our ideal of 55%. Call answering performance has been at target levels with 95.3% answered within 5 seconds in January and 95.8% answered in 5 seconds in February.

We produced circa 264,000 Ambulance Hours resourcing for January and February this year which was circa 19,000 hrs more than for the same period last year. This is just under an 8% increase in Double Crewed Ambulance (DCA) staffing. The average of the eight weeks staffing was 30.6K DCA hrs per week with four of the weeks in excess of 31k hrs and one over 32k hrs which is in line with the ORH recommendations.

FRU hours produced for January and February decreased by circa 13% to 112,648hrs compared to 126,628hrs for the same period as last year. Both months showed an equal decrease of circa 6.5K hrs although the percentile loss in February was greater as we produce less hours historically as it is only a 28 day month. The FRU incentive ran for both months at a cost of circa £77K (670 shifts) for January and circa £60K (527 shifts) for February. Some of this shortfall is attributed to the shorter month but also the fact that we had less funding for overtime and therefore could offer less shifts. We also predominately aimed the February incentive towards the week-ends.

The fact that we delivered such good Category A performance for the 2 months despite the dip in FRU staffing is due to the fact that Ambulance Category A performance has improved quite dramatically this year as a result of a number of small changes implemented such as earlier dispatch on address only. This has

seen the Ambulance portion of Category A performance increase to 73.9% this January; an improvement of nearly 7% over last year.

Total available overtime was 48k hrs for January and 29k hrs for February. Pure overtime spend for this period compared to last year (without enhancements or bonuses) decreased by circa 37% to 74,188hrs compared to 117,111hrs the previous year. Decreasing levels of overtime have always been planned as a result of the additional numbers of staff recruited and posted to front-line duties in recent months but further cuts had to be made in February due to the payment of the Cat B penalty.

A new hours produced compliance tool is being introduced within the Trust which will examine weekly Ambulance hours produced, against ORH modelling. This will encourage a reporting mechanism if the hours produced go beyond +/- 5% of ORH recommended staffing levels. It will be a self populating program examining the Trust, Areas and Complexes. A similar program is being developed for FRU and UCS and will be available in the coming weeks. The intention is to combine all of these tools into one report and also to report monthly.

CTAK changes have been frozen to facilitate the change to Command Point on February 22nd 2011. This means that some technical improvements that could see performance improvements cannot be implemented, but this is unavoidable because of the need to stabilise the platform up to the change date. Other technical changes have been delivered and more are planned for the coming months. In particular the roll-out of Airwave Radio has been completed and the existing Coretex/ VHF radio system is no longer routinely monitored, although it remains available if needed.

Within EOC arrangements are in place to reconfigure the location and number of Airwave ICCS systems (Integrated Communication Control System which essentially are digital radio communication control screens). This will lead to .result in the number of resources being handled by any one operator reducing to below 30 and as such this will lead to improved activation coupled with improved communication between the Control Room and crews on the road. This process will be trialled initially in the West and at the moment this trial is anticipated to start in early April.

A programme of work is underway to improve both the patient care experience for patients treated by Urgent Care Crews and the efficiency and productivity of this group of staff. The review will be completed by the end of April 2010 and will examine several key areas including:

- the location and number of UCS suitable calls by hour of day, and by day of the week.
- The numbers of UCS staff available, their locations and roster patterns
- The staffing of the Urgent Operations Centre
- The productivity of CTA staff
- The numbers of calls being passed to NHSD and whether there is any room to expand these numbers.

The expected outcomes of this review will include a more resilient service in UOC, decreased job cycle time for UOC vehicles together with increased utilisation and more patients directed to appropriate care pathways.

The Emergency Preparedness Department assisted in the implementation of the service adverse weather plan in response to the snow in February. This involved

coordinating hotel rooms, 4x4 vehicle provision and strategic pick up points to bring staff into work. We were ably assisted in this by the flexible use of the PTS fleet. There was a service wide debrief surrounding these events on Wednesday 17th March and lessons identified will be circulated in the coming weeks.

During January we put in place plans to mitigate the public order issues of both the Prime Minister's Afghan conference and at the same time the appearance of Tony Blair giving evidence to the Iraq enquiry in Westminster.

Emergency Preparedness training continues and a further course to ensure we have up to date and experienced Gold level officers was run in February. This is an ongoing course and will add extra senior managers to the Trust Gold rota in the near future. In addition the department was heavily involved in a large number of exercises at a local, regional, national and international level as well as working closely with the Medical Directorate. Staff from the Emergency Preparedness Unit will also be taking part in a London wide debrief on the lessons identified in our response to pandemic influenza later this month.

One of the key objectives for LAS for 2009/10 was to reduce the total hospital turnaround time by 5mins across London. Currently the average total turnaround time in London is 32.9mins, a 2min reduction since April 09. However this hides a distinct variation in performance towards this target between the acute Trusts and LAS. During the week ending 21st February the average arrival to patient handover time across London had risen to 13.6 minutes, a 6% rise since April 09. The LAS component of this time (which is the patient handover to crew becoming available) has continued to fall throughout the year and now stands at 19.3 minutes which is a saving of some 3.5 minutes since April. We are committed to driving this down still further to 15 minutes by the end of 2010/11.

Handover delays exceeding an hour are declared as potential SUIs for the Trust who have been unable to receive the patient. Over 200 potential Serious Untoward Incidents (SUIs) have been declared across London since mid November 2010. Delays within emergency departments continue to remain unacceptably high across London and key performance indicators (KPIs) for acute Trusts are now being proposed for the new acute commissioning round to reduce handover delays in 2010/11.

Over the last few months we have continued to work closely with NHS London and the Sector Acute Commissioning Units to ensure the emergency care pathway has remained viable during a number of hospital closures and diverts. January and February 2010 proved very difficult months for emergency departments in London particularly with bed closures as a result of Noro-virus. During this time two large hospitals closed their emergency departments, Whipps Cross and the South London Healthcare Trust (PRU site), resulting in crews being redirected to the nearest available ED. Our staff, both in EOC and on the road, worked admirably to accommodate these changes and to ensure the additional demands were spread as evenly as possible across the neighbouring sites.. The Las has received a great deal of praise from NHSL/Acute Trusts and PCTs for the pivotal role it has played in coordinating and responding to the difficulties we have all faced this winter.

We will end the 2009/10 year achieving two of the three key national performance targets with Cat A8 at 75.4% , Cat A 19 at 98.7%. category B performance will be at 86.4 which whilst less than we would have wished still represents the best Category B performance the Trust has ever achieved. The key focus for the coming months is to prepare for and deliver a strong start in April 2010, to mitigate any fall off of performance associated with the implementation of Command Point

later in the year.A range of strategies have been put in place to support the delivery of an improved Cat B position without threatening the success of Cat A. This will include 30% of total volume of all solo responders workload moving to Category B from April and to increase the utilisation of the urgent care fleet to 70% by September. Further work will be undertaken to both develop the Cat B trial and to implement lessons learned from the demand reduction group. AS mentioned previously work will also continue to reduce the hospital handover to available time yet further to a maximum of 15 minutes by March 2011 and thus support decreased utilisation levels and increase rest break allocation.

Delivery the Cat B target will require significant changes on behalf of the LAS and also on behalf of the wider heath community in London to drive down hospital delays and increase the numbers of alternative care pathways available to LAS staff . We will continue to work closely with commissioners on these and a range of demand reduction initiatives throughout the coming financial year. We anticipate continued improvements in Cat B performance throughout the year but it must be accepted that target performance of 95% will not be reached until September 2010. Trajectories for both Cat A and Cat B have been shared with NHSL and Commissioners..

2.1 PATIENT TRANSPORT SERVICE

Commercial

- South London Healthcare NHS Trust ((SLHT) existing business): All bidders, including the LAS, were asked to review their tender bids, as none were fully compliant with the tender specification.

  We made minor changes around the delivery of High Dependency patients and a revised submission was made in February. Consequently, the LAS has been invited to interview on Friday 26th March 2010.

  SLHT are interviewing all bidders on the 25th and 26th of March and we expect to be informed of a result during April 2010. The LAS currently provides PTS to all 3 main locations of this Trust and this will potentially affect 75 staff should we fail to secure this contract.

- London Procurement Programme (LPP): Bids were submitted for 7 new and 1 existing (Hillingdon PCT) contract in mid-January. The LPP has also asked all bidders to review their submissions again and has requested revised bids to be posted by 19th March 2010. Our revisions again centre around pricing of High Dependency work within each specification.

- Imperial College Healthcare NHS Trust: Imperial are approaching their tender process from a new direction. They have built in a 3 phase dialogue process, which will systematically test the claims made in each suppliers tender submission. The emphasis on this tender is aimed at procuring a high quality patient care service, with price only carrying a marginal weighting in the scoring process.

  The LAS has passed the first preliminary questionnaire stage, and have been invited to submit a tender detailing operational deployment model and general costings by 23rd March 2010. We have also been invited to present this to their tender team on 6th April 2010. If successful we will be invited to the 3rd phase testing process where their team will evaluate our service delivery on existing contracts; including visits to our Operations Centres and other customer sites.

This contract is currently undertaken by Medical Services and DHL.

- Wandsworth, Sutton & Merton PCTs: The LAS currently provides some of the services for these PCTs under two separate contracts. Additional work is also carried out under contract by OSL and M&L Ambulance Services. The PCTs have decided to amalgamate all of these disparate contracts, into one with a single supplier.

  We have been given notice on our existing contracts and this will affect 11 staff in the Richmond and New Malden area.

  We have requested that we be included in the list of suppliers considered for the provision of services under the new contract and are waiting for the Preliminary Qualifying Questionnaire to be issued on 22 March 2010. Timescales for this tender are tight; with the new provider expected to be in place by 1st July 2010.

Operations

- Consultative Framework: New consultative arrangements have been agreed with the Trades Unions at the last staff council meeting on 9th March 2010. Consequently, a urgent set of meetings will be convened to look at a revision of the current rota system, which does not adequately cover all service requirements.

- PDA deployment: All staff will finally be trained on the use of PDAs by the end of March 2010.

- Digital radios: Training on digital radios has commenced. However this has been complicated for PTS, as we have had to agree new call signs for PTS crews with Control Services. PTS crews are having to be trained on radio protocol as well as the technical use of the equipment, given that many staff have never used radios previously.

  Revised training has been given to Work Based Trainers (WBTs) on 17th March 2010 and training packs are being issued to all crews from 18th March 2010. WBTs will review training already received by staff within the Transport Operations Centres before end of March with all other crews being signed off by mid-May 2010.

- Chief Executive consultation meetings : An action plan arising from these meetings was issued on 18th February by way of PTS bulletin. Work on the issues raised is being undertaken. Feedback will be given via station meeting with local managers and a revised plan is due for issue in mid-May 2010.

Performance

Activity during December and January has been depressed mainly due to the Christmas period, snow and the Noro Virus, which resulted in appointments being cancelled and wards closed at some of our hospital sites. February's activity has bounced back, although is still 2000 journeys less than predicted.

Performance against the three main quality standards are shown below:

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

Arrival time has picked up by 3% in February with the factors stated above all affecting performance. Departure time and Time on Vehicle have all remained constant during this period.

3. HUMAN RESOURCES

Workforce Plan implementation

The report for A&E staff in post against funded establishment (now increased to 3353 by 42 wte for the new HART) shows a vacancy level of 63 at the end of February 2010. With all remaining training places fully allocated, 60 staff are due to commence in March. Dependant on turnover in March this will leave a shortfall of up to 15 wte on the increased establishment (0.45%)

From 1 April 2009 to 28 February 2010, 502 staff have successfully completed their initial training and transferred to operations. In addition 50 graduate Paramedics have commenced employment during the financial year, providing a total of 552 additional operational staff (418 net after accounting for turnover).

Recruitment to the Emergency Operations Centre has now delivered against the increased establishment for 2009/10 in preparation for the implementation of CommandPoint.

All ad hoc recruitment has continued as required.

Workforce information

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

Following a slight decease in December, the Trust sickness level for January has increased to 5.21%. The report also shows the year to date figure which remains within target at 4.54% (target is below 5% for the year as a whole). Sickness absence management activity, as evidenced by monthly audits, remains high.

Staff turnover remains on a downward trend, having fallen slightly again in December to 4.95% and currently standing at 4.99%.

Development of the MPET funding SLA

The Trust's position remains unchanged since the last report to the Trust Board. We are still awaiting completion of the formal contract for MPET funding for the recruitment and training of 377 Student Paramedics and 121 A&E Support staff. We have however received verbal confirmation that full funding against actual activity will be received from the SHA thus removing the £1m risk against this training activity. This will be confirmed in writing.

Partnership working, staff engagement and joint consultative arrangements

The Care Quality Commission published the annual NHS Staff Survey results in mid-March. Analysis of the reports is underway, but initial indications are that the Trust has seen an improvement in its scores across several indicators (not taking into account comparative scores against other ambulance or other Trusts). The key results will be reported to a future meeting of the Board, along with confirmation of next steps and the production of an action plan in response to the survey findings. To this end, the Staff

Survey Steering Group will recommence its schedule of meetings, these having previously been put "on hold" from close of field work pending release of results.

Draft staff engagement and staff well-being strategies are being prepared. The work of the Trust in terms of staff partnership and staff involvement was again acknowledged in a presentation by the Director of the Involvement and Participation Association at a national Social Partnership Forum event in early March. The new Health and Safety Partnership agreement and Health and Safety Policy, including joint consultative arrangements, were agreed in principle at the Staff Council on 9 March.

Health and Safety

Following the formal inspection visit undertaken by a team from the Health and Safety Executive between 2 and 5 March, the Trust has been issued with an Improvement Notice relating to manual handling training arrangements, and specifically to refresher training for staff. HSE has recognised and acknowledged that staff are trained initially, but requires assurance as to the formal delivery of a programme of refresher and update training. Compliance must be demonstrated by 18 June 2010. A team comprising management representatives from Operations, Health and Safety, Human Resources and Education and Development will co-ordinate the Trusts planning and response. The Trust's clinical training plan for the period to March 2011 has already made provision for manual handling training, but this will be reviewed and re-visited. There will also be a separate report on the observations of the Inspectors in general, with recommendations for consideration by Trust management expected.

Reported levels of adverse incidents for the calendar year to date against the key categories of clinical incidents, manual handling incidents, and physical and non-physical assault are included in the table below.

2009	Lifting Handling Carrying	Clinical Incident	Non Physical Abuse	Physical Violence	Total
Jan	46	74	67	34	221
Feb	44	48	84	23	199
Mar	40	59	86	30	215
Apr	49	81	101	22	253
May	65	100	89	25	279
Jun	35	95	68	31	229
Jul	31	92	102	29	254
Aug	33	70	73	41	217
Sep	44	81	56	20	201
Oct	50	95	85	29	259
Nov	59	126	84	24	293
Dec	57	105	77	29	268
Totals:	553	1026	972	337	2888

The Health and Safety team continues to work with local managers to encourage timely reporting of all incidents. Summary reports detailing the interval between date of incident and receipt of incident report by the Health and Safety team are provided to Assistant Directors of Operations. Where late reports are received, these are included in the above updated totals. There is a continued downward trend in reporting, most noticeably on physical violence (337 in 2009 from 542 in 2008, and649 in 2007).

The first meeting of the Project team undertaking the Trust-wide review of all incident reporting arrangements has been held to scope this piece or work. It is anticipated, due

to the scale of the exercise, that this will take 6-12 months to complete. Formal links have been established with the Medicines and Healthcare products Regulatory Agency (MHRA) with a view to working together as a pilot site for Ambulance Trusts on reporting arrangements and requirements for appropriate incidents (primarily equipment or drug-related).

Appeals against dismissal and Employment Tribunals

Since the last Trust Board meeting, 3 appeals against dismissal have been heard within the following timescales:

Case No.	Date of appeal letter	Hearing date	Further comments
1	31/12/09	09/02/10	
2	07/12/09	19/02/10	
3	16/01/10	08/03/10	

Since the last Trust Board five Employment Tribunal cases have been resolved.

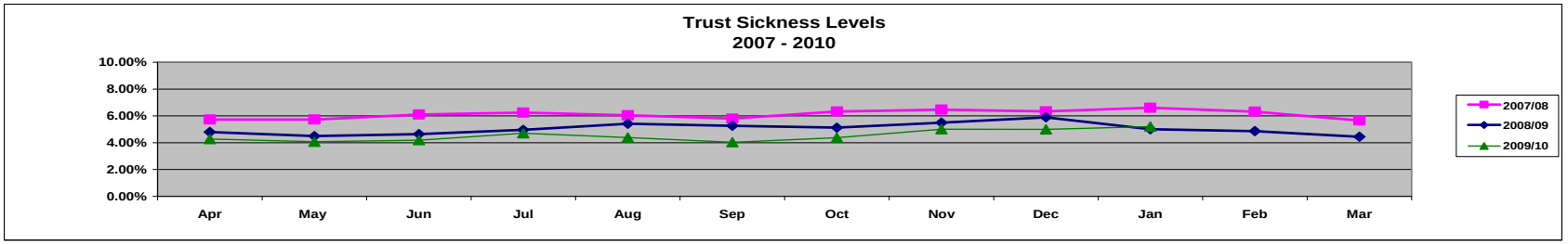
One joint claim (two male claimants) for sex discrimination and one single claim for unfair dismissal were withdrawn by the claimants; one joint claim (two claimants) for unfair dismissal and one single claim for unfair dismissal were dismissed following full hearings; and one single claim for unfair dismissal was struck out by the Tribunal.

Sickness absence

It should be noted that for complete accuracy, there has been some revision to some of the figures for sickness absence for this year. Comparison with the previous report has shown that the greatest change is .05% (June). Payroll staff are not always provided with the full data by the month end input deadlines. In future the previous month's figures will be reviewed and if necessary amended the following month.

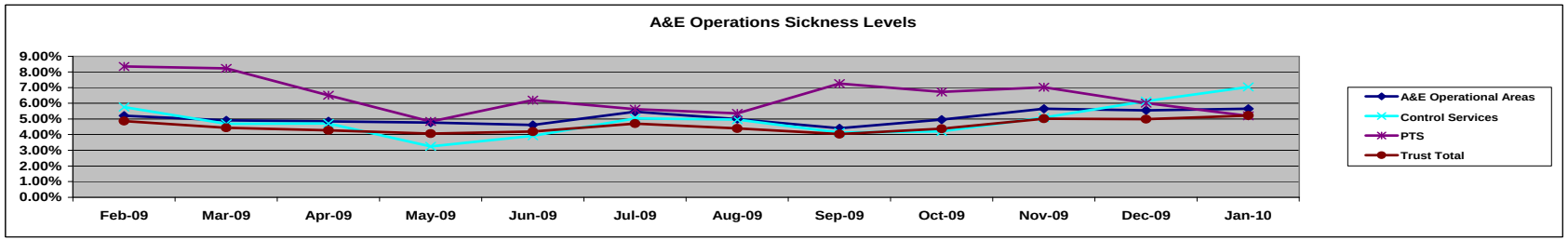
Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%
2009/10	4.27%	4.07%	4.19%	4.70%	4.39%	4.03%	4.38%	5.01%	4.99%	5.21%		



A&E Ops Sickness Levels

	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Calendar YTD	Financial YTD
A&E Operational Areas	5.21%	4.91%	4.84%	4.76%	4.61%	5.46%	4.98%	4.41%	4.96%	5.65%	5.55%	5.65%	5.09%	5.10%
Control Services	5.76%	4.70%	4.71%	3.25%	3.92%	5.03%	4.95%	4.14%	4.20%	5.09%	6.14%	7.04%	4.92%	4.87%
PTS	8.35%	8.23%	6.51%	4.84%	6.20%	5.62%	5.36%	7.25%	6.72%	7.03%	6.01%	5.19%	6.41%	6.07%
Trust Total	**4.87%**	**4.44%**	**4.27%**	**4.07%**	**4.19%**	**4.70%**	**4.39%**	**4.03%**	**4.38%**	**5.01%**	**4.99%**	**5.21%**	**4.55%**	**4.54%**



Staff Turnover

Staff Groups	Apr-08/Mar-09	May-08/Apr-09	Jun-08/May-09	Jul-08/Jun-09	Aug-08/Jul-09	Sep-08/Aug-09	Oct-08/Sep-09	Nov-08/Oct-09	Dec-08/Nov-09	Jan-09/Dec-09	Feb-09/Jan-10	Mar-09/Feb-10
A & C	14.06%	12.62%	12.30%	11.56%	10.03%	10.91%	9.94%	9.55%	8.70%	8.62%	9.36%	9.38%
A & E	5.10%	4.99%	4.86%	4.50%	4.34%	4.59%	4.49%	4.36%	4.28%	4.29%	4.22%	4.29%
CTA	7.69%	2.50%	2.56%	2.44%	4.88%	2.38%	4.26%	4.35%	3.92%	4.35%	3.77%	4.00%
EOC Watch Staff	10.76%	9.97%	10.00%	9.55%	10.54%	10.10%	9.30%	8.87%	8.91%	8.78%	8.70%	8.54%
Fleet	13.21%	10.53%	8.62%	8.47%	8.47%	8.62%	8.62%	3.45%	1.79%	1.72%	1.79%	5.56%
PTS	10.92%	9.27%	9.39%	9.05%	8.64%	8.68%	7.50%	6.25%	6.84%	6.47%	5.65%	6.14%
Resource Staff	4.26%	4.17%	4.17%	4.17%	4.17%	4.17%	8.33%	8.51%	7.84%	8.51%	8.00%	6.12%
SMP	6.94%	5.84%	5.47%	5.24%	5.43%	5.05%	5.15%	4.92%	4.42%	4.26%	3.37%	3.16%
Trust Total	**6.82%**	**6.32%**	**6.14%**	**5.77%**	**5.64%**	**5.78%**	**5.58%**	**5.28%**	**5.12%**	**5.09%**	**4.95%**	**4.99%**

A&E Establishment as at February 2010

Position Titles	Staff in post(Fte)	Funded Est.	Variance		Leavers
Team Leader Paramedic	159.20	194.00	34.80		1.00
ECP	66.40	74.00	7.60		0.00
Paramedic	912.78	1047.00	134.22		2.00
EMT 2-4	1139.72	956.00	-183.72		6.11
Student Paramedic 1	263.00	404.00	-229.00		3.00
Student Paramedic 2	370.00				1.00
Student Paramedic 3	33.00	300.00	267.00		0.00
EMT 1	20.64	328.00	19.30		0.00
A&E Support	288.06				1.00
EMD1	117.05	54.00	-63.05		1.00
EMD2	105.67	90.55	-15.12		0.00
EMD3	78.77	100.76	21.99		1.00
EMD Allocator	62.45	78.00	15.55		0.00
CTA	37.09	50.00	12.91		0.00
Total	**3653.83**	**3676.31**	**22.48**		**16.11**

4. COMMUNICATIONS

Issues management

Managing demand: Communication activity has continued to promote the national 'choose well' messages.

During the week commencing 1 February, BBC London TV ran a series of reports about healthcare in the capital. One report focused on how and when to use the ambulance service and featured the increased use of clinical telephone advice.

'Choose well' adverts continue to be applied to new ambulances, although this has been delayed since UVM, the provider of our vehicles, went into administration. Eight emergency ambulances now have the branding and the plan is to apply adverts to 65 new vehicles to be delivered during 2010/11.

Health promotion

Stroke awareness day – 17 April: A number of 'Know Your Blood Pressure' events will be held across the capital on Saturday 17 April to raise awareness among Londoners of stroke. Staff will offer blood pressure tests, pulse checks, and provide information about how to recognise a stroke at the events being organised at venues such as supermarkets and shopping centres.

Stakeholder engagement

Stakeholder perceptions audit: Ipsos MORI has been commissioned to carry out a stakeholder perceptions audit on behalf of the Service. Interviews with up to 100 key stakeholders will take place during May, and the findings of the research will be presented in early summer.

Ambulance News: The spring edition of the Service's community newspaper has been published and issued to members, GP surgeries and key stakeholders.

Staff recognition

LAS Awards: This year's awards evening will be held on 10 June at the Grand Connaught Rooms in Covent Garden. The awards were launched at the end of February, with a postcard attached to all payslips detailing the seven awards categories. The number of nominations received to date has already exceeded the total for the last awards.

Long service, retirements and Chief Ambulance Officer commendation: In a ceremony in Westminster, 24 members of staff marked 20 years' service, 14 retirees were recognised and Tower Hamlets DSO Martyn Tillett received a Chief Ambulance Officer's Commendation. Staff from Croydon, New Malden, Deptford, Lee and St Paul's Cray appeared in local newspapers for their long service/retirement.

Filming

City and Hackney ambulance crew Scott McIlwaine and Ben Lees starred in an ITV television documentary broadcast on 23 February. 'Seven Days in Traffic' looked at people's experiences of driving in London over one week last summer. Scott and Ben were joined by a film crew for two shifts last September and the one-hour show also featured trainee bus drivers, a celebrity photographer and London's traffic control centre.

Media

Meeting with the Evening Standard Health Editor: Chief Executive Peter Bradley gave an on-the-record briefing on current issues to Sophie Goodchild in March. Topics discussed included performance, measures being taken to manage demand, developments with stroke and trauma in the capital, and hospital reconfiguration.

Death in custody inquest: During January and February, the Service was involved in the inquest into the death of 32-year-old Paul Coker, who died in police custody in August 2005. The inquest found that Mr Coker's cause of death was cocaine intoxication with a variant of acute behavioural disorder. The Service was not criticised in the verdict, and has not been approached by the media. The assistant deputy coroner said that she would be writing to the Service with recommendations.

Ambulance fire: The Surrey Comet newspaper carried an article in February about an ambulance that caught fire at St Helier Hospital in September 2009. The piece was written following criticisms from local politicians who are unhappy that the Service's investigation into the fire hasn't been made public. A statement was provided to the paper stating that the investigation would be made public after it has been through the correct reporting channels.

Book by member of staff: A book by Emergency Medical Dispatcher Suzi Brent, based on her 'Nee Naw' blog, has been published by Penguin. The book, which is not authorised or endorsed by the Service, received media coverage on BBC Radio 4, and in the Daily Express, The Times, The Sun, and in Best magazine.

Other stories of note: Local press covered a 12-week sentence in a young offenders institute given to a man who assaulted a Fulham emergency medical technician.

Two stories about children who called 999 after relatives became unwell were also featured in local newspapers. Both youngsters had been invited to visit the control room and meet the staff who had taken their calls.

A staff reunion with a young man whose life was saved after he suffered a cardiac arrest while drumming at his home was reported in the Evening Standard. The same paper also followed up on a story about a delay to a patient who had fallen over on ice in Kingston in December, which was previously reported at the last Trust Board. In its response, the Service again emphasised that the incident happened at a time of very high demand and that the patient had not been in a life-threatening condition.

PPI activity report

Public education:

- A new public education resource library has been developed, and is available on the pulse. It includes information about regular public education activities (e.g. Junior Citizens' Schemes and the Tower Hamlets project), as well as links to relevant policies, lesson plans and the PPI and public education events database. There is also information about the materials available to support staff taking part in public education activities, and about the public education staff development programme. Finally, there is a "frequently asked questions" section and a list of useful contacts.

- All London boroughs are undertaking activities to reduce knife and gun crime, and the LAS is involved in a number of these initiatives. We plan to hold an event for people working on these events across London to come together and share information and

ideas.

- The Events & Schools Team is being re-named the Public Education Team, with Public Education Officers based in different parts of London. The post for West sector (based at Kenton) is currently going through the recruitment process. If funding is obtained for a third post, it will be based in the South sector, and will support public education activities there.

Category C Service User Survey:

- A group was established to look in detail at the findings of the Category C Service User Survey and draw up an action plan. Proposals are being presented to Commissioners at the end of March and to SMG in mid-April. It is expected that many activities and actions arising from the survey's findings will be incorporated into the Service Improvement Programme.

Local Involvement Networks:

- Through the Stakeholder Engagement and Communication project within the Olympics programme, meetings are being planned over the summer with the Local Involvement Networks (LINks) in the five Olympic boroughs. The first will be in June, at the Executive Committee of the Greenwich LINk.

Prince's Trust:

- An event is being planned for LAS staff who have been seconded to the Prince's Trust. At this meeting they will be able to discuss their experiences, and we can consider how best to use their new knowledge and experience within the Trust. For example, they may be the ideal group of staff to get involved with knife crime events and other activities involving teenagers and young people.

5. NHS FOUNDATION TRUST DEVELOPMENT - progress report

The project board has been reconvened with new membership and now includes Mark Brice from NHS London, and Neil Kennett-Brown from the North West London commissioning partnership. A standing invitation to attend has also been made to staff side. To date the project board has reviewed the progress made with governance and membership, workforce development, consultation and engagement, and commissioner engagement. The key risks have been discussed and the FT risk register updated. The main area for development now is the revision of the Integrated Business Plan (IBP) 2010-2015. The draft document has been fully reviewed and needs to be substantially updated and this is being informed by the recent work on the strategic goals and risks, and corporate objectives. Key areas of analysis (SWOT/PEST) should be finalised by the end of March 2010 which will then be incorporated into the IBP. The SMG have also identified 5-6 key business cases that will significantly impact upon the business in the next 5 years and these are being worked up ready for the IBP.

In terms of the timescale for our application, we are probably two months behind schedule due to the amount of work required on the IBP. If we were to submit the IBP at the end of June we would then commence the historical due diligence stages which take approximately 3 months. If this goes to plan we could be at Board to Board stage in the Autumn with a view to SHA approval at the end of the year. This includes the additional month at the SHA stage for the SHA Directors' Quality meeting. Secretary of State review then takes 6 weeks before we are passed to Monitor for the final stages.

6. CQC REGISTRATION

The Trust is awaiting confirmation of the level of registration and this should be available by the time of the Trust Board meeting. We initially applied for registration for one set of activities: 'Transport services, triage and medical advice provided remotely'. We had reviewed other activity areas and had canvassed other ambulance trusts and the CQC assessors and had been advised that this was the only activity to register for. Subsequent to application, the CQC have reviewed the activity areas for ambulance trusts and have advised that we apply for registration for 'Diagnostic and Screening procedures', and 'Treatment of disease, disorder or injury'. The SMG reviewed and agreed to these additional activities and we have submitted application forms to the CQC for these to be added to the registration. We are satisfied that we have the evidence available to support these.'

Peter Bradley CBE
Chief Executive Officer

22 March 2010

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

PI	PI Actual		Accountability	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual
Measures	R	V	Owner	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	Comments
A. OUTCOMES (What we want to achieve)																												
A01. Cardiac survival rates																												
A1.1 Percentage of patients with presumed cardiac aetiology who have a return of spontaneous circulation (ROSC) sustained to hospital	G	G	Gurkamal Virdi	13.5		13.5	20	13.5	22.2	13.5	22.2	13.5	26.8	13.5	25.1	13.5		13.5	23	13.5	21	13.5	21	13.5		13.5		GV 2010-03-05 The rate of ROSC sustained to hospital for cardiac arrest of cardiac aetiology remains consistent with previous months and exceeds the current milestone target. Please note, the data presented is the latest available; there is a month's lag between the cardiac arrest incident and the processing of the Patient Report Form, from its scanning at Management Information to the data then being audited by the Clinical Audit and Research Unit.
A02. Stroke																												
A2.1 To be determined post April 2010	?	?	Gurkamal Virdi																									-
A03. Trauma																												
A3.1 To be determined post April 2010	?	?	Gurkamal Virdi																									-
A04. Non conveyance																												
A4.1 A&E non conveyance	R	R	Sue Watkins	31200	20373	31200	22163	31200	22356	31200	26929	31200	22514	31200	20992	31200	22977	31200	22350	31200	23461	31200	20801	31200	20930	31200		SW 2010-03-18: The numbers shown for Feb are lower compared to previous months due to the fact there were 28 days. In addition, there were 10 new trainees for CTA during Feb. 8 CTA staff were used for training and mentoring for a minumum of 4 days each. When training takes place, the CTA capacity reduces as call cycle time increases, reducing the numbers of potential 'non conveyed'.Reduced number of calls passed to NHSD for the same reasons, reducing the number of potential 'non conveyed'.
A4.2 % total demand non conveyed	?	?	Sue Watkins		32		34		33		41		37		32		32		31		32		29		31			NB Caveat: Figures relating to vehicles responses (incidents) are subject to change. Late inclusions of PRF's can result in figures rising or falling. Changes should not be significant with exception to the current month for which data validation is not yet complete.
A4.3 Number of suitable completed patient episodes managed through Clinical Telephone Advice	R	R	Sue Watkins	5000	5356	5000	6252	5000	5721	5000	9290	5000	7181	5000	5063	5000	4960	5000	5035	5000	5445	5000	4585	5000	3413	5000		SW 2010-03-18: the numbers shown for Feb are lower compared to previous months due to the fact there were 28 days In addition, there were 10 new trainees for CTA during Feb. 8 CTA staff were used for training and mentoring for a minumum of 4 days each. When training takes place, the CTA capacity reduces as call cycle time increases. the total calls reflected here are episodes managed through PSIAM and not the total calls resolved by CTA (CTt codes - where a reviewer has resolved the call outside of PSIAM)
B. CUSTOMERS / STAKEHOLDERS (What we need to do for our customers)																												
B01. National response targets																												
B1.1 % Category A calls within 8 minutes	G	G	Jason Killens	76	75	74	73	71	71	72	72	74	75	78	77	79	75	76.5	72	75.5	71	75.5	80	76	79	77		JK 030310 CAT A performance continues to be above target
B1.2 % Category A calls within 19 minutes	?	G	Jason Killens	95	98	95	98	95	97	95	98	95	98	95	98	95	98	95	98	95	97	95	98	95	99	95		Cat A performance continues to be above target
B1.3 % Category B calls within 19 minutes	R	R	Jason Killens	87	86	86	85	83	82	86	81	87	86	93	88	95	89	91.5	89	94	82	95	90	95	88	95		In month performance has improved, however we recognise we are still short of the national target as a result of financial constraints production of assets has focused on CAT A responses.

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

B02. Infection control																										
B2.1 Compliance on Infection Control Audit	A	R	Trevor Hubbard												85		85		85		85	72	85	78.8	85		TH 2010/03/09: Q4 audits much better for this quarter. Average score of 78.8% with 14 achieving compliance, 7 partial compliance and 8 non compliant
B03. Call answering																										
B3.1 % Calls answered in 5 seconds	G	G	Phil Flower	95	95	95	94	95	92	95	91	95	94	95	95	95	94	95	95	95	90	95	94	95	95.8	95		
B04. Financial balance																										
B4.1 Cumulative Net surplus	G	R	Asif Islam	-286	-286	-235	-235	208	208	-249	-249	-482	-482	-628	-425	-229		-71		448	336	-328	749	-313		517		AI 2010-03-05 - M10 position better than plan due to recohnition of year to date HART income
B4.2 EBITDA margin %	G	R	Asif Islam	5.5	5	9.1	9	5.3	5	5.1	5	8	8	8.5	7	7.2		6.6		5.5	6	8	8.4	8		4.5		AI 2010-03-05 - Month position improved as a result of HART income recognition.
C. INTERNAL PROCESSES (What we need to do well to reach our goals)																										
C01. CPI																										
C1.1 CPI completed as % of plan	R	R	Jason Killens	95	40	95	46	95	35	95	29	95	35	95	43	95	46	95	43	95	46	95	47	95		95		Janaury CPI Report - LAS achieved 47%, up one perfect from December.
C1.2 Compliance with guidelines as a % of all	G	G	Jason Killens	95	93	95	93	95	93	95	93	95	93	95	95	95	95	95	95	95	95	95	95	95		95		Overall LAS compliance remained at 95% in January.
C02. Patient reporting																										
C2.1 %PRFs received within 7 days	G	G	Jason Killens	95	95	95	96	95	94	95	98	95	97	95	95	95	95	95	97	95	95	95	96	95	99	95		SH 030310 - No concerns. Continue to achieve target
C03. Health & Safety																										
C3.1 Number of H&S incidents	G	G	John Selby	266	249	275	267	266	211	275	214	275	192	266	170	275	249	266	201	275		275	155	248		275		AK 09-03-2010: A system and workflow is being drafted to allow for incident forms to be scanned and emailed to Safety and Risk, which should dramatically reduce the time taken between incident date and database entry. This will also reduce the time taken for the NPSA and CFSMS to be informed of incidents.
C04. Produced hours																										
C4.1 Average Daily - Produced hours - AEUs	A	R	Gareth Hughes	4684	3982	4684	3908	4684	4051	4684	4057	4684	3882	4684	4174	4684	4375	4426	4476	4426	4293	4426	4548	4426	4396	4426		GH 03-03-2010 DCA levels dropped off towards the end of the month as the amount of money available for overtime dropped by 20K hrs to 29K hrs compared to January
C4.2 Average Daily - Produced hours - FRUs	G	R	Gareth Hughes	1943	1971	1943	1913	1943	1898	1943	1924	1943	1804	1943	1883	1943	1849	1943	1777	1943	1875	1943	1979	1943	1833	1943		GH 03-03-2010 all available overtime was diverted to FRV cover during the month which kept the daily hrs above limits
C4.3 Average Daily - Produced hours - Other	G	G	Gareth Hughes	475	621	475	644	475	638	475	674	475	636	475	695	475	772	671	783	671	798	671	863	671	843	671		GH 03-03-2010 UCS hrs returned to the norm off 683. overtime was stopped on UCS during the last week of Feb to conserve funds
C4.4 Produced hours as % of plan	A	R	Gareth Hughes	100	92	100	90	100	90	100	91	100	87	100	93	100	91	100	89	100	96	100	97	100	93	100		GH 03-03-2010 reduction in overtime availability reduced hrs through out the month
C05. Productive hours																										
C5.1 Hours produced as % hours paid	A	?	Andrew Bell	68	76.4	68	74.3	68	74.3	68	73.4	68	69.8	68	73.4	68	74.7	68	73	68	8	68	75.7	68	67.5	68		AJB (Andrew Bell) 2010-03-05 I have compared the Monthly Paid Hours againsts a calculated monthly produced figure derived from the average daily amounts in C4 produced
C5.2 Non operational staff % time lost through sickness	G	G	Andrew Bell	5	3	5	2	5	2	5	2	5	3	5	1.4	5	2.05	5	2.87	5	1.87	5	2.7	5		5		AB 2010-03-05 1% increase on Dec figures, but remaining well under target.
C06. Job cycle times																										
C6.1 Job cycle time: Cat A	G	G	Jason Killens	65	58	65	65	65	65	65	65	65	65	65	49	65	49	65	49	65	49	65	48	65	49	65		Awaiting appropriate benchmark
C6.2 Job cycle time: Cat B	G	G	Jason Killens	73	60	73	73	73	73	73	73	73	73	73	88	73	43	73	47	73	44	73	43	73	45	73		Awaiting appropriate benchmark
C6.3 Job cycle time: Cat C	G	G	Jason Killens	66	72	66	66	66	66	66	66	66	66	66	46	66	43	66	38	66	38	66	35	66	38	66		Awaiting appropriate benchmark
C6.4 Job cycle time: Trust Average	G	?	Jason Killens		61		61		62		62		62				45		45		44		42		45			Awaiting appropriate benchmark

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

C07. Activation																										
C7.1 Average AEU (red calls) activation times (seconds)	G ▲ G	Peter McKenna	234	256	234	258	234	268	333	227.9	276	195.1	249	190.1	228	181.9	199	184.6	262	213.5	157	173.9	185	163.9	187		PM 2010-03-09: The timings in this report have changed to show Category A average activation times. The timings have further changed to that in the ORH FHA report (March 2009). This is due to the fact that the measurement of ORH activation recorded as time zero (when the call was connected) to the crew pushing amber to scene on the MDT activated in the vehicle. This is now recorded as wheels turning, not button push. This will show an increase in activation times due to the change in measurement. Since this has been introduced there has been a sustained reduction in mobilisation times
C7.2 Average FRU activation times (seconds)	G ▼ G	Peter McKenna	126	151	126	126	126	126	149.5	149.6	147.2	144.1	145	135.3	142.7	133.4	140.5	131.3	138.2	138.7	136	125.3	136	127.6	136		PM 2010-03-09: The timings in this report have changed to show Category A average activation times. The timings have further changed to that in the ORH FHA report (March 2009). This is due to the fact that the measurement of ORH activation recorded as time zero (when the call was connected) to the crew pushing amber to scene on the MDT activated in the vehicle. This is now recorded as wheels turning, not button push. This will show an increase in activation times due to the change in measurement. Since this has been introduced there has been a sustained reduction in mobilisation times
C08. Recruitment																										
C8.1 Student paramedics in training	G ▲ G	Ann Ball	277	277	275	275	251	251	259	259	264	264	249	444	228		237	204	215	176	245	188	235	262	176		AB 2010-03-05 On track
C8.2 Crew staff vacancy %	G ▷ ?	Ann Ball	12	12	11	10	10	10	9	9	9	8	6	8	5		2	4.9	2	3.86		2.34		0.82			AB 2010-03.05 On track
C8.3 Control Services staff vacancy %	G ▲ G	Ann Ball	9	9	7	7	5	4	8	7	4	4	4	2	4		4	1.3	-2	-0.33	-2	-0.03	-2	-4.1	-2		AB 2010-03-05 19.93 WTE over establishment.
C09. CTAK availability																										
C9.1 CAD System availability (unplanned downtime)	G ▼ G	John Downard	99.8	99.95	99.8	100	99.8	99.91	99.8	100	99.8	99.12	99.8	100	99.8	99.8	99.8	100	99.8	100	99.8	100	99.8	99.98	99.8		CTAK core functionality remained generally stable through February however a reoccurence of the Informix database locking symptom caused EOC to revert to manual 'cards' for 10 mins. In addition further inconvenience was caused by the MPS switching to their backup service causing a 7 hour loss of the CADlink.
C9.2 CAD System Environment availability (unplanned downtime)	R ▲ R	John Downard	99	94.78	99	97.61	99	90.22	99	97	99	97.67	99	97.78	99	98.73	99	99.57	99	99.72	99	95.11	99	98.93	99		
C10. Number of RTAs																										
C10.1 Number of RTAs	? ▷ ?	Nicola Foad	133	95	133	126	133	123	133	142	133	100	133	134	133	142	133	148	133	160	133	176	133		133		NAF 5/2/2010 It has not been possible to obtain the data in time to report to SMG. It is proposed that in future the updates should be 1 month in arrears.
D. RESOURCES, LEARNING AND GROWTH (What we need to enhance to succeed)																										
D01. Training																										
D1.1 Actual operational training days as per plan	G ▷ ?	Keith Miller	76	28	92	76	176	49	102	47	0	34	236	115	58	130	36	83		45		43		0			KM 2010/03/16. No planned activity this month.
D1.2 % of staff who have an operational workplace performance review twice per year	A ▷ ?	Keith Miller		17		14		14		15		13		12.5				8.2		0							KM 2010-01/13. No OWR recorded on Promis query due to increased performance pressures
D1.3 % of EOC staff who complete re-registration on MPDS	A ▶ R	Keith Miller		4		5		17		4		10	5		6		2		6		11		14	0	15		KM 2010/03/16. No staff requiring recerts
D02. Fleet																										
D2.1 Average VOR per day	? ▼ G	Christopher Vale		191		199		251		235	11	222	11	269	11	299	11	301	11	299	11	10	11	11	11		Target met for February.

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

D2.2 % AEU fleet available to operations	?	VG	Christopher Vale	89	97	89	97	89	96	89	96	89	96	89	95	89	95	89	95	89	95	89	95	89	89	89		Target met for February
D2.3 Mercedes AEU in fleet	R	VR	Christopher Vale	12	247	24	249	36	266	48	278	60	281	72	291	84	297	96	307	108	76	120	76	132	76	144		No further delivery of ambulances. Negotiations ongong with administrators of UVM about conversion of remaing 24 vehicles. MacNeillies working on prototype vehicle for next batch of 65.
D03. CAD2010																											
D3.1 CAD 2010 Milestones - % complete	A	VR	Nick Evans	14.29	14.29	21.43	14.29	28.57	28.57	28.57	28.57	28.57	28.57	28.57	28.57	35.71	35.71	35.71	35.71	35.71	35.71	42.86	35.71	42.86		42.86		Contract modifications have moved development Milestone to March 2010 from January 2010
D04. Airwave																											
D4.1 Airwave implementation - % of units operational	G	VR	Vic Wynn					24	15	47	31	75	54	89	85	100	87	100		100		100		100		100		
D05. Staff survey																											
D5.1 Staff survey action plan milestones - % complete	?	R	Kelly O'Brien															50	50	55		60	50	70	60	100		KOB 2010.04.03 - The February SSSG meeting was cancelled as inital staff survey results (provided by The Picker Institute) were not available in time. The next meeting is likely to take place in April. The agenda will include reviewing survey results and agreeing the post survey communications plan.
D06. Estates plan																											
D6.1 Estates capital spend as % of plan	?	VG	Martin Nelhams	0.3	0.3	0.3	0.3	3.6	3	7.8	7	-0.2	-1	7.3	22	26	34	42.8	20	59.6	20	78.9	30	68.5	40	100		
D07. Cost Improvement Programme																											
D7.1 CIP realised	G	AG	Asif Islam	207	207	207	207	207	207	147	147	107	107	6392		836		829		564	1074	702	541	689		712		AI 2010-03-05 - The CIP target for the year will be met

Legend

RAG Status - Owner Generated

- R — Red RAG Status represents a high level of concern
- A — Amber RAG Status represents a possible issue for concern
- G — Green RAG Status represents on track
- ? — RAG Status Not Set

PI Variance - System Generated

- R — Red Variance Indicator
- A — Amber Variance Indicator
- G — Green Variance Indicator
- ? — Variance Not Set

London Ambulance Service
NHS Trust

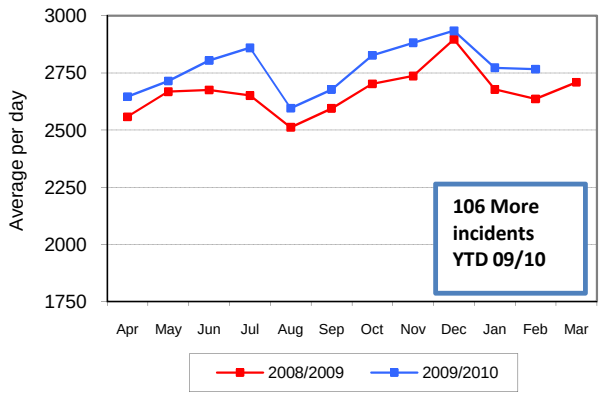
Information Pack for Trust Board

February 10

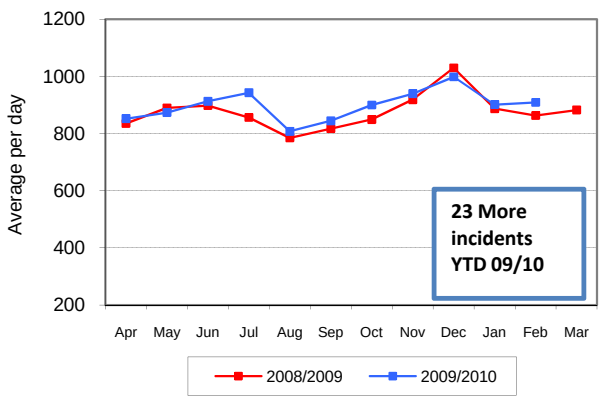
**** Please be aware that Hospital is only up to January as february PRF checking not yet complete**

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process - February 2010

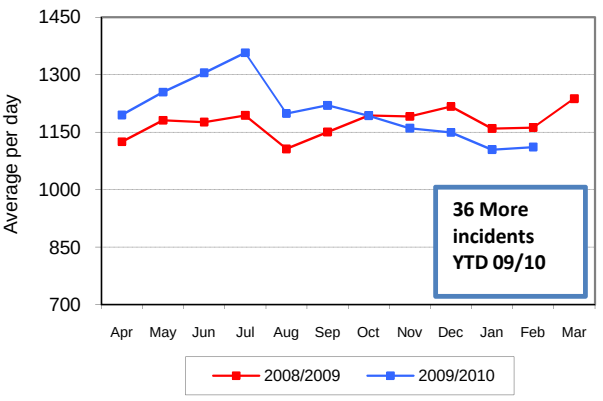
Graph 1
Average number of Cat A, B & C incidents per day



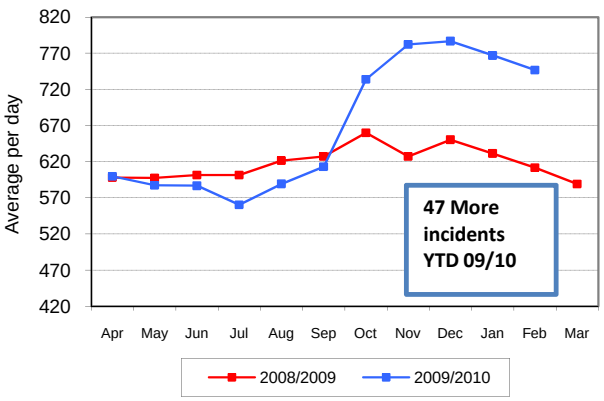
Graph 2
Average number of Cat A incidents per day



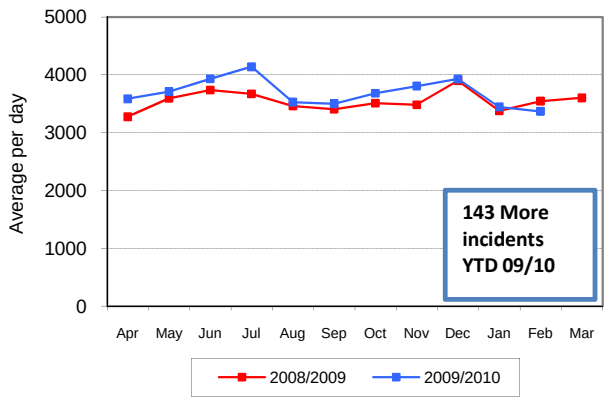
Graph 3
Average number of Cat B incidents per day



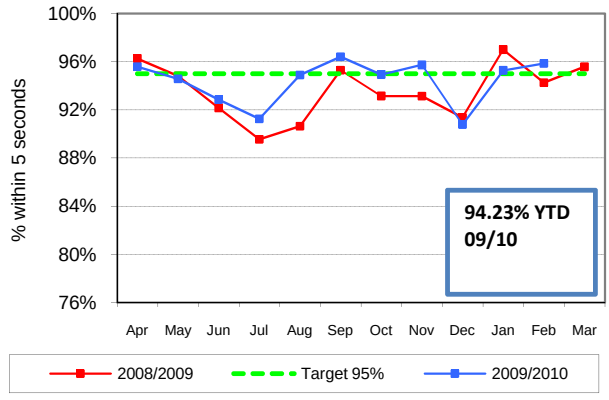
Graph 4
Average number of Cat C incidents per day



Graph 5
Average number of 999 calls received per day

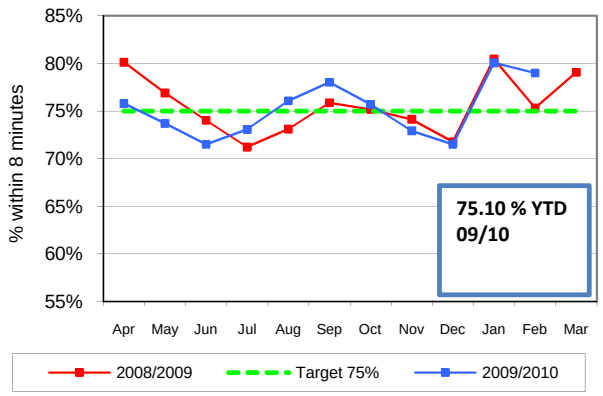


Graph 6
Percentage of calls answered within 5 seconds

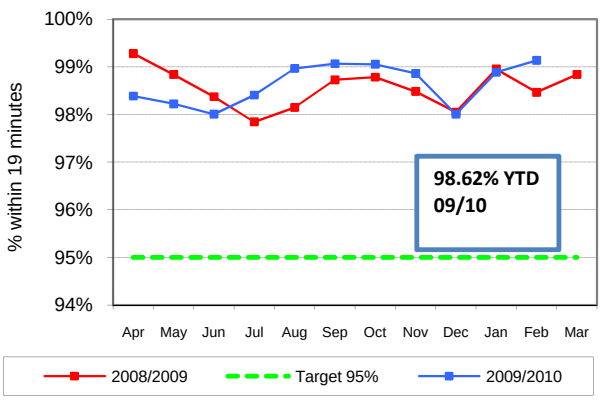


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - February 2010

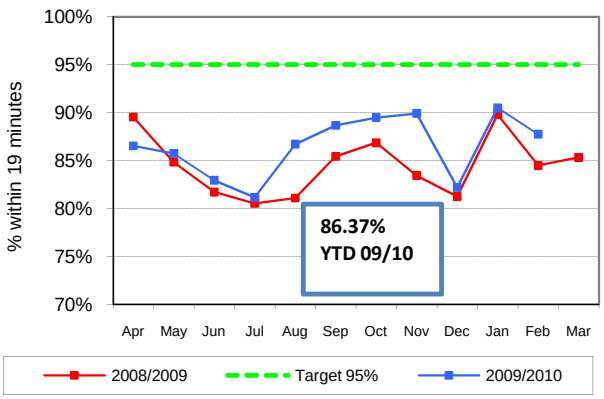
Graph 7
Category A 8 minute performance



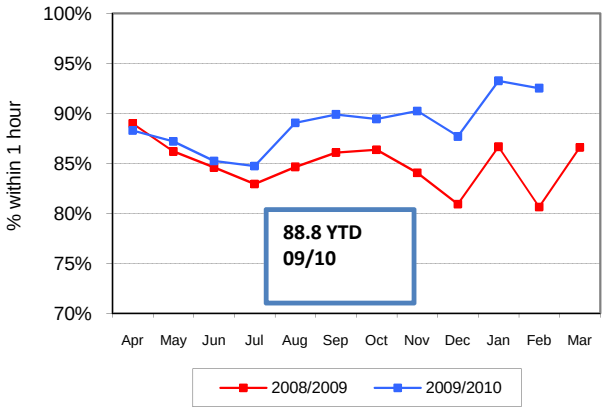
Graph 8
Category A 19 minute performance



Graph 9
Category B 19 minute performance

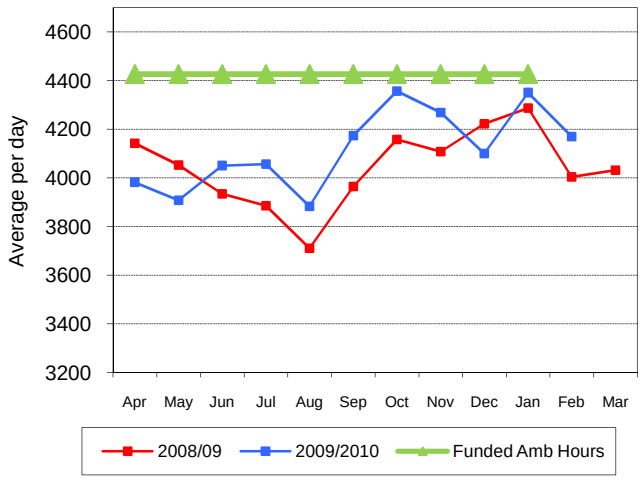


Graph 10
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)

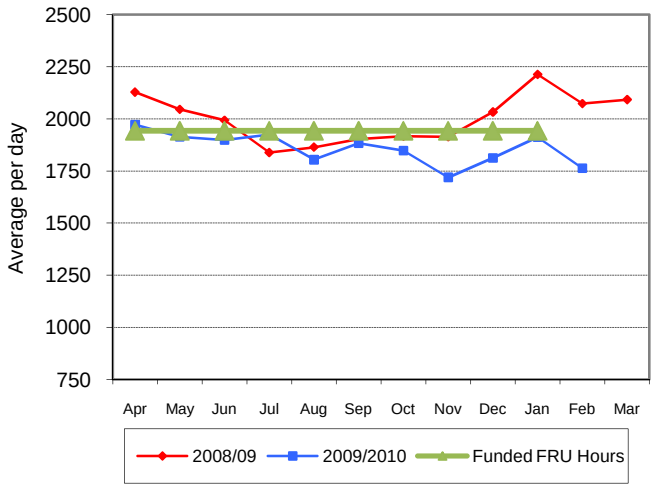


London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - February 2010

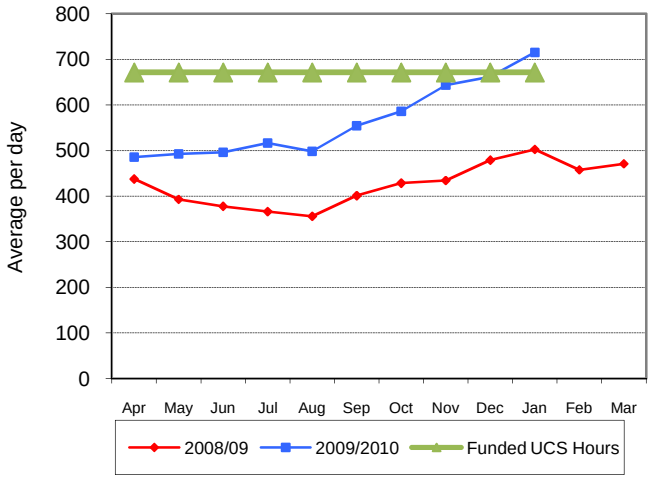
Graph 11
Ambulance Hours average available per day



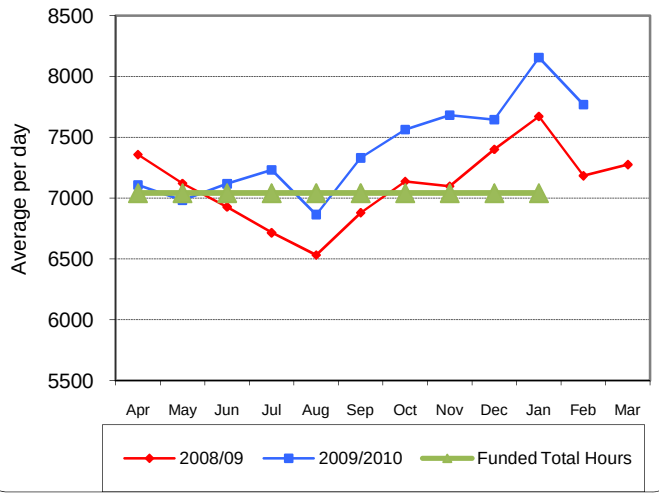
Graph 12
FRU hours average available per day



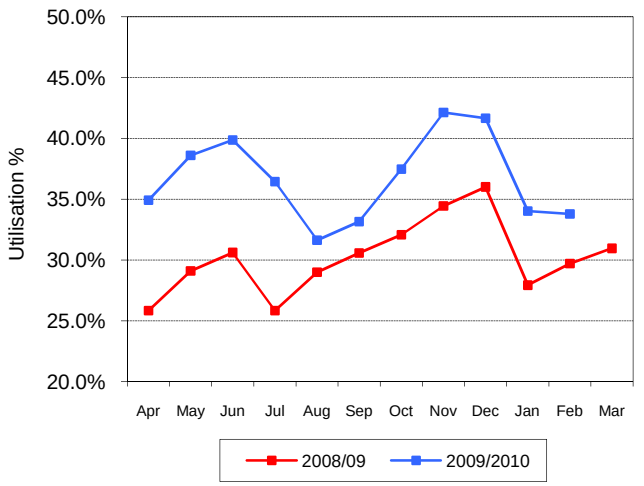
Graph 13
UOC Hours average available per day



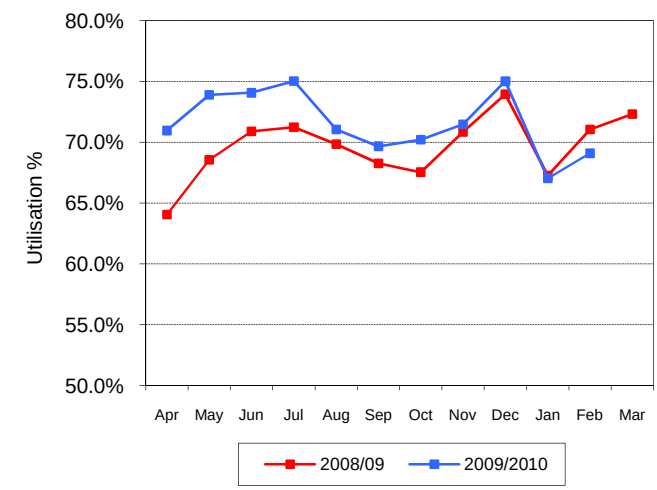
Graph 14
All Vehicle Hours average available per day



Graph 15
FRU Utilisation

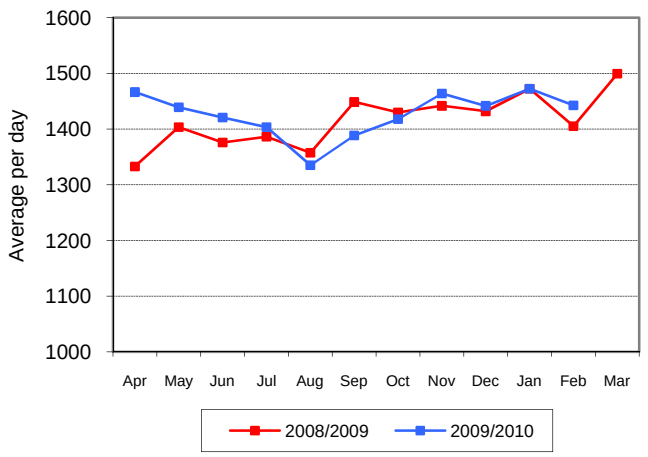


Graph 16
Ambulance Utilisation

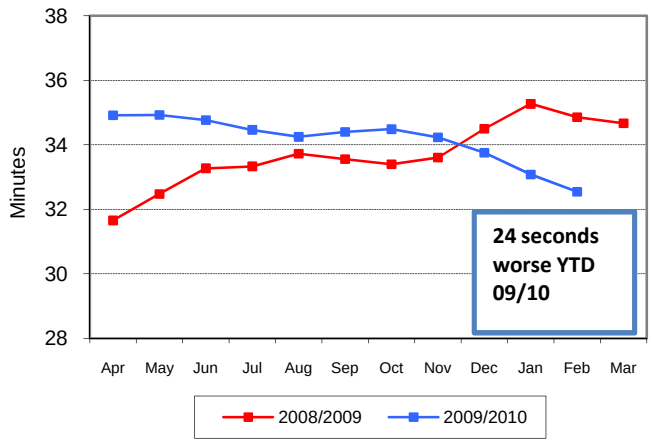


London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - February 2010

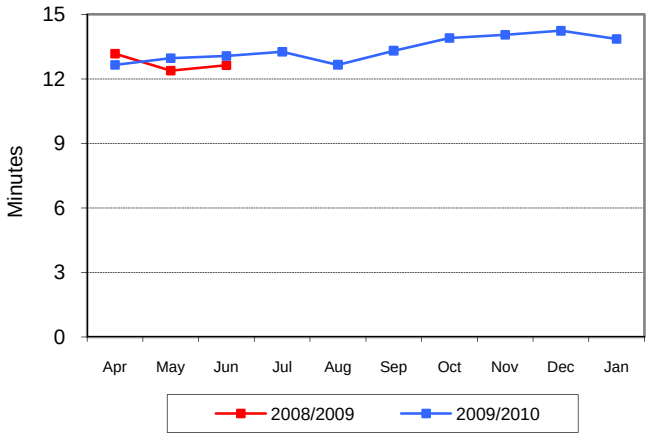
Graph 17
EOC hours staffed per day



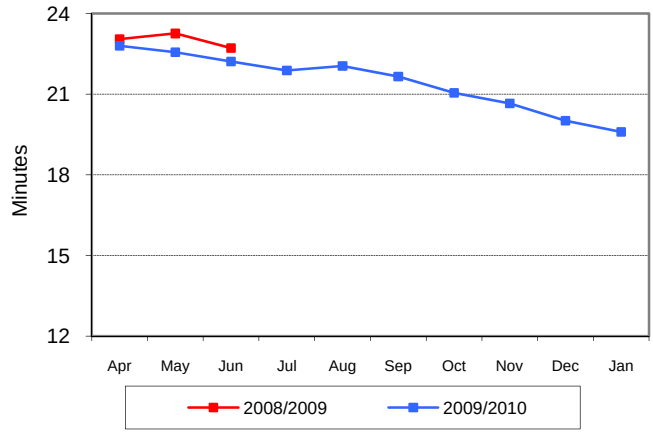
Graph 18
Average hospital turnaround time



Graph 19
Average Arrival at Hospital to Handover (Mins)

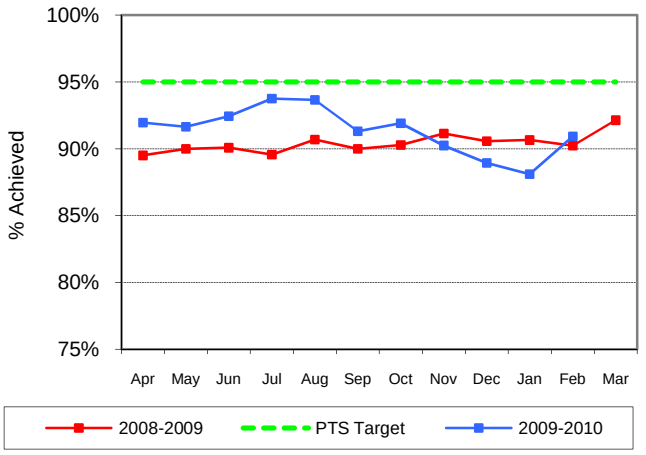


Graph 20
Average Handover to Green (Mins)

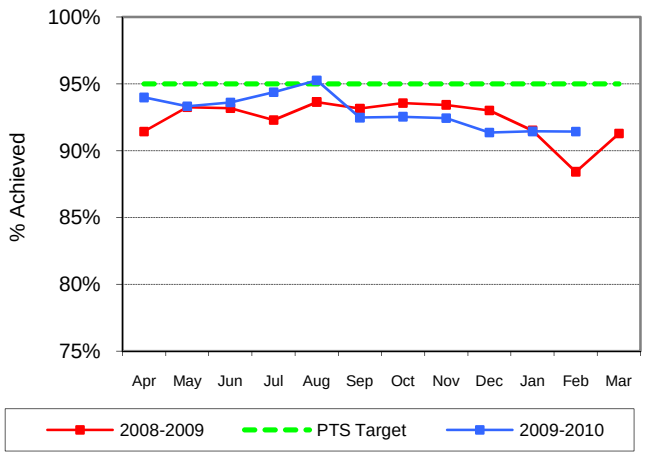


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - February 2010

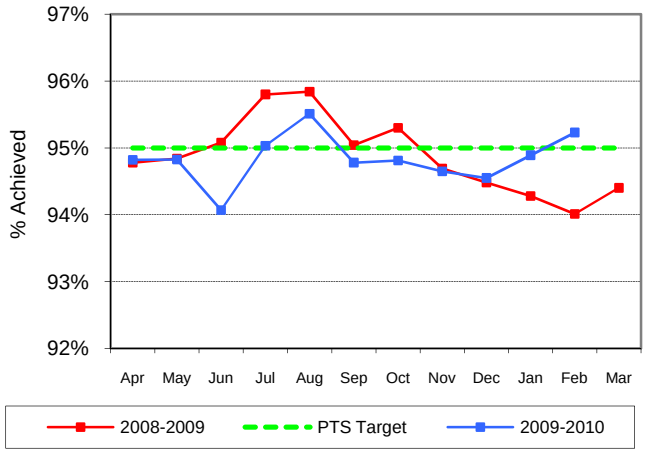
Graph 21
Arrival at Hospital Against Appointment Time



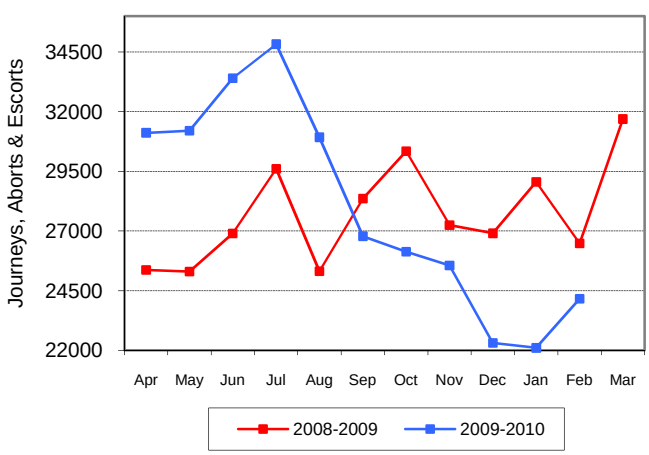
Graph 22
Departure Against Ready Time



Graph 23
Time spent on Vehicle



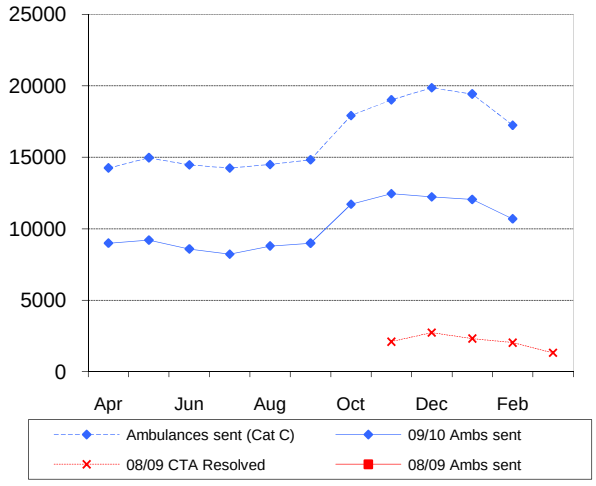
Graph 24
PTS Total Activity



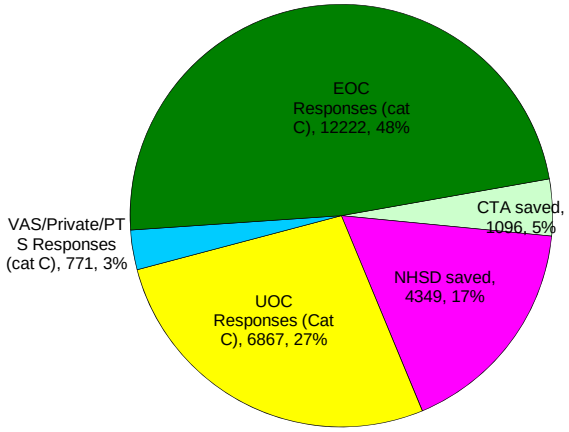
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - February 2010

Incident information is based on responses where a vehicle has arrived on scene for dispatches occuring during UOC operational hours (0700 -02259)

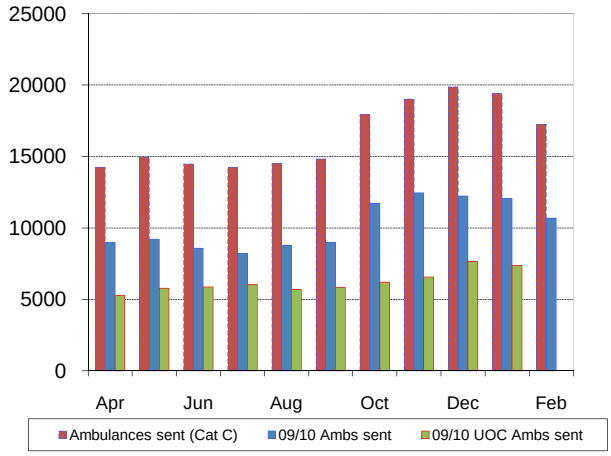
Graph 25
Cat C resolution by Month



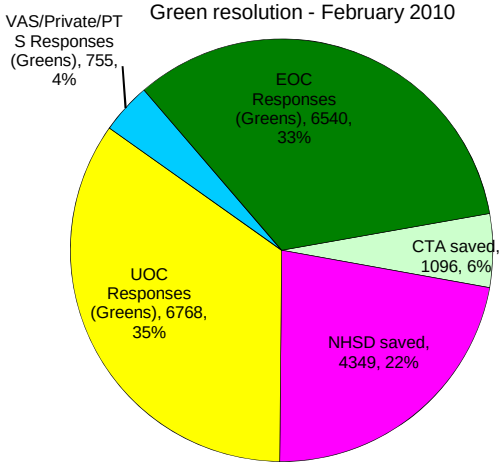
Graph 26
Cat C resolution - February 2010



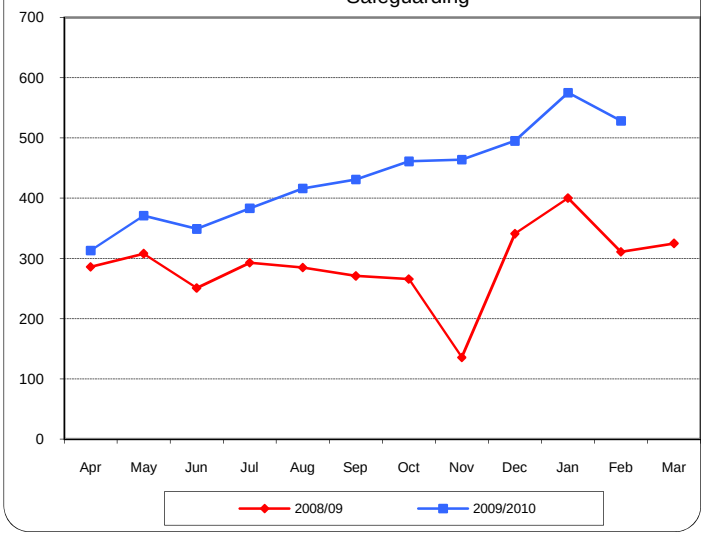
Graph 27
Cat C resolution by Month



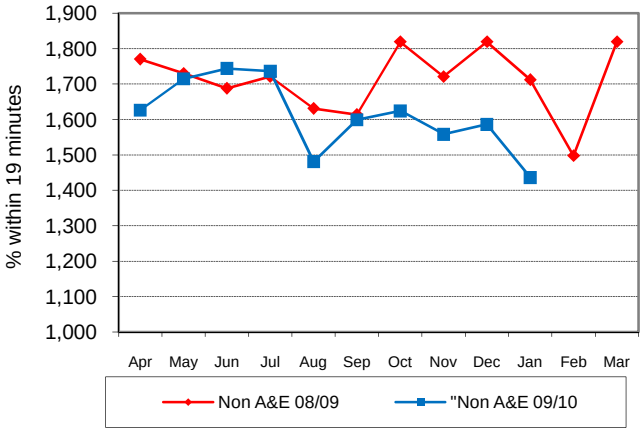
Graph 28
Green resolution - February 2010



Graph 289
Safeguarding



Graph 30
Patients conveyed to Non A&E hospital - LAS



TRUST BOARD M11 February

Document Title	**M11 - Finance Report**
Report Author(s)	**Finance Department**
Lead Director	**Mike Dinan**
Contact Details	**0207 7463 2585**
Aim	**Information**

Key Issues for the Service Development Committee

The result for the month is a surplus of £497k. The year to date result shows a surplus of £1581k. The full year result is forecast to be a surplus of £1591k. Total average monthly cost year to date was £23186k and Total average monthly cost for the full year is forecast to be £23156k.

Mitigating Actions (Controls)

Monitoring of expenditure and associated cost improvement plans . Intervention as required.

Recommendations to the Service Development Committee

To note the contents of this report.

Equality Impact Assessment

Has an EIA been carried out?	No
(If not, state reasons)	Not relevant for this paper

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

The key risks are around the achievement of the Cost Improvement Plan, the receipt of all budgeted income and the financial impact of responding to increased demand. Failure to achieve the financial targets set will impact on the standing of the LAS. The Trust has recognised an impairment effect of £1.3m. Whilst this is believed to be a prudent estimation, a risk remains that when the formal valuation is completed the figure may be higher.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate Objectives that the report links to

Achieve financial targets including control total, PTS profitability and efficiency savings

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE SERVICE

For the Month Ending 28th February 2009 - (Month 11)

Contents:

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 28th February 2009 - (Month 11)

£000s

	IN THE MONTH			YEAR TO DATE			ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Total Income	22,300	23,469	(1,170)U	256,627	258,461	(1,834)U	279,464	281,930	(2,466)U
Total Operational Costs	20,231	22,367	2,137F	239,880	245,040	5,160F	261,145	267,371	6,226F
EBITDA	**2,069**	**1,102**	**967F**	**16,747**	**13,421**	**3,326F**	**18,319**	**14,559**	**3,760F**
EBITDA Margin	***9.3%***	***4.7%***	**4.6%**	***6.5%***	***5.2%***	**1.3%**	***6.6%***	***5.2%***	**1.4%**
Depreciation & Interest	1,573	1,054	(518)U	15,165	11,598	(3,567)U	16,728	12,653	(4,075)U
Net *Surplus/(Deficit)*	**497**	**48**	**449F**	**1,581**	**1,822**	**(241)U**	**1,591**	**1,906**	**(315)U**
Net Margin	***2.2%***	***0.2%***	**2.0%**	***0.6%***	***0.7%***	***-0.1%***	***0.6%***	***0.7%***	***-0.1%***

Financial Commentary

For the Month Ending 28th February 2009 - (Month 11)

Year to Date
For the year to date, income expenditure by £1581k. The budgeted position is for income to exceed expenditure by £1822k, hence there is a year to date adverse variance of £241k. This is mainly due to additional demand pressures during the year resulted in higher than planned overtime and associated incentive costs The YTD in year PTS result , net of the impact of underaccruals in 2008/09 is a loss of £219k. This has been due a reduction in activity and recognition of costs not identified in earlier months.

Month
In the month there is a surplus against a budgeted surplus of £48k resulting in a favorable movement of £449k. This variance is mainly due to the net effect of the movement in vehicle provison (£1,000k favourable), reduction in reactive estates maintenace (£100k favourable) offset by recognition of liability in relation to Airwave project expenditure (£360k adverse) and higher than anticipated A&E overtime (£400k adverse)

Forecast
The year end forecast is surplus against a budgeted surplus of £1906k. The surplus has increased mainly due to required movement in vehicle provisions (£1,000 favorable) and a lower than anticipated holiday pay accrual (£500k favourable), offset by higher than planned expenditure on overtime (£900k).

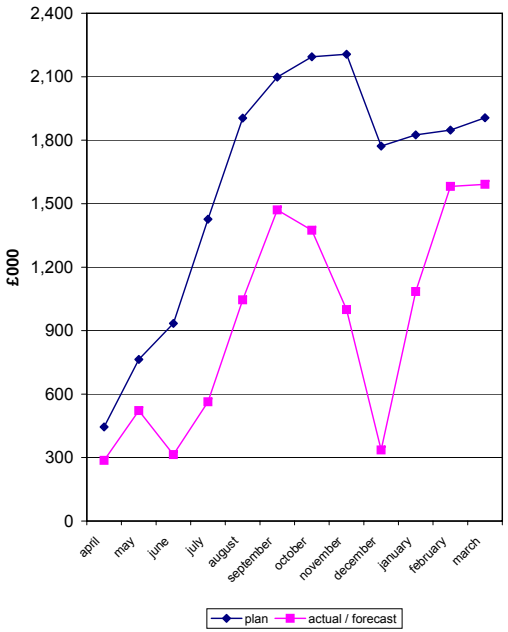
London Ambulance Service NHS Trust

Summary of Financial Performance

For the Month Ending 28th February 2009 - (Month 11)

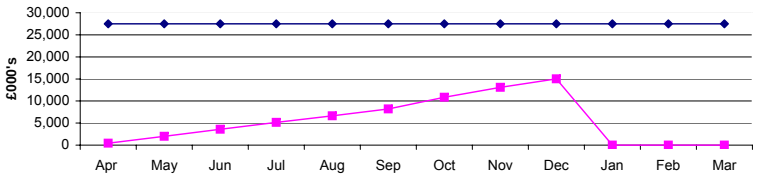
Income and Expenditure

Cumulative Net Financial Position

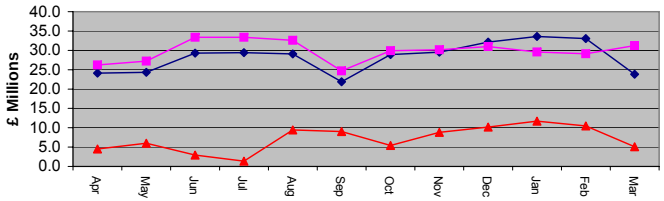


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	November	December	January	February	
Asset turnover ratio	2.04	2.09	2.03	2.03	●
Debtors % > 90 days	7.3%	12.6%	9.3%	7.2%	●
PSPP NHS	96%	80%	85%	92%	●
PSPP Non NHS	88%	85%	82%	89%	●

Key Financial Indicators

	Dec	Jan	Feb
A&E Overtime (£000) / Day (Month)	47	44	40
A&E Overtime (% of paybill)	8.36%	7.89%	6.49%
Subsistence (£000) / Day (Month)	8.19	5.20	8.01
Subsistence per head £	55.00	34.48	47.51
Third Party Transport expenditure / Day (M	8,411	6,416	8,982
Total operational cost per incident	191	200	200
EBITDA Margin (YTD)	6.0%	6.3%	6.5%
Net Margin (YTD) (% of Income)	0.2%	0.5%	0.6%
Cat B performance (cumulative)	85.83%	86.25%	86.38%

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
For the Month Ending 28th February 2009 - (Month 11)

												£000s
	MONTHLY SPEND											
	April	May	June	July	August	September	October	November r	January	February	March	Total
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	
Income	**22,954**	**23,240**	**23,606**	**23,337**	**23,143**	**23,512**	**23,424**	**23,465**	**24,386**	**22,300**	**22,837**	**279,464**
Pay Expenditure												
A&E Operational Staff	9,143	9,201	9,318	9,474	9,433	9,604	9,635	9,769	9,911	10,025	10,212	115,573
Overtime	1,695	1,552	1,680	1,417	1,514	1,457	1,342	1,349	1,356	1,113	855	16,776
Overtime Incentives	443	781	514	415	178	317	7	15	88	68	1	3,020
A&E Management	1,046	1,047	1,097	1,067	1,060	1,112	1,148	1,204	1,193	1,177	1,182	13,533
EOC Staff	1,008	1,044	1,039	1,066	1,047	1,064	1,072	1,076	1,101	1,093	1,132	12,815
PTS Operational Staff	491	527	511	494	487	491	477	489	471	474	464	5,852
PTS Management	59	52	53	53	59	52	73	73	79	87	88	807
Corporate Support	2,855	2,965	2,813	2,925	2,990	3,025	3,134	3,105	2,987	3,117	3,092	35,998
Sub Total	**16,740**	**17,168**	**17,025**	**16,910**	**16,767**	**17,123**	**16,887**	**17,081**	**17,187**	**17,153**	**17,025**	**204,374**
Average Daily	*558*	*554*	*568*	*545*	*541*	*571*	*545*	*569*	*554*	*613*	*549*	*560*
Non-Pay Expenditure												
Staff Related	368	340	300	235	287	287	290	220	303	345	332	3,751
Subsistence	170	184	208	174	156	196	176	173	161	224	216	2,292
Training	131	158	70	167	51	26	146	158	116	118	141	1,434
Medical Consummables & Equipment	517	454	498	836	573	507	525	539	468	402	431	6,355
Drugs	3	33	44	29	17	37	39	36	34	37	38	377
Fuel & Oil	367	375	389	386	365	376	392	419	505	428	476	4,929
Third Party Transport	154	220	196	150	223	194	171	222	199	251	164	2,406
Vehicle Costs	902	107	1,004	753	767	706	633	936	898	265	1,097	7,940
Accomodation & Estates	1,018	1,015	1,082	1,138	947	894	1,172	1,050	1,138	873	1,223	12,698
Telecommunications	592	617	800	981	582	891	882	362	769	825	620	8,524
Depreciation	623	1,255	976	965	1,023	920	1,028	1,045	899	969	1,069	11,970
Other Expenses	727	464	732	398	549	559	813	1,236	520	162	499	5,972
Profit/(Loss) on Disposal FA	1	0	2	1	1	5	0	0	36	0	0	93
Sub Total	**5,566**	**5,223**	**6,296**	**6,211**	**5,540**	**5,600**	**6,267**	**6,395**	**6,044**	**4,046**	**5,309**	**68,741**
Average Daily	*186*	*168*	*210*	*200*	*179*	*187*	*202*	*213*	*195*	*145*	*171*	*188*
Financial Expenditure	**362**	**613**	**493**	**34**	**353**	**365**	**366**	**364**	**406**	**604**	**493**	**4,757**
Average Daily	*12*	*20*	*16*	*1*	*11*	*12*	*12*	*12*	*13*	*22*	*16*	*13*
Monthly Expenditure	**22,667**	**23,004**	**23,814**	**23,087**	**22,660**	**23,087**	**23,520**	**23,840**	**23,637**	**21,803**	**22,827**	**277,873**
Cumulative	**22,667**	**45,672**	**69,486**	**92,573**	**115,234**	**138,321**	**161,841**	**185,681**	**233,242**	**255,045**	**277,873**	
Monthly Net	**287**	**235**	**(208)**	**249**	**482**	**425**	**(96)**	**(375)**	**749**	**497**	**10**	**1,591**
Cumulative Net	**287**	**522**	**314**	**563**	**1,046**	**1,470**	**1,374**	**999**	**1,085**	**1,581**	**1,591**	
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,306**	**1,306**

LONDON AMBULANCE SERVICE NHS TRUST
Forecast to Forecast Analysis
For the Month Ending 28th February 2009 - (Month 11)

	Forecast Month 11	Forecast Month 10	Variance	
Income	**279,464**	**279,417**	**-47**	
Pay Expenditure				
A&E Operational Staff	115,573	115,549	24	
Overtime	16,776	15,865	911	Forecast revised to meet forecast operational needs
Overtime Incentives	3,020	3,056	-36	
A&E Management	13,533	13,569	-36	
EOC Staff	12,815	12,880	-65	Lower than planned WTE now expected to join.
PTS Operational Staff	5,852	5,856	-4	
PTS Management	807	791	16	
Corporate Support	35,998	36,007	-9	
Sub Total	**204,374**	**203,573**	**801**	
Average Daily	*6,593*	*6,567*		
Non-Pay Expenditure				
Staff Related	3,751	3,749	2	
Subsistence	2,292	2,199	93	£44k additional spend above forecast in February extended to March
Training	1,434	1,462	-28	
Medical Consumables & Equipment	6,355	6,465	-110	Reduced spend due to year end expenditure control exercise giving realised savings
Drugs	377	378	-1	
Fuel & Oil	4,929	4,992	-63	Fuel reduced in line with revised price and volume projections
Third Party Transport	2,406	2,246	160	Forecast savings not achieved in PTS
Vehicle Costs	7,940	8,661	-721	Net Movement of Vehicle Provision
Accommodation & Estates	12,698	12,996	-298	£40k reduction in projected Make Ready spend, £100k reduction in reactive estates maintenance costs, £45k reduction in waste disposal costs
Telecommunications	8,524	8,667	-143	Reduction in expected telecomms spend in last quarter
Depreciation	11,970	12,062	-92	Reduction in forecast depreciation
Other Expenses	5,972	6,214	-242	Net reduction in expected unidentified savings.
Profit/(Loss) on Disposal FA	93	93	-0	
Sub Total	**68,741**	**70,184**	**-1,443**	
Average Daily	*2,217*	*2,264*		
Financial Expenditure	**4,757**	**4,709**	**48**	
Average Daily	*153*	*152*		
Total Expenditure	**277,873**	**278,466**	**-593**	
Monthly Net	**1,591**	**951**	**640**	
Impairment	**1,306**	**1,306**	**0**	

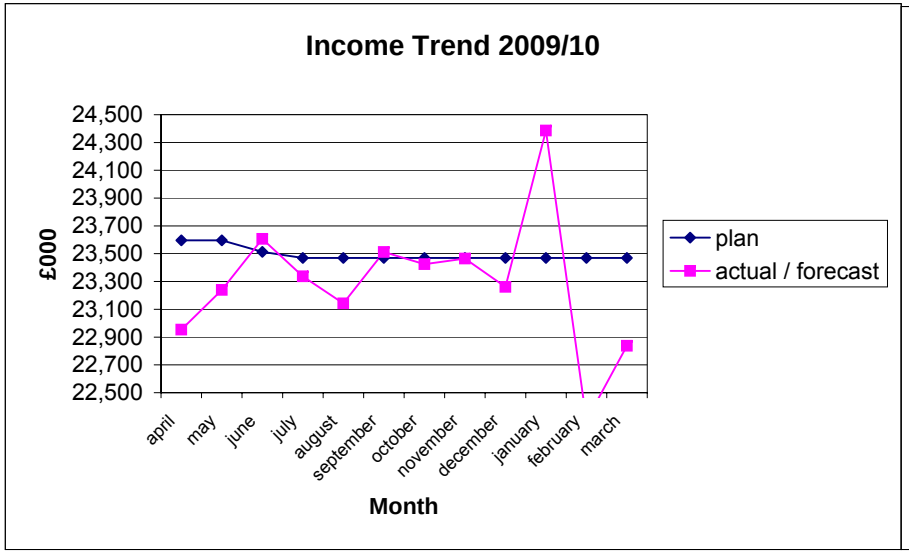
LONDON AMBULANCE SERVICE NHS TRUST

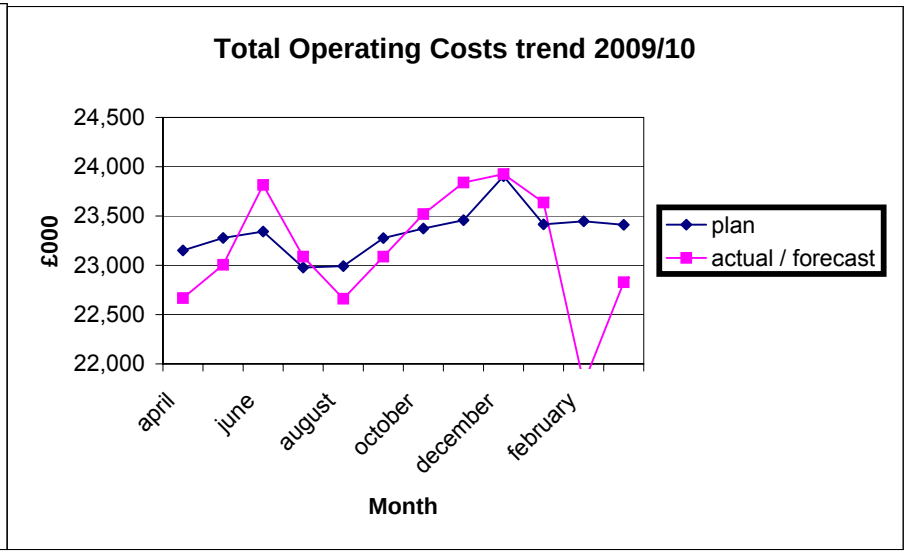
For the Month Ending 28th February 2010 (Month 11)
Month 11 Actual V Month 10 Actual

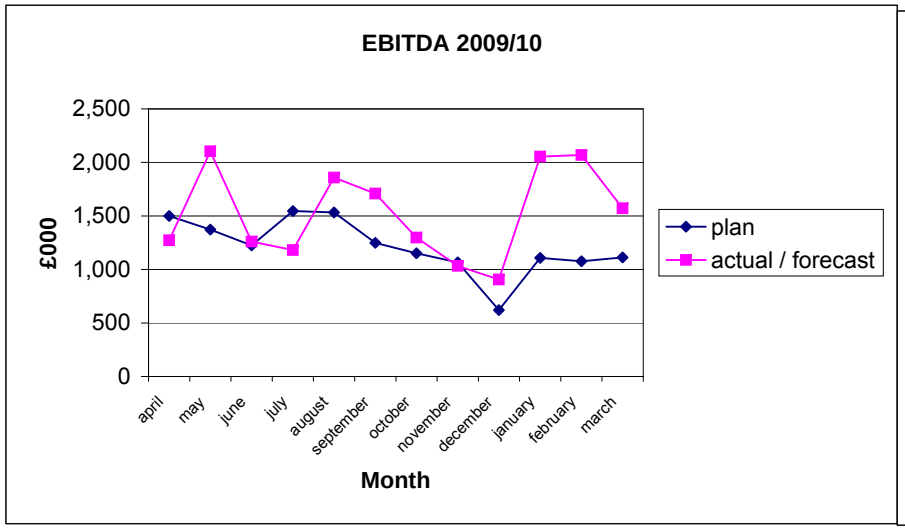
	M11 Actual	M10 Actual	var	Notes
	£000s	*£000s*	*£000s*	
Income	**-22,300**	**-24,386**	**2,086**	Realisation of CAT B penalty of £1.06m in M11, Reduction in HART Income (£1.18m) due to full YTD recognition in M10, Increase in MPET Income £218k
Pay Expenditure				
A&E Operational Staff	**10,025**	**9,911**	**114**	57 new Student Paramedics (£114k), 11 new A&E Support staff (£19k) offset by 10 of leavers (£21k).
Overtime Incentives	**68**	**88**	**-20**	Fewer FRU shifts due to shorter month
Overtime	**1,113**	**1,356**	**-243**	Increased A&E overtime due to demand pressures
A&E Management	**1,167**	**1,183**	**-16**	2 leavers in month
EOC Staff	**1,103**	**1,111**	**-9**	
PTS Operational Staff	**474**	**471**	**2**	
PTS Management	**88**	**79**	**9**	
Corporate Support	**3,117**	**2,987**	**130**	Reallocation of consultancy costs
Sub Total	**17,153**	**17,187**	**-34**	
Non-Pay Expenditure				
Staff Related	**348**	**303**	**45**	Purchase of MRU headsets
Subsistence	**224**	**161**	**63**	Higher subsitence paid in the month to due to adjusted subsistence policy in January
Training	**118**	**116**	**2**	
Medical Consumables & Equipment	**402**	**468**	**-66**	Reduced spend due to year end expenditure control exercise giving realised savings
Drugs	**37**	**34**	**4**	
Fuel & Oil	**428**	**505**	**-77**	Reduction due to shorter month and lower usage
Third Party Transport	**251**	**199**	**52**	Increased private ambulance hire in PTS
Vehicle Costs	**-265**	**898**	**-1,163**	Net movement of vehicle provisions
Accommodation & Estates	**877**	**1,137**	**-261**	£40k reduction in projected Make Ready spend, £101k reduction in estates maintenance costs, £45k reduction in waste disposal costs
Telecommunications	**825**	**769**	**56**	
Depreciation	**969**	**899**	**70**	
Other Expenses	**-162**	**520**	**-682**	reduction in unidentified savings and £200k release of Ill health provision. Also reallocation of consultancy costs to corporate support pay
Profit/(Loss) on Disposal FA	**0**	**36**	**-36**	
Sub Total	**4,052**	**6,044**	**-1,991**	
Total Expenditure	**21,206**	**23,230**	**-2,025**	
Financial Expenditure	**604**	**406**	**198**	PDC dividend adjustment
Total	**-490**	**-749**	**259**	

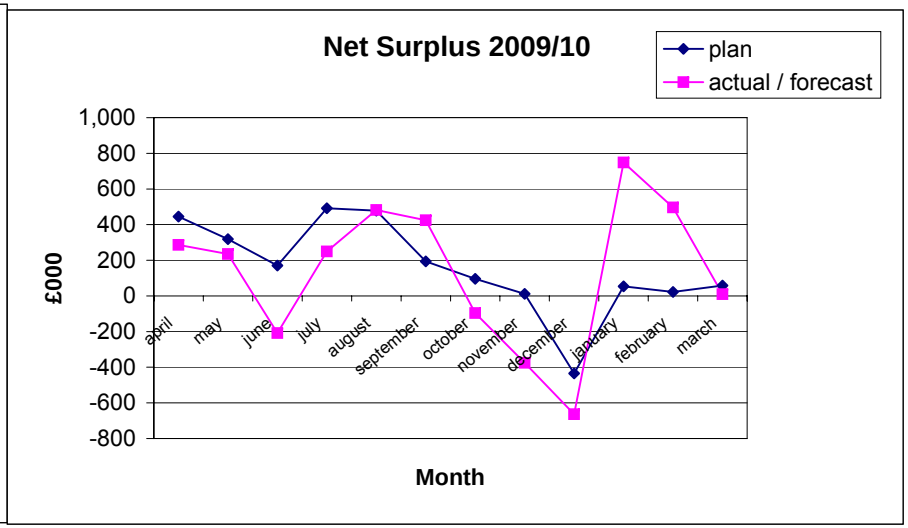
London Ambulance Service NHS Trust

For the Month Ending 28th February 2009 - (Month 11)









LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 28th February 2009 - (Month 11)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	10,025	10,445	420F	105,360	109,460	4,100F	3.9%F	115,573	119,869	4,296F
Overtime	1,113	977	(136)U	15,921	14,164	(1,758)U	(11.0%)U	16,776	15,140	(1,636)U
Overtime Incentives	68	0	(68)U	3,019	1,000	(2,019)U	(66.9%)U	3,020	1,000	(2,020)U
A&E Management	1,177	1,074	(103)U	12,351	11,594	(757)U	(6.1%)U	13,533	12,669	(864)U
EOC Staff	1,093	1,100	7F	11,683	11,815	131F	1.1%F	12,815	12,914	99F
PTS Operational Staff	474	448	(25)U	5,388	5,086	(302)U	(5.6%)U	5,852	5,534	(318)U
PTS Management	87	90	3F	719	998	278F	38.7%F	807	1,088	280F
Corporate Support	3,117	2,845	(272)U	32,906	31,184	(1,722)U	(5.2%)U	35,998	34,029	(1,969)U
	17,153	**16,978**	**(175)U**	**187,349**	**185,300**	**(2,049)U**	**(1.1%)U**	**204,374**	**202,242**	**(2,132)U**
Non-Pay Expenditure										
Staff Related	345	320	(25)U	3,419	3,518	99F	2.9%F	3,751	3,838	87F
Subsistence	224	121	(103)U	2,076	1,337	(739)U	(35.6%)U	2,292	1,458	(834)U
Training	118	208	91F	1,293	2,320	1,026F	79.4%F	1,434	2,528	1,094F
Medical Consumables & Equipment	402	497	95F	5,924	5,687	(236)U	(4.0%)U	6,355	6,184	(171)U
Drugs	37	35	(2)U	339	385	46F	13.7%F	377	420	44F
Fuel & Oil	428	377	(51)U	4,453	4,157	(296)U	(6.6%)U	4,929	4,534	(395)U
Third Party Transport	251	88	(164)U	2,242	966	(1,276)U	(56.9%)U	2,406	1,054	(1,352)U
Vehicle Costs	-265	1,278	1,544F	6,843	14,002	7,159F	104.6%F	7,940	15,281	7,340F
Accommodation & Estates	873	886	12F	11,474	9,683	(1,791)U	(15.6%)U	12,698	10,569	(2,129)U
Telecommunications	825	719	(106)U	7,904	8,043	139F	1.8%F	8,524	8,762	238F
Depreciation	969	652	(317)U	10,901	7,170	(3,732)U	(34.2%)U	11,970	7,822	(4,149)U
Other Expenses	-162	830	992F	6,471	9,320	2,849F	44.0%F	5,972	10,150	4,178F
Profit/(Loss) on Disposal FA	0	29	29F	93	321	228F	245.3%F	93	350	257F
	4,046	**6,041**	**1,995F**	**63,433**	**66,910**	**3,477F**	**5.5%F**	**68,741**	**72,951**	**4,209F**
Financial Expenditure	**604**	**403**	**(201)U**	**4,264**	**4,428**	**164F**	**3.9%F**	**4,757**	**4,831**	**74F**
Total Trust Expenditure	**21,803**	**23,422**	**1,619F**	**255,045**	**256,638**	**1,593F**	**0.6%F**	**277,873**	**280,024**	**2,151F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 28th February 2009 - (Month 11)

£000s

	IN THE MONTH			*YEAR TO DATE*					*ANNUAL*	
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	19,153	20,219	(1,066)U	221,318	222,407	(1,089)U	(0.4%)U	241,438	242,626	(1,188)U
HEMS Funding	11	11	0F	124	120	4F	3.6%F	127	131	(3)U
Emergency Bed Service	93	92	1F	1,020	1,013	6F	0.2%F	1,113	1,105	7F
CBRN Income	642	645	(2)U	7,064	7,090	(27)U	(0.4%)U	7,706	7,735	(29)U
BETS & SCBU Income	50	51	(1)U	511	562	(52)U	(6.0%)U	556	613	(57)U
A & E Long Distance Journey	40	33	6F	311	367	(56)U	(8.6%)U	333	400	(67)U
Stadia Attendance	31	85	(54)U	892	934	(42)U	3.0%F	947	1,019	(72)U
Heathrow BAA Contract	52	44	8F	739	488	251F	72.1%F	791	532	259F
PTS Income from FTs	72	27	45F	856	293	562F	206.6%F	934	320	614F
A&E Income from FTs	10	13	(3)U	109	138	(29)U	3.9%F	121	150	(29)U
Olympics Income	50	160	(110)U	550	1,760	(1,210)U	(71.9%)U	635	1,920	(1,285)U
HART Income	352	363	(11)U	3,868	3,994	(126)U	(46.0%)U	4,219	4,357	(138)U
Injury Recovery Income	104	77	27F	1,196	852	344F	41.2%F	1,301	929	372F
MPET Income	881	870	11F	9,336	9,573	(237)U	6.7%F	9,772	10,443	(671)U
	21,540	**22,690**	**1,150**	**247,892**	**249,590**	**(1,698)U**	**(0.9%)U**	**269,995**	**272,280**	**(2,286)U**
PTS Income	705	731	(26)U	7,513	8,337	(823)U	(0.9%)U	8,910	9,067	(157)U
Other Income	54	49	5F	462	534	(72)U	(14.4%)U	559	582	(24)U
Trust Result	**22,299**	**23,469**	**(1,170)U**	**255,867**	**258,461**	**(2,593)U**	**(0.8%)U**	**279,464**	**281,930**	**(2,466)U**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
For the Month Ending 28th February 2009 - (Month 11)

	Current Year											
	February	March	April	May	June	August	September	October	November	December	January	February
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**22,590**	**21,790**	**22,954**	**23,240**	**23,606**	**23,143**	**23,512**	**23,424**	**23,465**	**23,261**	**24,386**	**22,300**
Pay Expenditure												
A&E Operational Staff	8,624	8,880	9,143	9,201	9,318	9,433	9,604	9,635	9,769	9,849	9,911	10,025
Overtime	1,495	1,735	1,695	1,552	1,680	1,514	1,457	1,342	1,349	1,447	1,356	1,113
Overtime Incentives	893	274	443	781	513	178	317	7	15	194	88	68
A&E Management	980	1,001	1,023	1,024	1,072	1,031	1,088	1,114	1,204	1,199	1,193	1,177
EOC Staff	1,007	990	1,008	1,044	1,039	1,047	1,064	1,072	1,076	1,073	1,101	1,093
PTS Operational Staff	448	479	491	527	511	487	491	477	489	477	471	474
PTS Management	74	79	82	76	78	88	76	106	73	79	79	87
Corporate Support	2,431	3,600	2,855	2,965	2,813	2,990	3,025	3,134	3,105	2,990	2,987	3,117
Sub Total	**15,952**	**17,038**	**16,740**	**17,168**	**17,025**	**16,767**	**17,123**	**16,887**	**17,081**	**17,308**	**17,187**	**17,153**
Average Daily	*515*	*568*	*540*	*554*	*567*	*559*	*552*	*545*	*569*	*558*	*554*	*553*
Non-Pay Expenditure												
Staff Related	219	430	368	340	300	287	287	289	220	445	303	345
Subsistence	147	336	170	184	208	156	196	176	173	254	161	224
Training	120	262	131	158	70	51	26	146	158	154	116	118
Drugs	51	41	3	33	44	17	37	39	539	607	468	402
Medical Consumables & Equipment	396	367	517	450	498	573	507	525	36	35	34	37
Fuel & Oil	357	378	367	375	389	365	376	392	419	450	505	428
Third Party Transport	121	173	154	220	196	223	194	171	222	261	199	251
Vehicle Costs	836	1,507	902	107	1,004	767	706	633	936	403	898	265
Accommodation & Estates	1,085	1,187	1,018	1,019	1,082	947	894	1,172	1,050	1,145	1,138	873
Telecommunications	615	926	592	617	800	582	891	882	362	603	769	825
Depreciation	606	712	623	1,255	976	1,023	920	1,028	1,045	1,198	899	969
Other Expenses	392	750	727	464	732	549	559	813	1,236	634	520	162
Profit/(Loss) on Disposal FA	0	0	1	0	2	1	5	0	0	56	36	0
Sub Total	**4,942**	**5,664**	**5,566**	**5,223**	**6,296**	**5,540**	**5,600**	**6,266**	**6,395**	**6,245**	**6,044**	**4,046**
Average Daily	*159*	*189*	*180*	*168*	*210*	*185*	*181*	*202*	*213*	*201*	*195*	*131*
Financial Expenditure	**362**	**363**	**362**	**613**	**493**	**353**	**365**	**366**	**364**	**372**	**406**	**604**
Average Daily	*12*	*12*	*12*	*20*	*16*	*12*	*12*	*12*	*12*	*12*	*13*	*19*
Monthly Expenditure	**21,256**	**23,064**	**22,668**	**23,004**	**23,814**	**22,660**	**23,087**	**23,520**	**23,840**	**23,925**	**23,637**	**21,803**

CAPITAL PLAN February 2010

Cost Category	Note	Actuals YTD M11	Forecast M12	FYE Forecast YE	2009/10 BUDGET
Finance Lease - Ambulances	3	£0.00	£0.00	£0.00	£14,507,599.00
Fleet	3	£10,249,357.76	£3,058,031.00	£13,307,388.76	£1,200,438.24
IM&T		£4,885,813.07	£3,767,935.00	£8,653,748.07	£9,241,846.68
Equipment		£1,714,908.00	£3,031,988.00	£4,746,896.00	£4,848,558.00
Estates		£239,245.48	£492,910.55	£732,156.03	£3,109,558.08
Total:		**£17,089,324.31**	**£10,350,864.55**	**£27,440,188.86**	**£32,908,000.00**

Original CRL:	**£16,000,000**
CRL Increase for HART Capital	**£3,362,000**
Additional CRL approved by SHA	**£8,138,000**
Current CRL:	**£27,500,000**
Potential under spend on CRL:	**£59,811**

Notes

1 The forecast has reduced by £1m, due to unforeseen projects delays from Estates and IM&T

2 The Trust will spend over £10m in March. Notable items are defibs (£3M) CAD (£3M) and HART vehicle (£1.6M).

3 Sale and lease back of ambulances under a finance lease is expected to occur in March 2010.

4 The SHA has changed the CRL to £27.5m.

5 Wilesden Ambulance Station has been disposed. The sales proceeds were £0.3M

LONDON AMBULANCE SERVICE NHS Trust

Statement of Financial Position

For the Month Ending 28th February 2009 - (Month 11)

	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Non-Current Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*
Intangible assets	6,752	9,564	9,603	8,989	11,219	10,680	9,650	13,795	9,289	9,383	9,540	9,540
Property, Plant and Equipment	121,789	117,135	109,296	109,857	108,225	109,201	112,559	111,251	117,652	118,640	118,061	139,343
Trade and Other Receivables	12,462	12,484	12,507	12,654	12,716	12,781	12,751	12,075	10,434	10,498	10,562	10,562
Total Non-Current Assets	141,003	139,183	131,406	131,500	132,160	132,662	134,960	137,121	137,375	138,521	138,163	159,445
Current Assets												
Inventories	2,600	2,547	2,508	2,510	2,293	2,265	2,208	2,253	2,222	2,292	2,241	2,241
NHS Trade Receivables	2,773	4,339	1,680	8,978	10,641	2,003	5,734	271	2,645	4,088	5,495	2,041
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0
Other Receivables	6,140	5,769	5,629	5,659	5,988	5,958	5,455	5,961	7,242	7,392	7,505	7,505
Accrued Income	0	3,619	5,638	6,034	5,996	6,905	3,447	5,455	6,126	4,698	4,829	4,496
Prepayments	4,561	3,329	2,843	3,221	3,223	2,552	3,017	3,353	3,751	3,412	2,521	2,469
Investments	0	0	0	0	0	8,900	9,800	6,000	7,500	11,000	9,500	0
Cash and Cash Equivalents	2,533	4,513	6,013	2,925	1,353	531	(797)	2,814	2,661	712	972	5,081
Current Assets	18,607	24,116	24,311	29,327	29,494	29,114	28,864	26,107	32,147	33,594	33,063	23,833
Non-Current Assets Held for Sale	0	1,700	1,700	1,709	1,709	1,709	1,709	1,709	950	950	650	650
Total Current Assets	18,607	25,816	26,011	31,036	31,203	30,823	30,573	27,816	33,097	34,544	33,713	24,483
Total Assets	159,610	164,999	157,417	162,536	163,363	163,485	165,533	164,937	170,472	173,065	171,876	183,928
Current Liabilities												
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0
Trade Payables	7,531	6,518	6,333	6,851	6,672	6,545	8,167	8,740	8,250	8,897	9,348	10,595
Other Liabilities	3,887	9,845	9,868	9,728	9,579	9,481	9,529	9,001	9,141	9,080	8,731	8,731
PDC Dividend Liabilities	0	350	820	1,230	1,120	1,400	(89)	471	751	1,067	1,608	17
Capital Liabilities	1,926	132	149	162	80	83	73	105	156	332	388	7,039
Accruals	3,571	4,290	5,305	5,164	4,651	5,048	2,560	3,602	3,723	2,666	2,417	1,403
Deferred Income	0	930	561	6,171	7,162	6,550	5,053	4,739	5,484	4,078	3,193	20
DH Capital Loan Principal Repayment	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	3,602	3,602	3,602	3,562	3,549	3,522	3,522	3,496	3,482	3,469	3,456	3,443
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	0	0	0	0	0	0	0	0	0	0	0	0
Total Current Liabilities	20,517	25,667	26,638	32,868	32,813	32,629	28,815	30,154	30,987	29,589	29,141	31,248
Net Current Assets/(Liabilities)	(1,910)	149	(627)	(1,832)	(1,610)	(1,806)	1,758	(2,338)	2,110	4,955	4,572	(6,765)
Total Assets less Current Liabilities	139,093	139,332	130,779	129,668	130,550	130,856	136,718	134,783	139,485	143,476	142,735	152,680
Non-Current Liabilities												
DH Capital Loan Principal Repayment	0	0	0	0	1,000	1,000	4,941	4,941	9,941	9,941	9,941	9,382
Borrowings	25,002	25,002	25,002	24,141	23,856	23,567	23,280	22,707	22,421	22,135	21,847	21,561
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	11,931	11,884	11,832	11,789	11,707	11,820	11,903	10,952	10,968	11,044	10,094	10,180
Total Non-Current Liabilities	36,933	36,886	36,834	35,930	36,563	36,387	40,124	38,600	43,330	43,120	41,882	41,123
Total Assets Employed	102,160	102,446	93,945	93,738	93,987	94,469	96,594	96,183	96,155	100,356	100,853	111,557
Financed By Taxpayers' Equity												
Public Dividend Capital	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	60,885	60,885	60,885
Revaluation Reserve	32,810	33,129	24,394	24,348	24,348	24,348	26,805	26,047	25,227	25,316	25,316	37,316
Donated Asset Reserve	9	9	8	8	8	8	8	7	7	7	7	7
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Retained Earnings	12,237	12,204	12,439	12,278	12,527	13,009	12,677	13,025	13,817	14,567	15,064	13,768
Total Taxpayers' Equity	102,160	102,446	93,945	93,738	93,987	94,469	96,594	96,183	96,155	100,356	100,853	111,557
Control Total	0	0	0	0	0	0	0	0	0	0	0	0

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 28th February 2009 - (Month 11)

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	
Operating Activities												
Operating surplus/(deficit)	648	848	281	213	835	795	271	(292)	1,156	1,101	(803)	5,042
Depreciation and amortisation	623	1,255	976	965	1,023	920	1,028	1,198	899	969	1,069	11,970
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	0	(129)	(62)	(62)	(64)	(64)	(76)	(82)	(81)	(54)	(149)	(897)
Dividend Paid	0	0	0	0	0	(1,769)	0	0	0	0	(1,925)	(3,694)
(Increase)/Decrease in Inventories	53	39	(2)	217	28	57	(31)	31	(70)	51	0	359
(Increase)/Decrease in NHS Trade Receivables	(1,566)	2,659	(7,298)	(1,663)	8,638	(3,731)	504	(2,374)	(1,443)	(1,407)	3,454	732
(Increase)/Decrease in Long Term Receivables	(22)	(23)	(147)	(62)	(65)	30	(64)	1,641	(64)	(64)	0	1,900
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	371	140	(30)	(329)	30	503	(202)	(1,281)	(150)	(113)	0	(1,365)
(Increase)/Decrease in Accrued Income	(3,619)	(2,019)	(396)	38	(909)	3,458	(2,179)	(671)	1,428	(131)	333	(4,496)
(Increase)/Decrease in Prepayments	1,232	486	(378)	(2)	671	(465)	(892)	(398)	339	891	52	2,092
Increase/(Decrease) in Trade Payables	(1,013)	(185)	518	(179)	(127)	1,622	238	(490)	647	451	1,247	3,064
Increase/(Decrease) in Other Payables	6,718	(17)	448	913	(560)	(663)	(724)	(1,700)	1,214	(392)	(27)	4,768
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	719	1,015	(141)	(513)	397	(2,488)	753	121	(1,057)	(249)	(1,014)	(2,168)
Increase/(Decrease) in Deferred Income	930	(369)	5,610	991	(612)	(1,497)	341	745	(1,406)	(885)	(3,173)	20
Increase/(Decrease) in Provisions & Liabilities	(47)	(52)	(43)	(82)	113	83	113	16	76	(950)	86	(1,751)
Net Cash inflow/outflow from operating activities	5,027	3,648	(664)	445	9,398	(3,209)	(920)	(3,536)	1,488	(782)	(850)	15,576
Cashflows from Investing Activites												
Interest received	2	0	(6)	3	4	4	3	4	5	5	4	32
(Payments) for property, plant & equipment	(3,049)	(2,148)	(1,560)	(2,736)	(1,036)	(872)	(2,426)	(593)	(3,018)	(475)	(3,700)	(23,422)
Proceeds from disposal of property, plant & equipment	0	0	3	1	1	(5)	0	759	0	300	0	1,059
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(3,047)	(2,148)	(1,563)	(2,732)	(1,031)	(873)	(2,423)	170	(3,013)	(170)	(3,696)	(22,331)
Net Cash inflow/outflow before financing	1,980	1,500	(2,227)	(2,287)	8,367	(4,082)	(3,343)	(3,366)	(1,525)	(952)	(4,546)	(6,755)
Cashflows from Financing Activites												
Public Dividend Capital Received	0	0	0	0	0	0	0	0	3,362	0	0	3,362
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	1,000	0	4,000	0	5,000	0	0	0	10,000
Loans principal repaid to DH	0	0	0	0	0	(59)	0	0	0	0	(559)	(618)
Capital element of finance lease	0	0	(861)	(285)	(289)	(287)	(286)	(286)	(286)	(288)	(286)	(3,441)
Net Cashflow inflow/(outflow) from financing	0	0	(861)	715	(289)	3,654	(286)	4,714	3,076	(288)	(845)	9,303
Increase/(decrease) in cash & cash equivalents	1,980	1,500	(3,088)	(1,572)	8,078	(428)	(3,629)	1,348	1,551	(1,240)	(5,391)	2,548
Cash, cash equivalents and bank overdrafts at 1.4.09	2,533											2,533
Cash, cash equivalents and bank overdrafts at 31.3.10	4,513	6,013	2,925	1,353	9,431	9,003	5,374	10,161	11,712	10,472	5,081	5,081

Financial Risks (To be included in new Risk Register)
For the Month Ending 28th February 2009 - (Month 11)

Risk	Gross Value £k	2009/10 Fcast £k	Impact	Likelihood	Score	Comments/Mitigation
A&E penalty	7,100	1,660	Major	Possible	12	Settlement finalised
A&E Variable Income	1,600	1,600	Major	Unlikely	8	On track
CIP	11,600	11,600	Major	Unlikely	8	Shortfall in existing CIP offset by other savings in forecast
Olympics 2012	650	-	Moderate	Unlikely	0	
Other Income (MPET, HART, CBRN)	21,200	600	Moderate	Unlikely	6	
Economic & Environment (Fuel, NHS cuts, Swine Flu)	500	400	Minor	Unlikely	6	Review monthly
Other Non Core Business Profitability (PTS, BAA, Stadia)	250	250	Insignificant	Probable	4	PTS ytd in year loss of £219k

Revised Cost Analysis Schedule
For the Month Ending 28th February 2009 - (Month 11)

	Plan £k	YTD CIP achieved £k	Forecast Achievement £k
Planned CIP			
Overtime Incentive	-6,100	-4,081	-4,080
A&E Overtime	-1,600	7	-329
Agency	-2,000	559	713
Procurement	-600	21	-84
Subsistence	-700	113	151
Other Corporate Processes	-400	-386	-400
Accident Damage	-200	-396	-200
A&E Vacancies	0	0	0
Total Planned	**-11,600**	**-4,162**	**-4,229**
Other Identified CIP			
Staffing Review		-4,100	-4,296
Estates Management		93	-257
Non Essential Project Review		-1,248	-1,428
Fuel & Oil		-162	-105
Vehicle Procurement Slippage		-180	-200
PDC Dividend Adjustment		-933	-1,018
Total Other Identified CIP	**0**	**-6,530**	**-7,304**
Grand Total	**-11,600**	**-10,692**	**-11,533**
% of Revised CIP achieved		**92%**	**99%**

Explanation of Impairment

Impairment of Assets 2009/10

London Ambulance Trust was required to apply indices provided by the Treasury to asset values at the end of 2008/9 which reduced the carrying of assets by £16.7M. The trust has arranged with the District Valuer to carry out a formal valuation of properties using MEA (Modern Equivalent Asset methodically) between November and December. In late August a directive from the Department of Health required Trusts to disclose any potential impairments in 2009/10 in the Month 6 returns, clearly before the completion formal valuation exercise. The Trust has applied indices from the District Valuer to apply to carrying values as an interim measure prior to the formal valuation. These indices suggest a generic fall in the value of property approximately of 12%. In the absence of a better alternative the Trust has applied these to the carrying value of property. The Service Development Committee is requested to note the following:

1) Any property specific impairment is first offset against the revaluation reserve for that property,
2) Any excess of impairment over revaluation reserve is charged to Income and Expenditure
3) The value of this excess has been estimated to be £1.3M for 2009/10 based on the indices provided
4) The impairment charge does not affect the control agreed for the Trust
5) The impairment charge is included within the calculation of the Trust's surplus /deficit reported for statutory accounting.

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Clinical Quality and Patient Safety Report**
Report Author(s)	**Dr Fionna Moore, Medical Director**
Lead Director	**Dr Fionna Moore, Medical Director**
Contact Details	**Fionna.moore@lond-amb.nhs.uk**
Aim	**To provide the Board with evidence of progressing clinical quality and patient safety.**

Key Issues for the Board

The Medical Director's report has been renamed to ensure that greater assurance is provided on clinical quality matters and that patient safety issues are made more explicit. The report will continue to focus on the 7 Domains of Standards for Better Health.

Issues to highlight:

Safety:

- Update provided on SUIs under consideration.
- Compliant with Central Alerting System (CAS) reporting arrangements.

Clinical and cost effectiveness:

- Dr Fenella Wrigley has been appointed Deputy Medical Director.
- The findings from Cycle 3 of the National CPI database are presented. These show overall good compliance, with the majority of aspects of care measured being above the national average. The LAS performed especially well in the Stroke National CPI. There is however room for improvement in pain management in STEMI, and in undertaking direct referrals under the Hypoglycaemia National CPI. This result has highlighted the lack of referral routes for diabetic patients in London.

On the 1st March 2010 a major update to the LAS CPI database was released, with a number of improvements designed to make data entry by Team Leaders more efficient, and to ensure existing CPIs reflect updated national guidance.

- All Team Leaders have completed a 2 week 'Clinical Update' course. Delivery of the 3 hour training course has been completed for 66% of all front line staff

Governance:

- Safeguarding: update on requirement to bring the Trust up from 59% to 80% (CQC compliant) at level 2 training.
- Update on drug management; assurance that the LAS is making significant progress in the management of drug packs as well as controlled drugs.

Infection prevention and control:

- progress recorded against each of the work streams.

Mitigating Actions (Controls)

Action plans in place eg. Infection prevention and control, and controlled drugs;

Recommendations to the Board

That the Board notes the report.

Equality Impact Assessment

Has an EIA been carried out? N/A

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Compliant with CAS reporting arrangements.

Clinical Update training for Team leaders completed; package delivered to 66% staff thus far

Work undertaken to increase levels of safeguarding training

Improved arrangements for the management of controlled drugs

Infection Prevention and Control arrangements reported.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Compliance requirements: CQC registration 2010 and core standards 2009/10

Corporate Objectives that the report links to

Delivering high standards of clinical care

Meeting the educational needs of the workforce

Providing a safe environment for patients and staff

Undertaking high quality audit and research studies

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 30th March 2010

Clinical Quality and Patient Safety Report

Standards for Better Health

First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

Work is underway on the revised SUI policy and practice guidance, the Head of Patient Experiences having been in close liaison with NHS London. It is anticipated that this will be presented to the Board for formal adoption after SMG consideration in May.

5 SUIs have been declared since my report in January; one of these (the ambulance fire incident being made in retrospective at the suggestion of NHS London). Full details will be made available to the Board after the investigation reports have been completed, including any learning identified and recommendations made. However, briefly, these involve

- A delay in an ambulance being dispatched to a Category A patient
- An incident involving the loss of limited but sensitive documentation following a member of staff's vehicle being broken into.
- The call management in relation to a patient who subsequently died at hospital. This is a multi-agency review.
- The management of an incident investigation where a patient fell from the rear of a moving ambulance.
- An ambulance that caught on fire. This is again a multi-agency review.

Central Alerting System (CAS) formerly the Safety Alert Broadcasting System (SABS):

The Central Alerting System (CAS) is run by the Medicines and Healthcare Products Regulatory Agency (MHRA). When a CAS alert 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.

24 alerts were received from 6th January to 10th March 2010. All alerts were acknowledged; three required actions that have been completed, one relating to an estates and facilities alert, one to pregnancy testing kits and one relating to the cold storage of vaccines. Two alerts required further action; both relate to the Powerheart Automatic External Defibrillator.

Second domain – Clinical and Cost Effectiveness

Deputy Medical Director

Dr Fenella Wrigley has been appointed to the post of Deputy Medical Director.

Clinical Performance Indicator completion

The current target for CPI completion is 95%. The current unacceptably poor level of performance is partially due to REAP 4 for a significant part of the quarter, but possibly also due to other distractions such as the Clinical Update training course for Team Leaders. On a positive note we have seen the overall completion rates gradually increase since August.

Area	CPI Completion					
	July	August	September	October	November	December
East	23%	20%	23%	31%	30%	32%
South	30%	44%	46%	40%	45%	54%
West	32%	36%	56%	40%	49%	46%
LAS	**30%**	**36%**	**43%**	**46%**	**43%**	**46%**

Clinical Update for Team Leaders

All Team Leaders have now undertaken the two week 'Clinical Update' course. Feedback has been very positive. All front line staff are being stood down for a three hour period to allow Team Leaders to disseminate the major trauma decision tool and to reinforce messages around new clinical guidelines and infection prevention and control. The numbers completing this are being monitored on a weekly basis; currently 82 % in the South, 61 % in the West and 55 % in the East.

Clinical equipment and documentation update

41 LifePak15s have been delivered to main stations for FRUs. Once the units for the cars have been installed the delivery of the units for the ambulances will be organised.
The Major Trauma Decision Tree comes into effect in April.

A new (paper) PRF has been developed in conjunction with an operational paramedic from Barnehurst Complex and should be ready for release in May. This is likely to be the last paper release prior to implementing an electronic PRF.

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

- **Summary of Findings from Cycle 3 of the National Clinical Performance Indicators** (Authors: Frances Sheridan, Rosie Beverton, Stephen Gadd).

The LAS currently submits data to the National Clinical Performance Indicator (CPI) programme, which is part of a national quality improvement initiative run by the National Ambulance Clinical Audit Steering Group (NACASG) with oversight and steering from the Directors of Clinical Care (DOCC group). This initiative allows all ambulance services in England to compare their performance against each other in five clinical areas: ST-elevation myocardial infarction (STEMI), cardiac arrest, stroke, hypoglycaemia and asthma. Cycle 3 audits (May-September 2009) have now been completed and the main findings (with a comparison to Cycle 2 findings) are reported.

The LAS performed well in Cycle 3 of the National CPIs, with the majority of aspects of care measured being above the national average. The LAS performed especially well in the Stroke National CPI. However areas for improvement were highlighted in pain relief for STEMI patients and in the reporting of hypoglycaemic events.

- **Recent Changes to the LAS' Clinical Performance Indicator Database**

Details of improvement to the CPI database, designed both to make data entry for Team Leaders more efficient and to ensure the aspects of care are up to date and in line with national guidance, are presented.

Both reports are included under Appendix 1.

.

Third Domain – Governance

CQC Registration

An update on this item is provided in the Chief Executive's report.

Update on drug management; recent audit findings and progress

No incidents relating to loss, misuse or adverse effects of LAS drugs, including those used under Patient Group Directions (PGDs) have been reported since my last report of January 2010.

Over the course of the last 2 years there have been audits undertaken of both the "general" and controlled drugs used by the LAS. The results of those audits were disappointing to say the least. The main messages were that in essence the relevant policies and procedures laid down were sound, but that the compliance to the policies / procedures was poor across the service. Work has been undertaken to strengthen compliance to the policies / procedures, and where necessary re-write sections of the relevant policies / procedures. In the area of controlled drugs this has also led to extensive discussions with the Metropolitan Police Drugs Directorate.

Medicines management

The fundamental principles of robust drugs management have lost some of their impact around correctly completed paperwork, availability of drug packs and checking systems. To address this the LAS has started the process to establish a

Medicines Management Committee (MMC). The MMC will be chaired by the Senior Clinical Adviser to the Medical Director and will have oversight of **all** aspects of any drug utilised by the LAS. (It will, however, not deal with any drugs / vaccines used by LAS Occupational Health).

The first meeting of the MMC will be on the 20th April 2010. There will be representation from Operations, Staffside, Logistics and Finance. It is envisaged that the MMC will report to the Clinical Safety, Quality & Effectiveness Committee.

"General" drugs, including PGD Drugs used by LAS

This will be one of the major tasks facing the MMC. In terms of immediate work to be undertaken the MMC will be looking at whether the LAS can move to a vehicle based drug bag system.

Three the immediate work streams for the MMC include:

Review of the drug pack system
Review of the auditing / checking system for drug packs
Review of pharmacy contract in preparation for the pharmacy supply tender.

Controlled drugs

No incidents relating to loss, misuse or adverse effects of controlled drug have been reported since my last report of January 2010.

A major review of the Controlled Drugs policy has been undertaken in the light of the recent internal audit. The major changes that are being implemented are:

- All paramedics will be issued with a personal pouch in which to keep their two ampoules of morphine sulphate. This pouch will be kept on their belt. The pouches are in the process of being purchased from Boundtree and shipped over from China. The LAS has ordered 2,000 at a cost of approx £7 / pouch. It is envisaged that they will actually be issued in April 2010.

- The LAS will now destroy all its' own out of date controlled drugs on site at the Logistics Depot at Deptford. This is a new process for the LAS and will be overseen by the Met Police Drugs Directorate. The Controlled Drugs Policy has been updated to reflect this new activity.

- The Controlled Drugs Register has been redesigned and reprinted. The new registers are due to be in service during the first week of April 2010. A set date for all complexes to change over will be chosen once an assurance that all stations are in possession of he new CD Register(s).

- The Daily Audit and Checking Sheets are to be produced in a bound book. There will be 24 months of checking sheets per book. The precise instructions for what must be checked on a daily basis and how it is to be recorded will be printed on the inside cover of these books. These are hoped to be agreed in design and printed during May 2010. (These are not crucial, but will "tidy up" the process).

- Existing checking and auditing processes are being reinforced to LAS Management Teams and a small series of visits have been undertaken by the

- Stronger auditing processes are being designed in conjunction with the Governance Development Unit and the Met Police Drugs Directorate. (A first step in this direction will be a series of unannounced audit visits by the Metropolitan Police in April / May 2010 to a small selection of randomly picked complexes).

- The controlled drugs policy has been re-written to take account of all the above points. It is currently going through its final approval stages.

An update on progress will be provided in subsequent reports to the Board.

Safeguarding update

Our published Safeguarding Declaration is being amended to reflect that only 59% of clinical staff who have joined the Trust since 2005 have received safeguarding training to the Care Quality Commission benchmark standard . The target is 80%.

This is a situation common to many UK ambulance services. Proposals are being developed by the National Ambulance Safeguarding Group towards ensuring all UK ambulance services can put into place a common training programme and content. It is anticipated that these proposals will be made available to CQC. The Education & Development Department will be seeking to devise a delivery action plan and have recently revised the contents of the training sessions. This is being disseminated for comment to representatives from London Safeguarding Adults Network, NHS London and Westminster PCT (our lead commissioner).

We are also working closely with these agencies towards designing a bespoke training programme for those units (Patient Experiences department, clinical support desk, local complex representatives) who have more direct involvement in our safeguarding arrangements.

Work is also now being undertaken towards an analysis of safeguarding activity in terms of referrals made by crew staff, based on the data assimilated by EBS.

Examples of the Safeguarding activity data now routinely produced by EBS is included under Appendix 2

Finally, the government have recently announced proposals to place adults on the same statutory footing as children. It is likely this will involve the establishment of local Vulnerable Adult Boards in every local authority region akin to the structure of the Safeguarding Children's Board mechanism. This will have implications for the Trust in term of the responsibilities of local complex representatives and the workload to the Patient Experiences Department given the anticipated significant increase in managing cases that progress to Serious Case review level.

Mid-Staffordshire Hospitals, Francis Report

The Francis report issued 18 recommendations as a result of the Independent Inquiry into Mid Staffordshire Foundation Trust. Although there is limited relevance to an ambulance service, there are clearly lessons for all Trusts to learn. These recommendations will be brought back to the April SDC for further consideration.

Fourth Domain – Patient Focus

The Patient Experience report is due at the May Board.

Fifth Domain – Accessible and Responsive Care

Update on the Amber Trial

The findings of the Amber trial, where a limited number of Category B calls were identified as potentially suitable for a response outside the current 19 minute target, and passed to the Urgent Operations Centre, were considered by the DH Emergency Call Prioritisation Advisory Group (ECPAG). The recommendation considered was that 10 determinants were suitable to be managed as Category C calls, while a further 3 determinants required further evidence. ECPAG were broadly supportive of the initiative but requested that evidence be gathered from a sample of Patient Report Forms from the calls. This evidence is currently being considered and it is anticipated that all 13 determinants will be moved from Category B to C in April, following an update to members of ECPAG.

Sixth Domain – Care Environment and Amenities

Update on progress with Infection Prevention and Control Action plan:

(Key messages on progress since January 2010)

- Chemex installations ongoing across the service to provide an effective cleaning solution that is safer for both staff and patients
- Quarterly Infection Control Audits have improved for Q4 in both numbers returned and scores for compliance. The focus for next year will be on improving scores across the Service in all areas, including training centres which appear to have scored quite poorly.
- Training in the ‘5 moments of hand hygiene,’ aseptic technique and cannulation packs have been rolled out to all staff as part of the compulsory updates along with Stroke management and the use of the major trauma decision tree.
- Needle stick injuries have fallen for previous quarter with no high risk cases reported
- Hygiene Code on Performance Accelerator system is up and running with most areas having evidence supplied. This will form the basis of the infection control programme for 2010/11 and will also form part of the Annual DIPC report which will come to the Trust Board in May.
- Further development has taken place for the IPC Champions – there will be a formal review of the programme in future months.
- There has been a case of a possible viral haemorrhagic fever in the last few weeks where Category 3 procedures invoked – resultant review of procedures

- Blanket exchange trial underway at Chase Farm Hospital with further site aligned to NWOW sites agreed for near future.
- Following an inspection in March by the Health & Safety Executive, IPC was one of the areas scrutinised by the team. Initial feedback did not indicate any major issues in this area for the Trust. The final report is due at the end of the month.

Seventh Domain – Public Health

Nothing further to report.

Recommendation

That the Board notes the report.

Fionna Moore,
Medical Director
18th March 2010

Appendix 1

London Ambulance Service NHS Trust
Trust Board Meeting – March 2010
Clinical Reporting to the Board

Clinical Audit & Research Summary Reports for the Trust Board

Authors: Frances Sheridan, Rosie Beverton, Stephen Gadd.
Clinical Audit & Research Unit, Medical Directorate

Summary of Findings from Cycle 3 of the National Clinical Performance Indicators

Introduction

The LAS currently submits data to the National Clinical Performance Indicator (CPI) programme, which is part of a national quality improvement initiative run by the National Ambulance Clinical Audit Steering Group (NACASG) with oversight and steering from the Directors of Clinical Care (DOCCs). This initiative allows all ambulance services in England to compare their performance against each other in five clinical areas: ST-elevation myocardial infarction (STEMI), cardiac arrest, stroke, hypoglycaemia and asthma.

To enable ambulance services to assess changes in clinical performance over time the National CPI programme repeats the audit of each clinical area in cycles, every six months. Cycles 1 (May-September 2008) and 2 (November-March 2009) of the National CPI programme demonstrated that the LAS was performing well in the majority of areas and allowed potential improvements to be highlighted. A summary report relating to these cycles is available on the LAS's X drive (X:\Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\National CPIs\) or the full reports are available on request from the Clinical Audit & Research Unit. Cycle 3 audits (May-September 2009) have now been completed and the main findings (with a comparison to Cycle 2 findings) are summarised below.

Results

The table below shows the LAS compliance scores from Cycles 2 and 3 of the National CPIs compared with national average compliance scores. Aspects of care that were piloted during Cycle 3 are marked with N/A in the Cycle 2 column.

Indicator	Cycle 2		Cycle 3	
	LAS Compliance	National Average Compliance	LAS Compliance	National Average Compliance
STEMI				
Two pain scores recorded*	84.85%	65.52%	84%	72%
Morphine given	N/A	N/A	61%	55%
Aspirin administration*	89%	86%	96%	87%

GTN administration*	78%	81%	94%	81%
Analgesia given*	68%	54%	49%	54%
[pilot] $SP0_2$ recorded	N/A	N/A	99%	90%
[pilot] Care bundle[a]	N/A	N/A	42%	45%
Stroke				
FAST assessment*	97%	87%	95%	93%
Blood glucose measurement*	97%	82%	94%	89%
Blood pressure measurement*	99%	98%	99%	99%
[pilot] Time of onset of stroke recorded	N/A	N/A	63%	51%
[pilot] Care bundle[a]	N/A	N/A	88%	83%
Cardiac Arrest				
ROSC on arrival at hospital	27%	17%	22%	25%
Defibrillator on scene*	100%	99%	95%	98%
Time to respond ≤ 4[a] minutes*	15%	20%	18%	27%
[pilot] Care bundle[a]	N/A	N/A	17%	27%
Hypoglycaemia				
Blood glucose measured before treatment*	98%	97%	100%	98%
Blood glucose measured after treatment*	97%	96%	96%	96%
Treatment recorded*	99%	98%	98%	97%
[pilot] Direct referral made to an appropriate health professional	N/A	N/A	7%	27%
[pilot] Care bundle[a]	N/A	N/A	94%	92%
Asthma				
Respiratory rate recorded*	100%	97%	100%	98%
Peak flow recorded*	55%	31%	57%	31%
SpO_2 recorded*	79%	85%	78%	89%
Beta 2 agonist given*	96%	94%	97%	92%
Oxygen administered	96%	89%	95%	89%
[pilot] Care bundle[a]	N/A	N/A	51%	28%

[a] The care bundle assesses the number of patients that received a combination of aspects of care for a National CPI. The aspects of care which made up the care bundle are indicated by an asterisk (*).

[b] Call start to arrive scene

Discussion

The London Ambulance Service performed well in Cycle 3 of the National CPIs, with the majority of aspects of care measured being above the national average. The LAS performed especially well in the Stroke National CPI.

LAS scores from the Cardiac Arrest CPI for Cycle 3 are below the average. Nonetheless, the majority of these scores fall within acceptable performance limits. The LAS compliance score for 'Time to respond ≤ 4 minutes' has risen from Cycles 1 and 2, indicating that the LAS has improved its response times for these patients.

The LAS received a low compliance score for direct referrals under the Hypoglycaemia National CPI. This result has highlighted the lack of referral routes for diabetic patients in London.

Compliance scores for asthma were above the national average for all aspects of care apart from '$Sp0_2$ measured'. The LAS score for recording peak flow was particularly high.

Notably, administration of analgesia to STEMI patients scored particularly poorly, and decreased from Cycle 2. In order to improve STEMI analgesia compliance an improvement campaign was launched across the service in October 2009 in the form of posters and updates encouraging crews to administer analgesia to this patient group as per guidelines. The effect of this improvement campaign will be measured in subsequent Cycles.

Recent Changes to the LAS's Clinical Performance Indicator Database

Background

The LAS has its own, longstanding, programme of CPIs that measure clinical performance in 6 key areas: cardiac arrest; acute coronary syndrome, difficulty in breathing, glycaemic emergency, stroke and patients who are not conveyed to hospital. In addition, the CPIs assess the standard of general documentation applicable on every Patient Report Form (PRF).

Unlike the National CPIs, which were developed to enable the comparison of care between ambulance services, the LAS CPIs were developed to allow Team Leaders to audit the quality of care provided by our crews and provide to them structured, evidence-based feedback. The CPIs were first introduced into the LAS in 2000 and took the form of a paper based system. A major update followed in 2003 with the launch of an electronic CPI database. Two further updates took place in 2005 and 2007, when an online system was released featuring automated feedback generation and enhanced statistics reporting.

On the 1st March 2010 a major update to the CPI database was released, with a number of improvements:

- Electronic PRFs.

  The 2010 release provides Team Leaders with scanned images of PRFs via the database. PRFs are selected automatically by a computer program, based on illness or destination code, which ensures an objective sample of PRFs are audited. The database also informs Team Leaders how many PRFs are available for audit so that they can manage their workload effectively. Scanning provides a clearer PRF for auditing than the yellow carbon copy because the top copy of the PRF is used. In addition, the back page of the PRF and any additional attached information (for example ECG strips) is scanned. This allows Team Leaders to base their audit on more information.

- Dual monitors

  So Team Leaders can audit electronic images more easily, we provided each Complexes' Team Leader workstation with an additional computer monitor.

- Stroke CPI

A new Stroke CPI has replaced the Obstetric Emergencies CPI. This will support our management of this patient group and the introduction of the new stroke pathway. Obstetric emergencies will continue to be assessed through specific audit projects which will allow a more thorough assessment of this high risk group.

- Updated Aspects of Care

The CPIs have been reviewed and the aspects of care updated to ensure they are in line with current guidelines.

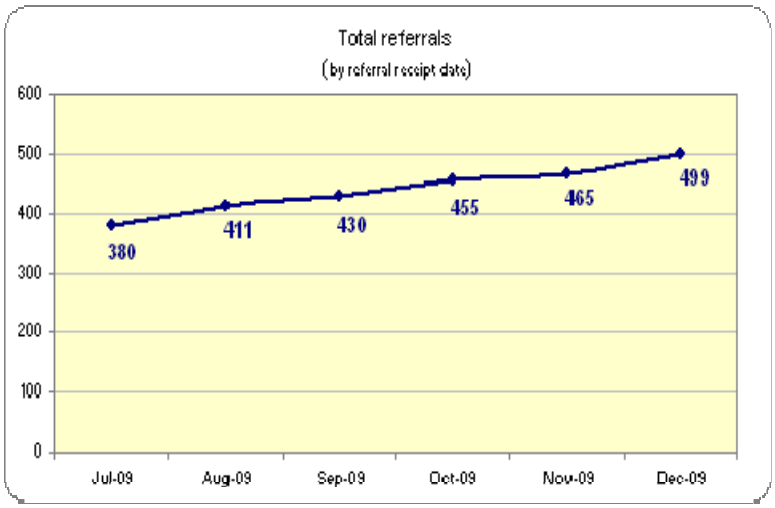
Conclusion

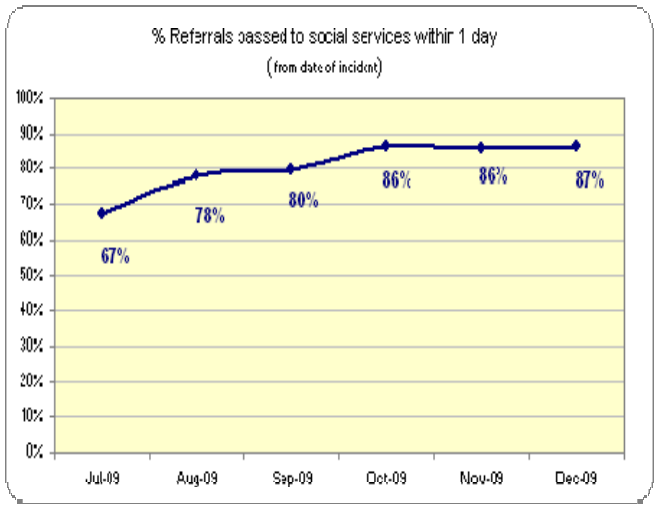
The updated database has realised a number of improvements designed to make the CPI audit process both easier and quicker for Team Leaders. Together, they should raise CPI completion rates giving us a better understanding of our care provision, give Team Leaders more time for CPI feedback and ultimately raise the quality of our patient care.

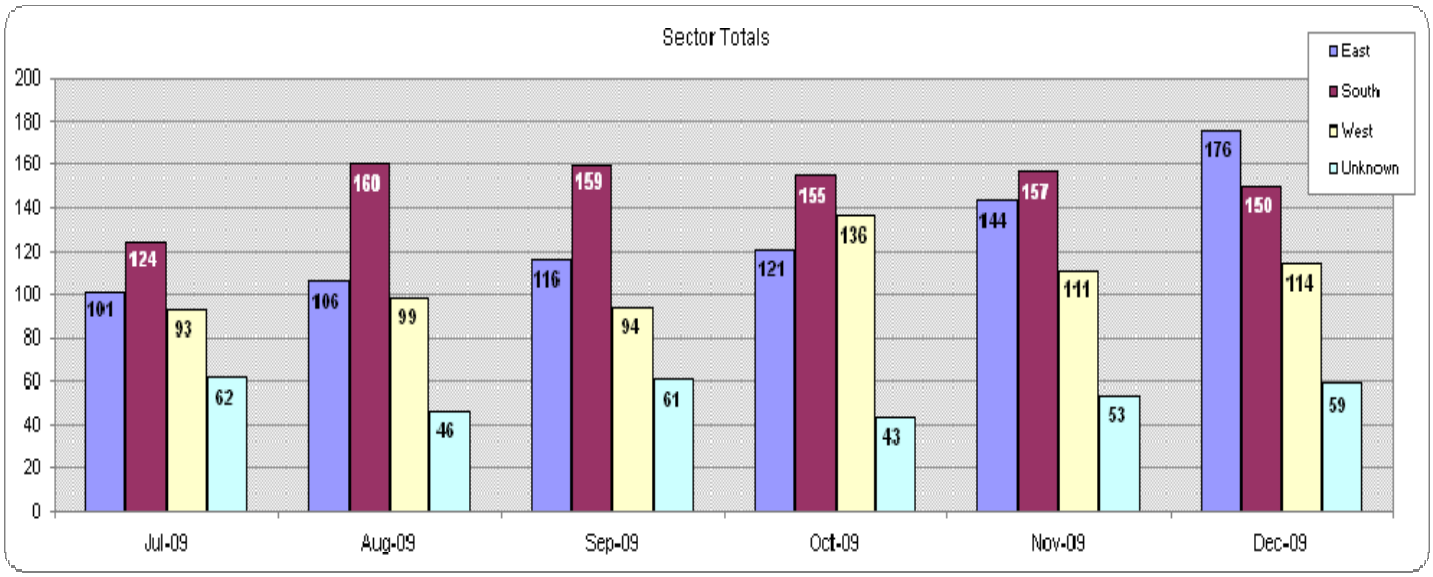
Appendix 2

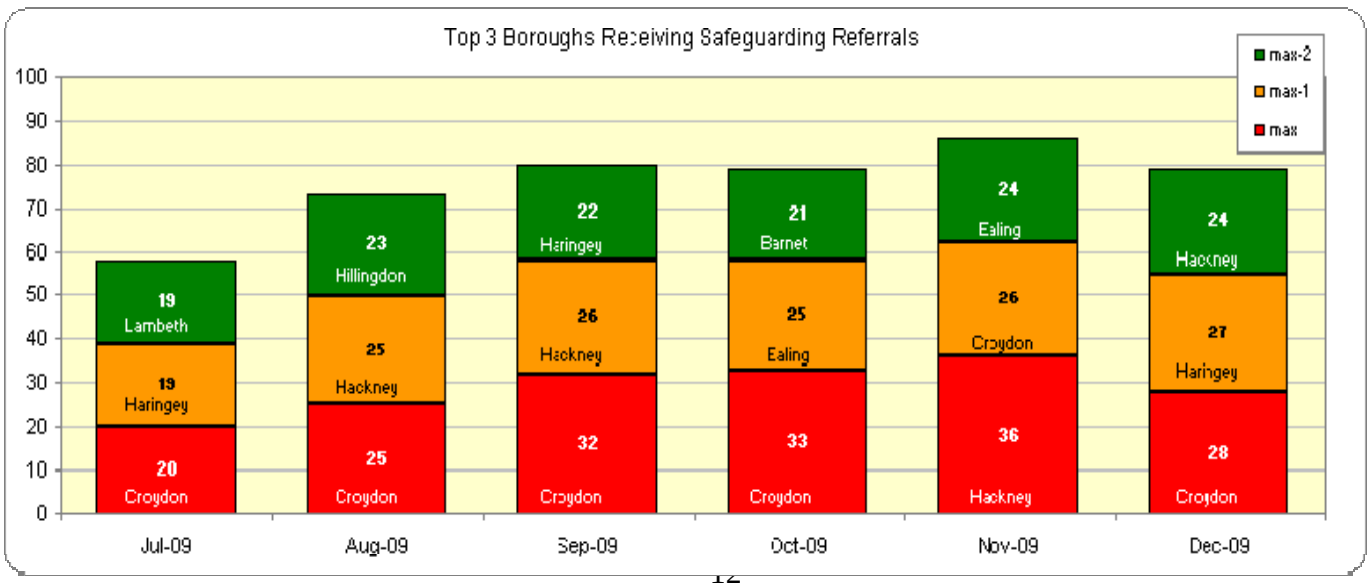
Safeguarding Activity Reports

July - December 2009

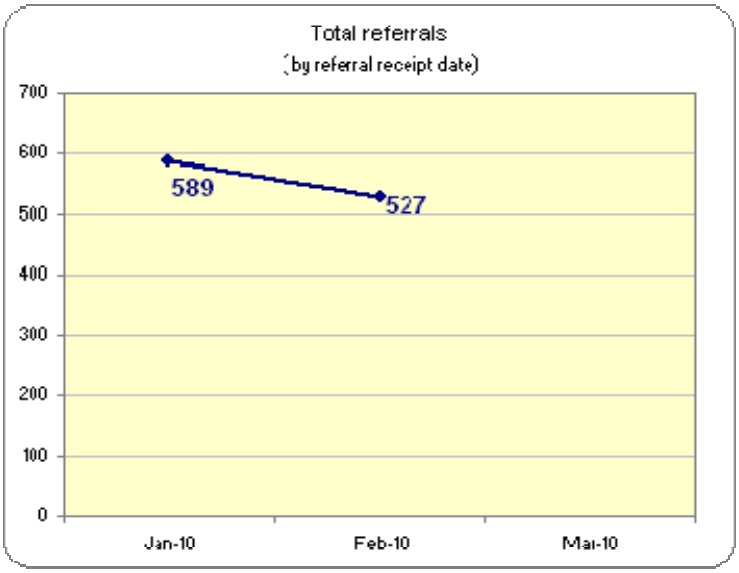


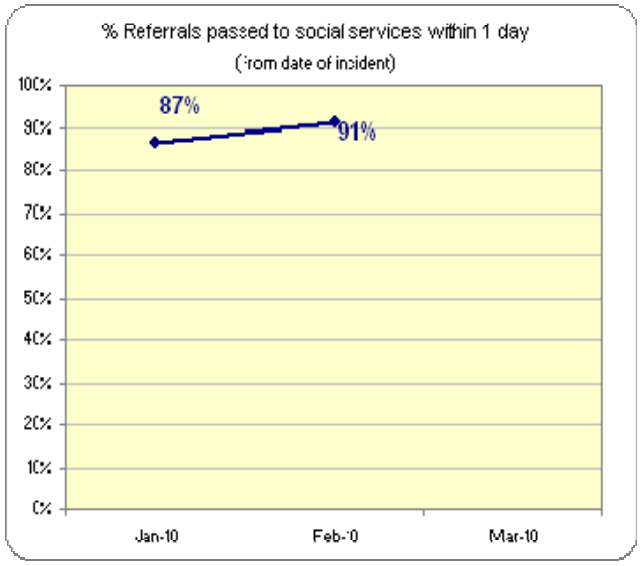


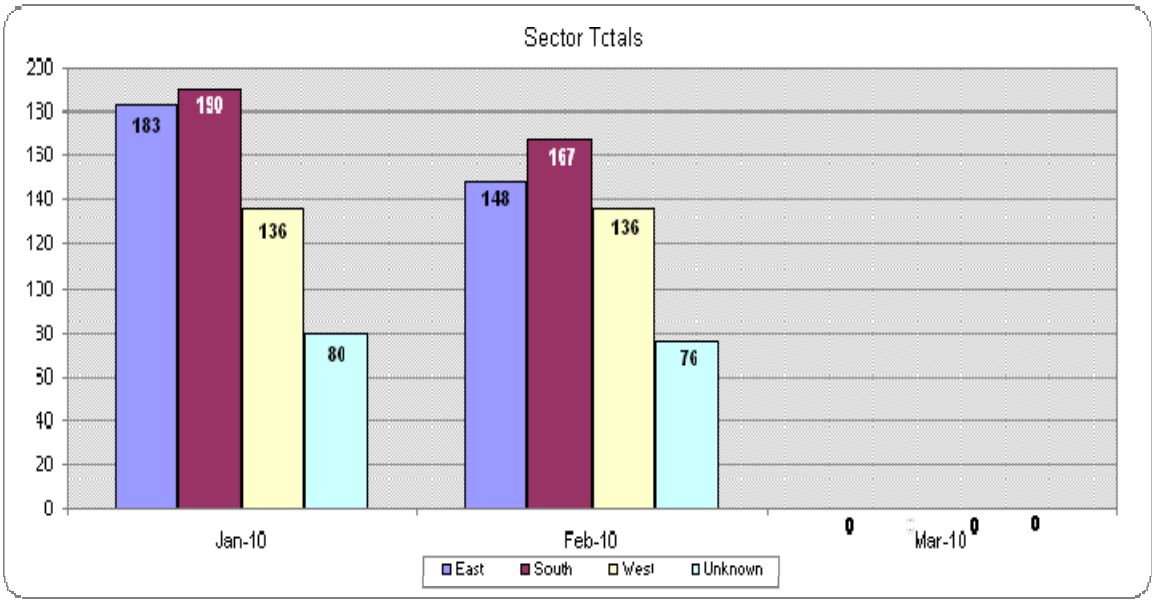




1st Quarter 2010 January - March 2010







London Ambulance Service NHS Trust

TRUST BOARD - 30 March 2010

Document Title	**Business Plan 2010/11**
Report Author(s)	**Mike Dinan**
Lead Director	**Mike Dinan**
Contact Details	**Michael.dinan@:lond-amb.nhs.uk**
Aim	**To seek Board approval for business plan**

Key Issues for the Board

The business plan for the LAS, previously reviewed by the Trust Board in Jan 2010 has been updated to reflect agreement with commissioners on core A&E funding. It also reflects the returns sent in to NHS London and the Department of Health.

A paper is attached

Some key numbers :

- Total income £286m
- A&E income £252m
- Surplus £ 2.3m
- Cost Improvement Program £ 17.6m
- Capital £23.7m

The budget is now being developed and completed with department managers to reflect this plan. A detailed workforce plan will be presented to the SDC in April 2010.

Mitigating Actions (Controls)

Budgetary process

Recommendations to the Board

To approve the Business Plan

Equality Impact Assessment

Has an EIA been carried out? No

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Financial risks outlined in Plan

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

See plan

Corporate Objectives that the report links to

- To create a framework to achieve effective management & utilisation of resources

NHS London

Trust Name: London Ambulance Service

Annual Plan date: 2010/11

NHS London

Key contacts at Trust (name, telephone number, email address)			
Name	**Title**	**Telephone**	**Email**
Executive Lead:	Michael Dinan	0207	Michael.dinan@lond-amb.nhs.uk
Finance:	Asif Islam	0207	Asif.islam@lond-amb.nhs.uk
Workforce:	Caron Hitchen	0207	Caron.hitchen@lond-amb.nhs.uk

SECTION 1: STRATEGIC OVERVIEW

Provider Landscape and timescale to end state as a result of implementation of Healthcare for London. Where do you expect to be at the end of and 2010/11 and 2011/12.

Please include a note on expected movements in activity, services and expenditure

999 Call volume is planned to grow at 5% and incident volume at 3.5% p.a.

The LAS will continue implementing its strategic plan, focusing on delivering more appropriate care to all its patients, developing a clinical model in line with HfL , reducing demand, deliver national targets and generate a surplus of 1%.

Total Operating expense is planned to increase by 1.5% to £277m (£759k per day or £33 per head of population)

What productivity improvements are expected by 2010/11 and 2011/12?

The LAS continue to handle calls in a more innovative way using Clinical Telephone Advice (CTA) and NHSD and treatment centres during specific periods of high 999 demand. The LAS expect to save 78,000 traditional ambulance responses p.a. in this way. The LAS is ready to utilise more non A&E pathways in 2010/11 in conjunction with London PCTs, concentrating particularly on the use of Minor Injury Units, Walk In Centres and appropriate referral for uninjured fallers..

The LAS will handle increased activity at a marginal rate of 60%, absorbing the balance with increased efficiencies.

The LAS will continue to reduce its portion of the hospital turnaround time to 15 minutes by the end of 2010/11 (20% reduction).

What impact are the HfL and productivity improvements envisaged to have on the workforce, including the impact on workforce utilisation?

The LAS will see increased ambulance journey time in 2010/11 as patients with stroke and trauma are taken directly to a specialist centre and local hospitals are bypassed.

The implementation of HFL will allow our better skilled workforce to deliver more appropriate care to a wider range of patients. While some of these initiatives will have the effect of increasing job cycle time, they will deliver significantly improved patient care.

As the workforce is up-skilled, the LAS expects to see a reduction in double sending of resource as increased numbers of staff make decisions as single responders (without the need for ambulance backup) and fewer patients are taken to hospital.

It will be critical that London PCTs provide significantly more alternative care pathways to allow better,

more appropriate patient care in line with the LAS strategy.

It is also critical that there is a clear commitment from London PCTs regarding a reduction in hospital closure & diverts.

What impact are the HfL and productivity improvements envisaged to have on asset utilisation?

As a result of HfL and productivity improvements changes the effect on asset utilisation is as follows:

	2009/10	2010/11	% Movement
Revenue	279,464	286,400	2%
Average Capital Employed	100,724	101,058	0%
	2.8	2.8	

SECTION 2: PERFORMANCE

Please describe your interaction with your Sector Acute Commissioning Unit

The LAS works closely with the new Ambulance Commissioning Unit hosted by NWL on behalf of London PCTs. There is now a full time team of 12 commissioners working with the LAS.

Are all operational targets forecast to be met? If not, which ones are unlikely to be met, is there an action plan in place and what is the timescale for achievement?

The LAS will hit two of the three national ambulance targets (CatA8 and CatA19) in 2009/10. The LAS will achieve 86% on the CatB19 target. This is above both 2008/09 and the CQC performance threshold. There is an action plan in place to deliver 91 % from April 2010 and 93% for the year as a whole. This will be dependent on :

1. Agreed PCT transformation plan
2. Continued joint reduction on hospital turnaround to deliver a net 5 minute reduction
3. Demand remaining within the planned thresholds

SECTION 3 FINANCIAL PLANNING

Clinical Revenue

£000	Plan 2009/10	Forecast 2009/10	Plan 2010/11	Plan 2011/12
PbR - Elective				
PbR - Non-Elective				
PbR - A&E				
PbR - Outpatient				
PbR - Other				
Non-PbR: critical care				
Non-PbR: mental health				
Non-PbR: community care				
Non-PbR: other				
Excluded drugs & devices				
Non Contract Activity	266,160	259,765	276,988	285,298
LSCG				
NCG				
Transitional funding				
TOTAL	**266,160**	**259,765**	**276,988**	**285,298**

Commentary on clinical revenue

Please explain the significant changes in clinical revenue including:

Clinical income has increased by £11m to £277m

A&E Contract

- 9/10 growth over baseline - £0.5M
- 10/11 Growth 3.5% at 60% marginal rate - £5.1M
- CQUIN £3.8M

Other Clinical income

HART £1.2M increase
Other £ 0.4M increase

Other revenue

£000	Plan 2009/10	Forecast 2009/10	Plan 2010/11	Plan 2011/12
Research and development				
Education and training	10,800	10,445	7,632	7,856
Transitional PFI				
Other				
TOTAL	**10,800**	**10,445**	**7,632**	**7,856**

Commentary on other revenue

Please explain the significant changes in other revenue

MPET income reduces to reflect activity.

Expenditure

Please explain the significant changes in expenditure

Pay:

- Additional activity is included at 60% of the average base cost
- There is a planned reduction of 53 (£1.2m) in non frontline staff as part of the CIP.
- There is a planned reduction in Agency Spend (£4m)
- Pay Inflation of 2.25% and Incremental Grade Drift of 0.5% of have been applied to all relevant staff at a cost of £3.66m
- Increase in National Insurance costs (£2m)

Drugs: No material Change

Clinical Supplies and Services:

Other :

New CAD system: £1.5m increase in incremental project costs

Estates Project Costs: £0.8m

Third Party Transport: Reduction in Third Party usage of £2.1m

Subsistence: Reduction of £1.8m
Depreciation:

- Impact of renewing fleet £6.0m

PDC Dividend: increase of £0.6m due increasing value of assets

Overall position

£000	Plan 2009/10	Forecast 2009/10	Plan 2010/11	Plan 2011/12
Revenue from Patient care activities	271,587	269,692	276,988	285,298
Other operating revenue	10,443	9,772	7,632	7,859
Operating expenses	-275,372	-274,731	-277,375	-282,995
Operating surplus/(deficit)	**6,658**	**4,733**	**7,245**	**10,162**
Other gains and losses	**0**	**-57**	**-1**	**-1**
Investment revenue	168	30	12	16
Finance costs	0	-1,061	-972	-980
PDC dividends payable	-4,920	-3,360	-3,960	-3,980
Retained surplus/(deficit) for the year	**1,906**	**285**	**2,324**	**5,217**
Impairments included	0	-1,306	0	0
IFRS impact included	0	0	0	0
Retained surplus/(deficit) excluding impairments and IFRS	**1,906**	**1,591**	**2,324**	**5,217**
Contingency included	600	0	1,200	1,200

Commentary on overall position

Please provide an explanation of your overall financial position including sections on:

The Net effect of IFRS is expected to be nil in 2009/10, 2010/11 and 2011/12 as the additional Finance Lease and Interest Payment costs Net off against the reduced Depreciation

Medium term Financial Strategy and historic debt

The Trust will achieve a surplus of over 0.8% in 2010/11 and 1.6% in 2011/12. In each year the Trust will remain cash positive whilst remaining within the Public Borrowing Limit (PBL). The Trust will seek, where appropriate, to finance capital assets through leasing arrangements thus releasing cash for other expenditure. The Trust has a £10M loan relating to the introduction of CommandPoint.

Contingency: 1.2m

Cash: The opening cash position is £5.1M the closing is £2.5M. The Trust expects to be cash positive though the year. Payment terms to suppliers will be maintained under the Public Sector Payment Policy. The cash outflow in respect of capital will be funded from depreciation.

The impact of IFRS

The impact of IFRS on the Trust has been in two areas:

Accounting for annual leave not taken by staff at year end
Reclassification of ambulance leases from operating to finance leases

Accounting for outstanding annual leave at year end

The value of annual leave untaken at the end of 2009/10 has been assumed to be unchanged from that in 2008/09. The amount provided is £2,571k.

For the purposes of business planning this provision has been kept constant because front line operational staff have moved from a leave year of April to March to an individual leave year based on the anniversary of joining. It has assumed that the reduction in annual leave liability at March 2010 will offset the effect of the increase in staffing.

Reclassification of ambulances

The trust has 260 ambulances held under lease arrangements. Under SSAP21 the trust treated these leases as operating leases. Payments made in respect of these leases were treated as expense items. Applying IAS 17 the trust has recognised these as finance leases. The effect of these on a like for like basis is summarised below summarised in the table below:

	2009/10	2010/11
Non Current Assets Property Plant and Equipment	£30,707k	£30,707k
Accumulated Depreciation	£20,508k	£23,075k
Liability	(£27,821k)	(£23,319k)
Finance Charges	£1,102k	£936k
Depreciation	£3,762k	£2,567k
PDC	£0	£0

It has been assumed that the lease replacements will be on like for like basis and will not change the

position above.

There is no change in cash.

Key Assumptions included within the plan

- Additional A&E activity is funded at 60% of the average cost
- Additional Non A&E activity such as the impact of the 2010 World Cup is adequately funded
- Non A&E income (CBRN, MPET, etc) is fully funded.
- NHSD do not charge for calls passed to NHSD and continue with the present arrangements of taking LAS calls
- The LAS delivers its plan to further improve Category B performance.
- Incident growth is assumed to increase by 3.5% in line with the 09/10 growth
- Call growth is assumed to increase by 5.4% in line with the 09/10 growth
- It is assumed that 100 additional frontline staff will be recruited in the year giving an additional £3M in pay cost. This together with the full year effect of staff recruited in the Q4 of 2009/10 will give a frontline resource increase of 11.8%. Inflation of 2.25% and grade drift will add £3.66M .Overall front line pay costs increase by 16.8M to £136.2M. Overtime will reduce by 62% to £4.9M, an £8M reduction in cost.
- The West Area HART team will be recruited giving an increase in WTE of 44 and pay cost increase of £2M.
- Corporate Support will deliver a full year reduction in WTE of 34 giving a 6.7% reduction in staffing
- PTS staff will reduce by 45 to reflect the decrease in activity giving an 18.6% reduction in WTE
- There will be a net increase in staff numbers 353 WTE n overall 7.9% reduction
- There will be a 55% (£4M) reduction in Agency costs
- Subsistence costs will reduce by £1.8M
- Third Party transport costs will reduce by £2.1M, a 95% reduction.
- A reduction in vehicle costs of £0.5M through the introduction of newer vehicles and better insurance rates
- Estates costs will increase by £0.8M as a result of new projects such as Cody Road and Islington
- Revenue costs associated with CommandPoint will increase by £1.5M

CQUINS

Describe what your commissioners have contracted for in relation to CQUINS

CQUIN is 1.5% of the contract value as per the operating framework. Emphasis is placed on :

1) Increasing the use of alternative care pathways which aims to improve effectiveness and innovation. This carries a weighting of 1.2% or £2,973k.
2) Improvement of patient outcomes which aims to improve safety effectiveness, experience and innovation. This carries a weighting of 0.3% or £743k.

Cost Improvement Programme (expenditure savings only)

CIPS targeted in the plan are :

		£000
Incentives	**£**	**2,997**
Corporate Support Payroll	**£**	**1,970**
Agency	**£**	**4,218**
Subs and Staff related	**£**	**2,088**
Third party transport	**£**	**2,052**
Other Non Pay	**£**	**4,251**
TOTAL	**£**	**17,576**

How will the achievement of these savings be managed in year and what risks are there to achievement?

CIP is delivered via both the budgetary process and the Service Improvement Programme .

Risks are that performance pressures will result in a slippage of the Pay CIP. This will be managed on a rolling weekly basis by the service.

A CIP Programme led by the SMG and managed by Martyn Salter will target trust wide savings.

Income generation included in the plan

NHS income over and above signed acute contracts – please give detail of commissioner and amounts

PTS: the plan is to retain and win sufficient business to deliver a £0.6M contribution to the Trust.

Other: the Trust plans to maintain the margin in line with 2009/10 e.g. Stadia attendance.

Please give detail of any other material non-NHS income change from last year

Demand management schemes (amount notified by commissioners, have they been included within your plans, how realistic are they, timing of implementation, how are you expecting to manage their impact etc.)

Note: must be scheme specific with clear explanation of implementation, activity reductions and expected benefits

The LAS has not yet agreed detailed demand management schemes with PCTs.

Two key schemes will be :

1. Non A&E attendance

In 2009/10, the LAS has managed to reduce unnecessary A&E attendances by c. 65,000 saving the local Health economy at least £7m. The LAS expects to continue this in 2010/11 as part of the agreed KPIs with PCTs. The LAS also required significant development by PCTs of alternative pathways to further develop better urgent care. PCTs will need to evidence a step change in the delivery of viable alternative pathways

The LAS will need to up skill its workforce and the pace of this will need to be aligned with the continued need to deliver performance

2. Additional activity at 60% marginal cost

Capital investment and disposal (including sources of funding)

The table below shows the summary of planned expenditure. All funding is from internally generated sources unless otherwise identified.

	Capital £K
Estates - General	688
Event Control Room (2012)	992
HART East Area funded by DoH	657
HART West Area funded by DoH	826
Workshop Reconfiguration	1,500
65 Ambulances Buy New Funded internally	5,330
Ambulances funded by lease (remount)	6000
Defibrillators	938
CAD2010	3500
IMT	993
FRU replacement	1,400
Total Capital	22,734

Final capital allocations will agreed with NHS London and the DH in April 2010

Key risks included within the plan

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Additional A&E activity not funded	H	No effective mitigating actions possible resulting in failure to achieve CatB target
MPET funding not received	M	Delay in implementing HfL and LAS strategic initiatives
CBRN funding not received	L	PCT will need to provide funding
Remount of Ambulances	M	Restructure of fleet plan

Key risks and opportunities not included in the financial plans

Key risks not included in the plan with mitigating actions

The key risk to income is the non achievement of the Cat A and Cat B target. Failure to achieve either risk equates to 2% of PCT commissioned income, both equates 4% or a total of £9.8M.

Failure to achieve locally agreed KPIs put a further 4% of income at risk.

The global volatility of fuel prices will continue to be a risk to the ambulance service that consumes (on average) 12,500 litres of fuel per day. Mitigating actions would be to seek to achieve savings in other non pay areas of the business in order to maintain the Trust's core activity.

Key opportunities not included in the plan with mitigating actions

Pathway development

Could you provide an explanation of the impact of up to a 10% downside funding scenario?

10% reduction would equate to c. £28 m shortfall in resource. Adjusting for both planned net profit (£3.5m) and overtime (£3m), this would require additional costs of c. £21.5m to be saved. This would require an additional staff reduction of c. 600 staff off of the planned base. The LAS would not recruit the planned additional 100 staff, leaving a potential pool of staff for redundancy of 500.

The National targets would not be achieved in this scenario with some calls receiving a lower level of response

ALE - plans to improve your score

The summary of the ALE scores historic and target is show below:

	2008/09	2009/10	2010/2011
Financial reporting	3	3	3
Financial Management	4	4	4
Financial Standing	4	4	4
Internal Control	3	3	4
Value for Money	3	4	4
Overall Actual / Target	4	4	4

Actions taken to improve the ALE scores are :
Formulation of a Carbon Reduction strategy.
Updating the Procurement Policy
Updating the Expenses Policy
Canvassing stakeholder views on format of the published accounts Value for money auditor
Collating evidence of the integration of the finance strategy with other Trust strategies
Finding a mechanism for the formal signing off of contracts with all PCT (not just the lead Commissioner)

WORKFORCE SECTION

Please see appendix 1 for guidance upon completing the table below.

Workforce Plan – Permanent (Contracted) Staff in Post				
Full Time Equivalent (FTE)	**Plan**	**Forecast**	**Current plan**	
	2009/10	**2009/10**	**2010/11**	**2011/12**
All Medical and Dental Staff	**2**	**2**	**2**	**2**
>> *Of which Medical and Dental Consultants*				
Ambulance Staff	**3,309**	**3,322**	**3,489**	**3,500**
Managers and Senior Managers	**216**	**202**	**160**	**192**
Administration and Estates Staff	**757**	**621**	**578**	**595**
Healthcare Assistants and Other Support Staff				
Qualified Nursing, Midwifery and Health Visiting Staff				
>>				
Qualified Scientific, Therapeutic & Technical Staff				
>>				
>>				
Others	**633**	**653**	**537**	**537**
Total*	**4,917**	**4,800**	**4,766**	**4,826**

** Total should not include staff sub-groups in italics*

Please provide a description of the key planned service developments or reconfigurations that are likely to significantly affect the required workforce e.g. Healthcare for London, new services, closure of services, TUPE transfers of staff

- **100 additional frontline staff** including HART
- **Reduction in Non Frontline Staffing:** There is a planned reduction of 53 WTE in non frontline staff as part of the CIP phased saving £1.2m. This will be the result of examining corporate services and streamlining corporate processes to make them more efficient.
- **Advanced Paramedics**: these staff are planned to be single responders who will contribute to more appropriate delivery of clinical care that will reduce unnecessary resource deployment and improve clinical outcomes for patients due to their additional clinical skills.
- **HFL implementation** : implementation of both Stroke and Trauma will significantly increase job cycle time for these cases
- **A&E closures (Chase Farm & QM Sidcup)** : Additional resource agreed in contract
- **More extensive cardiac network development** :
- **Better skilled single responders**

What is the organisational approach to Cost Improvement Programmes and what is the foreseen impact of these upon the workforce?

CIP are delivered via both the budgetary process (Pay) and the Service Improvement Programme (Non Pay).

The trust is looking to reduce it's non frontline establishment by 53 WTEs and reduce expensive agency usage by £4m. This will be achieved through restructuring corporate departments to improve the efficiency of corporate processes and recruiting, where appropriate to those roles which have typically been occupied by more expensive agency staff.

Incentive costs, subsistence and agency cost will be significantly reduced due to the full year effect of an additional 550 frontline staff

What is the organisational approach to improve Productivity & Efficiency and what is the foreseen impact of this upon the workforce?

The trust is looking to reduce it's non frontline establishment by 53 WTEs and reduce expensive agency usage by £4m. This will be achieved through restructuring corporate departments to improve the efficiency of corporate processes and recruiting, where appropriate to those roles which have typically been occupied by more expensive agency staff.

What is the organisational strategy in terms of using bank, agency and locum staff? Is there an approach to tackling vacancies rates? Are there particular staff groups that are problematic to recruit?

- There is a planned reduction in Agency Spend of £4.2m in 2009/10 and the organisational strategy is to move away from long term temporary staff usage in areas with full time vacancies.
- The trust does have a small number of bank staff that it utilises on an ad hoc basis.

Tackling Vacancy Rates

Recruiting University Paramedics: The trust has close ties with several universities and recruits approximately 50 paramedics per annum.

Large scale Trainee Paramedic recruitment programme: The Trust has recruited approximately 550 additional Trainee Paramedic in 2009/10 and will use its existing training model to build capacity in the future e.g. using London Wide newspaper adverts, working with Job Centres etc.

Developing Apprenticeship schemes for Fleet Technicians: The option of recruiting and training our own Fleet technician apprentices in house is currently being explored in order to deal with ongoing vacancies in this area.

Departmental Restructure to recruit staff at more appropriate levels: Where departments have found staff difficult to recruit the workforce structure can be re-examined to assess appropriate remuneration levels and working conditions in order to make the roles more desirable to permanent staff.

Staff Areas that are typically difficult to recruit include:

- Qualified Paramedics
- Fleet Technicians
- Senior IM&T professionals
- Clinical Telephone Advisors

Can you continue to maintain European Working Time Directive (EWTD) compliance? Does the current medical staffing configuration present a sustainable solution to EWTD? If not, what plans are in place to ensure that compliance is sustainable? What processes do you have in place to ensure medical revalidation is carried out effectively?

Yes

Has the organisation identified any changes to the delivery of Continuing Personal & Professional Development (CPPD) training that may be required as a result of your workforce strategy? What proportion of your education and training budget will be allocated to workforce transformation in order to deliver your service vision for the future?

The continuation of the Student Paramedic training programme to achieve the staffing levels required by the ORH model as agreed by the Commissioners.

The Trust has recognised the need to acquire enhanced assessment skills in keeping with the recommendations of *Taking Healthcare to the Patient*. The precise configuration of the skills and development required is part of a project that is chaired by the HR director. It is anticipated that the Trust will receive MPET funding for this project.

The total MPET funding planned is £6.9M to support The whole MPET program.

Are you able to demonstrate that there is a focus to develop talent and leadership in line with service delivery and financial management?

- Provision of Leadership and Senior Leadership programmes together with various line management programmes.
- Launch of the LAS Talent Management programme in spring 2010.
- Board Development Programme (FT process)
- LAS representation at the NHSL aspiring director programme

What challenges and risks have been identified by the organisation that may prevent it from achieving its workforce goals?
• Recruitment Slippage against plan • Availability of skills in the market at NHS pay rates • External funding constraints from commissioners • External funding constraints for CPPD (MPET)

Appendix 1

Plan 09/10 should reflect the planned position for 31st March 2010 as originally returned in the 2009/10 workforce plan to NHS London (submitted in March 2009).

Forecast 09/10 should reflect the revised forecast position for 31st March 2010. This is likely to differ from the number above due to in-year service changes.

Current Plan 10/11 should reflect the planned position as at 31st March 2011.

Current Plan 11/12 should reflect the planned position as at 31st March 2012.

Staff should be classified into groups using the following methodology:

Census occupation code(s)	FIMS staff groups
001-099 494-996	Medical and Dental
A*	Ambulance staff
G0*, G1*	Managers and senior managers
G2*, G3*	Administration and estates
H1*, H2* N8*, N9* P* T7*, T8* S8*, S9*	Healthcare assistants and other support staff
NA*-N7*	All qualified nursing, midwifery and health visiting staff
N2*	Qualified midwives
SA*-S7* TA*-T6*	All qualified scientific, therapeutic and technical staff
TA*, TB* T0-T6	Healthcare scientists
SOA-SOJ S1A-S1J S2D S4A-S4D S6C-S6J S7A-S7J SAA-SAJ	Allied health professionals
Z*	Others

Please note that certain occupation codes are included in the Qualified, Therapeutic and Scientific overall group but are not contained in either the Healthcare Scientist or Allied Health professionals groups.

Medical and Dental Consultants are classified using pay scales rather than occupation codes as follows:

Grade	Grade description
KC10	Consultant In PHM (Disc Pnts)
KC11	Consultant In PHM
LA41	Dental Surgeon (P/T Consultant CDS/Hr)
LC01	Consultant In PH (Dental)

LC10	Consultant In PH (Dental) - Disc Pnts
MC10	Consultant - Disc Pnts
MC21	Consultant (Medical)
YC*	Consultant (pre 31 Oct) – x yr Snr
YK*	Consultant (pre 31 Oct) – x yr Snr
YL*	Consultant (pre 31 Oct) – x yr Snr
YM*	Consultant (pre 31 Oct) – x yr Snr

Any Consultants on a local grade code will also need to be included.

London Ambulance Service NHS Trust

TRUST BOARD - 30 March 2010

Document Title	**Procurement Strategy**
Report Author(s)	**Richard Deakins**
Lead Director	**Mike Dinan, Director of Finance**
Contact Details	**Michael.dinan@lond-amb.nhs.uk**
Aim	**To seek Trust Board approval of the Procurement Strategy**

Key Issues for the Board

This strategy covers the procurement of goods and services undertaken by the Procurement department, which is responsible for the purchase and management arrangements for goods and services to the value of approximately £58m per annum (based on 2009/10 forecast).

It builds on existing good practice and is designed to advance effective procurement across the LAS.

Items to note include:

- Specific objectives. (page 5);
- Performance targets and monitoring (page 12);
- Workplan (page 13).

Specific measures will be set for 2010 and progress reported back to the Board as part of the monthly finance report.

Mitigating Actions (Controls)

None necessary

Recommendations to the Board

That the Trust Board approves the Procurement Strategy.

Equality Impact Assessment

Has an EIA been carried out? No
(If not, state reasons)

Key Issues from Assessment

No assessment necessary as the document consolidates existing national and Trust guidance into one document.

Risk Implications for the LAS (including clinical and financial consequences)

Non compliance with procurement legislation could both delay essential supply of goods and result in fines.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Compliance with Trust SFIs, public sector guidelines and procurement law.

Corporate Objectives that the report links to

To create a framework to achieve effective management & utilisation of resources.

LONDON AMBULANCE SERVICE

NHS TRUST

PROCUREMENT STRATEGY 2010 - 2013

FINAL 17-03-2010

Approval and Acceptance

Status (Approval or Acceptance)	Version	Date	Authority
Approved	Final	11-03-2010	Mike Dinan
Approved	Final	17-03-2010	SMG

Document History

Version	Date	Change Description	Authority
0.1	30-12-09	Re-formatted document	R Deakins
0.2	12-02-10	1) Added requirements for Equality and Inclusion and Corporate Social responsibility 2) Added Work plan	R Deakins
03	11-03-10	Amended with comments following peer review	R Deakins
04	17-03-2010	Amended with comments following SMG review	M Dinan

Distribution

Version	Date	Recipients
0.1	30-12-09	M Dinan,
0.2	12-02-10	M Dinan, Janice Markey
0.3	11-03-10	Mike Dinan
0.4	17-03-2010	SMG

CONTENTS

1. Introduction

The proper management of Procurement is essential to the efficiency and effectiveness of clinical and support services. Patient care depends on the assured availability of quality equipment, materials and services. Accountability for the expenditure of taxpayer's money requires that sound economic decisions are taken in relation to procurement.

2. Procurement can be defined as:

"The whole process of acquisition of goods & services spanning the whole life cycle from the initial concept and definition of business needs through to the end of the useful life of an asset or services contract or need for the activity".

The purpose of this strategy is to advance effective procurement across the whole organisation

3. Background

In 2009/10, total trust expenditure is forecast to be £278m. The forecast surplus is £1.4m

The Trust has an overall annual non spend (excluding depreciation) of £58m

A 1% recurrent reductions in annual non pay spend would equate to £600k. To put this in further context, a 2.4% reduction would equate to the Trusts surplus in 2009/10.

There are currently 790 suppliers managed within the purchasing system, generating 27,000 orders per year.

- 21 suppliers account for 80% of the orders raised
- Top 20 suppliers account for 50% of the spend

4. Strategic Scope

The Cabinet Office NHS Procurement Review recommends that trust strategies should cover all expenditure on goods, capital equipment and services.

This strategy covers the procurement of goods and services undertaken by the Procurement department, which is responsible for the purchase and management arrangements for goods and services to the value of approximately £58m per annum (based on 2009/10 forecast).

The major non pay procurement categories are:-

	Spend (£m)	% of Non Pay Spend
Staff Related	£7	12%
Medical Consumables, Equipment & Drugs	£7	12%
Fuel & Oil	£5	9%
Third Party Transport	£2	3%
Other Fleet	£9	16%
Accommodation & Estates	£13	22%
IT & Telecoms	£9	16%
Other	£6	10%
Total	£58	100%

5. Timeframe & Management Arrangements

The Procurement strategy covers a 3 year period from March 2010 to 2013 and is submitted to the London Ambulance Service Trust Board for approval.

A work plan is produced on an annual basis and is linked to and supports the procurement strategy, improvement projects and department performance.

The Director of Finance is responsible for the procurement function within the Trust and as such will review procurement performance against the action plan to the Trust Board on a quarterly basis;

6. Policy Framework

The procurement policy is to support the Trusts overall Vision and values, objectives and comply with the European Union & UK Procurement legislation, promoting competition in the market place and fair and open transparency in our dealings with suppliers.

The strategy also reflects the commitment to collaborate with other government bodies, including other Emergency services, Official of Government Commerce (OGC) Department of Health (DoH), and Procurement Hubs.

7. Strategic Objectives

The primary goal of the Procurement Department is to ensure that the right quality and quantity of equipment, materials and services is delivered on time to the Trust for the lowest overall cost.

Specific objectives are:

i. Develop clear understanding of what goods are services are required by Trust.
ii. Deliver improved value for money, focusing on whole life costs
iii. Improve internal stakeholder relationships by increased communication and engagement with staff
iv. Continuously improving quality & innovation
v. Develop strong & effective supplier management
vi. Develop the procurement and commercial competencies & skills of all relevant staff
vii. Develop high class internal customer service
viii. Ensure efficient purchasing processes & systems
ix. Identify value for money and efficiency gains, and to identify outcomes and targets for achievement of potential efficiency savings in the future
x. Actively collaborate with other emergency services and public sector agencies e.g. OGC & NHS Procurement hubs
xi. Ensure continuity of supply & sound business continuity arrangements
xii. Improve the Trust's knowledge of the supply market
xiii. Comply with Trust Standing Financial Instructions and Risk Management arrangements
xiv. Comply with all relevant UK & European legislation
xv. Comply with the Trusts own Corporate and Social Responsibility policy
xvi. Comply with the Trusts own Equality and Inclusion policy

8. Procurement Principles

i. A **competitive** process will provide the best opportunity to procure the goods or services with value for money, however it is recognised there may be a valid exception to this principle, due to the nature of the requirement.
ii. All procurement will be conducted on a **value for money** basis and will include both whole life costs and quality considerations.
iii. **Sustainability, Equality and Inclusion** issues will be considered where appropriate and when relevant to the contract.
iv. **Fair, open & transparent processes**
v. Procurement is a **means to deliver agreed business objectives**; it is not an end in itself.

8.1. Selection of Goods and Services

The selection of goods and services will be performed in consultation with relevant user groups. The procurement and selection of all consumables, equipment and services will be balanced to ensure that the Trust always achieves best value for money.
The selection procedure will include:

i. Procurement of capital items will be after preparation of a business case complete with investment appraisal and life cycle costing.
ii. Procurement of consumables and associated equipment for use of patient care will be effected through the successful application of the acquisition trial and procurement protocol
iii. The Trust with the aid of user groups, training department and the contract management group will continually seek to rationalise and standardise the product range of medical equipment.
iv. Public sector procurement framework agreements will be used wherever possible and appropriate

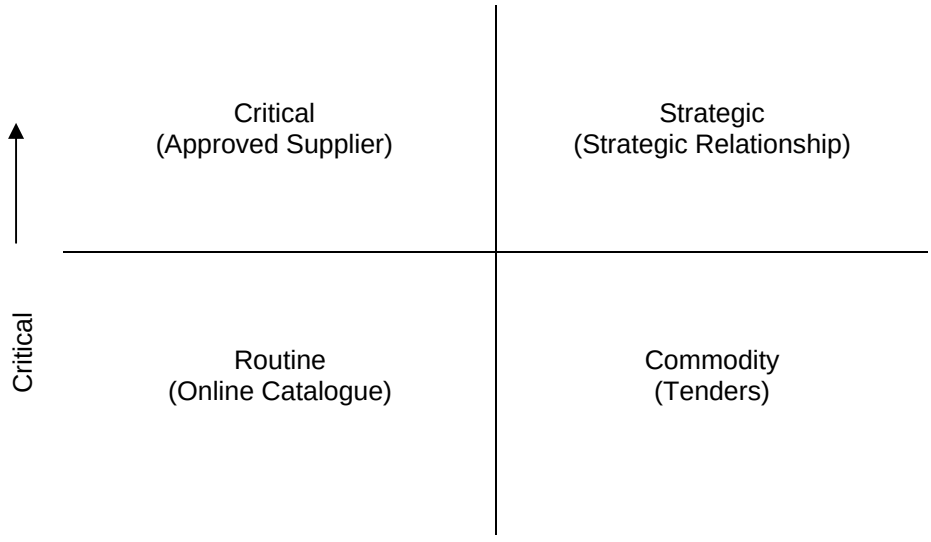
The Trust will establish specific catalogues for use by various Ambulance staff with an aim to aid the benefits encompassed with standardisation such as ease of ordering, better leverage and control of costs.

8.2. Selection of Suppliers

Suppliers will be selected on the basis of their ability to meet the Trusts requirements using an evaluation process including amongst others:

i. Initial supplier questionnaire
ii. Credit-worthiness report
iii. Finance department evaluation
iv. Technical capability
v. Quality
vi. Service support
vii. Total Cost
viii. Site visit
ix. References

The supplier base will be segmented as follows:



Value ⟶

8.3. Procurement tendering process

Tendering will follow European tendering rules and regulations and will begin with inviting expressions of interests from suppliers, in response to an OJEU notice or other calls to competition, depending on the value.

This will be supported by assessing the suppliers' responses to information requests in the OJEU notice, or pre-qualification questionnaire, and invite those selection of suppliers to tender depending on the procurement procedure selected. Unsuccessful bidders should be notified and debriefed, if requested.

8.4. Tendering evaluation

The tender evaluation process is designed to identify the supplier(s) who will provide the best value for money for a particular purchase, this will be based on the most economically advantaged tender and not necessarily the lowest bid as other factors will be taken into account in terms of quality issues, services support and whole life costs.

The evaluation process will be strictly controlled and objectively carried out against agreed award criteria. Each of the various criteria will be weighted to reflect their relative importance. The nature of the award criteria and their weightings will vary depending on the specific contract being considered.

During the evaluation process bidder’s maybe asked to demonstrate their products or services. We may also ask to visit their premises and possibly take up appropriate references

8.5. Price

The Trust recognises that the price is only part of the total acquisition costs, the strategy will therefore cover all aspects of the supply chain and will instigate a review to identify the total acquisition and supply costs for all goods and services procured for the Trust as a way of managing costs.

In addition the Trust will also:

i. Use competition
ii. Regularly review the high spend areas of all non pay expenditure
iii. Introduce contracts in high spend, high volume areas to ensure best price and control of prices is maintained

iv. Use NHS Agency contract agreements or other public sector frameworks
v. Ensure processes are in place to benefit from early payment discounts

8.6. Benchmarking

The Trust will aim to introduce a structured benchmarking programme with its partners (London Procurement Programme (LPP) Ambulance procurement Hub, and other Ambulance Services) to identify best practice, review the procurement department performance, value for money and supply chain processes.

8.7. People Issues

The Trust aims to ensure at all times procurement is conducted with professionalism to the highest standard and follows the LAS equality and inclusion policy, and is conducted and supported by people with the correct competencies.

9. Purchasing Processes

The Trust is committed to continually improving its business processes in purchasing. Areas of focus include:-

- eProcurement using electronic catalogues and eTendering
- Improved financial systems integration (eSeries)
- Electronic supplier management
- Purchase cards
- eAuctions

10. Procurement Department Structure

10.1. Category management in Procurement

Category Management will be introduced within the department and the Trust to manage the procurement of goods and services.

Category management identifies various categories of goods or services purchased to improve its controls, give support to changing priorities, demand and gain better market knowledge to maximise value for money.

The process flow for contract management will include the following stages:

Stage 1: Developing a thorough understanding of third party spend and future demand.

Stage 2: Segmenting spends into market sectors.

Stage 3: Developing market sector strategies

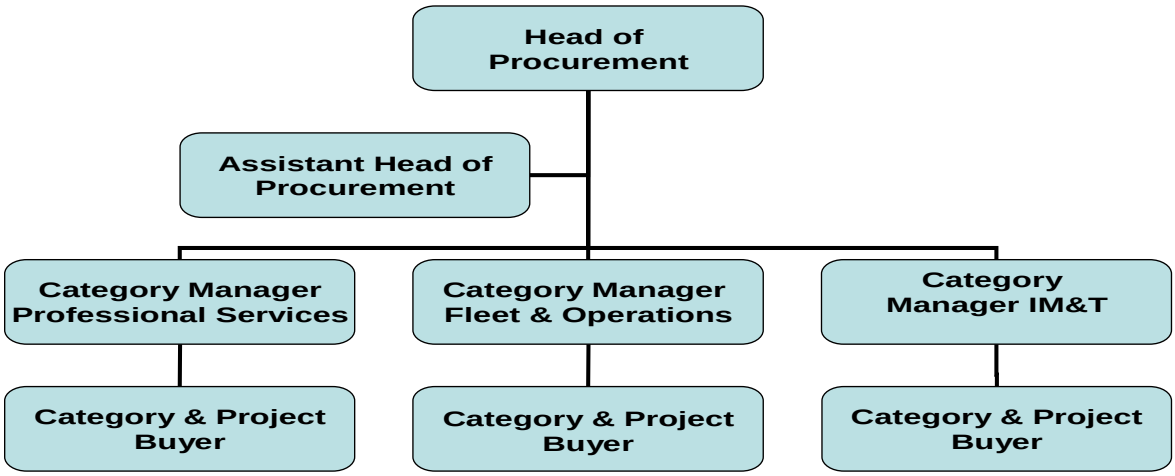
Stage 4: Supplier selection

Stage 5: Supplier performance management: including strategic supplier partnering. This will be done in conjunction with internal LAS customers/departments.

Category management will also identify examples and opportunities for collaborating with other organisations, future business requirements, market forces and the resources available.

10.2. Procurement structure

The department structure is detailed as below:



10.3. Supplier relationship management in procurement

Supplier Relationship Management (SRM) will be introduced.

SRM recognises that different relationships will be required with different
Suppliers / providers and goods and services purchased, the type of relationship will depend largely on the criticality and/or value of the goods or services supplied and factors such as the number of suppliers in the market, and the global availability of a requirement.

It is critical that internal customers/departments manage external suppliers in conjunction with the procurement team. SRM will be designed to support this process, not supplement it.

SRM will allow procurement to develop strategies for dealing with suppliers to achieve ongoing value for money, and reduce the risk of poor performance or non-delivery or non-availability. It allows the procurement organisation to focus effort on the right strategic suppliers with internal customers/departments.

11. Equality and Inclusion in procurement

11.1. Procurement

The Trust aims to ensure that equality & inclusion is embedded and absolutely integral to everything we do.

The procurement department is committed to ensuring its practices support the Trusts Equality & Inclusion Policy to enable it to meet its duties under equality and anti-discrimination legislation.

As part of this commitment, the procurement department and its processes will ensure there is a consistent approach to equality within all contracts and procurement activity across the Trust.

The procurement department will follow the guidance from the Official Government Commerce (OGC) detailed in their document “Make Equality Count” and all subsequent revisions. Available at www.ogc.gov.uk

11.2. Supplier Diversity

The Trust is committed to fostering a diverse supplier base and aim is to ensure that businesses of diverse backgrounds and ownership have the opportunity to become valued suppliers of the Trust.

12. Corporate and Social Responsibility

The Trust is committed to sustainable procurement by ensuring that social, economic and environmental issues are considered during all stages of a procurement process and as part of the whole life cost of a contract.

The procurement department will follow the guidance from the Official Government Commerce (OGC) detailed in their document “Office of Government Commerce & Department for Environment, Food & Rural Affairs Joint Note on environmental issues in purchasing – dated 2003” and all subsequent revision

13. Work Plan

The Work plans will be produced on an annual basis and used to translate the objectives and expectations of the procurement strategy into an operational programme that will form part of the Trusts annual service plan, and will be targeted and measured. **See appendix A.**

14. Performance targets and monitoring

Measures will be put in place to assess the performance of the procurement department and whether the strategy aims and objectives are being adhered to.

The measure will include:

Measurement Area	Objectives	Reporting Frequency
Expenditure influenced by procurement	To demonstrate that the Trust has effective control of expenditure	Quarterly
Expenditure and overall procurement efficiency	To demonstrate whether the Trust is receiving value for money	Quarterly
Cost of Procurement	To demonstrate added value of the procurement function	Annually
Procurement competencies	To improve skill levels and ensure they match the Trust requirements.	Annually
Supplier & product rationalisation	To reduce associated procurement costs	Annually
Service quality/stakeholder satisfaction	To assess the level of satisfaction of users/stakeholders	Quarterly
Benchmarking with other ambulance trusts	Value for Money	Six monthly

15. Communications

The procurement strategy will be communicated to its stakeholders via the LAS intranet and regular management briefing by both the Director of Finance and the Head of Procurement

16. References

The following documents were used to prepare this strategy:

i. The London Ambulance Service NHS Trust Standing Orders
ii. OGC “make Equality Count” document
iii. Office of Government Commerce & Department for Environment, Food & Rural Affairs Joint Note on environmental issues in purchasing – dated 2003 available at www.defra.gov.uk/sustainable/government/index.htm and www.ogc.gov.uk

APPENDIX A **DEPARTMENTAL** **WORKPLAN**

Key Action Point	Accountability	Actions	Outcomes	Time-scales
Develop Procurement Strategy document 2010 - 2013 Objective No. i	Director of Finance & Head of Procurement	a) Review procurement strategy documentation b) Agree changes with Finance Director c) Amend document accordingly d) Forward for Trust Approval	Set direction and objectives for the procurement function	Start 1/01/2010 Complete 31/03/2010
Departmental and service wide procurement policy and procedures Objective No. i Objective No. viii Objective No. xiii Objective No. xiv Objective No. xv Objective No. xvi	Head of Procurement	a) Review current procurement related documentation b) Identify policy areas c) Identify produce areas and required controls d) Introduce a Policy dealing with Equality and Inclusion in LAS procurement	Improve method of operations and understanding for the Procurement function Trust wide	Start 01/01/2010 Finish 31/12/2011 o Review quarterly
Procurement improvement programme Objective No. iv Objective No. xii	Head of Procurement	a) Increase in Contract management o Improvement in tendering process o Increase in Contract coverage o Introduction of Contract Register o Risk Management Coverage b) Performance testing process o Auditing Procurement o Savings o Benchmarking o Improvement in process and systems used in purchasing	Better value for money and risk reduction within contracts	Start 01/01/2010 Ongoing o Review monthly

		o Audit and improvement programme c) Creation and Monitoring of procurement departmental KPI's		
Customer service improvement programme Objective No. iii Objective No. vii	Head of Procurement	a) Produce Communications Plan to include o Customer questionnaires o Customer care awareness training o Better use of catalogues within Integra o Link's to LAS Web site o Improvement in product and service knowledge	Improved customer satisfaction	Start 0104/2010 Ongoing o Review monthly
Departmental development programme Objective No. vi	Head of Procurement	a) Introduction of PDP for all staff members b) Regular appraisal system c) Adaptable workforce d) Defined roles, responsibilities and accountabilities e) Structured training programme f) Team Development Programme	Improved, motivated and adaptable workforce able to provide a professional procurement service	Start 01/04/2010 o Review monthly
Supply Management Objective No. iii Objective No. v Objective No. xi	Head of Procurement	a) Create Key supplier database b) Strategic Supplier analysis…Routine, Commodity, Critical & Strategic c) Introduce key supplier management performance measurements	Better controls of the supply base and Improved flow of good and services, by way of reduction in delivery times and asset management	Start 01/04/2010 Ongoing o Review quarterly

			costs	
Purchasing Collaboration Objective No. x	Head of Procurement	a) Actively participate in Ambulance procurement confederation	Benefits will include: • Improved value for money due to economies of scale • Greater leverage in the market and greater provider loyalty • Access to resources and ideas from others working in the same environment • Sharing of the procurement burden.	Start 01/04/09 Ongoing o Review quarterly
Cost Reduction Objective No. ii Objective No. ix	Head of Procurement	a) Set year on year cost saving initiatives for non-pay spend	Reduction in spend	Start 01/04/2010 Ongoing o Review Monthly
Governance Objective No. ix	Head of Procurement	a) Ensure supplier performance is in line with Governance / Control Assurance framework	Improvement in ALE	Start 01/04/2010 Ongoing o Review quarterly

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Emergency Care System (ECS) Business Case**
Report Author(s)	**Peter Suter, Director of Information Management and Technology**
Lead Director	**Peter Suter, Director of Information Management and Technology**
Contact Details	**peter.suter@lond-amb.nhs.uk**
Aim	**To seek Trust Board approval of the ECS business case**

Key Issues for the Board

ECS will see every emergency vehicle in the LAS fleet equipped with a portable computer capable of wireless data transmission. As a replacement for the paper PRF system, ECS has the capacity to capture a complete and accurate set of personal, operational and clinical data for each patient encounter and to transmit it in virtual real time for immediate access both within the service and by outside agencies such as receiving destinations and GP surgeries. It also provides clinical staff on-scene with a repository of clinical guidance to support their decision-making about patient treatment and conveyance. Ultimately, it will retrieve patient history and outcome data from the Spine and make it available for operational use by crews and managers.

The ECS solution for Ambulance Trusts is a core element of the National Programme for IT. It is being provided by BT, the Local Service Provider (LSP) for London and is part funded by the London Programme for IT (LPfIT). The LAS is currently working with BT and LPfIT to define and agree the detailed terms of the contract that will determine the scope and scale of the London ECS solution. This work is scheduled to complete in June at which point, LAS will be asked to commit to funding the implementation of the service-wide solution. Two documents are attached:

- A high level paper outlining the business case
- The actual business case.

Mitigating Actions (Controls)

N/A

Recommendations to the Board

The Trust Board are asked to approve;

- the business case
- work to continue to allow completion of negotiations allowing the potential to sign a contract in June 2010.

Equality Impact Assessment

Has an EIA been carried out?

N/A

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

N/A

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

N/A

Corporate Objectives that the report links to N/A

Submission of the Emergency Care System (ECS) Business Case to the LAS Trust Board – 30th March 2010

1. Context and Status:

The Trust Board is advised that the ECS solution for Ambulance Trusts is a core element of the National Programme for IT. It is being provided by BT, the Local Service Provider (LSP) for London and is part funded by the London Programme for IT (LPfIT). BT has offered the Siren System from Medusa Technologies as their preferred solution. The same system is being implemented by four other UK Trusts and is becoming the de facto national standard.
LAS is currently working with BT and LPfIT to define and agree the detailed terms of the contract that will determine the scope and scale of the London ECS solution. This work is scheduled to complete in June at which point, LAS will be asked to commit to funding the implementation of the service-wide solution. The LPfIT contract permits the London Ambulance Service to determine its own implementation schedule, within the current life of the contract (to October 2015).

The Trust Board is asked to note the contract-related risks inherent in the LPfIT approach. The long-term availability of central funding cannot be guaranteed until the system is deemed to be live. This is estimated to be the second half of 2011 on the current project timeline, following the Command Point go-live. There is a significant risk that central funding could be curtailed during this pre-live period due to Government savings initiatives or LSP contract renegotiation. It is suggested that LAS seek suitable assurances from NHS London as part of the decision to commit to the LPfIT contract.
The final draft of the ECS Business Case is now presented for consideration and the Trust Board is asked to:

- note the headline benefits and outline costs summarised below,
- approve the provision of funding in principle, subject to satisfactory contract terms and subject to acceptable mitigation of the contract-related risk.
- consider the “next-steps” proposal at paragraph 5 below and approve the continuing work programme.

2. The ECS Solution in Summary

ECS will see every emergency vehicle in the LAS fleet equipped with a portable computer capable of wireless data transmission. As a replacement for the paper PRF system, ECS has the capacity to capture a complete and accurate set of personal, operational and clinical data for each patient encounter and to transmit it in virtual real time for immediate access both within the service and by outside agencies such as receiving destinations and GP surgeries.
It also provides clinical staff on-scene with a repository of clinical guidance to support their decision-making about patient treatment and conveyance. Ultimately, it will retrieve patient history and outcome data from the Spine and make it available for operational use by crews and managers.

3. Headline Benefits

ECS will support the drive to deliver the right care, in the right place at the right time, in a number of key areas:

- Clinical Risk Reduction: The ECS has the capacity to capture a complete and accurate set of personal, operational and clinical data for each patient encounter which will support daily, service–wide audits of the entire PRF data set leading to a

- Increased Utilisation of Referral Pathway Networks: ECS will support the initiative to reduce A&E attendances by providing crews with on-scene information to improve their assessment and conveyance decisions and by providing Team Managers with an enhanced monitoring capability.
- Improved Clinical Response: The clinical skills of individual crew can be maintained at a high level by providing Team Leaders with better quality clinical performance information so that training can be more precisely targeted to need. Crews will also be better supported on scene by being able to share real-time clinical data with other LAS practitioners and with external NHS care agencies so that they become more confident in their ability to achieve the most appropriate treatment and conveyance decisions.
- Team Based Working Approach: The enhanced clinical audit feature of ECS will increase the effectiveness of Team Leaders and Managers in improving clinical standards. The removal of the CPI Admin workload and the availability of high quality audit reports will improve their performance assessment capability, allowing them to make prompt and appropriate interventions.
- Improved AMPDS Categorisation: The high quality ECS clinical dataset will enable better assessment of the accuracy of the Call Prioritisation System and could support an initiative to reduce the incidence of 'double-sending' in London where our average response attendance to emergency calls is currently between 1.4 to 1.6 resources.
- Improved Hospital Turnaround Times: ECS will present a number of opportunities for efficiency improvements in the patient handover process; by providing A&E staff with early warning of patient presenting condition; by eliminating the need for a paper-based booking-in procedure; by providing LAS managers with the evidence necessary to address poor performance by A&E Departments.
- Improvements in Service Provision: Improved access to clinical information including presenting condition and clinical diagnosis will help to identify gaps in service provision leading to more effective service commissioning. Equally, this level of information across the service will provide early warning of infection outbreaks and enable a more timely and effective clinical and operational response.

4. Outline Costs:

Two procurement options have been identified. The high level costs for each are shown here apportioned over a six year period:

Capital Purchase Option:

Cost Element	Fin Yr 2010/11	Fin Yr 2011/12	Fin Yr 2012/13	Fin Yr 2013/14	Fin Yr 2014/15	Fin Yr 2015/16	Total
Capital:	£44,000	£602,000	£1,506,200	£1,506,100	0	£574,525	£4,232,800
Revenue:	£566,000	£854,300	£1,755,800	£1,764,600	£250,300	£250,300	£5,441,200
Trust Total:	£610,000	£1,456,300	£3,262,000	£3,270,700	£250,300	£824,800	£9,674,000
DCF:	£610,000	£1,407,100	£3,045,100	£2,949,900	£218,100	£694,500	

Managed Service Option:

Cost Element	Fin Yr 2010/11	Fin Yr 2011/12	Fin Yr 2012/13	Fin Yr 2013/14	Fin Yr 2014/15	Fin Yr 2015/16	Total
Capital:	0	0	0	0	0	0	0
Revenue:	£610,000	£1,273,20	£2,545,400	£2,947,800	£1,233,800	£1,233,800	£9,844,000
Trust Total:	£610,000	£1,273,20	£2,545,400	£2,947,800	£1,233,800	£1,233,800	£9,844,000
DCF:	£610,000	£1,230,10	£2,376,200	£2,658,700	£1,075,200	£1,038,800	

It is recognised that LAS will require financial support from Commissioners to meet the additional investment required to deliver the project and to absorb the increase in operational costs.

5. Next-Steps Proposal

The Trust Board is asked to approve the following programme of work to advance the ECS Project during the 2010/11 financial year:

- Continue to support the LPfIT contract development work and review the position in June to consider whether funding commitment is feasible at that time.
- Continue with a programme of planning and preparatory work that will include extensive consultation with Acute Trusts and GPs and will deliver an appropriate governance framework and implementation strategy, will develop new business processes and will establish communications networks with external stakeholders.
- Continue to support the development of NHS Pathways and the Capacity Management System in line with the PCT Transformation Plan.
- Maintain close liaison with LPfIT to ensure that the risks associated with the LSP contract are managed effectively.

The cost of this programme of work is estimated at £217,000.

London Ambulance Service NHS
NHS Trust

Report Author(s)	**Chris Vale/Tracey Freeman (Finance)**
Lead Director	**Mike Dinan**
Contact Details	**Michael.dinan@:lond-amb.nhs.uk**
Aim	**To seek Board approval for Combined Business Case (CBC)**

Key Issues for the Board

An executive summary of the CBC is attached. The full CBC is available on request.

The Trust Board approved the development of a consolidated workshop in West London as part of the Fleet Workshop review in July 2008.

A CBC has been developed which looks at consolidating the workshops in Hillingdon, Camden, Fulham, New Malden and Waterloo into a single site in West London.

The CBC shows an increase in revenue costs of £250k per annum based on the west area alone. It does not include the wider financial benefits of the London wide consolidated fleet restructure. This will be updated in the FBC

Mitigating Actions (Controls)

Budgetary control and MSP process

Recommendations to the Board

To approve Combined Business Case

- Search for appropriate premises
- Complete Full Business Case for Board approval

Equality Impact Assessment

Has an EIA been carried out? Not at this stage

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Financial cost of completing FBC including estates work is included in Trust budget for 2010

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

None at this stage

Corporate Objectives that the report links to

- To be efficient & productive in delivering all commitments and to continually improve in both productivity and value delivered
- To have staff who are skilled, confident, motivated and feel valued whilst working in a safe environment

LONDON AMBULANCE SERVICE

WORKSHOP RECONFIGURATION - WEST AREA

EXECUTIVE SUMMARY ONLY

Contents

1. EXECUTIVE SUMMARY

1.1. Preamble

1.1.1. The LAS Trust Board approved the Fleet Workshop Review in July 2008 with the proviso that a Business Case needed to be developed and approved for an initial site in West London in line with the review.

1.1.2. A combined business case has been prepared for your review and approval which will allow the development of a full business case for a west area workshop in West London.

1.1.3. Three options were considered in this business case

1.1.3.1. **Do Nothing**

1.1.3.2. **Option 1 - West London Lease and Convert**

1.1.3.3. **Option 2 - West London Design & Build**

1.2. Strategic Case

1.2.1. The primary objective of the Fleet Review is to provide the London Ambulance Service (LAS) with a more efficient, cost effective and robust Fleet support service. With improved vehicle visibility and a new west workshops operating on a 24/7 roster will allow greater use of vehicle down time to carry out planned maintenance. The improved use of vehicle downtime will assist operations in meeting their National target to reach 75% of Category “A” (life-threatening) calls within eight minutes of the primary diagnosis of the call.

1.2.2. Better utilisation of downtime will ease the pressure on vehicle availability, therefore we expect to see a modest reduction in front line vehicles despite the increase in front line operational staff. This will be a reduction in A&E vehicles of 15 ambulances and 5 RRUs.

1.3. Economic Case

1.3.1. The key objectives of this project are to

- Reduce VOR
- Improve efficiencies
- Invest in our workshop capabilities by introducing new services that are currently outsourced

1.3.2. A long list of 10 options were considered and reduced to a short list of Do Nothing and 2 options. These are

1.3.2.1. **Do Nothing** – Retain the existing twelve workshops and working practices.

1.3.2.2. **Option 1 - West London Lease and Convert** - an existing building newly built and yet unoccupied. The building meets our brief but as an existing development, there is a compromise for the Trust in the layout and access, which would lead to difficulties in manoeuvring vehicles within. The site has good parking which meets our brief. Should the Trust need to expand the services offered at the new workshop this could prove to be difficult with limited space to expand. The location has good main artillery access and is well supported with public transport services.

1.3.2.3. **Option 2 - West London Design & Build** – a 'brownfield' site on a new development on the outer edge of West London. The site offers the Trust the opportunity to develop a new workshop that will meet current and future need. The location offers good access by road and public transport and is close to the optimum location of Kew. This close proximity to Kew will reduce travel times for vehicle movements from complex and stations, reducing costs and minimising possible delays. Staff support for any of the options is an important aspect of the development and West London was always seen by staff as a good location for a west workshop.

1.3.3. A weighted benefits analysis was carried out and option 2 was identified as the option with the highest weighted score.

Weighted Benefit Analysis

Benefits	Weight	Options					
		Do Nothing		1		2	
		Score	WxS	Score	WxS	Score	WxS
The site(s) are capable of meeting the Trust's current needs	19.6	3	59	7	137	9	176
A 24/7 working environment and access	18.6	4	75	9	168	9	168
Improved working efficiency	16.8	5	84	8	134	9	151
Impact on travel from complex and stations for Operational vehicles	12.6	8	101	4	50	5	63
Option will allow for expansion of the Trust	10.7	2	21	9	96	10	107
Access and infrastructure for staff	8.0	7	56	5	40	5	40
Workshop facilities for staff	7.2	5	36	9	65	9	65
Suitability for contractors	4.3	3	13	8	35	9	39
Lead time on development	2.2	10	22	4	9	3	6
Minimal risk in developing the site(s)	1.5	10	15	6	9	2	3
Total	**100.0**		**481**		**743**		**818**

1.3.4. The capital & lifecycle costs of each option are summarised below and shown in full in Appendix 2.

Capital Summary	Do Nothing £'000	Option 1 £'000	Option 2 £'000
Initial	0	450	0
Lifecycle	0	276	276
Total Capital Costs	**0**	**726**	**276**

1.3.5. The revenue costs of each option are summarised below and shown in full in Appendix 3.

Revenue Costs Summary	Do Nothing £'000	Option 1 £'000	Option 2 £'000
Recurrent costs	4,013	4,578	4,625
Incremental recurrent costs		**566**	**612**
Net non recurrent (savings)	0	(110)	(288)
Incremental net non recurrent (saving)		**(110)**	**(288)**
Total Revenue Costs	**4,013**	**4,469**	**4,338**

1.3.6. This outline business case has identified incremental revenue costs for the preferred option of £612k per annum. Further savings will be realised when the second site is established and these will be quantified in the full business case.

1.3.7. The costs identified above have been entered into the DH's Generic Economic Model (GEM) and using the prevailing HM Treasury discount rate of 3.50% has generated the following analysis of the short listed options.

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Ranking
		£'000		£'000	
OBC Do Nothing	31 Years	4,012.7	481.2	8.34	3.0
Continue with Existing Workshops					
OPTION 1	27 Years	4,544.6	743.0	6.12	2.0
Lease & Convert - West London					
OPTION 2	27 Years	4,555.4	818.4	5.57	1.0
Design & Build - Brownfield Site West London					

1.4. Financial Case

1.4.1. The table below sets out the net impact of the proposed investment on the Trust's income & Expenditure (I&E) Account and CRL positions. The full table can be found in Appendix 4.

London Ambulance Service NHS Trust						
OPTION 2	**Sum of**	1st year	2nd year	3rd year	4th year	5th year
Design & Build - Brownfield Site West London	**Cashflows**	2009/10	2010/11	2011/12	2012/13	**2013/14**
		0	1	2	3	4
CASHFLOWS	£'000	£'000	£'000	£'000	£'000	**£'000**
CAPITAL						
15 Ramps @ £9.2k cost replaced each 10 years	276	0				
VAT	48	0				
Subtotal: Lifecycle Costs	324	0	0	0	0	0
TOTAL CAPITAL	324	0	0	0	0	0
REVENUE COSTS						
SERVICE COSTS						
Non Clinical Costs						
Pay expenditure	43,403	1,640	1,640	1,605	1,605	**1,605**
Vehicle recovery	7,230	226	226	271	271	**271**
MOT tests	107	22	22	3	3	**3**
Contract Labour	4,093	128	128	153	153	**153**
Other Vehicle Maintenance	45,511	1,475	1,475	1,702	1,702	**1,702**
Other Non Pay expenditure	5,180	176	176	193	193	**193**
Make ready	3,075	140	140	112	112	**112**
Lease Rental	12,953			573	516	**516**
Reduction o f15 A&E ambulances	(6,375)			(255)	(255)	**(255)**
Reduction of 5 FRU's	(750)			(30)	(30)	**(30)**
Sale of FA - one off saving	(63)				(63)	
Reduction in stock - one off saving	(225)				(225)	
VAT	12,429	379	379	476	466	466
Subtotal: Non-Clinical Services	126,568	4,187	4,187	4,804	4,449	**4,737**
Building Running Costs						
Estates costs (rates, maintenance, cleaning)	9,285	205	205	355	355	**355**
VAT	1,625	36	36	62	62	62
Subtotal: Building Running Costs	10,910	241	241	417	417	**417**
TOTAL SERVICE COSTS	137,478	4,428	4,428	5,221	4,866	**5,154**
TRUST TOTAL	137,802	4,428	4,428	5,221	4,866	**5,154**
Discount Factor		1.00	0.97	0.93	0.90	**0.87**
Discounted Cashflow	90,768	4,428	4,278	4,874	4,389	**4,491**

1.4.2. Subject to Board approval, the preferred option will be funded through the LAS's capital and revenue reserves.

1.4.3. When a suitable site is found the specific details of the lease will be reviewed by finance and recorded in accordance to the appropriate accounting standard.

1.5. Commercial Case

1.5.1. The two short listed sites all offer the same procurement option of lease.

1.5.2. West London which is a 'brownfield' site offers two lease options, which include breaks in the contract with the associated costs and discounts:

- Lease the land and LAS fund the build
- Lease the land and building as a design and build option

1.5.3. Upon approval of this business case negotiations for the chosen site will commence and the preferred lease option will be identified.

1.5.4. Because the sites are lease, and this is unlikely to change, it is doubtful whether PFI and PPP would apply.

1.6. Management Case

1.6.1. Project management arrangements for this project will conform to the principles of Prince2.

1.6.2. A project board has been established to monitor and review progress that is made and make effective and corrective decisions if required in the progression towards completion.

1.6.3. A project team has been established to ensure that all stakeholders and departments are engaged and can contribute and facilitate the business change and implementation requirements within the business area.

1.6.4. The project team will raise awareness amongst line managers and employees in accordance with the local communication strategy, which has been produced as part of the PID documentation.

1.6.5. The methodology is to improve productivity through a more efficient and robust working environment. The outline business case produced a model for two workshops in the west and east of London, but Trust Board approval granted permission to develop one in the west. Further development of the workshop model will commence upon recognition by the Trust Board that the west London workshop is meeting its objectives as covered in the business case.

1.6.6. Interfaces within the project will lie between the project management team, fleet, estates and operations. Because of the size of the project, much of this will be through the sub working groups who will manage the various workflows. From an external perspective, contractors will be working with the project team and estates to develop the new workshop and introduce the required services.

London Ambulance Service NHS
NHS Trust

Report Author(s)	**Jason Killens/Tracey Freeman (Finance)**
Lead Director	**Mike Dinan**
Contact Details	**Michael.dinan@lond-amb.nhs.uk**
Aim	**To seek Board approval for Combined Business Case (CBC)**

Key Issues for the Board

An executive summary of the CBC is attached. The full CBC is available on request

CBC is for a HART facility in West London similar to the approved facility being developed for East London in Cody Rd.

Both the incremental capital & revenue funding will be provided by the DH.

The decision whether to lease or buy will be further analysed at the FBC stage

Mitigating Actions (Controls)

Budgetary control and MSP processes

Recommendations to the Board

Approve Combined Business Case

- Search for appropriate premises
- Complete Full Business Case for Board approval

Equality Impact Assessment

Has an EIA been carried out? Not at this stage

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Financial cost of completing FBC including estates work is included in Trust budget for 2010

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

None at this stage

Corporate Objectives that the report links to

- To be efficient & productive in delivering all commitments and to continually improve in both productivity and value delivered
- To have staff who are skilled, confident, motivated and feel valued whilst working in a safe environment

LONDON AMBULANCE SERVICE

WEST LONDON

HAZARDOUS AREA RESPONSE TEAM (HART)

EXECUTIVE SUMMARY ONLY

Contents

1. EXECUTIVE SUMMARY

1.1. Strategic Case

1.1.1. The LAS Hazardous Area Response Team was established in December 2006 as part of a national programme which aims to ensure that fewer lives would be risked or lost in the event of a terrorist or accidental CBRN incident. Initially the team was established with Incident Response Unit (IRU) capacity only.

1.1.2. The initial LAS HART facility was located in south East London with access to the strategic locations in the City and Docklands. Strategic locations to the West of London are Heathrow Airport and parts of the West End thus requiring a second HART Team to cover this geographical area.

1.1.3. The footprint of a potential new facility to meet the needs of the West London HART team is approx. 1,500 sqm of which 1,000 sqm is garage space and 500 sqm is accommodation.

1.1.4. The LAS has undertaken a site search to look for suitable premises midway between Heathrow Airport and the West End.

The preferred location is in the A4/A40 area of West London .

1.2. Economic Case

1.2.1. The options considered were:

- Option 1 Do nothing – this is considered to be a no cost option and is not viable for the delivery of the HART service
- Option 2: Lease premises and convert
- Option 3: Purchase premises and convert

1.2.2. The table below summarises the results of the economic appraisal.

Economic Appraisal	Option 2 Lease and Convert £'000	Option 3 Purchase and Convert £'000
EAC - basic	327.7	251.8
EAC - risk	11.5	6.8
Total EAC	339.2	258.6
EAC Rank	**2**	**1**
Non-financial score	800	670
Cost per point	0.42	0.39
Cost per point rank	**2**	**1**

1.2.3. The economic appraisal confirms that the preferred option is to purchase a building and convert it for use as a HART team base for the West of London.

1.3. **Financial Case**

1.3.1. The table below shows that the annual revenue cost of the preferred option is £326k per annum including capital charges.

Revenue Consequences	Option 3 Buy and Convert £'000
Rent inc VAT	0
Rates (estimated)	75
Utilities (gas, water and electric)	25
Estates maintenance	20
Cleaning	8
Service charge (inc VAT)	0
Waste/Clinical	4
IM&T BT/data costs	10
Total Cost exc Capital charges	142
Capital Charges - Equipment	5
Capital Charges - Conversion	84
Capital Charges - Land and Building	95
Total Capital Charges	184
Total Additional Cost	**326**

1.3.2. The table below shows that the capital cost of the preferred option is £2.975m which includes the purchase of the building and its conversion to a HART base.

Capital Requirements	Buy and Convert £'000
Land and Building	1,800
Conversion	688
Equipment	30
Total Excluding VAT	**2,518**
VAT	457
Total	**2,975**

1.4. **Commercial Case**

1.4.1. The HART team is currently funded by the Department of Health and approval for the additional expenditure will be sought from them.

1.4.2. Site searches have commenced with a view to identifying potential premises. Although the preferred option is to purchase premises the initial site searches have indicated that there are more premises for lease than purchase and a lease option may be necessary in order to meet the required timescales.

1.5. **Management Case**

1.5.1. Subject to the necessary approvals, including planning permission, the new facility could be established within 21 months of funding being approved.

Task	Timescale
Feasibility study/initial floor plans preparation/agree brief	2 months
Preparation and submission of planning application	6 months
Lease negotiations and legal searches to run concurrently with above	6 months
Appoint relevant consultants	1 month
Detailed design/specification/tender/ Building control	3 months
Tender period	1 month
Tender analysis/approval of final budget	2 months
Contractor appointment and lead in	1 month
Contract period	4 months
Commissioning/handover	1 month
Total	**21 months**

1.5.2. The preferred location is in the A4/A40 Area of West London, which is also the preferred location for the West Workshop site, and Estates will consider combining the two sites when they commence their search for suitable premises.

London Ambulance Service NHS
NHS Trust

Document Title	**Ambulance Leasing**
Report Author(s)	**Asif Islam**
Lead Director	**Mike Dinan**
Contact Details	**Michael.dinan@:lond-amb.nhs.uk**
Aim	**To seek Trust Board approval to lease ambulances**

Key Issues for the Board

The LAS is in the process of completing an order for 165 new ambulances. A key decision is whether the purchase of 130 should be funded from internal resources or be leased.

The attached analysis shows that leasing the ambulances on a 5/6 year lease is more advantageous than purchasing and will free up cash resources as per the current business plan for 2010/11

The analysis compares the cash flows of both options and discounts them back to 2010 values using a discount rate of 3.5%. This technique is known as Discounted Cash Flow (DCF) analysis. It is the recommended method of analysis for comparing a lease vs buy option.

- The DCF for the purchase option over 5 years is £101,108
- The DCF for a equivalent lease option is £67,690

Further investigation is required to establish whether the leases should be operating or finance. For the purposes of this analysis, finance leases are assumed as they are the more prudent option. The Director of Finance will determine with the Audit Commission how to treat any leases accordingly.

Mitigating Actions (Controls)

Budgetary and Procurement control

Recommendations to the Board

To approve the leasing of ambulances

Equality Impact Assessment

Has an EIA been carried out? No

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Both a lease and a purchase are material financial commitments

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

None

Corporate Objectives that the report links to

- To create a framework to achieve effective management & utilisation of resources

Document Title:	**Lease vs. Buy**
Date :	**22 March , 2010**
Report Author(s):	**Asif Islam**
Lead Director:	**Mike Dinan**

PURPOSE:

In 2009/10, the Trust Board approved the acquisition of 165 ambulances. The LAS has the opportunity to finance at least 130 of these ambulances by leasing them rather than buying the ambulances outright. The initial 35 ambulances procured cannot be leased due to the length of time they have been in service. This analysis compares the cost of buying the ambulances and leasing them via a third party.

Executive Summary

The methodology described below has been applied to two scenarios:

1) Buying an asset from the trust's own internally generated resources
2) Acquiring the assets from a lessor company via a leasing arrangement

It has been found that the Present Value a lease taken out over five years is 33% more favourable than buying the asset out of internally generated funds.
In terms of affordability the lease option over five years generates a 3% more favourable position and over six years remain the same (Appendix 3).
The calculation in this paper shows that the most favourable option for acquiring an asset is to lease over five years.
The lease quotes have been based on a tender exercise run by the LAS under a NHS Procurement Framework

Decision Rule

The preferred option is the one generating the lowest Present Value (PV). The trust will only consider leasing if the total discounted cash outflow amount of the lease is less than the total discounted cash flow required to purchase the asset.

A simple example using the acquisition of one ambulance costing £113,000 is outlined below to illustrate the two options:

Example

Start Date	1/1/2010
Capital Cost LAS	£113,000 (Inc. VAT per vehicle)
Capital Cost Lessor	£ 96,170 (Ex. VAT)
Term	5 Years & 6 Years
Rental - Annual	£18,407 (5 Years) & £16,833 (6 Years)
Rental - Quarterly	£4,602 (5 Years) & £4,208 (6 Years)
Economic Life	10 Years

Discount Factor

Lease	14% Annually 3.5% Quarterly
Buy	3.50% Annually 0.875% Quarterly
Mileage	21,000 Per Annum

Methodology

Determine the Present Value (PV's) by discounting each cash-flow. Appendix 1 and 2 contain the detailed workings.

COMPARISON OF RESULTS

COMPARISON 5 Years

Leasing Purchase	Leasing	Purchase
Overall Present Value	£ 67,690.92	£ 101,108.07
Implied Interest Rate / Borrowing Rate	7.11%	3.50%
Annual Payment	£ 18,406.98	N/A
Residual Value / Sales Proceeds	£ 25,485.11	£ 25,485.11
Possible Penalties / Cost of Sale	£ 961.70	£ 100.00

COMPARISON 6 Years

Leasing Purchase	Leasing	Purchase
Overall Present Value	£ 69,945.46	£108,254.29
Implied Interest Rate / Borrowing Rate	7.06%	3.50%
Annual Payment	£ 16,833.63	N/A
Residual Value / Sales Proceeds	£ 19,714.89	£ 19,714.89
Possible Penalties / Cost of Sale	£ 961.70	£ 100.00

APPENDIX 1: LEASE

5 Year				6 Year				5 Year		6 Year
Period no	**Rental**	**Discount Factor**	**DPV**	**Period no**	**Rental**	**Discount Factor**	**DPV**	**IRR**		**IRR**
1	4602	1.000	£4,602	1	4208	1.000	£4,208	-91568		-91962
2	4602	1.035	£4,446	2	4208	1.035	£4,066	4602	1	4208
3	4602	1.071	£4,296	3	4208	1.071	£3,929	4602	2	4208
4	4602	1.109	£4,151	4	4208	1.109	£3,796	4602	3	4208
5	4602	1.148	£4,010	5	4208	1.148	£3,667	4602	4	4208
6	4602	1.188	£3,875	6	4208	1.188	£3,543	4602	5	4208
7	4602	1.229	£3,744	7	4208	1.229	£3,424	4602	6	4208
8	4602	1.272	£3,617	8	4208	1.272	£3,308	4602	7	4208
9	4602	1.317	£3,495	9	4208	1.317	£3,196	4602	8	4208
10	4602	1.363	£3,376	10	4208	1.363	£3,088	4602	9	4208
11	4602	1.411	£3,262	11	4208	1.411	£2,983	4602	10	4208
12	4602	1.460	£3,152	12	4208	1.460	£2,883	4602	11	4208
13	4602	1.511	£3,045	13	4208	1.511	£2,785	4602	12	4208
14	4602	1.564	£2,942	14	4208	1.564	£2,691	4602	13	4208
15	4602	1.619	£2,843	15	4208	1.619	£2,600	4602	14	4208
16	4602	1.675	£2,747	16	4208	1.675	£2,512	4602	15	4208
17	4602	1.734	£2,654	17	4208	1.734	£2,427	4602	16	4208
18	4602	1.795	£2,564	18	4208	1.795	£2,345	4602	17	4208
19	4602	1.857	£2,477	19	4208	1.857	£2,266	4602	18	4208
20	4602	1.923	£2,394	20	4208	1.923	£2,189	4602	19	4208
	-113000			21	4208	1.990	£2,115	25485	20	4208
				22	4208	2.059	£2,043		21	4208
				23	4208	2.132	£1,974		22	4208
				24	4208	2.206	£1,908		23	4208
	Present Value		£67,691		Present Value		£69,945		24	19715
								1.78%		1.76%
								7.11%	IRR	7.06%

	Lease				
	Purchase	£	113,000	£	113,000
	Residual	£	25,485	£	19,715
	Difference	**£**	**87,515**	**£**	**93,285**
	Rental Payments				
	PA	£	18,407	£	16,834
	Quarterly	£	4,602	£	4,208
0.14	Rate		3.50%		3.50%
	Periods		20		24
	Type		1		1
	Years		5		6
Quarterly	Cycle		4		4
	PV		-£67,690.92		-£69,945.46

Present Value (PV)

1. The rental of £18,407/4 for quarterly = £4,602
2. Dicount Factor Calculation is $(1+r)^{n-1}$ where r is the interest rate quarterly and n is the period number i.e. period 6 = $(1.035)^{(6-1)}$ = 1.188 (-1 because arrears)
3. Therefore we discount the cashflow by taking the quarterly cash and dividing it by the period discount factor in 2 above : £4,602/1.188 = £3,875
4. The summation of all of these cash flows discounted gives us the PV of £67,691

IRR -Internal Rate of Return

1. The interest rate that equates the initial investment back to a NPV (Net Present Value) of £0
2. The initial Capital of £113,000 needs VAT removed 113,000/1.175 = £96,170 less the first rental receipt of £4,602 = - £91,568 (- for outflow)
3. Cashflows are not discounted, and the residual (end sale value) needs to be included
4. Thus the formula for IRR will be to the calculate interest rate that when used as a discount factor as in the above PV we conclude an IRR of 7.11%

APENDIX 2: BUY

5 Year

Period no	Opening NBV	Closing NBV	Average NBV	Cost of Capital	Discount Factor	DPV
0	113000				1.000	£113,000
1	113000	107500	110250	965	1.009	£956
2	107500	102000	104750	917	1.018	£901
3	102000	96500	99250	868	1.026	£846
4	96500	91000	93750	820	1.035	£792
5	91000	85500	88250	772	1.045	£739
6	85500	80000	82750	724	1.054	£687
7	80000	74500	77250	676	1.063	£636
8	74500	69000	71750	628	1.072	£586
9	69000	63500	66250	580	1.082	£536
10	63500	58000	60750	532	1.091	£487
11	58000	52500	55250	483	1.101	£439
12	52500	47000	49750	435	1.110	£392
13	47000	41500	44250	387	1.120	£346
14	41500	36000	38750	339	1.130	£300
15	36000	30500	33250	291	1.140	£255
16	30500	25000	27750	243	1.150	£211
17	25000	19500	22250	195	1.160	£168
18	19500	14000	16750	147	1.170	£125
19	14000	8500	11250	98	1.180	£83
20	8500	0	4250	37	1.190	£31
	1328000			Present Value		£122,518
				25,485	1.190	£21,410
				Present Value		£101,108

6 Year

Period no	Opening NBV	Closing NBV	Average NBV	Cost of Capital	Discount Factor	DPV
0	113000				1.000	£113,000
1	113000	108396	110698	969	1.009	£960
2	108396	103792	106094	928	1.018	£912
3	103792	99188	101490	888	1.026	£865
4	99188	94583	96885	848	1.035	£819
5	94583	89979	92281	807	1.045	£773
6	89979	85375	87677	767	1.054	£728
7	85375	80771	83073	727	1.063	£684
8	80771	76167	78469	687	1.072	£640
9	76167	71563	73865	646	1.082	£598
10	71563	66958	69260	606	1.091	£555
11	66958	62354	64656	566	1.101	£514
12	62354	57750	60052	525	1.110	£473
13	57750	53146	55448	485	1.120	£433
14	53146	48542	50844	445	1.130	£394
15	48542	43938	46240	405	1.140	£355
16	43938	39333	41635	364	1.150	£317
17	39333	34729	37031	324	1.160	£279
18	34729	30125	32427	284	1.170	£243
19	30125	25521	27823	243	1.180	£206
20	25521	20917	23219	203	1.190	£171
21	20917	16313	18615	163	1.201	£136
22	16313	11708	14010	123	1.211	£101
23	11708	7104	9406	82	1.222	£67
24	7104	0	3552	31	1.233	£25
				Present Value		£124,249
				19714.89	1.233	£15,995
				Present Value		£108,254

Present Value

1. This time we have an outflow of the purchase price including VAT (£113,000) at period 0 plus interest payments quarterly on the purchase price that need to be discounted
2. We can take the opening book value and the closing book value (Opening BV – Depreciation) to calculate the average BV (each period eg p1 £113,000 + (£113,000 - £4,387)/2 = £110,812
3. Using the cost of Capital we can then work out the quarterly interest eg P1: £110,812 * 3.5%/4 = £970 (4 for the quarterly)
4. Then we need to discount these given the same discount method used in the Leasing Appendix. £970/1.009 = £961
5. Sum of the discounted PV's = £124,181 or £125,756 once we account for a sales proceed of £25,485 including fees.
6. The IRR is always the cost of capital annually i.e. 3.5%

Appendix 3

Comparative I&E and Balance Extracts assuming the leases are classified as finance leases

(The I&E impact if the lease is treated as an operating lease will be the lease payments made will be treated as revenue expense)

	I&E - Finance Lease				I&E Buy		
	Depreciation	PDC charge	Financing Charge	Total I&E effect	Depreciation	PDC charge	Total I&E effect
1	17,503	338	1,681	19,522	17,503	3570	21,072
2	17,503	338	1,384	19,225	17,503	2800	20,302
3	17,503	338	1,082	18,922	17,503	2030	19,532
4	17,503	338	774	18,614	17,503	1260	18,763
5	17,503	338	460	18,301	17,503	490	17,993
	87,515	1,690	5,381	94,585	87,515	10,150	97,662

	I&E - Finance Lease				I&E Buy		
	Depreciation	PDC charge	Financing Charge	Total I&E effect	Depreciation	PDC charge	Total I&E effect
1	15,548	317	1,741	17,605	15,548	3,683	19,230
2	15,548	317	1,600	17,465	15,548	3,139	18,686
3	15,548	317	1,459	17,324	15,548	2,595	18,142
4	15,548	317	1,318	17,183	15,548	2,050	17,598
5	15,548	317	1,178	17,042	15,548	1,506	17,054
6	15,548	317	1,037	16,902			

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**CommandPoint Update**
Report Author(s)	**Peter Suter, Director of Information Management and Technology**
Lead Director	**Peter Suter, Director of Information Management and Technology**
Contact Details	**peter.suter@lond-amb.nhs.uk**
Aim	**To provide Trust Board members with an update on the CommandPoint project.**

Key Issues for the Board

Following a 3 week delay in the schedule, FAT (Factory Acceptance Testing) commenced on 15 March 2010 and is scheduled to last two weeks. At the time of writing, initial results are favourable. A fuller update will be provided verbally at the Trust board meeting that will take place four days after FAT completes.

There are a number of current issues within the scope of the project that are currently being progressed, these are detailed within the paper.

Work between the project teams continues to progress well, with good and open communications.

Mitigating Actions (Controls)

N/A

Recommendations to the Board

To note progress of the CommandPoint project.

Equality Impact Assessment

Has an EIA been carried out?

N/A

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Delay to the implementation of CommandPoint results in the continued use of CTAK.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

N/A

Corporate Objectives that the report links to

N/A

LAS TRUST BOARD MARCH 2010

COMMANDPOINT UPDATE

1. INTRODUCTION

1.1 The objective of this paper is to advise the Trust Board of the current status of the CommandPoint Project with particular reference to the Factory Acceptance Testing Activities and forward planning.

2. FAT (FACTORY ACCEPTANCE TEST)

2.1 FAT is the first stage of formal testing. It is carried out by NG (Northrop Grumman), at their premises in Chantilly (USA) and witnessed by the LAS. Following FAT, NG will deliver the Factory Test Report to the LAS. This will present the test results and will identity any faults still outstanding along with plans to resolve these. Details of the test acceptance criteria are set out in the following section of this paper.

2.2 The original plan for FAT was to commence on 22 February. However, because the internal test results (the tests run by NG before FAT) identified more faults than were acceptable it was rescheduled to 15 March. It commenced on this date as planned. Initial results are encouraging although it is too early to draw any overall conclusions.

2.3 An area of concern that NG have made the LAS aware of (before FAT commenced) is in relation to problems with the performance testing of the overall system and how much it will be possible to fully run all the performance tests during FAT.

2.4 Linked to the successful completion of FAT is a significant payment and project milestone. This is payment of circa £2.6M and acceptance that the system has passed the first formal stage of testing. In terms of governance, the Project Executive (Director of IM&T) will present the FAT results to SMG with recommendations and seek authority to proceed. This will ensure full transparency of the process that will be reported to the Trust Board.

3. FAT ACCEPTANCE CRITERIA

3.1 As the system is tested and faults are found they are graded according to severity. This is defined within the contract as follows:

Priority 1 - Critical - Mission critical loss of major systems component or functionality
Priority 2 - Major - Some functionality is not working (but is not mission critical) and there is no acceptable work-around for the problem
Priority 3 - Minor - Some functionality not working but there is an acceptable documented work-around
Priority 4 - Cosmetic - Non-critical issues. Document and all other problems and requests for information

3.2 The number of faults permitted in each category is defined in the contract and is shown in the following table:

Priority	Number Permitted
1 - Critical	0
2 - Major	0
3 - Minor	20
4 - Cosmetic	125

In order to achieve successful completion of FAT, Northrop Grumman must demonstrate that the number of faults in each category does not exceed the contractually agreed level, and that plans are in place to resolve any outstanding faults.

4. IMPACT OF FAT SLIPPAGE

4.1 FAT commenced three weeks later than originally planned. Northrop Grumman are confident that this will not impact overall project timescales as they expect to recover the three weeks during SIT (Site Integration Testing). They intend to start these activities as planned during the week commencing 22 March 2010; these activities will now take place in parallel with completion of FAT and Preparation of the Factory Test Report.

5. SIT

5.1 During SIT the live interfaces to CommandPoint will be tested. Each interface will be fully tested in the Test and Disaster Recovery (DR) environments before live testing is undertaken. The LAS and NG Project Teams are currently developing detailed plans identifying how and when each interface will be tested. Although live testing of some interfaces may necessitate periods of down-time, every effort is being made to keep this to a minimum and the Project Team will work closely with Control Services to minimise disruption. The plans for and experience gained during SIT will contribute to the Cutover Plan to be used to manage the 'on the night' transition from CTAK to Command Point.

6. TRAINING

6.1 The Command Point Training Lead has visited Sedgwick County, Kansas, USA to see Command Point operating in a live control room environment. She will also travel to Chantilly during the second week of FAT to see the enhancements developed for the LAS.

6.2 A Deputy Training Lead has been identified to provide support to the Training Lead and resilience in case of absence. The Training Lead will start to prepare the training curriculum in May 2010, supported by the Deputy training Lead and Command Point Work Based Trainers.

7. NG CHARGE FOR LATE DELIVERY OF INTERFACE SIMULATORS

7.1 NG have submitted a RfC (Request for Change) including an additional cost of £100k resulting from late delivery of interface simulators required for development and testing activities. NG were requested to provide a more detailed breakdown of the RfC to justify the additional cost. This has been provided and has been considered by the LAS. It is scheduled to be discussed by the LAS Head of Procurement during his visit to the US in the week commencing 22 March 2010.

8. CTAK

8.1 The stability of the current Command & Control System, CTAK continues to be a concern. Since New Year's Eve there have been four instances of service disruption. Every effort is being made to stabilise the system and a complete change freeze has been implemented. While this is primarily to manage functionality change, it also provides the best basis for stability. However during SIT there is a requirement to work with the CTAK interfaces that will introduce an element of risk. The focus of the Command Point project must remain to replace CTAK as soon as is safely possible.

9. TIMETABLE

The plan is for transition from CTAK to CommandPoint to take place on 22 February 2011. However there are a number of issues that are of concern:

9.1 FAT Results: It is reasonable to assume an amount of re-work required as a result of FAT. This may potentially impact the overall timetable.

9.2 Release 1.1. This is the additional five RfC's that the LAS have identified as essential for go-live. They are scheduled for delivery in September during UAT (User Acceptance Testing). There is a plan, however there is task conflict and more work is required to resolve this.

9.3 Dynamic Deployment (LVM Interface). This is an additional RfC for a piece of functionality that the LAS require for go live. NG have now indicated that they cannot deliver it within the scope of release 1.1. Options are currently being investigated for how this can be delivered.

9.4 FRU (Fast Response Unit) Desk. Command Point does not currently support the operation of a dedicated FRU Desk. This was omitted from the original requirements and was intended to be resolved by submission of a Request for Change (RFC) for provision of this functionality in Release 1.1. The FRU desk was subsequently removed from the Emergency Operations Centre and the RFC was discontinued. However, the FRU Desk has now been reintroduced and options to fulfil this requirement are currently being evaluated. There is the potential for a further RfC.

9.5 PSIAM Interface: This is not critical for go-live, however details are included for completeness. It has been agreed that the interface for PSIAM (used for Clinical Telephone Advice) will be delivered after go–live. The approach being considered is the feasibility of a release 3 months after 'go live' to implement this interface. However with current issues this planning work has not yet commenced.

10. PROJECT COORDINATION AND ASSURANCE

10.1 At the November Trust Board, it was advised that the NG Project Manager had resigned. Since that time a new UK Project Manager has been appointed and the US based Deputy Project Manager (who is in charge of software development) has taken a more prominent role. These arrangements have worked well and the project does not appear to have been adversely effected by this change.

10.2 The CEO, Chairman, SMG, Lead Trust Board Members and Trust Board Consultant have been kept regularly updated with the progress of the project. There has also been contact with the NG UK Chairman who is keeping a watching brief on the project.

11. CONCLUSIONS

11.1 As expected there are a number of issues within the project that have the potential to effect the transition date. However there are still many variables and focus must remain on the current transition date of 22 February 2011.

12. RECOMMENDATION

12.1 The Trust Board to note the progress of the project.

Peter Suter
Director of IM&T
March 2010

London Ambulance Service NHS Trust

TRUST BOARD 30th March 2010

Document Title	**Rota Project Progress Update**
Report Author(s)	**Paul Gates**
Lead Director	**Richard Webber**
Contact Details	**Richard Webber**
Aim	**To update the Board on progress of the Rota Project**

Key Issues for the Board

A presentation will be given at the Trust Board meeting which provides a progress update to the Board on the Rota Project along with illustrating how compliance has changed on those stations where new rotas have been introduced. The project commenced 10 months ago with the aim of ensuring each station rota matched the ORH recommendations for resources so the Trust had the resources to meet demand each hour of the day, every day of the week. The project has included the allocation of c400 new staff into the Trust to ensure the rotas can be implemented. The project to date is 72% complete across the Trust with 29% of the rotas changed.

This is a complex organisation change project involving local staff side discussions and negotiations. The project has also included training hours on each rota to ensure the New Ways of Working strategy is developed on each station.

Mitigating Actions (Controls)

To ensure the Project team have a tight project process and focus on delivering within the timeframe the following actions have been developed:

Weekly reporting to Project Executive and Project Board on progress and where progress has not met the action plan, further remedial actions are agreed.

Quality Assurance process set up and being used to ensure the rota meets ORH recommendations and that the European Working Time Directive is being adhered to.

Dedicated Project Manager who is working directly with complexes to ensure delivery. The inclusion of the Project Manager has allowed greater focus and control of the project.

Action plans and trajectories being used to ensure project delivers within the timeframe.

Recommendations to the Board

The Trust Board is asked to note the presentation.

Equality Impact Assessment

EIA assessment has not been carried out

Risk Implications for the LAS (including clinical and financial consequences)

This project is critical for consistent delivery of operational performance targets and will impact on the delivery of category B target. Failure to meet the category B target will impose a financial penalty on the Trust and will potentially have an impact on Trust reputation externally as well as not providing the patients of London with a responsive service.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

The project introduces training time for staff into their rota. The project will also review Relief staff working once the new rotas have been introduced to ensure we are using them in a fair manner bearing in mind the need to improve their work/life balance.

Corporate Objectives that the report links to

1. Improve response times to patients at weekends. This will reduce poor performance during this period and will mitigate one of the highest risks currently on the Trust risk

register.

2. Achieve A8 and B19 patient waiting time targets. It will also reduce the performance dip seen at shift handover time especially noted between 1800 to 2000 hrs daily.
3. Assists in delivering the Trust training strategy and plan. This will allow the mandatory training to be delivered without interruption to the Trust operational delivery as well as potentially providing additional time for each member of staff to have their annual Personal Development Review within a protected timeframe. This will also mitigate a further high risk that is currently on the Trust Risk Register.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 30 March 2010

Document Title	**Core Standard 11b – Mandatory Training -** Healthcare organisations ensure that staff concerned with all aspects of healthcare participate in mandatory training programmes.
Report Author(s)	**Gill Heuchan** **Assistant Director of Professional Education Development**
Lead Director	**Caron Hitchen**
Contact Details	**gill.heuchan@lond-amb.nhs.uk**
Aim	**To provide information on the current position for the Trust board members to consider in relation the Care Quality Commission Core Standards Declaration.**

Key Issues for the Board

The Trust submitted a declaration of 'insufficient assurance' against this core standard in December 2009.

Evidence has been collected since late 2009 on the number of staff being trained against the programme of mandatory training. This includes reports from local Complex managers and indicates high levels of training delivery in key areas such as Infection Control and Manual Handling equipment.

Consideration needs to be given to this additional evidence now available together with the 2009 staff survey results, and the HSE improvement notice issued in March 2010 concerning refresher training for manual handling.

Mitigating Actions (Controls)

Implementation of the Clinical Training Plan 2009-2011 with particular focus on the priorities identified by SMG.

Implementation of the education framework defined in HS002 Safety and Risk Management Training and provision of Health and safety Information.

Review of the central data collection systems for training.

Development of new Core Training Policy

Implementation of regular and systematic monitoring and reporting of uptake.

Roll out of New Ways of Working.

Implementation of e-learning as part of a blended approach to learning.

Implementation of the Operational Workplace Review Policy to assess the application of learning, knowledge and skill in practice as part of a blended approach to learning.

Development and implementation of a suite of refresher training programmes to build on initial learning programmes.

Recommendations to the Board

To consider the information now available concerning mandatory training and to determine if the level of assurance provided supports compliance with the core standard.

To determine the impact of the HSE Improvement Notice on compliance with the core standard.

To determine the impact of the Staff Survey results on compliance with the core standard.

Equality Impact Assessment

This is a review of existing information and therefore does not require an EIA.

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

There is a risk of litigation from staff and patients if incidents occur where the Trust has insufficient evidence of training to defend a challenge.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

There is a risk that the organisation cannot unequivocally demonstrate its use of training to mitigate risk to the lowest level due to insufficient evidence of it taking place.

There is a potential risk to the Trust's registration with the Care Quality Commission which may adversely impact on the reputation of the organisation.

There is a risk to the Trust's NHSLA level one status and for the forthcoming level two assessment.

Corporate risk register: risk 314: There is a risk that front line staff may not be able to attend CPD training due to recurring operational pressures, which may impact upon the quality of patient care.

Corporate Objectives that the report links to

All staff are appropriately trained for the job they do:

A supportive working environment.

London Ambulance Service NHS Trust

Report to the Trust Board
Core Standard 11b – Mandatory Training

Introduction

The Care Quality Commission exists to promote improvements in the quality of healthcare and public health in England and promote continuous improvement for the benefit of patients and the public. Each year NHS Trusts are required to make a self assessment declaration in relation to the Core Standards.

Within the National Health Service there are several frameworks which define the training which is required by staff to undertake their duties safely and effectively, these are defined as Mandatory. The London Ambulance Service policy HS002 sets out the types and frequency of this training.

The Care Quality Commission Core Standard C11b requires the Trust to assess compliance which requires that "Healthcare organisations ensure that staff concerned with all aspects of healthcare participate in mandatory training programmes".

The Trust submitted a declaration of 'insufficient assurance' against this core standard in December 2009. Since making this declaration a number of activities and events have taken place which may impact on this declaration, these include:

- Delivery of Training and Development;
- The Annual Staff Survey;
- The Health and Safety Executive Inspection.

Delivery of Training and Development

The London Ambulance Service has significant programmes of education being delivered in all areas, however the trust recognises that the systems and processes to capture the information are not currently providing the evidence which assures the organisation that the activity planned is being delivered. This is primarily because multiple systems exist which contain data in different formats. This makes analysis and comparison difficult at best and for some staff groups and training types virtually impossible.

Since making the declaration reports have been gathered to determine the most up to date Mandatory Training position for the Trust in relation to all areas.

New Employees and Students

The Trust has clear and unequivocal evidence that all new employees and students have attended the corporate induction. This programme provides the Mandatory Health Safety and Risk training required within the first week of employment. All those who fail to attend are followed up with the line manager and attendance is reorganised for any individuals who do not make the initial dates booked for them.

Student Paramedics and A&E support workers both undertake well defined pathways of education specific to the role which include the mandatory as well as the developmental learning, skills acquisition and development necessary to undertake the role they are preparing for. Additionally whilst new to the role these staff groups are mentored until they are deemed to be competent in the elements commensurate with the level they are at. In the current year the Trust has employed 835 staff, representing 18% of the workforce, who are in date with their mandatory training. Over the last 2 years, 1385 new staff have commenced thus accessing this training which equates to 30% of the workforce.

New Ways of Working Complexes

In the two New Ways of Working complexes 100% of staff have received their mandatory training for 2009/10 and this is a clear demonstration of the positive impact rostered education days and complex based tutors can have on delivery and up take. In the current financial year the trust has evidence that 230 staff have received 100% of their mandatory training. This represents 4% of the workforce (7% of frontline).

Existing Clinical Staff

There are several sources of data for training of clinical staff these include

Currently several systems exist these include the local systems which capture complex based activity and ad hoc activity , the attendance record maintained by the clinical training administration team and the centralised PROMIS system which captures centralised allocations and attendances. These systems all collect data in different formats and against different criteria. Due to the differences in course data it is challenging to triangulate the information to determine whether the numbers are counting the same things, for example if a training item has no PROMIS code it will be coded as “other” therefore training which may be mandatory cannot be counted as such without lengthy searches to cross reference specific names and dates to reasons for abstractions. For this reason it is not currently possible to provide precise assurance about the number of staff in date with mandatory training, although the course scheduling and resource planning shows that activity is taking place it is the lack of clarity and consistency in the recording and reporting systems which is one of the main reasons for the declaration of insufficient assurance.

This position has not changed although local courses are running manual reports submitted by local management teams show training activity up to December 2010 in relation to 50 topics. Of specific relevance to this update are the areas of:

- Infection control (including FIT testing) – 2594 (77% of all frontline establishment). Recent training activity indicates a 90% completion of infection control training by the end of March.
- New vehicles (including manual handling equipment) plus manual handling aids – 2160 (64% of all frontline establishment)

Non Clinical Staff

The Learning and Development Team have developed and piloted an "All in One Day approach" to mandatory training. This has been piloted and is now being launched as the programme for all non-clinical staff. In the year to date 17 people have undertaken this training (in the pilot phase).

The Annual Staff Survey

The London Ambulance Service NHS Trust undertook a full staff survey with thirty eight per cent (1654) of those surveyed returning questionnaires. The staff survey shows that in most of the questions relating to training learning and development there have been statistically significant improvements in three areas, indicated by the plus symbol (below). As can be seen not all of the questions relate directly to mandatory training, however they provide a context of improvement on the previous year which is an endorsement of the efforts being made by the organisation to continually improve in relation to training provision and uptake. This therefore forms part of the evidence to demonstrate activity to support the self declaration.

		2008	2009
4a	No taught courses in past 12 months	43 %	**40 %**
4b	No on-the-job training in past 12 months	64 %	**60 %** +
4c	No mentor in past 12 months	83 %	**81 %**
4d	No shadowing someone in past 12 months	83 %	**80 %** +
4e	No e-learning/online training in past 12 months	87 %	**87 %**
4f	No keeping up to date with developments in work area	41 %	**39 %**
5a	No equality and diversity training	40 %	**39 %**
5b	No health and safety training	35 %	**34 %**
5c	No training in what to do if there is a major incident/emergency	30 %	**32 %**
5d	No training in how to handle violence to staff/patients/service users	35 %	**38 %**
5e	No infection control training	34 %	**29 %** +
5f	No computer skills training	71 %	**68 %**
5g	No training in how to handle confidential information	50 %	**48 %**
5h	No training in advising patients on condition/medication	50 %	**48 %**
6a	Training did not help me do job better	19 %	**20 %**
6b	Training has not helped me stay up-to-date with job	24 %	**24 %**
6c	Training has not helped me stay up-to-date with professional requirements	25 %	**25 %**

The Health and Safety Executive Inspection

In March 2010 The Health and Safety Executive undertook an inspection of the London Ambulance Service NHS Trust focussing on three areas:

- Manual handling
- Conflict resolution
- Infection prevention and control

As a result of this inspection the Trust has been issued with an Improvement Notice relating to Manual Handling and Training with a particular focus on refresher training for Manual handling.

Mitigating Actions

The London Ambulance Service had prior to making the declaration of insufficient assurance identified the urgent need to undertake a number of activities to address the issues in relation to mandatory training. Work is taking place to implement these actions which include:

- Implementation of the Clinical Training Plan 2009-2011 with particular focus on the priorities identified by SMG namely;

    - **Life Support- ALS and BLS** (Mandatory)
    - **Obstetrics** (Mandatory)
    - **Manual Handling** (Statutory)
    - **Patient Assessment** (Mandatory**)**

- Implementation of the education framework defined in HS002 Safety and Risk Management Training and provision of Health and safety Information
- Development of new Core Training Policy (to replace HS002)
- Review of the central data collection systems for training.
- Implementation of regular and systematic monitoring and reporting of uptake.
- Roll out of New Ways of Working.
- Implementation of e-learning as part of a blended approach to learning.
- Implementation of the Operational Workplace Review Policy to assess the application of learning, knowledge and skill in practice as part of a blended approach to learning.
- Development and implementation of a suite of refresher training programmes to build on initial learning programmes.

Recommendation

To consider the information now available concerning mandatory training and to determine if the level of assurance provided supports compliance with the core standard.

To determine the impact of the HSE Improvement Notice on compliance with the core standard.

To determine the impact of the Staff Survey results on compliance with the core standard

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Risk management structure**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To seek approval of the risk management structure and move towards a culture that promotes quality and safety**

Key Issues for the Board

Following the discussions at the Trust Board meeting on 26th January 2010 and the service development committee on 3rd March, the proposed structure has been reviewed and some changes made, specifically to title and membership.

The draft terms of reference for the Quality Committee have been revised to reflect the proposals, and the terms of reference for the Audit Committee have been updated to reflect title changes.

The proposed structure changes are as follows:

- Disband the Clinical Governance Committee and replace with the Quality Committee at Board level with oversight of quality performance;
- The Quality Committee membership would be: a minimum of 4 non-executive directors, one of whom is the chair of the committee, and the Chief Executive; regular attendees would be the chairs of the 3 committees responsible for clinical quality, safety, risk, patient experiences and learning from experience, and the Director of Corporate Services as the lead for risk management and corporate governance;
- The Quality Committee would hold to account those executives responsible for quality, safety and risk and would seek assurances supported by evidence of issues addressed and improvements made;
- The Quality Committee would meet bi-monthly;
- The establishment of a Clinical Quality, Safety and Effectiveness committee, chaired by the Medical Director, that focuses at an operational level on demonstrating how services are provided that are safe and effective, how changes are made where there is room for improvement, and how clinical audit and research can provide evidence and support; this then provides the assurance to the Quality Committee;
- Changing the title of the Feedback Learning & Improvement group to Learning from Experience and strengthening the arrangements for learning from the patient experience as well as other risk indicators such as claims and incidents;
- The Director of Finance would become the chair of the Risk Compliance & Assurance group as the Chief Executive becomes a member of the Quality Committee.

These changes are proposed within the context of the publication of The Healthy NHS Board and the proposals from Monitor for enhancements to the assessment of quality governance for applicant NHS foundation trusts. The overall aim is to strengthen the structure that will lead to a culture of quality and safety throughout the organisation, led from the Trust Board.

In addition:

- In light of concerns over the management drugs within agreed policies and procedures, the Medical Director is proposing to establish a Medicines Management

Mitigating Actions (Controls)

- Risk management strategy & policy and associated policies and procedures
- Standing Orders for the Trust Board
- Terms of reference for key risk management committees

Recommendations to the Board

That the proposed structure is approved with implementation commencing from April 2010;

That the structure is formally reviewed 12 months after it has been implemented.

Equality Impact Assessment

Has an EIA been carried out?

An initial assessment by the Director of Corporate Services suggests that outcome A applies: the structure is unlikely to result in any adverse impact for any equality strand group and promotes equality of opportunity.

(If not, state reasons)

Key Issues from Assessment

If the structure is approved a more comprehensive EQIA will be undertaken.

Risk Implications for the LAS (including clinical and financial consequences)

This should strengthen arrangements for clinical risk management.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Good governance practice as recommended by Taking it on Trust, and The Healthy NHS Board;

Clarity of roles for the Audit and Quality Committees; improved focus for clinical quality, safety and risk at an operational level.

Risk of delayed or non-implementation – NHSLA assessment in October 2010 will require evidence of the implementation of risk management arrangements including structure and policies.

Impact on the NHS foundation trust application during 2010/11 with the focus on assessment of quality governance arrangements, board awareness of the potential risks to quality, and clear roles and accountabilities in relation to quality governance.

Corporate Objectives that the report links to

Strategic objective of ‘improving delivery of safe and high quality patient care using all available care pathways;

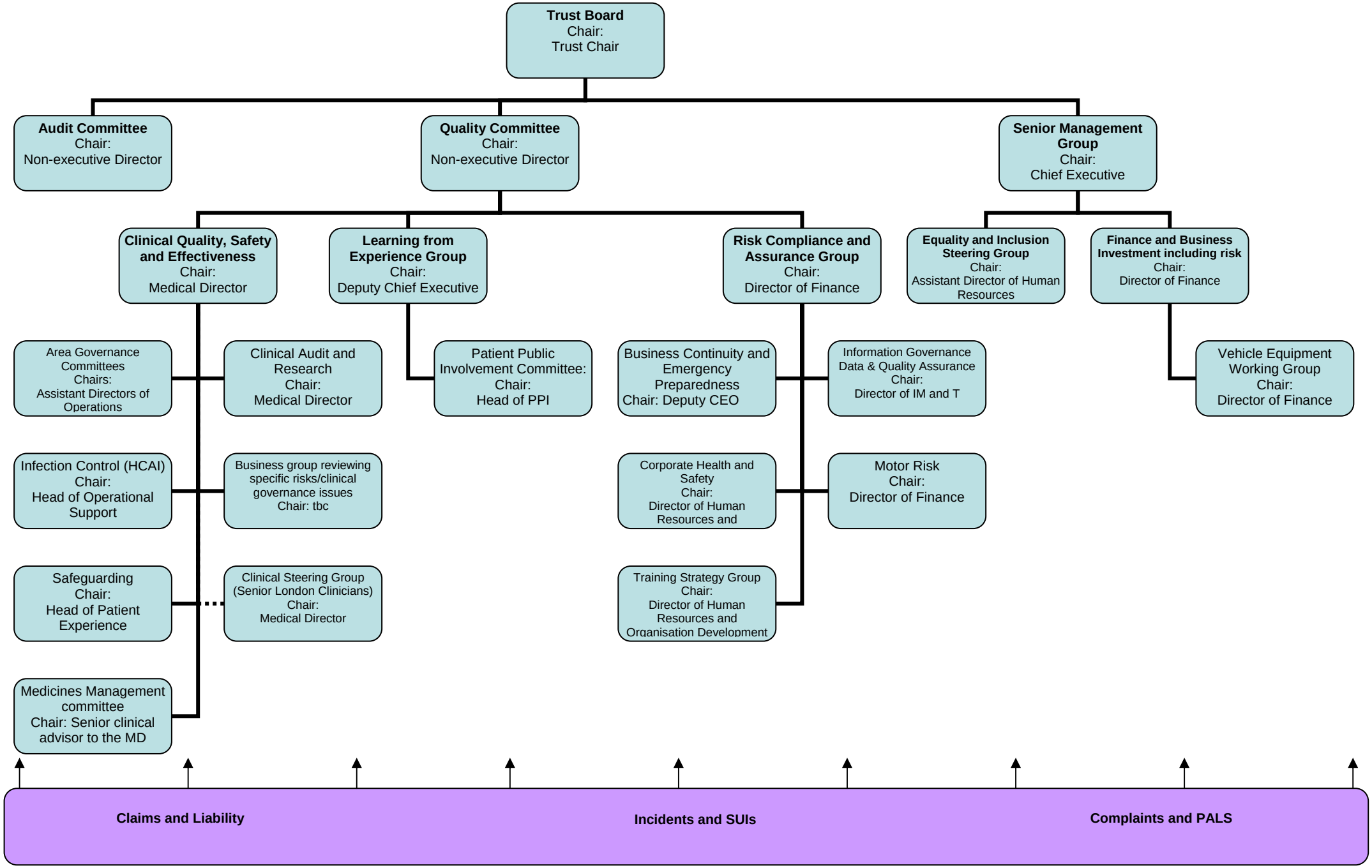
Plus:

All staff are trained appropriately for the job they do

Staff feel their opinions are valued and that they can influence

A supportive working environment

Proposed Risk Management Structure



DRAFT: Quality Committee - Terms of Reference

1 Authority

1.1 The Quality Committee is constituted as a Standing Committee of the Trust Board of Directors (the Board). Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board.

1.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external representatives with relevant experience and expertise if it considers this necessary.

1.4 The Committee provides assurance to the Trust's Audit Committee on the effectiveness of the risk management framework.

2 Purpose

The primary focus of the Quality Committee will be to assure the Board on clinical, corporate, quality and information governance, and on compliance matters, leading to the provision of safe and effective services of the highest quality.

The Committee shall:

2.1 Be responsible for governance and risk management arrangements and processes, including risk strategy and policy development, and overseeing/being assured of implementation and effectiveness;

2.2 Oversee the systems and processes in place to ensure that the Trust's services deliver safe, high quality, patient-centred care;

2.3 Review the Trust's performance against internal and external quality improvement targets and monitor action plans to address concerns;

2.4 Oversee the Care Quality Commission registration process and the preparation for the NHSLA risk management standards assessment;

2.5 Seek assurance from the management team that effective management processes are in place for patient safety, hygiene/infection prevention and control, and safeguarding.

3 Quality and safety assurance

3.1 The Committee shall ensure that there are robust and effective mechanisms in place to manage and measure the quality and safety of services provided for patients.

3.2 To oversee the annual registration processes for quality of services and infection prevention and control.

3.3 To receive reports on performance against quality initiatives commissioned by PCTs and to understand the risks in not meeting these.

3.4 To oversee and approve the development of the Trust's annual Quality Account.

3.5 To receive reports on outcomes and effectiveness of patient treatment, care and interventions.

3.6 To receive reports on the effectiveness of the implementation of Healthcare for London initiatives for Stroke, Trauma and Urgent Care.

3.7 To seek assurance on the effectiveness of clinical initiatives for cardiac care.

3.8 To oversee the programme for patient involvement and experience and to seek assurance that this incorporates the CQC regulatory requirements and the development of the annual Quality Accounts.

4 Risk management

4.1 To seek assurance on the effectiveness of processes and systems for managing clinical, corporate, quality and information governance and risks.

4.2 To oversee the strategic assessment of organisational risk, and to review the corporate risk register and identify key strategic risks to the Trust and recommend action to alleviate or control such risks.

4.3 To oversee the risk management processes throughout the organisation including regular review of the corporate risk register and board assurance framework.

4.4 To hold senior managers to account for the effective implementation of risk assessments, action plans, risk registers and a culture of proactive risk and governance.

4.5 To oversee the assessment of compliance against the NHSLA Risk Management standards and the development and implementation of action plans to achieve this.

4.6 To annually review the Risk Management policy and strategy.

5 Monitoring and Reporting

5.1 To review the objectives and outcomes of each of the Clinical Quality, Safety & Effectiveness, Learning from Experience, and Risk Compliance and Assurance committees, to agree action plans and priorities for the coming year.

5.2 To receive regular reports from the Clinical Quality, Safety & Effectiveness, Learning from Experience, and Risk Compliance and Assurance committees.

5.3 To ensure that quality is a core part of Board meetings, both as a standing item and as a core element of key discussions and decisions.

5.4 To submit an annual Quality Safety & Risk report to the Trust Board.

5.5 To report to external bodies (e.g. Monitor, Care Quality Commission, Health and Safety Executive, NHS London) in relation to risk.

5.6 To be kept up to date on national and local policy changes relating to the management of risk.

5.7 To ensure there is a policy review programme in place and monitored and to review new or revised policies against this programme.

5.8 To review attendance records for statutory and mandatory training programmes.

5.9 To create, implement and monitor key performance indicators for risk management.

5.10 To complement the work of the Audit Committee and exchange information and reports on a regular basis.

5.11 To receive and review reports on SUIs and associated action and outcomes from either the Clinical Quality Safety & Effectiveness committee or the Risk Compliance & Assurance committee.

5.12 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include but will not be limited to any reviews by the Care Quality Commission, NHS Litigation Authority, Health & Safety Executive or other regulators/inspectors etc; and professional bodies with responsibility for the performance of staff or functions (e.g. accreditation bodies etc).

5.13 The Quality Committee of the Trust is responsible for ensuring the Trust has effective risk management and governance systems and controls in place. The Director of Corporate Services (or another representative as authorised/delegated by the Chair of the Quality Committee) shall be the representative of the Quality committee and the Audit Committee. In addition the Audit Committee receives minutes from the Quality Committee.

6 Membership

6.1 The Committee shall be appointed by the Board and shall comprise the four non-executive directors and the Chief Executive.

6.2 The chairmen of the following sub-committees will routinely attend the Quality Committee along with the Director of Corporate Services:
- Clinical safety, Quality and Effectiveness
- Learning from Experience
- Risk Compliance & Assurance.

6.3 All committee members shall have voting rights.

6.4 One non-executive director shall be appointed by the Board to be the Chair of the committee and, in their absence, another non-executive director shall chair the meeting.

6.4 At least one non-executive director shall be a full member of the Audit Committee.

6.5 The Director of Corporate Services shall act as the executive team's link between the Quality Committee and the Audit Committee.

6.6 Other senior managers should be invited to attend when the Committee is discussing areas of quality, safety and risk that are their responsibility.

6.7 At least once a year the appropriate Internal Auditor representative should attend the meeting.

6.8 Full membership shall be as follows:
Four non-executive directors
Chief Executive
Attending:
Medical Director & chair of Clinical safety, Quality & Effectiveness
Deputy Chief Executive & chair of Learning from Experience
Director of Finance & chair of Risk compliance & assurance
Director of Corporate Services.

7 Accountability

The Quality Committee shall be accountable to the Board of Directors.

8 Responsibility

The Quality Committee is a formal sub-committee of the Board of Directors and has no executive powers other than those specifically delegated in these Terms of Reference.

9 Reporting

9.1 The minutes of the Quality Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Board of Directors;

9.2 The Chair of the Quality Committee shall draw the attention of the Board to any issues that require disclosure to the full Board or that require executive action;

9.3 An annual report monitoring the effectiveness of the committee will be prepared by the Chair and the Director of Corporate Services and submitted to the next meeting of the Audit Committee and then to the Board.

10 Administration

10.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the Agenda with the Chair of the Quality Committee and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

10.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

10.3 The draft minutes and action points will be available to Committee members within 7 working days of the meeting.

10.4 Papers will be tabled at the discretion of the Chair of the Quality Committee.

11 Quorum

The quorate number of members shall be 50% non-executive directors and the Chief Executive or nominated senior executive to deputise in his absence.

12 Frequency

12.1 Meetings shall be held at least quarterly and initially bi-monthly.

12.2 The Chief Executive may request a meeting if they consider that one is necessary.

12.3 Committee members are required to attend at least 75% of the committee's meetings per financial year.

13 Terms of reference review

13.1 The Quality Committee will review these Terms of Reference annually.

13.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Draft Terms of Reference
22nd March 2010

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Interim risk management policy and strategy**
Report Author(s)	**Laila Abraham & Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**0207 783 2045**
Aim	**To seek Trust Board approval of the updated risk management policy and strategy that reflects changes to structure, people in post and reporting arrangements.**

Key Issues for the Board

- It is a key requirement of the NHS Litigation Authority that the Trust has an organisation-wide risk management policy and strategy that has been approved by the board;
- The document describes the organisational risk management structure, the process for high level review of the corporate risk register, the process for local risk management, and the duties of key individuals including those with authority with regards to managing risk;
- The document includes the proposed risk management committee structure;
- This is an interim document pending the approval of the changes to the risk management structure and the revision to terms of reference of key risk committees;
- The Risk Compliance and Assurance Group and Senior Management Group have reviewed and approved the updated document.

Mitigating Actions (Controls)

- Risk management committee structure and terms of reference
- Statement on Internal Control
- Associated policies and procedures

Recommendations to the Board

- To approve the interim Risk Management Strategy and Policy so that it can be published and implemented.

Equality Impact Assessment

Has an EIA been carried out? An initial assessment suggests Outcome A: the policy is not likely to result in any adverse impact.

(If not, state reasons)

Key Issues from Assessment

Full EQIA to be undertaken.

Risk Implications for the LAS (including clinical and financial consequences)

Clarity of roles and responsibilities that can be communicated throughout the organisation and to support those with risk management responsibilities.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) As above. Also, NHSLA requirement, Statement on Internal Control, Annual Report, governance arrangements for the FT application.
Corporate Objectives that the report links to Regulatory

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Board assurance framework and corporate risk register**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To present the revised board assurance framework (pack A) and the corporate risk register for approval (pack B)**

Key Issues for the Board

- The Trust Board last reviewed the board assurance framework (BAF) on 31st March 2009;
- The corporate risk register (pack B) is an abridged version of the full risk register, representing only those risks with a severity rating of >15 and therefore deemed to be the most significant risks facing the Trust;
- The BAF sets out the Trust's strategic objectives and the risks to achieving these. It describes the controls in place to manage the risks and the assurances available on the effectiveness of the controls;
- The BAF has been revised following the strategic risk review and the development of the strategic goals and corporate objectives for the Trust from April 2010;
- The BAF should be routinely reviewed and used by the Trust Board to oversee the progress towards the strategic goals and to understand the risks, strategic and corporate, that are being managed/mitigated in order to support achievement of corporate objectives and strategic goals;
- Work is still required on mapping across the CQC regulations and this will be reported to the next meeting of the Risk Compliance and Assurance group on 17th May;
- The corporate risk register and BAF should be viewed together and can become an effective tool for the Trust Board on the management of risk and will be monitored after 6 months to assess the progress made with managing and reducing risks;
- The Risk Compliance and Assurance group will undertake a full review of the corporate risks and the BAF at its next meeting with a focus on strengthening the description of controls;
- The Audit Committee has a primary focus on the risks, controls and related assurances that underpin the achievement of the Trust's objectives and this will be supported by regular review of the board assurance framework that pulls all of this together.

Mitigating Actions (Controls)

- Internal audit review in 2009/10 and due in 2010/11;
- Statement on Internal Control 2009/10;
- RCAG review of the corporate risks and the BAF;
- Mapping to the CQC regulations to be completed;

Recommendations to the Board

- To consider and approve the board assurance framework;
- To consider and approve the corporate risk register.

Equality Impact Assessment

Has an EIA been carried out? Not fully assessed and would need to be reviewed by objective and risk.

(If not, state reasons)

Key Issues from Assessment

See above.

Risk Implications for the LAS (including clinical and financial consequences)

Risks are described within both documents.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Risk of not having an updated BAF in place – governance requirement that is referred to within the Statement on Internal Control (SIC). Internal audit will assess the BAF.

Corporate Objectives that the report links to

All but specifically regulatory requirements.

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Standing Orders**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**0207 7832045**
Aim	**To approve the updated document**

Key Issues for the Board

- As an NHS Trust we are required to agree Standing Orders (SOs) for the regulation of our proceedings and business.
- Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations 1990 (SI(1990)2024) requires the meetings and proceedings of an NHS Trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under regulation 19 (2).
- The Codes of Conduct and Accountability 2004 require Boards to adopt schedules of reservation of powers and delegation of powers.
- These documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.
- The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.
- The Standing Orders were reviewed by the Audit Committee on 8th March 2010. In keeping with good governance practice, these should be reviewed every year to 18 months. These were approved subject to agreement on the risk management structure.

Key changes are highlighted:

- Amendment from Vice to Deputy Chairman throughout;
- Page 22 – deletion of Clinical Governance Committee and insertion of Quality Committee – SO 22
- Page 34 - Procurement Framework: figures may need review in the coming year;
- Page 39 – Standard procurement: please consider the comment against 6.1;
- Page 51 – The register form has been updated.;
- Page 52 - The terms of reference referred to will be included once agreed.

The Standing Financial Instructions need further detailed review and will be presented to the Trust Board in May 2010.

Mitigating Actions (Controls)

- Statement on Internal Control
- Audit opinion.

Recommendations to the Board To approve the updated Standing Orders subject to agreement on the risk management structure.
Equality Impact Assessment Has an EIA been carried out? Not assessed as yet. (If not, state reasons) **Key Issues from Assessment**
Risk Implications for the LAS (including clinical and financial consequences) None identified
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) It is a requirement that NHS Trusts have these in place.
Corporate Objectives that the report links to All

Key changes to the Standing Orders

Page and paragraph	Amendment	Rationale
Page 10, Para 2.2 Admission of the public and observers to Trust meetings	Delete 'both at the beginning and'	To manage the agenda and timing of the meeting, formally allocate an agenda item at the end of the meeting for questions from the public.
Page 11, Para 4 Page 12, Para 5 Deputy Chairman	Delete 'Vice' and insert 'Deputy' throughout	More official description. Would like to use 'Vice' for the Council of Governors when this role would be held by a public governor.
Page 13, Para 8.1 Record of attendance	Add 'attending directors and observers'	Consistency with Appendix XI 2.1.2
Page 20, Para 17.2 Arrangements for the exercise of functions	Removed as S16B of the NHS Act 1977 refers to PCT functions. Para 17.3 – over-riding SOs becomes 17.2	Not applicable
Page 21, Para 22	Delete Clinical Governance Committee and replace with Quality Committee	Subject to agreement on the new risk management structure
Page 21, Para 23	Delete risk management	The Risk Compliance and Assurance group is not a board committee. The risk function will be reflected in the terms of reference for the Audit and Quality committees
Page 41, Para 8.2 Invitations to tender	Delete reference to tenders for computer equipment; specify that this is the NHS Standard Contracts Conditions	Untidy reference that did not apply.
Page 53, Appendix VI Standards of business conduct	Re-word to include 2004	EL(94)40 superseded by the 2004 codes of conduct and accountability

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Expenses Policy**
Report Author(s)	**Martyn Salter**
Lead Director	**Mike Dinan**
Contact Details	**Michael.dinan@lond-amb.nhs.uk**
Aim	**To seek the Trust Board's approval of the Expenses Policy**

Key Issues for the Board

The document consolidates existing guidance; there is little that is new. The policy is required for ALE Level 4. The new policy items are:

1. Expenses claims should be submitted within 3 months of the item being incurred.
2. Sections 4.4, 13 and 14 set out the responsibilities of Board members in respect of this policy.
3. Advice on 'Duty of Care' and 'Carbon Foot Print' reduction.

Mitigating Actions (Controls)

None necessary.

Recommendations to the Board

That the Trust Board approves the Expenses Policy.

Equality Impact Assessment

Has an EIA been carried out? No.

Key Issues from Assessment

No assessment is considered necessary as the document consolidates existing national and Trust guidance into one document.

Risk Implications for the LAS (including clinical and financial consequences)

None.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Only implication relates to the policy not being agreed. This will risk the continuance of confusion about what is claimable, leading to potential additional costs.

Corporate Objectives that the report links to

To create a framework to achieve effective management & utilisation of resources.

London Ambulance Service NHS
NHS Trust

Expenses Policy

DOCUMENT PROFILE and CONTROL

Purpose of the document: The purpose of this Expenses Policy is to set out the policy, allowances and requirements for receipts when LAS staff submit expenses claims. It has been produced at this time to provide a framework and consolidated guidance for staff as the system for electronically claiming expenses (***expenses***) is rolled out across the Trust.

Sponsor Department: Corporate Process & Governance Programme Team and the Electronic Expenses Project Board.

Author/ Reviewer: HR Employee Services Manager & Financial Controller. To be reviewed by March 2012 or when revised Sections 17 & 18 of the national AfC Terms & Conditions are published. Subsequently, the policy will be reviewed every 3 years.

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
17/08/09	0.1	Corporate Processes Programme Manager	Initial draft
19/08/09	0.2	Corporate Processes Programme Manager	Formatting comments from GDU
01/09/09	0.3	Corporate Processes Programme Manager	Initial comments from Greg Masters
20/10/09	0.4	Corporate Processes Programme Manager	Changes from meeting with Greg Masters & Tony Crabtree
	0.5	Corporate Processes Programme Manager	Changes Tony Crabtree
21/12/09	0.6	Corporate Processes Programme Manager	Changes agreed with Tony Crabtree
22/12/09	0.7	Corporate Processes Programme Manager	Minor modifications to layout from GDU and changes requested by Tony Crabtree.
5/01/10	1.0	Corporate Processes Programme Manager	Issues document for SMG approval
13/01/10	1.1	Corporate Processes Programme Manager	Minor changes following SMG meeting
16/03/10	1.2	Corporate Processes Programme Manager	Minor changes to section related to tube and train travel.
16/03/10	2.0	Corporate Processes Programme Manager	Version for Board Approval

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
		1.0
Agreed by Trust Board (If appropriate):		
		1.0

Published on:	Date	By	Dept
The Pulse		Records Manager	GDU
LAS Website			
Announced on:	**Date**	**By**	**Dept**
The RIB			

EqIA completed on	By
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Agenda for Change Terms & Conditions	
	Maternity Leave and Pay Policy	
	The system supplied by Software Europe is referred as ***expenses*** throughout the document irrespective of the version currently being used, e.g. ***expenses2010***.	
	The AfC Terms & Conditions can be found on the NHS Employers web site at http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-Homepage.aspx.	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are neither controlled nor substantive.

1. Introduction

In March 2008, the LAS initiated a project to introduce a process whereby staff would submit their expenses claims using an electronic system. To facilitate this, a product called Expenses[1] was procured from Software Europe Ltd. The system comprises a 'hosted' website allowing staff to submit claims from any location where they have access to the World Wide Web. Following a pilot stage, the system is being rolled out to staff from July 2009.

In planning the rollout phase, it was discovered that there was a need to consolidate the various guidance on claiming expenses and related allowances. While the creation of a detailed policy is the responsibility of the HR and Finance directorates the Electronic Expenses project team agreed to produce this ' Expenses Policy' so there was a guidance document available for staff as they started to use the system (***expenses*** has been configured to reflect the policies and rates used by the Trust.)

This Expenses Policy is to set out the policy, allowances and requirements for receipts when LAS staff submit expense claims. It is an '' policy and will be further developed over the coming months by the HR and Finance directorates.

2. Scope

The scope of this document is to supplement Sections 17 and 18 of the national 'Agenda for Change' (AfC) Terms & Conditions (T&Cs)[2] and set out the 'rules' by which LAS staff may claim expenses. This includes:

- The various rates and allowances used within the Trust. When and by whom these may be varied is also set out.
- When expenses may be claimed and, as importantly, when claiming expenses is not permissible.
- The rules associated with attaching receipts as proof that expenditure has been legitimately incurred are also set out below.

This document does not detail which allowances are subject to taxation. The rules for this are set by HM Revenue & Customs (HMRC).

[1] The system supplied by Software Europe is referred as ***expenses*** throughout the document irrespective of the version currently being used, e.g. ***expenses2010***.

[2] The AfC Terms & Conditions can be found on the NHS Employers web site at http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-Homepage.aspx.

3. Objectives

1. To set out the policy for LAS staff claiming expenses.

2. Meet HMRC requirements for an Expenses Policy.

4. Responsibilities

4.1 Staff

It is the responsibility of all claimants[3] to ensure they only claim for allowable expenses and allowances actually incurred and only up to the maximum allowed by AfC and supplemented by the Trust's own T&Cs.

Claimants will ensure that no item being claimed is more than 3 months old. (*expenses* has been configured to prevent old claims.) The only exceptions are where staff are on long-term sick leave.

Claimants need to be aware that expense items covered by *expenses* will no longer be claimable from petty cash, purchasing cards or by the use of cheque request forms except in exceptional circumstances approved by the Financial Controller.

4.2 Line Management

In reviewing claims from staff, line managers will ensure items within the claim have been necessarily incurred during periods of duty and conform to this policy document, including examination of receipts attached to the claim.

It is the responsibility of line managers to ensure that items within the claim represent expenses that have been legitimately incurred or allowances, which may be legitimately claimed in accordance with this policy, including the requirement to examine receipts and other supplementary documentation provided by the claimant.

4.3 HR and Finance Directorates

The responsible staff within the two directorates are responsible for ensuring this policy is periodically reviewed, including making amendments to reflect changes in rates issued nationally.

The two directorates are also responsible for monitoring information from *expenses* to ensure that claims are being appropriately examined and only legitimate claims are being authorised for payment. This will be done using a variety of methods, including exception reports on 'outliers'.

[3] Within this document, staff who claim expenses, irrespective of grade, will be described as claimants.

4.4 Trust Board Members & Non-Board Directors

When claiming expenses or other allowances Trust Board Members and Non-Board Directors are subject to the general provisions of this policy unless otherwise specifically stated within the text.

The Chief Executive has line management responsibility for authorising claims from executive directors and ensuring items have been necessarily incurred during periods of duty and conform to this policy document, including examination of receipts attached to the claim. This policy places similar responsibilities on the Chairman in respect of claims from non executive directors.

Claims made by the Chairman, in accordance with this policy will be duly authorised by the Director of Finance.

5. Travel

5.1 Mileage

Staff may claim for mileage travelled when they necessarily in the course of their duty move between LAS, NHS or other sites. Mileage may not be claimed for journeys which start at their normal place of residence unless their normal 'base' is not the first location visited. In such instances the mileage claimable is limited to the distance which would have been travelled if the journey had started and finished at the designated headquarters, or the distance actually travelled if less[4]. Similar rules apply when this is the last journey claimed on a particular day. Simply stopping off to visit a workplace that lies between home and your usual place of work does not automatically render the rest of the journey as business mileage. Section 17.21 of the AfC T&Cs does not apply to lease cars[5]

The only exceptions to the rule in 0 above are when a lease vehicle is used or the journey is for an overtime shift or because of an on-call requirement.

There are four different mileage rates. Within these differing levels of reimbursement may apply depending on the annual miles driven for work and the engine size. Each of these is explained below:

Lease car users are entitled to reimbursement at the rates published by HMRC twice a year.

Reimbursement of mileage costs for lease car users are aligned with the advisory fuel rates for company cars approved by HMRC. By adopting this approach all lease car users could be assured that reimbursement rates would in future be regularly (twice a year, 1 January and 1 July) and independently reviewed.

[4] Section 17.21 of AfC T&Cs.
[5] Section 17.23 of AfC T&Cs.

These rates are effective from 1 January 2009. Please be aware also that, given recent fuel price volatility, HMRC has advised that there will be additional reviews outside of the normal schedule if there is a 5% fluctuation in fuel rates, which, in their opinion, is likely to be sustained.

5.2 Regular User Allowance is not paid to LAS staff.

Standard User mileage allowance is paid by agreement to staff who use their own vehicles when travelling on official business and, in doing so, either:

- travel an average of more than 3,500 miles a year;

or

- travel an average of at least 1,250 miles a year; and necessarily use their car an average of three days a week;

or

- spend an average of at least 50 per cent of their time on such travel, including the duties performed during the visits;

or

- travel an average of at least 1,000 miles a year and spend an average of at least four days a week on such travel, including the duties performed during the visits.

Standard users are entitled to reimbursement at the rates published by the NHS Staff Council, reviewed twice a year.

Trust Mileage Rate is paid to operational staff that use their own vehicles when travelling between sites as 'singles' to double man a vehicle or attending mandatory training as defined in Trust policy. Trust mileage rates can only be claimed for eligible journeys and local managers do not have authority to vary these.

Other than the above, all journeys will be paid at the public transport rate.

The Trust does not support the use of an employee's own vehicle being used for any journey directly involving an emergency 'blue light' response. Therefore the payment of mileage claims is made for the use of an employee's own vehicle, are limited to journeys that do not involve any emergency blue light response.

Passenger Miles are paid at the rate of 5.0p per mile for each passenger, where their journey is for official business.

Motor Cycles users are entitled to reimbursement at the rates published by the NHS Staff Council, reviewed twice a year.

Where, at the requirement of the LAS, an employee carries heavy or bulky equipment in a private car, an allowance at half the passenger rate set out in Annex L shall be paid for journeys on which the equipment is carried, provided that either:

- The equipment exceeds a weight which could reasonably be carried by hand; or

- The equipment cannot be carried in the boot of the car and is so bulky as to reduce the seating capacity of the vehicle.

Pedal Cycles users are entitled to reimbursement at the rates published by the NHS Staff Council, reviewed twice a year.

6. Duty of Care

6.1 Statistically, travelling by road is less safe than using public transport. Managers are, therefore, required to encourage staff wherever practical to use public transport rather than cars. This also has the benefit of reducing the Trust's carbon footprint.

6.2 The Trust is required under the Corporate Manslaughter Act to ensure that all vehicles used for business travel, whether owned by the Trust or the driver are taxed, insured for business use, hold a current MOT certificate (if over 3 years old) and road worthy recommendations. Consequently, line managers will be required to confirm within the expenses system that they have seen the relevant documents and entered the expiry dates of each document.

6.3 Claimants are not allow to enter mileage claims after the expiry dates of any item listed in paragraph 6.2 above until the new documents have been witnessed as having been seen by the line manager.

7. Tolls, Congestion Charge and Parking

7.1 Tolls charges are reclaimable where they have necessarily been incurred making a business journey. Toll charge receipts should be submitted where available.

7.2 Congestion Charges are reclaimable where they have necessarily been incurred making a business journey and will be reimbursed when supported by an attached receipt from TfL. Certain supporting information is required, as in certain circumstance the LAS is able to reclaim the charge from TfL. The detailed guide to the re-imbursement of congestion charges can be found at

http://thepulse/uploaded_files/Managing/congestion_charge_review_2007.pdf.

7.3 Employees who necessarily incur charges in the performance of their duties, in relation to parking, garage costs, tolls and ferries shall be refunded these expenses on production of receipts, whenever these are available. Charges for overnight garaging or parking, however, shall not be reimbursed unless the employee is entitled to night subsistence, and reimbursement of parking charges incurred as a result of attendance at the employee's normal place of work will not be considered."

8. Excess Travel

8.1Excess Mileage can be claimed following a temporary or permanent relocation. The claimable number of miles is the number of excess miles driven in compared to your normal place of work. This allowance is only payable up to the first four years after the relocation.

8.2 Excess Travel can be claimed following a temporary or permanent relocation. The claimable cost is the value of any fares in excess of the cost to your normal place of work. This allowance is only payable for the first four years after the relocation. The allowance ceases if voluntarily accepting another post, promotion or there is a change in personal circumstances so that the excess is no longer incurred. Voluntary moves will not normally create a claim for excess travel.

9. Other Travel

9.1 Taxis should not be used for travelling in the local area except in exceptional circumstances and only relating to genuine business needs. Taxis used for business trips will be reimbursed on production of the appropriate original receipt.

9.2 Bus/ Tube journeys may be claimed where the journey is for business use and the original receipt or ticket is attached to the claim. It is, however, recognised that in some stations the ticket is retained by the platform machinery. In these circumstances, reimbursement will be made provided the employee makes a statement to that effect when making the claim. In all other cases, no payment will be made without a receipt.

9.3 Staff that have purchased weekly, monthly or annual travel (Oyster) cards for travel from home to and from work are not eligible to claim for travel in the zones for which the travel card has been purchased.

9.4 Staff with 'Pay As You Go' Oyster cards may claim for legitimate business journeys. A copy of the journey history report should be used as the receipt for such journeys.

9.5 Train Tickets should be purchased through the Trust's use of rail warrants. Where this is not relevant or a cheaper ticket can be obtained using the internet, journeys may be claimed where the journey is for business use and the original receipt is attached to the claim. It is, however, recognised that in some stations the ticket is retained by the platform machinery. In these circumstances, reimbursement will be made provided the employee makes a statement to that effect when making the claim. In all other cases, no payment will be made without a receipt. When ordering the ticket all discount/value for money options should be explored including early booking, two singles etc.

9.6 Rail warrants can be obtained using the form LA6, which can be found on the Pulse at http://thepulse/uploaded_files/Forms/2008-05-09_la6_travel_ticket_order_form_v2.0.doc.

9.7 Air Fares should only be incurred in circumstances where it is the only feasible mode of transport, or it is deemed the best use of Trust resources (time, money). Tickets should normally be obtained in the Trust's name from the Travel Agents assigned for this purpose, thus ensuring that the Trust obtains the best rate and does not pay VAT when not required. Where in exceptional circumstances, it was not possible to make prior arrangements then reimbursement will be made on production of the actual original receipt. Where the travel is overseas then the appropriate form should be signed by the Chief Executive and forwarded to The Chief Cashier.

9.8 Overseas travel, on official business, may only be undertaken with the prior approval of the Chief Executive on the designated form, which can be obtained from the Chief Cashier.

9.9 Pool Car Fuel may be claimed where the use of an LAS pool car required it to be fuelled. The production of a receipt will be required for the reimbursement to be approved.

10. Accommodation and Meals

10.1 The purpose of this section is to set out the rules under which circumstances staff may be reimbursed for the necessary extra costs of meals, accommodation and travel arising because of official duties away from home. Business expenses, which may arise, such as the cost of a fax or official telephone calls, may be reimbursed with certificated proof of expenditure attached to the claim.

10.2 The national terms and conditions handbook allows for night allowance to be claimed for the first 30 nights' cost of bed and breakfast up to a maximum of £55 per night, provided an actual receipt is attached. This rate has not been reviewed for a number of years, and is unlikely to reflect current commercial accommodation rates. Consequently, subject to the provisions of paragraph 18.3 of section 18 if this maximum limit is

exceeded for genuine business reasons, e.g., the choice of hotel was not within the employee's control or cheaper hotels were fully booked, the additional cost may be granted at the discretion of the employer provided the receipt is attached to the claim and an explanation of the cost is entered into expenses 2010.

10.3 Overnight Non-Commercial may be claimed where the stay is with family or friends. The flat rate sum of £25 is payable. This includes an allowance for meals. No receipts will be required.

10.4 Employees staying in accommodation provided by the employer or host organisation shall be entitled to an allowance to cover meals which are not provided free of charge up to the total set out in paragraph 2 of Annex N of AfC Terms & Conditions.

10.5 Where accommodation and meals are provided without charge to employees, e.g., on residential training courses, an incidental expenses allowance at the rate set out in paragraph 6 of Annex N of AfC Terms & Conditions will be payable.

10.6 Where an employee is required to stay away for more than 30 nights in the same location the entitlement to night subsistence shall be reduced to the maximum rates set out in paragraph 4 of Annex N of AfC Terms & Conditions. Meals allowances are not payable to these employees. Those who continue to stay in non-commercial accommodation will continue to be entitled to the rate set out in paragraph 3 of Annex N.

11. Meals

11.1 A meal allowance is payable when an employee is necessarily absent from home on official business and more than five miles from their base, by the shortest practicable route, on official business. Day meals allowance rates are set out in paragraph 5 of Annex N of AfC Terms & Conditions. These allowances are not paid where meals are provided free at the temporary place of work. This does not apply to crew staff working a rostered shift.

11.2 A day meals allowance is payable only when an employee necessarily spends more on a meal/meals than would have been spent at their place of work. An employee shall certify accordingly on each occasion for which day meals allowance is claimed but a receipt is not required.

11.3 Normally, an employee claiming a lunch meal allowance would be expected to be away from his/her base for a period of more than five hours and covering the normal lunch time period of 12:00 pm to 2:00 pm. To claim an evening meals allowance an employee would normally be expected to be away from base for more than ten hours and unable to return to base or home before 7:00 pm and as a result of the late return is required to have an evening meal. Employees may qualify for both lunch

and evening meal allowance in some circumstances. There will be occasions where, due to the time of departure, there will be the necessity to take a meal but the conditions relating to the time absent from the base are not met. This, and any other exceptions to the rules, may be allowed at the discretion of the employer.

11.4 Entertainment or hospitality provided for third parties may be claimed where the prior approval of the relevant director has been obtained. Details of location, name status and company of every person entertained should be provided and the receipts must be attached to the claim.

12. Other Claimable Items

12.1 Display Screen Equipment Eye Tests and Lenses

12.2 Display screen equipment Eye Tests may be claimed by employees who habitually use display screen equipment for a significant part of their normal work may reclaim the cost of an eyesight examination up to £18 each year. A receipt must be attached to the claim.

12.3 Display screen equipment Lenses may be claimed by employees if, as a result of a display screen equipment eyesight test, employees are required to have their eyesight corrected for display screen equipment use, the cost of lenses up to £51.90 may be reclaimed once per year. A receipt must be attached to the claim.

12.4 The requirement to be using display screen equipment for a significant part of their normal working day precludes crew staff from claiming this item.

12.5 Maternity Wear - Female uniformed staff, excluding managerial staff, may claim up to £40 to cover the cost of maternity wear on production of a valid confirmation from their general practitioner. All claims must be covered by a receipt.[6].

13. Executive Directors

13.1 Executive Directors whether Trust Board members or non Board members are subject to the same provisions as all other LAS staff. Their claims will be approved by the Chief Executive.

14. Chairman and Non Executive Directors

14.1 The Appointments Commission publish detailed guidance on items Chairman and Non Executive Directors are able to claim when incurred on official business for the LAS. A copy of the guidance document can be obtained from the Employee Relations manager on request.

[6] See Maternity Leave and Pay Policy, Appendix 5, page 18.

15. Miscellaneous

15.1 Other items may be claimed where appropriate, but receipts must be attached to the claim. Items may include the cost of courses or books required for business use.

IMPLEMENTATION PLAN	
Intended Audience	For all LAS staff
Dissemination	Available to all staff on the Pulse, including a link from ***expenses*.**
Communications	Revised Procedure to be announced in the RIB and a link provided to the document in ***expenses.***
Training	No Training is required
Monitoring	Many of the provisions within this policy are built into ***expenses*** as mandatory controls. Adherence to the content of this policy will be monitored by Finance and HR staff using reports generated by ***expenses***, Internal Audit and NHS Counter Fraud will also have access to the reporting facilities within ***expenses.***

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Carbon Reduction Policy**
Report Author(s)	**Christine McMahon**
Lead Director	**Michael Dinan**
Contact Details	**020 7783 2719 and mob 07717806329**
Aim	**The endorsement of the Carbon Reduction Policy's objective of the LAS reducing its carbon footprint over the next five years, achieving the NHS target of 10% by 2015.**

Key Issues for the Board

The London Ambulance Service has not had a co-ordinated approach in respect of reducing its carbon footprint. The policy sets down the Trust's commitment to meet the undertaking that the NHS will reduce its carbon footprint by 10% by 2015 (measured against the benchmark of the 2007 carbon footprint). Although there have been a number of projects undertaken in isolation across the Trust, the Policy and the supporting documentation will give a focus, co-ordinated approach to the reduction of the Trust's carbon footprint. It is anticipated that saving carbon will also save money and so there is a double imperative to support this initiative.

Mitigating Actions (Controls)

1. Key measurements will be included in the monthly Balanced Scorecard presented to the Senior Management Group and the Trust Board.
2. The Management Action Plan has been drawn up in response to the findings of the Good Corporate Citizen Assessment which helped identify how the Trust could take forward its carbon reduction programme.
3. The Carbon Reduction Working Group, whose membership will comprise representatives from across the Trust, will monitor progress of the Management Action Plan and make recommendations to the Senior Management Group when appropriate.

Recommendations to the Board

That the Trust Board :

1. Approve the Carbon Reduction Policy
2. Note the Carbon Reduction Management Action Plan
3. Note the Communications Plan

Equality Impact Assessment

Has an EIA been carried out? Yes, this was undertaken on Friday 19th March

(If not, state reasons)

Key Issues from Assessment

Amend wording to include 'whenever possible' with reference to 'avoid asking staff to travel to meetings when a conference call or video conference would be as effective; cross referencing to the Procurement Strategy and widening the scope of 'training' to include briefings to members of staff,

Risk Implications for the LAS (including clinical and financial consequences)

That it will not meet the 10% reduction in carbon footprint which will have reputation, clinical (in the greater sense of the word in respect of the consequences of climate warming) and financial consequences for the Trust. The Risk Compliance & Assurance Group will be asked at its next meeting to consider including a risk on the Trust's Risk Register to this effect.

That it will not satisfy external regulators e.g. the Audit Commission (currently two Key Line of Enquires), and the Commissioners who have wanted information on the Trust's efforts to reduce its carbon footprint which will have reputational risks for the Trust.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

The Trust has a responsibility as corporate body to reduce its impact on the environment, as not doing so would have an adverse impact in terms of pollution, climate change and the consequential impact on public health. In addition to undertaking measures to reduce its carbon footprint there will also be the need to educate members of staff and members of the public on the role they can play in assisting the Trust to reduce its carbon footprint.

Corporate Objectives that the report links to

The Trust's seven strategic goals for 2010-11 includes: " to be efficient and productive, and continually improve" which has a subset number of objectives that include the following:

- reducing our impact on the environment and contribute to sustainability
- constantly streamline processes
- deliver cost improvements year on year.

Carbon Reduction Management Action Plan

(Adopted from the Good Corporate Citizen Assessment model)

KEY: **2010-11 yellow**
2011/12 green
2012-15 blue

1.1	Energy & carbon Managements	What	Who	How	Measurement
1.2		SALIX match funding for projects that reduce carbon footprint.	Julian Smith Senior Building Services Engineer	Boilers - replacement cast iron sectional Cooling - plant replacement/upgrade BEMS - not remotely managed Voltage reduction equipment Ventilation - presence controls BEMS - remotely managed BEMS Boilers - replacement cast iron sectional - remotely managed Heating - discrete controls Boilers - control systems T5 lighting including changing the fitting T5 lighting including changing the fitting Roof insulation Boilers - replacement cast iron sectional Boilers - control systems	forecast to deliver carbon reduction of 1,563,988 annual energy saving kWh which will be measured on a quarterly basis - annual report to SALIX Savings achieved from investing in the works listed will be reinvested in other carbon reduction projects (as per agreement with SALIX).
1.3		Encourage use of green space/biodiversity	Nikki Smith support from Comms team & local AOMs	Participation in local competition (support from Chartable Funds) - provision of water butts/compost bins	**Comms exercise to encourage greater participation than in previous years, raise awareness re. biodiversity etc**
1.4		Carbon management	Nikki Smith (Estates) Procurement team working with colleagues across the Trust	Policies: • Waste • Procurement (March 2010)	Data available - re. waste (non medical) and clinical waste – alternative treatment is available for benchmarking purposes) 2007 data (benchmark) **SMART targets to be agreed**

			Karen Merritt (logistics) IM&T Nikki Smith (HQ) & Gadge Nijjar (logistic – complex cleaners)	• Logistics • Travel Plan (draft 2004 – this was not officially adopted by the Trust. Local travel plans are drawn up for new ambulance stations (required under local planning regulations). • PCs to be turned off automatically at night (pilot group – Trust-wide (excluding Operational) Apr-May to test feasibility. 'thin client technology (replacement of desk top PCs) More efficient servers to reduce the data centre overhead for cooling and power demands (cutting energy consumption) – Bow & HQ *Energy mgt service level agreements to be incorporated within existing and future maintenance contracts + further responsibilities should be formally assigned to cleaning staff & security staff & catering staff- vital role in conservation energy use. This will be part of general communications to staff re. Good housekeeping & saving energy.*	**SMART targets to be agreed** **Trust does not currently have a Travel Plan** **If feasible - this will be undertaken in the first quarter of 2010-11** **This will be an important step in educating members of staff re. carbon reduction and encourage 'good housekeeping' behaviour.** **Will have input power savings – 80% of current power output of existing desk top PCs**
2011/12 1.5		Salix	Julian Smith Estates team IM&T	Tranche3 and 4 – further projects (to be identified) that will deliver carbon reduction performance Refurbishment of existing stock – 2010/11 plan New Build Data centre refurbishment	SMART Carbon saving measures will be identified as part of the process for applying to SALIX. Improvement works re. lighting, water, energy usage. Will have measurable reduction in energy requirements.

2012/15 1.6		Salix	Julian Smith Estates Team IM&T	Tranche3 and 4 – further projects (to be identified) that will deliver carbon reduction performance Refurbishment of existing stock – 2010/11 plan New Build New control room (tba) will include efficient environmental controls to ensure optimum performance for the data centre, minimising power and cooling demand.	SMART Carbon saving measures will be identified as part of the process for applying to SALIX. Improvement works re. Lighting, water, energy usage. Will have measurable reduction in energy requirements.
2.1	Procurement & food	Procurement dept.	Richard Deakins/Paul Candler	Recycle/reuse/replace/reduction!!!! minimise deliveries (control of ordering process – comms/education	**SMART targets to be agreed**
2.2		Food	Nikki Smith	HQ canteen, Healthy alternatives are offered, Locally sourced? d/k 'green' credentials	NB: This is quite a small area of operation for the Trust, with examples of good practice adopted.
2.3		Comms	Aidan Brisland	Comms – reminders on IT and other equipment to turn it off/turn it down i.e. when exiting meeting rooms turn off lights/air conditioning; printers, photocopiers & desktop computers & screens at night (good housekeeping). Recruitment of IT/local green champion to ensure that default for printing is set to double-sided!	**Local 'green' champions to be recruited to implement good housekeeping measures locally.** **Using new smart metering service to capture data over a 3 month period – before & after comms exercise to evaluate impact??**
2.4		Logistics	Chris Vale/Karen Merritt	recycle/reuse/replace/reduction review contracts – minimise journeys introduction of lean concept – stock control, minimise inefficiencies/wastage	**Data available re. Material disposed of because out of date??** **Data available re. Estimate mileage – thereby see a reduction??** **Further work needed re. SMART targets**
2011/12 2.5			Logistics	Introduction of inventory management	Reduction in out of date stock, wastage

2012/15 2.6					
3.1	Low carbon travel, transport & access	Travel plan	Tony Crabtree	Trust is considering signing up with the London NHS Cycle to Work Scheme. Travel Plan (draft 2004) Local travel plans are produced on an ad hoc basis as/when new builds are undertaken. **RECOMMEDNATION:** **Ref to flying – domestic? + active promotion of public transport**	Uptake of the scheme? Expenses – reimbursement **Further work needed re. capturing data** **Flying – domestic/foreign** **Train journeys £ y but not mileage (carbon saved)** **Car expenses - mileage** **Cycle reimbursement – mileage**
3.2		Alternative response to patients	ADO Control Dir. Of Ops	CTA & NHSD Operations • reduction in double sends • reduction in 'frequent callers' – working with NHS/Social Services • Active area cover -vehicles in an appropriate location to better respond to the needs of our patients (plus reduction in unnecessary journey mileage/time)	Data available Reduction in vehicles despatched Provide a better service to patients with complex medical/social needs.
3.3		" "	Tom Lynch	Cycle response scheme	Data available re. deployment
3.4		Green fleet	Nick Pope	Review being undertaken by Energy Saving Trust Under investigation – the purchase of low carbon pool/lease cars Purchase/lease of electric vehicles	Before/after data capture re. emissions **VANMAN (new data mgt system) - data re. Emissions?**
3.5		Changes to fleet mgt.	Nick Pope	Replacement of older model of ambulances by new fleet of Mercedes - **greater** % of recycle ability material; reduction in energy required on vehicle plus change in fuel (from petrol to diesel)	Approx data available **Further work needed re. data**
3.6		PTS	Nic Daw	Introduction of journey planning technology to maximise efficiencies in transporting patients Issued PDAs to PTS drivers, containing details re. journeys (paper free) + Sat Nav capability. Working closely with Acutes to manage demand , thereby reducing patient journeys	Reduction in carbon (+ generated savings for the NHS economy as a whole). Working towards paper free process **Further work needed re. data**

2011/12 3.7					
2012/15 3.8		Car lease	Tony Crabtree	**Car lease scheme (published April 2009) due for three year review) review in light of green agenda – hybrid/engine size/etc**	Car lease scheme to be reviewed.
3.9		ePRF	Peter Suter	The introduction of this technology to the LAS will negate the need for paper PRFs – will improve patient care in that there should be better data capture – CPI data.	
4.1	Waste	Recycling	Nikki Smith	In the last year lot of work undertaken to expand the % of recycling undertaken Comms plan – story re. how material generated by LAS is recycled (remove desk bins)	Data available – comparison data with other similar organisation ?
4.2		IM&T	Robert Clifford Sonja Perilli	**Redundant kit is being decommissioned (WIEE directive) reclamation, raised £15,000 cashback 2010/11 so no 'budget' for 2010/11 because it will be dependent on desk top replacement programme.**	
4.3		Medical waste	Nikki Smith	Recycled	Data available
2011/12					
2012/15					
5.1	Organisational & workforce development	Training	Nick Nixon?	Remote access – use of IT learning packages	
5.2		Remote working/working at home is currently included in the Flexible Working Arrangements Policy	Tony Crabtree Ann Ball	Does the Trust currently have a policy concerning working at home	Data? (informal arrangements – discretion of mgrs) Small no. remote access to facilitate working at home
5.3		CTA – Area location	Sue Watkins	Is this in the planning/or happening?	Negates having to travel to HQ (disincentive) + improves availability of CTA (?)
5.5		Alternative meeting arrangements	IM&T	Teleconferencing Web based – to date pandemic but intention is to wide out	Comparison data available (ADOs using for weekly mgt meeting) Capture data (carbon saved!)

5.6		Recruitment		Change in practice to web based recruitment, lessening usage of paper & postage	Changes in current practice will be implemented in 2010-11.
5.7		Staff training		Energy champions are trained via a series of regular day events: demonstrations, site visits, group exercises, sessions for generating ideas etc Keen & interested, drawn from x Trust & all levels of organisation	Identify training – recruit energy champions **Energy Efficiency Advice Centre??** Publication of results, successes & proposed measures & initiatives
2010/11					
2012-15					
6.1	Role of partnership & networks	Sustainability Development Unit - London	Julian Smith Christine McMahon	Networking – learning from other NHS trusts in respect of estate/energy mgt & other projects	
6.2		Energy Saving Trust	Nick Pope	Review of fleet – advising Trust as to what additional measures it can adopt to reduce its carbon footprint. Initial meeting scheduled for 16th March 2010.	
6.3		Commissioners	Kathy Jones	Regular reports on measures taken by the LAS to promote sustainability	Interim report presented Nov 2009 – end of year March 2010 :evidence areas where work has been undertaken to reduce carbon
6.4		SALIX – Carbon Trust	Julian Smith	Interest free credit, with loans repaid over period up to 4 years. Have applied for funding (matched) – no. of projects deliver carbon reduction	Application outlines the expected carbon reduction savings to be achieved
6.5		Carbon Trust		Undertook 2007 report (have offered to do another one – consultant – in 2 minds) 5 sites: HQ;Ilford; Bromley; Woolwich; Bexleyheath The majority of the recommended actions have/will be implemented in 2010/11 e.g. adoption of an energy policy (carbon reduction policy and the accompanying management action plan.	Results of 2007 report available for benchmarking
6.6		Audit Commission	Mike Dinan	Reviews both financial and Value for Money efficiencies/effectives & the good governance supporting them.	Progress to date reviewed on a quarterly basis - included within remit of carbon trust working group.
2011/12		Carbon Trust		LAS to apply for Carbon Trust Standard	Need to have 2/3 years of supporting data re. carbon footprint
2012/15					

7.1	Finance	SALIX	Charles	Putting in place mechanism for capturing evidence of savings achieved via undertaking of SALIX supported projects	Regular detailed reports to SALIX?
7.2		The 2009/10 ALE contained 2 KLoE relate to carbon reduction	(MJS) Christine (MJ) XX	Capture evidence of Trust's endeavours to reduce carbon – level & compliance with the Good Corporate Citizen Assessment tool????	Progress report monitored by Auditors Local Evaluation (ALE) champion(s)
7.3		Purchase card/travel warrants/credit card statements	CP&G project	Review processes to enable data captured to be able to make more accurate statements as to 'carbon footprint' – Number of CP&G projects will have a carbon reduction element in that the majority of them involve using web based systems moving towards reducing need for paper based systems.	'carbon footprint' – Journeys to/from – mileage • Cars • Bicycles • Trains • Taxis • Planes – domestic • Planes – long haul • Planes – short haul
7.4		Business Cases to incorporate environmental impact	MJS	Ref. Ruth Carnell letter of Dec 2009 capital investment business cases to include environmental impact assessments that address carbon reduction	Currently business case makes reference – **impact assessment may need additional consideration when drafting business cases.**
7.5		CIP -	Mike Dinan	CIP – reviewing processes & procedures to ensure maximum efficiency & effectiveness and minimising waste – reducing carbon where possible and saving money!	Reduction in expenditure on energy, procurement, stationery – data available
2011/12 7.6		CIP -	Mike Dinan	CIP – reviewing processes & procedures to ensure maximum efficiency & effectiveness and minimising waste – reducing carbon where possible and saving money!	Reduction in expenditure on energy, procurement, stationery – data available
2012/15 7.7		Energy budgets		Consideration will be given to introducing energy budgets which will promote efficiency; budget holders to be provided with all relevant information	

London Ambulance Service - Carbon Reduction Project

Draft communication plan – March 2010

1 Background

The London Ambulance Service (LAS) acknowledges that its activity and operations have an effect on the local, regional and global environment.

To minimise the impact of this effect the Service is committed to making improvements in its environmental performance to prevent pollution. In making this commitment the Service aims to meet the requirements of current environmental regulations, laws and codes of practice as a minimum standard. The NHS Carbon Reduction Strategy establishes that the NHS should have a target of reducing its 2007 carbon footprint by 10 per cent by 2015.

External bodies such as the Audit Commission and the Good Corporate Citizen Assessment include the requirement to communicate with both internal and external stakeholders on the work being done by the Service to reduce its carbon footprint. A recent survey of Waterloo headquarters by an external consultancy that produced an energy opportunity report and carbon reduction plan highlighted that there were 'no signs that an energy awareness campaign was being carried out'.

2 Objectives

- To highlight the health-related elements of climate change/carbon reduction
- To encourage staff to reduce their own carbon footprint both at work and at home
- To provide timely information to staff on the work being done by the Service to reduce its organisational carbon footprint

3 Audiences

<u>Staff</u>
Front line staff
Support staff
Managers

<u>Partner organisations</u>
St John
Red Cross

<u>External</u>
PCT/Commissioners
Audit Commission (ALE)
People who live and work in London

4 Key message

- We need to reduce our carbon footprint by 10 per cent by 2015
- We can all make a difference to climate change no matter how small
- Cutting our carbon footprint will make the Service more efficient, meaning saved money can be reinvested into patient care
- We're already working to cut our carbon footprint:
    - More use of CTA cutting unnecessary ambulance journeys
    - More fuel-efficient vehicles are joining the Service
    - More use of improved technology to allow telephone and video conferencing reducing journeys between sites
    - We're replacing light bulbs and boilers with more efficient versions

5 Strategy

The carbon reduction project is supported the Service's corporate objectives for 2010/11. The Service will sign up to the Good Corporate Citizen Model and the Carbon Trust Standard which will form the basis for the Service's management action plan in respect of reducing its carbon footprint.

To ensure we become more environmentally friendly, the Service will regularly measure its carbon footprint over the next five years as we seek to reduce it by 10 per cent. Progress will be publicised to all staff.

Staff will be encouraged to get involved in green initiatives to help us meet the target, such as encouraging them to recycle, use public transport or walk to work, while the Service will continue to improve its energy efficiency.

'Green champions' will be recruited at a local level to implement cultural changes and will be supported by the carbon reduction working group.

The carbon reduction email address will be republished, and staff will be encouraged to make suggestions on how we can tackle reduce our carbon footprint.

6 Tactics and Training

6.1 Internal communication

6.1.1 Face to face

Staff can be kept up to date with progress on reducing the Service's carbon footprint at conferences and other meetings. For example, update to be included in the Finance Director's briefings – thereby allowing a question and answer sessions. Also, consideration of appropriateness of using information display boards to give examples of work being undertaken across the Trust.

Upcoming conferences include:

- Senior Managers' Conference 16 April 2010
- Managers' Conferences 21 and 28 April
- Support Services' Conferences 21 and 28 April.

6.1.2 Existing channels

There are a number of existing channels that can be used to keep staff informed and encourage them to work in an environmentally friend way:

- Chief Executive's consultation meetings updating staff on what the Trust is doing to reduce its carbon footprint.
- Routine Information Bulletin – regular updates and announcements of planned work or initiatives
- LAS News – articles on what the Service is doing to meet the target, updates at key milestones, what happens to the recycled material , interesting green initiatives
- Ambulance News and the website to reflect the good work the Service is doing
- *The pulse* – development of a section where key documents can be accessed.

6.2 External Communication

6.2.1 Partner organisations and other stakeholders

Partner organisations and other stakeholders to be undated on the work being undertaken by the Trust in respect of carbon reduction

The Commissioners will receive progress reports on the work being carried out by the Service to reduce its carbon footprint and improve sustainability. These reports will build upon on interim report presented to the Commissioners in November 2009.

The Audit Commission will also be kept up to date with progress, as it requires the Service to evidence how it has progressed in reducing its carbon output (via two Key Lines of Enquiry).

7 Timescales

It is expected that the project will be broadly conducted in three stages over the next five years.

Stage 1 – 2009/10 & 2010/11

This is the commencement of the project – policy and management action plan agreed by Trust Board, establishment of a working group to oversee

implementation and monitor progress, establishment of reporting matrices for Balanced Scorecard (2010/11).

The management action plan will incorporate work scheduled for next two years. Corporate business plans, as well as project initiation documentation and applications for financial approval (AFA), will be amended to include carbon reduction and sustainability.

See the communications year plan at the end of this document.

Stage 2 – 2011/12 & 2012/13

Implementation of management action plan – which will be regularly reviewed to capture initiatives taking place across the Service.

Raising awareness across the Service (across silos) to promote sustainable ways of working. Carbon reducing practices and approaches to work will be encouraged and new developments highlighted.

A detailed communications plan is yet to be finalised.

Stage 3 – 2013/14 & 2014/15

This stage is potentially the most difficult, as the easier changes in practice ('low hanging fruit') will have been implemented and the Service may need to adopt more radical initiatives to meet the target of reducing its carbon footprint by 10 per cent by 2015.

A detailed communications plan is yet to be finalised.

8 Resources

It is anticipated that existing resources will be used to carry out all communication work.

9 Evaluation

Evaluation of the communications activity will be possible through a variety of ways:

- Has the 10 per cent reduction target been met?
- ERIC returns showing downward trajectory of energy consumption
- Reviewing the Good Corporate Assessment Tool and assessing the progress achieved on an annual basis 2010-2015.
- Increase in recycling material
- Increase in the number of staff using bicycles/public transport to travel to work – have numbers using the Cycle to Work scheme increased?
- Use of telephone conference/web conference call facilities

- Hits on the dedicated *pulse* pages?
- Use of carbon reduction email address by members of staff to put forward their suggestions on how the Service can reduce its carbon footprint.

Communications plan for Internet carbon reduction Project
Feb 2010 – March 2011 VERSION 2

Actions	**Month**												
	Feb	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
Internal communication													
Development and approval of comms plan		#											
Development of Carbon Reduction section on *the pulse* - update as appropriate		#	#										
RIB updates			#										
Managers													
Area bulletins ????			#			#			#			#	
LAS News updates to tie in with key milestones - Policy approved by Trust Board 6 monthly update			#						**#**				
Senior managers conference								#					
Updates at other conferences? - Managers (TBA) - Team leaders (TBA)									#				
External communication	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
PCT/Commissioners 6 monthly reports			**#**						**#**				
NHS London													
Mayor's Office ??													
Stakeholder communication													
Governors (once FT)													

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Taking it on Trust: Questions for Boards**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To review the checklist: Questions for Boards** **2 documents for review: Pack A) Summary checklist; Pack B) Full checklist**

Key Issues for the Board

1. It is a requirement for the ALE 2009/10 assessment on internal control that the Trust Board reviews the findings of Taking it on Trust and considers the 'Questions for Boards';
2. The questions should help the Trust Board to assess the strength of the internal controls and to identify what improvements may be required;
3. The Audit Commission report states that: 'good assurance requires the right governance framework; requires good internal controls, effective risk management and a good assurance framework; and it requires good data quality;
4. A briefing on the checklist was brought to the January Trust Board and the checklist has since been discussed by the Audit Committee and Senior Management Group;
5. The data quality section and assurance framework sections still need review this month;
6. Particular areas the Trust Board may wish to focus on are:
    - Governance structures (questions 6 &7)
    - Board meetings and the agenda (questions 10-16)
    - Board operation and skills (questions 17-20)
    - Risk culture (questions 32-34).

    These are provided in more detail in the attached document (Pack A).
7. These will be considered as part of the Board development discussions and for the Service Development Committee agenda in April 2010.

Mitigating Actions (Controls)

External auditors: Audit Commission

ALE 2009/10 assessment on internal control

Internal audit: board assurance framework

2009/10 review of strategic goals and risks

Corporate risk register

Recommendations to the Board

To note:

- the checklist and the areas completed so far;
- the plan to review the areas outlined in 6) above at the April SDC.

Equality Impact Assessment

Has an EIA been carried out? Yes: Initial screening undertaken by the lead director. **Key Issues from Assessment** Outcome A: No known adverse impact for any equality strand group and promotes equality of opportunity.
Risk Implications for the LAS (including clinical and financial consequences) Implications for the ALE 2009/10 score 2009/10 statement on internal control
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) As above
Corporate Objectives that the report links to Meeting regulatory requirements.

London Ambulance Service NHS Trust

TRUST BOARD - 30th March 2010

Document Title	**Report of the Trust Secretary**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**0207 7832045**
Aim	**To ensure compliance with Standing Orders and Standing Financial Instructions**

Key Issues for the Board

There have been two tenders received, opened and entered into the tender book:

1) Redevelopment of 88 Brewery Road
2) Perceptions Audit.

There has been one entry to the register for the Use of the Trust Seal:

1) Lease and deed for 88 Brewery Road, London N7.

The Register of Interests is being updated for the Trust Board members and senior managers.

Mitigating Actions (Controls)

Standing Orders and Standing Financial Instructions

Recommendations to the Board

To note the report.

Equality Impact Assessment

Has an EIA been carried out? No - Not applicable at this stage

(If not, state reasons)

Key Issues from Assessment - Not applicable

Risk Implications for the LAS (including clinical and financial consequences)

These will be assessed during the review of the tenders received.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

As above.

Corporate Objectives that the report links to

Regulatory compliance.

London Ambulance Service NHS Trust
Trust Board of Directors
30th March 2010

Report of the Trust Secretary
Tenders received and the use of the Trust Seal

1. Introduction

1.1 In accordance with Standing Order 19, this report summarises tenders received and the names of those organisations tendering.

1.2 In accordance with Standing Order 31, this report summarises the entries in the register held by the Trust Secretary of documents sealed.

2. Tenders received

There have been 2 tenders received since the last Trust Board meeting.

2.1 88 Brewery Road – redevelopment of industrial unit to ambulance station

Tenders received and opened on 28th January 2010:
Coniston Ltd
Kier Group
Millane Contract Services
Mitie Property Services
TCL Granby Ltd.

2.2 Perceptions Audit

Tenders received and opened on 15th February 2010
IPSOS MORI
Jigsaw Research Ltd.

3. Use of the Trust Seal

There has been one entry to the register:
Lease and deed for 88 Brewer Road, London N7 between London Ambulance Service NHS Trust and Arden Estates Ltd.

4. Register of Interests

The Register of Interests for the Trust Board will be up to date by 31st March 2010. Senior Managers have been asked to confirm their entries and any changes and we anticipate this being completed in April 2010.

5. Recommendation

That the Trust Board notes this report.

Sandra Adams
Director of Corporate Services
17th March 2010

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 30th March 2010

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

As planned at the outset, work has been progressing in developing an approach to tracking the implementation of not only enabling projects as hitherto but also of the subsequent business changes and benefits. As enabling projects which were initiated in 2009/10 move into the business change and benefits phases programme reports will progressively move in 2010/11 towards have three parts, progress against:

- milestones for enabling projects;
- business changes using enabling project deliverables;
- benefits as a consequence of making the business changes.

The approach to performance managing the service improvement programme has up until now been based on tracking only the first of these which, for the time being, remains the case for this report. Using the milestone tracking approach the report consists of sections for each of the three sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A list of enabling projects giving project progress status using a Traffic Light reporting system (projects annotated with a white triangle are either in the process of being scoped or the most recent statistics are not available in time for this report);
- 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.

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 the implementation mechanism to achieve the necessary changes in the London Ambulance Service required to realise the Vision and strategic goals. The purpose of this is to ensure that the Trust serves the people of London by providing appropriate care for all its patients whether they have a need for emergency or urgent care, meeting performance targets sustainably while achieving financial balance.

The structure of SIP2012 is as follows:

- *Clinical Development, Leadership and Workforce Programme* - led by the Deputy Chief Executive and focused on patients and staff, covering New Ways of Working, Organisation Development and People, Healthcare for London, clinical developments and new service development arising from Foundation Trust status;

- *Performance and Service Delivery Programme* - led by the Director of Human Resources and Organisation Development covering performance in its widest sense and the tangible infrastructure and operating systems which enable staff to provide patient care;

- *Preparing for the Olympics* - led by the Deputy Chief Executive.

There is also a supporting Stakeholder Engagement and Communications Strategy.

4. Exceptions

This section provides commentary on those projects (not individual milestones) identified as being of red status (i.e. not on track and cause for concern). This month there are three projects in this category:

Clinical Development, Leadership and Workforce Programme

e-Learning

The development and planned delivery of the e-learning mental health and obstetrics modules from April is at significant risk due to the funding not being released. There is also an issue with the IM&T infrastructure that is preventing the modules from operating from the host site.

Corrective action

Caron Hitchen is seeking to resolve the funding issue with Finance while IM&T have agreed to appoint a dedicated delivery manager to the project. A work package has been provided to IM&T detailing technical requirements.

Performance and Service Delivery Programme:

Real Time Fleet Management

- Due to delays with the equipment list that needs to be loaded into the Tranman system the final delivery date is at risk of further slippage. The list consists of stretchers, chairs and scoops. Some errors were picked up in the data that subsequently required cleansing before it could be loaded into Tranman.

Corrective action

- With increasing deployment of front line crews it is becoming paramount to ensure full visibility of the location of the vehicle fleet. One of the principal benefits of Tranman is it will allow an overview of vehicles in workshops. To speed up delivery of Tranman the decision has been taken not to include the stock management aspect of the system within the project at present as inclusion at this time would slow the rollout to workshops and delay the vital visibility needed.

Vehicle fleet procurement:

- Assetco placed UVM in Administration with Price Waterhouse Coopers on Friday 15th January and all the workforce have been made redundant. UVM had completed 76 vehicles as at 22nd January. There are 24 vehicles to complete, 12 chassis have box bodies and have been fitted to varying levels of build with the remainder just having chassis cabs. Negotiations are progressing slowly with the Administrators as there are two interested parties with technical and legal discussions ongoing.

Corrective action

- Ten Mercedes chassis cabs were delivered to MacNeillie & Son by 27th January to commence the build while the tender for the next 65 AEU's has been reviewed and awarded to them. Delivery for the next build is being planned for prototype completion by the end of April 2010 for subsequent testing. However MacNeillie are challenged by the level of design changes made to the product received from UVM (from the previous 416 chassis vehicle body). Tail-lift supply could be problematic as well and alternative supply routes are being explored.

5. Recommendation

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

Kathy Jones
Director of Service Development