LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD

Tuesday 27 January 2009 at 10:00 am
Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

Present:	Sigurd Reinton	Chairman
	Sarah Waller	Vice Chairman
	Peter Bradley	Chief Executive Officer
	Mike Dinan	Executive - Director of Finance
	Roy Griffins	Non Executive Director
	Caron Hitchen	Executive - Director of Human Resources & Organisation Development
	Brian Huckett	Non Executive Director
	Beryl Magrath	Non Executive Director
	Fionna Moore	Executive - Medical Director
	Ingrid Prescod	Non Executive Director
	Caroline Silver	Non Executive Director
In attendance:	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	Angie Patton	Head of Communications
	Richard Webber	Acting Director of Operations
	John Ellman-Brown	Trust Secretary
Apologies:	Martin Flaherty	Executive - Director of Operations

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AGENDA

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LONDON AMBULANCE SERVICE NHS TRUST

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- SDC: 24 February 2009
- Trust Board: 31 March 2009

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part I

**Minutes of the meeting of the Trust Board held on Tuesday 25 November 2008
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD**

Present:	Sigurd Reinton	Chairman
	Sarah Waller	Vice Chairman *(from 10:55)*
	Peter Bradley	Chief Executive Officer
	Mike Dinan	Executive Director: Director of Finance
	Martin Flaherty	Executive Director: Director of Operations
	Roy Griffins	Non Executive Director
	Caron Hitchen	Executive Director: Director of Human Resources & Organisation Development *(until 12:45)*
	Brian Huckett	Non Executive Director
	Beryl Magrath	Non Executive Director
	Fionna Moore	Executive Director: Medical Director *(until 11:55)*
	Ingrid Prescod	Non Executive Director
	Caroline Silver	Non Executive Director
In attendance:	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	Laila Abraham	Head of Governance
	Nick Evans	CAD 2010 Project Manager
	Steve Irving	Staff Officer to Chief Executive
	Anna King	Member of the Public
	Florence Odeke	Patients' Forum Ambulance Service (London)
	Mark Squires	Assistant Director of Estates & Procurement, Yorkshire Ambulance Service
	Margaret Vander	Patient & Public Involvement Manager
	John Wilkins	Foundation Trust Lead
	John Ellman-Brown	Trust Secretary
	Marilyn Cameron	PA to Chairman
Apologies:	Christine McMahon	

120/08   Introduction and Apologies

The Chairman noted that the Vice Chairman, Roy Griffins and Brian Huckett would join
the meeting as soon as possible, and that Fionna Moore, Caron Hitchen and Ingrid Prescod
had to leave before the end. He also received apologies from Christine McMahon (ill),
and introduced John Ellman-Brown who would act as Interim Trust Secretary for a period
of 3 months while recruitment for a permanent Trust Secretary was conducted.

121/08   David Jervis Retirement

The Chairman reported that this was the last Trust Board meeting to be attended by David
Jervis, Director of Communications, who was retiring from the Service at the end of
November 2008. He was the longest serving director, having joined in 1995, during
which time the Service had been transformed. On behalf of the Board and the London

Ambulance Service, the Chairman thanked Mr Jervis for all his efforts on behalf of the Service over the years, and wished him well for the future.

Mr Jervis responded, thanking the Chairman, the Board and the Service for their kind words, and wished them all well in their ongoing endeavours in the future.

122/08 **Minutes**

After review and due consideration by the Board:

IT WAS RESOLVED THAT the minutes of the Part I Board meeting held on 30 September 2008 be and are hereby approved as a true record of the meeting, and that they be signed by the Chairman.

123/08 **Trust Board Meeting 30 September 2008: Part II Minutes Synopsis**

The synopsis of the minutes from the Trust Board Part II meeting held on 30 September 2008 was noted.

124/08 **Matters Arising**

The Director of Human Resources & Organisation Development reported that a central database was being introduced to record those staff with second jobs.

125/08 **Chairman's Update**

The Chairman reported on various meetings, visits and issues of interest since the last meeting:

- He had met Baroness Young, Chairman of the Care Quality Commission, and was encouraged by her approach to the Commission's responsibilities;
- The Strategic Health Authority ("SHA") was currently in a state of flux with an acting Chairman in place and the CEO of the Provider Agency due to leave shortly. It was likely the SHA would be reorganised in the near future;
- A number of PCTs were considering genuinely tendering out PCT provided services whilst others intended to retain control of such services even as they were being put into separate 'provider arms';
- He had had an enlightening visit to French colleagues in Paris. The 'Sapeurs Pompiers' provide the vast majority of responses to medical emergencies there but the same personnel also deal with fires. It has no trained paramedics but does field a small number of vehicles with emergency physicians on board. It operates alongside the (smaller) emergency medical assistance system ("SAMU") which also operates a small number of vehicles manned by doctors. It is hoped to make changes to allow the use of paramedics but primary legislation must first be enacted;
- During the period, the GLA Deputy Chairman, Richard Barnes, paid a visit to both the EOC and the UOC.

126/08 **Chief Executive's Report**

The Board considered the report of the Chief Executive.

Mr Bradley advised that discussions with the Commissioners in respect of funding for the following year were progressing well, and he was confident the Service would receive the funding required. A further 428 staff and significant investment were required in the next 12 months.

Issues surrounding vehicle utilisation and associated staffing were discussed in depth: in order to drive the current mean of 67% down to 60%, circa 200 new staff were required, with a further 228 required to reduce the figure to 55%. The Board requested the Director of Operations proceed with resolution of these issues as expeditiously as possible.

After due consideration:

IT WAS RESOLVED THAT the Report of the Chief Executive Officer be and is hereby received.

127/08 Finance Report: Month 7

The Finance Report for October 2008 (month 7) was reviewed.

Directors' attention was drawn to the current over commitment forecast of £1.9m on CAPEX – this was a worst case scenario, and the Director of Finance believed the January figures would be in line with forecast. Additional funding of £2m had however been sought from the SHA.

After due consideration:

IT WAS RESOLVED THAT the Finance Report for October 2008 (month 7) be and is hereby received.

128/08 Report of the Medical Director

The Report of the Medical Director was reviewed. Dr Moore highlighted in particular the following:

- The British Thoracic Society Guidelines for Emergency Oxygen Therapy, which guidelines had been adopted by the LAS.
- The proposed DANCE Study, where patients with cardiac chest pain but without the classical ECG changes would be transported to 'Heart Attack Centres' would potentially increase their numbers of patients; however, all 8 heart attach centres had expressed their keenness to work with the LAS on the project.

After further discussion:

IT WAS RESOLVED THAT the Report of the Medical Director be and is hereby received and noted.

129/08 Proposed Approach by the LAS towards STROKE

The Board considered the paper on Stroke.

Dr Moore stated that the proposed approach towards stroke victims would provide significant benefits to them but would take a long time to implement in full.

The potential impact on performance was discussed, in particular the upgrading from Amber to Red on AMPDS. It was however pointed out that this would only apply in those cases where an onset of symptoms was within the past 2 hours.

After due consideration:

IT WAS RESOLVED THAT:

- a comprehensive survey of PCTs be conducted to establish which of them wish to designate a preferred location for thrombolysis-eligible FAST+ patients, and for discussion to be co-ordinated via the joint commissioning arrangements;
- a stakeholder communications plan be agreed to make clear that this is a temporary measure until local services are set up (as part of the Healthcare for London strategy), and is in no way intended to influence future stroke centre designation;
- destination acute stroke units are consulted on their capacity to receive patients;
- extra demand on resources is modelled and PCTs approached for extra funding if/where applicable, both for interim measures and full pan-London strategy;
- for operational clarity, as far as possible, all interim changes take place at the same time, the target date being 1 January 2009 at the earliest;
- the Director of Operations be and is hereby authorised to agree the final start date, without further recourse to the Trust Board.

130/08   CAD2010 Contract Award

The Board considered the paper in respect of the CAD2010 Contract Award.

The contract terms had been reviewed in detail by both the Director of Information Management & Technology and the Director of Finance: the contract was in place and affordable; approval from the SHA had been received, subject to 2 conditions (the 2nd of which required a response); the required risk management was in place to mitigate the relevant risks; and extra diligence had been provided by PwC.

2 items remained outstanding: insurances were required and would be put in place; and the Government's security plan was awaited, but would be included once received.

After further consideration:

IT WAS RESOLVED THAT:

1. the Chief Executive Officer be and is hereby authorised by the Board to sign on behalf of the Trust the CAD 2010 contract with Northrop Grumman Information Technology Global Corp ("NG"), subject to:

   - confirmation from the Director of Finance and Investment, NHS London that he is satisfied with the further due diligence on the financial robustness of NG; and
   - final contract clarifications not substantially altering the contract in terms of scope or vary the overall contract value by more than 1%.

2. the External Consultant providing independent assurance to date be and is hereby retained until further notice, along with further support from Methods Consulting.

131/08   Lease Car Policy

The Board discussed the Lease Car Policy paper presented by the Director of HR, noting the key areas of clarification and changes between the current and proposed policies. The document was a draft only for discussion and comment. The final policy would be presented to the Board at the next meeting on 27 January 2009.

The general view was that the proposed policy was an improvement on the current policy. It was therefore agreed that the draft be circulated for consultation and the final policy be presented to the Board at the next meeting in January 2009.

132/08   **LDV Replacement – Business Case**

The Board considered the business case for replacement of the existing LDV ambulance fleet presented by the Director of Finance, who confirmed that the proposal had been reviewed, was affordable and therefore recommended.

Mr Dinan confirmed the proposal was for the replacement of A&E vehicles and not PTS vehicles, and that he would return to the Board at the meeting in January 2009 for approval of the recommended financing approach.

After further discussion and due consideration:

IT WAS RESOLVED THAT the procurement of replacement vehicles for the existing LDV ambulance fleet, as proposed, be and is hereby approved.

133/08   **IM&T Strategy 2008/09-2012/13**

Directors considered the proposed IM&T Strategy of the Trust for the period 2008/09-2012/13, noting that the strategy had been formally reviewed by the Service Development Committee in June 2008.

After due consideration therefore:

IT WAS RESOLVED THAT the IM&T Strategy 2008/09 – 2012/13 be and is hereby approved.

134/08   **Risk Management Policy**

Directors considered updates to the Risk Management policy, previously approved in September 2008. The policy had been updated following recommendations arising from the NHSLA Assessment undertaken during October 2008.

After due consideration:

IT WAS RESOLVED THAT the updated Risk Management Policy and structure, as circulated, be and is hereby approved.

135/08   **Foundation Trust Update**

Directors noted the update on the current progress of the LAS application for Foundation Trust status.

136/08   **Corporate Social Responsibility**

The Director of Finance circulated a paper detailing the Trust's current major CSR activity. This was discussed, but it was noted the paper covered only "green issues". Mr Dinan agreed therefore to rename the current elements of the CSR activity, and provide a further update to Directors in the first half of 2009.

137/08   **Standing Orders, Financial Instructions and the Scheme of Delegation**

Directors considered the paper presented by the Director of Finance.

The Board noted that the Standing Orders, Financial Instructions and the Scheme of Delegation had been reviewed and updated in line with the NHS Model Rules published in March 2006. The Audit Committee had considered the proposed amendments at its last meeting in November 2008, and had approved submission of the amended documents to the Board.

It was noted that the Audit Committee had questioned if the current limit of £3,000 (laid down in the LAS standard procurement procedures in circumstances where expenditure for the purchase of goods and services was less than £3,000) was too low, and had agreed that the Director of Finance review the figure and recommend whether it should be increased.

After further discussion and due consideration:

IT WAS RESOLVED THAT the amended Standing Orders, Financial Instructions and the Scheme of Delegation be and are hereby approved, and that the current limit of £3,000 laid down in the LAS standard procurement procedures paragraph 6 be and is hereby increased to a maximum of £10,000, with discretion given to the Director of Finance to decide the final level.

138/08 Service Improvement Programme 2012

Directors discussed the paper presented by Ms Jones.

Certain non-critical projects were noted as being behind schedule, in particular the 'Referral Pathways' project which had been delayed for some time. Ms Jones advised of problems experienced by crews in using many agreed pathways in practice.

An update on the Olympic programme would be presented to the meeting of the Service Development Committee in February 2009.

After further discussion and due consideration therefore:

IT WAS RESOLVED THAT the progress made with the Service Improvement Programme 2012, as presented, be and is hereby noted.

139/08 Charitable Funds Annual Report

The Annual Report of the Trustees of the LAS Charitable Fund (the "Fund") was considered.

The Board was advised that the Fund's investments were now worth less than before and the Fund Manager's advice was to sit tight; the intended strategy remained to run the Fund down to zero. It was also noted that no funds had been placed with Icelandic banks.

After due consideration therefore:

IT WAS RESOLVED THAT the Annual Report of the Trustees of the LAS Charitable Fund, as presented, be and is hereby noted.

140/08 Draft Audit Committee Minutes

The draft minutes from the Audit Committee meeting held on 10 November 2008 were reviewed, and Ms Silver highlighted various issues that had arisen at that meeting, as noted in the summary.

After due consideration therefore:

IT WAS RESOLVED THAT the minutes from the meeting of the LAS Audit Committee held on 10 November 2008, as presented, be and are hereby noted.

141/08   Draft Clinical Governance Committee minutes

The draft minutes from the Clinical Governance Committee meeting held on 12 November 2008 were reviewed, and Dr Magrath highlighted various issues that had arisen at that meeting, as noted in the summary.

After due consideration therefore:

IT WAS RESOLVED THAT the minutes from the meeting of the LAS Clinical Governance Committee held on 12 November 2008, as presented, be and are hereby noted.

142/08   Report of Trust Secretary on tenders opened and use of the Trust seal

Directors noted that there had been 4 tenders received since the last Trust Board meeting:

Romford – extension to increase staff facilities

Building Associates	Millane Contract Services Ltd	Coniston Ltd
Lakehouse Contracts		

AEDs

Zoll	Physio Control	Laerdal

Refurbishment & alteration of 32 Southwark Bridge Road

Building Associates	TCL Granby Ltd	Coniston Ltd
Lakehouse Contracts	Fairhurst Ward Abbotts	

Remodelling of Smithfield Ambulance Service

Expert Property Solutions	Coniston Ltd	Fisk Construction Ltd
Lakehouse Contracts		

Use of the Trust's Seal: there have been two entries, references 125 and 126, since the last Trust Board meeting. The entries related to:

No. 125   Assignment Lease of Unit 28, Bermondsey Trading Estate between the LAS, Servicetec Ltd and Industrial Property Investment Fund

No. 126   Lease regarding 4th Floor 46 Loman Street between the LAS and Good Harvest Properties

143/08   Opportunity for the Public to ask questions

The following questions were asked by Florence Odeke:

Q1.   How will the proposed stroke strategy of bypassing certain units and proceeding to designated hyper-acute stroke units affect the patient's right of choice?

A1.   Ms. Jones responded that in most cases it was better for stroke patients' long term recovery prospects to be taken direct to specific stroke units. Following the introduction of the MI policy to take patients to such units, patients understood when reasons were explained.

Q2.   Who will be in charge of PTS funding for polyclinics as they will have an impact on Taxi Card holders?

A2   Ms. Jones replied that, with effect from April 2009, PCTs are expected to fund PTS but that it was not expected that this would be happening consistently until 2010/11. It was known that patients sometimes used their taxi cards to attend hospital appointments and this effectively meant that Local Authorities were subsidising the NHS in this respect.

Q3.   Could the Acute Mental Health Trust beds be included in the Emergency Bed Service Development plan?

A3.   Ms. Jones replied that this was currently already done. The Service was also working with the police to persuade MH Trusts to become more coordinated in the use of the small number of beds for violent patients. EBS was able currently to advise HC professionals of the correct Trust to which to take such patients; it should therefore be only a small further step for EBS to make referrals.

The Chairman questioned, when EBS provided such advice, if a contract was awarded to the Service and, if so, by whom? Ms. Jones confirmed that this was the PCTs, therefore agreement was required from them to broaden these contracts to include MH beds.

Q4.   Why negotiate a lower CAT B target? Are you aware of the implications for your application for Foundation Trust status?

A4.   The Chief Executive advised that the change was to 95% and would be applicable from March 2009. In respect of the implications for the FT status application, the LAS was aware that it was not able to apply for FT status until it achieved its performance targets for a period still to be defined.

Q5.   In regards to the daily delays for ambulances at multiple hospitals across London, we have not yet received the data which was requested six months ago and could help when we contact the MPs in areas concerned.

A5.   The Director of Operations advised that this information was being pulled together and would be circulated as soon as possible.

Q6.   Are the CRB checks and procedures robust enough or do they need to be revised?

A6.   The Director of Operations confirmed that, in his view, the procedures were sufficiently robust for purpose. Currently, CRB checks are carried out on new staff as a matter of course. The 109 staff whose reports had raised concerns had been employed before the revised checks came into existence and had been identified as a consequence of conducting retrospective checks which is additional to requirements. Of these, 1 had been dismissed, 1 had resigned and 26 remained under investigation.

Q7.   When Patient Safety risks are identified, what evidence is there, bearing in mind The Risk Compliance and Assurance Group's responsibility (page 25 of The Risk Management Policy) to show that the result is significant in reducing the risk? Is there sufficient data to prove that any identified risks have been mitigated?

A7.   The Director of Operations confirmed that there was plenty of data available to support the assertion that all identified risks had been mitigated. The Chief Executive considered that the new complaints procedure would assist the Trust in learning from its past mistakes and make follow-up plans.

144/08   <u>Next Meeting</u>

It was noted that the next Trust Board meeting would be held at 10:00 am on Tuesday 27 January 2009 in the Conference Room at LAS HQ.

145/08   <u>Any Other Business</u>

There being no further business, the Chairman declared the meeting closed at 13:20.

…………………………
Chairman

London Ambulance Service NHS Trust

TRUST BOARD MEETING
Part II

Summary of discussions on 25 November 2008
held in the Conference Room, LAS HQ, London SE1

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

In Part II of the Trust Board meeting held on 25 November 2008, the Board received reports on:

- the CAD 2010 Project transitional arrangements, which were subject to further review with the preferred supplier to whom the contract had been awarded; and
- a case involving the death of a baby, where the LAS was assisting with police investigations.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

CHIEF EXECUTIVE'S REPORT

1   SERVICE DEVELOPMENT

Healthcare for London

Work continues to ensure that the ambulance service is involved in and contributes to NHS London's work on Healthcare for London.

Clinical and policy staff remain engaged in all of the workstreams to an appropriate extent.

Current progress includes:

Stroke
Clinical teams have visited the hospitals that applied to become hyper-acute and acute stroke units and identified a number that are ready to accept patients for potential thrombolysis 24/7. These are not located evenly across London, which poses a challenge as the consultation period is due to begin.

Meanwhile most London PCTs confirmed, through the commissioning process, that they are content for the LAS not to implement any stroke proposals ahead of the HfL timetable. The exceptions are SW London, where the pilot project has been in place for around a year, NE London, where PCTs have requested that patients not be taken to Queen's Hospital for the time being, and Bexley, where the PCT has requested its FAST positive patients be taken to King's College Hospital.

Trauma
Three hospital networks were successful in the initial designation process and it is possible that one or both of the unsuccessful bidders will be reassessed.

Travel times and LAS resource implications
HfL have engaged consultants to examine the impact of hospital changes on journey times for patients. This material is designed to help inform the public consultation on stroke and trauma that is due to begin later this month or early next month. LAS has engaged with the consultants in order to ensure that they understand the resource implications for the LAS.

Consultation process
The LAS communications team have been working closely with HfL in order to understand the consultation timetable on stroke and trauma. The LAS will clearly need to have a presence at these meetings and offer appropriate support for the changes.

Unscheduled Care
The HfL project team has issued an invitation to tender for a consultancy project on the appropriate way of implementing a new three digit number. LAS were consulted over this tender document. The consultants are expected to produce a proposal by March. Although this delays implementation of the response hub concept yet further, it is a welcome development, as it will bring an objective eye to bear on the discussion of what a response hub should look like.

Polyclinics
Local managers, supported by the Policy, Evaluation and Development team, continue to be involved in the implementation of the early polyclinics.

2 SERVICE DELIVERY

2.1 A&E Operations (graphs 1 – 14)

The work of the Trust has been closely scrutinised via monthly commissioner meetings and at Strategic Health Authority performance review meetings. The last one of these was held on the 14th January where the current position and intended actions were discussed. The plan for the Trust to attain the targets was shared, as were the potential risks to achievement. Some new trajectories were discussed that showed the potential monthly performance under the best and worst case scenarios. In order to support this the 21 week Performance Improvement Plan continues to be robustly monitored internally with several improvements already implemented.

The jointly commissioned ORH study into LAS efficiencies and resourcing levels required to deliver sustainable call connect performance is in its final stages and initial resource requirements for 09/10 have been determined. These currently require an additional investment of 428 Staff to achieve both CAT A and CAT B targets in a sustainable manner during 09/10. This is contingent on the LAS and PCTs/NHSL being able to reduce hospital turnarounds times by five minutes and should this not be possible due to hospital pressures a further 157 Staff will be required to replace the lost hours. This investment in resources will also reduce the exceptionally high ambulance utilisation levels in London from 68% (the highest in the UK) to circa 55% which is more in line with levels in other urban ambulance trusts across the UK. This will also eliminate the unacceptable levels of clinical risk which currently exist at weekends when 999 calls are stacked waiting for a resource to become available

Internal REAP levels were constantly reviewed in light of the Operational demands and on December 16th the service raised it's REAP level to Level 4 'Critical'. This was done in conjunction with Commissioners and NHSL and triggered the penultimate stages of our capacity plan to ensure that everything possible was being done to protect patients across London. This situation was reviewed weekly and on January 12th the service returned to Level 3 'Severe Pressure' in response to a reduction in demand.

The Emergency Bed Service (EBS) has been working closely with NHS London and London Acute Trusts to establish a new pan London A&E capacity dataset. This exciting new project enables LAS to oversee the A&E capacity across London and proactively respond to arising issues. In addition work continues to deliver the EBS Development Strategy.

Emergency Care Practitioners are working more closely with EOC and UOC teams to improve the tasking of our advanced paramedics. For the next 2 months there will be an ECP based in the Control Room. The aim is to increase the number of calls as well as the suitability of the calls that ECPs are tasked to. This work is a critical part of the ECP Development plan.

Live monitoring of the performance of call takers has been delayed owing to difficulties being experienced with the contract for the new telephone system. A number of deliverables essential to the development of a technical method for live time monitoring of call taking have still to be met.

The recruitment of Clinical Telephone Advisers continues to be problematic. As a short term solution for the acute shortages within CTA, arrangements are being made for a number of suitably qualified staff, many of them on restricted duties owing to health or maternity reasons, are to be offered the opportunity of undertaking three month secondments to UOC whilst increased effort is being made to recruit staff on a permanent basis. It is strongly believed that the enabling of remote site working, which is still being scoped, will greatly assist this.

The functioning of UOC has now been reviewed and a project plan developed for the introduction of a number of key changes to the work of the unit including:

- The introduction of a UOC specific performance monitoring pack together with performance trajectories mapped against target.
- Software changes to PSIAM to improve performance data capture.
- Individual Performance Management System for staff working within the UOC based on the new data.
- A review of all staff rotas, particularly individual rotas, to ensure they align to business need.
- A Quality Assurance regime for the work of the Clinical Telephone Advisors and Reviewers.
- An increase in the use of Patient Transport Services and A&E support crews to reduce call demand on EOC and ensure the most effective use of resources.
- A system of breach analysis is being developed to review calls that have been passed from UOC to EOC.
- Changes have been made to the management structure and reporting lines improving leadership and supervision within UOC.

The project piloting the use of GPs in EOC went live on 20th December 2008. The project involves assisting in the prioritising and ringing back of calls which are being 'stacked' because we have no available resource to send together with general support to CTA in terms of resolving Category C calls. Unfortunately only one GP was able to commit to shifts over the Christmas period (total hours worked 4 shifts of four hours each). He called back 58 patients and from that seven ambulance journeys were saved. In general terms it was felt useful but the dataset is, at this time, too small to be meaningful. Since this date a further seven GPs have been trained for this work and the project will be expanded over the next two months so that a full and meaningful data set is obtained for evaluation. A more detailed review will be reported back in the next Trust Board report.

The past couple of months have seen a particularly busy period for Emergency Preparedness, in terms of both exercises and events. During early November several large firework displays took place, one of the largest being on Blackheath in South East London.

The planning for the service response to the New Year celebrations in central London worked well with the Emergency Preparedness department planning for the previous 12 months. Approx 100 dedicated central London staff were deployed. Some 3,500 call were dealt with across London from midnight to 7am, with the service response led by ADO Jason Killens.

Over several weekends in January we have deployed Public Order Cells to provide cover for the anti Israeli -war demonstrations. This has consisted of operational staff, control services, emergency preparedness, patient transport, logistics and fleet. So far the four demonstrations that have taken place up to the second weekend of the month have resulted in 44 patients being treated with 21 patients conveyed to hospital with injuries such as head injuries, fractures, soft tissue injuries, burns from fireworks and the serious assault of a police officer. There are plans in place for further demonstrations scheduled for the coming weeks.

During late October the LAS were involved in Operation Torch this exercise looked at Disaster Victim Identification following CBRN incidents, staff from HART, CBRN, Operations and EPU were involved. There were a number of learning points identified and a full debrief is planned to take place in the near future.

Again during late October the Emergency Preparedness Department participated in a national counter terrorism exercise called Wooden Pride which took place in NW London.

The Health Protection Agency hosted on behalf the of Guy's and St Thomas NHS Trust a table top exercise "exercise South bank" which focused on a flooding scenario and the evacuation of the hospital, this was a very useful exercise and many lessons will be taken from this.

On 11th November the Metropolitan Police Service hosted a seminar "Update London" this was aimed at the emergency preparedness community, the event was well attend and three representatives from emergency preparedness attended.

Accident & Emergency service performance and activity

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

	CAT A8	CAT A19	CAT B19
Standard	***75.0%***	***95.0%***	***90.%***
Year to date	73.3%	98.06%	83.0%
November 2008	72.4%	98.3%	82.8%
December 2008	70.3%	97.6%	80.5%
1-14 January 09	78.5%	98.2%	88.5%

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

- The overall demand increase so far this year is running at 2.7% to the end of December. It is interesting to note that the Category C calls have seen the greatest percentage increase year to date, with an overall increase of 3.7% over the previous year.

- Category A performance reached 72.2% in November but fell back slightly during December to 70.3%. This has been as a direct result of exceptional demand coupled with extensive hospital delays. In November there was an overall workload increase over the previous year of 1.6% but in December the increase was 4.6%. The greatest increase was in Category A calls where workload increased by 5.5%.

- For December the daily average of Category A calls was 1,034 calls, an increase of 54 as compared to last year when the average was 980. Over a period of 19 days the daily Cat A workload did not fall below 1000 calls on any day, with the peak period from the 11th to the 18th December when the Category A workload did not fall below 1,100 Cat A calls a day consistently over this 8-day period.

- It is important to retain some perspective here in that Call Connect performance last November and December was 62.9% and 60.4% with virtually identical staffing levels. The levels now being achieved against a higher workload continue to represent a step change in performance.

- Category B performance fell as demand and hospital pressures rose during December but is now improving as demand has fallen back to more 'normal' levels and there is some improvement in the hospital situation. Once again given the significant increase in life threatening calls, we have continued to prioritise resources to FRUs and Cat A workload. Nevertheless we are now delivering some of the best Category B performance ever. Category B performance is largely reliant on ambulance availability and currently ambulance utilisation levels remain too high reaching a peak of 74.3% in December against a mean figure for England of 55%.

- Call taking achieved 93.1% for November and 91.4% for December. Whilst this was slightly disappointing, it is an improvement over the previous year of about 2% across each month. There were weeks that did achieve above 95% during this period, and the overall figure was brought down by the big spikes in workload.

- Hospital Pressures continued to be profound and the situation deteriorated markedly during December with extensive delays at Hospitals across the London Area and various Diverts and Closures put in place. Ambulances have queued in large numbers for up to five hours to unload at various hospitals and two hour delays have become relatively common. LAS managers have been increasingly involved in supporting A&E Departments to resolve ambulance delays and have also Chaired multiple conference calls at Director and CEO Level to broker Diverts and assist in managing pressures across multiple hospitals. NHSL involvement has increased which is welcomed and this has led in turn to increasing PCT involvement. It is important to note that not only has this depleted us of the capacity to respond but also resulted in vehicles travelling much further and often out of area which in turn results in poorer response times.

- Persistent cold weather coupled with Flu and the Winter Vomiting Virus have been driving some of the demand increases, with the growth areas again being in the respiratory and cardiac areas. This situation was mirrored nationally with all Ambulance Trusts reporting severe pressures in terms of workload and hospital delays.

- Staffing has improved over the last two months. We produced circa 254,000hrs Ambulance Hours resourcing for November and December this year which is 2700 hrs more than for the same period last year. FRU hours produced increased by circa 17% to 120,000hrs compared to 102,000 for the same period last year.

- The re-introduction of the "Attendance Bonus" for the Christmas period proved very successful again this year. This initiative improved staffing levels, however it did remain challenging on certain days, such as the 25th and 27th December and on the morning of the 1st January 2009. However, these days coincided with the reduction in demand so the levels of performance reported were not outliers compared to other days in the month.

- We have continued to incentivise staff working additional hours in January, in broadly the same manner as the previous months. However in addition we have introduced a "Performance Improvement and Attendance Initiative" This targets improvements in individuals performance specifically to the area they work. For example Operational Staff are required to show a maximum of 30 seconds mobilisation across the month. In EOC staff are required to achieve a minimum of 95% in Call Taking by watch and in UOC and CTA there is a requirement for a greater number of calls to be resolved. It is the intention to expand this side of the scheme further in the coming months and reduce the amount paid for undertaking additional hours.

- The recruitment programme to train 300 Student Paramedics and circa 100 other grades of A&E staff remains broadly on track although we have had some difficulty filling course places close to Xmas with new joiners preferring to start their training in the New Year. We have now increased course numbers by 24 places on the courses between January and March to make up this shortfall and we are now expecting to be at our full current

establishment (2913) by mid March 09. The number of staff available operationally lags behind the recruitment vacancies as it takes six months to fully train new Student Paramedics. Thus until September we will remain reliant on high levels of overtime working to bridge this.

- New Ways of Working continues at our early implementer sites, Chase Farm and Barnehurst Estates and IT work are currently being undertaken to enable both complexes to have up to date training and development facilities. New clinical tutors are also being recruited. In addition, new ECP teams will join the complexes in February.

2.2   PATIENT TRANSPORT SERVICE (graphs 15 – 18)

Commercial

The London Procurement Programme has announced the following awards:

- Barnet, Enfield and Haringey Mental Health Trust (new business) - London Ambulance Service
- Lewisham Hospital (new business) – Savoy Ventures

We are waiting for results on the following contracts under this programme:

- Barking, Havering and Redbridge Hospitals (new business) - £3,300,000
- North East London Mental Health Trust (existing business) - £425,000
- North West London Hospitals (new business) - £930,000
- Royal National Orthopaedic Hospitals (existing business) – £487,500
- South London and the Maudsley Mental Health Trust (existing business) - £212,500

The LAS will commence operation on the Barnet, Enfield and Haringey Mental Health Trust on 1 April 2009 and is worth £ 700,000 per annum.

South West London and St George's Mental Health Trust (existing business) have also awarded its new contract to London Ambulance Service. This contract is worth £1,065,000.

Performance

Performance on the quality statistics continue to remain consistent for December 2008 at:

- Arrival time: 91%
- Departure time: 93%
- Time on Vehicle: 94%

PTS undertook 26,902 patient journeys in December 2008 a fall from 27,248 in November. However, this figure is 2,600 more journeys than were completed in December 2007.

In addition a total of 619 calls were completed on behalf of UOC throughout December as part of the PTS50 project. Around 900 calls were passed to PTS from UOC and throughout January we are looking at how we can manage our crews to complete a higher number of journeys.

3   HUMAN RESOURCES

Workforce Plan implementation

Recruitment of Student Paramedics (SP) continues and is progressing well with 90 of the 96 places on courses starting in January and February having been filled. All courses are being planned at maximum capacity to year end to recover slippage over December and we are still on track to recruit to planned numbers by mid-March.

There are currently 620 applications at various stages of the recruitment process. The number awaiting C1 qualification has fallen to 61.

The December recruitment event was successful. 96 people were assessed; 49 passed; 23 of the 30 who were interviewed on the day were offered places. Another event will take place on 17th January. 100 people have been invited; all of whom already have C1.

Unions and Partnership Arrangements

The national "day of action" announced by TGWU/Unite in protest at the three year pay deal agreed between the Department of Health and the majority of NHS Trade Unions went ahead in December with no impact or implications on Trust staffing or service delivery. The NHS Pay Review Body has since confirmed that the case to reopen the discussions on the agreement and review year two has not been accepted, and the second stage of the national award will be implemented with effect from April 2009. This includes an increase in all pay points for staff covered by the Agenda for Change arrangements of 2.4%.

In terms of the Trust's internal joint consultative arrangements, the first meeting of the revised Staff Council was held in November 2008. Unison and Amicus/Unite, as trade union signatories to the agreement, attended that meeting. Since then both GMB and TGWU/Unite have signed to confirm their agreement to the new arrangements, which are in the process of being implemented across the Trust. As part of the new arrangements a Partnership Conference is proposed for April/May 2009.

NHS London

The Trust, through the Director of Human Resources, has sought agreement from the SHA to retain any surplus from this year's Education and Development SLA to support the Paramedic training courses provided to EMT staff this year. This would allow funds to be released for continued performance support to achieve performance targets. We await a response to this proposal.

The draft of the 3 year investment plan has received initial comments from the SHA and other stakeholders such as commissioners and Healthcare for London. The final draft is due for submission late February which will reflect actual training needs (numbers) associated with the final agreement of the business plan for 2009/10. The Trust has been informed that the investment plan will compete with bids to the SHA from all other London NHS Trusts this year (which was not the case for last year's SLA).

PTS Human Resources

The consultation paper in respect of the restructure of middle management and supervisory grades will be issued before the end of January 2009. This will affect 21 individuals, who will have an opportunity to apply for the revised posts on offer. The restructure will be concluded by

the beginning of March 2009, with the process following the Trust's management of change policy.

TUPE meetings with M&L Ambulance staff currently employed on the Barnet, Enfield and Haringey Mental Health Trust commence on Wednesday 21st January 2008. This is in line with the project plan set out for the start of this new contract. 19 Members of M&L staff will be eligible to TUPE across to the LAS.

Equality & Diversity

With the Diversity team now fully staffed following a gap of nine months, work has begun to regain momentum on developing and delivering the future Equality and Diversity agenda particularly in light of future equality legislation. This Trust Board meeting will receive the annual Equality and Diversity report for 2007/08 as the first stage of this work.

Workforce information

Sickness levels continue to be monitored and managed closely and have remained stable though with a slight increase in November at 5.50% for the Trust. This continues to be within target.

Staff turnover remains stable within the year at 7.39% with a slight fall in CTA and EOC.

For the month of December, the A&E establishment of 2913 shows a vacancy of 130 wte. The Trust remains on track to achieve full establishment (recruited) against the 2913 by mid March 2009.

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%				

Trust Sickness Levels
Apr 07/Mar 08 cf Apr 08/Mar 09
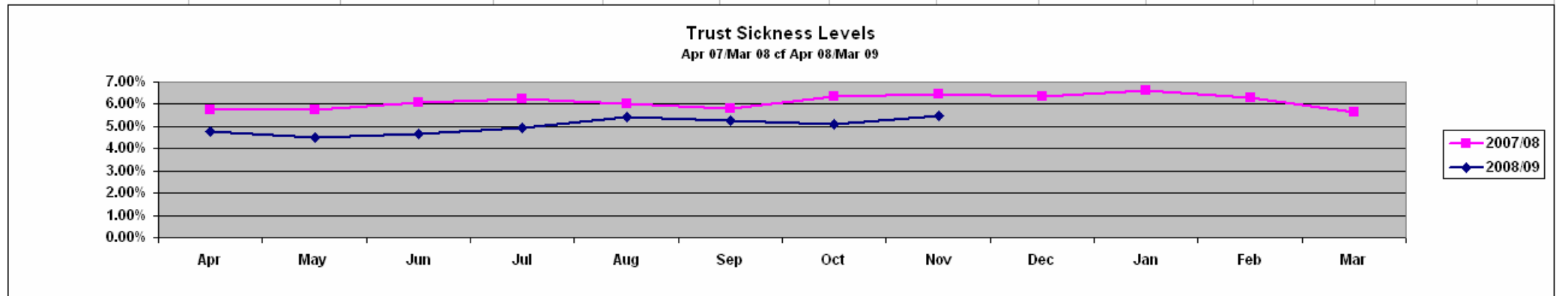
A&E Ops Sickness Levels												
A&E Ops Areas	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08
A&E Ops East	6.92%	6.64%	6.23%	5.63%	4.67%	4.18%	5.27%	5.88%	5.47%	5.50%	4.36%	6.20%
A&E Ops South	7.00%	7.02%	6.36%	5.91%	4.86%	4.18%	3.62%	3.85%	5.24%	5.34%	5.41%	6.00%
A&E Ops West	6.52%	7.78%	6.77%	6.61%	6.41%	5.69%	4.96%	4.79%	5.51%	5.20%	6.34%	5.86%
Control Services	6.83%	6.98%	6.79%	5.40%	4.45%	5.11%	5.55%	6.53%	6.78%	6.52%	7.04%	6.23%
PTS	7.13%	8.27%	9.86%	8.36%	6.80%	6.02%	7.30%	9.22%	8.47%	7.65%	7.16%	6.69%
Trust Total	6.34%	6.61%	6.32%	5.66%	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%

A&E Operations Sickness Levels
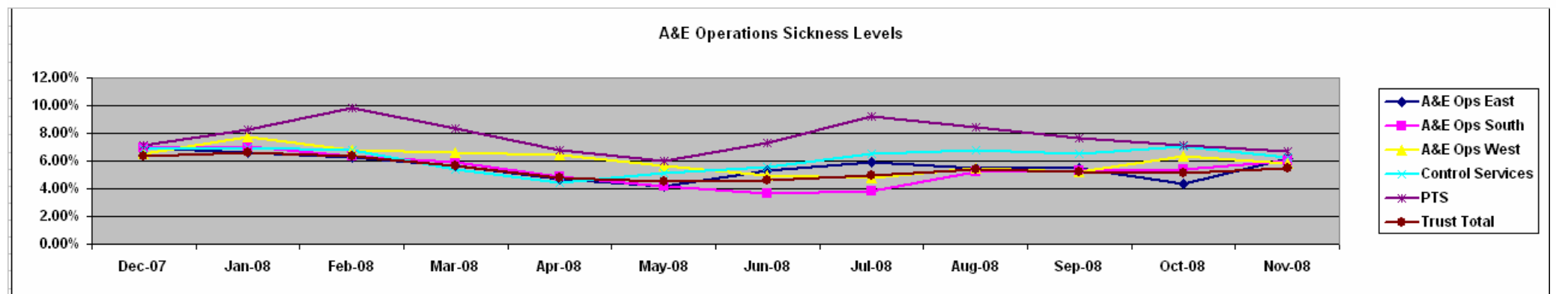
Staff Turnover

Staff Groups	Apr-06/Mar-07	Apr-07/Mar-08	May-07/Apr-08	Jun-07/May-08	Jul-07/Jun-08	Aug-07/Jul-08	Sep-07/Aug-08	Oct-07/Sep-08	Nov-07/Oct-08	Dec-07/Nov-08	Jan-08/Dec-08
A & C	11.04%	13.13%	13.48%	15.29%	14.20%	14.79%	13.35%	14.59%	15.38%	15.27%	15.76%
A & E	4.64%	5.13%	5.36%	5.46%	5.75%	5.58%	5.47%	5.44%	5.64%	5.60%	5.58%
CTA	0.00%	5.13%	11.11%	10.26%	10.00%	8.51%	10.87%	8.51%	9.09%	9.52%	7.14%
EOC Watch Staff	11.04%	11.70%	12.80%	11.85%	13.57%	12.57%	12.20%	12.87%	13.31%	13.55%	11.70%
Fleet	5.08%	10.91%	13.21%	13.21%	13.21%	13.21%	7.55%	5.66%	11.32%	14.00%	14.00%
PTS	6.16%	11.02%	11.86%	12.60%	12.50%	12.34%	11.97%	12.61%	12.55%	11.86%	12.45%
Resource Staff	1.96%	2.04%	2.08%	2.08%	2.08%	2.08%	2.08%	2.13%	2.13%	0.00%	0.00%
SMP	6.72%	6.74%	6.99%	7.83%	8.12%	7.36%	7.32%	7.37%	6.88%	6.61%	6.99%
Trust Total	**5.87%**	**6.83%**	**7.24%**	**7.51%**	**7.80%**	**7.57%**	**7.27%**	**7.35%**	**7.57%**	**7.50%**	**7.39%**

A&E Establishment as at December 2008

Position Titles	Funded Establishment	Staff in post	Variance	Leavers
Team Leader	175.00	157.58	17.42	1.00
ECP	86.00	48.62	37.38	1.00
Paramedic	830.00	871.26	-41.26	2.00
EMT	1220.00	1317.50	-97.50	5.61
Student Paramedic	300.00	179.00	121.00	3.00
A&E Support	232.00	167.79	64.21	0.53
EMD1	54.00	72.02	-18.02	0.31
EMD2	90.55	109.56	-19.01	0.00
EMD3	100.76	65.38	35.38	0.00
EMD Allocator	78.00	64.06	13.94	0.75
CTA	70.00	41.25	28.75	0.00
Total	**3236.31**	**3094.02**	**142.29**	**14.20**

5   INFORMATION MANAGEMENT & TECHNOLOGY

CTAK UPDATE

The last two reports to the Trust board have detailed problems with CTAK, the command and control system. I am pleased to report that over the last period the system has remained stable. This has allowed some configuration changes have been made that have improved vehicle dispatch which is assisting with overall performance improvement. Vigilance remains on checking and monitoring the system, and work is underway testing new hardware that once implemented will assist with the system's overall reliability. Proposed implementation dates for this upgrade are currently under consideration.

CAD 2010

The long term solution for the problems with CTAK is full replacement by the new CAD 2010 system. At the November Trust board, authorisation was given to award the contract for the new command and control system to Northrop Grumman. The formal signing of the contract took place on 15 December during a ceremony at Loman Street, attended by senior representative from NG and the LAS.

Respective project teams are currently working on harmonising project plans with a view to complete implementation of the new system by December 2010. One of the first tasks will be to confirm the arrangements by which we will change from CTAK to CAD 2010 (known as 'Transition'). The Trust Board have previously expressed a view to be directly involved in this decision; hence there is a separate paper at this meeting.

AIRWAVE

As previously reported, the Airwave implementation for the LAS has been delayed due to issues at a national level. Work has however progressed and it is anticipated that full roll out will commence in June and be completed by October this year. This is still dependent on testing, but there is now a greater level of optimism in being able to achieve these dates.

IM&T SERVICE IMPROVEMENT

Towards the end of 2008, a customer survey was undertaken to gauge internal LAS customers' perception of the level of service provided by IM&T, in particular the service desk. All employees were invited to participate in the customer survey. There were 234 respondents, most were members of management or senior management and over half the respondents were HQ based. The headline result is that of the respondents, 59% rate the service provided between satisfactory and excellent (26% satisfactory; 33% excellent/very good or good), 41% rate it as poor.

The customer survey has provided a clear benchmark from where to base an IM&T service improvement plan. This has been constructed analysing all of the results received and has been subject to consultation with IM&T staff to ensure support for the improvement measures. It includes clear performance measures (IM&T Service standards) against which teams will be managed and reviewed at weekly performance meetings. It is planned to re-run the survey in October 2009, with a view to obtaining an overall satisfaction rating of at least 75%.

6   COMMUNICATIONS

Media issues

Service pressures and alcohol-related calls: Proactive media work around the impact of alcohol-related calls, combined with extensive media interest in pressures on the ambulance service, led to a significant amount of coverage in the run-up to Christmas.

The issue received particular coverage throughout December in the Evening Standard, The London Paper and London Lite, and on BBC London Radio. The central London Booze Bus and a treatment centre set up at Liverpool Street station were visited by both regional and national media and features appeared in The Times and the Daily Mirror, and on the BBC website, among others.

Local media across London also covered the story, with local statistics provided along with interviews with operational managers. Some journalists also observed crews in their local area, resulting in positive coverage in places such as Croydon and Harrow.

Nationally, extensive coverage of demand on ambulance services across the country was reflected in enquiries from London media. As well as confirming that the Service had been experiencing some of its busiest ever weeks, the opportunity was also taken to remind the public of the other healthcare options that are available to less seriously ill or injured patients before they call 999.

YouTube video: Work around alcohol-related pressure was supported by a video, produced by the Media Resources department in conjunction with Communications staff, featuring the work of the central London 'Booze Bus'. The video was the first to be posted on the Service's official YouTube channel and was also made available through the new corporate website. It was viewed more than 7,000 times before Christmas itself, rising to 9,000 views by mid-January.

New Year: Media coverage continued between Christmas and the New Year, with a feature in The Sun newspaper and radio interviews on LBC, BBC Radio London and Radio 5 Live. The Service's demand figures were also covered in articles in the Daily Mail and Evening Standard.

Staff safety: In early December, the Evening Standard printed an article about the high risk register and attacks on staff, which also led to approaches from local papers asking for figures for their areas.

A Romford emergency medical technician who was assaulted by a patient he was trying to treat was interviewed on ITV London Today, along with the local Assistant Director of Operations. The story also appeared in the Evening Standard, the London Lite and on the front page of a local newspaper.

NHS Champions: Romford Ambulance Operations Manager Steve Colhoun was named the winner of the ambulance category in the NHS Champions Awards 2008. As well as being featured in the Evening Standard, the story was also covered by a local newspaper.

Vehicle issues: Following concerns about carbon monoxide levels in a number of older ambulances, which led to some staff being assessed in hospital, a story was published in The London Paper. In response, the Service confirmed that action has since been taken to repair any faults.

CAD 2010: The signing of the CAD2010 contract led to three website articles from UK and US computer trade publications.

Patient and Public Involvement (PPI)

Changes to management arrangements:

- Following the departure of the Director of Communications, the Patient & Public Involvement Manager now reports to the Director of Operations. Since 1st January she has taken over management responsibility for the Events & Schools and Media Resources Manager and his team.

Public Education:

- All six modules of the pilot development programme for public education staff have now been completed. A full evaluation will be carried out during February and March, with the aim of adapting the programme and extending it to a new group early in the summer. Feedback received from participants about individual modules has been very positive. It is hoped that it will be possible to have the programme approved as accredited learning.

Tower Hamlets project:

- Due to operational pressures, the Bengali course for Silvertown staff planned for January has been postponed until the spring.

- Another emergency life support training course is being held for Tower Hamlets women with young babies at the Barkentine Health Centre.

New Ways of Working:

- The Community Involvement Officers have now been in post for more than three months and are involved in a range of projects and initiatives in their respective areas. They have also completed the public education staff development programme.

PPI activity:

- A Team Leader at Silvertown (Donna Williams) represented the Service at an event organised by Tower Hamlets PCT to promote urgent care service developments in the area.
- Members of the Community Resuscitation Training Team attended an event in Leyton focusing on work and training opportunities.
- A Safe Drive Stay Alive event was held in November at Hornchurch, filling the theatre for sessions twice a day for two weeks. Once again this was a powerful and moving experience, both for participants and the audience, with the impact of young people driving without sufficient care being graphically shown and described. One participant, a young man seriously disabled in a road traffic collision, has subsequently won a "young person of the year" award for his work in raising awareness amongst young people.
- A "Suzie Lamplugh Community Safety Award" has been won by Wandsworth Safety Schemes. Wimbledon DSO Taff Roberts has led on work in this area and will represent the LAS at the awards ceremony.
- The PPI Manager continues to meet Local Involvement Network (LINk) representatives, including the London-wide lead for LINKs - based at the King's Fund - who is keen to work with the LAS across London.

The London Borough of Ealing has brought legal proceedings against the London Ambulance Service NHS Trust for contravention of the Health and Safety at Work, etc. Act 1974 following the tragic death of Oliver Ladwa on 8 June 2006 at a local play school.

A full investigation under the Serious Untoward Incident Procedure was undertaken and copies of the report were shared with HM Coroner, the family, the London Borough of Ealing, and other interested parties at the Inquest into Oliver's death.

On 27 April 2007 the Inquest jury concluded that that it was an accidental death and gave a narrative verdict.

The prosecution by the London Borough of Ealing has been listed at Acton Magistrates Court on 29 January 2009.

Peter Bradley CBE
Chief Executive Officer
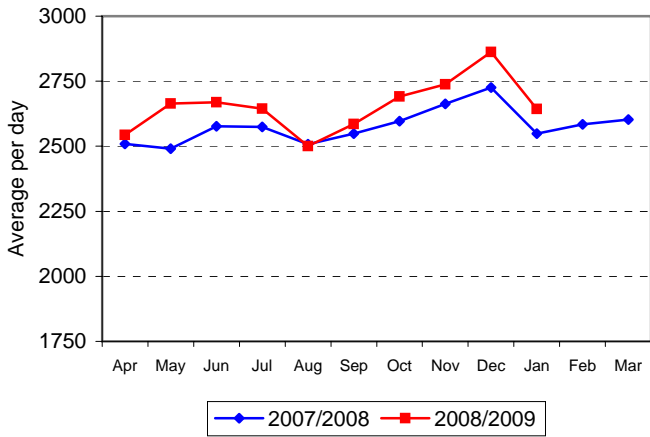
20 January 2009

London Ambulance Service
NHS Trust

Information Pack for Trust Board
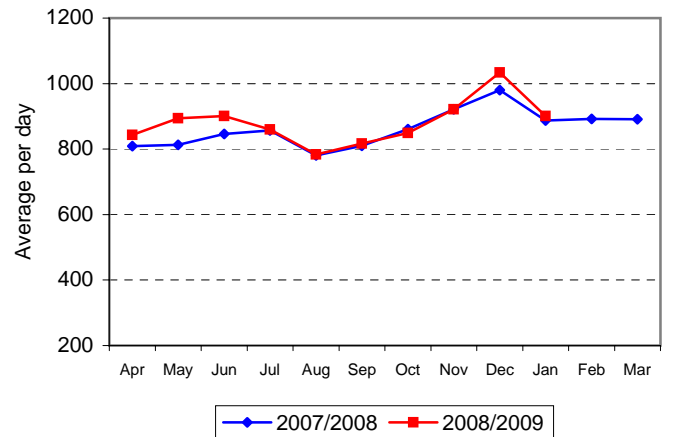
January so far 09

Please note: PRF input is not yet complete for December 08

London Ambulance Service NHS Trust
Accident and Emergency Service
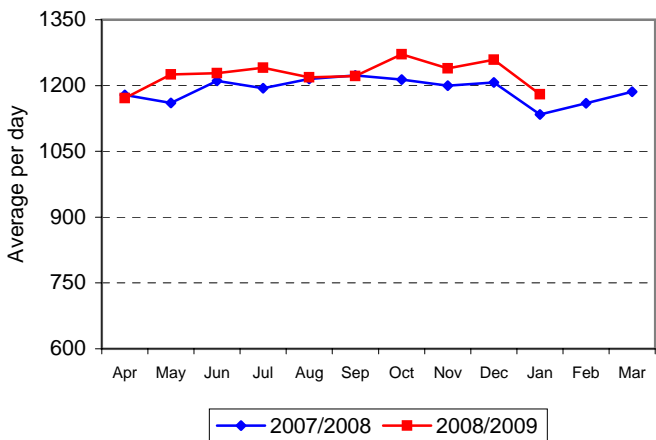**Activity - January so far 2009**

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 999 calls received per day
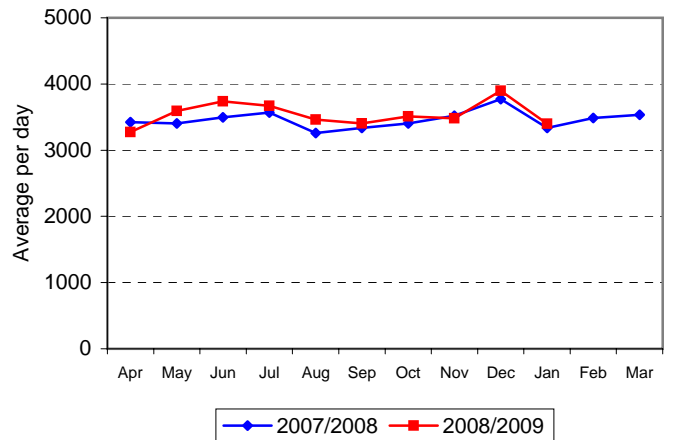
London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - January so far 2009

Graph 5
Category A 8 minute performance
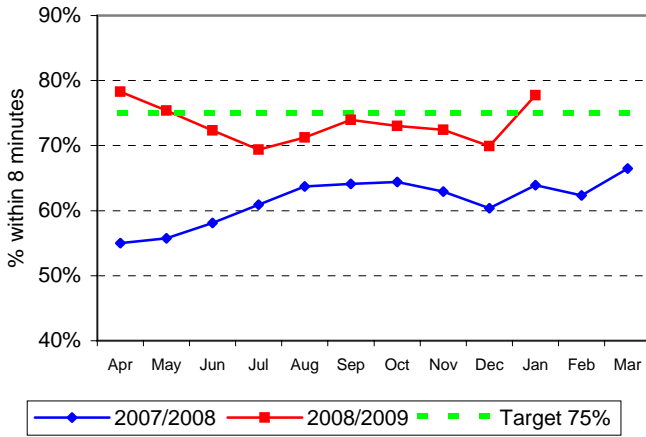
Graph 6
Category A 19 minute performance
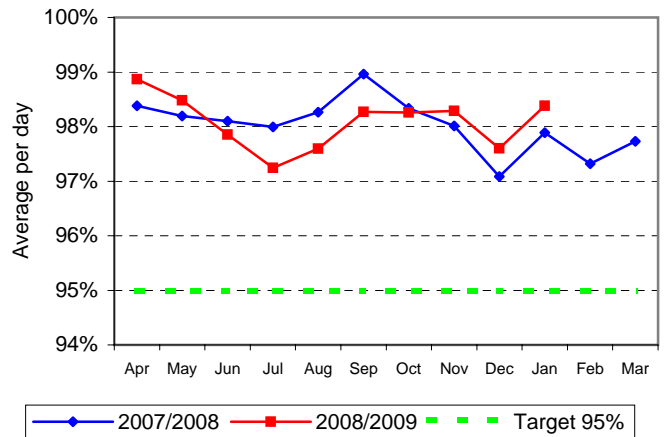
Graph 7
Category B 19 minute performance
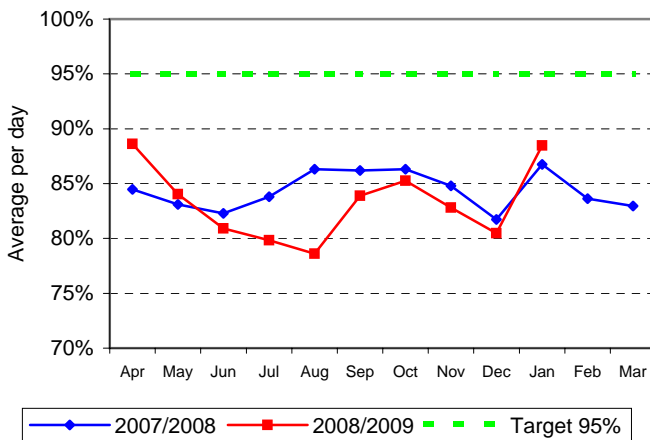
Graph 8
Percentage of calls answered within 5 seconds
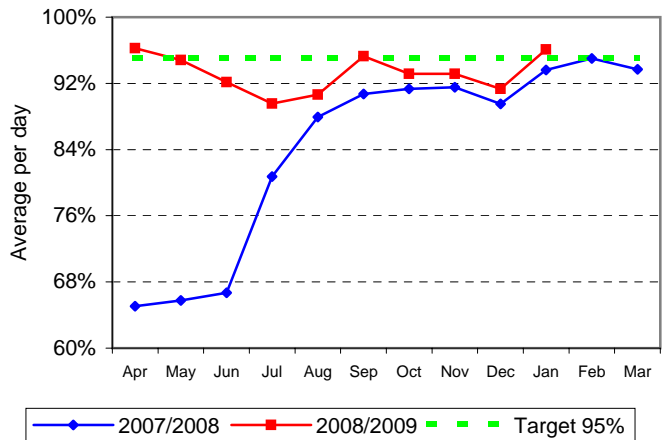
London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - December 2008

Graph 9
Arrival at Hospital Against Appointment Time
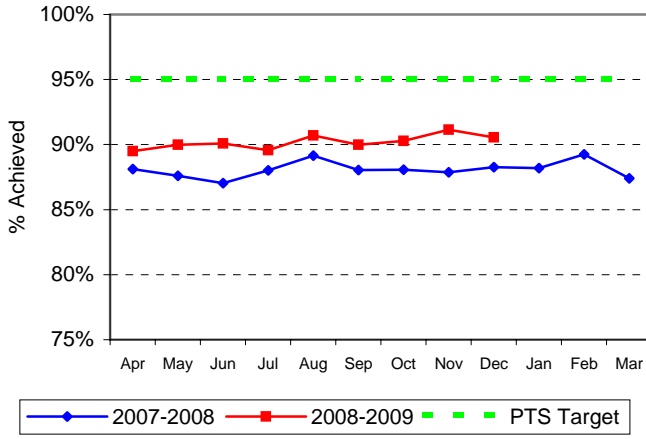
Graph 10
Departure Against Ready Time
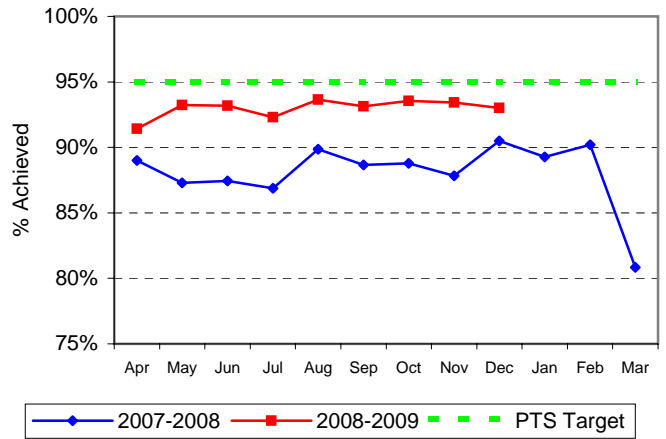
Graph 11
Time spent on Vehicle
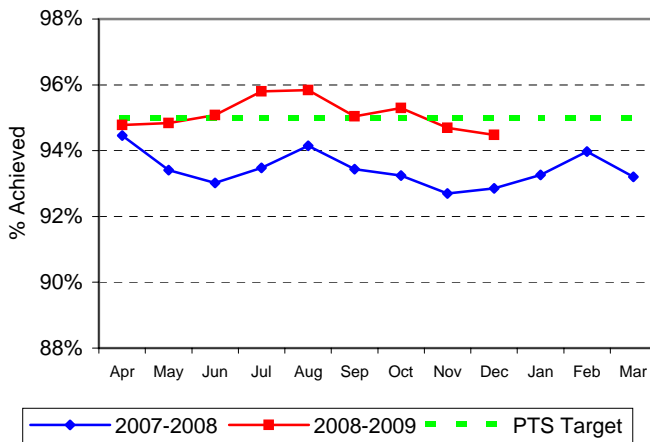
Graph 12
PTS Total Activity
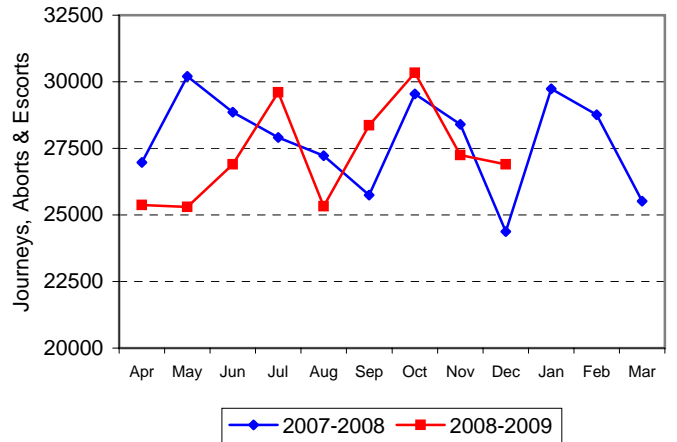
London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - January so far 2009

Graph 13
% of vehicles given a rest breaks

Legend: 2007/2008, 2008/2009
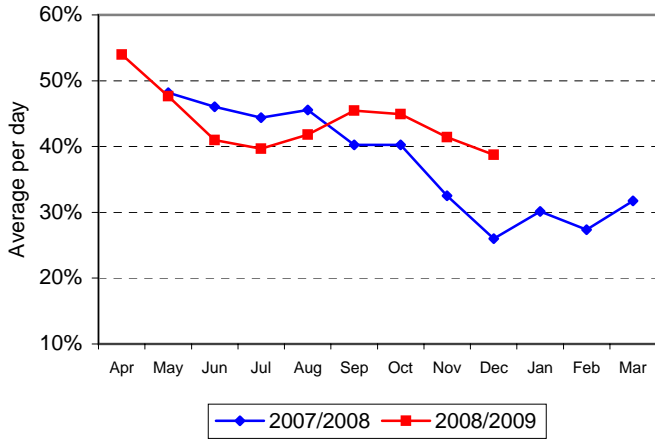
Graph 14
EOC Staffing as a % of the plan

Legend: 2007/2008, 2008/2009
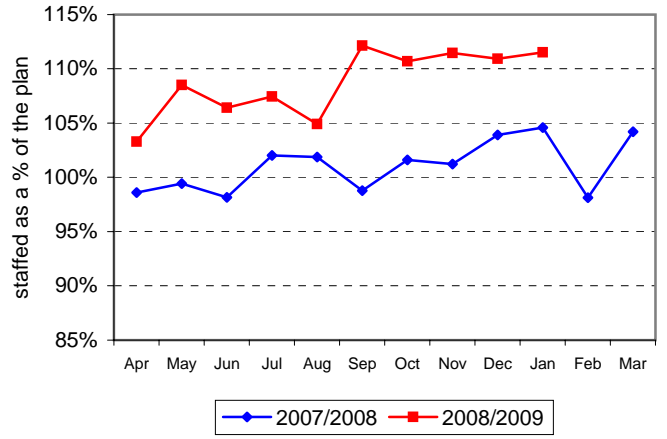
Graph 15
EOC hours staffed per day

Legend: 2007/2008, 2008/2009
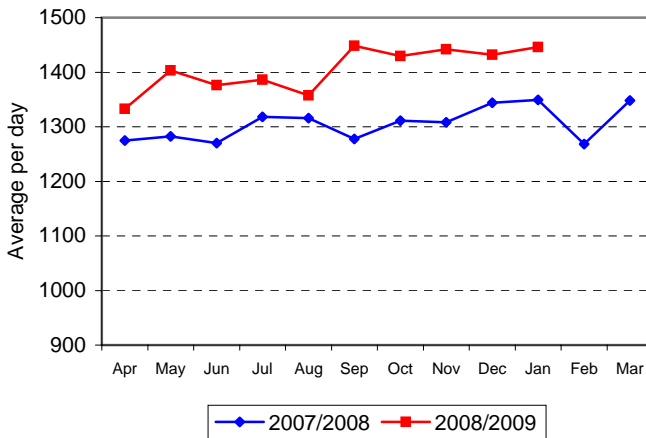
Graph 16
Ambulance hours available per day

Legend: 2007/08, 2008/09
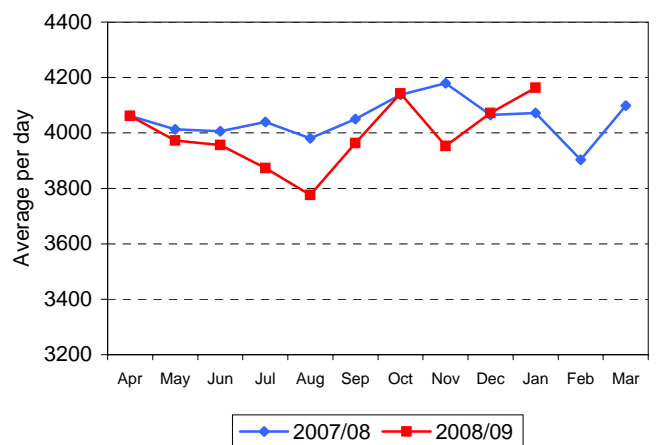
Graph 17
FRU hours available per day

Legend: 2007/08, 2008/09
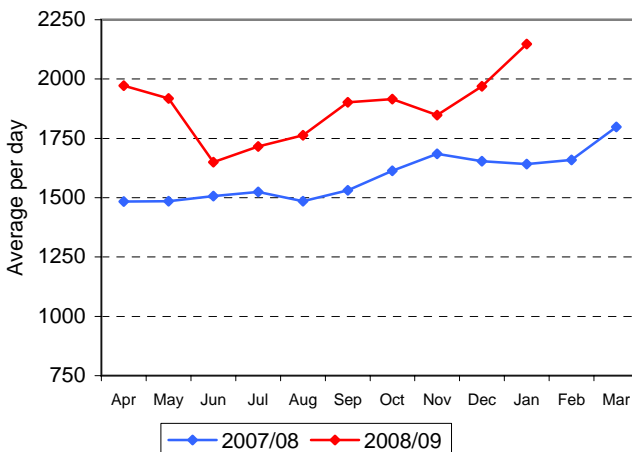
Graph 18
Vehicle availability as a percentage of the plan

Legend: Amb 2007/08, Amb 2008/09, FRU 2007/08, FRU 2008/09
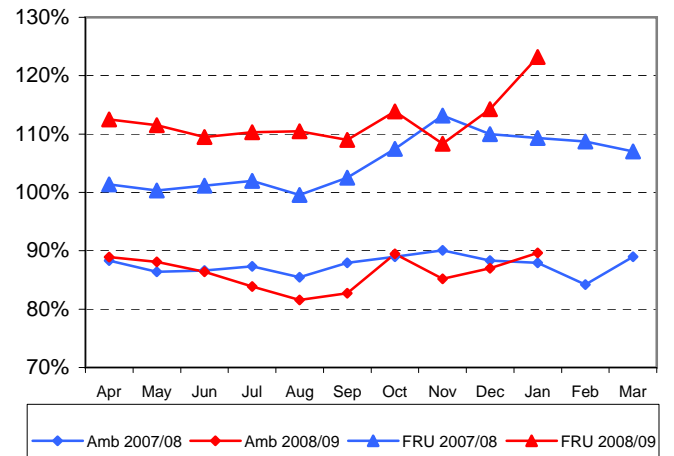
London Ambulance Service NHS Trust
Accident and Emergency Service
Vehicle Utilisation - December 2008

Distribution of hourly vehicle utilisations by complex : 01/12/08 to 31/12/08

mean: 74.3%
std. dev.: 0.271
over 70% utilised: 53.6%
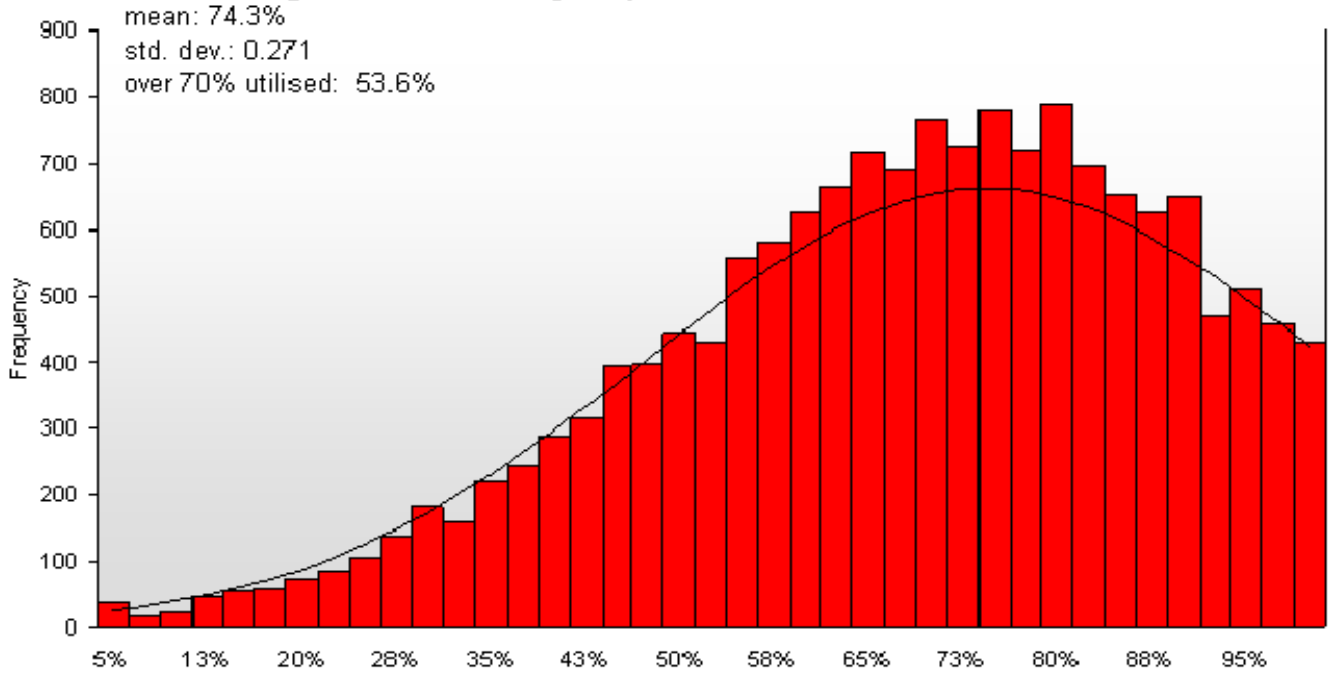
London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Report of Finance Director
Month 9 (December 2008)

1. **Sponsoring Director:**   Michael Dinan

2. **Purpose:**   *For noting*

3. **Summary:**   *The month 9 Finance pack is attached.*

    The month result shows a surplus of £787k, resulting in a year to date surplus of £1,948k.

    The forecast for the year is a surplus of £912k which is within the NHS London control range.

    Total Cost for the month was £22.2m compared to a forecast of £23.1m. Non Pay expense was £690k below forecast with development cost, Olympics and telecoms costs being the key drivers.

    An updated analysis of capital expenditure will be presented at the meeting.

4. **Recommendation:**   *That the Trust Board note the report*

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD
DECEMBER 09 (MONTH 9)

Contents:

London Ambulance Service NHS Trust
Summary of Financial Performance for the month ending 30th December 08 (Month 9)

Income and Expenditure

Cumulative Net Financial Position

Legend: Actual, Forecast, Plan
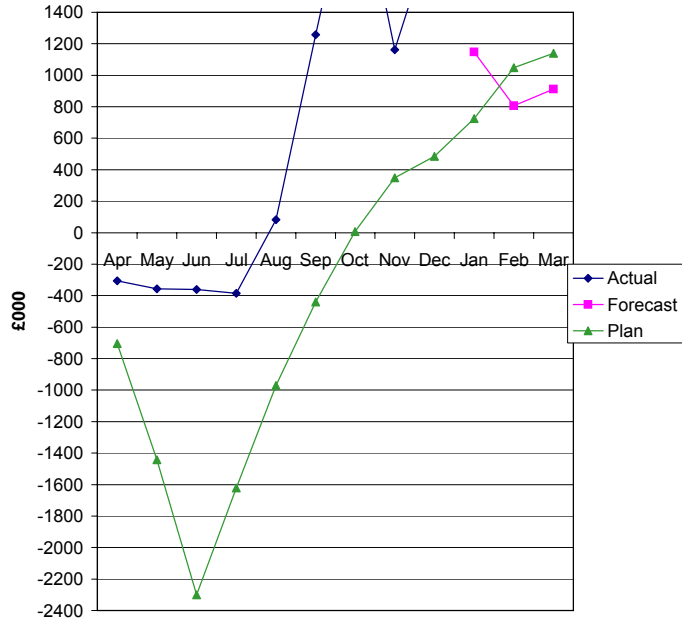
Balance Sheet

Distance from Capital Resource Limit

Legend: Target, Actual

Working capital

Legend: Debtors, Creditors, Cash
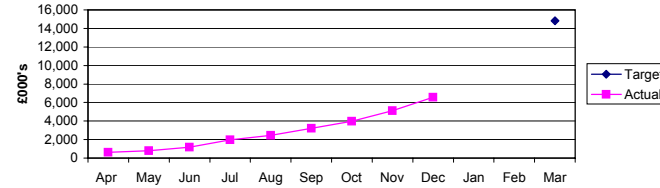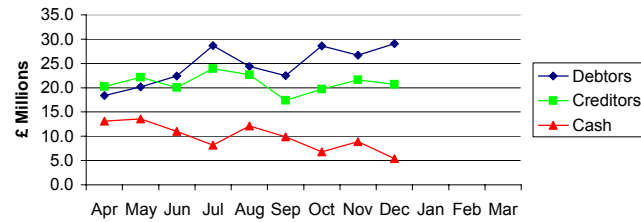
Ratios	Oct	Nov	Dec	
Asset turnover ratio	2.04	2.01	2.01	●
Debtors % > 90 days	8%	11%	7%	●
A&E Debtor days	4	4	5	●
PTS Debtor days	57	139	59	●
PSPP NHS	83%	100%	95%	●
PSPP Non NHS	89%	90%	88%	●

Key Financial Indicators

	October	November	December
A&E Overtime (£000) / Day (Month)	56	53	55
A&E Overtime (% of paybill)	10.84%	10.04%	10.48%
Subsistence (£000) / Day (Month)	4.90	5.56	7.17
Subsistence per head £	38.24	41.58	54.59
Third Party Transport expenditure / Day (Month)	3,053	3,826	4,029
Total operational cost per incident	255	247	239
A&E Gross Surplus (YTD) (% of Income)	22.9%	22.3%	22.6%
A&E Net Margin (YTD) (% of Income)	1.9%	0.9%	1.2%
PTS Gross Margin (YTD) (% of Income)	-6.9%	-6.0%	-4.7%
Cat B performance (cumulative)	82.92%	82.93%	82.73%

Financial Risks

Overall risk rating		MED	●
1	Cat B Penalty imposed for not meeting activity targets	MED	●
2	Failure to manage A&E overtime within plan	MED	●
3	Fuel prices rise in excess of planned figures	LOW	●
4	Failure to meet Trust CIP	LOW	●
5	PTS profitability less than forecast	MED	●

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31 December 2008 (Month 9)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	22,955	21,053	1,901F	194,614	189,478	5,136F	2.7%F	260,424	252,638	7,787F
Total Operational Costs	21,235	19,941	(1,294)U	184,271	180,208	(4,063)U	(2.3%)U	248,215	239,785	(8,430)U
EBITDA	1,720	1,112	607F	10,343	9,270	1,073F	0F	12,209	12,852	(643)U
EBITDA Margin	7%	5%	2%	5%	5%	0%		5%	5%	0%
Depreciation & Interest	933	976	43F	8,394	8,784	390F	4.4%F	11,298	11,712	414F
Net Surplus/(Deficit)	787	136	650F	1,948	486	1,462 F	(4.0%)U	912	1,140	(229)U
Net Margin	3%	-1%	4%	1%	0%	1%		0%	0%	0%

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending December 31st 2008

Year to Date

- For the year to date, income exceeds expenditure by £1,948k. The budgeted position is for income to exceed expenditure by £486k, hence there is a year to date favourable variance of £1462k.
- Income is higher than plan due to increases in contract income to account for changes in the High Cost Area allowance, additional A&E contract income to meet operational pressures and RTA income.
- Expenditure exceeds plan by £4063k due to additional overtime and incentive payments to meet operational performance.
- PTS is reporting a loss to date of £345k against a planned surplus of £63k. The loss arises as a result of the use of third party providers. There is a recovery plan in place to bring the service to breakeven by the end of the financial year.

Month
- In the month there is a £787k surplus against a planned surplus of £136k resulting in an favourable movement of £651k.
- The main reason for the favourable movement is due to the addition to PCT income £800k
- The forecast position for the month as at month 8 was a loss of £875k against the actual result, a surplus of £787k. This variance is made up of income (£760k increase) resulting from additional PCT income accrued, Pay (£202k decrease) primarily due to overtime being lower than forecast £181k, Non Pay £690k lower than forecast due £124k under spend in telecoms resulting from prior month adjustment of £180k partially offset by £65k spend on software cost, Other expenses £455k made up of Olympics under spend £110k and under spend in development costs.
- PTS reported a surplus of £43k.

Forecast
- The year end forecast is £912k surplus against a planned surplus of £1140k.
- The forecast for the year at month 8 was £905k surplus. Forecast income reduced by £368k while forecast pay expenditure is increased by £1219kcompared to the month 8 forecast due to increase in bonus costs £560k and increase in overtime £678 as well as £131k increase in agency staff forecast . Non pay expenditure has reduced by £1583 due to £500k subsistence write back, £270k reduction in development expenditure, £171k reduction in consultancy forecast and £450k reduction in Olympics spend as well as reduced forecast on telecoms £300k partially offset by £200k and £149 overspend in medical consumables.

Key assumptions in the forecast:

- Additional PCT funding of £5.895m.
- E&D bid funding of £8.4m.
- PTS Breakeven.
- Expenditure on yet to be approved SPPPs £500k.
- Estimated slippage against the workforce plan £50k.
- LARP deferred to 09/10.

London Ambulance Service NHS Trust
Month 9 Trust Board report - forecast data

Income Trend 2008/09

Total Operating Costs trend 2008/09

EBITDA 2008/09

Net Surplus 2008/09

EBITDA Graph M09 graph

20/01/2009
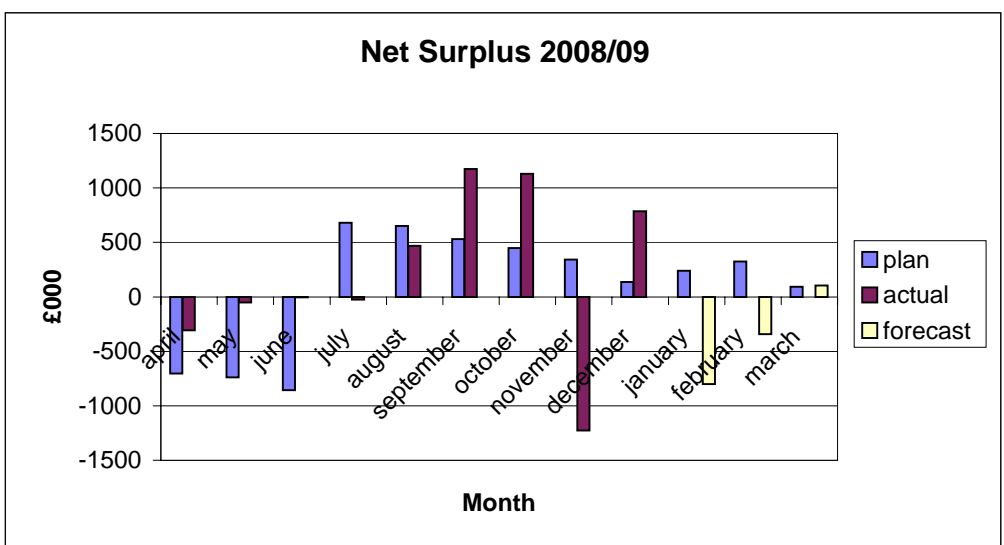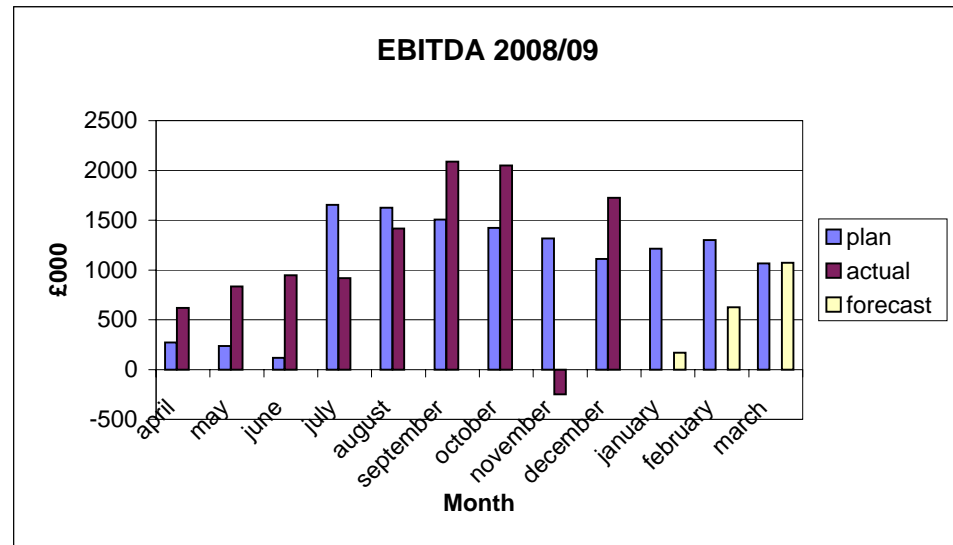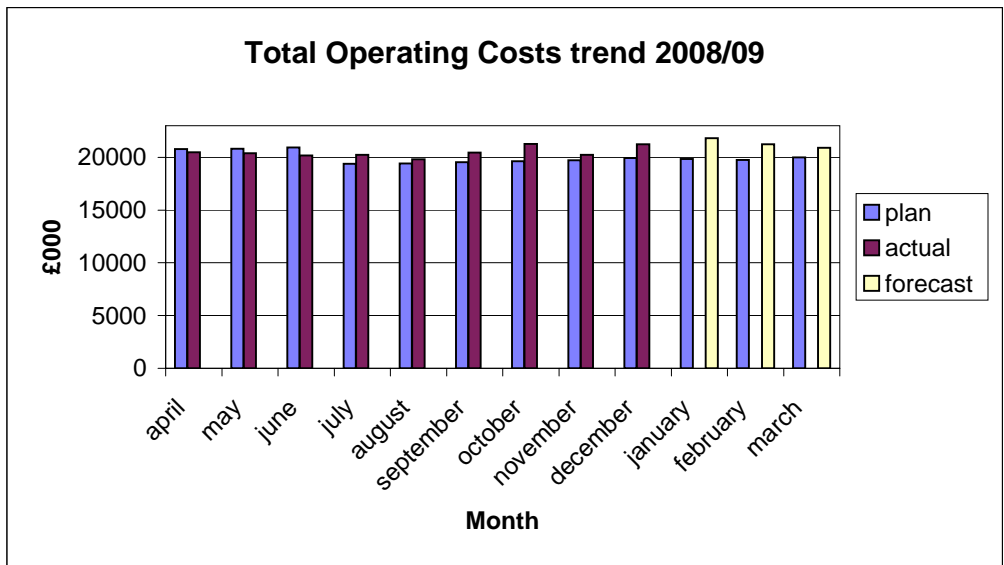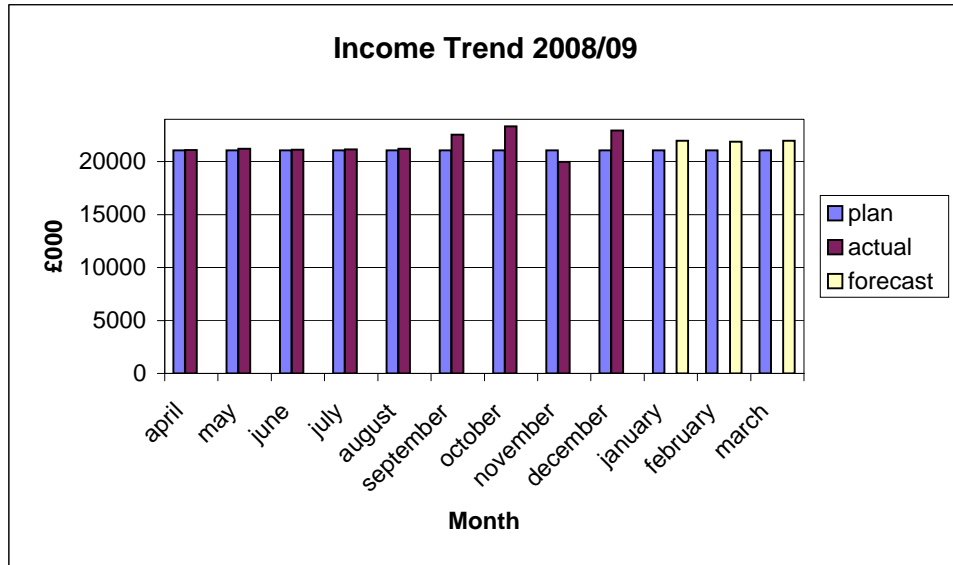
LONDON AMBULANCE SERVICE NHS TRUST

Comparison of annual forecasts at Month 9 and Month 8
As at 31 December 2008 (Month 9)

	Month 9	Month 8	Variance	
Income	260,424	260,793	(368)U	Reduction in Olympics Income £450k
Pay Expenditure				
A&E Operational Staff	109,342	108,830	511	Increase in Bonus costs of £560k based on bonus spend and estimated additional cost of attendance/activation bonus offset by £50k Workforce plan slippage
Overtime	20,512	19,834	678	Additional Overtime added in line with expected spend to year end (£678k), This is in line with Operational and EOC consumption to date and expectation to year end
A&E Management	11,982	11,950	(32)	
EOC Staff	11,597	11,715	(118)	Reduction in forecast recruitment in EOC
PTS Operational Staff	5,592	5,581	11	
PTS Management	671	698	26	
Corporate Support	31,842	31,711	131	Increase in Agency Forecast (FT Project and GDU)
Sub Total	**191,538**	**190,319**	**1,219**	
Non-Pay Expenditure				
Staff Related	3,314	3,781	(468)	£333k for New Paramedic uniform costs (due to change in price), £76k prior year adjustment, £18k Misc Staff Related decrease
Subsistence	2,154	2,029	125	Subsistence higher due to under forecast in November and higher Subs in december due to demand pressures - forecast has been increased in line with lasrt 3 months average
Training	1,435	1,556	(121)	in month lower than prev forecast. January includes fees for University Students £58k, DIQ and IM and IQ £120k, March - University Fees £96k
Drugs	381	414	(33)	fine - last 2 months is Ambulance equipment. Additional 5 Ambulance costs now included
Medical Consumables & Equipment	5,960	5,811	149	
Fuel & Oil	5,058	5,084	(26)	
Third Party Transport	1,527	1,402	125	Third party increased usage in line with December
Vehicle Costs	12,733	12,550	184	Additional 5 Ambulance costs now included in forecast plus other general cost increases
Accommodation & Estates	10,481	10,282	200	Redecoration costs £100k, New Q3 rental catch up costs (e.g. Loman street 4th floor) £50k.
Telecommunications	6,912	7,213	(302)	Data Network Spend Correction from Prev Mth (£64k) plus Correction of M08 accrual on Mobile phones £117k offset by £130k increase in Computer software spend (£65k AMPDS, £20k New Budgeting Module). Reduction in Forecast of cost of 30 MDTs (£117k)
Depreciation	7,403	7,419	(15)	
Other Expenses	6,671	8,138	(1,467)	£500k Subsistence Write back, £450k reduction in Olympics spend, £270k reduction in SPPP spend, reduction of £171k consultancy costs, £150k reduction in Legal Spend Forecast. Removal of £300k unalllocated savings (£100k still in forecast)
Profit/(Loss) on Disposal FA	52	15	67	Loss on disposal of 12 motorcycles
	64,081	65,664	(1,583)	
Financial Expenditure	**3,894**	**3,906**	**(12)**	
Total Expenditure	**259,513**	**259,888**	**(375)**	
Net	**-912**	**-905**	**-7**	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 December 2008 (Month 9)

£000s

	April	May	June	July	August	September	October	November	December	January	February	March	Total
						MONTHLY SPEND							
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	
Income	21,086	21,217	21,130	21,147	21,219	22,551	23,328	19,982	22,955	21,975	21,871	21,965	260,424
Pay Expenditure													
A&E Operational Staff	9,087	9,030	8,936	8,790	8,779	8,912	9,011	9,070	9,471	9,461	9,352	9,442	109,342
Overtime	1,910	1,994	1,897	1,647	1,566	1,620	1,739	1,601	1,712	1,679	1,572	1,574	20,512
A&E Management	970	968	973	994	977	995	1,007	998	1,052	1,025	1,011	1,011	11,982
EOC Staff	977	978	979	1,006	982	985	948	962	918	931	963	970	11,597
PTS Operational Staff	450	475	468	468	476	454	485	468	470	459	459	459	5,592
PTS Management	53	52	58	59	63	55	60	65	32	59	59	59	671
Corporate Support	2,345	2,672	2,304	2,539	2,581	2,690	2,791	2,781	2,687	2,770	2,813	2,871	31,842
Sub Total	15,791	16,169	15,616	15,503	15,423	15,710	16,041	15,946	16,342	16,383	16,229	16,385	191,538
Average Daily	526	522	521	500	498	524	517	532	527	528	580	529	525
Non-Pay Expenditure													
Staff Related	223	251	369	207	258	260	355	223	186	331	316	337	3,314
Subsistence	343	44	149	193	200	195	152	167	222	196	189	191	2,154
Training	64	1	129	54	85	65	226	10	131	314	128	228	1,435
Medical Consumables & Equipment	450	537	410	498	433	547	486	374	494	576	566	588	5,958
Drugs	37	25	9	9	49	9	47	49	26	40	40	40	381
Fuel & Oil	415	455	440	450	399	400	427	392	421	419	419	419	5,058
Third Party Transport	213	183	76	142	89	105	95	115	125	128	128	128	1,527
Vehicle Costs	1,114	1,039	943	1,083	948	1,013	1,128	1,017	1,153	1,129	1,107	1,060	12,733
Accommodation & Estates	783	807	750	928	833	874	926	938	1,052	857	889	845	10,483
Telecommunications	558	517	718	397	510	749	582	613	537	671	545	531	6,927
Depreciation	597	597	695	630	611	611	609	609	596	616	616	616	7,403
Other Expenses	476	442	585	766	576	538	813	392	473	763	688	139	6,650
Profit/(Loss) on Disposal FA	0	0	12	0	1	0	0	2	67	0	0	0	52
Sub Total	5,273	4,810	5,261	5,356	4,989	5,364	5,845	4,896	5,485	6,041	5,632	5,123	64,075
Average Daily	176	155	175	173	161	179	189	163	177	195	201	165	176
Financial Expenditure	328	289	256	313	340	302	310	368	341	351	351	351	3,900
Average Daily	11	9	9	10	11	10	10	12	11	11	13	11	11
Monthly Expenditure	21,392	21,268	21,133	21,171	20,751	21,375	22,196	21,210	22,168	22,775	22,212	21,860	259,513
Cumulative	21,392	42,660	63,793	84,965	105,716	127,092	149,288	170,498	192,666	215,441	237,653	259,513	
Monthly Net	(306)	(51)	(3)	(25)	468	1,175	1,131	(1,227)	787	(800)	(341)	105	912
Cumulative Net	(306)	(357)	(360)	(385)	82	1,258	2,389	1,162	1,948	1,148	807	912	

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 December 2008 (Month 9)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	9,471	9,201	(270)U	81,087	81,063	(24)U	(0.0%)U	109,342	108,890	(452)U
Overtime	1,712	636	(1,076)U	15,688	8,229	(7,458)U	(90.6%)U	20,512	9,772	(10,740)U
A&E Management	1,052	978	(74)U	8,934	8,781	(153)U	(1.7%)U	11,982	11,714	(268)U
EOC Staff	918	1,090	173F	8,733	9,813	1,080F	11.0%F	11,597	13,084	1,487F
PTS Operational Staff	470	434	(36)U	4,214	3,909	(305)U	(7.8%)U	5,592	5,212	(380)U
PTS Management	32	95	63F	496	855	360F	42.1%F	671	1,140	469F
Corporate Support	2,687	2,675	(13)U	23,389	23,676	287F	1.2%F	31,842	31,700	(143)U
	16,342	15,109	(1,233)U	142,541	136,327	(6,214)U	(45.9%)U	191,538	181,512	10,026
Non-Pay Expenditure										
Staff Related	186	281	95F	2,331	2,525	194F	7.7%F	3,314	3,362	49F
Subsistence	222	115	(107)U	1,577	1,035	(542)U	(52.4%)U	2,154	1,380	(774)U
Training	131	199	67F	765	1,650	885F	53.6%F	1,435	2,195	760F
Drugs	26	43	17F	261	391	130F	33.3%F	381	521	140F
Medical Consumables & Equipment	494	350	(144)U	4,230	3,143	(1,087)U	(34.6%)U	5,960	4,311	(1,649)U
Fuel & Oil	421	461	40F	3,799	3,922	123F	3.1%F	5,058	5,216	159F
Third Party Transport	125	66	(59)U	1,143	602	(541)U	(89.9%)U	1,527	793	(734)U
Vehicle Costs	1,153	977	(177)U	9,438	8,872	(566)U	(6.4%)U	12,733	11,801	(932)U
Accommodation & Estates	1,052	800	(252)U	7,889	7,169	(720)U	(10.0%)U	10,481	9,592	(890)U
Telecommunications	537	544	7F	5,179	5,152	(27)U	(0.5%)U	6,927	6,837	(89)U
Depreciation	596	652	56F	5,554	5,864	310F	5.3%F	7,403	7,819	415F
Other Expenses	477	995	518F	5,066	9,421	4,355F	46.2%F	6,656	12,264	5,608F
Profit/(Loss) on Disposal FA	67	0	(67)	52	0	(52)U		52	0	(52)U
	5,489	5,483	(6)U	47,284	49,745	2,461F	4.9%F	64,081	66,092	2,011F
Financial Expenditure	337	324	(13)U	2,840	2,920	80F	2.7%F	3,894	3,893	(1)U
Total Trust Expenditure	22,168	20,917	(1,251)U	192,666	188,992	(3,673)U	(1.9%)U	259,513	251,497	(8,015)U

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 December 2008 (Month 9)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	22,199	20,343	1,856F	187,223	183,087	4,136F	2.3%F	250,153	244,116	6,037F
Sector Services	13,497	12,017	(1,480)U	118,312	109,050	(9,263)U	(8.5%)U	157,862	145,050	(12,812)U
A&E Operational Support	1,375	1,078	(297)U	10,913	9,665	(1,248)U	(12.9%)U	15,257	12,994	(2,263)U
Control Services	1,545	1,522	(23)U	14,040	13,937	(103)U	(0.7%)U	18,500	18,472	(28)U
Planning and Specialised Ops	217	366	148F	1,652	3,296	1,644F	49.9%F	2,250	4,391	2,141F
Total Operations Cost	**16,634**	**14,983**	**(1,651)U**	**144,917**	**135,948**	**(8,970)U**	**(6.6%)U**	**193,869**	**180,907**	**(12,962)U**
A&E Gross Surplus/(Deficit)	5,564	5,360	204F	42,305	47,139	(4,834)U	(10.3%)U	56,285	63,209	(6,925)U
Gross Margin	25.1%	26.3%	0.9%F	22.6%	25.7%	-3.2%		22.5%	25.9%	-3.4%
Medical Directorate	72	87	15F	589	755	166F	21.9%F	763	1,015	252F
Service Development	33	86	52F	577	735	158F	21.5%F	741	992	251F
Communications	231	190	(41)U	1,554	1,583	29F	1.9%F	2,009	2,154	145F
Human Resources	1,659	1,672	13F	10,900	14,391	3,491F	24.3%F	16,799	19,224	2,425F
IM&T	899	1,052	152F	9,289	9,408	119F	1.3%F	12,334	12,621	286F
Finance	1,838	2,048	210F	16,198	18,974	2,776F	14.6%F	21,497	24,992	3,495F
Chief Executive	96	97	1F	904	871	(33)U	(3.8%)U	1,233	1,161	(71)U
Total Corporate	**4,828**	**5,232**	**403F**	**40,012**	**46,717**	**6,705F**	**(14.4%)U**	**55,376**	**62,158**	**6,782F**
A&E Net Surplus/(Deficit)	**736**	**129**	**607F**	**2,294**	**423**	**1,871F**	**(442.6%)U**	**909**	**1,051**	**(142)U**
A&E Net Margin	3.3%	0.6%	3.0%F	1.2%	0.2%	1.0%	431%	0.4%	0.4%	-0.1%
Patient Transport Service	**50**	**8**	**43F**	**(345)**	**63**	**(409)U**	**(647.1%)U**	**3**	**89**	**(86)U**
PTS Gross Margin	6.7%	1.1%	6.0%F	(4.7%)	1.0%	(6.4%)U		0.0%	1.0%	(1.0%)U
Trust Result *Surplus/(Deficit)*	**787**	**136**	**650F**	**1,948**	**486**	**1,462F**	**(301.0%)U**	**912**	**1,140**	**(229)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 December 2008 (Month 9)

£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	19,699	18,139	1,560F	168,897	163,252	5,645F	3.5%F	223,273	217,669	5,604F
HEMS Funding	11	11	(0)U	96	96	(0)U	(0.5%)U	127	128	(1)U
Other A&E Income	91	91	0F	818	818	1F	0.1%F	1,218	1,090	127F
Foundation Trust Income	31	16	15F	131	144	(12)U	(8.6%)U	259	242	17F
CBRN Income	917	897	19F	8,132	8,077	55F	0.7%F	10,837	10,769	68F
ECP Income	78	13	65F	211	115	97F	84.2%F	211	153	58F
BETS & SCBU Income	52	76	(24)U	470	683	(214)U	(31.3%)U	626	911	(285)U
A & E Long Distance Journey	38	37	1F	349	329	20F	6.0%F	463	439	24F
Stadia Attendance	87	89	(2)U	864	805	59F	7.4%F	1,153	1,074	79F
Heathrow BAA Contract	44	44	0F	399	399	(0)U	(0.0%)U	532	532	(0)U
Resus Training Fees	10	10	0F	47	89	(41)U	(46.6%)U	73	118	(45)U
Education & Training Income	1,243	686	557F	4,980	6,173	(1,193)U	(19.3%)U	8,818	8,231	587F
	22,301	**20,109**	**2,193**	**185,394**	**180,979**	**4,415F**	**(4.5%)U**	**247,590**	**241,355**	**6,235F**
PTS Income	756	710	46F	7,340	6,391	949F	14.9%F	10,155	8,471	1,684F
									0	
Other Income	103	234	(337)U	1,879	2,108	(229)U	(10.9%)U	2,679	2,811	(132)U
Trust Result	**22,955**	**21,053**	**1,901F**	**194,614**	**189,478**	**5,136**	**(0.5%)U**	**260,424**	**252,638**	**7,787F**

LONDON AMBULANCE SERVICE NHS TRUST
CIP Monitoring Schedule 2008/09
As at 31st December 2008 (Month 9)

CIP Programme	Dept	Expense type	Target CIP to Month 9 £000	Actual CIP to month 9 £000	Variance to month 8 £000	Target CIP Full Year £000	Forecast CIP Full Year £000	Variance Full Year £000
A&E Productivity	Deputy Director Of Operations	Paramedic	3,506	3,506	(0)	4,578	4,578	(0)
Control Services Productivity	Urgent Care Services (Control)	Paramedic	363	363	0	484	484	0
Corporate Support Efficiency	Corporate Support	Support Staff	344	200	(144)	432	261	(171)
Non Pay - Facilities	All	Facilities	273	243	(30)	364	319	(45)
Non Pay - Fleet & Logistics	Fleet & Logistics	Fleet & Logistics	254	123	(130)	338	180	(158)
Non Pay - IM&T	IM&T	Technology	39	31	(8)	52	41	(11)
Non Pay - Other	Corporate Support	Other	305	210	(95)	407	293	(113)
Non Pay - Professional Services	Corporate Support	Consultancy	237	208	(28)	316	275	(41)
PTS efficiency	Centrally Held Funds	Efficiency Savings	185	0	(185)	247	0	(247)
			5,505	**4,884**	**(621)**	**7,217**	**6,430**	**(786)**

● To month 9 the Trust made a £4.884m CIP against a target for those programmes of £5.505m. This table shows the position against the original CIP programmes and does not include areas where savings may have been realised but which are outside these listed CIP programmes. The forecast for the year indicates there will be a shortfall of £786k against the target or 11%.

● The main reasons for the shortfall against target are:
   1. Efficiencies in Corporate Support staff have not been realised in part due to vacancies not being realised or staff restructures being delayed.
   2. Planned reductions in non pay, especially in fleet have not been realised due to operational pressures.
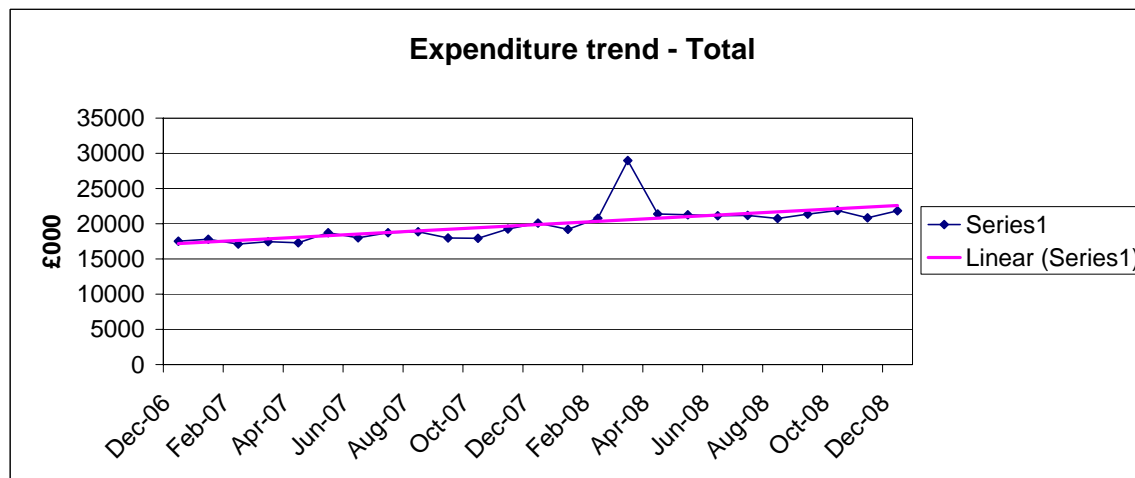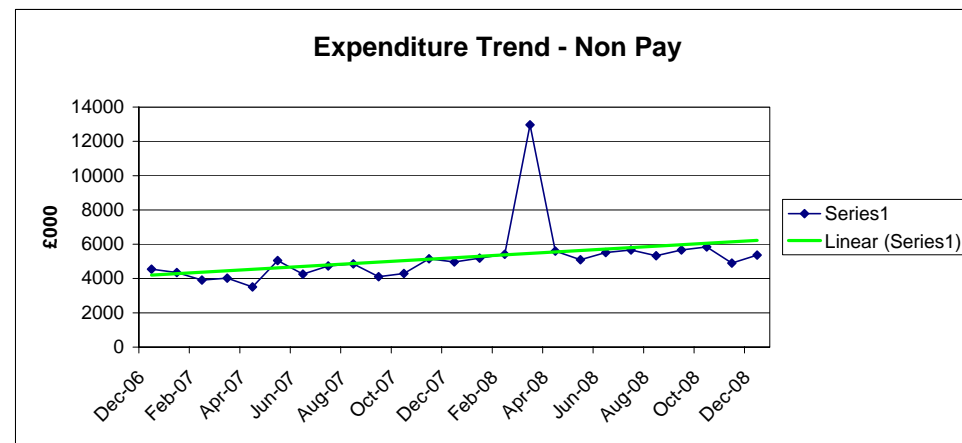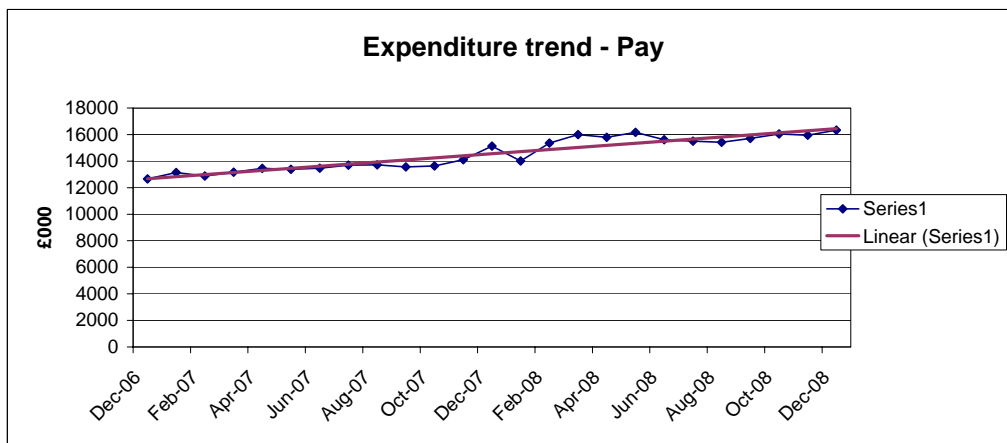
LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
As at 31 December 2008 (Month 9)

	December	January	February	March	April	May	June	July	August	September	October	November	December
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**19,154**	**20,068**	**19,641**	**25,743**	**21,086**	**21,218**	**21,128**	**21,147**	**21,219**	**22,551**	**23,328**	**19,982**	**22,955**
Pay Expenditure													
A&E Operational Staff	9,149	8,227	8,468	8,677	9,087	9,030	8,936	8,790	8,779	8,912	9,011	9,070	9,471
Overtime	1,245	1,168	1,118	1,764	1,910	1,994	1,897	1,647	1,566	1,620	1,739	1,601	1,712
A&E Management	968	940	1,055	939	970	968	973	994	977	995	1,007	998	1,052
EOC Staff	985	954	953	946	977	978	979	1,006	982	985	948	962	918
PTS Operational Staff	487	462	466	459	450	475	468	468	476	454	485	468	470
PTS Management	59	57	56	60	53	52	58	59	63	55	60	65	32
Corporate Support	2,239	2,199	3,242	3,154	2,345	2,672	2,304	2,539	2,581	2,690	2,791	2,781	2,687
Sub Total	**15,132**	**14,007**	**15,357**	**15,999**	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**	**15,946**	**16,342**
Average Daily	*488*	*452*	*495*	*533*	*509*	*539*	*504*	*500*	*514*	*507*	*535*	*514*	*527*
Non-Pay Expenditure													
Staff Related	189	271	231	386	223	251	369	207	258	260	355	223	186
Subsistence	188	244	190	209	343	44	149	193	200	195	152	167	222
Training	30	119	123	258	64	1	129	54	85	65	226	10	131
Drugs	36	22	46	28	37	25	9	9	49	9	47	49	26
Medical Consumables & Equipment	396	510	533	1,814	450	537	410	499	433	547	486	374	494
Fuel & Oil	405	406	391	417	415	455	440	450	399	400	427	392	421
Third Party Transport	84	133	161	173	213	183	76	142	89	105	95	115	125
Vehicle Costs	1,681	1,091	1,034	2,895	1,114	1,039	943	1,083	948	1,013	1,128	1,017	1,153
Accommodation & Estates	543	922	832	1,702	783	807	750	927	833	874	926	938	1,052
Telecommunications	516	477	677	2,129	558	517	718	397	510	749	582	613	537
Depreciation	542	524	524	706	597	597	695	630	611	611	609	609	596
Other Expenses	109	214	425	2,051	476	442	585	766	574	540	813	394	477
Profit/(Loss) on Disposal FA	0	0	0	29	0	0	12	0	1	0	0	2	67
Sub Total	**4,719**	**4,932**	**5,167**	**12,797**	**5,273**	**4,810**	**5,261**	**5,356**	**4,987**	**5,366**	**5,845**	**4,897**	**5,489**
Average Daily	*152*	*159*	*167*	*427*	*170*	*160*	*170*	*173*	*166*	*173*	*195*	*158*	*177*
Financial Expenditure	**244**	**260**	**246**	**170**	**328**	**289**	**256**	**313**	**342**	**299**	**310**	**366**	**337**
Average Daily	*8*	*8*	*8*	*6*	*11*	*10*	*8*	*10*	*11*	*10*	*10*	*12*	*11*
Monthly	**20,096**	**19,199**	**20,770**	**28,966**	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**	**21,210**	**22,168**

I&E Run rates including last year M9Sheet1

20/01/2009

Expenditure trend - Pay

Expenditure Trend - Non Pay

Expenditure trend - Total

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 December 2008 (Month 9)

	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	
EBITDA after exceptionals	619	836	936	918	1,417	2,082	2,050	(254)	1,787	135	576	1,157	12,259
Excluding Non cash I&E items	(18)	(20)	(21)	0	0	0	0	0	0	0	0	0	(59)
Movement in working capital													
Stocks & Work in Progress	4	(1)	0	(7)	6	5	(3)	1	3	0	0	0	8
NHS Trade Debtors	807	(373)	(523)	(9,894)	5,048	2,795	(976)	1,071	(2,206)	3,267	497	293	(194)
Long Term Debtors	(18)	(17)	52	(45)	(23)	56	(111)	(13)	(4)	0	0	0	(123)
Non NHS Trade Debtors	(46)	(105)	37	102	(7)	4	30	(10)	(17)	(25)	(10)	(16)	(63)
Other Debtors	49	(190)	126	51	(90)	259	(153)	106	(20)	0	0	0	138
Accrued Income	(1,870)	(1,911)	(1,648)	3,210	(1,294)	(1,360)	(4,890)	519	706	239	(107)	6,053	(2,353)
Prepayments	177	726	(295)	383	736	149	4	223	(901)	434	434	434	2,504
Trade Creditors	(3,079)	1,319	(621)	(1,879)	(94)	(592)	1,390	415	(1,672)	243	(760)	(1,116)	(6,446)
Other Creditors	4,990	(14)	255	415	(902)	(596)	(231)	(86)	469	(3)	(78)	(884)	3,335
Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Accruals	1,527	(231)	(319)	(207)	285	(382)	(29)	517	(88)	(100)	(150)	(250)	573
Deferred Income	41	361	32	5,019	(858)	(2,093)	739	256	(375)	(833)	(681)	(681)	927
Provisions & Liabilities	(57)	(19)	(257)	(20)	88	28	(213)	32	29	(310)	(198)	(198)	(1,095)
Net Cashflow from operating activities	2,525	(455)	(3,161)	(2,872)	2,895	(1,727)	(4,443)	3,031	(4,076)	2,912	(1,053)	3,635	(2,789)
Returns on Investments & Servicing of Finance													
Interest received	54	92	125	68	39	82	71	15	44	30	30	30	680
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from returns on investments & servicing of finance	54	92	125	68	39	82	71	15	44	30	30	30	680
Capital Expenditure													
Tangible fixed assets acquired	(2,981)	(46)	(456)	(787)	(386)	(511)	(741)	(767)	(1,154)	(1,521)	(4,675)	(3,155)	(17,180)
Tangible fixed assets disposed	3,900	0	0	0	0	0	0	0	0	0	0	1,000	4,900
Other	0	0	12	0	1	0	0	2	(67)	0	0	0	(52)
Net Cashflow from capital expenditure	919	(46)	(444)	(787)	(385)	(511)	(741)	(765)	(1,221)	(1,521)	(4,675)	(2,155)	(12,332)
PDC Dividends paid	0	0	0	0	0	(2,206)	0	0	(1)	0	0	(2,207)	(4,414)
Net Cashflow before financing	4,099	407	(2,565)	(2,673)	3,966	(2,280)	(3,063)	2,027	(3,467)	1,556	(5,122)	460	(6,655)
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	1,035	1,035
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow inflow/(outflow) from financing	0	0	0	0	0	0	0	0	0	0	0	1,035	1,035
Increase/(decrease) in cash	4,099	407	(2,565)	(2,673)	3,966	(2,280)	(3,063)	2,027	(3,467)	1,556	(5,122)	1,495	(5,620)
Closing cash balance	13,064	13,471	10,906	8,233	12,199	9,919	6,856	8,883	5,416	6,972	1,850	3,345	3,345

LONDON AMBULANCE SERVICE NHS Trust

Forecast Balance Sheet
For the Month Ending 31 December 2008 (Month 9)

	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	
Intangible assets	3,765	4,511	4,523	3,784	3,854	3,797	3,790	4,016	4,043	4,530	4,530	4,530	4,530	
Tangible assets	119,652	123,612	123,179	123,607	124,108	123,640	123,778	123,755	124,225	124,654	128,712	131,250	132,028	
	123,417	128,123	127,702	127,391	127,962	127,437	127,568	127,771	128,268	129,184	133,242	135,780	136,558	
Current Assets														
Stocks & WIP	1,930	1,934	1,933	1,933	1,926	1,932	1,937	1,934	1,935	1,938	1,938	1,938	1,938	Trade Debtors
NHS Trade Debtors	1,628	821	1,194	1,717	11,611	6,563	3,768	4,744	3,673	5,879	2,612	2,115	1,822	A&E £-3.5k > 60 days (-0.06%), Nov - £-46k > 60 days (-1.25%)
Non NHS Trade Debtors	93	139	244	207	105	112	108	78	88	105	130	140	156	PTS £442k > 60 days (7.51%), Nov - £611k > 60 days (16.52%)
Other Debtors	4,337	388	578	452	401	491	232	385	279	299	299	299	299	
Accrued Income	247	2,117	4,028	5,676	2,466	3,760	5,120	10,010	9,491	8,785	8,546	8,653	2,600	
Prepayments	5,237	5,060	4,334	4,629	4,246	3,510	3,361	3,357	3,134	4,035	3,601	3,167	2,733	
Investments	0	14,000	11,000	10,000	9,000	11,100	9,500	0	0	0	0	0	0	
Cash at Bank and in Hand	8,965	(936)	2,471	906	(767)	1,099	419	6,856	8,883	5,416	6,972	1,850	3,345	
Total Current Assets	22,437	23,523	25,782	25,520	28,988	28,567	24,445	27,364	27,483	26,457	24,098	18,162	12,893	
Creditors: Amounts falling due within one year														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Trade Creditors	11,660	8,581	9,900	9,279	7,400	7,306	6,714	8,104	8,519	6,847	7,090	6,330	5,214	NHS PSPP - This month (95%), Nov (100%), Ytd (86%)
Other Creditors	1,772	7,066	7,145	7,275	7,663	6,974	6,437	6,505	6,590	7,643	7,653	7,588	6,717	Non NHS PSPP - This month (88%), Nov (90%), Ytd (84%)
PDC Dividend Creditor	0	368	736	1,104	1,472	1,840	0	368	736	1,103	1,471	1,839	0	
Capital Creditors	2,756	104	153	219	659	168	365	144	338	132	3,286	1,766	1,006	
Accruals	618	2,145	1,914	1,595	1,388	1,673	1,291	1,262	1,779	1,691	1,591	1,441	1,191	
Deferred Income	152	193	554	586	5,605	4,747	2,654	3,393	3,649	3,274	2,441	1,760	1,079	
Total Current Liabilities	16,958	18,457	20,402	20,058	24,187	22,708	17,461	19,776	21,611	20,690	23,532	20,724	15,207	
Net Current Assets	5,479	5,066	5,380	5,462	4,801	5,859	6,984	7,588	5,872	5,767	566	(2,562)	(2,314)	
Long Term Debtors	9,875	9,893	9,910	9,858	9,903	9,926	9,870	9,981	9,994	9,998	9,998	9,998	9,998	
Total Assets less current liabilities	138,771	143,082	142,992	142,711	142,666	143,222	144,422	145,340	144,134	144,949	143,806	143,216	144,242	
Creditors: Amounts falling due after more than one year														
Provisions for Liabilities & Charges	18,589	18,532	18,513	18,256	18,236	18,324	18,352	18,139	18,158	18,187	17,877	17,679	17,481	
Total Assets Employed	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	125,976	126,762	125,929	125,537	126,761	
Taxpayers' Equity														
Public Dividend Capital	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	57,523	
Revaluation Reserve	50,605	55,297	55,297	55,294	55,294	55,294	55,280	55,280	55,280	55,276	55,276	55,276	55,276	
Donated Asset Reserve	68	50	30	9	9	9	9	9	9	9	9	9	9	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Income & Expenditure Reserve	13,440	13,134	13,083	13,083	13,058	13,526	14,712	15,843	14,618	15,408	14,575	14,183	14,372	
Total Taxpayers' Equity	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	125,976	126,762	125,929	125,537	126,761	

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 27th January 2009

Report of the Medical Director

Standards for Better Health

1.   First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

No new Serious Untoward Incidents have been declared since my last report in November. Action plans for all previous SUIs are up to date with no actions outstanding.

We have been liaising with East London Foundation Trust (previously East London Mental Health Trust) following their declaration of a Serious Untoward Incident involving a patient under their care who had become unwell while taking clozapine. This drug had previously been implicated in a Serious Untoward Incident investigated by both Trusts, and the local PCT in 2003. We have reviewed the recommendations made following that investigation and implemented further changes within the Control Rooms which include ensuring that up to date drug information is available.

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.

Fifteen alerts were received from 30th October 2008 to 6th January 2009. All alerts were acknowledged; two required action which has now been completed for both alerts.

Update on Safeguarding Children and Vulnerable Adults

A report is provided under a separate agenda item.

Policy and Procedure for the Management of Frequent Callers

This policy and procedure has been produced to ensure that an appropriate care strategy is adopted by the Trust when responding to frequent caller service users.

Its objectives are:-

1) To achieve an appropriate care pathway for frequent service users, where the deployment of an emergency ambulance may not be the most appropriate response.

2) To create local multi-disciplinary network forums in partnership with local authority Social Services departments, Primary Care, Mental Health and Acute Trusts and other agencies towards resolving the issues presented by this patient community.

The policy and procedure was approved by the Clinical Governance Committee on 12 November 2008 and the Trust Board is requested to ratify this decision.

Policy for Pre-Hospital Blood-Taking

This policy has been produced to establish the training and assessment for paramedics working for the London Ambulance Service NHS Trust (LAS) in the management of patients requiring the taking of Pre Hospital Bloods (PHB).

It aims to ensure that:-

1) All patients who require the taking of PHB have the procedure performed by a practitioner competent in this skill.
2) Training of all staff in PHB will take place within the approved guidelines and standards for the Trust.
3) A standard level of competency and training, based on adequate knowledge, supervised practice and assessment, is established throughout the service.

The policy was approved by the Clinical Governance Committee on 12 November 2008 and the Trust Board is requested to ratify this decision.

Health, Safety & Risk Management Training and Provision of H&S Information Policy

This policy outlines the London Ambulance Service NHS Trust approach to identify the risk management training requirements for all permanent staff and production of the annual training needs analysis.

It aims to ensure the effective development of staff, through constructive health, safety and risk management training to enhance performance of individuals and thereby improve the performance and efficiency of the Trust.

The policy was approved by the Clinical Governance Committee on 12th November 2008 and the Trust Board is requested to ratify this decision.

2.   Second domain – Clinical and Cost Effectiveness

Clinical Update Newsletter

The November edition (issue 14) covers issues arising around the Recognition of Life Extinct procedure (ROLE), advanced decisions, and reminders to staff about London Street Rescue, an initiative to identify and help isolated rough sleepers. It also emphasises the importance of monitoring patients who have symptoms suggestive of an acute coronary syndrome and the pitfalls of managing intoxicated patients. It introduces the concept of continuous positive airway pressure (CPAP) in the management of patients with acute left ventricular failure. These patients are currently treated with the drug furosemide, but evidence from the acute sector and from EMS in the USA suggests that CPAP may be a superior form of treatment.

The potential problem of 'Aide Memoire' cards produced in house by LAS staff is highlighted; staff are reminded of the potential pitfalls of unauthorised documentation and asked to share any such initiatives with the Medical Directorate so the accuracy can be checked.

This edition contains the 'ECG of the Month' and an explanation of the previous month's trace.

Copies of this bulletin will be available at the meeting.

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

Appendix 1 provides summary information on management of STEMI patients by LAS staff in the year 2007 -2008. This report was circulated to staff earlier this month and highlights the increase in the number of STEMIs along with a number of action points.

3.   Third Domain – Governance

Clinical Support Desk – update from December 2008

A total of 1084 entries were logged during the month, a significant increase on September. This includes a sharp rise in the number of calls from A&E Support crews, generally requesting clinical advice, but also represents a significant rise in the amount of work being done on patient specific information. The latter is often under-recorded, as a pile of 60 palliative care records may be dealt with as a single log entry. While most of these require only indexing and filing, some (especially the paediatric forms) require extensive work.

The team has been much more pro-active at ringing calls back, especially during the busy periods of mid December and New Year's Eve. Considering the calls that have been rung back and the cases where A&E support crews being deemed safe to leave a patient without further on scene assessment, the team has saved 122 journeys.

Recruitment has again been disappointing, with only four applicants, three of whom were short listed. Only one of those passed the assessment centre and is currently awaiting OHD clearance in view of a pre-existing injury. A further advert attracted three applicants, two of whom will be attending an assessment centre in January. A total of 15 Team Leaders are now trained to work on the desk, but are currently unable to provide the cover hoped for due to operational pressures.

Examples of work:

The team played a major role in dealing with more than 80 child protection / vulnerable adult forms over the holiday period. Some of these were urgent, and it remains a concern that these were not being dealt with in a timely manner by EOC staff. As highlighted in the report on Safeguarding Children and Vulnerable Adults the LAS is open to criticism from Social Services departments should delays occur in processing these referrals.

Eight calls were referred on to the on call Medical Directorate representative for further advice. Seven shifts went uncovered, with EOC staff contacting the on-call clinician direct.

Looking Forward:

It is obvious from the workload that the desk continues to have a significant impact on patient care. The team is doing more in just about every field. Two members of staff will be moving on, one to the Medical Directorate in February, and one to become an ECP, starting her training in September.

Continued recruitment, both of full time seconded staff and another small group of staff willing to work ad – hoc shifts, is needed to avoid having to close the desk, and to enable staff to have adequate breaks, a current cause for concern. Where the desk is staffed for both shifts, an additional late shift can be staffed to ease pressure around meal breaks and handover periods.

Appendix 2 provides details of the call volume and types.

4.   Fourth Domain – Patient Focus

Clinical Developments in the Control Rooms

Governance arrangements for Clinical Telephone Advice (CTA):
A quality assurance process for calls made outside of PSIAM by Clinical Reviewers in CTA was introduced on the 22nd December 2008. 2% of calls will be reviewed initially but hope is to increase this to 5%. This process was signed off by Dr Fenella Wrigley and has received a warm welcome by CTA staff themselves. Dr Wrigley has indicated that she will work with QA to review a number of these calls to ensure the new process is working or whether it needs some refinement and this offer has been gratefully received by UOC management. Huge efforts have been made by Quality Assurance to increase the number of CTA calls that are reviewed and this work will continue.

UOC Project Group:
An UOC project group has been convened to implement a phased development and improvement plan for UOC with a robust clinical governance structure. It has been recognised that the performance of UOC as a unit contributes significantly to the overall performance of London Ambulance Service performance. It has been identified that improvements in working practices and processes across UOC can be made but that clinical safety and improved patient care are paramount in these developments. UOC has had difficulty in assessing performance however by implementing transparency in UOC performance both as a unit and individually it will allow the recognition and validation of excellence and the correction of under performance.

Providing updated clinical advice:
Additional clinical guidelines have been written focussing on current clinical issues i.e. Norovirus and Influenza to provide the CTA team with more knowledge and guidance where alternative pathways are being suggested. These have also been made available to front-line staff through the Clinical Support Desk. A pathway is being developed to be used for normal labour in maternity cases to encourage utilisation of other modes of transport.

Doctors in Control Room

The trial period for Doctors in Control Room has begun. The purpose of this trial is to assess the effectiveness of employing doctors in EOC to:

> ➢ Improve patient care by reviewing the most appropriate care pathway in parallel with the dispatch process
> ➢ Reduce clinical risk at times of heightened demand for ambulance services,
> ➢ Rigorously assess whether a doctor's intervention on some calls can reduce inappropriate sending of an ambulance and thus improve response performance.

During the trial period the doctors will be asked to work every Monday (12 noon to 8 pm), Friday (4 pm to 12 midnight), and Saturday (4 pm to 12 midnight). In addition to the regular days identified above, 'Camidoc' doctors will also be required for work on public holidays.

There was an initial delay whilst recruitment and rostering, liability and Clinical Governance issues were agreed between London Ambulance Service and Camidoc. Although the recruitment is being undertaken by Camidoc the essential person specification criteria are checked by LAS. During December two open evenings were held to inform interested GPs about the proposed project and answer any questions. Interested GPs undertake a four hour CTAK training session prior to commencing any shifts in the control room Over the Christmas period a GP undertook three sessions in EOC; Saturday 20th December [16-00 till 23-59], Monday 22nd December [12-00 till 16-00] and Wednesday 31st December [12-00 till 16-00], a total of 16 hours. During this time 58 callers were rung back and although the intervention had less impact than hoped for on ambulance dispatch principally it was noticeable that during these sessions the volumes of calls was low particularly *AMBER* calls where an alternative care pathway would be deemed clinically safe. The exercise did produce clear benefits in terms of improvement to clinical governance (e.g. advice to patients about taking prescription medicines in combination with other medication, maternity advice) and curtailing multiple ring-backs from patients by providing reassurance during the waiting period before the ambulance arrived. Since Christmas an additional 7 doctors have been trained in CTAK and 4 are currently working within the control room. A review of each shift is undertaken by LAS to identify any immediate problems. An interim audit of outcomes will be undertaken after one month and then a full review on completion of the trial period.

5. Fifth Domain – Accessible and Responsive Care

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

6. Sixth Domain – Care Environment and Amenities

Infection Control

The post of Infection Control Co-ordinator has now been filled on a part time basis by an Ambulance Operations Manager with a background in nursing. He is taking forward a number of initiatives, including working with the National Ambulance Infection Prevention and Control Group.

An agenda item dealing with registering the Trust with the Care Quality Commission in relation to Health Care Associated Infections is presented under a separate agenda item. This refers to the requirement to complete an online application form stating that the Trust complies with the overall healthcare associated infections regulations and meets the nine hygiene code criteria. The forms will require electronic sign-off by the Chief Executive, certifying that the forms have been considered by, and have the approval of, the Trust's Board.

7. Seventh Domain – Public Health

Nothing further to report.

Recommendation

That the Board notes the report

Fionna Moore
Medical Director
16th January 2009

Appendix 1

<p style="text-align:center">Clinical Audit & Research Summary Report for the Trust Board</p>

<p style="text-align:center">Summary of the ST Elevation Myocardial Infarction Annual Report: 2007/08</p>

Authors: Andy Stainthorpe, Gurkamal Virdi & Yvette Thomas, Clinical Audit & Research Unit.
_____

Introduction

This report provides summary information on management of STEMI patients by LAS staff. Between April 2007 and March 2008 the LAS treated 1497 (808)* ST-elevation myocardial infarction (STEMI) patients. This is a considerable increase over 2006/07 (808). Information for each of these patients was collected by the Clinical Audit & Research Unit (CARU) from Patient Report Forms (PRFs), Mobile Data Terminals and Emergency Operations Centre records. Where possible, outcomes for patient were obtained from hospital records and national databases.

Key findings from the 2007/08 STEMI Annual Report are presented below. Further information can be found in the full report available on the LAS server and web pages.

Key Findings

Patient details

The average age of the patient diagnosed with STEMI was 62 years with an age range of 11 – 104 years. The majority of patients were male 76%. Male patient were on average 14 years younger than females, 59 vs. 73 years respectively.

Response times

Of STEMI patients, 77% were attended within the 8 minute target, a decrease of 1% from 2006/07. The Table below provides information on response times. It is noteworthy that call connect adds 2 minutes to the recorded response time for STEMI patients.

Time Interval	Average time in minutes	Range of times in minutes
999 call – arrival on-scene (ORCON)	7	1- 95
999 call – arrival on-scene (Call Connect)	9	2- 96
Arrival on scene – leave scene	32	1 - 107

The average time spent on scene has increased progressively over the years:
25 minutes in 2004/05; 27 minutes in 2005/06; 30 minutes in 2006/07; and 32 in 2007/08.

Pain assessment

Initial, pre-treatment, pain assessment was recorded on 93% of PRFs. Final, post treatment, pain assessment was recorded for 86% of patients.

Aspirin

LAS crews administered aspirin to 84% n=1252 of STEMI patients. A further 12% n=177 were not eligible to receive aspirin, 4% having already taken aspirin prior to LAS arrival and it being contraindicated for 8%.

Therefore, 4% of STEMI patients who might have received aspirin were not recorded on the PRF as having received it.

GTN

GTN was administered to 1110 patients (74%). A further of 366 patients (25%) were not eligible to receive GTN; in 247 (17%) it was contraindicated and in 110 (7%) it had already been administered prior to the arrival of the crew.

Conveyance Destination

The majority of STEMI patients, 1280 (86%) were taken directly to a Heart Attack Centre (Cardiac Catheter Lab) which is a considerable increase over last year. A further 3% were appropriately transported directly to A&E instead. However, 123 patients (8%) were taken to A&E when, the PRF documentation indicated they should have been taken to a Heart Attack Centre.   This indicates that the LAS policy for direct transfer of all STEMI patients to a Cardiac Catheter Lab is being followed against a backdrop of increasing numbers of STEMI patients.

Conveyance Response Times

When patients were taken directly to a Cardiac Catheter Lab the journey times were, on average, only 2 minutes longer than the journey times to A&E.

	Number of patients^	Average Time (minutes)	Range (minutes)
999 call – arrival at Cardiac Cath Lab	1278	55	23 - 157
999 call – arrival at A&E (call to door)	170	53	24 – 166

^ *Number of patients with both times available.*

Reperfusion

Of the 344 STEMI patients where hospital treatment data is known, 250 (73%) received primary angioplasty. The average time from the 999 call to receiving angioplasty was 98 minutes, 45 minutes of which were attributable to the hospital.

Six STEMI patients received thrombolytic treatment. The National Service Framework for Coronary Heart Disease states that thrombolysis should be given within 60 minutes of the call for professional help. Two patients received thrombolysis within the 60 minute target. The average time from 999 call to receiving thrombolysis was 100 minutes.

Patient Outcome

Patient outcome data was available for 411 patients, of which 395 (94%) were discharged alive. The average length of hospital stay for patients who survived to discharge was five days.

Points for Action

Staff should be encouraged to facilitate data collection and the reporting of clinical care by:

- Recording both pre- and post-treatment pain assessments, using numerical scores wherever possible.
- Ensuring that all eligible patients are taken directly to a cardiac cath lab or that a valid reason for conveyance to A&E is clearly documented on the PRF.
- Correctly documenting the destination hospital name, code and ward to allow accurate identification of patients directly transported to cardiac cath labs.
- Using illness code 87 for all patients with an MI confirmed by 12-lead ECG.
- Submitting a copy of all 12-lead ECGs to the Clinical Audit & Research Unit (with requests for clinical feedback if desired

Appendix 2

Data from Clinical Support Desk – December 2008

Workload
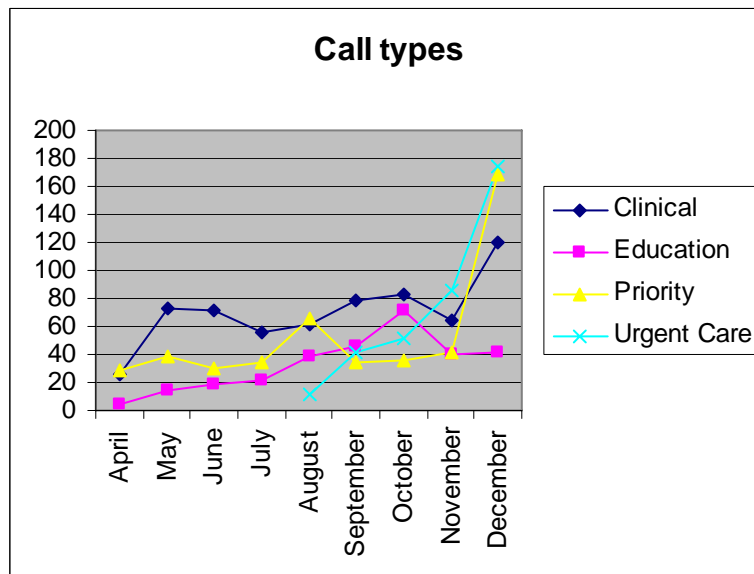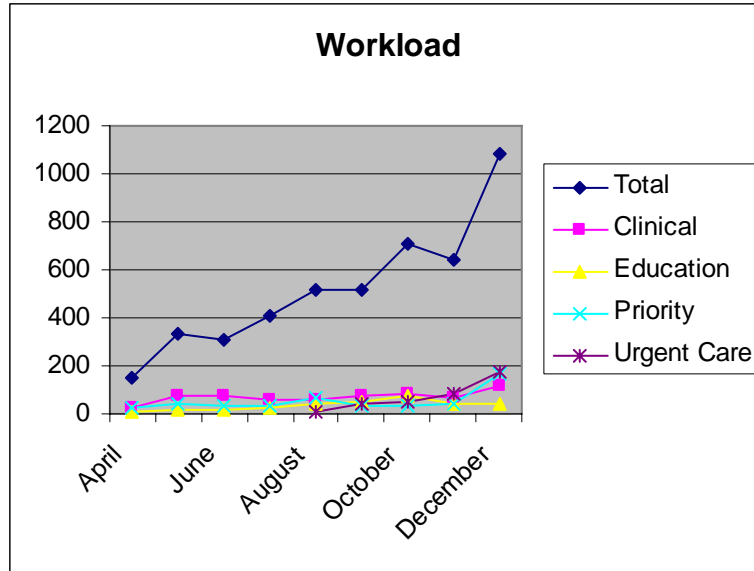
London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Business Plan 2009/10 submission to NHS London

1. **Sponsoring Director:**   Michael Dinan

2. **Purpose:**   *To approve the submission of the Business Plan 2009/10 to NHS London*

3. **Summary:**   *Attached is the Business Plan Commentary submitted to the London Provider Agency (LPA) on 19*th *Jan, 2008.*

   The commentary is in the format prescribed by NHS London.

   I will provide a more detailed presentation at the Trust Board on the numbers provided.

   For 2009/10, the plan shows :
   - *Revenue increasing from £260m to £287m largely driven by a planned increase in PCT income*
   - *Operating Expense increasing from £248m to £267m*
   - *Resulting EBITDA increasing from £12m to £20m. £5m of this increase is caused by a change in accounting policy (IFRS) which has resulted in a decrease in vehicle leasing costs and a corresponding increase in depreciation below the EBITDA line.*
   - *Net surplus is planned to increase to £1.9m from £1m in 2008/09.*

   Also attached is the required LPA Board self certification form which has not yet been submitted.

   *LAS senior management will review this plan on the 5*th *Feb 2009, with a second submission planned to the LPA before 20*th *Feb, 2009*

   A final detailed budget will be submitted to the SDC in Feb with a final planned approval planned for the Trust Board in March 2009.

4. **Recommendation:**   *THAT the Trust Board approve the submission of the current plan to the LPA*

NHS London

Provider Management Regime

Annual Plan 2009/10
Commentary

Trust details

Trust name
London Ambulance Service NHS Trust
Key contact at trust (name, contact details)
michael.dinan@lond-amb.nhs.uk
Annual plan date
18 January, 2008

1. Past year performance

    1.1. Chief executive's summary of the year

    1.2. Summary of financial performance

    1.3. Other major performance issues

2. Future business plans

    2.1. Strategic overview

    2.2. Achievement of FT status

    2.3. Service and workforce development plans

    2.4. Other revenue

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3. Risk analysis

    3.1. Financial risk

    3.2. Governance risk

    3.3. Risk to services provided

    3.4. Quality and safety risk

    3.5. Other risks

4. Declarations and self-certifications

    4.1. Board statements

1. Past year performance

1.1. Chief executive's summary of the year

Chief executive's summary of the year

The LAS has continued to provide better clinical care to more Londoners than ever before while maintaining financial balance.

Despite a 3% growth in activity and challenges resulting from excessive hospital delays, the LAS is forecasting to hit both Cat A targets. Excessive ambulance utilisation (74% in Dec) will result in a CatB result of 85%, below the commissioned 90%.

1.1   Review of 2008/09 - achievement against the Service Plan

The 2009/09 Service Plan was focused on delivery of two aspirations for the London Ambulance Service:

- To improve the delivery and outcomes of services for our patients and the public;

- To ensure that change is sustainable through investment in Organisational Development.

These aspirations informed the key objectives for the Senior Management Team and definition of the five component parts of the overall Service Improvement Programme (SIP2012) through which the Strategic Plan is being implemented .

The remainder of this section reviews achievement against key objectives for 2008/09.

- It should be noted that the measurement of the National Response time targets changed significantly in 2008/09 with all responses now measured from the time at which the 999 call was received. This has required an improvement of over two minutes a response in order to maintain the targets at 2007/08 levels.

- A major transformational programme was put in place to enhance the Trusts Operational Response regime in order to meet the 'Call Connect' challenge.

1.   **Response time targets**

High levels of demand continued in 2008/09 with significant peaks being experienced over the third quarter.

Forecast Performance against the main response time targets for 2008/09 year to date is:

	Response Time Target	Forecast As At: 14/01/08
Connect A8	75% in 8 minutes of telephone operator call connect to control room	74.5%
Current A19	95% in 19 minutes of address & key determinant	98.0%
Connect B19	95% in 19 minutes of telephone operator call connect to control room	85.0%

Performance has proved challenging for three primary reasons

1. 1 Staffing

A delay in agreeing the 2008/09 A&E agreement delayed the significant recruitment required to hit the commissioned targets. For most of 2008/09, the LAS was carrying frontline vacancies in excess of 200 per month. This coupled with staff reluctance to work overtime in the quantities previously worked resulted in a shortfall of operating staff. In the summer of 2008, the LAS developed an extensive recruitment and training plan to achieve full establishment as soon as possible. Unfortunately, the lead time required to recruit and train a student paramedic is considerable (c. 5 months training following recruitment). An innovative system of overtime incentives was developed and introduced. This has largely been able to mitigate some of the shortfall in staffing within the year.

1.2 Hospital Delays

Hospital pressures have been profound in 2008/09 with particular challenges from August 2008. Daily delays have been occuring across multiple hospitals. These severely damage the ability of the LAS to hit the core targets. The LAS has calculated the impact of the Ambulance Hours lost to hospital delays in excess of 40 minutes (25 minutes should be the norm based on the national acute hospital contract that has 15 minutes as a target for hospital handover). It equates to a half a days total production per month and the impact on CatA performance for each month is 1.5 to 2% and 3 to 5% on CatB.

The LAS has taken a lead with NHS London to manage the impact of the hospital delays. While this helped reduce some of the delays, it has resulted in significant LAS senior management resource being involved who would otherwise be responsible for driving up core Ambulance performance. It has been recognised that a 'whole system' approach is required to resolve these difficulties and the LAS is working closely with NHSL and PCT Commissioners to take this work forward through the final quarter and into 2009/10.

1.3 Activity

Incident volume is up 3% on an annual basis. This masks higher increases in both November and December. The first three weeks of December were the busiest in the history of the LAS. Persistent cold weather coupled with the Flu and the Winter Vomiting Virus have been driving some of this demand with the growth areas again being in the respiratory and cardiac conditions. This situation has been mirrored nationally with all Ambulance Trusts reporting severe pressures in terms of workload and hospital delays

2.   Financial Balance

On track to deliver a surplus of £900k in line with control total

3.   FBC approval for CAD2010

Achieved. Approval for what is the largest ambulance command and control system in Europe was approved in Dec, 2008.

4.   Improve weekend waiting times

Achieved

5.   Full establishment against workforce plan

Will be delivered by 31/3/08

6.   Deliver agreed training plan

Part achieved. Operating pressures have resulted in the deferment of some training courses.

7.   Successfully live at two New Ways of Working (NWoW) sites

Achieved

8.   Agree 5 year fleet plan and deliver on year one with 35 new ambulances in operation.

Achieved

9.   Approve Estates strategy

Will be completed by 31//3/08

10.   Implement Airwave ambulance radio project

Not achieved due to a delay in the National Programme rollout. A date of May 2009 has now been set for the LAS.

11.   Agree way forward and demonstrable progress on Healthcare for London, particularly in the areas of stroke, trauma and unscheduled care

Achieved. The LAS has actively participated in the relevant workstreams.

12.   Complete FT pilot and progress application

Achieved

13.   Improve Logistics function

Achieved

14.   Complete Benefits Realisation Planning for Strategic Plan

Achieved

15.   Improve IM&T customer service

Achieved. A full customer survey was completed. Action plan and service targets agreed – on target to show improvement by 31 march with a full rerun of the survey scheduled for October 2009 and an overall service improvement target agreed.

16.   Improve cardiac arrest survival to discharge results on previous year

Not achieved, though survival is still double what is was 5 years ago.

17.   Agree PTS and EBS strategy and make progress agianst year 1 deliverables

Achieved.

1.2 Summary of financial performance

Summary of financial performance: commentary

The LAS is forecasting a financial surplus of £900k. This is in line with the required control range from NHS London.

Total Income is forecast to be £260m, which is £7.7m (2.8%) over plan. Additional in-year funding of £6m was provided by PCTs to support the CatB performance drive. PTS income was £1.5m over a conservative plan.

Total Operating Expense is forecast to be £248m. This is £8.4m (3%) over plan.

Payroll expense is forecast to be £191m compared to a plan of £182m. Additional overtime (£10m) and incentives (£7m) have been partially offset by the additional PCT funding (£6m) and frontline vacancies (£8m).

Non Pay is forecast to be £57m vs. a plan of £58m.

Financial Expenditure (incl depreciation) is forecast to be £11m vs. a plan of £12m.

Overall, total average monthly expenditure of £21.5m remained reasonably consistent.

Capital Investment of £16m remains on track.

CIP is forecast at £6.5m vs. a plan of £7.2m (90%). The slippage is across a range of projects including Estates Maintenance, PTS Efficiency and Fleet & Logistics where additional activity to support frontline performance delayed CIP initiatives.

Summary of financial performance: high-level comparison between historical plan performance and actual performance

£m	2008/09 plan	2008/09 forecast*	Variance
Income			
Clinical income (Tariff & Non-Tariff)	226.1	233.8	7.7
PbR Clawback			
Private Patients			
Other income	26.5	26.5	0
Total income	**252.6**	**260.3**	**7.7**
Expenses			
Pay costs	181.5	191.5	10.0
Non-pay costs	58.3	56.7	-1.6
Other costs			
Total costs	**239.8**	**248.2**	**8.4**
EBITDA	**12.8**	**12.1**	**-0.7**
Exceptional costs			
Exceptional income			
Depreciation and Amortisation	7.8	7.4	-0.4
Interest Receivable	-0.1	-0.4	0.3
Interest Payable			
PDC Dividend	4.0	4.4	0.4
Net surplus/(deficit)	1.1	0.9	0.2
Net surplus/(deficit) excluding impairments			

*Based on month 8 or 9 actual plus 4 or 3 months forecast initially

1.3   Other major performance issues

Other major performance issues

Staff Engagement

Communicating with staff and involving them in Service initiatives and changes is a vital ingredient in Trust plans to continue developing the organisation. The LAS believes that its success depends on staff feeling informed, listened to, involved and valued. A number of communication tools have been enhanced and will continue to be developed – intranet, internal magazine, routine bulletins – and much attention has been given to face to face communication although this is a vital area which needs constant attention and development.

The seventh annual series of Chief Executive consultation meetings face to face with staff at each complex are planned for May/June 2009.

During the year, a series of 15 conferences were held with managers, clinical team leaders, support staff and admin staff.

The LAS plan to use information from its staff survey results in February to inform its future communications and engagement strategy.

A new Partnership Agreement with the unions was agreed following a Partnership Conference held in October. A new consultative agreement has also been implemented to support the Partnership Agreement and to continue to strengthen the principles of the partnership approach. Regular internal conferences for managers and team leaders continue to be used to share key messages and information and to reiterate the importance of the LAS values.

It is accepted that developing effective communications throughout the Service is key to the organisation's success and considerable focus will always be placed on ensuring that we continue to develop and improve the methods we use to inform staff, listen to them, act on what we hear and engage them in the development of the Service. Stakeholder Engagement and Communications has been identified as a crucial enabling strategy to support the new Service Improvement Programme.

1.3.2 Diversity and Public and Patient Involvement

The London Ambulance Service is committed not only to meeting its statutory obligations to equality and public and patient involvement legislation, but also to the spirit behind these and wants to go beyond mandatory obligations. The Trust has particular challenges in engaging public and patients generally within the various diverse communities in the geographical area it covers given that it is the only London-wide Trust. These are challenges are pro-actively and creatively being addressed. For example, a consultation conference was held on the service improvement programme which focused on this area by developing detailed equality impact assessments for the SIP.

2.0 Future business plans

2.1 Strategic overview

Strategic overview, incorporating turnaround and reconfiguration

Drivers for Change

There are three different types of drivers for change which the LAS has to take account of: those arising from Government policy for the NHS; those identified from the wider operating environment; and those arising from within the LAS itself. The new Service Improvement Programme 2012, and many core activities, link to these drivers for change.

Policy drivers

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

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

The key national target for the LAS remains maintaining response time performance of reaching 75% of patients with conditions prioritised as Category A in eight minutes. The LAS must also concentrate on other national targets (Category A19, Category B19) as well as improve performance against clinically focused indicators.

The National Ambulance Review is of particular importance to the LAS as it envisages a reduction of one million in the number of patients taken by ambulance to hospital annually in England and Wales. Over the next 3-4 years ambulance trusts, working with patients and the public are required to achieve not only operational but also cultural change becoming services which respond appropriately to all patients and which look, feel, behave and deliver differently, building on the principles that there should be:

•   High case completion at point of both telephone contact and physical contact;

•   Reduced duplication;

•   Localisation - embedded with primary care and community services;

•   Flexible and highly empowered workforce as the key to cost efficiency.

The implications for the LAS are that approximately 200,000 fewer patients per annum will be taken to hospital Accident and Emergency departments than would otherwise have been taken. A new approach to patients, callers and the public is necessary, requiring changes in vehicle, skill and workforce mix (with increasing focus on solo first responders), training and education, roles, responsibilities and relationships, information management and technology as well as structure and operating arrangements. This Service Plan for 2009/10 progresses the approach the LAS is taking to these challenges in order to realise in London the benefits defined by the National Ambulance Review.

The February 2006 Government White paper *"Our Health, Our Care, Our Say"* signalled a fundamental shift in the running of the NHS which will impact on the development of care pathways. The operational implications for ambulance services as players in a "whole systems" approach to care will need to be worked through.

Significant aspects of the White paper potentially are:

a requirement for Primary Care Trusts to move 5% of acute hospital activity into primary care over the next 10 years;

a re-think on the closure of community hospitals;

turnaround teams will become service re-configuration teams in areas with persistent financial deficits;

a duty on local authorities and the NHS to work together to improve the health and well-being of older people to mirror the one improving services for children.

Lord Darzi's autumn 2007 report "Healthcare for London: A Framework For Action" proposes fundamental change in the pattern of acute trust service provision. This will have an effect on the ambulance service and the LAS is also crucial to the success of the reforms which are currently out to consultation.

The LAS has been engaging with Healthcare for London workstreams in order to understand the contribution

needed to realise these changes.

This Service Plan, and many core activities, link to these principles, policy objectives and targets. It is designed not only to maintain performance against the Core Standards documented in "Standards for Better Health" but also to make demonstrable progress against the Developmental Standards. In 2007/08, the LAS was rated 'Good' for both Use of Resources and Quality of Services

Operating environment drivers

In addition to drivers for change which arise from health policy, a number of emerging themes have been identified from the wider operating environment:

1. *Stakeholder feedback to the Trust* on what they want it to deliver to them over the forthcoming years (see section 2.1.2);

2. *The requirements of Primary Care Trust commissioners* that the LAS:

    - assist them in preventing unnecessary hospital attendances through alternative methods of responding to 999 calls;

    - assist in the management of chronic diseases outside of hospital and meet response time targets in an environment of zero growth in funding;

    - provide more equitable performance across London;

    - more effectively integrate with the wider health economy and play a full part in local emergency care networks.

3. *The consequences of demand growth*

4. *The need to respond to population and visitor growth, particularly in the Thames Gateway area and the substantial increase in passenger throughput at Heathrow as a consequence of Terminal 5. Three main issues arise from this: the impact on relative PCT contributions to the LAS; resource requirements; and the potential to develop new models of care;*

5. *Opportunities for co-location with PCT facilities when they consider new builds to realise service and cost benefits and the potential for new models of care;*

6. *The need to further develop and deliver new locally agreed Category C outcome measures for specific disease groups in response to abolition of the national response time target for Category C patients;*

7. *Any possible requirement for PCTs to divest themselves of their provider functions presents a potential opportunity to form closer association with other healthcare professionals such as District Nurses who bring the NHS into peoples homes and external providers;*

8. *Demographic changes with fewer young people reducing the recruitment pool and hyper-diversity (28.8% of the population Black and Minority Ethnic (BME), 25% of born outside the UK and 300 languages are spoken in the Capital.*

9. *Emergency preparedness for and response to terrorist threats and conventional major incidents a priority issue in the wake of events on 7 July 2005;*

10. *The 2012 London Olympic and Paralympic Games bringing an influx of people to the capital and the need to provide dedicated cover at sporting venues;*

Internal LAS drivers

The LAS has traditionally been perceived as an emergency service responding to 999 calls with a 'Blue Light' response to get patients to hospital Emergency Departments as quickly as possible. Only around 10% of the Service's patients are in immediate danger of dying and around another 10% also require an immediate response because unless attended to quickly, their condition may deteriorate seriously. Another 20% of patients are in no danger of dying but nevertheless need the LAS to be there quickly (for example they may be in pain). The remaining approximate 60% of patients do not need a double-crewed ambulance and a variety of responses are possible.

A balance needs to be struck between focus on current performance and development for the future. The challenge for the Trust is to move to a position as quickly as possible whereby it manages demand differently. The Strategic Plan 2006/07-2012/13 maps the long-term route. This Service Plan maps the steps in 2009/10 along the way.

2.1.2   London Ambulance Service Strategic Direction and Objectives 2006/07-2012/13

The London Ambulance Services aspires as its Vision to be "A world-class ambulance service". In reality "World Class" looks like different things to different people and requires the organisation to meet differing stakeholder needs.

The eight stakeholder groups consulted (see section 1.1.1) told the LAS that they wanted it to be an accessible service that responds appropriately, engages the public, its patients and partners, provides greater options for patients, continues to focus on delivery and has a culture built around its Values.

In addition to understanding what stakeholders want from the organisation a second consideration is the scope and scale of future operations. Given that the organisation does not exist in a vacuum, delivery of the identified "Stakeholder Aspirations" has to take place with cognisance of the drivers for change identified earlier in section 2.1.1 of this Service Plan.

The direction of travel over forthcoming years for the LAS is to seek to keep the organisation's current 'market share' of calls to the NHS in London but consolidate the Trust's position, service provision and performance by embracing, promoting and integrating the majority of non-life threatening but often complex calls (Category C) as core LAS work.

The approach of focusing on urgent care while maintaining emergency service provision implies significant changes to Service support, provision and culture and positions the organisation to move, if it wishes or is required, to:

- co-ordinate response to additional Out of Hours demand (that is undertake a wider call taking and tasking role for other healthcare providers) and/or;

- manage services currently provided directly by Primary Care Trusts which have synergies with the current service portfolio, should the latter decide or be required to relinquish management of such provision;

- be in a position to apply for Foundation Trust status (see section 2.2).

Over the years 2007/08 to 2012/13 the London Ambulance Service has as prime objectives to:

- re-define itself as a provider of urgent care in London as much as it is a provider of emergency care, and demonstrate to partners and the public that it is of equal significance to the health service in this respect;

- develop an organisation which "responds appropriately to all our patients" whether their need is of an emergency or urgent nature.

The strategic direction will be implemented through the five programmes that make up the overall service improvement programme "SIP 2012" as outlined in section 2.3 and this Service Plan is intended to progress these programmes and other identified objectives in 2009/10.

The LAS has been refreshing its business strategy as part of the work to become an FT. Many of the principles established in the preparation of the current SIP continue to pertain.

High-level financial and investment implications of the proposed strategy

The LAS will require additional investment from PCTs, NHS London and the Department of Health to deliver on its proposed strategy. While the LAS continues to develop and deliver effective CIP programmes, both the timing and the costs of some of the proposed developments are unaffordable without additional support.

As an example, the cost of implementing the proposed Stroke strategy would require additional revenue investments of c. £2m for North East London alone.

Also, the lead time for adding front line resource (6 months) does require upfront investment to deliver any additional ambulance resource to support any externally driven strategic initiatives.

2.2   Achievement of FT status

Actions identified to achieve FT status

The LAS submitted an IBP to NHS London as part of a pilot diagnostic and undertook a board to board assessment in July 2008. Positive feedback and an action plan has been received and an FT Programme has been instituted.

The target date for a submission to Monitor is Q2 in FY 2009/10.

Progress to date

An FT Programme board chaired by the CEO has been instituted to drive the process forward with representation from both the PCT Commissioner and NHS London.

Key personnel have been recruited to support the Programme including a Programme Lead, a Membership Manager and a Finance Lead. A Director of Corporate Services/Trust Secretary has been now also been recruited to help drive the process.

The Programme is on track with the next key development being the launch of the consultation process in Feb, 2009.

Key outstanding actions and milestones for coming year

Launch of Consultation Process	Feb 2009
Consultation completed	April 2009
Membership Database selection	Feb 2009
Governance rationale completed	May 2009
SHA review	July 2009
Secretary of State support	Aug 2009

2.3   Service and workforce development plans

Service development plans

1   Transformational Change

The implementation programme to achieve the long-term objectives of the LAS comprises eight programmes (portfolios of projects) and an enabling Stakeholder Engagement and Communications Strategy:

Programmes

1.   *Access and Connecting (the LAS) for Health* - covers not only access to LAS services by patients and the public but also Connecting for Health. Access/connectivity/information flows within the LAS and between it and partners, led by the Director of Information Management and Technology. In 2009/10 the focus will continue to be development and implementation of the large infrastructure projects CAD2012, digital radio (LARP), Data Warehouse along with improved computer network enhancements for resilience and Access for Speech and Hearing Impaired People (see section 1.1.2).

The CAD2010 Project made significant progress in 2008/09 with a contract being a awarded to Northrup Grumman to deliver a new CAD system in 2010.

 A second key project has been the development of the digital radio project. Its full implementation will address the shortcomings in communications identified in the aftermath of the terrorist attacks of July 2005. In support of a national initiative, work has commenced on a project to improve access for people with hearing and speech difficulties. Other projects will be developed to enhance the Data warehouse (improved use of data within the Trust), network enhancements, support Operational initiatives for new ways of working and improve the IT infrastructure. Work has also commenced on seeking altenative methods for deaf people to access LAS emergency services.

2.   *Improving our Response: Operational Model -* covers the comprehensive review of our operational response regime. It includes significantly improving processes and management within our emergency Control Rooms, coupled with the introduction of additional Fast Response Units and also improving the way in which all our vehicles are deployed to ensure that they are always geographically placed in the optimum positions to reach patients as quickly as possible. Finally it also involves developing a comprehensive clinical telephone advice system backed up by an urgent care fleet designed to minimise unnecessary emergency responses.

3.   *Organisation Development And People* - covers Organisation Development, culture, HR strategy, education and training (clinical and non-clinical), Diversity and workforce skill mix (including recruitment and retention) and IR, led by the Human Resources Director. In 2009/10 the focus will be on defining and starting the implementation of the changes to working practices envisaged to go alongside the shift to more solo responding under the Operational Model, in particular moving to a genuine team based watch system .

4.   *Corporate Processes and Governance* - covers Corporate and Clinical Governance and development of all corporate management processes, led by the Director of Finance. In 2009/10 the focus will be on developing significant changes in many of key corporate processes in the Trust. In particular, the development of a Balanced Scorecard method for performance management) along with new cost saving initiatives to achieve the efficiency savings expected through the Cost Improvement Programme .

5.   *London Olympics 2012* – covers preparations to meet the requirements of "The Olympic Games Medical Services, Technical Manual on Medical Services" (2005) which requires that "the level of medical services to the community must not be compromised during the Games-time. Capacity issues must be addressed during the planning phases to ensure optimal use of community-based health resources and appropriate level of care for the community and Olympic related populations." In 2008/09 the focus has been on implementing the initial tranche of projects identified in the scoping work undertaken in 2007/08. These revolve around the assessment of the impact of the 2012 games on the LAS and identification of the capacity required for those areas identified as being affected during Games time. This reflects the first phase of the International Olympic Committee/London Organising Committee for the Olympic Games Readiness Integrated Plan.

Enabling Support Strategy

6.   *Stakeholder Engagement and Communications Strategy -* covers relationships with external stakeholders

and their involvement with the LAS especially Patients and the Public (PPI) but also other healthcare professionals, emergency services, social services, key suppliers etc., led by the Director of Communications. In 2009/10 the focus will be on PPI and other communication and engagement activity associated with the Operational Model and Organisation Development work collectively know as "New ways of Working: Clinical Leadership on Complexes"

7.   Foundation Trust Progamme (See FT section)

8.   New Ways of Working

A major organisational change Initiative known as "New Ways of Working"; Transforming Clinical Leadership on Complexes" (NWoW) was initiated in 2008. Its objective is to create on each ambulance station the perfect environment for clinical leadership to grow and flourish, improving not only the patient's experience, but also the job satisfaction of all staff. This is to be achieved through a cross section of enabling projects that are being delivered through the existing SIP 2012 Programmes excluding the Olympics that collectively have come to be known as NWoW, with the outputs of these projects being shaped locally at each complex to form their vision of NWoW.

The Initiatives are mainly drawn from Operational Model and Organisational Development & People Programme portfolios enabling improvements in how the management team and watch systems operate, how crews respond to calls, how training is delivered and promotes the ethos of clinical leadership, and how the complex will engage with the local population and partners more closely and effectively. These will be supported by improvements to IT infrastructure and business processes, as well as the day-to-day process such as station administration.

NWoW is currently being developed in two early implementer complexes and with a longer-term roll-out across the Trust. Amongst the benefits sought NWoW will deliver fewer conveyances to hospital, enable patient needs without them having to leave home, achieve better survival rates for patients who are seriously ill or injured, and improve both patient and staff satisfaction.

Two complexes, Barnehurst and Chase Farm, were successfully selected through an assessment process as early implementer sites in 2008 to roll out their local vision of NWoW. Over the next six months a central implementation team will support them on site with their implementation whilst helping to support their core business delivery. Enabling projects from the four SIP 2012 programmes will hand over their completed products for the complexes and implementation team to implement locally.   Towards the end of this roll out the next cohort of complexes will be invited to partake in the application process, and upon selection commence their planning work with the implementation team. Although there will be a local vision of NWoW of working on each complex to best align to local needs, the critical success factors and lessons learned from the implementer sites will guide the subsequent roll out across the Trust.

This initiative supports our strategy by consolidating and building up how we deliver our core services through excellent patient care, as well as by establishing stronger links with local communities and partners improving our ability to gather local intelligence and form strategic partnerships when the opportunities arise in the future.

The LAS is in the process of refining its programme structure in order to reducethe total number of programmes while continuing all of the planned activity

These eight programmes and the support strategy provide the structure for all development activity in the Trust.

2.3.2

2.3.3 Delivery of Core and Developmental Standards and the Diversity agenda

A key requirement for the Trust is to meet the requirements of the NHS planning and governance framework "Standards for Better Health" published in July 2004. This Service Plan is designed not only to maintain performance against the Core Standards but also to make demonstrable progress against the Developmental Standards. These will be used by the HealthCare Commission to determine the Trust's annual performance rating, along with delivery against national targets, the Information Governance Toolkit and achieving financial balance.

Compliance with national targets and performance criteria although supported by development activity remains part of routine operational work and not a separate work stream however. Work under the Corporate Processes and Governance Programme will drive forward LAS activity to ensure compliance.

The Trust has an established Diversity team and in accordance with legislation is in the process of carrying out Equality and Diversity Impact Assessments on its relevant policies, procedures, functions and practices. The

actions arising from these assessments will be incorporated into the Trust's existing Equality Schemes and their associated action plans.

While responsibility exists and implementation takes place across the Trust to progress equality and diversity, through all directorates and programmes, the oversight and driving forward of development and implementation will take place through the Organisation Development and People Programme.

2.3.4   Organisation Development

The changes described in the Service Improvement Programme will make Trust services quite different. This means the organisation will be different in many ways too.

An organisation built around the idea that every patient is in immediate danger of losing their lives has to respond quickly and provide technically expert care. When life depends on getting things right fast, discipline is needed, and a "command and control" style of management is sometimes necessary .

The LAS will still need to be like this at times, for example at the scene of a major incident.

However, many patients need a caring response more than they need a quick one. They need the Service to spend time with them – understanding their situations and resolving their problems. The skills needed will often be less "technical" and will require skilled communication alongside education in assessment and understanding of underlying causes and chronic illnesses as well as the ability to work with other health professionals in the community to secure the right next step for the patient.

The ambulance professional of the future will have far more independence and responsibility in decision-making and they will follow guidelines, rather than rules. A "command and control" management style will only be right for these professionals on the rare occasions when life depends on giving and following instructions.

This is what is meant by "an organisation that looks, feels and behaves differently".

> To some extent this "cultural change" will happen over time by virtue of the fact that the LAS changes its response regime and increases workforce skills. However, the Trust is committed to a range of actions that will support this and speed it up and make it sustainable

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Workforce development plans

To achieve the future aim of providing appropriate responses to the population of London, a long term workforce plan has been developed. This provides a skill mix and associated training plan to provide a wider range of interventions dependent on patient need, utilises a wider range of alternative care pathways and reduces the number of patients unnecessarily conveyed to hospital.

This workforce plan will produce a larger number of qualified paramedic staff with enhanced patient assessment skills, supported by a newly created support role. It will also create more Emergency Care Practitioners together with Clinical Telephone Advisors who will resolve more patient need fully over the telephone.

To develop this workforce the Trust will review its existing training models and will access more professional training through Higher Education Institutions

Comparison between historical achievement and current plan					
Clinical revenue					
£m	**Plan**	**Forecast**	**Current plan**		
	2008/09	**2008/08**	**2009/10**	**2010/11**	**2011/12**
LAS PCT /A&E	217.7	223.5	244.7	251.6	258.6
Clinical activity (NHS and non-NHS)					
Activity numbers (000s)	**Plan**	**Forecast**	**Current plan**		
	2008/09	**2008/08**	**2009/10**	**2010/11**	**2011/12**
LAS PCT/A&E Inncidents	986.9	977.3	1011.5	1043.9	1077.3

Assessment of financial impact of the new 2009/10 tariff and Market Forces Factor
Not applicable

2.4   Other Revenue

Comparison between historical achievement and current plan					
£m	**Plan**	**Forecast**	**Current plan**		
	2008/09	**2008/08**	**2009/10**	**2010/11**	**2011/12**
Research and Development					
Education and Training	8.2	8.8	10.7	3.9	4.3
PFI Specific					
Other					
Total	**8.2**	**8.8**	**10.7**	**3.9**	**4.3**

Commentary on any issues arising
The Education & Training financial plans are, in part, based on the staffing plans funded by PCTs. For 2009/10, it is assumed that an additional 428 student paramedics will be recruited and trained in-year. The E&T bid covers the associated initial training cost.

2.5 Operating resources required to deliver service development

Resources required to deliver service development

The LAS has worked with London PCTs to model the required LAS efficencies and resourcing levels required to deliver sustainable call connect performance on the primary targets and lower utilisation to national averages.

- 428 additional staff are required to achieve both CatA and CatB national targets in a sustainable manner.

- This will reduce excessive ambulance utilisation to 55% from 68% which is in line with other urban ambulance trusts in the UK.

- The modelling assumes that PCTs/NHSL working with the LAS will reduce hospital turnaround by 5 minutes. Failure to deliver this would require an additional 157 frontline staff.

- The cost of the bid to London PCTs c. £28m including inflation.

- The bid is contingent of the LAS receiving £4m in E&D support for training the additional paramedics as well as funding to continue the three year training programme for those recruited in 2008/09.

The LAS is working with NHS London on developing a significant change in how training and development of staff is delivered. NHS London asked the LAS to bid for MPET funds to fund this change. A bid of £10.7m was submitted for 2009/10, covering improved paramedic training, additional investment in ECPs and an enhanced e-Learning capability. Costs matching this funding have also been included in the plan.

Current discussions with the SHA indicate that at least two HART teams will be required in London. We are finalising how these teams will be delivered and funded. In the plan, we have assumed that income of £3.8m will be provided from the Department of Health to support this requirement on a phased basis. Costs matching this income have also been included in the plan.

As part of the recent CSR submission, planning costs for the 2012 Olympics of £1.9m have been included for 2009/19. It is assumed in the plan that this activity will be funded centrally, with associated costs also planned.

Additional resources for Service Development will be delivered by additional cost improvement programmes.

Gross capital investment of £16.1m is included in the plan for 2009/10 covering additional vehicles, CAD2010 investment and a range of estates projects

A loan of c. £10m will be required to supplement the planned capital programme. This loan was envisaged when the CAD2010 FBC was approved by NHS London in 2009/10. This service plan will form part of the loan application.

No additional resource has been planned to implement Healthcare for London changes.

Comparison between historic achievement and current plan					
Operating expenses*					
£m	**Plan**	**Forecast**	**Current plan**		
	2008/09	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Pay costs	181.5	191.5	209.5	210.0	209.7
Drug costs	0.5	0.4	0.5	0.5	0.5
Clinical supplies and services costs	4.3	6.0	6.5	6.6	6.7
PFI specific costs					
Other operating costs	53.4	50.3	54.6	53.9	57.3
Contingency reserve	.		0.6	0.6	0.6
Total Operating Expenses	**239.7**	**248.2**	**271.7**	**271.6**	**274.8**

* This section of the table for the analysis of operating expenses is based on the items relevant to an acute trust. Please use the appropriate items for analysis of operating expenses for your trust type, changing headings where needed

Cost Improvement Plans						
Cost Reduction Plans	A&E Productivity			1.2	5.0	5.0
	A&E Incentive			6.1		
	Agency			2.0	1.0	1.0
	Subsistence			0.6		
	Corporate Processes			1.7	4.0	4.2
				11.6	10.0	10.2
Total						

Commentary on cost improvement plans

A significant Cost Improvement programme has been largely delivered in 2008/09.

Further developments in IT systems, planning software and staff engagement will allow further improvements in overall productivity.

For 2009/11, this is planned to continue using the SIP Programme methodology. In particular, the Corporate Processes & Governance programme is looking at all key processes within the LAS to identify further efficiencies. Areas such as procurement, logistics and staff administration are a key focus.

2.6   Summary Financial Plans

Comparison between historical achievement and current plan					
£m	Plan	Forecast	Current plan		
	2008/09	2008/08	2009/10	2010/11	2011/12
Total Operating Revenue	251.4	260.4	286.7	290.0	302.9
Total Operating Expenses	238.6	248.1	266.6	266.8	270.3
EBITDA	12.8	12.4	20.1	23.2	32.6
Profit/(Loss) on asset disposal	0.0	(0.1)	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0
Depreciation and amortisation	7.8	7.4	12.2	13.3	16.4
Interest Receivable	0.7	0.7	0.2	0.2	0.2
Interest Payable	0.2	0.2	1.2	1.2	1.2
PDC dividend	4.4	4.4	4.9	5.5	6.1
Other Non-operating Revenue	0.0	0.0	0.0	0.0	0.0
Other Non-operating Costs	0.0	0.0	0.0	0.0	0.0
Net Surplus (Deficit)	1.1	1.0	1.9	3.4	9.2
Net Surplus (Deficit) excluding impairments					

Commentary on issues arising
EBITDA increases primarily due to the impact of IFRS which reduces total operating expenses by c.£5m and increases depreciation by 5%.

Assessment of the impact of IFRS
Minor impact on Revenue. An increase in depreciation is largely offset by a decrease in operating lease cost resulting in a significantly higher EBITDA. Major impact on Balance Sheet where an additional £18m of loans have been added. LS investigating what impact this will have on our Prudential Borrowing requirement.

2.7 Service Line Management

Progress to date on implementation of service line management and key milestones for 2009/10
The LAS currently splits out its business into A&E and PTS. Analysis is completed on a dircect costs basis for all other income streams. Further analysis will be completed in 2009/10 to attribute indirect cost to major income streams. This work is being managed through the FT programme.

2.8 Investment and disposal strategy

Plans for investment and disposal
Key areas of investment over the next 3 years include CAD2010, new ambulances and a reconfigured estate. Estimates have been made regarding the split for capital and revenue for these projects. The Estates strategy for the Trust is currently being updated. There will be significant investment in new fleet workshops and control infrastructure. The NWOW project will further inform the shape of the required A&E infrastructure. A new HQ will also form part of the Estates plan. This , in part will be offset by a planned disposal of non strategic sites.

Comparison between historic achievement and current plan					
Investment and disposal strategy					
£m	**Plan**	**Forecast**	**Current plan**		
	2008/09	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Investment in fixed assets (non-maintenance)	1.2	1.5	3.0	3.7	2.5
Investment in fixed assets (maintenance)	1.4	1.4	1.4	1.0	1.0
Asset disposals	1.5	1.0	0.5	1.5	1.5

2.9   Summary of key financial assumptions

Key assumptions			
	2009/10	**2010/11**	**2011/12**
A&E Incidents	3.5%	3.2%	3.2%
A&E Income (Base)	1.7%	1.2%	1.2%
Pay Inflation	2.4%	2.3%	2.3%
Non pay Inflation	1.5%	1.5%	1.5%
CIP (Minimum)	3.0%	3.5%	3.5%
			1

3.0 Risk analysis

3.1 Financial risk

3.1.1 Commentary on financial risk rating

Financial commentary
The provisional rating for 2009/10 is 2. This is primarily driven by the net margin indicator which has a score of 2 caused by the the net surplus being 0.7% rather than 1.0%. To achieve a margin of 1% would require additional profits of £965k. The weighted average score for 2009/10 is 3.1. By 2010/11, the weighted risk rating rises to 3. By 2011/12, the score is 4

3.1.2 Key risks and opportunities not included in financial plans

Financial commentary
5 minute turnaround in Hospital handover. Failure to deliver would require an additional 157 staff (c. £7m). Current fuel prices were used to develop the plan. Based on 12,000 litres per day, any material fuel price increase would have an impact. The costs of hedging this risk would outweigh any benefits. The LAS will continue to work with other Ambulance Trusts, Emergency Services and the MoD to explore any central options in this area. No additional resource has been assumed for the implementation of HfL.

3.1.3 Contingency reserve 2009/10

Commentary justifying level of contingency
LAS philosophy is that planned surplus is primary source of contingency planning. In 2009/10, a small reserve of £600k will be held.

3.2 Governance risk

3.2.1 Commentary on governance and associated risks

Governance commentary

<u>Compliance with statutory requirements, contracts with commissioners and the Agency Guidance</u>

The LAS follows the statutory requirements using the 2007/8 Planning framework and the guidance set out in the London Commissioning Regime and Provider Regulatory Framework. It assures compliance by following NHS London guidance and Monitor's Compliance Framework.

<u>Compliance with operational and financial requirements used by the Agency</u>

The LAS has produced a Strategic Plan for the next three years with additional consideration for the 2012 Olympics. The plan establishes direction and includes specific priorities.

The LAS has provided an Annual Operations Plan with a three year horizon setting as detailed targets and financial plans. The Service Improvement Programme incorporates elements of the LDP and uses the health outcome targets from the Annual Health check.

The LAS has a range of approaches which constitute an Organisational Capability Development Plan setting out the capability needs and gaps with action plans to address them.

The LAS has a risk rating system focusing on the delivery of key performance targets at national and local level. Based on the May 2006 self assessment of governance systems, the Board receives annual reports from its core committees and responds to feedback on its governance approach from NHS London , the Healthcare Commission and the NHSLA. It undertakes a Financial Risk rating which is forward looking using reports to the Board with forecasts as well as comparative analysis using data from immediate past years. The risk management regime will be re-analysed as part of the FT appliocation process

<u>Compliance with the Agency Board's rights to participate in key appointments</u>

The Trust accepts the Agency Board's right to participate in key appointments and has followed the requirements of the NHS Appointments Commission when recently appointing Non Executive Directors.

<u>Compliance with Best Practice for Corporate and Clinical Governance including appropriate board roles, structure and composition</u>

The Trust has worked with the Audit Commission and Healthcare Commission to achieve positive scores in the Annual Healthcheck using the Inspection Guidance for the Core Standards of Better Health and the Auditors based evaluation (ALE) key lines of enquiry (KLOE) guidance. The Trust allows the principles of intelligent information to Boards as set out in *the Intelligent Ambulance Board* including a broad planner based on the annual board cycle in Annex 3 of that report. For clinical governance best practice the Trust follows the Joint Royal Medical Colleges Ambulance Liaison Committee (JRCALC) guidance. The Board have nominated the Medical Director as the Director of Infection Prevention and Control and receive infection control reports as required by the *National Infection Control Policy Clean, safe care: Reducing infections and saving lives.*

<u>Effective risk and performance management</u>

The LAS fulfils its responsibility for ensuring that its statutory obligations are met at all times. The Trust uses a risk-based approach to management receiving exception reports where there is an intensified risk of failure to meet national targets. This is known internally as the REAP system. In addition to this the Assurance Framework reports to the Board on the management of low risks that threaten the achievements of its principal objectives, using the domains of the Annual Healthcheck. The Trust uses a transparent method for risk assessing set out in a performance management framework underpinned by its Risk Management policy and the Statement of Internal control.

<u>Implementation of national policy and guidance on planning for an incident</u>

The LAS monitors its compliance with the Civil Contingencies Act 2004 and works within the framework of the London Regional Resilience forum. It is represented on the membership of the London Emergency Services Liaison Panel (LESLP). The LAS has an Emergency Planning Unit which uses the LESLP manual as a guide when following interagency processes. The LAS utilises the NHS Emergency Planning Guidance (Department of Health 2005) and has recently undergone an audit of its emergency planning arrangements as part of a Department of Health Emergency Planning Audit of ambulance service trusts undertaken in September 2007. Initial feedback has been positive. The Trust has also trained and exercised with partners to an agreed schedule.

The Trust has identified financial resources required for responding to incident and emergency situations.

Maintaining an up to date Business Continuity Plan

The Trust has a Business Continuity Plan (BCP) which is maintained so that it reduces to a minimum the disruption of the normal work of the service. The plan includes contingency arrangements for business continuity in the event of a protracted incident or failure of utilities and systems. The Trust's Business Continuity Policy is supported by the BCP which is an overarching generic plan including specific plans produced by all LAS departments. The BCP is intended to ensure that the LAS provides vital core services and maintain its essential support functions; restoring non critical support function as required

3.3 Risk to services provided

3.3.1 Commentary on services provided and associated risks

Commentary on services provided

The planned performance is to achieve all national targets while achieving financial balance.

This is contingent on securing the funding required from London commissioners to cover the increased investment required for delivery of all of the national ambulance targets as well as a material reduction in ambulance utilisation.

Failure to achieve the requisite funding would result in a trade-off with London PCTs on performance standards.

For Education& Development, further feedback is required from NHS London to identify both the required activity and funding. The plan assumes that any such income is matched by expenditure on the plan.

For CBRN, HART and the Olympics 2012 programme, services will be provided in line with funding as per current practice. The experience of the LAS is that funding will continue to be provided centrally.

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Quality and safety risk

For London Ambulance Service:

Progress to date and key actions and milestones in 2009/10 to respond to 75% of category A calls within 8 minutes
- Significant additional Training Capacity introduced   - Large scale recruitment programme successfully introduced   - Innovative overtime enhancement schemes introduced to maintain staffing.   - Additional Motorcycle Response Units established   - Additional Cycle Response Units established   - Operational Managers providing additional response capacity   - Fast Response Units targeted to Category B calls   - Activation times for Fast Response units significantly improved   - Sustained improvements in 999 call answering performance   - Enhanced automated dispatch systems introduced   - Numbers of Fast Response units increased from 95 to 120 at peak demand   - Flexible Dynamic Deployment Regime introduced   - Community Responder schemes introduced   - Increased numbers of Static Defibrillator Sites established

Progress to date and key actions and milestones in 2009/10 to respond to 95% of category A calls within 19 minutes
See above

Progress to date and key actions and milestones in 2009/10 to respond to 95% of category B calls within 19 minutes
See above

3.4 Other risks

3.4.1 Commentary on any other risks

Commentary on other risks

4.0   Declarations and self-certifications

4.1   Board statements

Commentary

The LAS Senior Management Team has reviewed and agreed the submission of this plan.

The LAS Board will approve the plan at it's next board meeting (27 Jan, 2009)

The Chief Executive and Director of Finance have reviewed and approved this submission.

NHS London

Provider Management Regime

Annual Plan 2009/10
Self Certification

NHS
London

Declarations and self-certification

The Board of Directors is required to confirm that:	
GOVERNANCE STATEMENTS **Risk and performance management**	**Tick**
Issues and concerns raised by external audit and external assessment groups (including the RPST and CNST reports for NHS Litigation Authority assessments and Healthcare Commission and Audit Commission investigations and reports) have been addressed and resolved. Where any issues or concerns are outstanding, the Board is confident that there are appropriate action plans in place to address the issues in a timely manner	☒
All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	☒
All proposed and actual capital investments are compliant with the most relevant recent guidance, including the Capital Regime for NHS Trusts and the NHS Trust Manual for Accounts	☒
The necessary planning, performance management and risk management processes are in place to deliver the annual plan	☒
A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the latest guidance from HM Treasury	☒
The trust has taken appropriate steps to ensure the 'faster closure' of 2008/09 accounts and IFRS compliant financial reporting from 2009/10	☒
All key risks to the trust's ability to operate within the parameters set by the Agency have been identified and addressed, especially including external risks	☒
The trust has implemented national policy and guidance on emergency preparedness and has a robust Major Incident Plan and business continuity plan in place	☒
The trust has an appropriate workforce strategy in place	☒
The trust has an appropriate IM&T strategy in place	☒
Board roles, structures and capacity	**Tick**
The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	☒
The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	☒
The selection process and training programs in place ensure that the NEDs have appropriate experience, knowledge and skills and reflect the population being served	☒
The management team has the capability and experience, supported by timely interventions for required development, necessary to deliver the annual plan and lead the Trust to FT status	☒
The management structure in place is adequate to deliver the annual plan objectives for the next three years, including any preparations for achievement of NHS Foundation Trust status	☒
The decisions taken by the Board comply with its legal duties	☒
The trust operates its systems of corporate and clinical governance in accordance with recognised good practice for NHS organisations	☒
SERVICES PROVIDED STATEMENTS	**Tick**
Contracts have been signed with commissioners	☐
The activity assumptions underpinning the annual plan are consistent with the trust's contracts	☒

QUALITY AND SAFETY STATEMENTS	Tick
The Board is satisfied that, to the best of its knowledge and using its own processes (supported by Healthcare Commission metrics and including any further metrics it chooses to adopt), the trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	☒
The Board is satisfied that plans are in place to ensure that all relevant national core standards and targets can be met going forwards, including all national core standards and targets due to come into force within the following 12 months	☐

OVERALL COMPLIANCE STATEMENTS	Tick
The Board will ensure that the trust remains at all times compliant with its statutory duties and operates within the parameters set by the Agency	☒
The Board has considered all likely future risks to compliance with statutory duties and to ability to operate within the parameters, the level of severity and likelihood of a failure occurring and the plans for mitigation of these risks	☒
The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance	☒

Commentary on areas where you have been unable to self-certify
Contracts have not yet been signed with PCT Commissioners.

Signed on behalf of the Board of Directors

Chief Executive and Accounting Officer	Chairman

Trust name

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Business Case for 88 Brewery Rd

1. **Sponsoring Director:**   Michael Dinan

2. **Purpose:**   *To seek Trust Board approval of the business case*

3. **Summary**   *The Business Case seeks to gain Trust Board approval to obtain larger premises for Islington Ambulance Station.*

    The current premises is 690 m^2, whilst the proposed site is 1291m^2.

    The lease on the existing station is for 15 years which is due to expire in May 2016. Current annual costs including lease, rates, insurances, etc are £104,699.66 approx.

    Formal discussions regarding the term of the lease for the proposed site are awaiting the outcome of this proposal, but are expected to be for a period of 10 years, with a break point at the 5 year point. Estimated annual running costs for the new site are forecast as £224,350.00.

    The proposal is to take on the lease on the new property and prepare the site for use as an ambulance station, and to determine the lease on the existing property and return the building to its original layout. Capital costs for this work will be approximately £200,000.

4. **Recommendations:**   *THAT the Trust Board approves the business case*

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

ISLINGTON AMBULANCE STATION BUSINESS CASE

Executive Summary

1   **Strategic Case**
The requirement for the funding for the proposed new accommodation next door to the current Islington Ambulance Station site is to provide more suitable facilities for staff working while on duty at Islington station. In addition to this it will provide additional estate in the central London area to support major incident asset location, Olympic assets as well as be able to take future expansion of staff numbers in this area of London.

Present Station facilities
Islington is located in Brewery Road, London N7 and is set among various industrial units of the same or similar type of build. It is within the boundaries of the London Borough of Islington serving parts of the London Boroughs of Camden, Hackney and the City as well. Its position allows prompt access to hotspots of demand in Islington, the City and Camden within the required performance times to achieve call connect targets.

Access to and from the present site is problematic because the one double gateway to the site is shared by other industrial users. At times delays to LAS vehicles are caused by other users of the sites who park their vehicles inconsiderately. The sightlines from the gateway to Brewery Road are poor and parked vehicles in Brewery Road may delay the speed of any vehicle leaving the station.

There are only 3 spaces set aside for LAS use in the communal car parking area of the site. The garage space of the station is shared by both LAS vehicles and staff private vehicles. Brewery Road has controlled parking bays and if staff parks their cars in these they are awarded penalties by the borough's car parking contractor. There are bays marked out for ambulances in Brewery Road which allow the parking of up to 4 LAS vehicles without penalty. Staff may have to cross Brewery Road to access these vehicles and there are no speed reduction measures in Brewery Road to slow traffic speeds. Overall the space for parking LAS vehicles and for staff to park their private vehicles is inadequate and insecure.

The station has an establishment of 71wte, including administrators and managers. There is no room for increasing this number within the present site. Facilities are used to the maximum and the layout of the site does not allow any extra works. All office space is upstairs which does not allow managers and Team Leaders to work in close proximity of their staff.

The station has no air conditioning and the entire front of the office areas of the building is glass. Excessive temperatures are recorded in these areas throughout spring, summer and autumn. These temperatures reach above 105 degrees Fahrenheit and the administrators are regularly sent home before 1300hrs in the summer because of the extreme working conditions.

The space for storage of equipment and stores is limited to one room in the garage area. This is inadequate and additional space is required to safely store all equipment and stores.

Future service configurations and facilities
Larger garage space, at least twice the size of the existing station to provide –
- Secure parking for all LAS vehicles
- The provision of store rooms that provide secure storage of equipment and supplies
- A specific mess room to allow operational staff facilities for rest, recreation and administration close to their vehicles.
- Offices for operational managers and Team Leaders so they may work in close proximity of their staff

Access and egress to the station used only by LAS
- This allows unobstructed response to all types of mobilisation
- Reduces the risk of accidents to staff and damage to vehicles accessing Brewery Road

Accommodation
- There is a need for adequate facilities for up to 90 wte to allowing operational growth (likely to be substantial growth in WTE in the coming 2 to 3 years across the area)
- Islington may become a main station with a satellite station. This may occur as a result of active consideration to realign stations in the South area
- To assist with the strategic deployment of appropriate operational assets across the East area any growth in accommodation would be used to relocate some existing staff and ambulances from other stations i.e. make it a 'green hub'
- As part of the move from sectors to areas, East Area lost 12 WTE and 6 AEUs to the West Area, these were ISSRs housed at Camden due to estates limitations within the East Central sector. As a result of the growth funding this year and that for which we are hopeful in 2009/10 it is likely that these 12 WTE will be repatriated to East Area, subject to the physical abilities within the estate it would be preferable to re-house these ISSRs in old East Central area thus improving operational cover during periods of peak demand

Environment
- Office space that has adequate means of temperature control and is fit for purpose.
- The station needs to continue to be in this area as it is within half a mile of the optimum cover point for the East Central area, according to ORH.

Parking
- That allows space for staff private vehicles on site or very close by.

The case for change
In order to deliver the requirements outlined above there is a need to move from the current site in Brewery Road to a site in close proximity which provides these facilities.

2   **Option Appraisal**

  2.1   **Investment Objectives and Benefits Evaluation Criteria**
    2.1.1   Objectives
        o   To provide accommodation that can house the assets currently assigned to Islington station
        o   To provide additional assets with a site in central London close to Olympic and other locations.
        o   To provide an appropriate staff area and office space

o To be close to the current station location due to operational stand by location needs.

2.1.2 Benefit Criteria
The preferred option should be able to fulfil all the following benefits:
o Larger garage space to house Trust assets
o Increase flexibility for expansion
o Improve staff facilities and office space
o Reduce risk exposure to accidents and theft

2.2 Options

2.2.1 Stay at current site
Whilst this option is included, it is for comparative purposes only. It is recommended that this option is not adopted as the preferred option. This option does not fulfil any objectives laid out in 3.1.1 above and does not solve the problem of being able to expand in this part of London.

The current site occupies 68-70 Brewery Road, N7 with the dimensions of the current site below

Detail	Measurements
Square area of site	690 sq m. (7427 sq ft)
Garage space	
Office space	
Allocated ext spaces	3

The station currently has garage space for 8 vehicles in total. The rest of the complex resources are parked on the street in Brewery Road. Clearly this increases the chances of them being broken into making them a potential terrorist target. Guidance was issued subsequently to the 9/11 attacks regarding ambulance safety as they were seen as a soft target for those wanting to attack.

Costs of current site
The costs of the current site are shown below:

The current lease on the property was taken out on 23 May 2001 and was for 15 years (expires 23 May 2016). No separate lease costs exist.

Service Charge	0
Rent	£62,000 per annum (£8.41 per sq ft)
Rates	£32,215.50 per annum
Terrorism	£3,384.16 per annum
Gas	£1,400.00 per annum
Electricity	£5,500.00 per annum
Water	£200.00 per annum

Staff have difficulty parking their own cars and other modes of transport due to the restricted number of spaces allocated to the building. Staff cars have been broken into while they have been on duty lowering morale and causing them additional stress.

2.2.2 88 Brewery Road, N7 and release current site

88 Brewery Road N7 is located next door to the current site and will be available for lease in the immediate future.

The measurements for 88 Brewery Road are shown below:

Detail	Measurement
Sq area of site	1291 sq m (13,905 sq ft)
Garage space	10,259 sq ft
Office space	3618 sq ft
Allocated parking	5

Costs

The costs of use of this site are shown below:

Service Charge	0
Rent	£140,000 per annum
Rates	£70,000 per annum
Terrorism	£5,000 per annum
Gas	£2,000 per annum
Electricity	£7,000 per annum
Water	£350.00 per annum

In addition to the above costs there would be one off set up costs for the new station of £200,000. This would be to convert the inside of the building and make it fit for purpose. There would also be costs of £25,000 to return the current site to that which is in the lease agreement.

3 Lease another site in the area

Following a search of the area limited accommodation is available of the size we require. The area has a high demand due to its closeness to the city and west end and finding estate of the size and requirements above along with the required location has not uncovered anything.

3.1 Options Appraisal

The three options above are appraised against the objectives and benefits in the chart below:

	Objective 1	Objective 2	Objective 3	Objective 4
Stay at current site	X	X	X	X
88 Brewery Road	√	√	√	√
Another site	X	X	X	X

Please note option 3 has all crosses as no estate in the area is available to meet the criteria other than this property.

3.1.1 Benefits Criteria

	Benefit 1	Benefit 2	Benefit 3	Benefit 4
Stay at current site	X	X	X	X
88 Brewery Road	√	√	√	√
Another site	X	X	X	X

4 Recommendations

From the options appraisal against the objectives and benefits criteria the option to lease 88 Brewery Road N7 is the recommended course of action.

5 Economic Case: discounted cash flow

5.1 A discounted cash flow exercise is applied to two options: Option 1 "Do nothing – stay at current site" and the preferred option, Option 2 – "88 Brewery road site". This enables the net present value (NPV) and equivalent annual cost (EAC) to be calculated to allow cost comparison of both options.

5.2 The results of the discounted cash flow exercise is shown in the following table:

Option 1 : Do Nothing

Yr	Capital outlay	Lease/ rental	Rates	Utilities	Total	Discount factor	NPV
		£000	£000	£000	£000		£000
0	25	62	36	7	130	1.00	130
1		62	36	7	105	0.97	101
2		62	36	7	105	0.93	98
3		62	36	7	105	0.90	94
4		62	36	7	105	0.87	91
5		62	36	7	105	0.84	88
6		62	36	7	105	0.81	85
7		62	36	7	105	0.79	82
8		62	36	7	105	0.76	80
9		62	36	7	105	0.73	77
NPV							926
EAC							93

Option 2: 88 Brewery Road

Yr	Capital outlay	Lease/ rental	Rates	Utilities	Total	Discount factor	NPV
		£000	£000	£000	£000		£000
0	200	140	75	9	424	1.00	424
1		140	75	9	224	0.97	217
2		140	75	9	224	0.93	209
3		140	75	9	224	0.90	202
4		140	75	9	224	0.87	196
5		140	75	9	224	0.84	189
6		140	75	9	224	0.81	183
7		140	75	9	224	0.79	176
8		140	75	9	224	0.76	170
9		140	75	9	224	0.73	165
NPV							2,131
EAC							213

5.3 The NPV of the preferred option is £2.131m and the NPV of the Do Nothing option is £0.926m. This is because the new site is 47% larger than the current site. A comparison of revenue costs per square metre shows that the preferred option is marginally more expensive than the do nothing option at £173 per sqm compared to £151 per sqm. This needs to be considered in light of current market conditions and the relatively better state of the preferred option's building.

6 Affordability

6.1 The table below shows the impact on revenue cost of the Do Nothing option against the preferred option and the increase in revenue costs.

	Option 1 Do Nothing £000	Option 2 88 Brewery Road £000	Increase in cost £000
Lease rental	62	140	78
Rates	36	75	39
Utilities	7	9	2
Depreciation	1	10	9
capital charge	0	4	3
Total revenue cost	106	238	131

6.2 The increase in revenue costs of £131k will be met by internally generated funds.

6.3 The capital impact is an investment of £200k to bring the building into use as an ambulance station. Again this will form part of the Trust's capital programme and will be financed from internal funds.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

**Registering with the Care Quality Commission
in relation to healthcare associated infection 2009 – 2010**

1. **Sponsoring Director:**   Dr. Fionna Moore

2. **Purpose:**   *For consideration and approval*

3. **Summary:**   *This paper outlines the new requirement for all Trusts to register with the Care Quality Commission in relation to healthcare associated infection 2009 – 2010.*

     A copy of the online application form stating the Trust's compliance with the overall Health Care Associated Infections regulations and the current status on the nine hygiene code criteria is enclosed The form requires electronic sign-off by the Chief Executive, certifying that the forms have been considered by, and have the approval of, the Trust Board.

4. **Recommendation:**   *THAT the Trust Board formally consider the declaration on the form and approve submission to CQC by 6th February 2009*

London Ambulance Service NHS
NHS Trust

Report to Trust Board
27 January 2009

Registering the Trust with the Care Quality Commission
in relation to healthcare associated infection 2009 – 2010

Introduction

There is a new legal requirement on Trusts to protect patients and staff from healthcare associated infections (HCAI). The requirements (intended to come into force from 1st April 2009) apply to the healthcare services provided by all NHS trusts. The new Act and regulations build on the existing arrangements for NHS providers to prevent and control HCAI: Trusts can still tailor their response to HCAI to deal with particular local risks and circumstances

The Key dates in the registration process are given in Table 1 and the main changes in Table 2 (Appendices 1 and 2).

From 1st April 2009, any trust providing services that has not registered with the Care Quality Commission (CQC) will be committing an offence. When applying, the Trusts will need to state whether they comply with the new regulations relating to HCAI. CQC will assess trusts' applications to determine the category of registration. They will monitor, inspect and take enforcement action when necessary to protect patients. Information and action plans from reviews and inspections will also be shared with strategic health authorities (SHAs) and Monitor.

The CQC will send an email to the Chief Executive, with a link to the online webform on the day the application process opens (12 January 2009). The Trust will need to complete the online application form. The application form (Appendix 3) will ask the Trust to state whether it complies with the overall regulations and meets the nine hygiene code criteria. The forms will require electronic sign-off by the Chief Executive, certifying that the forms have been considered by, and have the approval of, the trust's board.

Table 1: Key dates in the registration process	
Milestones	
Department of Health's consultation on the new legal framework relating to HCAI.	11 August – 20 October 2008
Regional workshops to explain the registration process and answer any questions.	November – December 2008
Draft HCAI regulations laid before Parliament for approval.	Early January 2009
Trusts apply to register.	12 January – 6 February 2009
The regulations come into force (if approved by Parliament).	March 2009
The Care Quality Commission assesses applications, makes registration decisions and informs trusts electronically.	February – March 2009
Date from which trusts must be registered with the Care Quality Commission.	1 April 2009
The Care Quality Commission issues registration certificates and makes the register available to the public.	April 2009
Any representations and/or appeals from trusts are considered and registration decisions modified as necessary.	From April 2009
As part of ongoing monitoring and inspection, the Care Quality Commission carries out further checks and revises registration classifications, as necessary.	From April 2009
The Care Quality Commission takes any enforcement action that it considers necessary.	From April 2009
An aligned registration system for the NHS, independent healthcare and adult social care is in place, including HCAI.	From April 2010

1

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[1] Registering with the Care Quality Commission in relation to healthcare associated infection: guidance for trusts 2009/10. p.4.

Table 2: The changes

Current system	New system
• At the moment, trusts are legally obliged to "observe the provisions" of the hygiene code.	• The new legal requirement is that each trust is, and will continue to be, in compliance with the regulations setting out the requirements on HCAI. • Trusts will need to apply to the Care Quality Commission for registration – any unregistered trust that continues to provide services without our permission would be acting illegally.
• The detailed provisions of the hygiene code are fairly prescriptive.	• The Care Quality Commission will decide whether trusts are meeting the legal requirements. We will make this decision by referring to the high level compliance criteria of the revised code, using information provided by the trust on its application, and other relevant evidence.
• The annual health check links three core standards to the provisions of the hygiene code (C4a, C4c, C21) and trusts must make a statement on the measures they have in place to comply with the code.	• Applications for registration look at the present and also the future. Trusts will, in this transitional year, still be required to declare retrospectively against the three relevant core standards for the 2008/09 annual health check, but will not be required to make an additional statement about HCAI.
• Each acute trust receives an annual inspection visit from the Healthcare Commission's HCAI team. The Healthcare Commission is also visiting some non-acute trusts during 2008/09.	• Following registration the Care Quality Commission will continue to monitor all trusts and carry out inspections.
• The Healthcare Commission has powers to issue improvement notices and recommend special measures.	• The Care Quality Commission will have a wider range of enforcement powers.
	• A wider registration system, covering all aspects of care (not just HCAI), will apply from April 2010. It will align registration systems for the NHS, independent healthcare and adult social care.

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[2] Registering with the Care Quality Commission in relation to healthcare associated infection: guidance for trusts 2009/10. p.5.

Part 1: Details for registration.

Name of trust:

Contact address:

Email address:
(For all electronic communication about this application)

Part 2: Statement of compliance with the proposed requirement for the regulation of regulated activities relating to health care associated infections (HCAI) that will, subject to parliamentary approval, come into force on 1 April 2009.

Requirement: A service provider in respect of carrying on of a regulated activity must, so far as practicable, ensure that patients, healthcare workers and others who may be at risk of acquiring a healthcare associated infection, are protected against identifiable risks of acquiring such an infection by the means specified in the regulations.

Statement: The trust considers it is, and will continue to be, in compliance with this requirement that will, subject to parliamentary approval, come into force on 1 April 2009.

☐ Compliant ☐ Not compliant

3

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3 Registering with the Care Quality Commission in relation to healthcare associated infection: guidance for trusts 2009/10. p.18-20.

Part 3: Statement on whether the criteria set out in the Code of Practice about compliance with the regulation on HCAI are being, and will continue to be, met.

The supporting guidance to the Code of Practice illustrates how each of these criteria may be reliably met. Declaration of an improvement plan to strengthen systems of compliance will not necessarily be reflected in conditions being imposed on registration: this will be reserved for cases where it is considered there is a need for action to address a significant risk of the registration requirement being breached.

Criterion 1: The trust has in place and operates effective management systems for the prevention and control of HCAI that are informed by risk assessments and analysis of infection incidents
☐ meets   ☐ partly meets   ☐ not met
[drop down cell if entry is other than "meets"]
Description of the issue: summary of action planned (with dates for completion)

Criterion 2: The trust provides and maintains a clean and appropriate environment that facilitates the prevention and control of HCAI
☐ meets   ☐ partly meets   ☐ not met

Criterion 3: The trust provides suitable and sufficient information on HCAI to patients and the public and to other service providers when patients move to the care of another healthcare or social care provider
☐ meets   ☐ partly meets   ☐ not met

Criterion 4: The trust ensures patients presenting with an infection or who acquire an infection during treatment are identified promptly and receive appropriate treatment and care to reduce the risk of transmission
☐ meets   ☐ partly meets   ☐ not met

Criterion 5: The trust gains the co-operation of staff, contractors and others involved in the provision of healthcare in preventing and controlling infection
☐ meets   ☐ partly meets   ☐ not met

Criterion 6: The trust provides or can secure adequate isolation facilities
☐ meets   ☐ partly meets   ☐ not met

Criterion 7: The trust secures adequate access to laboratory support
☐ meets   ☐ partly meets   ☐ not met

Criterion 8: The trust has, and adheres to, appropriate policies and protocols for the prevention and control of HCAI
☐ meets   ☐ partly meets   ☐ not met

Criterion 9: The trust ensures, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAI
☐ meets   ☐ partly meets   ☐ not met

Part 4: Supplementary information to support this application.

Trusts may wish to record here significant information that provides additional evidence that the requirement to protect patients, healthcare workers and others from identifiable risks of acquiring an HCAI are, and will continue to be, met. This should include confirmation whether any planned action to address non-compliance in the Core Standards Declaration for 2007/08 regarding C4a, C4c and C21 has been completed, or will be by 31 March 2009). It may also include brief comment on how well targets on the reduction of HCAI, as appropriate, are being met.

Part 5: Indication of willingness to receive notices by electronic communication.

☐ The trust is willing to receive notices with respect to this application for registration by electronic communication to the email address provided in Part 1.

☐ The trust is not willing to receive electronic communications.

(This will include any notice of proposals and the notice of decision provided by ss 26 & 28 of the 2008 Act)

Part 6: Electronic sign off by the trust chief executive.

☐ This application has been considered by the trust board and has been formally agreed by it prior to my sign off.

Title	Full name of chief executive

Date:

It is an offence under section 37 of the 2008 Act to make a statement that is false or misleading in a material aspect in an application form.
Please ensure that the form does not contain any confidential information about patients or staff.

Application for registration with the Care Quality Commission in relation to healthcare associated infection

Part 1: Details for registration.

Name of trust: **London Ambulance Service NHS Trust**

Contact address: **220 Waterloo Road**

London
Greater London

Email address: **peter.bradley@lond-amb.nhs.uk**
(For all electronic communication with respect to this application)

Part 2: Statement of Compliance with the proposed requirement for the regulation of regulated activities relating to health care associated infections (HCAI) that will, subject to Parliamentary approval, come into force on 1 April 2009.

Requirement: A service provider in respect of carrying on of a regulated activity must, so far as reasonably practicable, ensure that patients, healthcare workers and others who may be at risk of acquiring a healthcare associated infection, are protected against identifiable risks of acquiring such an infection by the means specified in the regulations.

Statement: The trust considers it is, and will continue to be, in compliance with this requirement that will, subject to parliamentary approval, come into force on 1 April 2009.

● **Compliant**   ○ **Not Compliant**

Care Quality Commission

Part 3: Statement on whether the criteria set out in the Code of Practice about compliance with the regulation on HCAIs are being, and will continue to be, met.

(The supporting guidance to the Code of Practice illustrates how each of these criteria may be reliably met. Declaration of an improvement plan to strengthen systems of compliance will not necessarily be reflected in conditions being imposed on registration: this will be reserved for cases where it is considered there is a need for action to address a significant risk of the registration requirement being breached.)

Criterion 1: The trust has in place and operates effective management systems for the prevention and control of HCAI that are informed by risk assessments and analysis of infection incidents
meets
Criterion 2: The trust provides and maintains a clean and appropriate environment that facilitates the prevention and control of HCAI
meets
Criterion 3: The trust provides suitable and sufficient information on HCAI to patients and the public and to other service providers when patients move to the care of another healthcare or social care provider
partly meets
An action plan is being developed to fully meet the Criteria by March 2009
Criterion 4: The trust ensures patients presenting with an infection or who acquire an infection during care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission
meets
Criterion 5: The trust gains the co-operation of staff, contractors and others involved in the provision of healthcare in preventing and controlling infection
partly meets
A training package for Prevention and Control of Infection is being developed for all staff in the Trust
Criterion 6: The trust provides or can secure adequate isolation facilities
meets
Criterion 7: The trust secures adequate access to laboratory support
not met
This criteria is not applicable to Ambulance Trusts
Criterion 8: The trust has, and adheres to, appropriate policies and protocols for the prevention and control of HCAI
meets

Criterion 9: The trust ensures, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAI

meets

Part 4: Supplementary Information to support this application.

Trusts may wish to record here significant information that provides additional evidence that the requirement to protect patients, healthcare workers and others from identifiable risks of acquiring an HCAI are, and will continue to be, met. This should include confirmation whether any planned action to address non-compliance in the Core Standards Declaration for 2007/08 regarding C4a, C4c and C21 has been completed, or will be by 31 March 2009. It may also include a brief comment on how well targets on the reduction of HCAI, as appropriate, are being met.

The Trust was compliant with core standards C4a and C21 in 2007/08 and is planning to declare compliant with C4a,C4c and C21 in the 2008/09 declaration in March 2009.
The Trust achieved Level 1 NHSLA Risk Management standards for Ambulance Trust in Nov 08 and an action plan is developed based on the comments received from the assessors on infection control.

The Trust is also reviewing the National Patient Safety Agency recommendations on Infection Control and will develop an action plan for implementation in 2009/10

Part 5: Indication of willingness to receive notices by electronic communication.

The trust is willing to receive notices with respect to this application for registration by electronic communication to the email address provided in Part 1.

(This will include any notice of proposals and the notice of decision provided by ss 26 & 28 of the 2008 Act)

Part 6: Electronic sign off by the trust chief executive.

This application has been considered by the trust board and has been formally agreed by it prior to my sign off.

Name of chief executive:

Mr Peter Bradley

Signature of chief executive ....

Date of chief executive sign-off........................

Name of person completing the electronic form:

Mrs Laila Abraham

It is an offence under section 37 of the 2008 Act to make a statement that is false or misleading in a material aspect in an application form

Please ensure that the form does not contain any confidential information about patients or staff.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Adoption of Nolan Principles of Standards in Public Life &
Code of Conduct for NHS Managers

1. **Sponsoring Director:** Michael Dinan

2. **Purpose:** *For adoption and approval*

3. **Summary:** *The adoption of these Standards is deemed as "good practice" and ensures compliance with the requirements of the Healthcare Commission and the Auditor's Local Evaluation (ALE) process as they form part of the Annual Health Check score. ALE has an explicit requirement for the Trust Board to pro-actively raise the standards of ethical conduct among all staff by formally adopting the Nolan Principles and the Code of Conduct for NHS Managers.*

4. **Recommendation:** *THAT the Trust Board formally adopts the Nolan Principles of Standards in Public Life and the Code of Conduct for NHS Managers.*

London Ambulance Service **NHS**

NHS Trust

Report to Trust Board
27 January 2009

Standards of Business Conduct

1. **Introduction**

As a public service funded by the taxpayer, the NHS and those that work in it have a duty to conduct NHS business with probity. They also have a responsibility to respond to staff, patients and suppliers impartially; to achieve value for money from public funds and to demonstrate high ethical standards of personal conduct.

In order to demonstrate these duties and responsibilities, NHS bodies are encouraged to recognise the seven principles of public life, as defined by the Committee on Standards in Public Life (the Nolan Committee) (1995), and adopt the NHS Code of Conduct for Managers and staff, as part of the provisions of the Auditors Local Evaluation (ALE) requirements

This report provides the means of meeting the above requirements.

2. **The Seven Principles of Public Life – the 'Nolan' Principles**

The first report of the Committee on Standards in Public Life (the 'Nolan Committee') issued in May 1995, identified seven principles which underpin all aspects of public life. These principles are:-

(1) Selflessness – Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

(2) Integrity – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

(3) Objectivity – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

(4) Accountability – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

(5) Openness – Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

(6) <u>Honesty</u> – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

(7) <u>Leadership</u> – Holders of public office should promote and support these principles by leadership and example.

The Trust Board is invited to formally recognise these principles as indicating the standards it expects from Board Members and staff individually and will hold all Members and staff accountable for meeting those standards. Following the Board's considerations , it is also proposed to communicate these principles to staff through publishing it on **PULSE** and RIB which provides evidence for key line of enquiry (KLOE) 4.3.8 (level 3) of the 2008/09 ALE requirements.

3. Code of Conduct for NHS Managers

The Code of Conduct for NHS Managers sets out the core standards of conduct expected of NHS managers, which underpins the principles by which NHS organisations, management and staff make decisions and can be held accountable. It aims to serve two purposes: to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make, and to reassure the public that these important decisions are being made against a background of professional standards and accountability.

A copy of the Code of Conduct for NHS Managers is attached. A copy will also be sent to all the senior managers within the Trust.

4. Recommendations

The Trust Board is invited to:

- **Acknowledge and adopt the Nolan Principles;**

- **Acknowledge and adopt the Code of Conduct for NHS Managers and NHS Staff;**

- **Agree to support Trust staff in upholding those principles at all times**.

Code of Conduct for NHS Managers

Code of Conduct
for
NHS Managers
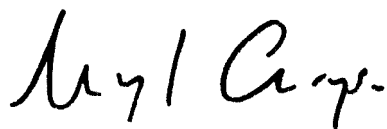
Introduction

1.	As part of the response to the Kennedy Report, the attached *Code of Conduct for NHS Managers* has been produced by a Working Group chaired by Ken Jarrold CBE.

2.	The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

	●	to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.

	●	to reassure the public that these important decisions are being made against a background of professional standards and accountability.

3.	The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

4. The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity. A document on implementation is attached.

NIGEL CRISP   **9 October 2002**
NHS Chief Executive

Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;

- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;

- be honest and act with integrity;

- accept responsibility for my own work and the proper performance of the people I manage;

- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;

- take responsibility for my own learning and development.

This means in particular that:

1   I will:

- respect patient confidentiality;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;

- be guided by the interests of the patients while ensuring a safe working environment;

- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and

- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

2   I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;

- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;

- relatives and carers are, with the informed consent of patients, involved in the care of patients;

- partners in other agencies are invited to make their contribution to improving health and health services; and

- NHS staff are:

   – valued as colleagues;

   – properly informed about the management of the NHS;

   – given appropriate opportunities to take part in decision-making.

   – given all reasonable protection from harassment and bullying;

   – provided with a safe working environment;

   – helped to maintain and improve their knowledge and skills and achieve their potential; and

   – helped to achieve a reasonable balance between their working and personal lives.

3   I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;

- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;

- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and

- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4   I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;

- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and

- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;

- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5   I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;

- leadership is encouraged and developed at all levels and in all staff groups; and

- the NHS plays its full part in community development.

6   I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;

- keep up to date with best practice; and

- share my learning and development with others.

Department of Health   **October 2002**

Implementing the Code

IMPLEMENTING THE CODE

1.   The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life', the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

2   In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

     In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who

     (i)   manage their staff or services; *or*

     (ii)   manage units which are primarily providing services to their patients

     also observe the Code.

3   It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek

to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;

- given clear, achievable targets;

- judged consistently and fairly through appraisal;

- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and

- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

Breaching the Code

4   Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5   Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

Application of Code

6   This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the 'Agenda for Change' negotiations is likely to be

used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7   For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;

- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

Action

8   Employers are asked to:

(i)   incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity *and* include the Code in the employment contracts of new appointments to that group;

(ii)   identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

(iii)   investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

(iv)   provide a supportive environment to managers (see paragraph three above).

October 2002

NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

The Code of Conduct for NHS Managers Directions 2002

The Secretary of State for Health, in exercise of the powers conferred by section 17(**a**), paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977, and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990(**b**), hereby gives the following Directions:

Application, commencement, interpretation

1.-(1) These Directions apply to all NHS bodies in England and shall come into force on 9 October 2002.

(2) These Directions shall be referred to as The Code of Conduct for NHS Managers Directions 2002.

(3) In these Directions "NHS bodies" means:

  (i) Strategic Health Authorities

  (ii) Special Health Authorities

  (iii) NHS Trusts

  (iv) Primary Care Trusts

Implementation of Code of Conduct for NHS Managers

2. NHS bodies shall take all reasonable steps to comply with the requirements set out in the *Code of Conduct for NHS Managers* appended to these Directions.

Effect of Direction 2

3. The fact of compliance or non-compliance with Direction 2 shall in itself have no effect on the validity or enforceability of a contract entered into by an NHS body to which these Directions apply.

Signed by authority of the Secretary of State for Health

M G Sturges

4 October 2002   Department of Health

(**a**) 1977 c. 49. Section 17 was substituted by section 12(1) of the Health Act 1999 (c.8) and was amended by Schedule 5, Part 1, paragraph 5(1) and (3), to the Health and Social Care Act 2001 (c.15) and by Schedule 1, paragraph 7 to the NHS Reform and Health Care Professions Act 2002 (c.17).

(**b**) Paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977 (1977 c.49), and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990 were amended by section 6 of the Health and Social Care Act 2001 (c.15).

Working Group Members

Ken Jarrold CBE

Chief Executive
County Durham and Tees Strategic Health Authority

Dr Gill Morgan

Chief Executive
NHS Confederation

Stuart Marples

Chief Executive
Institute of Healthcare Management

Professor Jenny Simpson OBE

Chief Executive
British Association of Medical Managers

John Flook

Chairman
Healthcare Financial Management Association

Penny Humphris

Director
NHS Leadership Centre

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Draft Assurance framework and top ten corporate risks

1.	**Sponsoring Director:**	Michael Dinan
2.	**Purpose:**	*For discussion and noting*
3.	**Summary:**	*The Assurance Framework is the key mechanism by which the Board assures itself that the risks to its strategic objectives are being managed. As such, it is central to systems of internal control and feeds into the Statement of Internal Control produced on an annual basis. The Assurance Framework identifies and quantifies all risks that may potentially compromise the organisation's ability to meet its strategic objectives.*
		The Trust Assurance Framework document is being updated with the current high risks from the Risk Register. The risks within the Risk Register are also being reviewed and updated with the risk owners and the risk register template is being updated to reflect best practice.
		The top 10 risks from the Trust's Risk Register are presented separately.
		The Assurances Framework and the Risk Register will be presented to the Audit Committee and Trust Board in March 2009.
		The Trust is planning to use Performance Accelerator for managing the Assurances Framework and Risk Register in the new financial year (2009/10).
4.	**Recommendation:**	*THAT the Trust Board note the draft Assurance framework and the top ten risks from the risk register, mitigating actions and assurances.*

London Ambulance Services NHS Trust Assurance Framework									
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**	**Compliance**
	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
What the Organisation aims to deliver		*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*			*Standards that the Government have set and expects all Trust's to aspire to in order to improve the quality of care and treatment provided to patients.*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective.*	*We have evidence that shows we are reasonably managing our risks and objective are being delivered.*	*Where are we failing to put controls /systems in place. Where are we failing in making them effective*	
2) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt, (b) To meet Accident and Emergency targets and prepare for new ones, as follows:- (1) 75% category A 8 minute (for the year as a whole), (2) 95% Category A 19 minute (for the year as a whole), (3) 95% Category B 19 minute by March 2009. (c) Financial break-even		There is a risk that the Trust may fail to meet national, local and Trust targets	OPER	20	Martin Flaherty	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	• LAS Performance Improvement Plan (PIP) updated and now in week 11 of 21 • Briefings are continuing to be held at senior and middle manager level across the Trust • Stretch Targets reviewed and regularly monitored for each Ambulance Complex (Geographical Area) • Communications Strategy for final four months finalised • Technology enhancements to improve Fast Response Unit activation implemented resulting in 30 second improvement in FRU activation. • Numbers of FRUs increased from 95 to 115 at peak times. • 9% overall improvement in FRU Cat A performance secured as a result of technical and operational changes. • December Staffing Plan successfully delivered maintaining safe levels of performance across the Christmas period. • New incentive scheme implemented across the trust in January rewarding improved activation and mobilisation. • Improved procedures negotiated with trade unions designed to improve resource availability • Improved tasking regime for Motorcycle and Cycle Response Units implemented. • New Patient Report Form with improved 'Clinical Handover' and 'Patient Offload' dat	Regular performance meetimgs with SHA, PCT and Trust Board	Performance Reports Minutes of SMG, Trust Board		

London Ambulance Services NHS Trust Assurance Framework									
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	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	250	There is a risk that out of date equipment (PALS PACK) may result in inability to treat Paediatrics.	LOG	20	Christoph er Vale	1) Safety - **C4(b)** Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	• Vehicle and Equipment Working Group. 1. Ongoing audit of all PALS Packs and update equipment to vehicle working groups, to be included in Asset tracking system. 2. A more robust process for monitoring	• Logistic team check PALS packs are maintained on vehicles • Systems in place to minimise risks from acquisition and use of medical devices in accordance with guidance issued by MHRA.	• Provision and Maintenance of Defibrillators • Trolley bed, Manger Elk spec • Suction units	Asset tracking system dependant on IM&T and when new server available	
3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	265	Inability to match resources to demand. Rosters do not match current demand. Weak at weekends.	OPER	20		3) Governance - **C7(f)** Healthcare organisations meet the existing performance requirements.	• The Trust is to achieve the new clock start government target of 75% within 8 minutes; Category B 90% within 19 minutes. • Performance Improvement Managers (PIMs) will start to review rotas and allocate new staff toting of need to match demand. • The Trust has implemented many of the recommendations made in the final report by ORH October 2007; - Blue 8 Software introduced to EOC to identify high areas of demands with a view of Resource in the high demand area and peripheral areas. - The Trust implemented AAC (Active Area Cover) to strategically place Resource in areas of high demand along with covering areas with little or no cover. 1. Moderate uptake with weekend-only rotas for relief staff. 2. Introduction of sector support rotas for weekend cover. 3. Re-profile overtime to times of greatest need. 4. Change core rotas in new model - Agreement being negotiated with unions.	• NWOW is currently on schedule • Sector support rotas have been introduced for staff to work solely at night or during weekends • Over time at 'double time' has been made available to staff between 11pm and 3am on Fri., Sat. and Sun. • All new staff join a relief rota where they work 7/10 weekends. • Overtime widely allocated amongst staff - less concern about excessive hours • "New ideal" matches demand to resources (trialled in South, due to roll out to all RCs Mar 08)	• Chief Executive Board Reports • Interim Workforce Information	• core rotas are under discussion.	

Prinicipal Objectives	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	267	Delay in activating vehicles due to the unavailability of vehicles	OPER	20	Richard Webber	3) Governance - **C7(f)** Healthcare organisations meet the existing performance requirements.	• AMPDS prioritisation. • OP/023 Procedure for Dispatch of Resources by EOC (incorporates the section ' Communication of a Delay for Emergency, Urgent and Non urgent Calls'). • DSO and AOMs ensure and encourage crews to be available for calls as quickly as possible after patient hand over • Fleet Status Report Additional funding received and increased mobile workshop provision. • Active Area Cover (AAC) implemented, being monitored by both Staff side and Senior Management. • Ongoing recruitment drive by the Trust advertising for 400 new staff of which some will be to bring Urgent Care back up to their funded establishment 1. Team Leaders and managers to staff extra vehicles, every day, from every complex between 11.00 - 20.00hrs. 2. More use of single responders, by increased numbers of FRUs, MRUs, and CRUs. 3. Single responders as standard response (part of new model). 4. Shorter job cycle (freeing up ambulances) by having ambulances closer to calls, via dynamic deployment. 5. Increase in Urgent Care (to 202) and	• Fleet and Transport Management • Operational performance • The Trust is now fully staffed. • Work is underway to reduce the job cycle time, in order to produce more available ambulances. • A reduction in the double-sending of vehicles and more calls receiving a response by FRU will reduce the risk. FRUs will be dispatched to AMBER 1 & 2 calls, but not where there is another ambulance nearer and available. • FRU staff encouraged to advise Sector ASAP when an ambulance is no longer required.	• SMG reports • Chief executive Board Reports		
5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	269	At shift changeover times, LAS performance falls as we take longer to reach patients.	CLIN	20	Richard Webber	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	1. Existing rest break arrangements to be reinforced following the review. 2. New rotas agreed with staff will not allow a 7am/pm start/finish. 3. Team Leaders have started a new shift, working from 14.00 - 20.00 each day to bridge the evening changeover period. 4. 'New Ways of Working' model will introduce staggered start and finish times at all stations.	• Performance Monitoring • Staggered start and finish times for FRUs and 24 hours ambulances. • Increased numbers of crews having rest breaks due to better management from EOC	• Chief Executive Board Reports		

London Ambulance Services NHS Trust Assurance Framework										
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London Ambulance Services NHS Trust Assurance Framework									
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7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews. (b) Processes with DH to prepare Single Equality Scheme for publication in 2007. (c) Improve Trust administrative and five management processs.		There is risk that failure to address business continuity in all critical systems may lead to critical system failure	BC	20		7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	• Requirement being monitored by Business Continuity Steering Group • Major Incident Plan • Emergency Planning Strategy Steering Group	• Emergency Planning Manager to determine the requirements for ICR back-up with Director of Operations.	• Major Incident Plan • Audit of Civil Contingencies Act report • Training and fall back tests undertaken Trust Board Minutes		

London Ambulance Services NHS Trust Assurance Framework									
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7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.		There is a risk that that the Trust may find it difficult to recruit the right membership deliver Foundation Trust application	FINANCE	20	John Wilkins		Trust Board Foundation Trust Lead meetings		Board minutes		

London Ambulance Services NHS Trust Assurance Framework									
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**	**Compliance**
	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	9	Risk of RTA injury to persons travelling in an LAS A&E vehicle.	HS	16	Richard Webber	1) Safety - **C1(a)** Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	• Process for monitoring incidents reports is regular; received by Corporate Health and Safety Groups • Risk Information report to CGC and RCAG. • Motor Risk Group. 1. Review adequacy of driving course and include training for specific vehicles (i.e. FRUs). 2. Monitor process at Corporate Health and Safety Group. 3. Investigate benefits of a reward scheme. 4. Ensure refresher training is provided following RTA's. 5. Introduce Black Box technology in 20-25 FRU's located in Old West Sector on a phased basis. 6. Develop robust system for tracking individual accident rates, including lease car drivers.	• A&E Op's bulletin issued, also H&S bulletin updating on legal requirement. • Incident reporting to NPSA • Risk Reporting and Assessment Procedure. • NWOW is an ongoing project – seminar incorporating rostas and changeover times to aid performance with a view of minimising patient's waits for an ambulance. • All new A&E ambulances fitted with recessed child harness in head and attendants seats. • All new PTS ambulances are fitted with all age (above yrs) adjustable harnesses. • All vehicles have a "must be worn" sign. • A&E Op's bulletin issued, also H&S bulletin updating on legal requirement.	• Complaint action plan • RCA criteria and training • Health, Safety and Risk Training and Provision of H&S Information • Patient Safety - learning and changes • Clinical Governance Annual Report • Incident Reporting Procedure (LA52s)	
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	31	There is a risk that the control and operational staff may fail to recognise serious materity issues or fail to apply correct guidelines which may lead to serious adverse patient outcome in maternity cases.	CLIN	16	Fionna Moore	1) Safety - **C1(a)** Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	• Monitoring by Clinical Governance Committee • Obstetrics Incident Report and Action plan held under review by Clinical Governance Committee • Medical Director has appointed LAS consultant midwife as Trust representative on NPSA Obstetrics Pan London Forum • Prompt sheet issued to crews as part of maternity packs	• Working closely with the NPSA and other organisations where there are incidents involving both maternity and ambulance services. • Themed Risk Information Report on Obstetric cases and action plan, presented to CGC. • Complexes arranged for local midwifes to deliver training sessions • Obstetrics modules ready for delivery as a CPD course • Data shows reduction in potential obstetric claims compared with previous year (RCAG Oct08) - low number of cases but is still a high risk to the Trust.	• SUI and complaint action plans • RCA criteria and training • Quality Assurance Department newsletters • Infection Control Report • Health, Safety and Risk Training and Provision of H&S Information • Patient Safety - learning and changes • Incident Reporting Procedure (LA52s)	

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3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	35	Risk of loss of Patient Report Forms or inappropriate access to patient related information, due to lack of security.	OPER	16	Richard Webber	3) Governance - **C9** Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	• Information Governance Toolkit return • Information Governance Group • PRF monitoring by CARU and Management Information teams • Records Management Strategy • Records Management Policy • Records & Information Management Team 1. Development of procedure. 2. Audit on PRFs.	• Secure post boxes installed on each station • Business Continuity Plans include arrangements for securing patient related information • Minutes of Information Governance Group • PRF Project PID to be written following receipt of Final Audit - Internal Audit recommendations to minimise loss of Patient Report Forms or inappropriate access to patient records; reducing loss of PRFs and tighten up on patient confidentiality • PRF user guide and PFR code card	• Records Management Policy • Audit of PRFs • Access to Health Records Policy • Plan for updating TP017 • effective systems in place as advised by Records Management NHS Code of Practice April 2006		
3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	34	Risk of operational staff not being released to attend regular CPD modules and complex based training activities, as defined in the Training Plan.	OPER	16	Martin Flaherty	3) Governance - **C11(b)** Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.	• Training Services Committee • Processes now in place to ensure that staff who do not attend mandatory training are re-booked and that an audit will take place to ensure that they attend and that their managers are informed. • Successful IHCD inspection of Education and Development completed in February 2006. • TNA reported to Training Service Committee and monitored • Training Plan reported to RCAG 1. New Ways of Working will have protected training time 2. Staff will be able to self book on to modules as and when suits 3. Large recruitment drive for front line staff, which will assist and support staff to attend regular CPD modules.	• Discrete packages to update skills are delivered to EMTs on a continuous rolling basis. • Training Records. • Any EMT3 who wishes to progress to EMT 4 is required to have the evidence of having attended all mandatory training • Training Service Committee Minutes • Format for delivering refresher/development courses redesigned to provide training on a one day modular basis. • E&D tutor vacancies have impacted upon some complex based activities • Recruitment - additional open days. • NWOW - training days incorporated into the rota therefore staff will be able to develop skills accordingly.	• Corporate induction • Station local induction records • Mandatory training • HPC standards of proficiency • Policy on the Registration of Professional Clinical Staff		

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5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	138	Failing to appreciate the significance of psychiatric illnesses.	CLIN	16	Bill O'Neill	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	• In EOC - AMPDS provides a call prioritisation for all calls including those where the patient has a mental illness. • Addressed on EMT course and intermediate tier course. • ECP training. • Mental Health Strategy. • Training for all operational staff in managing Children and Vulnerable Adults. • Use of guidance for treatment of psychiatric patients in JRCALC Guidelines. • Awareness for Uk influenza pandemic contingency plan are discussed at the Emergency Planning Steering Group.	• Reporting procedure for patients who are assessed as being "at risk". • Review of TP/018 suspected causes of Child Abuse procedure and TP/019 Suspected Abuse of Vulnerable Adults procedure has been completed, and revised procedures approved by CGC. • Service works with Local Resilience Forum • Mental Health CPD module included in Training Plan	• Highlighted at Chief Executive Consultation Meetings. • Work on e-learning project suitable for on-line learning		
7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	273	There is a risk that methods of working at FBC can no longer mirror working practices in Control Services at HQ. In particular at present UOC & CTA cannot operate as part of Fallback at Bow.	BC	16	Stephen Moore	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	• Fall back test undertaken on 16/17 October • Fall back results being monitored by Business Continuity Steering Group(BCSG)) • DH Audit Report • Major Incident Plan • Emergency Preparedness Strategic Steering Group 1. Develop Plan if required to ensure that UOC will transfer successfully to FBC Bow. 2. Provide adequate training in order that personnel deployed to FBC are familiar with the processes in use.	• Action plan under review pending outcome from recent test and to prepare for next test. • BCSG Minutes are reported to Risk Compliance & Assurance Group • Fallback test reviewed at debrief held on 12/11 and Report produced Dec 07 to be discussed at SMG. • Plans in hand to carry out regular tests from May 2008 and first meeting of Project Board took place 21/12. However, Fallback will not provide for operation of UOC or CTA at Bow.	• Major Incident Plan • Audit of Civil Contingencies Act report • Training and fall back tests undertaken		
7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	274	No Incident Control Room (ICR) back-up site.	BC	16	Stephen Moore	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	• Requirement being monitored by Business Continuity Steering Group • Major Incident Plan • Emergency Planning Strategy Steering Group	• Emergency Planning Manager to determine the requirements for ICR back-up with Director of Operations.	• Major Incident Plan • Audit of Civil Contingencies of English Ambulance Service report		

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London Ambulance Services NHS Trust Assurance Framework									
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2) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt, (b) To meet Accident and Emergency targets and prepare for new ones, as follows:- (1) 75% category A 8 minute (for the year as a whole), (2) 95% Category A 19 minute (for the year as a whole), (3) 95% Category B 19 minute by March 2009.	22	There is a risk that failure to undertake comprehensive clinical assessments which may result in the inappropriate non-conveyance or t/ment of patient	CLIN	15	Fionna Moore	2) Clinical and Cost Effectiveness - **C5(b)** Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.	1. Explore the current use of treat and refer protocols – focus on NWOW sights to roll out pathways and trial local initiatives. 2. Use Datix to demonstrate a reduction in incidents. 3. Operational workplace review to take place twice a year. 4. Develop systems whereby staff learn from mistakes – reflective practice, staff learning from complaints, who is encouraging this and developing systems accordingly, for example, the introduction of reflective practice.	• EMT4 Modular training provides Standardised lessons on how to undertake comprehensive clinical assessments • Themed report on non conveyance presented to the CGC on 4th Feb and the patient assessment module delivered to staff. • CPI's identify an array of clinical skills that indicate the level of patient care by auditing PRF's. • EOC Training officers now conduct such exercises with EOC staff. • Outcome reports completed to indicate the action taken • The terms of reference of the Complaints Panel are being reviewed to ensure emerging themes, practice and methodology can be widely incorporated. • Reports regularly presented to CGC • Proforma for the OWR finalised and communicated with managers and staff	• Information about local management structure / role of Team Leaders / CPIs etc. • KPIs for Rideouts recorded locally by team leaders. Should be available via individual files • Quarterly Rideout form • Annual Complaints Report		
7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	279	Pandemic – Total of 25% personnel ill for about 8 days (Duration of pandemic c.12 weeks), with predicted 10% additional absenteeism due to caring for dependants = 35% over total period.	BC	15	Stephen Moore	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	• Pandemic flu plans developed with LAS staff involved in DH planning groups • V6 of LAS Pandemic Flu Plan issued for comment 24/4/07. • Progress being monitored by Emergency Preparedness Strategic Steering Group and Business Continuity Steering Group. 1. Encourage take-up of appropriate vaccine as available /developed by LAS personnel (critical services and vital support) 2. New version of LAS Pandemic Plan to be produced	• V.6 LAS Pandemic Plan issued + Pandemic Communications Plan, under development • Strategic Plan produced and to be sent out to Pandemic Flu group, and operational plan being developed	• Pandemic Influenza Plan currently being rewritten • Major Incident Plan • Audit of Civil Contingencies of English Ambulance Service report		

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7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	299	No surplus power at HQ resulting in there being no capacity to introduce new equipment, as services are currently being used to the maximum.	BC	15	Martin Nelhams	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	• Install a sub-station/transformer on the site to allow additional power to be supplied by EDF	• Capita have been appointed to undertake the feasibility study.	• Major Incident Plan • Audit of Civil Contingencies of English Ambulance Service report		
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	306	Failure to undertake Vehicle Daily Inspections before driving vehicles in relation to roadworthiness checks as required by Road Traffic law.	LOG	12	Christoph er Vale	1) Safety - **C1(a)** Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	1. Introduce personal issue roadworthiness VDI carbonated book. To be completed by first driver of vehicle pre-shift or at commencement of shift. Top copy to be attached to revised LA1 form at end of shift. Maintain existing audit of LA1 (and attached form) and require additional "spot checks" of carbonated books during shifts to check compliance. 2. Freight Transport Association to carry out adhoc checking of vehicles and records to assess compliance.	Staff required to complete roadworthiness checks on form LA1. Percentage of LA1 forms audited by Team Leaders for compliance			

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1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	296	There is a risk that staff may be exposure to carbon monoxide fumes as a result of attending 999 calls	CLIN	12	Marc Rainey	1) Safety - **C1(a)** Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	1. Complete feasibility study 2. Extensive staff awareness campaign 3. Evaluation of CO monitors on ambulances. 4. Evaluation of personal CO alarms. 5. Put in place robust safety measures to protect crew staff from exposure to CO. 6. Assess AMPDS for effectiveness of detecting CO poisoning.	• Action plan to be drafted and feasibility of having CO monitors on all cars to be investigated.		Very few existing controls, only HART and Deptford FRU's carry carbo-oxyhaemoglobin monitors. Expert views are being sought from HART, who need to advise on action plan to be taken.	

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3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	249	Loss of FRU cover due to inappropriate tasking.	OPER	12	Richard Webber	3) Governance - **C7(b)** Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.	1. Review EOC performance targets.	• Both desks can now see each others resources. Auto dispatch making better use of resources. • Implementation of FREDA in November 2007 has tightened and improved the business rules around auto dispatch further with a greater clinical element added to the equation. • As FREDA has been activating ambulances quicker, FRED activations of FRU's has reduced, this in turn reduces the number of dual responses.	• Reports to SMG, CGC, RCAG		

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5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	293	The risk that that Patient Specific Protocols (PSP) and palliative care, out of hours forms, etc. may not be triggered when the patient's address is identified during 999 call.	OPER	12	David Whitmore	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	1. All existing PSPs to be cross referenced againt the hard copy files held by the Medical Directorate. • All PSPs, out of hours forms and 'clinical flags' have been checked for accurate addresses and clinical reason for the flag	• Management Information have inherited the system from EOC only relatively recently • Currently checks are made to verify the address against the LAS Gazetteer, and to check for duplicate entries. It is surmised that over previous years this was not always the case.	• SMG reports - Chief executive Board Reports		

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7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	238	Inability to dispatch to MDTs from FALL back Centre at Bow.	IMT	12	Peter Suter	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	1. Introduction of new MDT messaging system hardware. 2. Full operational testing of entire system.	• ExpressQ infrastructure has been upgraded at FBC in line with the live configuration at HQ. • A full Fall Back test has been completed, however it was not conclusive regarding this problem. • A further test is currently being planned - this risk should therefore remain live until this is completed.	• Major Incident Plan • Audit of Civil Contingencies of English Ambulance Service report	
5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	133	There is a risk that inadequate processing of safeguarding children referrals may lead to legal actions	CLIN	9	Gary Bassett	1) Safety - **C2** Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	• Undertake at recruitment, standard level CRB checks for staff with direct patient contact only. This includes POCA and POVA checks. • Guidance issued following the recommendations from the Climbie report has been implemented. • Children and Vulnerable Adults procedures (Agreed at CG 13th Oct) • EOC use Datix to log all reported incidents • PALS staff administer Children and Vulnerable Adult procedures 1. SMG approval of additional resourcing agreed 2. Draft revised procedure completed 3. Two stage implementation - change management and pilot NWOW.	• Children Act 1989 Victoria Climbie Enquiry – adherence to recommendations • Resource materials, booklets etc. • Trainers trained in the new procedures including PTS and a 3-hour session on adult/child protection was included in the initial Clinical Guidelines training, ECPs and Team Leaders also trained. • Operational procedures have been agreed by the Union, available on the Pulse, along with the reporting forms and guidance notes. • All child and adult referrals are being followed up within 10 working days of the referral being made . • Protection of Children Working Party has produced a procedure reporting mechanism and training package. Child and Adult Protection Internal Audit Number of referrals made (reported at CGC)Child and Adult Protection Group monitor quality and quantity of referrals made by staff.	Protection of Children and Vulnerable Adults Working Party - monitor compliance with LAS policies and procedures relating to this group. Procedure, reporting mechanism and training package produced.	

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1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	290	Non-availability of a Manager when required to support crew staff at incidents.	OPER	9	Richard Webber	1) Safety - **C1(a)** Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	1. A review of DSO rostering arrangements, to make cover more robust. 2. A requirement for on duty Silver Officer to respond where appropriate. 3. General broadcast to other vehicles where requirement for a manager is due to crew safety.	• DSO annual leave is restricted to ensure 5 are always available Pan-London. This can be reduced by sickness etc. • Team Leaders are also available to respond to incidents in support of crew members. • Risk is reduced by safety training to crew staff and advice to await arrival of police in high risk situations.			

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1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	46	Risk of infection to staff due to sharps injury.	INFECTION CONTROL	9	David Whitmore	1) Safety - **C4(c)** Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.	1. Ensure that all staff are using new cannulas. 2. Remind Team Leaders to monitor this issue and encourage better practice where appropriate. 3. Head of Op's to present a report to the CGC on the 'Introduction of the Braun Safety Cannula'. 4. Infection Control manual will to be re-issued 5. Number of actions for staff training at different levels 6. Analysis of LA52's	• Introduced the Safety Canulae - trial. The introduction of the new cannulas should reduce the risk of sharp injuries and therefore minimise the risk of infection. • Additionally the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual, one of which related to a cannula scratch incident to a crew staff left arm (re35781 - 3/9/07, Kenton crew). This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. • H&S bulletin related to 'Disposal of Sharps' was issued.	• Monitor via Infection Control Steering Group		

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2) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt, (b) To meet Accident and Emergency targets and prepare for new ones, as follows:- (1) 75% category A 8 minute (for the year as a whole), (2) 95% Category A 19 minute (for the year as a whole), (3) 95% Category B 19 minute by March 2009.	244	Lack of protected time for staff professional and career development.	OPER	9	Bill O'Neill	2) Clinical and Cost Effectiveness - **C5(c)** Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	1. Funding per member of staff per year with robust and focused training plan. 2. To encompass "Protected Time" into staff rotas.	• Training and development days have now been introduced into EOCs new rota this now allows staff to develop new skills. • Protected training time being designed into new operating model - on target for first three complexes. • All staff have some development time allocated currently, on CPD courses (approx. 3 days per year). Protected training/development shifts are being incorporated into all FRU rotas.			
2) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt, (b) To meet Accident and Emergency targets and prepare for new ones, as follows:- (1) 75% category A 8 minute (for the year as a whole), (2) 95% Category A 19 minute (for the year as a whole), (3) 95% Category B 19 minute by March 2009.	266	Cancellation of Update Training, which could lead to inappropriate treatment of patient.	OPER	9	Richard Webber	2) Clinical and Cost Effectiveness - **C5(c)** Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	1. Training to be scheduled annually to avoid periods of peak ambulance demand. 2. Fixed training days to be set into rotas in new model. 3. Training to be localised and made modular (allowing easier release to attend)	• Being written in to new operating model			

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3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	170	There is a risk of Vehicle Defect Reporting Forms not used/ used inappropriately.	LOG	9	Christoph er Vale	3) Governance - **C7(f)** Healthcare organisations meet the existing performance requirements.	1. Increase staff accountability. 2. Vehicle defect book to be developed for staff.	• A new fault reporting book is close to agreement at VEWG - Book ordered, delivered and implemented Aug 2007.	• Revised VDI designed to record roadworthiness of vehicles. New personal VDI book to be launced winter 2008. • A new fault reporting book delivered and implemented.	

London Ambulance Services NHS Trust Assurance Framework									
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**	**Compliance**
	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	72	There is a risk that inconsistent action relating to the maintenance and repair of trolley beds due to inadequate record keeping.	LOG	9	Christoph er Vale	3) Governance - **C9** Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	1. Set up specific record files for Trolley Beds. 2. SSO's to co-ordinate audit of beds. 3. Considering implementation of asset tracking as part of Integra.	• Transferred records to electronic database. • Asset Tracking tool will also assist in locating trolleys. • Fleet Dept. considering replacement of Fleet Plan Computer Record System.		Asset tracking system dependant on IM&T and when new server available	
4) Public Education Strategy and PPI Strategy have local implementation plans that are followed through by Senior Manager's in all areas.	165	Delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones.	CLIN	9	Kathy Jones	4) Patient Focus - **C13(a)** Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.	1. Research study "Fit to be left". 2. Update of Older People's Strategy. 3. Development of referral pathways as part of Operational Model Programme strand. 4. Training for front-line staff on use of referral pathways (as part of 3.).	• Action Plan (section 5 - Older People's Strategy) through which the delivery of "sub optimal care for patients with age-related illnesses" is being addressed. • Older People's Strategy agreed by trust board (including action plan) • Roll out @ NWOW exemplar sites • Referral Pathways Project in progress. • Results of "Fit To Be Left" research project on older fallers to be presented to SMG with recommendation for action.			

London Ambulance Services NHS Trust Assurance Framework										
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**	**Compliance**
	Risk ID	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**
5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	235	EOC lack info. at time of disp. and co-ord. between sect. & FRU desks. Sect. desks lack full info., as call is still underway.	OPER	9	Richard Webber	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	• EOC Governance Group minutes • Performance monitored by performance improvement manager post 1. FRU desk will be disbanded and vehicles will move to Sector desk.	• All updates sent to crew automatically installed review of deployment all the time. Further information on calls is passed to crew once call is complete. • All resources now despatched automatically.		
5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	172	Not meeting operational targets and unnecessary pressure on fleet due to unavailability of vehicles because of poor local care.	LOG	9	Christoph er Vale	5) Accessible and Responsive Care - **C19** Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	• The Driving and Care of Service Vehicles procedure has been issued. • Vehicle Resource Centre now in operation which finds spare vehicles and equipment to meet any deficiencies. 1. Develop a vehicle / equipment checklist/guide to increase staff compliance with existing policies/procedures. 2. Complete Driving and Care of Service Vehicles procedure.	• Fleet Status reporting in place. • Asset Tracking Tool will also monitor the vehicle location. • Flexible Fleet Management Project being extended to further station complexes.		

London Ambulance Services NHS Trust Assurance Framework										
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**	**Compliance**
	Risk ID	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Rest breaks, (b) Individual Performance Monitoring, (c) Home responding, (d) Improved standby and area cover arrangements, (e) Reduced job cycle times, (f) Shift Change over (roster changes).	305	Morphine – Management of Morphine at Station level not in accordance with LAS procedure OP/30 version 4 – Controlled Drugs.	CLIN	8	Richard Webber	1) Safety - **C4(d)** Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.	1. Continue to reinforcement the importance of the procedure OP/30 and consequences for the Trust in not following it.	• Director of Operations/Medical Director to issue bulletin reminding staff of the necessity of adhering to Trust procedure re. drug control. • Internal Audit carried out annually. • Procedure reinforced by bulletins. • Legally have to submit a local intelligence network report to Richmond and Twickenham PCT detailing every instance of non compliance to drug legislation and or loss or theft of a control drug • Attendance by Accountable Office at Lin meetings is madatory			
3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard, (b) Implement Actions from diversity plan, (c) Disability Equality Scheme, (d) Review and changes to recruitment practice and policy (including life skills), (e) Gender Equality Scheme prepared for publication in April 2007, (f) Work with DH to prepare a single Equality Scheme, (g) Introduce summary level SMG balanced scorecard, (h) Complete key supplier review, (i) Replace EROS purchasing system, (j) Revise Trust Standing Orders, (k) Implement ESR.	222	Lack of frontline management staff at weekend. Risk to staff welfare and staff support who require advice , could lead to SUI.	OPER	8	Richard Webber	3) Governance - **C7(a)** Healthcare organisations apply the principles of sound clinical and corporate governance.	1. Agree new leave rules for DSOs. 2. Maintain full DSO establishment by topping up ADSO pool every 6 months.	• Use of FAST to identify and fast track Stroke patients. • Primary angioplasty arrangements London – wide, individual patient protocols, recent work by D Whitmore on living wills, memorandum of understanding with Police from recent board meeting. • LA279 and LA280 available on ' The Pulse' Anonymised patient specific protocol/information. • High Risk Address Register held in EOC. • Handover form for patients with specialist palliative care needs. • Case Conferences – PALS records		Development of systematic joint clinical audit between the LAS and A&E Departments on the outcomes of clinical care provided by LAS.	

London Ambulance Services NHS Trust Assurance Framework										
Prinicipal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**		**Compliance**
	Risk ID	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services), (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.	184	There is a risk of failure to meet Fleet Support requirements to Service vehicles without putting staff at addit.risk of injury working excess O/T.	LOG	8	Christopher Vale	5) Accessible and Responsive Care - **C18** Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	1. To agree and implement appropriate fleet support levels 2. Implement rigourous policy to ensure vehicles are removed for servicing on time.	• Fleet Review discussed at Trust Board in July. Agreement to proceed with large Workshop in West of London and then to review further configuration. New JD under discussion with Fleet Staff Side. Ongong recruitement campaign in place for vehicle technicians. • Agreement to proceed with large Workshop in West of London and then to review further configuration. • New JD under discussion with Fleet Staff Side. • Ongoing recruitement campaign in place for vehicle technicians			
7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	283	EBS fall back cannot be accommodated at Bow.	BC	8	Stephen Moore	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	1. Arrangements to accommodate EBS at Fielden House to be put into place.	• Six workstations for EBS were identified at Loman St. (conference room) but issue with transfer of Comms. • Alternative fallback site (Fielden House) identified. • 6 laptops available for use in the Conference Room at FH from end June. Phones can be borrowed from existing desks & Networks should be able to switch phones back to FH.CTAK access is available from CTAK support team.			

Prinicipal Objectives	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews, (b) Processes with DH to prepare Single Equality Scheme for publication in 2007, (c) Improve Trust administrative and five management processes.	300	LAS HQ has an Uninterrupted power supply & generator as a back up to the essential power supplies, primarily serving EOC, UOC, Gold command & the comms room. The UPS & generator are both running at 100%, in hot weather it could fail if there was a mains power outrage & it was required to run at 100%	BC	8	Martin Nelhams	7) Public Health - **C24** Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	1. Install Sine wave harminics compensator 2. Replacement of UPS	• Installation of new UPS complete. • IM&T have Change control and permit to work in place to prevent additional equipment being installed in the comms room. Estates have a monitorium on the use of any additional power. • Sine wave harmonics compensator being installed w/c 7th July to filter "dirty" load, which may reduce load on UPS. Complete and successful. • Looking at options for sourcing commercial comms room space and is currently in discussion with BT.			

High Level Corporate Risks

Top 10 High Level Corporate Risks

(1)   There is a risk that the Trust may fail to meet national, local and Trust targets

(2) There is a risk that out of date equipment (PALS PACK) may result in inability to treat Paediatrics.

(3) Inability to match resources to demand. Rosters do not match current demand. Weak at weekends.

(4) Delay in activating vehicles due to the unavailability of vehicles

(5) At shift changeover times, LAS performance falls as we take longer to reach patients.

(6) There is a risk that failure in clinical practice could lead to scrutiny/damage to reputation for the Trust

(7) There is a risk that staff may not appropriately trained to trust agreed Clinical standards because of operational pressures

(8) There is risk that failure to address business continuity in all critical systems may lead to critical system failure

(9) There is a risk of IT and infrastructure failure disrupting key business operations

(10) There is a risk that that the Trust may find it difficult to recruit the right membership deliver Foundation Trust application

Overview of High Level Corporate Risk Scoring
Risk Heat Map

A **Risk** is……..

A possible _future situation_ or event that may negatively impact the successful achievement of the corporate objectives of an organisation

An **Issue** is……..

Situation or event that is _currently happening_ and is impacting the delivery of the of objectives

Risk Scoring					
Impact					
Catastrophic	5	10	15	20	25
Major	4	8	12	16	20
Moderate	3	6	9	12	15
Minor	2	4	6	8	10
None / Insignificant	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Certain
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	< 1%	1 – 5%	6 – 25%	26 – 60 %	>60%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not
Likelihood of Recurrence					
Grading Bands	1-3 = LOW	4-6 = MODERATE	8-12 = SIGNIFICANT	15-25 = HIGH	

Suggested Heat Map for High Level Corporate Risks

	Rare	Unlikely	Possible	Likely	Certain
Catastrophic	5	10	15	20 (1) There is a risk that the Trust may fail to meet national, local and Trust targets (6) There is a risk that failure in clinical practice could lead to scrutiny/damage to reputation for the Trust (7) There is a risk that staff may not appropriately trained to trust agreed Clinical standards because of operational pressures (8) There is risk that failure to address business continuity in all critical systems may lead to critical system failure (9) There is a risk of IT and infrastructure failure disrupting key business operations	25
Major	4	8	12	16	20 (2) There is a risk that out of date equipment (PALS PACK) may result in inability to treat Paediatrics. (3) Inability to match resources to demand. Rosters do not match current demand. Weak at weekends. (4) Delay in activating vehicles due to the unavailability of vehicles (5) At shift changeover times, LAS performance falls as we take longer to reach patients. (10) There is a risk that that the Trust may find it difficult to recruit the right membership deliver Foundation Trust application
Moderate	3	6	9	12	15
Minor	2	4	6	8	10
None / Insignificant	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Certain

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

CAD 2010 Transition Process

1. **Sponsoring Director:**   Peter Bradley

2. **Purpose:**   *For Approval*

3. **Summary:**   *This paper describes the process to determine the preferred approach for the transition of Control Services Operations from the existing CTAK system to the CommandPoint system supplied by Northrop Grumman. In order to support the best timetable possible, approval is sought to delegate authority to the February SDC to approve the transition approach.*

      An iterative timetable has been developed to include 2 evaluation workshops, SMG and Trust board meetings. The objective is to enable the Transition Process to be agreed and approved by the Trust Board, supporting the requirement to implement CommandPoint in as short a timeframe as realistically possible.

      Workshop 1 has taken place, selecting 4 out of 14 transition options. These 4 options have been reviewed and agreed by the SMG and will be considered by workshop 2 at the end January. From this, 1 transition option will be put forward to the SMG in February and finally to the Trust Board (SDC) in February for approval.

4. **Recommendations:**   *The Trust Board is asked to:*

   - *Support the approach to the CAD transition decision process detailed in this paper*

   - *Delegate authority to the SDC in February to approve the CAD 2010 Transition approach*

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

CAD 2010 TRANSITION DECISION PROCESS

1. INTRODUCTION

1.1 This paper describes the process to determine the preferred approach for the transition of Control Services Operations from the existing CTAK system to the CommandPoint system supplied by Northrop Grumman. In order to support the best timetable possible, approval is sought to delegate authority to the February SDC to approve the transition approach. All of the work described in this paper is included within specifically defined project documentation – details of which are not included here.

2. BACKGROUND

2.1 The Outline Implementation Plan proposed a staged transition supported by a two-way interface transferring all incident and resource information between the two systems. This approach was designed to limit operational risk by ensuring that the LAS was not fully reliant on the new system until it had been fully proven.

2.2 Now that the contract has been awarded to Northrop Grumman and the actual project plan is being finalised, it is appropriate to review the previously favoured transition approach and identify potential alternatives. Factors influencing this review include:

- The proposed approach described above is unproven; it has not been used previously by other organisations undertaking similar transitions.
- The proposed approach was subject to significant challenge by the Gate 3 review team who recommended re-evaluation of it and investigation of alternatives.
- Repeated CTAK failures during 2008 have raised concerns that further development of CTAK to support a full two-way interface may negatively impact the stability of the system.
- LAS and Northrop Grumman technicians have expressed some concern regarding the feasibility of a full two-way interface.
- Concerns raised by the independent consultant advising the Trust Board.

2.3 The actual requirements for Transition and risks have been previously defined within the overall project documentation. They are included at appendix A and B respectively.

3. TIMETABLE

3.1 An iterative timetable has been developed to include 2 evaluation workshops, SMG and Trust board meetings. The objective is to enable the Transition Process to be agreed and approved by the Trust Board, supporting the requirement to implement CommandPoint in as short a timeframe as realistically possible.

3.2   <u>Outline Timetable</u>

Date	Activity	Notes
6 January 2009	Workshop 1	To agree process and shortlist of options
14 January 2009	SMG meeting	Describe Transition decision process
27 January 2009	Trust Board Meeting	Describe Transition decision process and seek delegated authority to SDC.
30 January 2009	Workshop 2	Selection of preferred approach.
11 February 2009	SMG Meeting	Agree recommendation to SDC
24 February 2009	SDC Meeting	Approve transition approach
31 March 2009	Trust Board Meeting	Formally note Transition approach

4.   WORKSHOP 1

4.1   Workshop 1 took place on 6 January 2008 and was attended by the Director of IM&T (SRO) the CAD 2010 Project Manager and three other senior IM&T/CAD 2010 project staff.

4.2   The objectives of this workshop were to:
- Agree the process to be followed
- Agree the 'transition requirements' and transition risks
- Review the 'long list' of transition options
- Agree the shortlisted transition options

4.3   The long list of options considered is at Appendix C. From this long list (14 options), 4 options were shortlisted for further consideration at workshop 2; these are described in detail in Appendix D. This short listing exercise was reviewed and the 4 options agreed by SMG on 14 January. It should be noted that the previously preferred approach (option 1-Progressive with 2-way Replication - All Data) has not been short listed. The recommendation to the SDC in February will therefore be for a change from the previously agreed approach.

5.   WORKSHOP 2

5.1   This workshop is scheduled to take place on 30 January. The CAD2010 Project Board have been invited, along with personnel from the LAS and Northrop Grumman project teams, the two Non-executive Directors responsible for CAD2010 and the consultant providing Trust Board Assurance.

5.2   The workshop will consider the shortlisted transition options and for each one evaluate the probability and impact of each of the 'transition risks' should that approach be adopted. From this a clear recommendation will be made to the SMG and put forward to the SDC in February for final approval.

5.3   Appropriate change control will then be raised in order for the selected approach to be used by Northrop Grumman to develop Functional Design Documents necessary to support the transition. LAS technicians will develop any interfaces necessary to support the agreed transition approach. A final report will be given to the Trust Board in March for noting.

6.   RECOMMENDATIONS

6.1   The Trust Board are asked to:

- Support the approach to the CAD transition decision process detailed in this paper.

- Delegate authority to the SDC in February to approve the CAD 2010 Transition approach.

Peter Suter
Director of Information Management & Technology

TRANSITION REQUIREMENTS

1. The requirements of transition are derived from the "Objectives for Transition to New CAD System" set out within the "Initial Transition Plan" (Product No. 10.1.2) and from subsequent discussions.

2. The requirements of transition are to:

   a. Address those lessons from the failed project of 1992 that remain relevant to this project and the current operating environment.

   b. Ensure there is no interruption in the provision of 24/7 emergency and urgent care services by the LAS.

   c. Ensure there is no increase in the risk to patient or staff safety.

   d. Minimise any degradation to service performance.

   e. Retain a capability for all or any part of the Control Services operations using the new CAD system to revert to the use of CTAK at anytime prior to the completing transition or such other time as may be agreed with the Project Executive.

   f. Ensure operational users are provided with adequate training and preparation in the use of the new system.

   g. Minimise the risk of 'Training Fade' caused by increase in the time between when students undertake training and when they commence operational use of the new system.

   h. Ensure sufficient operational support exists, during the first few days of user's live use of the new system, to minimise service degradation through a lack of familiarity with the new system. (e.g. through progressive roll-out, use of expert 'floor walkers', etc.).

   i. Gain users' and managers' confidence in the new systems.

   j. Gain users' and managers' confidence in the transition process and the support provided to ensure the maintenance of service delivery at an acceptable level.

   k. Maintain staff welfare and minimise the imposition of unreasonable additional stress or risk within Control Services during transition.

   l. Allow management control over the decisions to start, suspend, reverse or restart transition and the rate at which transition progresses.

   m. Minimise the technical complexity and technical risk of transition.

   n. Ensure completion of transition to the new system within acceptable timescales

   o. Ensure that at all times during transition live data is retained and available to Management Information Department.

   p. Ensure that the functionality of the LAS interface to the Metropolitan Police CAD system (Met CAD Link) is maintained throughout the transition period and beyond.

TRANSITION RISKS

The following transition risks will be taken into account when deciding the preferred approach to transition:

TR 1)   Interrupted 24/7 Emergency or Urgent Care Services

TR 2)   Training not Adequate

TR 3)   Training Fade

TR 4)   Loss of Synergy between Man & Machine

TR 5)   Inability to Revert ('Fallback') to CTAK

TR 6)   Repeated Loss of 'Operational Picture'

TR 7)   Loss of Confidence by Users or Managers

TR 8)   Loss of Confidence by Sector Staff

TR 9)   Extended or Repeated use of Paper-Based Call Recording

TR 10) Transition Technology & Processes Unstable or Unreliable etc.

TR 11) Live Data not Available to Management Information

TR 12) Loss of Met Police CAD Link Interface

TR 13) Functionality, Stability or Reliability of new CAD Inadequate

TR 14) Repeated Use of 'Fallback'

TR 15) Increase to CAD User's Workload

TR 16) Interfaces Not Fully Exposed at OAT

TR 17) Progressive Deskilling of Operators in Use of CTAK

LONG LIST OF TRANSITION OPTIONS
(input to workshop 1)

Option No. 1.   Progressive with 2-way Replication - All Data

Option No. 2.   Progressive with 2-way Replication - Incidents & Partial Status Data

Option No. 3.   Progressive with 2-way Replication - Incidents Only

Option No. 4.   Progressive with 1-way [CP to CTAK] Replication - All Data

Option No. 5.   Progressive with 1-way [CP to CTAK] Replication - Incidents Only

Option No. 6.   Progressive with 1-way [CTAK to CP] Replication - Incidents Only - Dispatch 1st

Option No. 7.   Immediate Transition by Geographic Area

Option No. 8.   Paper Supported – Until All Users Trained

Option No. 9.   Paper Supported – for Dispatch but After Call Takers are Trained

Option No. 10. Paper Support Only for System Switch

Option No. 11. Progressive Flip-Flop of Trained Users Between Systems at Non-Peak Periods

Option No. 12. Parallel Dual Entry - Single Staffing

Option No. 13. Parallel Dual Entry - Double Staffing

Option No. 14. Immediate Response to Total Irrecoverable CTAK Failure

SHORTLISTED OPTIONS TO BE CONSIDERED BY WORKSHOP 2
(Output from Workshop 1)

Option 5 - Progressive Transition with 1-way [CP to CTAK] Replication - Incidents Only

1. This option was identified through discussions between technical staff from LAS and Northrop Grumman and it applies to call taking and dispatch.
2. Call taking would be undertaken first and would be a progressive transition while dispatch would be undertaken second and as an immediate transition.
3. Call takers will be trained separately from Dispatch. Dispatch training requires most or all to be trained prior to an immediate (paper supported) transition to ensure that the control room can be operated on an ongoing 24-hour basis.
4. This option will allow Call Takers to gradually use CP as they are trained with Incidents (NG Events) being 'pushed' to CTAK for dispatch and auto closed on CP; this negates the need for complex technical two way interface. Dispatch will be implemented later as an immediate (paper supported) transition.
5. Once a CTAK Call Taker 'completes' no further changes can be made to the incident details. Updates will be added as log entries. During transition CP 'update' commands will be disabled.

Option 7 - Immediate Transition by Geographic Area

1. This option originates from investigations conducted during an earlier stage of the project and has been further discussed by technical staff from LAS and Northrop Grumman.
2. It applies to call taking and dispatch and involves the parallel running of both CTAK and CP but without data replication between the two systems.
3. This option is where Call Taking and Dispatch functions will be transitioned geographically (probably by sector) resulting in all calls for that area being recorded (Call Taking) and dispatched within CP.
4. All users covering the selected area will need to complete their training before the area can be transitioned to CP.
5. Incoming calls will need to be filtered and redirected to suitable answering positions dependent upon the origin of the call and the system that will deal with it.

Option 10 – Paper Supported Transition - Only for System Switch

1. This option originated as the 'Paper Based' option during earlier investigations.
2. Users will all continue to use CTAK at the start of this option.
3. All training will be undertaken at the agreed rate and over the period agreed as being necessary. Once trained, users will return to the control room and continue to operate CTAK.
4. After training some opportunity may be possible for maintaining learned skills through the use of a non-live CP system at times of reduced pressure but this opportunity still needs confirmation.
5. Once all users are trained (Call Taking and Dispatch) they will cease using CTAK and will switch to an entirely paper based system.
6. The interfaces will be switched to enable live operation of CP. Any requirement to fallback to CTAK hereafter will require the switching to be reversed and the users will operate on paper during such a period.
7. All users will then all start using CP collectively.

Option 11 - Progressive Flip-Flop of Trained Users between Systems at Non-Peak Periods

1. This option was identified through discussions between technical staff from LAS and Northrop Grumman. It applies to call taking and dispatch.
2. This option provides for the repeated use of the new system during periods of lower demand and therefore of greater capacity to absorb any performance impact of using a new system.
3. It requires a whole 'team' or 'shift' to have been trained so that the whole control room can be switched (or 'flipped') as an entire entity.
4. During an identified period of reduced demand and therefore extra control room capacity all operators would first switch to a full paper based operation while CP was 'Flipped' into operation.
5. Users, supported by 'floor walker' would then gain experience in the use of the new system before 'Flopping' back to CTAK, via another interim period of paper based operation when either demand increased or an on-coming shift was due which had not fully completed training.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

SAFEGUARDING ACTIVITY

1.	**Sponsoring Director:**	Dr Fionna Moore
2.	**Purpose:**	*For approval*
3.	**Summary:**	*The Trust Board is asked to consider this report detailing current safeguarding activity, in terms of the protection of children and vulnerable adults; to note the activity following the Baby P Serious Case Review, the joint Review of Haringey Children's Services Authority and the implications for LAS practice. A series of recommendations are presented which will form the basis of an action plan.*
4.	**Recommendations:**	*THAT:*

THAT:
- *the report be noted;*
- *the recommendations presented be approved.*

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

SAFEGUARDING ACTIVITY

Introduction
During 2007/2008, London Ambulance Service staff made 4850 Vulnerable Adult and 1287 Child Protection referrals.

Our Safeguarding Group, chaired by the Medical Director, has lead responsibility for policy and practice. This group includes external expert practitioners and has effected some notable achievements, for example we recently lead pan-London clarification of the role of LAS in Sudden Unexpected Death in infants, children and adolescents. This is likely to influence national practice.

We are also participating in the NHS Advisory Group, at the invitation of the Department of Health, in relation to the *Consultation on the Review of the No secrets guidance.*

Baby P
The Director of Operations has participated in an interview, as part of a review commissioned by NHS London. All records held by LAS have been made available.

In particular, we reported that the LAS were not approached to contribute to the Serious Case Review by Haringey Safeguarding Board and only received the report (November 2008) via another local safeguarding board. Neither were we invited to contribute to the recent Joint Area Review of Haringey Children's Services Authority (November 2008). Finally, we have only been advised of one address and have therefore not been able to confirm any comprehensive LAS involvement with the family.

The Joint Area Review of Haringey Children's Services Authority

Findings (extracts)
"There is a managerial failure to ensure full compliance with some requirements of the inquiry into the death of Victoria Climbie, such as the lack of written feedback to those making referrals to social care service".

"Social care, health and police authorities do not communicate and collaborate routinely and consistently to ensure effective assessment, planning and review of cases of vulnerable children and young people".

"Too often assessments of children and young people, in all agencies, fail to identify those who are at immediate risk of harm and to address their needs"

The report recommends that there is a need to:

"establish rigorous arrangements *for management of performance across all agencies, which ensure that the quality of practice is evaluated and reported regularly and reliably, and that accountability for each action is defined and monitored"*

and to:

"establish clear procedures and protocols for communication and collaboration between social care, health and police services to support safeguarding of children, and ensure that these are adhered to".

<u>Implications for LAS practice</u>

1. There are delays in referrals reaching EOC. Until recently this has not been routinely monitored. In the last 5 weeks, 60 such late referrals have been identified. Some of these were over a week late, several over 10 days.

2. Additional delays have historically occurred in the onward referral by EOC to local authority Social Services departments. At the instigation of the Deputy Director of Operations, the position has recently vastly improved, but there were no staff available to facilitate this over the Xmas and New Year period. Clinical Support Desk (CSD) assumed this responsibility, managing 84 referrals pan-London.

3. We are not in a position to decide what referrals are urgent or otherwise, as we have insufficient information, for example whether a child is placed on the local authority safeguarding Risk Register.

4. It is problematic to maintain up-to-date contact information for each local authority. The position is exacerbated given that local authority safeguarding management arrangements and structures vary widely.

5. We do not have in place a satisfactory system to receive an acknowledgement of a referral or to ensure we receive feedback that action has been taken, requirements first recommended by *the Climbie report*. Consequently, this extremely time-consuming task has been episodically undertaken by staff on light duties, when available.

6. We have not historically used a recognised case management system to record referrals. Recently, a temp had to be employed to data enter referrals after a significant backlog had built up. This makes the verification of acknowledgement of receipt and feedback reporting even more problematic.

7. We do not have any adequate storage facilities for safeguarding referral documentation.

8. Although each complex should have a nominated safeguarding lead, usually the AOM, attendance at Serious Case Review, Strategy and other related safeguarding mechanism meetings is infrequent.

9. In the case of Rapid Response meetings relating to Sudden Unexpected Death of a child, by definition these meetings are called at very short notice and it can be consequently be problematic for local LAS representatives to attend. Operational pressure should also be taken into account as this consideration inhibits representatives' ability to attend.

10. Crews can be difficult to contact in a timely fashion when we need clarification about an incident.

11. Operational staff rarely make a referral in relation to patients with mental health difficulties; conversely, many such patients have been placed on the High Risk register, most often without any liaison with other health and social care agencies, any regular review and without advising the patient involved of their right to challenge this decision. This is contrary to the Information Commissioner's guidance and most likely unlawful.

12. There are implications in terms of the services we outsource. We need to be satisfied that agencies providing these services on our behalf are able to meet the requisite safeguarding practice standards.

13. There has not historically been a single point of contact for safeguarding professionals to elicit further information following a referral.

14. We have very little information about the outcomes, where a child is not conveyed to hospital.

<u>Conclusion</u>

Although considerable progress has been made, the Trust remains at risk of non-compliance in many areas of safeguarding practice and has already attracted criticism from local safeguarding boards and practitioners in relation to some of the issues highlighted.

<u>Proposals</u>

1. All referrals should be made in as timely a fashion as possible and within 24 hours of the incident.

2. It has been agreed that the processing of safeguarding referrals should not be the responsibility of EOC, who should be enabled to concentrate on their primary function. As a 24/7 facility is required, and EOC is the only available facility, I have therefore sought to arrange an IT facility, fax >email> fax, also utilising Datix as a case management system, for ease of administration. As an interim measure, CSD will receive referrals and forward them on to the Patient Experiences Team to manage any resulting enquiries from social workers etc during office hours. There is now a dedicated officer to facilitate this work. CSD will act in this capacity on the rare occasion that a soc wkr requires information outside core hours. At the time of writing, this IT facility is however as yet incomplete as there are some technical, capacity and security problems. I would however recommend that resolution of these is an immediate priority.

   I would also recommend that the Trust employ dedicated staff to administer referrals 5 days per week, with CSD picking these up outside office hours and at weekends and bank holidays, for initial management and subsequent handover to Patient Experiences Department.

3. A longer term solution may be for crews to make direct electronic referrals. Work on this is well advanced by IMT. We will need to approach local authorities to provide a secure email address to enable such referrals and preferably a single point of contact for both adult and child referrals. I do not see that there should be any more downtime than is currently the case. I would recommend that this be piloted as soon as practicable.

4. We are not in a position to differentiate between how the issues raised are classified, and the management of a referral must rest with the host local authority; as we cannot possibly expect staff to be familiar with each local authority's management process. Some local authorities have however decided that any referral from the LAS will be managed as a vulnerable adult or child protection issue, irrespective of whether the substantive issues meet the authority's definitions. This position should be agreed with local authorities' pan-London. We can utilise existing forums to achieve this.

5. Assuming the technical difficulties described can be resolved, I propose to provide each local authority lead with a monthly report on those referrals where an acknowledgement or feedback on the outcome has not been received. This will more efficiently manage these considerations, placing the onus on the host authority.

6. The contact point issue has now been resolved and relevant information and LAS safeguarding practice is now available on the Trust website at
http://www.londonambulance.nhs.uk/health_professionals/safeguarding_-_child_protectio.aspx

7. Guidance should be issued reminding staff of their responsibility in making referrals in a timely way. Similarly, the Trust's expectations about achieving the full and timely cooperation of staff where a follow-up enquiry is made should be widely disseminated using the existing Trust-wide media.

8. Additional training should be provided in safeguarding practice, including raising awareness of mental health issues and the completion of safeguarding referrals.

9. The implementation of the new High Risk Register policy, together with the Frequent Caller Policy, should assist the development of local agency working.

10. Each complex should be required to nominate a Safeguarding Lead of at least DSO level, as part of their work portfolio, and the responsibility to represent the LAS at safeguarding meetings be an obligation.

11. Practice standards should be agreed with outsourced service providers.

12. An audit/research should be undertaken in relation to incidents where a child has not been conveyed to hospital, to identify any potential risks.

13. The Trust should employ a Safeguarding Social Work Practitioner, to assist the Trust in much the same way as the recently appointed Community Liaison Social Work Practitioner.

14. Secure facilities should be obtained to enable storage of referrals. This will however become less necessary the more use is made of electronic administration and case management.

15. Work should be undertaken to explore local authorities sharing information with the LAS about children and adults determined as being at risk, within a care plan approach framework.

Gary Bassett
Head of Patient Experiences

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1.   **Sponsoring Director:**   Peter Bradley

2.   **Purpose:**   *For Noting*

3.   **Summary:**   *The report provides an update on progress in implementing the Service Improvement Programme (SIP2012).*

The following reporting procedure to Trust Board and SDC was approved by the Board in September 2007:

- *Trust Board – every meeting;*

- *SDC – one of the seven sub-programmes which make up the Service Improvement Programme will be presented to each of the five SDC meetings which take place during the year in rotation.*

4.   **Recommendation:**   *That the Trust Board note the progress made with the Service Improvement Programme 2012 outlined in the report.*

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1.   **Purpose**

To update the Trust Board with progress in implementing the Service Improvement Programme (SIP2012).

2.   **Approach to Performance Management of SIP 2012**

The approach to performance managing the service improvement programme is based on tracking achievement of planned milestones. Using this approach the report consists of seven sections, one for each of the sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A brief description of the live projects within the sub-programme concerned;
- A graphical representation of progress for each project focusing on planned milestone achievement. [Please note that as the Olympics team are in the project initiation stage there is no agreed milestone plan at this point in time and the programme team are planning to be in a position to start working to a definitive plan from February 2009.]

Trust Board members are invited to raise any questions for programme lead directors to answer at the meeting.

3.   **Overview of programme structure**

The service improvement programme is made up of the following seven sub-programmes:

- *Access and Connecting (the LAS) for Health* led by the Director of Information Management and Technology);
- *Improving our Response* (known as the "Operational Model") led by the Director of Operations;
- *Organisation Development and People* led by the Director of Human Resources and Organisation Development;
- *Preparing for the Olympics* led by the Director of Operations;
- *Corporate Processes and Governance* led by the Director of Finance.
- *New Ways of Working* led by the Chief Executive;
- *Foundation Trust Application* led by the Director of Finance.

There has also been a supporting *Stakeholder Engagement and Communications Strategy*.

4.   Exceptions

This section provides commentary on those <u>projects</u> (not individual milestones) identified as being of red status (i.e. not on track and cause for concern).

<u>Access</u>

LARP
The project has now come out of a period of waiting for a software fix, the new version of the radio control software (ICCS) is being installed at both the main site and the fallback centre. Integration testing will commence from Mid February with the Trust planning to perform operational Scenario testing in May, with a view to commence the rollout phase of the project in June through to September.

As a result of a crew safety issue the project team have been instructed to prepare the control room and distribute handsets to FRU users which could impact upon the rollout of the MRU service and preparation for integration testing. In order to manage the risk that the supplier does not have adequate resources during the migration period, the project team are looking at the detailed planning to ensure any impact can be minimised.

<u>Corporate Processes and Governance</u>

Re-engineer Income Collection
The project has been on hold pending recruitment of a financial analyst to the programme team.

Asset Tracking
The project is on hold due to capacity constraints on power to the server room, IM&T have steps in hand to address this issue at which point the project can progress.

<u>New Ways of Working</u>

Team Based Working
Progress is dependent upon and awaiting outcomes of ORH modelling, feedback and agreement on a drafted clinical leadership paper and work on proposed clinical models to shape what Team Based Working will look like. However, work is continuing on roster/working practice reviews at Barnehurst following the Complex away day. Work also will continue regarding the gap analysis required to define requirements, identify leadership structure changes and develop a local training plan.

5.   Recommendation

That the Trust Board <u>notes</u> the progress made with the Service Improvement Programme 2012.

Kathy Jones
Director of Service Development

OVERVIEW OF ACCESS / CONNECTING for HEALTH PROGRAMME

CAD 2010
Project Manager: Nick Evans
The purpose of this project is to replace the core Call Taking and Dispatch capabilities within Control Services, including replacement or development of any interfaces with existing systems, applications or services.

CTAK Enhancements
Project Manager: Rony Zaman
The objective is to enhance CTAK capability as an interim measure pending its ultimate replacement by the system put in place by the CAD 2010 project.
This has been achieved through a series of software releases, incrementally delivering new functionality.

Data Warehousing
Project Manager: James Cook
Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse information. Information is not available from outside the LAS network and therefore it is not accessible to our partners and stakeholders.
To address these issues a data warehouse will be developed that stores LAS data. Eventually this data warehouse will encompass the whole of the LAS, including A&E and PTS data, resources, fleet, finance, estates, staff, recruitment and more. This project is the first step towards that goal and will limit the scope of its data to A&E data and vehicle manning and availability.

LARP (London Ambulance Radio Project)
Project Manager: Rony Zaman
As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable radios, EOC / UOC dispatcher equipment and the integration with CTAK

PTS System; Meridian Mobile Technology
Project Manger: Robert Utchanah
The intension of this project is to introduce handheld information terminals to build upon the functionality of the upgraded Meridian booking, billing and management reporting system used to support Patient Transport Services operations.
The system eliminates paper-based dispatching. The use of handheld terminals to receive and feed back operational and management information related either to the patient or of relevance to the customer in a more timely manner and in a secure technological environment, is expected to deliver efficiency savings over time and a more flexible operation on a day-to-day basis.

TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)
Project Manager: Grenville Gifford
The objective is to provide the capability to respond to patients or their carers who have a speech or hearing impairment that prevents use of the normal '999' facility.
A method piloted by several U.K. police services is to use texting from mobile telephones and at present this would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.
Our intention is to adopt this solution for call taking and this was initially expected to be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up during 2008.
Because of continuing delay and uncertain surrounding the national initiative the project is also investigating the feasibility of establishing an in-house solution that would deliver text messages directly to ambulance control rooms.

Access CfH Schedule Summary

Project Name													
Project Status Key:	2008												
✅ On track	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY
⚠️ Not on track but under control													
❌ Not on track and cause for concern													

CAD 2010
PM: Nick Evans
Status: ✅ On track

- Receive & Review Tenders
- Trust Board approve draft FBC / Gateway review
- Trust Board approve FBC
- SHA approve of BC
- Signed Contract
- Delivery of Detailed Implementation Plan

CTAK Enhancements
PM: Rony Zaman
Status: ⚠️ Not on track but under control

- Release 8
- Wallboards in EOC
- Mapping

Data Warehousing
PM: James Cook
Status: ⚠️ Not on track but under control

- BI Portal framework complete
- Full production environment
- BI Portal framework complete
- Full production environment

LARP
PM: Rony Zaman
Status: ❌ Not on track and cause for concern

- Service handover begins
- Full migration complete (Q-2, 2009, date tbc)
- Service handover commences

PTS Mobile Data Solutions
PM: Robert Utchanah
Status: ⚠️ Not on track but under control

- Project Launch
- Complete H/W upgrades
- GPRS network in place
- Pilot operation
- GPRS network in place

Text Emergency Access
PM: Grenville Gifford
Status: ✅ On track

- Scoping Meeting
- National service launch
- Project board setup & PID agreed
- Solutions workshop
- User register setup
- Technical proposal complete

ePRF Pilot for NWoW
PM: Vacant
Status:

- Agree mandate & brief
- Agree scope

30/11/2008

Legend

- △ Awaiting approval
- △ Planned milestone
- ▲ Milestone achieved
- ▲ (yellow) Minor slippage but under control
- ▲ (red) Critical Slippage- requires intervention

Access Programme Report to SSG 8/10/2008

OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

1

First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe

The LAS is looking to revise and expand existing responder schemes which broadly fall into one of three categories: Static defibrillator sites where staff who work in the vicinity are trained to provide Emergency Life support, Co-responders that work for established organisations and who respond to selected emergency calls as part of their work, and community responder who are groups of local people who volunteer to share the provision of a single responder within their local area.

Mobile Office
Project Manager: Stuart Crichton

This project is tasked with equipping DSO vehicles with laptops to enable staff to work remotely, giving them immediate access to information whilst also allowing them to spend more time out in the field. The project will establish hardware and software requirements, examine security concerns and establish the best way to transport the laptops in the vehicles.

Vehicle Fleet Procurement
Project Manager: Nick Pope

This project is responsible for delivering a 5 year fleet procurement and policy plan. This includes; ambulances, PTS, bariatric and training vehicles

Area Project Portfolio - Schedule Summary

Project Name											
Project Status Key:	2008		2009								
✅ On track	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
🔔 Not on track but under control											
❌ Not on track and not in control											

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

8 trial sites live

2nd Trainer recruited

Remainder 103 BHF defibs phased to be delivered by March 09
(only if recruited to training posts & BHF have provided)

79 AEDs for static sites

12 Community Responder schemes live

MOBILE OFFICE
PM: Stuart Crichton
Status: 🔔

PID complete

VEHICLE FLEET PROCUREMENT
PM: Nick Pope
Status: ✅

Approval Bariatric vehicle

Prototype MSV completed

Mercedes complete chassis builds

First converted A & E ambulances delivered

Approx 30 ambulances delivered

Orders placed for 123 ambulances (subject to funding)

Vehicles delivered

10/12/08

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

OVERVIEW OF OD & PEOPLE PROJECTS

Recruitment & Induction
Project Manager: Jo Davis

This initiative will revise the recruitment process to enable the organisation to assess and recruit candidates for values, attitudes and behaviours. This project will also help LAS to deliver diversity targets for achieving a more representative workforce and insuring fairness and equity for all candidates. The induction process will also be revised to reflect these same themes.

Leadership Development – project closed
Project Manager: Jo Anthony

This initiative is to establish and support new styles of leadership at all levels underpinned by the right skills; through continuing the current leadership programmes available and developing new leadership programmes. The programme will be comprised of a number of courses and qualifications aimed at specific groups within the organisation to support both the New Ways of Working and OD and People Programmes.

Individual Performance Management
Project Manager: Steve Sale

The aim of this initiative is to develop a comprehensive performance management process that is accepted and used by all staff members. This performance management framework will enable all staff to accept responsibility and accountability for their personal performance, rewarding and recognising good performance, whilst identifying and supporting staff with poor performance, and where necessary enabling appropriate exit strategies.

Workforce Re-Configuration – project closed
Caron Hitchen

The aim of this initiative is to develop the workforce plan that supports the Operational Model and implements a staff profile that is representative of the population of London.

Modularised Training
Project Manager: Keith Miller

The aim of this initiative is to provide all staff with access to appropriate professional development through training and development packages delivered through a variety of media. There are currently three training modules in operation with the intention to develop a number more, prioritised by clinical need.

Talent Management
Project Manager: Johnny Pigott

The aim of this initiative is to provide a clear career development framework for all staff that allows staff to progress their career according to their choice and their own pace, whilst recognising and providing the opportunity for talented staff, anticipating and targeting opportunities for talented individuals and ensuring equality of access.

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

Training Restructure
Bill O'Neill

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

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

E-Learning
Project Manager: Johnny Pigott

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

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

Team Briefings
Project Manager: Alex Bass

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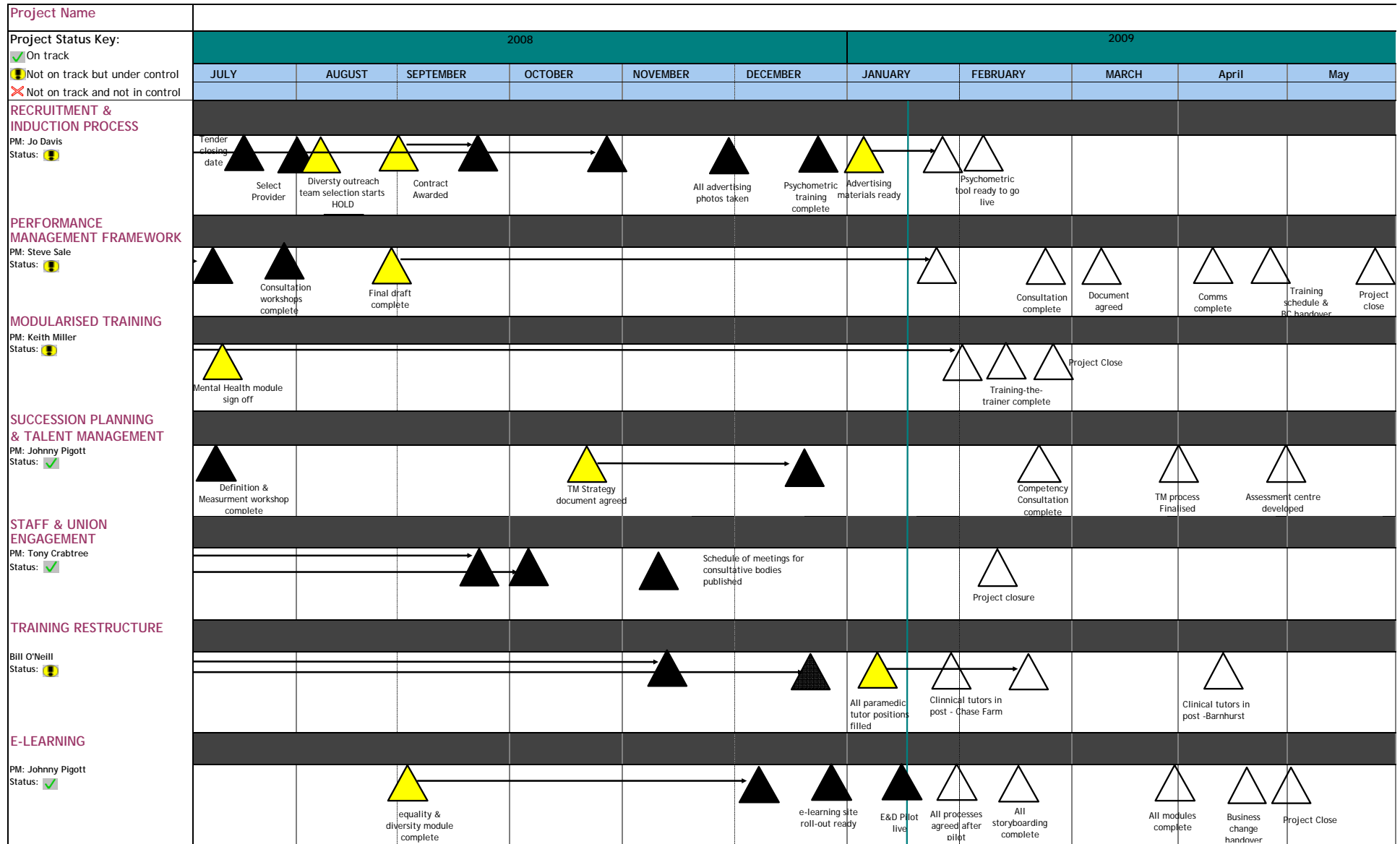
Learning Management Systems
Project Manager: Johnny Pigott

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

Workforce Plan Implementation
Project Manager: Ann Ball

The project is stage 2 of the workforce re-configuration with the scope to recruit 300 student paramedics by 31st of March, and deliver the student paramedic course. The project has been split into three mainstreams, the sourcing and operationalisation of additional external training facilities, the recruitment of the 300 staff, and the running of the student paramedic training course.

OD and People Project Portfolio - Schedule Summary

Project Name												
Project Status Key:	2008						2009					
✅ On track	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	April	May	
😐 Not on track but under control												
❌ Not on track and not in control												

RECRUITMENT & INDUCTION PROCESS
PM: Jo Davis
Status: 😐

- Tender closing date
- Select Provider
- Diversty outreach team selection starts HOLD
- Contract Awarded
- All advertising photos taken
- Psychometric training complete
- Advertising materials ready
- Psychometric tool ready to go live

PERFORMANCE MANAGEMENT FRAMEWORK
PM: Steve Sale
Status: 😐

- Consultation workshops complete
- Final draft complete
- Consultation complete
- Document agreed
- Comms complete
- Training schedule & BC handover
- Project close

MODULARISED TRAINING
PM: Keith Miller
Status: 😐

- Mental Health module sign off
- Training-the-trainer complete
- Project Close

SUCCESSION PLANNING & TALENT MANAGEMENT
PM: Johnny Pigott
Status: ✅

- Definition & Measurment workshop complete
- TM Strategy document agreed
- Competency Consultation complete
- TM process Finalised
- Assessment centre developed

STAFF & UNION ENGAGEMENT
PM: Tony Crabtree
Status: ✅

- Schedule of meetings for consultative bodies published
- Project closure

TRAINING RESTRUCTURE
Bill O'Neill
Status: 😐

- All paramedic tutor positions filled
- Clinnical tutors in post - Chase Farm
- Clinical tutors in post -Barnhurst

E-LEARNING
PM: Johnny Pigott
Status: ✅

- equality & diversity module complete
- e-learning site roll-out ready
- E&D Pilot live
- All processes agreed after pilot
- All storyboarding complete
- All modules complete
- Business change handover
- Project Close

05/11/2008

OD and People Project Portfolio - Schedule Summary

Project Name											
Project Status Key:	2008						2009				
✅ On track	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	April	May
😊 Not on track but under control											
❌ Not on track and not in control											
TEAM BRIEFINGS											
PM: Alex Bass Status: 😊						Team Breifing Consultation complete	Agree team briefing proposal		Commence trial of system	Evaluation of Trial	
Learning Management Systems											
PM: Johnny Pigott Status: 😊	Options Appraisal			Outcome of interface known		(achieved)	System agreed				
Workforce Plan Implemenation											
PM: Ann Ball Status: 😊		Hannibal House lease secured	Hannibal House 1st cohort live			Hannibal House refurbishment complete	300 staff in post		(planned)		

15/01/2009

Legend

- △ Planned milestone
- ▲ Milestone achieved
- ⚠ (yellow) Minor slippage but under control
- ▲ (red) Critical Slippage- requires intervention

05/11/2008

OVERVIEW OF OLYMPIC PROGRAMME TRANCHE 2 PROJECTS

T2P1: Operational Planning
Project Executive: Peter Thorpe; Project Manager: Alan Palmer/Lewis Tasker

T2P2: Workforce
Project Executive: Peter Thorpe; Project Manager: Sandy Thompson

T2P3: Skills Acquisition
Project Executive: Anna Kilpin; Project Manager: Alan Taylor

T2P4: Infrastructure and Support
Project Executive: Peter Thorpe; Project Manager: Anna Kilpin

T2P5: Communication and Involvement
Project Executive: Anna Kilpin; Project Manager: Liz McAndrew

OVERVIEW OF PROGRAMME: CORPORATE PROCESSES AND GOVERNANCE TRANCHE 2 PROGRESS REPORT -

Map all Processes
Project Manager: Martyn Salter

This project involves identifying all corporate processes, producing a Process Mapping Standard for use throughout the Trust and then using the standard to map all key processes. These process maps will then be used by subsequent projects to review processes and improve upon them to deliver the programme vision. A central repository will be identified and developed so that process maps can be stored reliably and are accessible as required.

Staff Administration
Project Manager: Jonathan Nevison

The project consists of a review and redesign of staff administration processes at complex level. Previous process mapping indicates that an interface between ESR and ProMis could substantially improve efficiency by reducing duplication and hard copy paper flows and the project is tasked with exploring this further. There is also an urgent need to replace the Station Operating System, which is becoming increasingly difficult to support.

Real-Time Fleet Management Information
Project Manager: Chris Miles

The project consists of implementing TranMan across the whole of Fleet Support and ensuring that all business changes are implemented.

Re-Engineer Income Collection
Project Manager: Chizoba Okoli

This project has been set up to map and document all income streams and collection processes with a view to streamlining them to improve cashflow.

The Intelligent Trust
Project Manager: Stephen Moore

This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement SharePoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

Electronic Expenses
Project Manager: Jonathan Nevison

Select and implement an electronic system for claiming and authorising staff expenses. The systems must interface with ESR to eliminate manual input of data into the payroll system.

Asset Tracking
Project Manager: Gadge Nijjar

This project is the roll-out phase of a piloted system for tracking the dozen or so pieces of EBME (Electro Bio-Medical Engineering) on each ambulance, developed in conjunction with the 'make-ready' contractor. This will also offer the facility to track and manage EBME servicing more robustly.

Inventory Management
Project Manager: David Selwood

This project is to develop electronic stock management in the Trust enabling better management of stock levels and real-time stock information. This is being done using a new module within the Trust's accounting package. The initial stage is to roll-out a paper-based stock control system which will subsequently be automated.

Performance Measurement Phase 2
Project Manager: David Hodgkinson

This project is to implement Performance Accelerator, which will provide a repository for all the evidence required by external agencies, e.g. Healthcare Commission.

IM&T Procurement Process Improvement
Project Manager: Natalie Makin

This project will use process improvement techniques to document and analyse the existing process. The process will be redesigned with a clear customer focus and will include the collection of metrics to monitor the performance of the process into the future.

VRC Process Improvement
Project Manager: David Hodgkinson

This project is to review the processes used by the VRC with the intention of streamlining then and allowing faster resolution of problems. The intention is to provide information and capacity to solve potential problems proactively.

New Workshop Commissioning
Project Manager: Chris Miles

This project is a continuation of the Workshop Reconfiguration in tranche 1, and is delivering a new large scale workshop on premises to be identified in West London.

Corporate Processes Governance Project Portfolio Tranche 2 - Schedule Summary

Project Name				
Project Status Key:				
✅ On track	September	October	November	December
😟 Not on track but under control				
❌ Not on track and not in control				

MAP ALL PROCESSES
PM: Martyn Salter
Status: ✅

Configure LIVE repository · Core Process Listing · Approve existing process maps · Process Improvement Training · Define Process improvement methodology

STAFF ADMINISTRATION
PM: Jon Nevison
Status: 😟

Revised roll out plan · T&A live on pilot complex · Local Testing comple... · Training · AEM1 · ESR/ProMis recon · Overtime report testin...

REAL-TIME FLEET MANAGEMENT INFO
PM: Christopher W Miles
Status: 😟

Detailed process mapping · Finance interface

RE-ENGINEER INCOME COLLECTION
PM: Chizoba Okoli
Status: ❌ ON HOLD

PRF PROCESSING
PM: tbc
✅ P1 closed - awaiting P2 Exec

Phase 2 project brief · Phase 1 project closure report

THE INTELLIGENT TRUST
PM: Stephen Moore
Status: ✅

Funding approved · milestone plan complete

ELECTRONIC EXPENSES
PM: Jonathan Nevison
Status: ✅

Corporate Processes Governance Project Portfolio Tranche 2 - Schedule Summary

Project Name	September	October	November	December
Project Status Key: ✅ On track ⚠️ Not on track but under control ❌ Not on track and not in control	Start pilot of HQ departments			Document expenses policy
ASSET TRACKING PM: David Selwood Status: ❌				
INVENTORY MANAGEMENT PM: David Hodgkinson Status: ✅	▲ Current Processes mapped	▲ Future state mapped		
PERFORMANCE MEASUREMENT PHASE 2 PM: David Hodgkinson Status: ⚠️	▲ Re-Plan Project	△ Training		△ Sign off business processes
IM&T PROCUREMENT PROCESS IMPROVEMENT PM: Natalie Makin Status: ✅		▲ Project Initiation		
VRC PROCESS IMPROVEMENT PROJECT PM: David Hodgkinson Status: ✅		▲ Project Initiation ▲ map current processes		△ Future state mapped
NEW WORKSHOP COMMISSIONING PM: Chris Miles Status: ✅			▲ Project Initiation △ locate site	△ submit planning reqeust

Legend

△ Planned milestone

▲ Milestone achieved

△ (yellow) Minor slippage but under control

▲ (red) Critical Slippage - requires intervention

31/12/200

OVERVIEW OF FOUNDATION TRUST PROGRAMME WORKSTREAMS

Finance

The objective of this Workstream is to produce information to feed into the IBP to prove that the London Ambulance Service is financially stable and able to remain financially viable and ultimately self sustaining in the long term through the use of trend analysis, forecasting and historic data. Finance also plays a key role in other Workstreams specifically in aligned Strategy

Historical Data and forecasting will provide a clear view of how we have performed and can expect to perform, enabling opportunities to improve efficiency across the business.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Providing Financial information for the Integrated Business Plan, such as

    o Historical Performance Analysis (2 year)

    o Income and Expenditure 5 year projection (best and worst case scenarios)

    o Income and Expenditure Historic Data (2 year)

    o Capex 5 Year Plan (best and worst case scenario)

    o Capex Historic Data (2 year)

    o Cash flow and Balance sheet 5 year Projections

    o Breakdown of Income Historic last 5 years per source/service

- Providing Benchmarking KPIs and Balanced Scorecard

- Developing Financial Models

- Participating in Business Risk Review and Performance Management (Workforce)

Governance & Membership

Governance and Membership is the largest Workstream in the Programme.

The Governance objective of this Workstream is to define how the Organisation will function following FT approval and specifically how the Organisation will be managed.

The Membership objective of this Workstream is to define the population of London, actively seek public buy-in (through the Consultation and Communication Workstream), and set up a mechanism for controlling membership interest.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Preparing the framework for a public 'owned' organisation

- Review the Organisation Structure

- Gathering information on the population of London, with a view to creating a membership base

- Maintaining a membership database after Foundation Trust status has been awarded

- Provide the means to create a membership database

- Provide a contact point for Membership enquiries

Business Strategy & Marketing

The objective of this Workstream is to assess the market place in which London Ambulance Service plays a major role, identify opportunities and competition, thereby defining a strategy upon which the Organisation can strengthen its base.

Scope:

The scope of work is to facilitate the Foundation Trust Application by:

- Analysis of the market place in terms of opportunities and competition

- Prepare a Business Strategy which will give direction to the services we provide and aid decision making for the future

- Analysis of business risks, based on opportunities, competition and strategy.

- Prepare a Relationship Management Strategy, based on the above

PCT Engagement

The objective of this Workstream is to work with the PCTs to gain agreement and approval of the Foundation Trust Integrated Business Plan, ensuring that as an Foundation Trust we can meet (and exceed) client expectations.

Scope:

The scope of work is to facilitate the PCTs approval of the Integrated Business Plan by:

- Working with and building relationships with the Commissioners via a commissioner engagement strategy

- Develop a Payment by Results pilot. PbR is in the FT programme to ensure that any decisions taken within the PbR pilot which may impact on the income to the trust in future years can be demonstrated via scenarios in the FT long term financial model.

- Model and agree five year activity projections for input to the Long Term Financial Model

- Undertake a strategic event to facilitate pan London PCT engagement

Business Plan

The objective of the Business Plan Workstream is to collaborate and collate all the outputs from the other Workstreams to produce a robust Integrated Business Plan ensuring exceptional quality through use of action plans and reviews.

Scope:

The scope of work is to facilitate the Foundation Trust Application by:

- Developing the Integrated Business Plan

- Working with the other Workstreams to provide input to the IBP

- Submission of the IBP and supporting information to Monitor

Work Force Development

The objective of this Workstream is to enable the organisation to function efficiently and effectively by implementing strategy which reflects the changes being made to the organisation, the services we provide and how the organisation is managed.

Scope:

The scope of work is to facilitate the Foundation Trust Application by:

- Development of the Trust Board through a development plan

- Development of a workforce expansion programme

- Staff training

Consultation & Communication

The Consultation and Communication Workstream is to ensure that the Public and Staff are engaged in the Consultation process to facilitate membership to the Trust should the application be successful.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Communicating the desire to achieve Foundation Trust status to the Public, Staff, union, partners

- Preparation of communications for Public Consultations and Staff Briefings

- Make available relevant documentation, such as the Consultation Document, in a variety of formats.

FOUNDATION TRUST APPLICATION PROGRAMME - MAJOR MILESTONES

PROJECT STATUS KEY:	2008				2009				
✅ On track									
❗ Not on track but under control									
❌ Not on track and not in control	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
FINANCE Workstream Lead: Reuven Vazan Status: ❗					SFM Approval / Benchmarking KPIs & Balanced Scorecard	LTFM Review	Final Finance Approval		
GOVERNANCE & MEMBERSHIP Workstream Lead: John Wilkins Status: ✅	Governance Rationale Drafted / Governance Strategy Drafted	Membership Strategy Drafted / Membership Rationale Drafted	Constitution Drafted	Constitution Agreed for Consultation / Tender for Membership Database	Supplier Contracts Signed				Finalise Governance Documents based on Consultation Feedback
WORK FORCE DEVELOPMENT Workstream Lead: Caron Hitchens Status: ✅				Agree Board Development Plans	Start Board development				Board Training Complete
BUSINESS STRATEGY & MARKETING Workstream Lead: Paul Cain-Renshaw Status: ✅	SMG Away Day 1	SMG Away Day 2	SMG Away Day 3	Strategy Approval	Business Risks Agreed				
COMMISSIONER ENGAGEMENT Workstream Lead: Paul Cain-Renshaw Status: ❗	PbR Scenarios Complete		Review Activity Projections & PbR Tariffs with Commissioners		A&E SLA Sign-off				
BUSINESS PLAN Workstream Lead: Kerrie Martsch Status: ✅			SDC Go/No Go Decision			TB Review IBP		Formal Submission of IBP and supporting documentation	
CONSULTATION & COMMUNICATION Workstream Lead: Angie Patton Status: ✅			Consultation Document Approved		Start Consultation			Finish Consultation / Publish Consultation Feedback	

Legend

△ Awaiting approval

△ Planned milestone

▲ Milestone Achieved

△ (yellow) Minor Slippage but under control

△ (yellow) Critical Slippage - requires intervention

▲ (red)

OVERVIEW OF NEW WAYS OF WORKING PROJECTS

Clinical Training
Project Manager: Jane Worthington

This project aims to identify the clinical training requirements in order to achieve a fully trained staff base (including management) on New Ways of Working Complex sites.
Initially a training need analysis will be performed manually, based on information provided by IM. This will then be analyzed to develop training development plans for each member of staff, in conjunction with the Team Based Working project and Non-clinical Training Needs Analysis project and integrated with local clinical requirements

Non-Clinical Training
Project Manager: Jo Anthony

Major change, such as New Ways of Working, requires highly effective leadership and this project aims to align the management on each Complex with the requirements and intent of NWoW. Capacity and capability will be assessed on each Complex and identified development areas will be addressed. This might take the form of formal training, 1-1 coaching and feedback or team development work, as well as making recommendations for the ideal configuration of the individual management teams. Psychometric analysis and preference auditing will further inform this work and assist in creating a benchmark for ideal management/leadership skills. The project will also respond to any identified non-clinical development required for staff on Complex - eg: chairing forum meetings.

Complex Away Days
Project Manager: Astrid Thomas

Complex Away Days are part of the commitment of LAS HQ for NWoW Complexes. Away Days aim to achieve individual goals for each complex which have so far included:
- Increased staff engagement
- Increased awareness of the NWoW Project
- Increased communication from and to staff and complex / senior management
- Increased staff skills with regards to communications forums available to them

Team Based Working
Project Manager: Hazel Smith

This project involves working with staff and management at New Ways of Working Complexes in the formation and development of a team based working environment. Fundamental to this will be the need to move away from fixed rota systems towards more flexible working practices. Teams will be created and given the responsibility for providing the cover required to meet demand along with organisational objectives. The creation of teams and development of a team based working environment will enable communication and access to training/development to be improved and more focused. A teamwork culture will also be beneficial to the organisation in terms of improved attendance and performance.

Communications
Project Manager: Alex Bass

The NWoW Communications strategy has been developed by the communications department. It is currently awaiting feedback from Senior Management.
The communications strategy aims to integrate with other projects and form a holistic approach to communications to and from NWoW Complex staff and Complex / senior management.

IM&T
Project Manager: Astrid Thomas

IM&T Project will act as an enabler for New Ways of working to be develop at complex level. The clinical and Non-Clinical training modules are dependent on IM&T resources and equipment. The IM&T deliveries at Complex level will be aligned to the complex vision to ensure the project benefits are delivered.

IM&T
Project Manager: Astrid Thomas

NWoW Barnehurst Milestones

Supplier

Project Status Key:	October	November	December	January	February	March	April
✔ On track							
❗ Not on track but under control							
✖ Not on track and not in control							

ENABLING PROJECT DELIVERY

Central Forum Updates
Status: ✔

- Central Forum 7th Nov
- Technology 26th Nov
- Referral Forum 3rd Dec
- Clinical Support Forum 11th Dec

Complex Estate Strategy
Status: ✔

- Design Process
- Finalise the Design process

Clinical TNA
Status: ✔

- Gap questionaire received
- Commence Core competencies
- Commence Individual skills and education
- Begin Delivery of Core Competency TL

IM&T Project
Status: ✔

- Plasma's Ordered
- IM&T Contact identified
- Initial project meeting with IM&T, Estates and NWoW
- Hardware and software agreed, plasma's received and installed
- Complex staff receive training on remote access
- End project

IM&T Project Networking

- networking floor plans Completed
- Cabling site survey completed
- Networking equipment ordered
- Networking quotation process
- Purchasaing order Authorized
- Commence cabling
- Rsc scheduling?
- Cabling work completed

Referral Pathway

Project Support

- Meeting Barnehurst review Forum Objective
- Support Forum objectives PID with Project Plan
- Review Project plan
- Design and sign off PID and PP
- Project Board in Place

NWoW Chase Farm Milestones

Supplier

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

ENABLING PROJECT DELIVERY

	October	November	December	January	February	March	April

Complex Staff updates — Status:
- Update 3 (October)
- Update 4 (November)

Complex Estate Strategy — Status:
- Porter Cabin Ordered (October)
- Cabin installed, electric completed (November)
- Cabin Carpeting completed (December)
- Refurbishment Mess Room (December)
- Cabin and E-Learning Furniture (January)

Complex Away Day — Status:
- Chase Farm Away Day completed (November)
- Meetings arranged with Forum chair to review (December)

Clinical TNA — Status:
- Commence individual skills and education packages (November)
- Collate Information ie Ed & Skills (December)
- Commence T/L core competencies (December)
- Commence Individual skills and educ (December)

Management Traning

Patient Public Involvement — Status:
- Ongoing consultation with crew, pts, (October)
- Initial contact with key stakeholders (November)

Community Responder Scheme — Status:
- Evaluation Day 1 (November)
- Evaluation Day 2 (December)
- Review of Process (January)

Referral Pathway

IM&T Networking
- Cabling Site Survey Conducted (October)
- Networking Cable ordered — 28/11/2008 (November)
- Authorisation Networking cable (December)
- Installation curcuit lines (December)
- Telephony Survey quote (December)

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Capsticks Solicitors LLP Legal Update
Corporate Manslaughter and Corporate Homicide Act 2007
Health and Safety (Offences) Act 2008

1. **Sponsoring Director:**   Human Resources and Organisation Development/Finance

2. **Purpose:**   A concise top level legal briefing

3. **Summary:**   The issues to be addressed will cover:

   - Why has a new corporate manslaughter law been introduced and how does it differ from the law up to 6th April 2008?
   - Senior management involvement in the commission of the new offence;
   - Consequences of conviction for corporate manslaughter:
     - for the organisation;
     - for individuals within it;
   - How the Health and Safety at Work Act 1974 is closely associated with the new Corporate Manslaughter Act; and
   - The new sentencing regime introduced by the Health and Safety (Offences) Act 2008.

4. **Recommendation:**
   - For noting

   - The Director of Human Resources and Organisation Development will invite Non Executive Directors to join the workshop presentation on the obligations under the corporate manslaughter legislation to the senior managers' conference on 27 March 2009.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

EQUALITY & DIVERSITY REPORT 07-08

1. **Sponsoring Director:**   Caron Hitchen

2. **Purpose:**   *For Noting*

3. **Summary:**   *Following the successful recruitment to the vacancy of Diversity Manager in December 2008, the attached annual Equality and Diversity report is presented for the period 2007/08.*

   The report meets the public duty placed on the Trust and highlights areas for further development and improvement (recommendations below). Whilst recognising existing good practice, the report identifies inconsistencies in the quality of recording, reporting and monitoring of equalities data within different functions of the Trust which will be a focus for future improvement.

4. **Recommendation:**   *The Trust Board are asked to note the report and the recommendations as stated on pages 23 – 24 which have been accepted by the SMG.*

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

EQUALITY & DIVERSITY REPORT 2007- 2008

1   INTRODUCTION

1.1.   The last Equality & Diversity Report for the Trust was presented in May 2007. Due to vacancies in the Equality & Diversity Team and the Diversity Manager only commencing employment with the Trust in December 08, this is the earliest date at which a report could be submitted. LAS is completely committed to ensuring steady progress is made on equality & diversity issues and yearly reporting will take   place in May each year, to ensure timely reporting of work completed in the previous year. The report will also be published on the LAS website and be made available on request in alternative formats to our customers and stakeholders.

2   CURRENT EQUALITY SCHEMES

2.1.   Currently, the London Ambulance Service has three separate equality schemes in force: the Race Equality Scheme, which was reviewed in 2005 and last updated in 2007; the Disability Equality Scheme, published in October 2006 and due to be reviewed in October 09; and the Gender Equality Scheme, approved by the Trust Board in March 2007 and due for review by 2010.

3   SINGLE EQUALITY SCHEME

3.1.   In preparation for the forthcoming Single Equality Act, which will harmonise existing equalities legislation and extend statutory duties for public sector bodies across all six equality strands, a new generic single equality, diversity & inclusion strategy will be drawn up and consulted on with staff and stakeholder groups within and outside of the LAS.

4   GOVERNANCE

4.1   The Clinical Governance Committee receives minutes from the meetings of the Race Equality and Diversity Implementation Team, and the Race Equality and Diversity Strategy Group. These groups will be renewed by the newly appointed Diversity Manager and any replacement arrangements will continue to report to the Clinical Governance Committee.

4.2 .   The Non-executive Chair of the Clinical Governance Committee provides the scrutiny and focus for equality and diversity, with the Director Human Resources and Organisation Development providing the executive lead.

4.3.   The Governance team ensures that all policies and procedures are assessed for equality impacts and these documents are published on the Trust website.

4.4.   The Trust is fully compliant with the core standards C7e – Healthcare Organisations challenge discrimination, promote equality and respect human rights.

4.5.   The Trust Diversity Officer was seconded to the Department of Health in 2008 to help with developing policies and procedures.

5   STAFF DIVERSITY NETWORKS

5.1.   There are two existing staff diversity networks in the Trust, Glass and Label.

5.2.   Staff diversity networks provide a clear, two-way channel of communication between equality strand groups, enabling greater involvement in consultation and input into policy development and review.

5.3.   Their existence also sends out a clear message of an organization's commitment to equality & diversity and helps to promote the organization as an employer of choice, thus assisting attracting and retaining talented staff.

5.4.   Consideration should be given to seeking staff views on the establishment of any new staff diversity networks or a diversity forum.
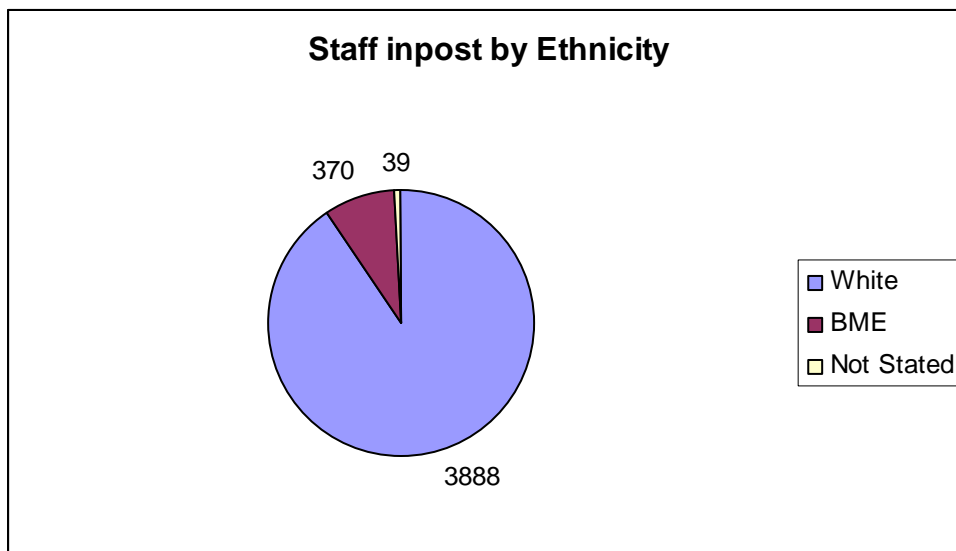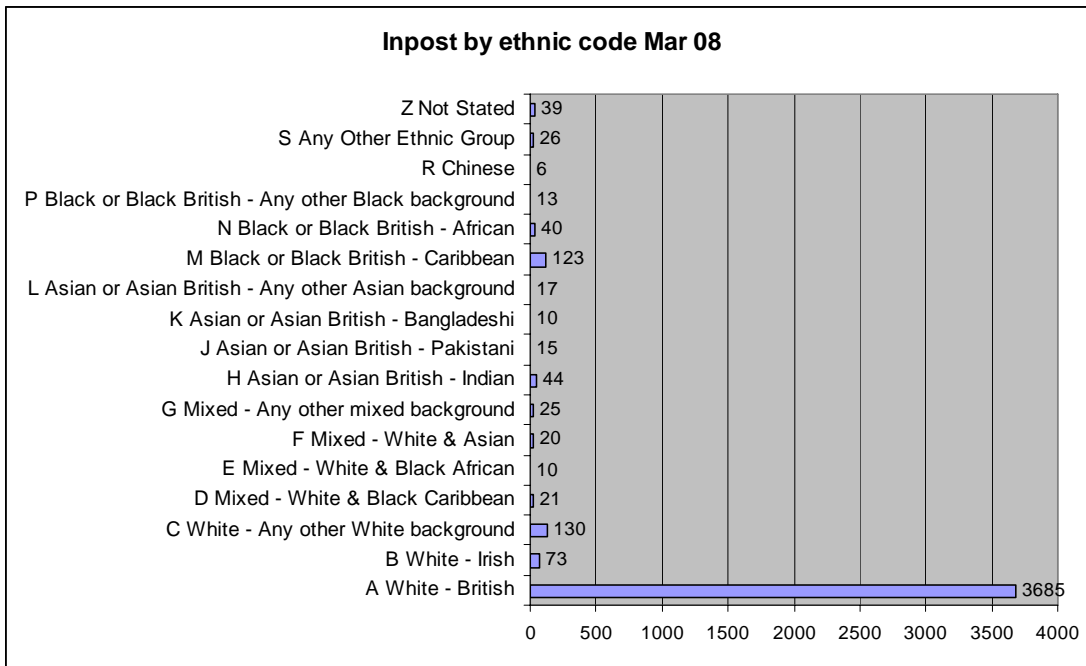
6   TRAINING & DEVELOPMENT

6.1.   An e-learning equality & diversity module will shortly be available to support the delivery of the classroom-based module provided through the Education & Development Department. The e-learning module will support this through a review of the classroom-based session finished with an assessment at the end to test the students' learning.

7   WORKFORCE DIVERSITY PROFILE

7.1.   CURRENT STAFFING

7.1.1. The last workforce diversity profile report went to the Trust Board in May 07, showing the profile for 06-07, which showed that BME staff made up 8.4% of the workforce with women making up 38.9%.

7.1.2. From April 07 to March 08 LAS staff comprised:

- 8.6 % Black & minority ethnic people (see graph below), which is almost the same as the figure in the last Annual Equality Report of (May 2007). This is still well below the 2001Census figure of 28.8% in the London population.

Staff inpost by Ethnicity

370   39

White
BME
Not Stated

3888

Inpost by ethnic code Mar 08

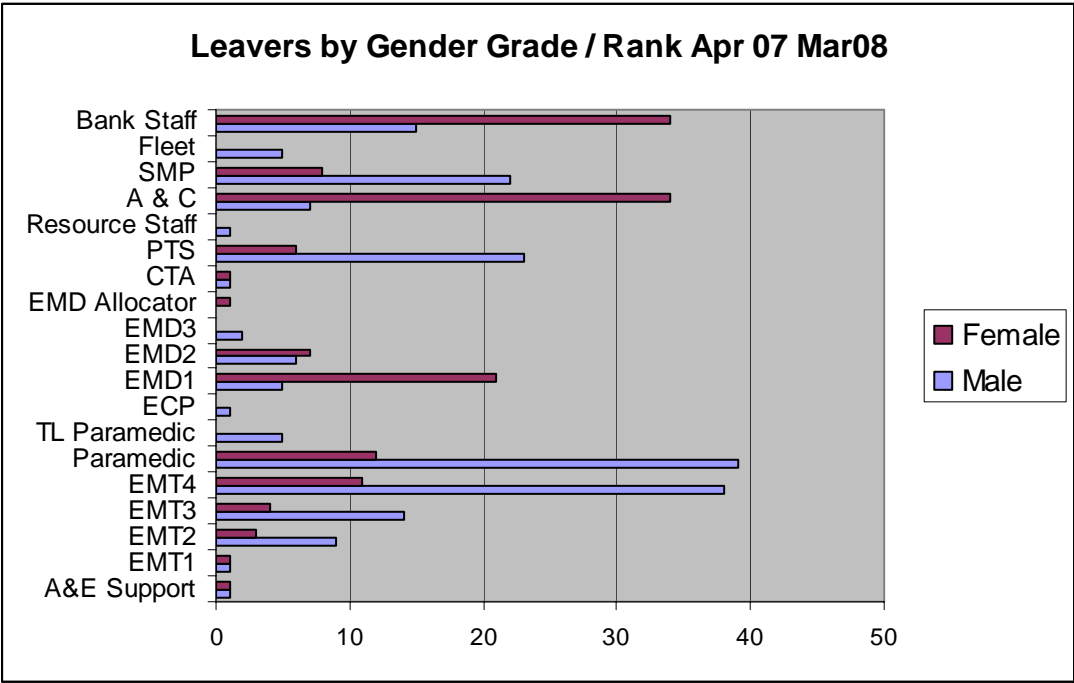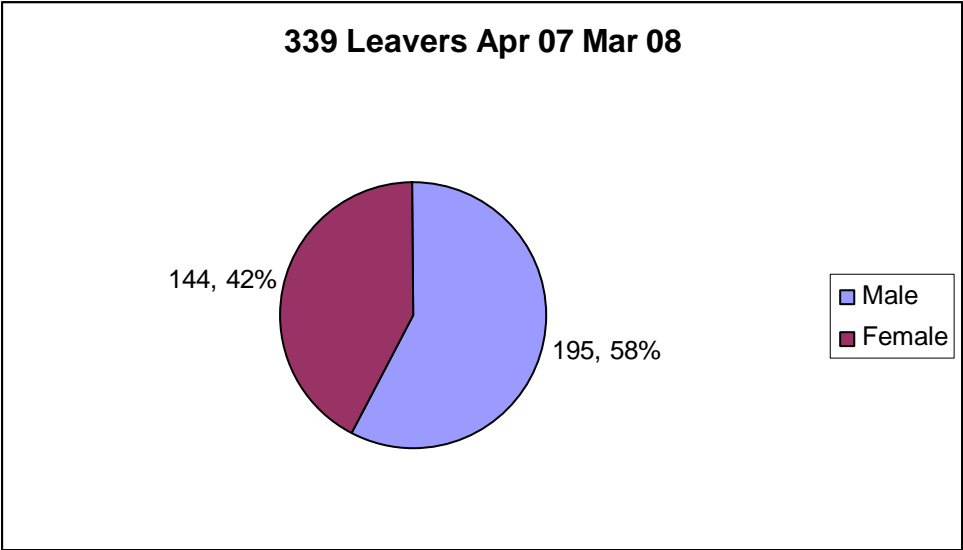| Ethnic code	Count
Z Not Stated	39
S Any Other Ethnic Group	26
R Chinese	6
P Black or Black British - Any other Black background	13
N Black or Black British - African	40
M Black or Black British - Caribbean	123
L Asian or Asian British - Any other Asian background	17
K Asian or Asian British - Bangladeshi	10
J Asian or Asian British - Pakistani	15
H Asian or Asian British - Indian	44
G Mixed - Any other mixed background	25
F Mixed - White & Asian	20
E Mixed - White & Black African	10
D Mixed - White & Black Caribbean	21
C White - Any other White background	130
B White - Irish	73
A White - British	3685

- 39.7%% women (see graph below), which is a slight increase to the 2007 figure of 38.9%, again however short of the 2001 Census figure of 51%.

LAS Staff Gender Percentage

|	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08
Male	61.0%	60.9%	60.9%	60.8%	60.6%	60.6%	60.7%	60.5%	60.5%	60.4%	60.3%	60.3%
Female	39.0%	39.1%	39.1%	39.2%	39.4%	39.4%	39.3%	39.5%	39.5%	39.6%	39.7%	39.7%
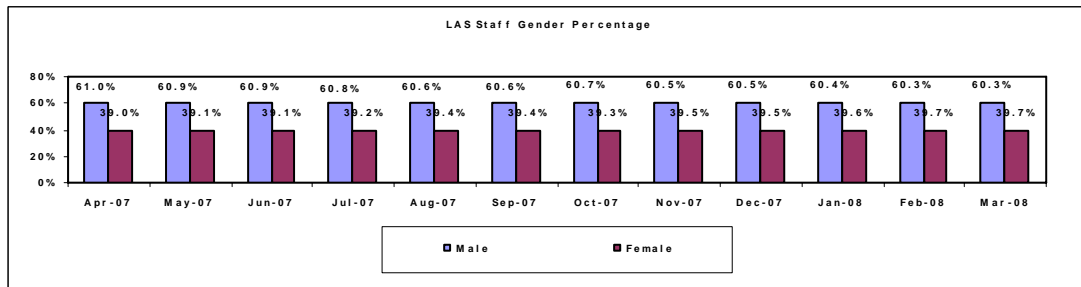
7.1.3. At present just over 90% of staff records are "undefined" in terms of disability; it is currently therefore not possible to provide any meaningful data on this.

7.1.4. At the time of writing this report information is also not readily available on the levels of representation at senior management level of staff who are black & minority ethic, women or disabled people. This information will be available in the report published in May 09.

7.1.5. Of the new starters to the service, 10.7% were BME (06-07 report figure: 10.1%), 51.2% female (06-07 report figure: 50% achieved), with no figures available on the disability status of new starters. The previous target figure for BME new starters was 15%, which was achieved in 07-08 (15.8%), while the target for women starters overall has also been achieved again in 07-08.
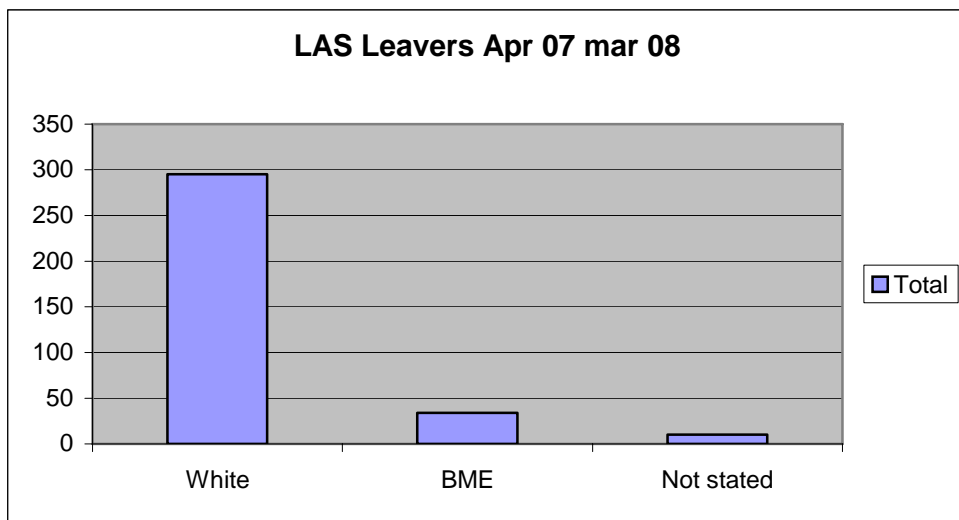
7.2. LEAVERS

7.2.1. Of a total of 339 leavers in the year from April 07 to March 08 58% were male and 42% female.

**339 Leavers Apr 07 Mar 08**

Male
Female

144, 42%

195, 58%

Leavers by Gender Grade / Rank Apr 07 Mar08

Female
Male

7.2.2.   The majority of female staff leaving LAS were Bank staff or from A&C; the majority of
male staff Paramedics or EMT4.

Leavers by Staff Group / Gender Apr 07 Mar08
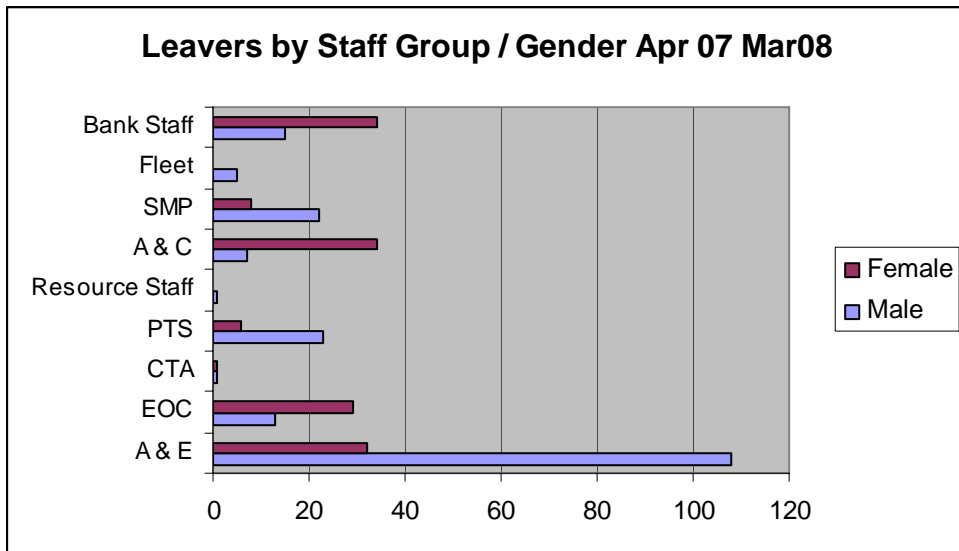
7.2.3. Of the 339 leavers 10% were from BME communities, 87% were white and 2.9% were not stated.

LAS Leavers Apr 07 mar 08

7.2.4. Of these the majority of staff were in the age range 21-30 – 31.9% and the age range 31-40 – 30.7%.

LAS Leavers by Age band Apr 07 Mar 08
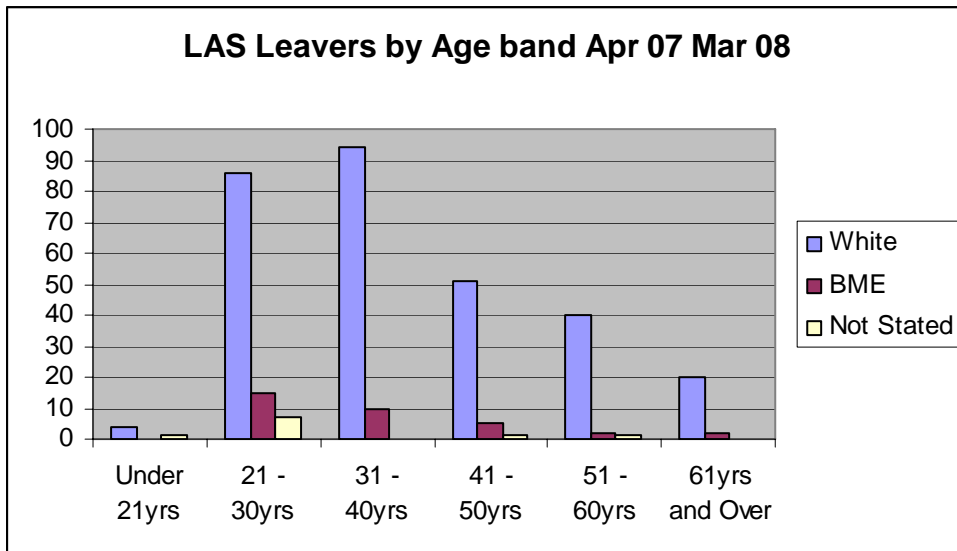
7.2.5. Of these the majority of leavers were in the ranks of EMD1, A&C and Bank staff for the age range of 21-30 and EMT4 & Paramedic for the age range 31-40.

LAS Leavers By Grade / Rank Apr 07 Mar 08
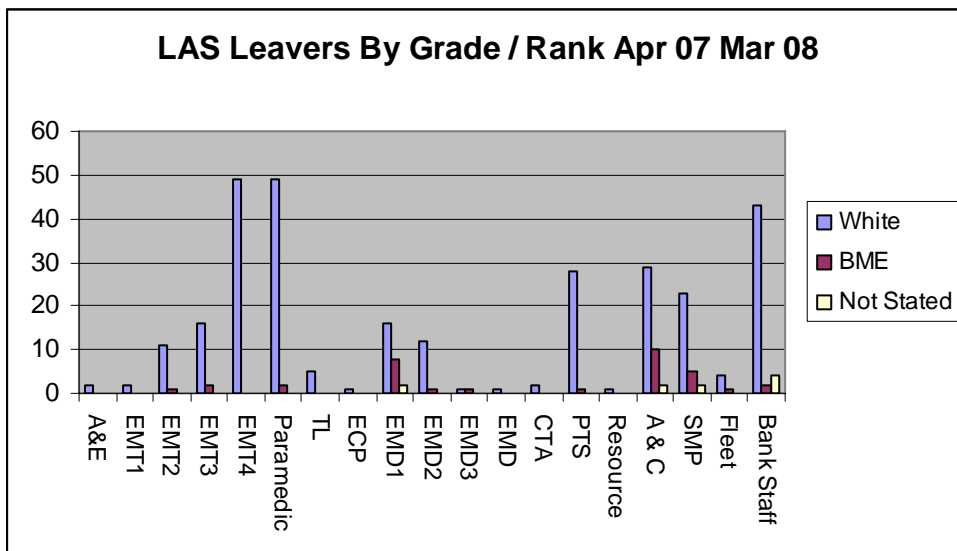
7.2.6. The majority of leavers were in A&E, which spanned the age ranges of 21- 30, 31-40, 41-50 and 51-60; EOC, particularly 21-30 and 31-40, A&C, in particular 21-30 and 31-40 and Bank staff especially in the age range 21-30.

LAS Leavers By Staff group Apr 07 Mar 08
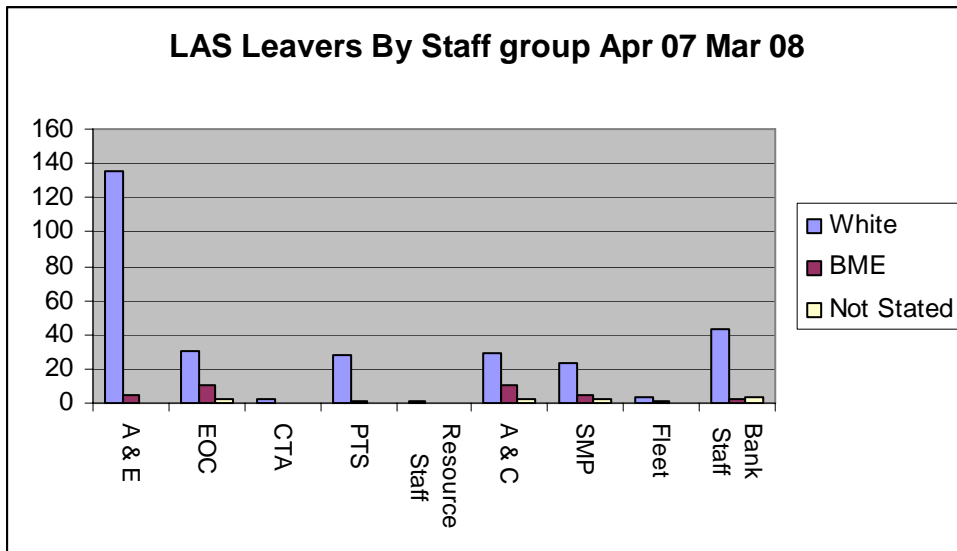
7.2.7. No comparable statistics were provided in the 2006-07 report, so it is not possible to gauge any progress in this area.

7.3   PROMOTIONS

7.3.1. A total of 244 LAS staff were promoted from April 07 to March 08.

Staff groups by Gender Apr-7-mar08
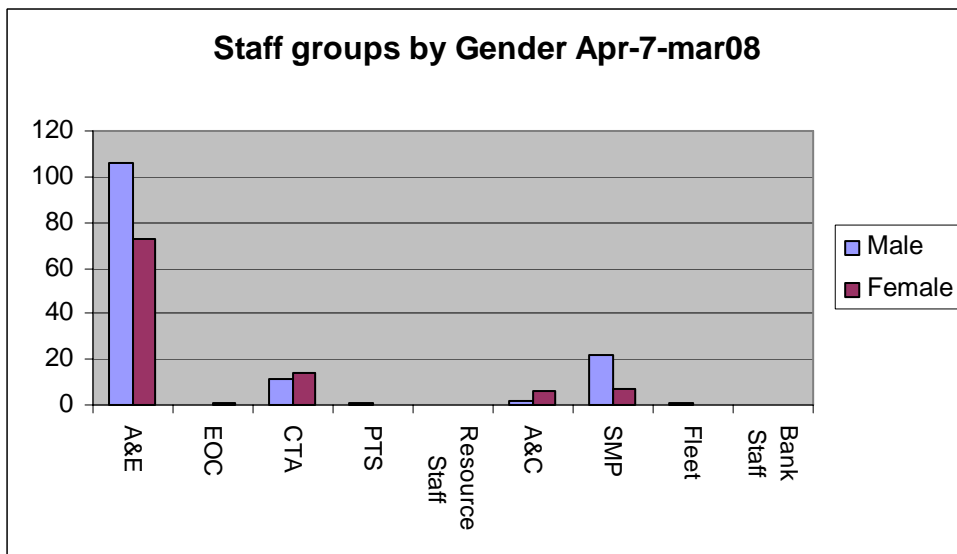
7.3.2. The overwhelming majority of these were white British or any other white, with less than 5% BME staff, which is less than the percentage of BME staff in the workforce for this time period.

7.3.3. Over 60% were male.

7.3.4. The department with the overwhelming majority of promotions was A&E.

7.3.5. The overwhelming majority of promotions were in the age ranges 21-30 and 31-40.

7.3.6. No comparable statistics were available in the 2006-07 report, so it is not possible to determine progress.

7.4   CAPABILITY/ATTENDANCE/PROCEDURES/DISCIPLINARIES/ GRIEVANCES/EMPLOYMENT TRIBUNALS

7.4.1.   Below is the information on the total number of capability/attendance/disciplinary and grievance cases from April 07-March 08.

7.4.2.   In total, the Capability procedure was instituted 38 times, Disciplinary procedure 94 times, Grievance 49 and Attendance 71.

7.4.3.   The Capability Procedure was instituted against a total of 38 staff, 17 women and 21 men, of whom 1 was Black of Black British Caribbean, 1 White Irish, 1 White Other, 29 White British and 6 staff, for whom no ethnicity details were recorded.

7.4.4.   8 women (21% of the total) suffered detriment (receipt of warnings/dismissal) as a result of the Capability proceedings; 1 BME staff member (2.7%%)   .

7.4.5.   The Disciplinary Procedure was instituted against a total of 94 staff, 28 women and 66 men, of whom 2 were Asian or Asian British Bangladeshi, 1 Asian or Asian British Indian, 1 Black of Black British African, 2 Black or Black British Caribbean, 3 Mixed White & Black Caribbean, 1 White Other, 75 White British and 9 staff, for whom no ethnicity details were recorded.

7.4.6.   17 women (18.1%) suffered detriment as a result of the Disciplinary proceedings; 8 BME staff (8.5%).

7.4.7.   The Grievance Procedure was instituted by a total of 49 staff, 12 women and 37 men, of whom 1 was Asian or Asian British Pakistani, 2 Black of Black British African, 1 Black of Black British Other, 26 White British and 19 staff, for whom no ethnicity details were recorded.

7.4.8.   Of the grievances submitted, two by women staff were upheld and one by a BME staff member was only partially upheld. However, as the overwhelmingly number had conclusions which were "not stated", this can not considered conclusive.

7.4.9.   The Attendance Procedure was instituted against 71 members of staff in total, 31 women and 40 men, 6 of whom were Black British or Black British Caribbean, 2 Mixed Other, 2 Mixed White & Black Caribbean, 1 Mixed White Asian, 53 White British and 5 members of staff, for whom no ethnicity details were recorded.

7.4.10. 27 women (38%) suffered detriment as a result of the Attendance proceedings; 11 (15.4%) BME staff.

7.4.11. No details are available on disability status for any of the procedures.

7.4.12. In the year 2007-08 there were a total of 19 Employment Tribunal claims, just under 50% of which were from women.

7.4.13. Only one of the ET claims was submitted by a black and minority ethnic staff member.

7.4.14. 8 out of the 19 claims submitted were from disabled people. This appears a very high figure, although, given that currently records on disability status are not being kept comprehensively, it is not possible to determine how proportionate this is to the representation of disabled people within the current workforce.

7.4.15. The claims submitted by the 8 disabled people were all for Disability Discrimination.

7.4.16. The remaining claims submitted were for Unfair dismissal (5), Breach of contract / unlawful deduction of wages (2), Constructive dismissal (1), Unfair dismissal/racial discrimination (1) (submitted by a black and minority ethnic staff member) and Unfair dismissal/disability discrimination (submitted by two respondents, neither of whom self-identified as disabled).

7.4.17. Only one claim (Unfair Dismissal) submitted by a non-disabled white male member of staff was successful.

7.4.18. In the last report there were 48 disciplinary actions, of which 8.33% were of BME staff and 49 grievances, of which 12.24% were from BME staff. No complaints on racial grounds had been submitted to an Employment Tribunal.

7.4.19. In this last year, 07-08, of the total number of disciplinaries 10.6% were of staff from BME groups (higher than the previous year); of the total number of capability procedures, 5.2% were from BME staff groups (no comparable data available in the last report), which is less than the current representation of BME staff in the workforce; of the total number of grievances 8.2% were submitted by staff from BME groups, a sizable decrease on the previous report total; and of the total number of attendance procedures 15.5% were of staff from BME groups (no previous data available for comparison).

7.4.20. No previous data on gender or disability was available on these   procedures in the last report.

7.4.21. In terms of gender, over the year 07-08 of the total number of capability procedures 42.8% were of women, which is 3.1% over the percentage of current representation in the workforce; of the total number of disciplinaries 36% were of women, below the percentage in the current workforce; of the total number of grievances 29.8% were of women, which is considerably below their representation in the workforce; and of the total number of attendance procedures 43.7% were from women, which is 4% over their representation in the workplace.

8.5   TRAINING
8.5.1.   There were 4664 applications for training courses organized by Learning & Development.

8.5.2.   Of these 564 were from BME staff (see chart below).

8.5.3.   262 applications were from women (see chart below).

8.5.4.   6 applications were from disabled people (see chart below).

8.5.5.   However, 4131 staff are not recorded in terms of gender, 4179 not recorded in terms of disability and 174 not recorded in terms of ethnicity, so no clear trends can be detected from this data.

8.5.6.   A total of 345 staff (7%) received training.

8.5.7.   Of these 63 (18%) were BME staff.

8.5.8.   120 were women.

8.5.9.   2 were disabled people.

8.5.10. 97 staff were not recorded in terms of gender, 127 staff were not recorded in terms of disability and 18 staff were not recorded in terms of ethnicity, which makes it not possible to detect any clear trends in this data.
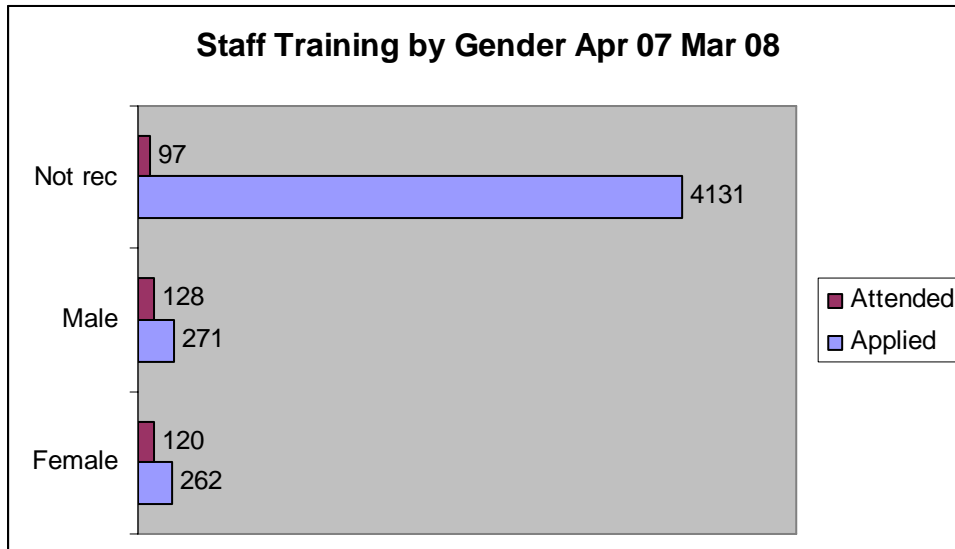
TRAINING APPLICATION & TAKE-UP BY ETHNICITY

Training by ethnicity (Ex White British) Apr 07 Mar 08

Code	Attended	Applied
Z	18	174
S		
R	0	6
P	0	19
N	4	41
M	14	133
L	2	21
K	2	7
J	2	18
H	3	47
G	4	29
F	1	16
E	0	10
D	5	21
C	20	123
B	6	73

(2001 Census Codes)
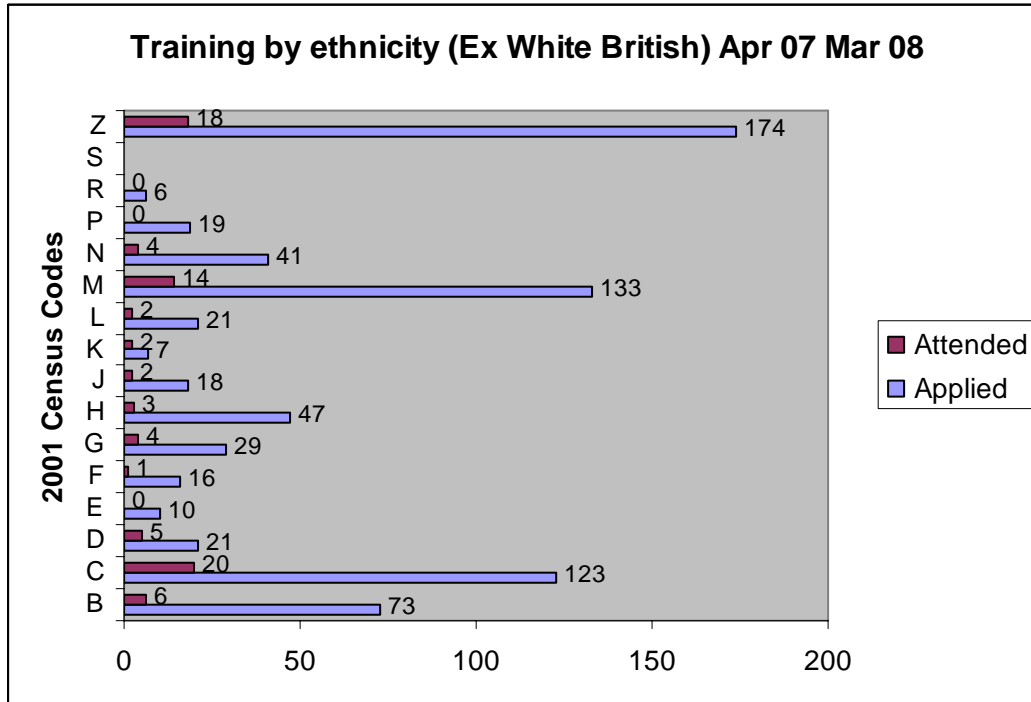
Ethnicity Codes:
B –   White – Irish
C –   White – Any other background
D – Mixed – White & Black Caribbean
E – Mixed – White & Black African
F – Mixed – White & Asian
G – Mixed – Any other mixed background
H – Asian or Asian British – Indian
J –   Asian or Asian British – Pakistani
K – Asian or Asian British – Bangladeshi
L – Asian or Asian British – Any other Asian background
M – Black of Black British – Caribbean
N –   Black or Black British – African
P – Black or Black British – Any other background
R –   Chinese
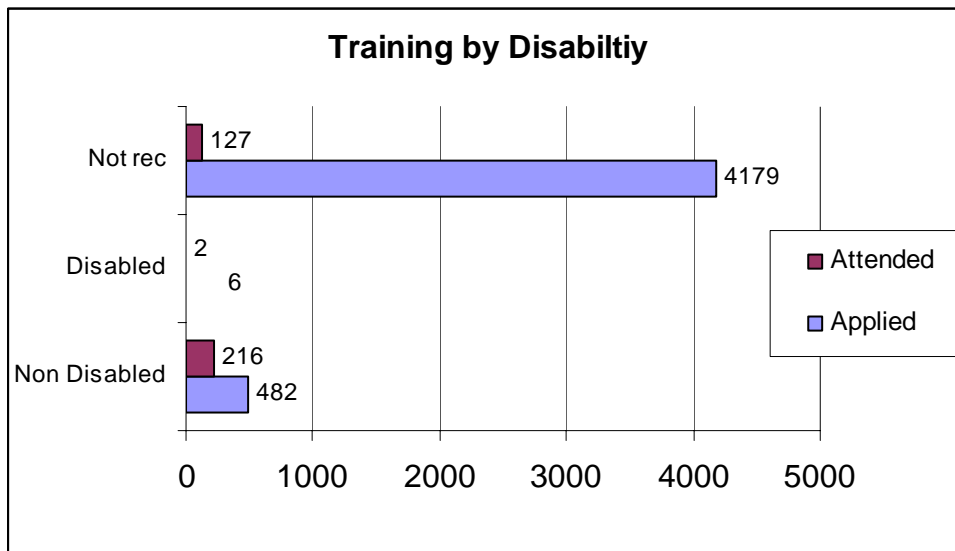**S – Any other ethnic group**
Z –   Not stated

A- White British:
  Applied 3926
  Attended 264

TRAINING APPLICATION & TAKE-UP BY GENDER

Staff Training by Gender Apr 07 Mar 08

Gender	Attended	Applied
Not rec	97	4131
Male	128	271
Female	120	262

TRAINING APPLICATION & TAKE-UP BY DISABILITY

Training by Disabiltiy

	Attended	Applied
Not rec	127	4179
Disabled	2	6
Non Disabled	216	482

8.5.11. No statistics on applications or take-up of training were available for the Education & Development division.

8.5.12. No statistics on application for or take-up of training were provided in the 2006-07 report, so it is not possible to gauge any progress.

9   EQUALITIES INITIATIVES
9.1   EQUALITY IMPACT ASSESSMENTS

A revised Equality Impact Assessment Procedure will be devised, with revised guidance and template, accompanied by training, which will assist the manager responsible for each function or policy and his/her team to complete the relevant impact assessments to the scheduled target date. A new Equality Impact Assessment Schedule, spanning the next three years, will be produced in consultation with Chief Officers, to ensure that all the policies and functions of the London Ambulance Service, in line with existing equalities legislation, are adequately robust and subject to the requisite review and monitoring.

11

9.2. MEMBERSHIP OF EMPLOYER DIVERSITY FORUMS

9.2.1. LAS joined the Employers' Forum on Disability in March 1997 and the Stonewall Diversity Champions Programme in February 2008. To ensure that the LAS is also best placed to meet the other additional forthcoming requirements of the Single Equality Act on religion and   belief and age, consideration should also be given to pursuing membership of the Employers' Forum on Age and the Employers' Forum on Religion & Belief.

9.3   RECRUITMENT & RETENTION

9.3.1. In conjunction with the recruitment manager, the Diversity Team will undertake an analysis of the advertising and recruitment initiatives previously undertaken to ensure a diverse range of media and outreach initiatives can be undertaken for 09-10, aimed at greatly increasing the levels of representation by equality strand groups at each level and within each profession in the organization.

9.3.2. The introduction of a systematic approach to equality impact assessments of policies should ensure that all policies within LAS are inclusive of all staff and therefore actively assist in the retention of under-represented groups. Equality strand monitoring information from those leaving the organization as well as from staff surveys should also assist in highlighting any areas which need to be addressed, to prevent the service from losing valuable staff from these groups.

10   ACTIVITIES OF THE LONDON AMBULANCE SERVICE
10.1. PATIENT & PUBLIC INVOLVEMENT (PPI)

- The PPI Manager and PPI Committee aim to ensure that the Trust's PPI activities focus on the communities which will most benefit from engaging with the LAS, including those which experience health inequalities. For this reason, the Trust continues its work with the Bengali community in Tower Hamlets, as this is a community which currently suffers some of the worst health outcomes.

- Eight members of LAS staff at Tower Hamlets complex have undergone a 10-week course (60 hours in total) in the Bengali language, which has led to improved understanding between our staff and patients. There are plans to repeat this course – with another group of staff – early in 2009.

- Training sessions in paediatric emergency life support (including choking and bleeding) are being held in Children's Centres in Tower Hamlets, developed and led by an Emergency Medical Technician from Tower Hamlets complex. This group has been chosen because of the high infant mortality rate in the Bengali community. There are plans to work with Tower Hamlets PCT in 2009 to ensure these sessions are targeted at the women with the greatest need.

- A health education pack, "Get the Right Treatment," was produced in conjunction with Tower Hamlets PCT. This pack provides health advice and information about which part of the NHS to access in a variety of circumstances, with the aim of reducing A&E attendances at the Royal London Hospital for people with conditions which could be treated in another setting, e.g. a walk-in centre. The LAS wrote, directed and produced the DVD which is used in training sessions with NHS staff and people from the community in Tower Hamlets, showing a series of scenarios followed by health advice from a local GP and information about services available for people with each of the complaints illustrated. Get the Right Treatment won a London Health & Social Care Award in 2008.

- New Ways of Working includes the introduction of a new role, Community Involvement Officer. Two of these posts have been filled for the first two NWOW sites – Barnehurst and Chase Farm. The role includes engaging with local communities and identifying priority groups in the area on which to focus our PPI and public education activity.

- The Public Education Strategy and Action Plans for 2007-08 and 2008-09 describe how particular sections of the community should be prioritized when the Trust is planning its public education activities. Materials and resources are being developed for use by LAS staff engaged in Public Education work and during 2008-09 10 staff have been undergoing a pilot development programme to ensure they have the right knowledge and skills to do this work effectively. This programme will be evaluated early in 2009 and will be extended to another group of staff in the spring or early summer of 2009. A Public Education Co-ordinator will also be appointed early in 2009 to support developments in this area of work.

- The Trust continues its involvement with multi-agency projects to improve health outcomes and reduce harm to a variety of vulnerable groups, e.g. those at risk of being victims of gun and knife crime. Two further examples are "Prison Me No Way" (demonstrating the effects on young people of getting involved with crime) and "Safe Drive, Stay Alive," a powerful live event illustrating the importance of driving safely.

- In 2008 four schools in Barking & Dagenham came together to provide work experience placements for their year 12 students. This new approach to work experience provided teams of students with the opportunity to work together on a 'real' project within an organization. A team of five students came to the LAS and were supported by the Events & Schools Team. They conducted a project to find out about perceptions of the LAS amongst 14-16 year olds. The surveys were designed to find out people's experience of the Service, their views about its plans for the future, and whether they would consider a future career in the ambulance service. 186 surveys were completed and produced some interesting findings.

- The Trust also includes its work with younger children (age 10-11) through the Junior Citizens Scheme, which gives children an opportunity to learn how to call an ambulance and how to carry out basic first aid.

- The Trust routinely takes part in public events throughout London, e.g. the London Mela festivals (aimed at the Asian communities), the borough shows, local fairs and fetes, recruitment events, safety days, events at schools, etc.

- A member of staff has spoken on Asian radio stations a number of times, encouraging the community to access Heartstart training.

- Consultation and engagement events have been held for Patient Transport Service users; members of the public wishing to learn about – and comment on - the Service Improvement Programme, and help the Trust complete its equality impact assessment; and to develop the new mental health strategy, long term conditions strategy and older people's strategy. Large-scale consultation events are planned for early 2009, when the Trust will be consulting on its future plans, including the plan to become a Foundation Trust.

- The Trust continues to engage with the Patients' Forum, which continues its work as an unregistered charity following changes in the law which saw Patients' Forums being abolished elsewhere. The Patients' Forum has a diverse membership, including a number of disabled people, a number of older people, and members from various ethnic backgrounds. Three deaf members of the Forum have been involved in the Service Improvement Programme project to improve access to the Service for deaf people.

- The Trust is also increasing its involvement and engagement with the borough Overview and Scrutiny Committees, and the new Local Involvement Networks, which exist in each borough. Local Involvement Networks, or LINks, will be a good way of engaging with a wide variety of local people in all areas of London.

- A major public event in March 2008 "It's your call" (referred to later under "Stakeholder Engagement") which showcased the work LAS has been doing on equality impact assessments.

10.2. THE PATIENT TRANSPORT SERVICE
10.2.1. Although PTS has within its remit the recording of records by ethnicity, only 2% of records have been recorded, and only since this year, which does not make it possible to analyse take-up of this service.
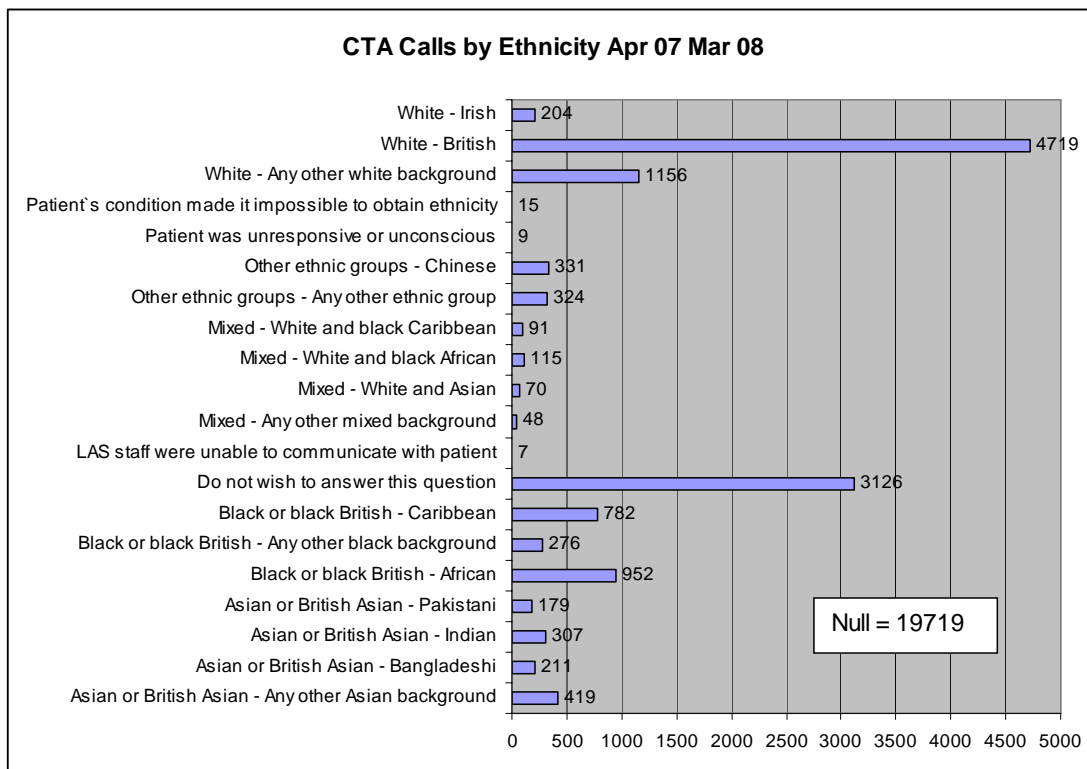
10.3. CLINICAL TELEPHONE ADVICE
10.3.1. Currently, the only data which can be provided is:
- Ethnicity data obtained from the emergency dataset, which would have been taken from the Patient Report Form
- Age and gender, taken from PSIAM

10.3.2. No information is currently available for "no sends", due to inconsistencies within the data, which makes it impossible to determine conclusively which are "sends" and "no sends". The data requested does not include ethnicity.

10.3.3. The graph below indicates the usage by ethnicity from April 07- March 08.

CTA Calls by Ethnicity Apr 07 Mar 08

Ethnicity	Value
White - Irish	204
White - British	4719
White - Any other white background	1156
Patient`s condition made it impossible to obtain ethnicity	15
Patient was unresponsive or unconscious	9
Other ethnic groups - Chinese	331
Other ethnic groups - Any other ethnic group	324
Mixed - White and black Caribbean	91
Mixed - White and black African	115
Mixed - White and Asian	70
Mixed - Any other mixed background	48
LAS staff were unable to communicate with patient	7
Do not wish to answer this question	3126
Black or black British - Caribbean	782
Black or black British - Any other black background	276
Black or black British - African	952
Asian or British Asian - Pakistani	179
Asian or British Asian - Indian	307
Asian or British Asian - Bangladeshi	211
Asian or British Asian - Any other Asian background	419

Null = 19719

Ethnicity has been obtained through the data collected form PRF's where a crew has arrived on scene. (Field question "Patient declined to indicate ethnicity" has been merged with "Do not wish to answer this question".)

10.3.4. From April 2007 to March 2008 there was a total of 15,128 calls made through PSIAM (the CTA system) made by women, of whom the largest number were by women in the age ranges 16 to 25, 25 to 34 and 35 to 44.

10.3.5. In the same timeframe a total of 10,652 calls were made by/for men, of whom the largest number were in the same age ranges as above.

10.4. COMPLAINTS

10.4.1. Equalities data on complaints is limited, as ethnicity monitoring forms are sent to complainants, rather than the information being sought over the telephone, following a recent complaint about a member of ambulance staff seeking to ask ethnic monitoring questions of a patient, who viewed this as instrumental in determining what she considered to be poor treatment. Although an SAE is always provided, only a relatively small percentage of completed forms are received back, making the provision of this data at best only very partial.

10.4.2. Ethnicity details on the patient are currently given by the complainant in the cases where someone other than the patient calls to complain.

10.4.3. The statistics on complaints received from April 07 to March 08 reveal that as indicated on the following graph that:
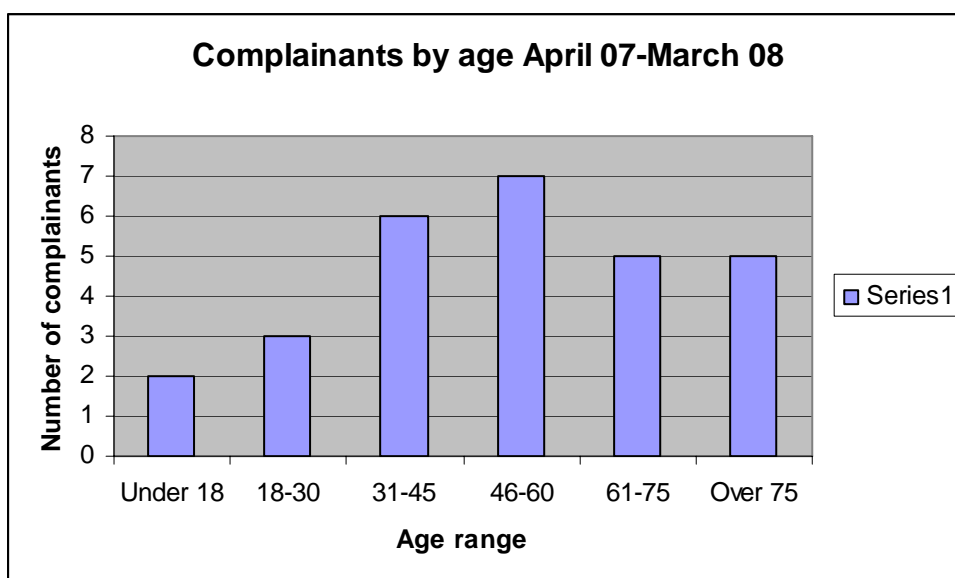- The overwhelming number of complainants did not state their ethnicity
- The second highest reported ethnic background was White British
- Equal third highest reported was Any other ethnic group and African

Ethnicity of complainants April 07-March 08
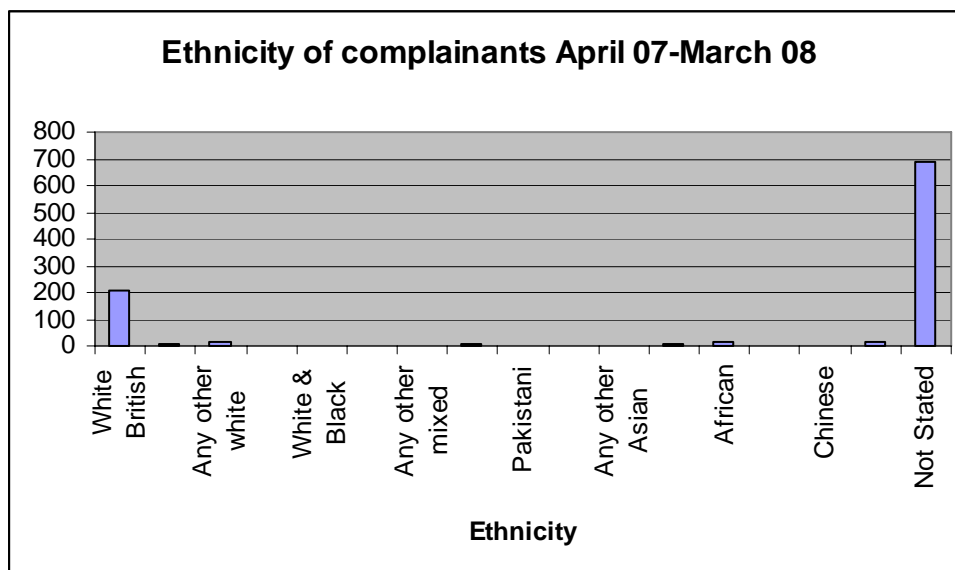
(The above figures combine the information collected on patient and complainant; in some cases the complainant is the patient, although there is currently no data to determine what percentage this would comprise.)

10.4.4. Currently, although the gender and age of the patient/complainant are recorded, there is no easy way of obtaining a report on these statistics other than by going through more than 500 individual records on the database, so there is no reliable comprehensive information currently to hand.

10.4.5. The graph below indicates the age range of complainants (gained from the ethnic monitoring forms).

Complainants by age April 07-March 08

Number of complainants (y-axis): 0 to 8

Age range (x-axis): Under 18, 18-30, 31-45, 46-60, 61-75, Over 75

- Under 18: 2
- 18-30: 3
- 31-45: 6
- 46-60: 7
- 61-75: 5
- Over 75: 5

Series1

10.4.6. The greatest number of complainants come from the 46-60 age range, followed by 31-45 then equally 61-75 and over 75. However, given that the sample obtained is very low (28), these statistics are not necessarily indicative of an overall pattern in the service take-up.

10.5. Patient Experiences Data (Formerly PALS)

10.5.1. Equalities data is limited, owing to to the lack of opportunity to go through an ethnicity questionnaire each time an enquiry is received, as it currently may often appear inappropriate. An Equalities Monitoring Form is however sent out with each response to a PALS enquiry or a complaint, although the returns are relatively few. Attempts by crew staff to seek information have also resulted in complaints, in the light of misunderstandings about the purpose and possibly less than optimum explanations as to the rationale for asking for equalities information.

10.5.2. The lack of any systematic analysis is also inhibited as the Datix case management module for PALS was never set up to record this information. A bolt-on field was added on but it is not entirely satisfactory for this purpose.

10.5.3. From April 2007 to March 2008 from a total of possible 4709 contacts to PALS in terms of ethnicity the highest number of contacts (Enquirer/Contact) were not stated, followed by White British and any other White background. However, the low frequency of reporting precludes any reliability in this data.

10.6. PATIENT PROFILING

10.6.1. Recording of the ethnicity of patients started in 2005 through the use of the Patient Report Form.
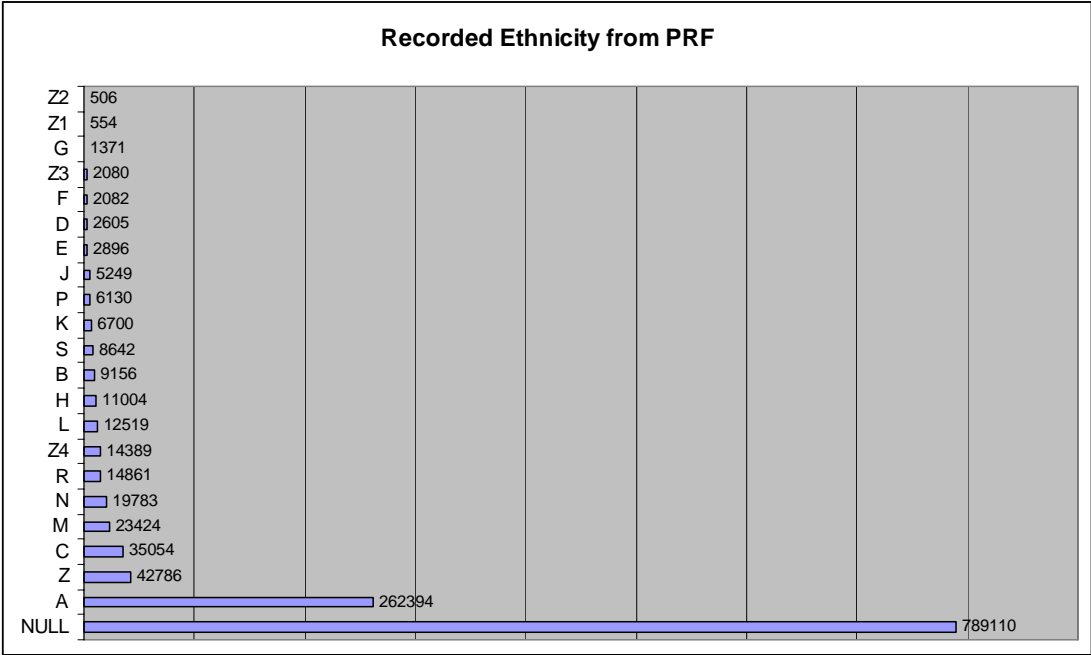
10.6.2. In 2006-7 forms completed showed that the patient profile was then:
  - Minority ethnic – 24.7%
  - White – 75.3%

10.6.3. As the graph below shows, the current statistics indicate that the 2007-08 profile is now:
  - Minority ethnic – 13%
  - White – 77%

Given the Census 2001 estimate of 28.8% BME population in London, this represents a lesser take-up than expected. However, a sizable number of service users were either unwilling or unable to provide their ethnicity, so the accuracy of this profile is not possible to confirm.
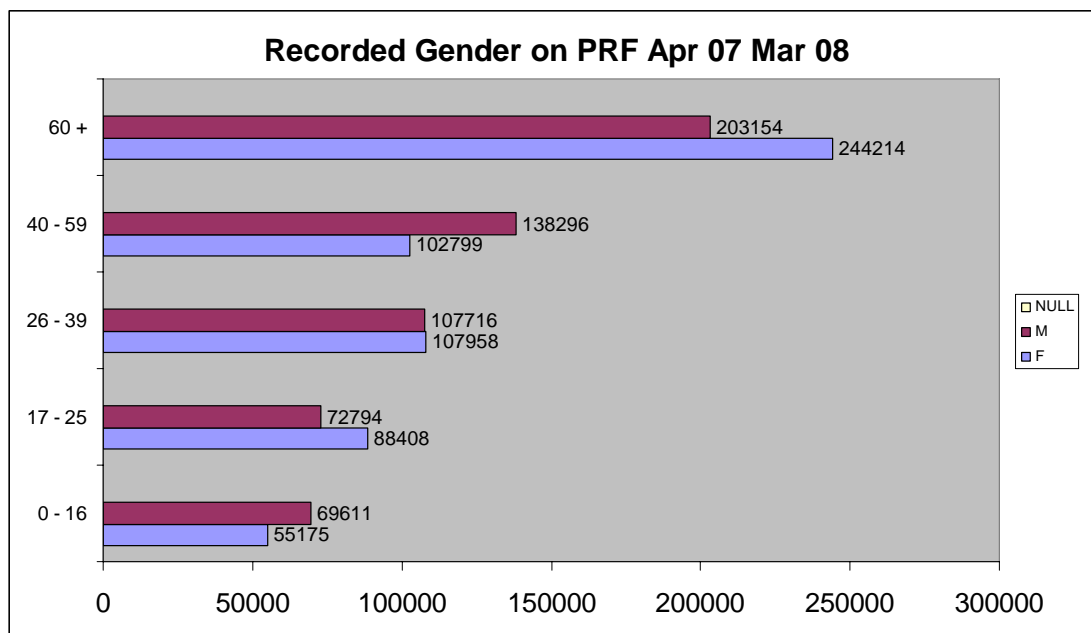
Recorded Ethnicity from PRF

Code	Value
Z2	506
Z1	554
G	1371
Z3	2080
F	2082
D	2605
E	2896
J	5249
P	6130
K	6700
S	8642
B	9156
H	11004
L	12519
Z4	14389
R	14861
N	19783
M	23424
C	35054
Z	42786
A	262394
NULL	789110

Key
Based on the 2001 Census Ethnic coding and additional LAS PRF field codes. (see below)

Ethnicity Codes:
A – White - British:
B – White – Irish
C – White – Any other background
D – Mixed – White & Black Caribbean
E – Mixed – White & Black African
F – Mixed - White & Asian
G – Mixed – Any other mixed background
H – Asian or Asian British – Indian
J – Asian or Asian British – Pakistani
K – Asian or Asian British – Bangladeshi
L – Asian or Asian British – Any other Asian background
M – Black of Black British – Caribbean
N – Black or Black British – African
P – Black or Black British – Any other background
R – Chinese
S – Any other ethnic group
Z – Do not wish to answer this question
Z1 – patient was unresponsive or unconscious
Z2 – LAS staff were unable to communicate with the patient
Z3 – Patient's condition made it impossible to obtain ethnicity
Z4 – Patient declined to indicate ethnicity

10.6.4. The current profile in terms of gender, as shown by the chart below shows that in terms of gender of respondents, both males and females accessed the service in roughly equal sizes, with the most predominant age range being that of the 60+ followed by 40-59.

10.6.5. This information was not provided in the 2007 report, so it is not possible to determine any progress in this area.

Recorded Gender on PRF Apr 07 Mar 08

Age Group	M	F
60 +	203154	244214
40 - 59	138296	102799
26 - 39	107716	107958
17 - 25	72794	88408
0 - 16	69611	55175

Legend: NULL, M, F

X-axis: 0, 50000, 100000, 150000, 200000, 250000, 300000

11.   STAKEHOLDER ENGAGEMENT

11.1.   A highly successful stakeholder engagement event, the first Service Improvement Forum ("It's your call"), was held at the end of March 2008.

11.2.   The Service Improvement Forum focused on LAS's plans for the future.

11.3.   Speakers and workshops went through the five key areas of the Strategic Plan and asked participants for their feedback on proposals.

11.4.   The first session focused on how people accessed the ambulance service and how LAS shared information with other healthcare services.

11.5.   Two key projects were highlighted during the presentation:
- Work with the speech and hearing-impaired community to find a way they can access the service
- Use of translation cards by ambulance staff to improve how LAS staff communicate with service users whose first language is not English

11.6.   Feedback was very positive:
- one of the key suggestions for improvements in access was for LAS to make use of EasyRead aids
- people were very keen to see the number of staff within the Trust who were able to speak additional languages increase; this was viewed as particularly beneficial with regard to the forthcoming Olympic and Paralympic Games being held in London Ambulance Service
- it was recommended that visitor packs for visitors be provided, to enable them how to find help and to contact where necessary the emergency services
- raising public awareness about LAS activities was also felt to be very important, particularly in regard to educating people and their carers about what to expect when a crew arrives

- another popular idea was to increase the work with school children of all ages, in regard to dialling for help or careers in the ambulance service
- suggestions included working with specific community groups and schools to promote careers in the service

12 CONCLUSION

12.1.1. A lot of highly positive work, highlighted above, has taken place in the year from 2007 to 2008 and the conclusions and recommendations contained in this report are aimed at making further improvements on this position. Equality & diversity issues need to be further mainstreamed and embedded throughout every area of the Trust, including the collection, provision of and reporting on the management information required to show the Trust's compliance with equalities legislation and promotion of good practice.

12.1.2. There is a wide variation in the quantity and quality of management information being collected on the different functions & activities of the Trust, which does not allow for a detailed analysis of progress in terms of workforce representation; access to, or satisfaction with the services LAS provides, in keeping with the requirements of current equalities legislation.

12.1.3. Currently there is a lack of consistency in regard to the information being gathered on equality strand categories of frequency or quality of the information being collected.

12.1.4. There is minimal data on disability throughout the Trust.

12.1.5. The way in which equality strand information is collected continues to inhibit best practice in this area, i.e. at times ethnicity data may be being classified by LAS personnel rather than allowing for self-identification by service users, which can be due to the circumstances surrounding the data collection, e.g. asking patients in an ambulance for this information when they are ill or anxious.

12.1.6. Information is not readily available on representation by BME staff, women or disabled people at senior grade level. However, there is scope for future reporting on this. This should be remedied by the next reporting period in May.

12.1.7. Some service areas in LAS are not systematically collecting information across the equality strands at all, although monitoring and reviewing information on access to and satisfaction with services is the responsibility of the function holder.

12.1.8. Some of the I.T. systems in place for collection of data are not best suited to capturing the data in sufficient comprehensiveness or quality.

12.1.9. To ensure LAS is able to meet fully its duties under existing equalities legislation, the information being gathered and reported on for each of the Trust's functions and services on race, gender and disability needs to be consistent, comprehensive and qualitatively robust, which currently is not the case across the Trust.

13 RECOMMENDATIONS

13.1. To ensure the Trust is best placed to meet its obligations under existing and forthcoming equalities legislation, it is recommended that:

- a standard monitoring template for the collection of equalities data be drawn up, to be used by each service area across all its functions, activities, employment & training and engagement practices;

- staff be surveyed on the possible establishment of new staff diversity networks;

- consideration be given to LAS joining the Employer's Forum on Age and Employer's Forum on Religion or Belief, to ensure LAS stays at the forefront of good practice on all equality strands;

- consideration be given to LAS seeking to become one of the top 100 UK employers on the Stonewall Workplace Equality Index;

- current management information collection, review & reporting processes across the Trust be reviewed, with a view to ensuring standard, comprehensive and detailed data is readily available on each aspect of the Trust's functions and activities; this should include a review of the I.T. systems currently being used to collect data in service areas;

- progress on equality & diversity in LAS be benchmarked against other ambulance services & leading NHS Trusts, including those who have successfully achieved Foundation Status;

- regular review and monitoring of equalities information on their service be undertaken by the function holders throughout the Trust, as well as being part of the equality impact assessment procedure; a new user-friendly procedure will be produced for use across the Trust in 2009;

- to address the low representation in the LAS workforce of 8.44% minority ethnic staff and the potential low percentage of disabled staff, specific recruitment initiatives should be considered and planned over the coming year to target these under-represented groups and to investigate the reasons for the lack of take-up of a career in LAS by them;

- to assist with the recruitment & retention of under-represented groups a targeted communications campaign should be considered, which could feature life stories of LAS personnel who are women, minority ethnic and disabled, to encourage more people from these sections of the population to join the service;

- LAS should seek to be included in the free Stonewall Recruitment Guide for college & university leavers, "Starting Out", to further raise the profile of the service as an employer of choice.

EQUALITY & DIVERSITY REPORT

APPENDIX A – ETHNICITY CODES

Based on the 2001 Census data, the following ethnicity codes are currently in use throughout the Trust:

A – White – British
B – White – Irish
C – White – Any other background
D – Mixed – White & Black Caribbean
E – Mixed – White & Black African
F – Mixed – White & Asian
G – Mixed – Any other mixed background
H – Asian or Asian British – Indian
J – Asian or Asian British – Pakistani
K – Asian or Asian British – Bangladeshi
L – Asian or Asian British – Any other Asian background
M – Black of Black British – Caribbean
N – Black or Black British – African
P – Black or Black British – Any other background
R – Chinese
S – Any other ethnic group
Z – Not stated

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Draft Meeting Dates 2010

1.   Purpose of Report

To consider for approval the 2010 meeting dates for both the Trust Board and the Service Development Committee.

2.   Proposed Dates

Month	Meeting	2010	(2010 PH)	2009	2008	Alternative Dates	Reasons for Alternative Dates
January	TB	26	(1st)	27	29	-	-
February	SDC	23		24	26	-	-
March	TB	30		31	18	23 or 16	30 March is after start of school holidays and in Easter week (Good Friday 2 April; Easter Monday 5 April)
April	Away Day	27	(2nd/5th)	28	29	-	-
May	TB	25	(3rd/31st)	19	20	18	25 May is in Half Term week
June	SDC	29		30	24	-	-
July	TB	27		28	29	-	-
August	-	-	(30th)	-	-	-	-
September	TB	28		29	30	-	-
October	SDC	26		27	28	19	26 October is in Half Term week
November	TB	23		24	25	-	-
December	SDC	14	(27th/28th)	15	16	-	-

3.   Recommendation

Directors are requested to consider these dates for approval.

London Ambulance Service NHS Trust

TRUST BOARD MEETING
27 January 2009

Report of the Trust Secretary
Tenders Received and Use of the Trust Seal

1. Purpose of Report

a. The Trust's Standing Orders require that tenders received be reported to the Board. Set out below are those tenders received since the last Board meeting on 25 November 2008.

b. It is a requirement under Standing Order 32 that all sealings entered into the Sealing Register are reported at the next meeting of the Trust Board. Directors may inspect the register after the meeting should they so wish.

2. Tenders Received

There have been 2 tenders received since the last Trust Board meeting, as follows:

Main defibrillator

Laerdal	Zoll	Medtronic

Driver training units

Wilker UK Ltd	U V Modular	S MacNellie & Son

3. Use of Seal

There have been 2 entries, Nos. 127 – 128, since the last Trust Board meeting. The entries related to:

No. 127   Intermediate building contract (JCT 05) between the London Ambulance Service and Lakehouse Contracts re. alteration and refurbishment works to form ambulance station, Units 2 & 3.

No. 128   Deed of Surrender relating to rights of way over Wardalls Grove and Deptford AS between Lewisham PCT and the London Ambulance Service.