LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD

Tuesday 19 May 2009 at 10:00am
Conference room, LAS HQ 220 Waterloo Road, London SE1 8SD

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Present:	Sigurd Reinton	Chairman
	Sarah Waller	Vice Chairman
	Peter Bradley	Chief Executive
	Martin Flaherty	Deputy Chief Executive
	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
	Caroline Silver	Non Executive Director
	Ingrid Prescod	Non Executive Director
In attendance:	Richard Webber	Director of Operations
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	Angie Patton	Head of Communications
	John Ellman-Brown	Capita Company Secretarial Services

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AGENDA

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- **23 February 2009**
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- Trust Board: 28 July 2009

DRAFT
London Ambulance Service NHS Trust

TRUST BOARD
Part 1

Minutes of the meeting held on Tuesday 31st March 2009
In the Conference Room, LAS, 220 Waterloo Road, London SE1 8SD

Present:	Sigurd Reinton	Chairman
	Sarah Waller	Vice Chairman
	Peter Bradley	Chief Executive Officer
	Mike Dinan	Director of Finance
	Roy Griffins	Non Executive Director
	Caron Hitchen	Director of Human Resources & Organisation Development
	Brian Huckett	Non Executive Director
	Beryl Magrath	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
	Janice Markey	Equality and Diversity Manager
	Laila Abraham	Interim Head of Governance
	Malcolm Alexander	Chair of Patients' Forum
	Seaton During	Enfield Links
	Steve Roberts	NTL Telewest
Apologies:	Ingrid Prescod	Non Executive Director
	Caroline Silver	Non Executive Director

23/09 Apologies

The Chairman noted apologies had been received from Caroline Silver and Ingrid Prescod.

24/09 Minutes Part 1 , 27 Jan 2009

After review and due consideration by the Committee, IT WAS RESOLVED that the minutes of the Trust Board held on 27 January 2009 be and are hereby approved as a true record of the meeting and that they are signed by the Chairman.

25/09 Synopsis Part 2 Minutes , 27 Jan 2009

The synopsis of the minutes from the Trust Board Part 2 meeting held on 27 Jan 2009 was noted.

26/09 Matters Arising

There were no matters arising

27/09 Chairman's update

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

- Martin Smith, new Director of Corporate Services was introduced
- Martin Flaherty was formally congratulated on his appointment as the new Deputy Chief Executive
- Richard Webber was formally congratulated on his appointment as the new Director of Operations
- The Chairman mentioned his own succession. Advertisements for the Chair's role would be going out. Shortlisting was due to be done in May and interviews in early June, with the appointment being made on 1st July 2009.
- NHSL now forming six sectors, Chairs and CEOs (groups of PCTs).
- On 6th April Sir Richard Sykes, new Chairman of SHA will be visiting.

28/09 Report of the Chief Executive Officer

The Board received a paper from the Chief Executive. Key points included:

- CAD2010 decision to revised migration plan
- Record thanks for the support of Joan Mager, CEO R&T PCT who has worked hard to secure appropriate funding for the LAS
- Record thanks to Martin Flaherty and his contribution over the last 7 years as Operations Director
- CatB19 performance lowest in country. B19 target expected to be around for another 2/3 years

After further discussion, IT WAS RESOLVED THAT the report of the Chief Executive be received.

29/09 Report of the Director of Finance

The report of the Finance Director for Feb 2009 (month 11) was reviewed.

Directors noted a year to date surplus of £2m and a forecast surplus of £881k for 2008/09.

Additional non recurrent CBRN income of £1.1m was received in Feb 2009.

On the expense side, the A&E incentive and increased A&E overtime were forecast to continue in month 12.

After further discussion, IT WAS RESOLVED THAT the report of the Director of Finance be received.

30/09 Report of the Medical Director

The report of the Medical Director was reviewed.

After further discussion, IT WAS RESOLVED THAT the report of the Medical Director be received.

31/09 Service Improvement Programme update

Kathy Jones presented an update on the programme and progress was noted by the Board.

32/09 Lease Car policy : for approval

The Director of Human Resources and Organisation Development presented the revised policy for approval. Revisions include car choice linked to CO2 emissions

The policy was approved.

33/09 Staff Survey Results

The Director of Human Resources and Organisational Development presented the results Areas to focus on include:

- Reporting of errors/near misses
- Staff feeling valued
- Appraisals/PDRs
- Bullying & Harassment

Action : Further analysis required to look at longer term trends

34/09 Business Plan & Budget 2009/10 : for approval

The Director of Finance delivered a short presentation on the business plan and budget for 2009/10.

It was an update on the plan submitted to the Trust Board in Jan, 2009.

Key elements of the financial plan for 2009/10 include :

- Total income £283m
- EBITDA (IFRS) £19m
- Cost Improvement Programme £12m

- Capital Investment £17m
- Capital Employed £125m
- Financial Risk rating (LPA) 2
- Total staffing 4,805

After further discussion, IT WAS RESOLVED THAT the business plan and budget be approved.

35/09 LAS Objectives 2009/10

The Chief Executive tabled a set of draft LAS objectives and asked for feedback from Board members.

The objectives would be measured through the Balanced Scorecard process.

36/09 HART Business case: for approval

The Director of Finance presented a business case relating to the leasing of a HART facility for East London. The funding for the project would be provided directly from the Department of Health.

After further discussion, IT WAS RESOLVED THAT the business case be approved.

37/09 Assurance Framework for 2008/09

The Director of Corporate Services presented the Assurance Framework for 2009/10.

After further discussion, IT WAS RESOLVED THAT the assurance framework be noted.

38/09 2008/09 Core Standards Declaration : for approval

The Director of Corporate Services presented the HCC Core Standards Declaration for 2008/09 for approval.

After further discussion, IT WAS RESOLVED THAT the Core Standards Declaration be approved.

39/09 Report of the Trust Secretary

Directors noted that the Trust Seal had been used on 2 occasions since the last Trust meeting

The entries related to:

- Engrossment of deed of surrender relating to Crooked billet Roundabout, Wadham Road, Walthamstow, between the LAS and the Transport for London.

- Section 106 agreement for Park Royal Ambulance Station, London NW10

40/09 Questions from Members of the public

Malcolm Alexander asked if the new Care Quality Commission will be licensing all emergency vehicles in London including third party PTS providers. Peter Bradley replied that the LAS has lobbied the CQC accordingly

Seaton During asked if the Trust was looking at improving its Carbon Footprint and if the Trust was looking to access additional funding (including from the EC) for this. Mike Dinan responded that our current plans were to review our carbon footprint, to reduce it and to seek all funds possible.

41/09 Any other business

There was no other business

42/09 Next Meeting

Next Trust Board meeting was planned for Tuesday 19th May, 2009 in the main conference room at the LAS HQ.

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 19th MAY 2009
CHIEF EXECUTIVES REPORT

1 SERVICE DEVELOPMENT

Work continues to ensure that LAS 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 position:

Stroke & Major Trauma

HfL's consultation closed on Friday 8th May. Early responses suggest c80% of respondents are in favour of the proposals.

LAS have presented to London Councils and the JHOSC. Concerns focused on

- whether funding would be available to deliver our part of the pathways (yes),
- the training required (none for stroke, some for MT), and
- journey times (specifically from outer London boroughs such as Enfield; where some patients may not benefit from hugely improved journey times to HASUs under the proposals, but will receive better care when they arrive.)

LAS (via Policy, Evaluation and Development) will provide evidence to inform JCPCT decision. Deadline 19th June (to be presented at June SMG).

Stroke
Potential issues:

- Chelsea and Westminster FT are mobilising their members to object to the possible movement of the HASU at Charing Cross (as proposed by the HfL document) to St Mary's (which would make a better strategic fit with Major Trauma proposals).
- Some HASUs will be ready to receive patients before others. Therefore HfL have mooted the possibility of "switching on" the pathway by post code. They have been alerted that LAS would not support this. If resources were limited initially, a fairer way of introducing the service would be to open it to all patients who meet thrombolysis criteria rather than all FAST+ patients who present in a certain area.

Trauma

- A pan-London pre-hospital care group has been established, chaired by Fionna Moore, drawing membership from trauma network representatives, HfL and ambulance services.
- A pan-London triage tool has been developed to provide staff with clear guidance when determining the most appropriate destination for trauma patients. Operational staff will require training in use of this algorithm in order to reduce overtriage to major trauma centres.

- In the event of under triage and self presentation robust critical transfer procedures will be required.
- LAS are investigating the best way to deliver support to staff in determining the most appropriate location for patients and their clinical decision making.
- The LAS is currently investigating our future role in the provision of critical transfers
- St Mary's will not come on line at the same time as other Major Trauma centres and LAS will need to ensure that patients in London are provided for.

Unscheduled Care

Response Hubs
LAS attended two KPMG-run workshops at which it was clear that we had been successful in manoeuvring the focus away from a 3DN towards the links required to seamlessly transfer patients between call taking organisations (i.e. a response hub).

The outcome of this work is awaited.

The HfL project lead is keen to implement a multi PCT pilot of any proposals, probably from April 2010.

Urgent Care Centres
Hammersmith & Fulham PCT have opened the first Urgent Care Centre at the front end of Charing Cross hospital. This has had no impact on LAS staff as triage decision takes place after LAS handover. This may change and LAS are keeping abreast of developments here and are seeking to ensure consistency for such triage protocols across London.

Polyclinics

The first seven polyclinics officially opened on 28th April at Hammersmith Hospital, Alexandra Avenue (Harrow), Heart of Hounslow, Gracefield Gardens (Lambeth) Loxford (NHS Redbridge), The Barkantine (Tower Hamlets PCT) and Oliver Road (NHS Waltham Forest)

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 PATIENT TRANSPORT SERVICE

Commercial

North East London Foundation Trust (formerly North East London Mental Health Trust) have confirmed that LAS has retained the PTS contract for a period of 5 years from 1 April 2009. The new contract includes an additional day unit which was previously covered as part of the Barking, Havering and Redbridge NHS Trust and covers an additional 5000 patient journeys per year.

We are waiting for the 2nd phase of the London Procurement Programme to be announced which we expect to include:

- Epsom & St Hellier NHS Trust
- Imperial Collage Hospitals NHS Trust
- North West London Hospitals NHS Trust
- Barnet and Chase Farm Hospitals NHS Trust
- South East London NHS Trust (partial contract for Bromley and Queen Mary's, Sidcup, hospitals).

Human Resources

Restructure of the Site Manager and Crew Team Leader grades is underway. The consultation process ended on 8th May 2009 with assessments due to be held on 14th and 15th May 2009. Interviews are due to be held between 18th and 29th May 2009 and results published the following week.

Performance

Performance on the quality statistics for March 2009 are:

- Arrival time: 92%
- Departure time: 91%
- Time on Vehicle: 94%

Arrival and departure times increased by 2% and 3% respectively in spite of an increase 5,207 journeys in March to 31,688.

2.2 A&E Operations (graphs 1 – 14)

I am very pleased to be able to start my report by confirming that the Trust achieved the new Call Connect standard for the last financial year, one of only 6 Trusts to do so in England. The Category A performance for the Trust for the year was 75.55%. In terms of the number of Cat A patients reached within the call connect target, there were 241,522 reached within 8 minutes as compared with 194,350 for the previous year; an increase of 47,168 patients or 24%.

Whilst the Target is a Trust-wide target, I am pleased to be able to report that the levels of performance across London have also been much less variable than in previous years and have shown the least variation nationally. Out of thirty one PCTs, nineteen achieved above 75%, a further six achieved above 72% and none attained less than the commissioned lowest level of 70%.

The Category B performance was disappointing with the year ending at 84.5%. However, this means that 2008/2009 was the best performance the LAS has ever achieved for each of the above measures and is a credit to the hard work of all of our staff.

The main disappointment is associated with the fact that we did not manage to achieve above 85% for Category B calls. However, it is our intention to submit two areas for

consideration to the Healthcare Commission /CQC under the 'Extenuating Circumstances' procedures for our Category B result. These are to request dispensation to exclude from our performance data the short period at the beginning of February when the exceptional snowfall in the Capital meant that it was quite impossible for us to meet time based targets. We will also be arguing that the exceptional handover delays which we experienced during the winter led to thousands of lost ambulance hours which in turn impacted heavily on performance and particularly on Cat B performance. ORH have been commissioned to undertake an independent analysis of the issues and to quantify the performance impact of the delays from November through to the end of February which will form part of our submission.

REAP levels have continued to be closely monitored in light of the Operational demands and have remained at Level 3 'Severe Pressure' which reflects the levels of demand and performance being achieved.

At the beginning of April a number of significant changes were implemented in the Control Room. MPDS Version 12 was introduced which should see a reduction in the proportion of calls categorised as Category A. The Fast Response Unit (FRU) desk was closed and all resources moved to be under the control of the Ambulance allocators. This should see a reduction in dual sends as well as provide a greater focus on tasking the most appropriate and closest resource for all calls. This will also enable the necessary increase on Category B workload on FRUs as identified in the ORH report. To date this has produced an increase in Category B tasking of FRUs of about 5%, but it is too early to determine the impact on dual sends.

Technical services with our main computer systems and some associated network issues on Saturday 18th April and Thursday 23rd April led to periods operating on our backup paper systems which again significantly affected our ability to perform better than we could have.

There have been a number of additional operational workstreams implemented at the beginning of this financial year. One of these will oversee a fundamental review of all rosters across the service and ensure that the current rosters provide the appropriate levels of cover and accommodate the additional staff currently being recruited. This should also ensure a more consistent delivery of care across the day and reduce the fall off in performance experienced in the early evening and at weekends. Further workstreams will review the application of Active Area Cover and the allocation of Rest Breaks.

Following a robust selection process, nine new Ambulance Operations Managers (AOMs) have been appointed to work across the 3 Operational areas and Control Services. This is the first time that there have been sufficient numbers appointed to substantively fill all posts and provide appropriate release for existing managers to support the developments identified above across the service.

A number of new Mercedes Ambulances have now been delivered and are in use across the Service. It has been disappointing that these have been delivered much later than planned as a result of quality issues, but at last some of the older LDVs have started to leave the Service. The replacement programme continues with the aim of all LDVs leaving the service in the next year which will improve the quality of the fleet as well as reduce mechanical failure related downtime further.

The Emergency Bed Service continues to work on improvements in line with the EBS development strategy. These include the future reporting of KPIs to the Trust Board from autumn 09. In addition the team have recently been inducting new staff to the team and participating in plans for an in-utero transfer service for pregnant women in London.

The Emergency Care Practitioner Clinical Leads have continued to embed themselves into their new sectors over recent months reviewing the effectiveness of clinical placements and ensuring appropriate rotas are in place for all complexes. Considerable ECP and EPU resource, both management and clinical, has been taken up caring for the Tamil hunger strikers in parliament square. The following month will see the establishment of Complex and PCT reporting mechanisms to strengthen the case for further investment from commissioners in ECPs in the future.

The Hospital Turnaround project has been established this financial year to support and implement a reduction in hospital turnaround times by 5 mins. This work is initially focusing in 2 key areas. The first area is intensive work with 6 major London acute Trusts where LAS has regular problems and secondly the collation of good practice from across London, and nationally, in order to ensure this is communicated and utilised across the Service.

The Emergency Preparedness Department has had a particularly busy last 2 months. TUC demonstrations took place in central London on the 28th March, which were linked to a series of demonstrations across London in connection with the G20 summit which took place over three days at the end of March and the beginning of April. This was one of the largest and most complex events the LAS has ever dealt with. Six months planning for the events in conjunction with the Metropolitan Police were undertaken. This planning led to the largest use of mutual aid in the UK to date. The LAS deployed over 150 staff per day plus in excess of 30 staff from various Trusts across the UK and crown dependencies. Whilst the event attracted a large degree of media coverage, from an LAS perspective the event was deemed a success.

During April the London Marathon took place and planning as usual proved a great success. This year was an extremely busy one with over 6,000 patient contacts, which was achieved with minimal disruption to the core workload of the Trust as a result of the good joint working between us and our partner agency St. John Ambulance.

The Tamil demonstrations in Parliament Square incorporating the hunger strikers have also required a fair degree of planning and oversight to ensure that appropriate plans are in place in case of any incidents.

The unit has been extremely busy working in partnership with the Medical Director's Department to define the service's response to the recent outbreak of swine flu. The Head of Emergency Preparedness has overseen the Trust's flu preparedness and a flu group made up of representatives from operations, medical directorate, Communications, HR, infection control, emergency preparedness, logistics and procurement has been formed to oversee the planning and response.

To date we have issued a regularly updated Medical Director's Bulletin to all frontline staff giving advice on dealing with callers/patients with flu like symptoms and there is a flow

chart available on the pulse. Various other communication methods for staff have also been put in place, which includes a flu newsletter due to be published shortly, a central e-mail for flu enquires, a dedicated flu line within the control room and a flu section on the Pulse. We are working closely with our partners and regular meetings/telephone conferences are taking place across London. These include; Ambulance Clinical Leads, Directors of Operations and Emergency Preparedness Leads. The Head of Emergency Preparedness takes part in a daily telephone conference with the HPA and NHS London to ensure that we are up to date with current issues across the region. AOMs are also attending meetings at Borough levels with PCTs.

A Trust wide audit of facemasks has been conducted and the logistics department have moved the stock around the Trust to ensure balanced distribution. The Trust has placed orders for more facemasks, eye protection, respirators and general PPE which we expect to be delivered shortly. We are in the process of finalising the procedure to issue, fit test and then train staff in the application of FFP3 respirators. The DH will shortly issue the Trust with sufficient Tamiflu for us to issue to our staff should they become symptomatic.

Work has continued to plan for a new 'Event Control' which will be distinct from the Incident Control Room and Gold Suite. This is required to allow us to more effectively support the increasing number of large events that take place across London. It is being planned in such a way as to be capable of being our main control centre for the 2012 Olympics as well, and plans are now being finalised for this to be built at Bow.

The Airwave radio project is continuing with an objective for going live with the Motorcycles (MRUs) on the 22nd of June, followed by 3 stations in the West Area on the 30th June. Once these two radio channels have gone live, the rest of the service will switch over during the course of the summer in a planned way based on an agreed migration plan. That plan takes into account training for all staff, review periods, and technical upgrades to EOC and UOC. As part of the overall improvement to dispatch in EOC and to allow the fitting of the new radio system, the dispatch area of EOC will be refurbished and technically upgraded. This refurbishment is planned to be completed by mid June. To ensure a smooth transition from the Cortex Radio System to Airwave, a number of new policies and procedures have been developed and a new training programme written. There have also been a number of meetings with operational managers with more to follow before the Trust goes live, to ensure the objectives of the project are understood and met.

The Clinical Support Desk has continued to provide a vital support to the Control rooms and to operational staff. It was accessed 989 times during April and managed to successfully resolve nearly 200 cases, which resulted in a front-line vehicle not being dispatched to a call as a patient was able to be safely left home following assessment.

In order to support the Clinical Telephone Advice scheme, we have continued to refer about 1,000 calls per week across to NHS Direct. The volume of calls that they have continued to resolve without the requirement to dispatch an Ambulance has been in excess of two thirds over the last two months. It is anticipated that we will continue using this service for the foreseeable future and are closely monitoring its effectiveness.

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for the complete year 2008/9 and for the last two months.

	CAT A8	CAT A19	CAT B19
Standard	**75.0%**	**95.0%**	**90 %***
2008/09	75.6%	98.6%	84.5%
March 2009	79.1%	98.8%	85.3%
April 2009	75.5%	98.4%	86.1%
1Apr-7 May 09	74.5%	98.3%	85.7%

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

- The overall demand increase so far this year is running at 3.0% for April. The Category B calls have seen the greatest percentage increase, with an overall increase of 7.2% over the previous year.
- Category A performance reached 79.1% in March which was one of the best ever months for the Trust. This fell back in April to 75.5% but supported the increase on Category B performance as the focus changed to allow us to maximise performance with the existing resources until the significant additional numbers of staff are posted to operations in the next few months and so the Hours of cover produced on Ambulances increases.
- Call taking achieved 95.5% for March and 95.6% for April. This continued good performance in call taking is pleasing to note and has supported the achievements noted in Call Connect performance.
- We produced circa 235,500hrs Ambulance Hours for March and April this year which is 14,000 hrs less than for the same period last year. The majority of this drop was in April where the take up of overtime was 10,000hrs less then for April 08. FRU hours produced for March/April 09 increased by circa 4.4% to 119,310hrs compared to 114,300hrs for last year however this increase was seen in March with April producing slightly less hours per day then the same period last year. Again this is due to the reduction in take up of overtime.
- The “Bonus Incentive” continued in March aimed specifically at reaching patients more quickly. All operational staff were required to have 100% attendance and produce complex based targets 5% (Cat A) and 3% (Cat B) above January 09’s performance capped at 85% and 95% respectively. As our end of year financial situation became clearer additional bonuses were offered to cover specific shifts on a pro rata basis. A higher bonus was paid to individuals covering a week-end night shift than a week-day early. This additional bonus proved popular with staff and increased staffing levels considerably. This shift basis bonus was continued in April and May.
- All operational staffs’ Annual Leave and Time off in Lieu (TOiL) is now managed in ProMis by Station Administrators. The entering of Pre and Post shift overtime was very successful in the five pilot sites during March and this has now increased

formally to 15 sites although we are aware that other sites are also dual entering data (ProMis and SOS). Initial data comparison was excellent and we are finalising the Abstraction and AEM1 reports. All complexes are planned to be live at the start of the next pay month (18th May).

3 HUMAN RESOURCES

Workforce Plan implementation

The Trust achieved its recruitment plan for 2008/09 with 327 Student paramedics in recruited by 31 March 2009. The activity undertaken to achieve these results (for Student paramedics alone) included:

- Sending c7700 application packs
- Screening 5340 applications received
- Assessing over 1300 candidates
- Interviewing over 560 candidates

This level of activity continues as we aim to recruit 377 Student paramedics, 50 university paramedic graduates and 121 A&E Support staff in 2009/10. These figures include recruitment to additional posts (398 wte) plus anticipated turnover.

Other recruitment activity will include Emergency Operations Centre staff and all other support and managerial roles.

Unions and Partnership Arrangements

Election of station representatives is complete with subsequent elections of senior representatives due for completion by the end of May. The completion of the roll-out of the new consultative arrangements across the Trust will then be finalised. The Partnership Conference scheduled for 15 May, will launch these new arrangements and will focus on joint work on Foundation Trust, Olympics, flu planning and staff survey results. A bid has been submitted under the "Engaging for Quality and Embedding Partnership Locally – Innovation Fund" initiative from NHS London. If successful this will provide training for focus group facilitators to support the work on taking forward the staff survey results and also joint work around clinical outcome measures.

NHS London

The Trust continues to work with NHS London to reach agreement on the 3 year transformational investment funding. NHS London has indicated an expectation that this should be achieved by the end of May 2009. Activity against the plan has continued at risk pending agreement of funding in order that the plan (which includes the recruitment and training of additional front line staff) is not jeopardised by delaying implementation.

Disciplinary Appeals and Employment Tribunals

Since the last Trust Board meeting 2 appeals against dismissal have been heard with the following timescales:

Case No.	Date of appeal letter	Hearing date	Further comments
1	7.10.08	6.5.09	Original hearing scheduled for 23 January. Lack of availability of Non Executive Director. Original date then postponed by appellant on 16 January due to lack of representation.
2	28.1.09	5.5.09	First available date of all parties

The Trust has had no Employment Tribunal case heard in the period since the last Trust Board.

Workforce information

Trust sickness levels for March are the lowest they have been for the year at 4.44%. (the highest level being in December at 5.89%). Reductions are seen across all areas of the Trust.

Staff turnover has also reduced to its lowest level in year to 6.32% as at April 2009 showing a steady decline month on month since July 2008 when it was reported at 7.80%.

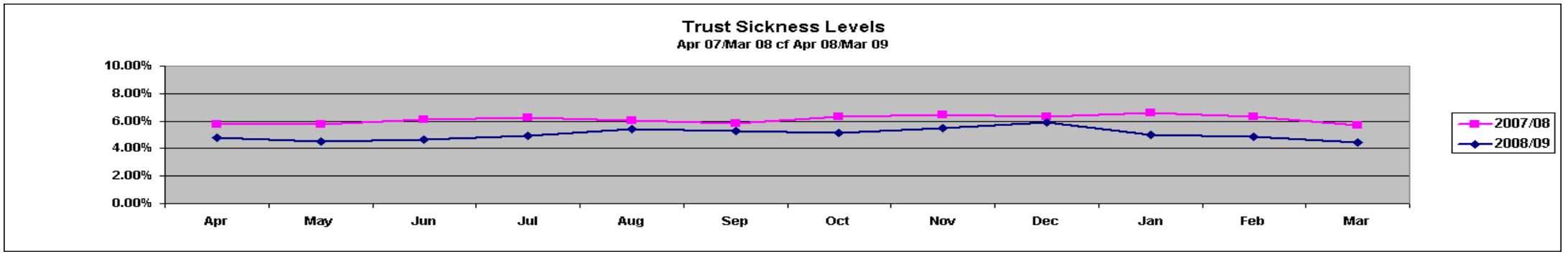
The A&E establishment of 2913 has not yet been amended to reflect the new establishment of 3311 for 2009/10. Work is currently underway to finalise the update of ESR establishment for 2009/10 to provide relevant future reports. Recruitment for April was on track with 48 Student Paramedics commencing training and the first training programme for A&E Support staff in May is fully allocated.

A&E Establishment as at April 2009

Position Titles	Funded Establishment	Staff in post	Variance	Leavers
Team Leader	175.00	162.86	12.14	0.00
ECP	86.00	68.16	17.84	0.65
Paramedic	830.00	850.36	-20.36	0.00
EMT	1220.00	1232.20	-12.20	5.00
Student Paramedic	300.00	366.00	-66.00	3.00
A&E Support	232.00	179.06	52.94	1.00
EMD1	54.00	106.75	-52.75	1.00
EMD2	90.55	104.80	-14.25	0.68
EMD3	100.76	58.34	42.42	0.00
EMD Allocator	78.00	70.81	7.19	0.00
CTA	70.00	45.91	24.09	0.00
Total	**3236.31**	**3245.25**	**-8.94**	**11.33**

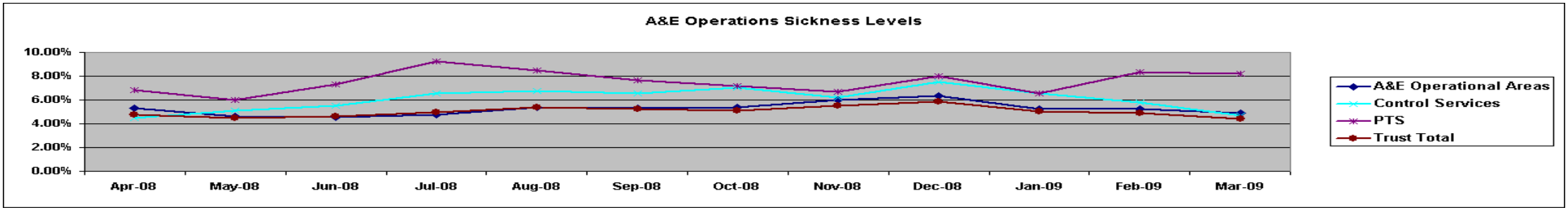
Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%



A&E Ops Sickness Levels

	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
A&E Operational Areas	5.29%	4.65%	4.55%	4.78%	5.40%	5.34%	5.37%	6.02%	6.35%	5.23%	5.21%	4.91%
Control Services	4.45%	5.11%	5.55%	6.53%	6.78%	6.52%	7.04%	6.23%	7.55%	6.52%	5.76%	4.70%
PTS	6.80%	6.02%	7.30%	9.22%	8.47%	7.65%	7.16%	6.69%	7.98%	6.57%	8.35%	8.23%
Trust Total	**4.79%**	**4.49%**	**4.64%**	**4.96%**	**5.41%**	**5.26%**	**5.12%**	**5.50%**	**5.89%**	**5.01%**	**4.87%**	**4.44%**



Staff Turnover

Staff Groups	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	Feb-08/Jan-09	Mar-08/Feb-09	Apr-08/Mar-09	May-08/Apr-09
A & C	15.29%	14.20%	14.79%	13.35%	14.59%	15.38%	15.27%	15.76%	15.14%	14.51%	14.06%	12.62%
A & E	5.46%	5.75%	5.58%	5.47%	5.44%	5.64%	5.60%	5.58%	5.51%	5.45%	5.10%	4.99%
CTA	10.26%	10.00%	8.51%	10.87%	8.51%	9.09%	9.52%	7.14%	6.97%	7.32%	7.69%	2.50%
EOC Watch Staff	11.85%	13.57%	12.57%	12.20%	12.87%	13.31%	13.55%	11.70%	11.52%	11.47%	10.76%	9.97%
Fleet	13.21%	13.21%	13.21%	7.55%	5.66%	11.32%	14.00%	14.00%	14.00%	13.46%	13.21%	10.53%
PTS	12.60%	12.50%	12.34%	11.97%	12.61%	12.55%	11.86%	12.45%	12.98%	12.13%	10.92%	9.27%
Resource Staff	2.08%	2.08%	2.08%	2.08%	2.13%	2.13%	0.00%	0.00%	0.00%	2.04%	4.26%	4.17%
SMP	7.83%	8.12%	7.36%	7.32%	7.37%	6.88%	6.61%	6.99%	6.77%	6.75%	6.94%	5.84%
Trust Total	**7.51%**	**7.80%**	**7.57%**	**7.27%**	**7.35%**	**7.57%**	**7.50%**	**7.39%**	**7.30%**	**7.18%**	**6.82%**	**6.32%**

4 COMMUNICATIONS

Swine flu: Following the World Health Organisation raising its pandemic flu alert level to four and subsequently five, after the outbreak of cases of swine flu, a number of internal communications initiatives took place to promote understanding of the issue and the need for infection control among staff. A number of Medical Director's bulletins were issued, the homepage of *the pulse* was kept updated with latest news, and *the pulse's* dedicated flu pandemic section was further developed. A specially produced newsletter about swine flu was issued to stations and departments.

Media issues

Patient specific protocols: An article was published on the front page of the Evening Standard about patient specific protocols and advance directives. Unfortunately, it focused on 'do not resuscitate' orders and mistakenly indicated these agreements were directly applicable to road traffic collision victims. The article was followed up by The Sun, Daily Express, and Daily Mail; the latter took a more balanced approach to the story.
LBC Radio also picked up on the story, and a clinical advisor was made available to take part in a phone-in to help clarify some of the issues that were being discussed.
A letter to the Evening Standard's editor from the Medical Director addressing the errors in the report was not printed.

Alcohol-related issues: The work of the 'booze bus' was featured in a BBC3 programme, 'Drinking with the Girls', after a reporter went out to see first hand how the team deals with alcohol-related calls in the West End and the dangers of binge-drinking.
ITV News also highlighted its role in a news report announcing the start of a parliamentary inquiry about the impacts of alcohol. Team Leader Brian Hayes was among a group of medical professionals to give evidence to the health select committee, and this was covered by The Daily Telegraph, The Sun and the Daily Mail.

G20: The death of a man following demonstrations connected to the G20 summit at the beginning of April resulted in a large number of media calls about the Service's response to the incident.

Protest in Parliament Square: A protest by members of the Tamil community, including a man who went on hunger strike for more than three weeks, led to a number of media enquiries.

Other stories: The Evening Standard ran a story about an epilepsy charity calling for a paramedic to be sent to all patients who suffer a seizure. The Service's response highlighted the fact that procedures for responding to these type of calls had already changed.
The same paper, along with one in Islington, also covered a reunion between a mother and her baby daughter and the staff who had helped save the child's life after she had stopped breathing in a shop last December.
Other local coverage included stories about a number of staff who ran for charity in the London Marathon.
BBC London Radio, meanwhile, picked up on the issue of community responders, and an assistant director of operations gave a live interview about their role in the capital.

Foundation trust consultation

Consultation on our plans to become a foundation trust concluded at the end of last week (15 May).

During the consultation period, over thirty public events were held across London boroughs where over 1500 people were spoken to about our plans. Consultation documents were also sent to approximately 8,000 stakeholders including staff.

Over 250 responses have been received and are currently being analysed. The Board will consider whether any areas of the proposed constitution should be amended as a result of the consultation findings.

PPI activity

Public education:

- The pilot public education staff development programme is currently being evaluated, with a view to running the next course during the summer.

- A number of new materials have been produced, including a general information leaflet and two different designs of Oyster-card holder.

Olympics:

- A timetable for PPI and public education activity in the run-up to the Olympics has been developed.

Prince's Trust:

- An open day was held in April for staff interested in working for the Prince's Trust as a secondment. The event was very successful, with over 40 staff taking part. As well as the benefits for the young people involved, releasing staff for these secondments will be an opportunity for significant staff development, and will also benefit the Trust when they come back into their core roles.

Recruitment:

- Beverley Jeal, previously an EMT at Poplar, has been appointed as PPI and Public Education Co-ordinator. Her role will be to PPI and public education activity is better co-ordinated across the Service, and that the people involved have the support and materials they need.

- Julie Carpenter has been appointed into the permanent post of Community Involvement Officer at Barnehurst.

Other activities:

- The Patient Care Conference will be held on 15th September and will focus on the theme of engagement.

- The work of the Events & Schools Team is currently being reviewed. The review includes setting priorities for the team's activities, planning ahead more effectively, and possibly taking on new areas of work such as the co-ordination of work experience students.

Peter Bradley CBE
Chief Executive Officer

12 May 2009

London Ambulance Service
NHS Trust

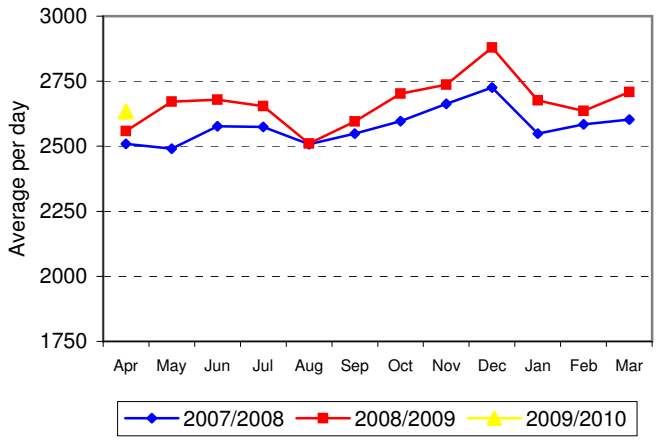
Information Pack for Trust Board

April 2009

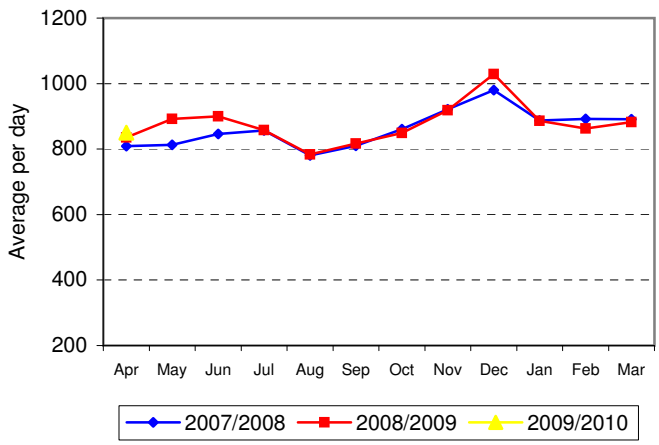
Please note: PRF input is not yet complete for April 09

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity - April 2009

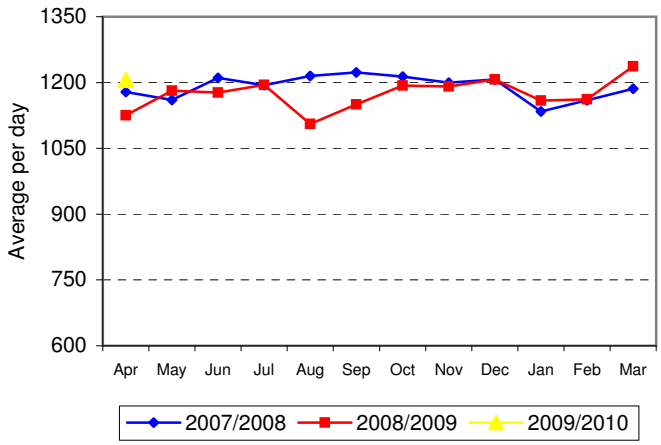
Graph 1
Average number of Cat A, B & C incidents per day



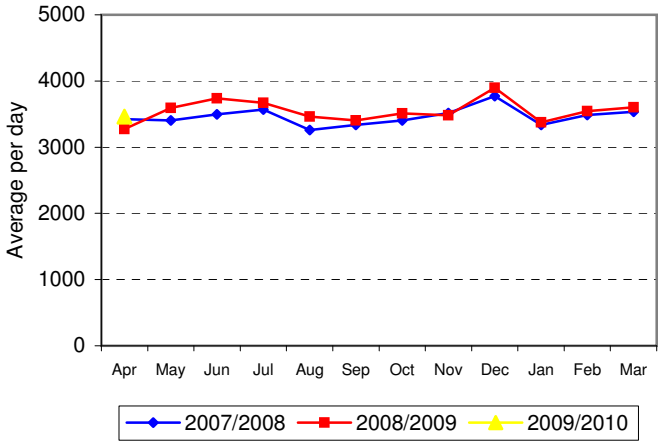
Graph 2
Average number of Cat A incidents per day



Graph 3
Average number of Cat B incidents per day

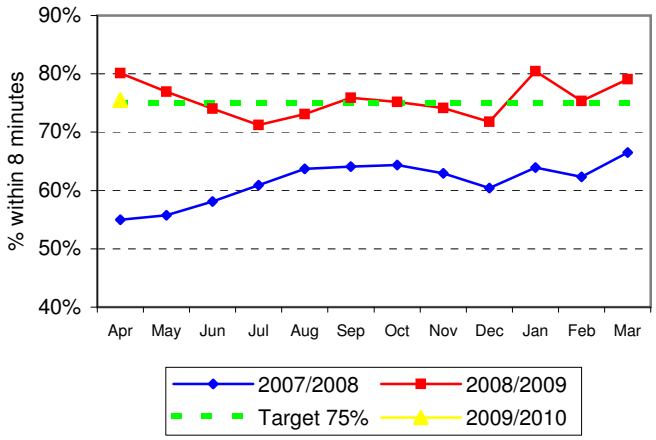


Graph 4
Average number of 999 calls received per day

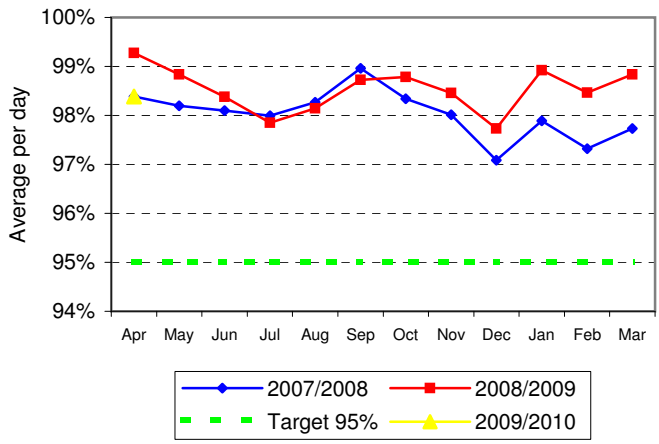


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2009

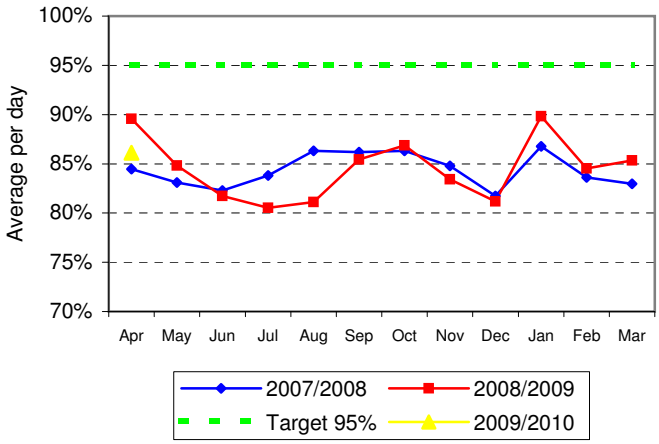
Graph 5
Category A 8 minute performance



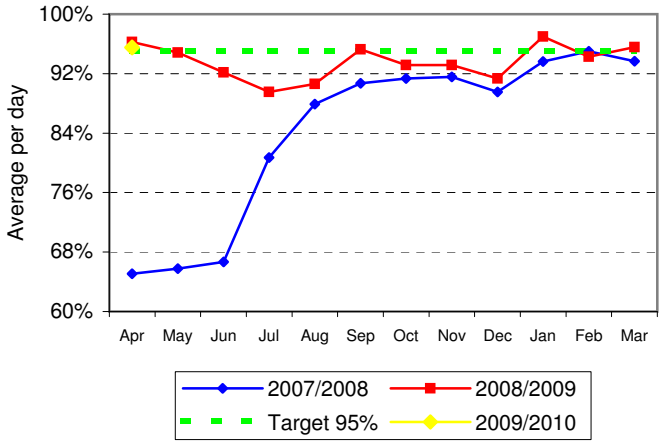
Graph 6
Category A 19 minute performance



Graph 7
Category B 19 minute performance

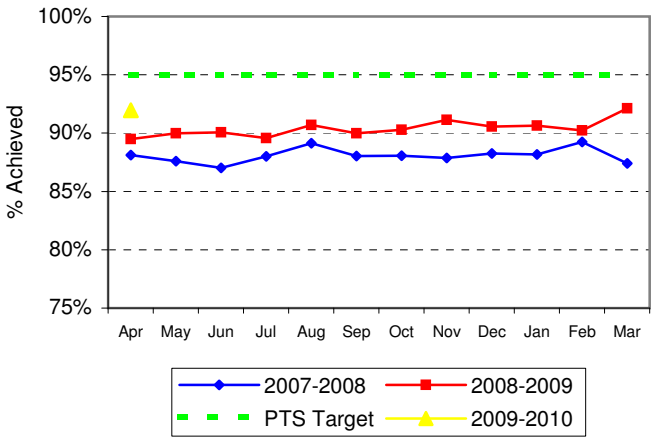


Graph 8
Percentage of calls answered within 5 seconds

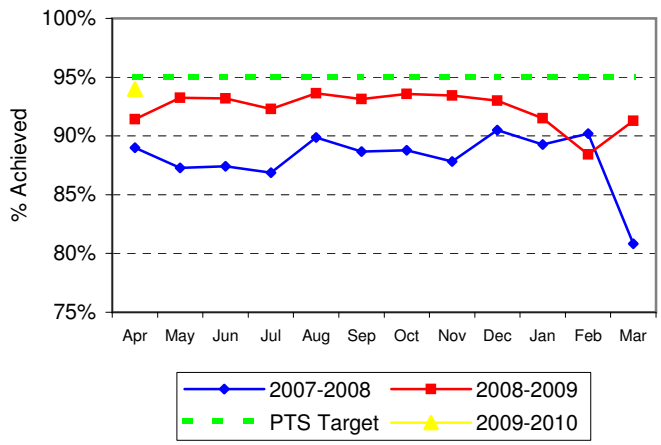


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - April 2009

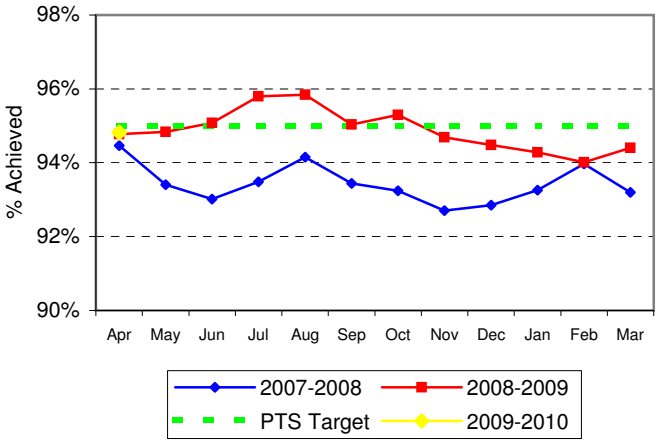
Graph 9
Arrival at Hospital Against Appointment Time



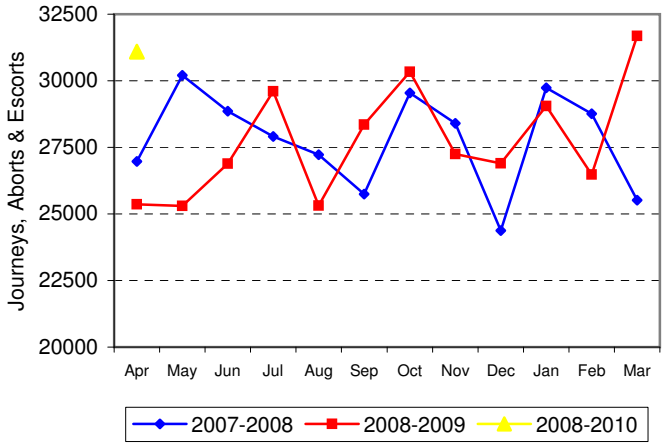
Graph 10
Departure Against Ready Time



Graph 11
Time spent on Vehicle

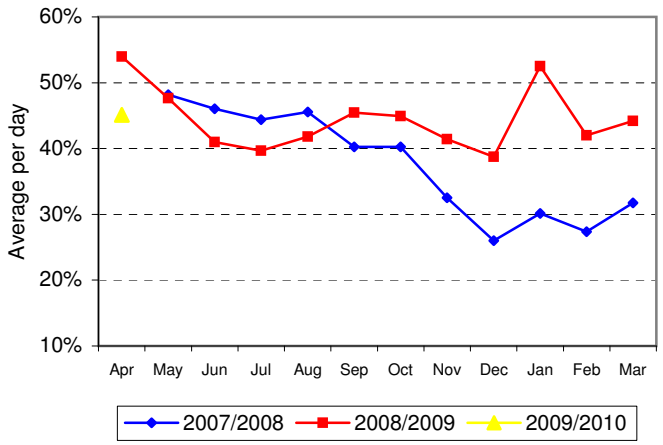


Graph 12
PTS Total Activity

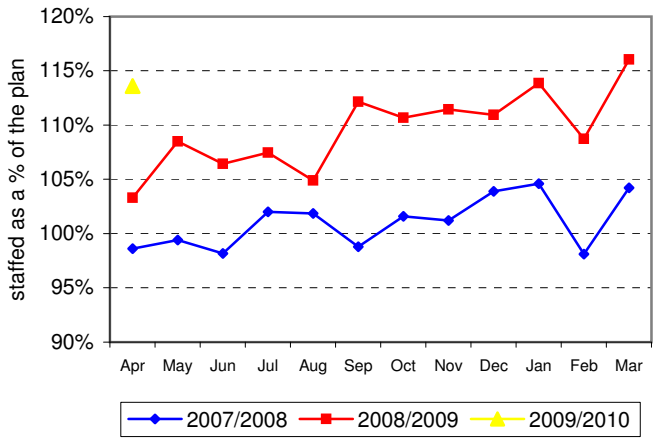


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - April 2009

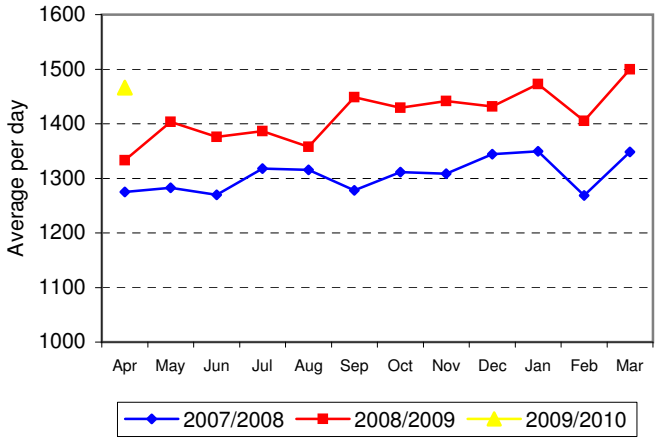
Graph 13
% of vehicles given a rest breaks



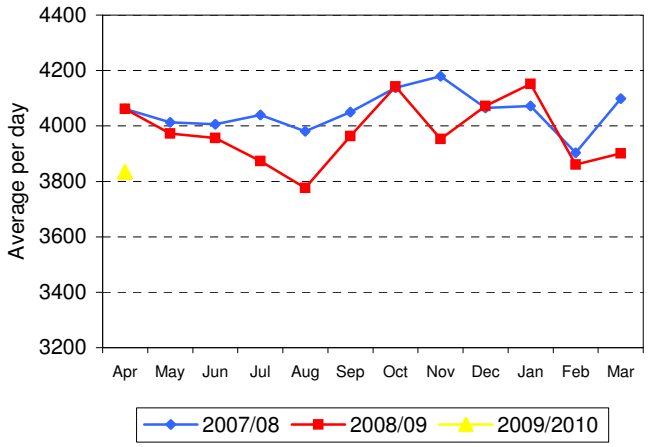
Graph 14
EOC Staffing as a % of the plan



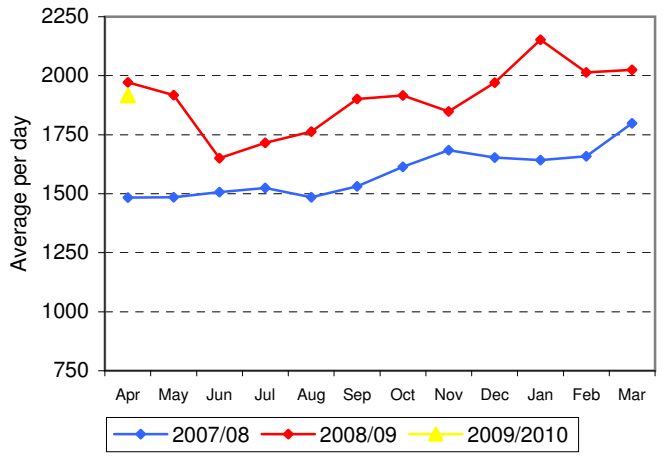
Graph 15
EOC hours staffed per day



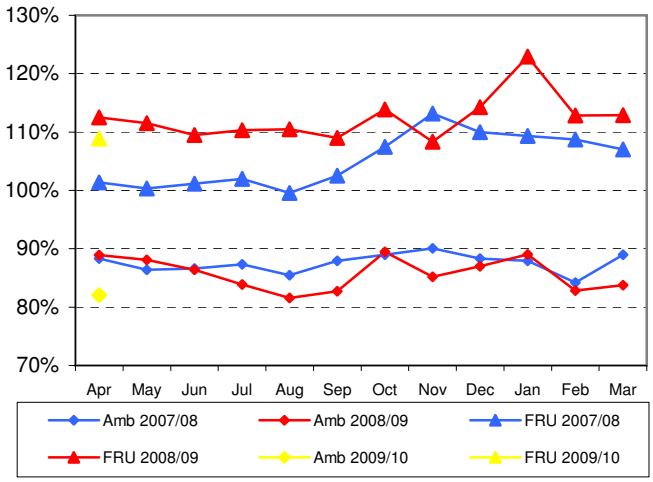
Graph 16
Ambulance hours available per day



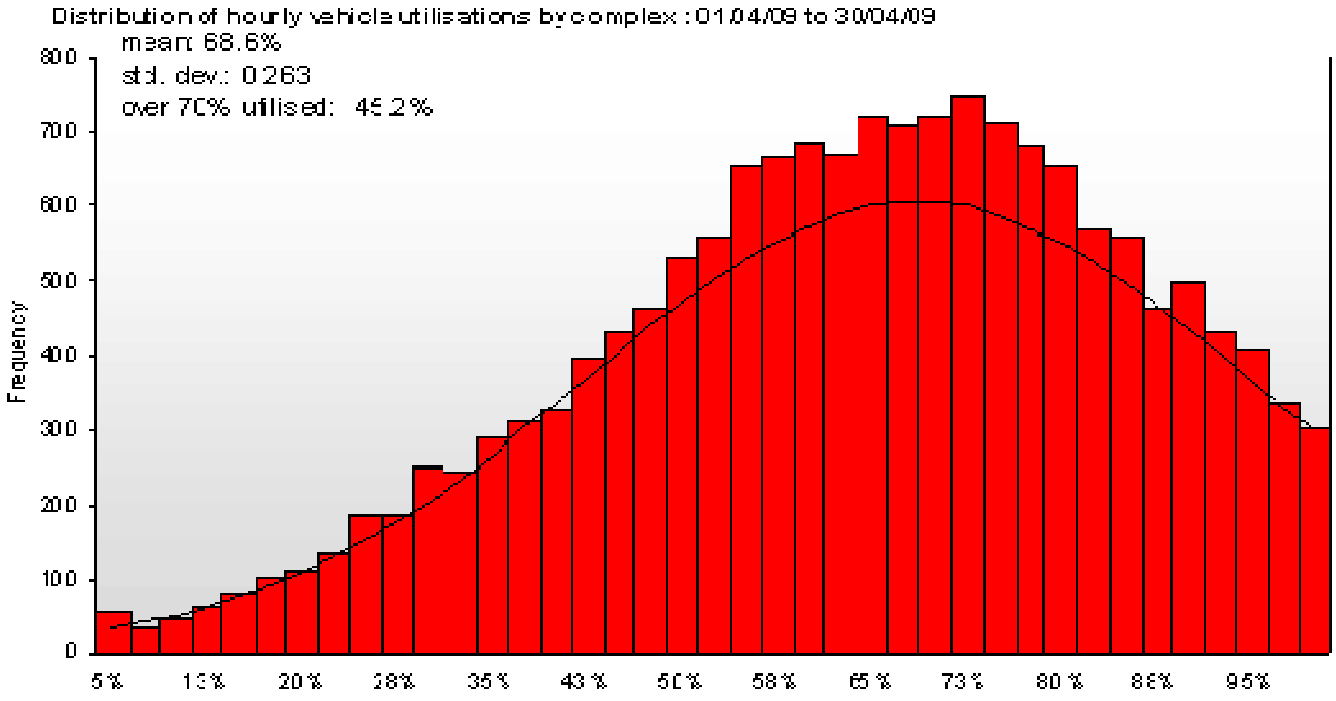
Graph 17
FRU hours available per day



Graph 18
Vehicle availability as a percentage of the plan



London Ambulance Service NHS Trust
Accident and Emergency Service
Vehicle Utilisation - April 2009



London Ambulance Service NHS TRUST

TRUST BOARD DATE 19 May , 2009

M12 2008/09 Finance Report & M1 Finance Flash result

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

The unaudited results for m12 show a surplus of £723k for the year 2008/09. This is within the control range set by NHS London.

Additional expenses incurred in March compared to February include Capitalised expense reversal £157k, Payroll adjustment £190k, CTaK writedown £381k, Merc Remount provision £381k.

Tangible assets were also revalued down by £20m following Department of Health guidance.

The m1 2009/10 Flash result shows a surplus of £287k for the month.

4. Recommendation

The Trust Board note the report

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD
March 12 (MONTH 12)

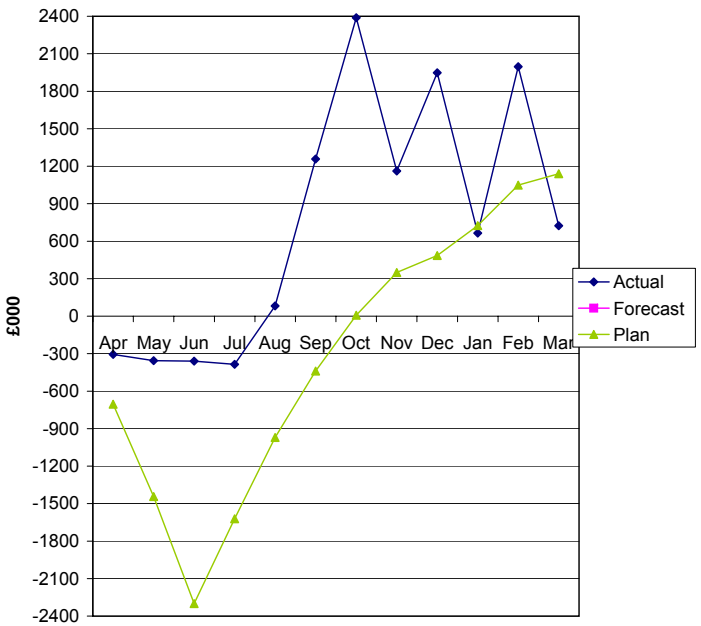
Contents:

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 31st March (Month 12)

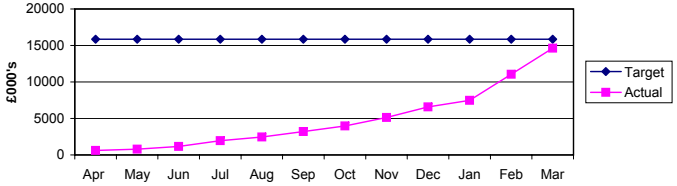
Income and Expenditure

Cumulative Net Financial Position

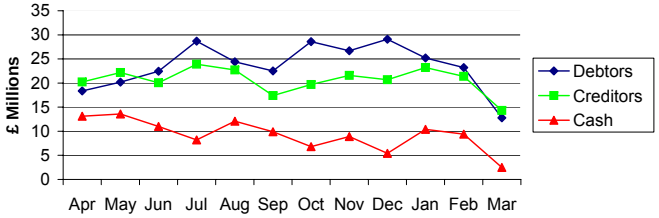


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	Jan	Feb	March	
Asset turnover ratio	2.02	1.98	2.3	●
Debtors % > 90 days	10%	5%	12.91%	●
A&E Debtor days	4	5	6	●
PTS Debtor days	62	63	35	●
PSPP NHS	93%	100%	97%	●
PSPP Non NHS	82%	88%	94%	●

Key Financial Indicators

	January	February	March
A&E Overtime (£000) / Day (Month)	55	53	56
A&E Overtime (% of paybill)	9.80%	9.37%	10.18%
Subsistence (£000) / Day (Month)	4.79	5.24	-10.83
Subsistence per head £	36.19	35.43	-79.79
Third Party Transport expenditure / Day (Month)	4,926	4,330	5,589
Total operational cost per incident	278	275	262
A&E Gross Surplus (YTD) (% of Income)	22.1%	22.6%	22.7%
A&E Net Margin (YTD) (% of Income)	0.4%	0.9%	0.3%
PTS Gross Margin (YTD) (% of Income)	-2.8%	-1.6%	-0.04%
Cat B performance (cumulative)	83.36%	84.05%	84.50%

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 March 2009 (Month 12)

	IN THE MONTH				*YEAR TO DATE*					*ANNUAL*		**£000s**
	Actual	Budget	Variance		Actual	Budget	Variance	% Variance		Forecast	Budget	Variance
Income	21,790	21,053	(737)U		261,721	252,638	(9,083)U	3.6%F		261,721	252,638	(9,083)U
Total Operational Costs	21,989	19,986	(2,003)U		249,593	239,785	9,807F	(4.1%)U		249,593	239,785	9,807F
Total Expenditure	23,064	20,962	(2,102)U		260,998	251,497	9,501F	(3.8%)U		260,998	251,497	9,501F
EBITDA	**-199**	**-1,067**	**-1,266**		**-12,128**	**-12,852**	**724**	**0**		**-12,128**	**-12,852**	**724**
EBITDA Margin	***-0.9%***	***5.0%***	-5.9%		***4.6%***	***5.1%***	**-0.4%**			***4.6%***	***5.1%***	**-0.4%**
Depreciation & Interest	1,075	976	(99)U		11,405	11,712	(307)U	2.6%F		11,405	11,712	(307)U
Net *Surplus/(Deficit)*	**-1,274**	**-91**	**-1,365**		**-723**	**-1,140**	**418**	**0**		**723**	**1,140**	**418**
Net Margin	***-5.8%***	***-0.4%***	-5.5%		***0.3%***	***-0.5%***	***-0.2%***			***-0.3%***	***-0.5%***	***0.2%***

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending March 31st 2009

Year to Date

• For the year to date, income exceeds expenditure by £723k. The budgeted position is for income to exceed expenditure by £1,140k, hence there is a year to date adverse variance of £418k.
• 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 , RTA income and £1,100k additional income for CBRN.
• Expenditure exceeds plan by £9,501k due to additional overtime and incentive payments to meet operational performance.
• PTS is reporting a break even position against a planned surplus of £89k.

Month

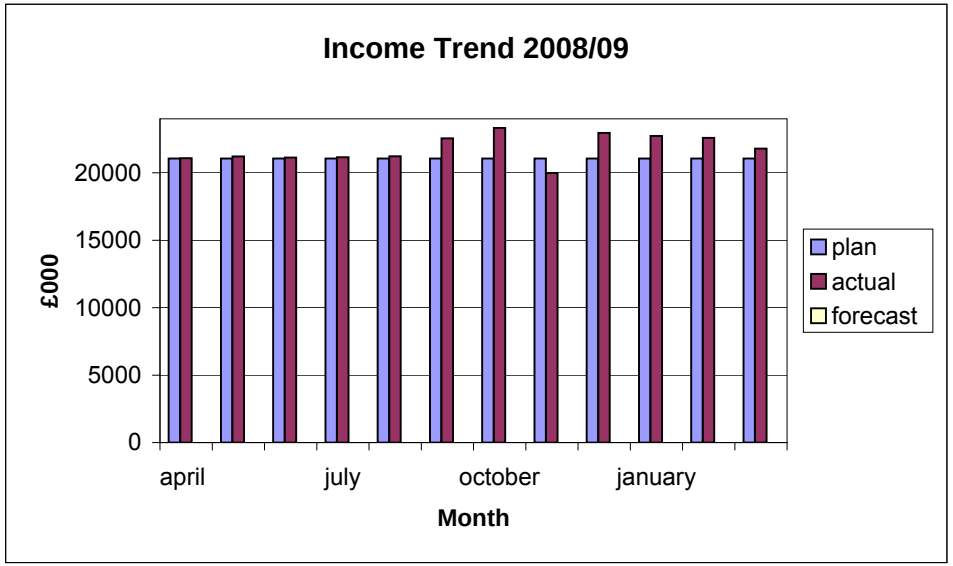
• In the month there is a £199k loss against a planned surplus of £1,067k resulting in a unfavourable movement of £1,266k.
• The main reason for the unfavourable movement is due to additional income from CBRN of £1,100k recognised in February but relating to spend incurred in March.
• The forecast position for the month as at month 11 was a loss of £1.116k against the actual result, a loss of £1,274k.
• PTS reported a surplus of £106k.

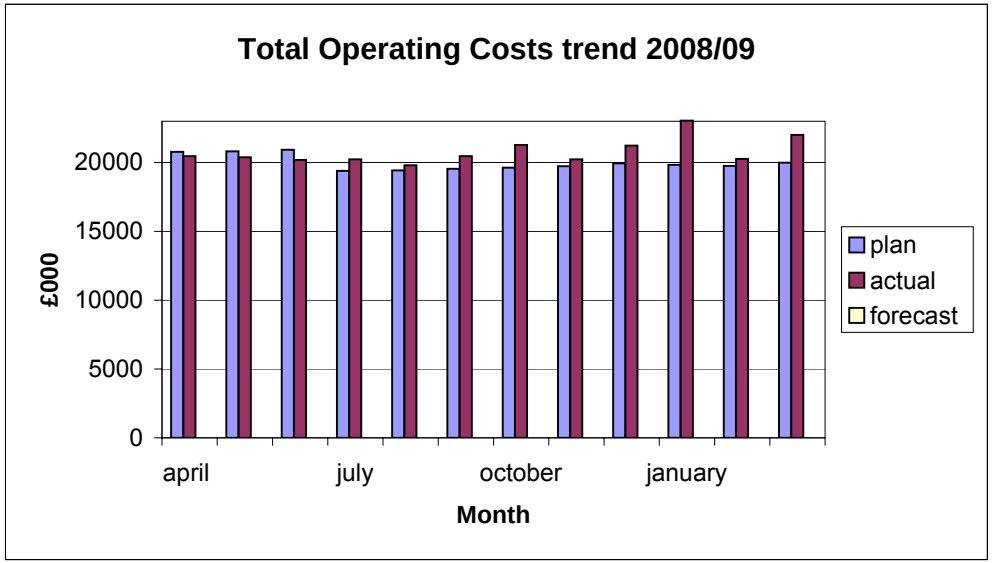
Forecast

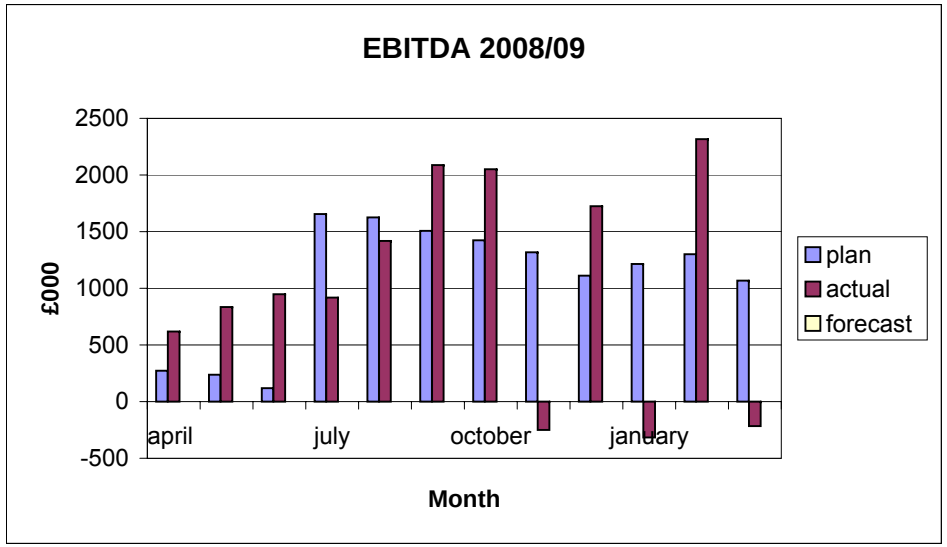
• The year end forecast is £723k surplus against a planned surplus of £1,140k.
• The forecast for the year at month 11 was £881k surplus.
• Forecast Income decreased by £157k
• Forecast Non Pay increased by £512k mainly due to additional provision for vehicle remount costs, higher IT project costs and Accelerated depreciation on CTAK partially offset by stock adjustments.

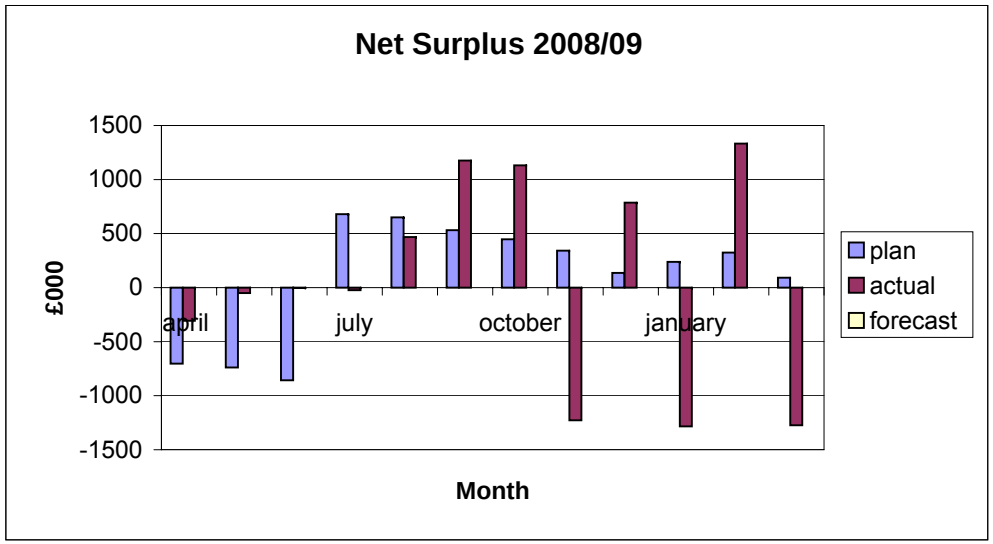
London Ambulance Service NHS Trust

Month 12 Trust Board report - forecast data









ON AMBULANCE SERVICE NHS TRUST

Month 12 and Month 11
As at 31 March 2009 (Month 12)

	YEAR TO DATE			
	Month 12	Month 11	Variance	
Income	**261,722**	**261,666**	**56F**	Reversal of 0708 BETS Income provision (£160k) Offset by reduction in expected Long Distance Journeys income
Pay Expenditure				
A&E Operational Staff	110,188	111,277	(1,088)	Reduction in Actual M11 Incentive paid of £220k, Remainder is a reduction in M12 Incentive of £805k (£1,300k less £495k)
Overtime	20,628	20,444	183	Additional OT usage due to direct in-month shift incentives
A&E Management	11,665	11,651	14	
EOC Staff	11,695	11,748	(53)	
PTS Operational Staff	5,605	5,589	16	
PTS Management	981	980	1	
Corporate Support	32,224	31,574	650	Capital Revenue Reallocation £157k, Payroll Adjustments £190k, £40k agency recode, £25k PTS agency adjustment, £57k IM&T agency adjustment
Sub Total	**192,985**	**193,263**	**(278)**	
Non-Pay Expenditure				
Staff Related	3,305	3,223	83	£54k stab vest testing (warranty extension), £15k relating to accomodation costs for G20
Subsistence	1,537	2,037	(500)	Includes benefit from provision for Subsistence (£500k)
Training	1,314	1,203	110	Increase in University Fees Not previously accounted for
Drugs	387	376	11	
Medical Consumables & Equipment	4,948	5,680	(732)	£750k Stock adjustment. Reduction in Ambulance equipment costs
Fuel & Oil	4,937	4,942	(5)	
Third Party Transport	1,590	1,564	26	fine
Vehicle Costs	13,006	12,625	380	Increases in Provision for Ambulance Remount Costs (£358k). Offset by increase in stock levels (£88k)
Accommodation & Estates	11,012	11,044	(32)	
Telecommunications	7,693	7,417	276	£125k relating to e-CMS not in previous fcast. £88k increase in AMPDS & decrease in stock £35k. CTAK Accelerated Dep'n £381k
Depreciation	7,480	7,382	97	
Other Expenses	6,828	6,031	797	Variance due to Subsistence Provision being moved to Subsistence line (£500k), £113k IT Consultancy costs for IPT. Increase in advertising spend £70k. £68k for the London Procurement Hub.
Profit/(Loss) on Disposal FA	52	52	(0)	
	64,087	**63,576**	**512**	
Financial Expenditure	**3,925**	**3,946**	**(20)**	
Total Expenditure	**260,998**	**260,785**	**213**	
Net	**-724**	**-881**	**157**	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 March 2009 (Month 12)

£000s

	MONTHLY SPEND												
	April *Actual*	**May** *Actual*	**June** *Actual*	**July** *Actual*	**August** *Actual*	**September** *Actual*	**October** *Actual*	**November** *Actual*	**December** *Actual*	**January** *Actual*	**February** *Actual*	**March** *Actual*	**Total**
Income	**21,086**	**21,217**	**21,130**	**21,147**	**21,219**	**22,551**	**23,328**	**19,982**	**22,955**	**22,728**	**22,589**	**21,790**	**261,721**
Pay Expenditure													
A&E Operational Staff	9,087	9,030	8,936	8,790	8,779	8,912	9,011	9,070	9,471	10,430	9,517	9,154	110,188
Overtime	1,910	1,994	1,897	1,647	1,566	1,620	1,739	1,601	1,712	1,710	1,495	1,735	20,628
A&E Management	942	940	945	966	949	967	979	970	1,024	1,001	980	1,001	11,665
EOC Staff	977	978	979	1,006	982	985	948	962	918	965	1,007	990	11,695
PTS Operational Staff	450	475	468	468	476	454	485	468	470	464	448	479	5,605
PTS Management	81	80	86	87	91	83	88	93	60	80	74	79	981
Corporate Support	2,345	2,672	2,304	2,539	2,581	2,690	2,791	2,781	2,687	2,804	2,431	3,600	32,224
Sub Total	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**	**15,946**	**16,342**	**17,455**	**15,952**	**17,038**	**192,985**
Average Daily	*526*	*522*	*521*	*500*	*498*	*524*	*517*	*532*	*527*	*563*	*570*	*550*	*529*
Non-Pay Expenditure													
Staff Related	223	251	369	207	258	260	355	223	186	326	219	430	3,305
Subsistence	343	44	149	193	200	195	152	167	222	149	147	336	1,537
Training	64	1	129	54	85	65	226	10	131	167	120	262	1,314
Medical Consumables & Equipment	450	537	410	498	433	547	486	374	494	526	396	367	4,784
Drugs	37	25	9	9	49	9	47	49	26	34	51	41	387
Fuel & Oil	415	455	440	450	399	400	427	392	421	403	357	378	4,937
Third Party Transport	213	183	76	142	89	105	95	115	125	153	121	173	1,590
Vehicle Costs	1,114	1,039	943	1,083	948	1,013	1,128	1,017	1,153	1,225	836	1,507	13,006
Accommodation & Estates	783	807	750	928	833	874	926	938	1,052	1,013	1,085	1,187	11,175
Telecommunications	558	517	718	397	510	749	582	613	537	973	615	926	7,693
Depreciation	597	597	695	630	611	611	609	609	596	608	606	712	7,480
Other Expenses	476	442	585	766	576	538	813	392	473	621	376	767	6,824
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**	**6,197**	**4,927**	**5,680**	**64,083**
Average Daily	*176*	*155*	*175*	*173*	*161*	*179*	*189*	*163*	*177*	*200*	*176*	*183*	*176*
Financial Expenditure	**328**	**289**	**256**	**313**	**340**	**302**	**310**	**368**	**341**	**360**	**378**	**346**	**3,930**
Average Daily	*11*	*9*	*9*	*10*	*11*	*10*	*10*	*12*	*11*	*12*	*13*	*11*	*11*
Monthly Expenditure	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**	**21,210**	**22,168**	**24,012**	**21,256**	**23,064**	**260,998**
Cumulative	**21,392**	**42,660**	**63,793**	**84,965**	**105,716**	**127,092**	**149,288**	**170,498**	**192,666**	**216,677**	**237,933**	**260,998**	
Monthly Net	**(306)**	**(51)**	**(3)**	**(25)**	**468**	**1,175**	**1,131**	**(1,227)**	**787**	**(1,284)**	**1,333**	**(1,274)**	**723**
Cumulative Net	**(306)**	**(357)**	**(360)**	**(385)**	**82**	**1,258**	**2,389**	**1,162**	**1,948**	**664**	**1,997**	**723**	

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 March 2009 (Month 12)

£000s

	IN THE MONTH				*YEAR TO DATE*					*ANNUAL*		
	Actual	**Budget**	**Variance**		**Actual**	**Budget**	**Variance**	**% Variance**		**Forecast**	**Budget**	**Variance**
Pay Expenditure												
A&E Operational Staff	9,154	9,333	179F		110,188	108,890	(1,298)U	(1.2%)U		110,188	108,890	(1,298)U
Overtime	1,735	575	(1,160)U		20,628	9,772	(10,856)U	(111.1%)U		20,628	9,772	(10,856)U
A&E Management	1,001	978	(24)U		11,665	11,714	49F	0.4%F		11,665	11,714	49F
EOC Staff	990	1,090	100F		11,695	13,084	1,389F	10.6%F		11,695	13,084	1,389F
PTS Operational Staff	479	434	(44)U		5,605	5,212	(393)U	(7.5%)U		5,605	5,212	(393)U
PTS Management	79	95	16F		981	1,140	159F	14.0%F		981	1,140	159F
Corporate Support	3,600	2,674	(904)U		32,224	31,700	(524)U	(1.2%)U		32,224	31,700	(524)U
	17,038	**15,180**	**(1,837)U**		**192,985**	**181,512**	**(11,473)U**	**(6.2%)U**		**192,985**	**181,512**	**11,473**
Non-Pay Expenditure												
Staff Related	430	278	(152)U		3,305	3,362	57F	1.7%F		3,305	3,362	57F
Subsistence	-336	115	451F		1,537	1,380	(157)U	(11.4%)U		1,537	1,380	(157)U
Training	262	182	(80)U		1,314	2,195	881F	40.2%F		1,314	2,195	881F
Drugs	41	43	3F		387	521	134F	25.8%F		387	521	134F
Medical Consumables & Equipment	-272	409	681F		4,948	4,311	(637)U	(14.8%)U		4,948	4,311	(637)U
Fuel & Oil	378	442	64F		4,937	5,216	280F	5.4%F		4,937	5,216	280F
Third Party Transport	173	63	(111)U		1,590	793	(797)U	(100.5%)U		1,590	793	(797)U
Vehicle Costs	1,507	977	(530)U		13,006	11,801	(1,204)U	(10.2%)U		13,006	11,801	(1,204)U
Accommodation & Estates	1,091	811	(280)U		11,012	9,592	(1,420)U	(14.8%)U		11,012	9,592	(1,420)U
Telecommunications	926	562	(365)U		7,693	6,837	(855)U	(12.5%)U		7,693	6,837	(855)U
Depreciation	712	652	(61)U		7,480	7,819	339F	4.3%F		7,480	7,819	339F
Other Expenses	750	924	168F		6,828	12,264	5,436F	43.7%F		6,828	12,264	5,436F
Profit/(Loss) on Disposal FA	(0)	0	0		52	0	(52)U	#DIV/0!		52	0	(52)U
	5,664	**5,458**	**(212)U**		**64,087**	**66,092**	**2,005F**	**2.8%F**		**64,087**	**66,092**	**2,005F**
Financial Expenditure	**363**	**324**	**(39)U**		**3,925**	**3,893**	**(32)U**	**(0.8%)U**		**3,925**	**3,893**	**(32)U**
Total Trust Expenditure	**23,064**	**20,962**	**(2,087)U**		**260,998**	**251,497**	**(9,501)U**	**(3.8%)U**		**260,998**	**251,497**	**(9,501)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 March 2009 (Month 12)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	20,845	20,343	502F	251,834	244,116	7,718F	3.2%F	251,834	244,116	7,718F
		0								
Sector Services	12,562	12,145	(418)U	158,287	145,050	(13,237)U	(9.1%)U	158,287	145,050	(13,237)U
A&E Operational Support	1,331	1,132	(198)U	15,149	12,994	(2,155)U	(16.3%)U	15,149	12,994	(2,155)U
Control Services	1,621	1,517	(104)U	18,784	18,472	(312)U	(1.1%)U	18,784	18,472	(312)U
Planning and Specialised Ops	338	365	26F	2,421	4,391	1,970F	44.9%F	2,421	4,391	1,970F
Total Operations Cost	**15,852**	**15,159**	**(693)U**	**194,642**	**180,907**	**(13,735)U**	**(7.5%)U**	**194,642**	**180,907**	**(13,735)U**
		0								
A&E Gross Surplus/(Deficit)	**4,993**	**5,184**	**(191)U**	**57,192**	**63,209**	**(6,017)U**	**(9.3%)U**	**57,192**	**63,209**	**(6,017)U**
Gross Margin	24.0%	0.0%	(0.9%)U	22.7%	25.9%	-3.1%		22.7%	25.9%	-3.1%
		0								
Medical Directorate	86	87	(1)U	873	1,015	141F	13.9%F	873	1,015	141F
Service Development	80	86	(6)U	799	992	193F	23.3%F	799	992	193F
Communications	237	190	47F	2,107	2,154	46F	2.2%F	2,107	2,154	46F
Human Resources	1,843	1,589	254F	16,034	19,224	3,190F	16.6%F	16,034	19,224	3,190F
IM&T	1,934	1,071	863F	13,744	12,621	(1,123)U	(8.9%)U	13,744	12,621	(1,123)U
Finance	2,072	1,982	89F	21,687	24,992	3,305F	12.8%F	21,687	24,992	3,305F
Chief Executive	158	97	62F	1,225	1,161	(64)U	(5.5%)U	1,225	1,161	(64)U
Total Corporate	**6,410**	**5,102**	***1,308F***	**56,469**	**62,158**	***(5,689)U***	**(9.1%)U**	**56,469**	**62,158**	**(5,689)U**
		0								
A&E Net Surplus/(Deficit)	**(1,418)**	**82**	**(1,500)U**	**723**	**1,051**	**(328)U**	**25.5%F**	**723**	**1,051**	**(328)U**
A&E Net Margin	(6.6%)	(0.0%)	(7.1%)U	0.3%	0.4%	-0.1%	-28%	0.3%	0.4%	-0.1%
		0								
Patient Transport Service	***144***	**9**	***135F***	***(0)***	**89**	***(89)U***	**(142.3%)U**	**(0)**	**89**	**(89)U**
PTS Gross Margin	11.3%	0.0%	13.7%F	(0.4%)	1.0%	(1.5%)U		(0.4%)	1.0%	(1.5%)U
		0								
Trust Result *Surplus/(Deficit)*	**(1,274)**	**91**	**(1,365)U**	**723**	**1,140**	**(418)U**	**34.9%F**	**723**	**1,140**	**(418)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 March 2009 (Month 12)

£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	18,050	18,139	(89)U		223,639	217,669	5,969F	(2.7%)U		223,639	217,669	5,969F
HEMS Funding	11	11	(0)U		127	128	(1)U	0.5%F		127	128	(1)U
Other A&E Income	91	91	0F		1,091	1,090	1F	(0.1%)U		1,091	1,090	1F
Foundation Trust Income	218	20	198F		357	242	115F	(47.5%)U		357	242	115F
CBRN Income	903	897	6F		11,942	10,769	1,173F	(10.9%)U		11,942	10,769	1,173F
ECP Income	15	13	(27)U		305	153	152F	(99.4%)U		305	153	152F
BETS & SCBU Income	109	76	33F		687	911	(224)U	24.6%F		687	911	(224)U
A & E Long Distance Journey	26	37	(62)U		397	439	(41)U	9.4%F		397	439	(41)U
Stadia Attendance	14	89	(75)U		939	1,074	(135)U	12.5%F		939	1,074	(135)U
Heathrow BAA Contract	44	44	(0)U		532	532	0F	0.0%F		532	532	0F
Resus Training Fees	5	10	(15)U		48	118	(70)U	59.7%F		48	118	(70)U
Education & Training Income	830	686	144F		8,321	8,231	90F	(1.1%)U		8,321	8,231	90F
	20,226	**20,113**	**113**		**248,385**	**241,355**	**7,029**	**(55.0%)U**		**248,385**	**241,355**	**7,029F**
PTS Income	946	706	240F		9,886	8,471	1,414F	(16.7%)U		9,886	8,471	1,414F
Other Income	618	234	384F		3,451	2,811	640F	(22.8%)U		3,451	2,811	640F
Trust Result	**21,790**	**21,053**	**737F**		**261,722**	**252,638**	**9,084F**	**(3.6%)U**		**261,722**	**252,638**	**9,084F**

LONDON AMBULANCE SERVICE NHS TRUST
CIP Monitoring Schedule 2008/09
As at 31st March 2009 (Month 12)

CIP Programme	Dept	Expense type	Actual CIP to Month 12 £000	Targetl CIP to month 12 £000	Variance to month 12 £000	Target CIP Full Year £000	Forecast CIP Full Year £000	Variance Full Year £000
A&E Productivity	Deputy Director Of Operations	Paramedic	4,578	4,578	0	4,578	4,578	(0)
Control Services Productivity	Urgent Care Services (Control)	Paramedic	484	484	0	484	484	0
Corporate Support Efficiency	Corporate Support	Support Staff	233	432	(199)	432	233	(199)
Non Pay - Facilities	All	Facilities	332	364	(32)	364	332	(32)
Non Pay - Fleet & Logistics	Fleet & Logistics	Fleet & Logistics	164	338	(174)	338	164	(174)
Non Pay - IM&T	IM&T	Technology	41	52	(11)	52	41	(11)
Non Pay - Other	Corporate Support	Other	233	407	(173)	407	233	(173)
Non Pay - Professional Services	Corporate Support	Consultancy	269	316	(47)	316	269	(47)
PTS efficiency	Centrally Held Funds	Efficiency Savings	0	247	(247)	247	0	(247)
			6,333	**7,217**	**(883)**	**7,217**	**6,333**	**(884)**

● To month 12 the Trust made a £6.3m CIP against a target for those programmes of £7.2m. 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 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

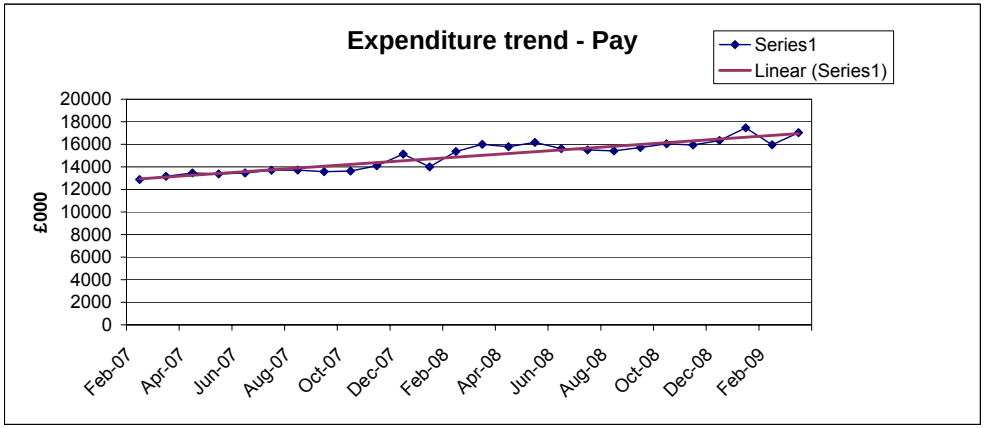
Expenditure Trends Including Last Year
As at 31 March 2009 (Month 12)

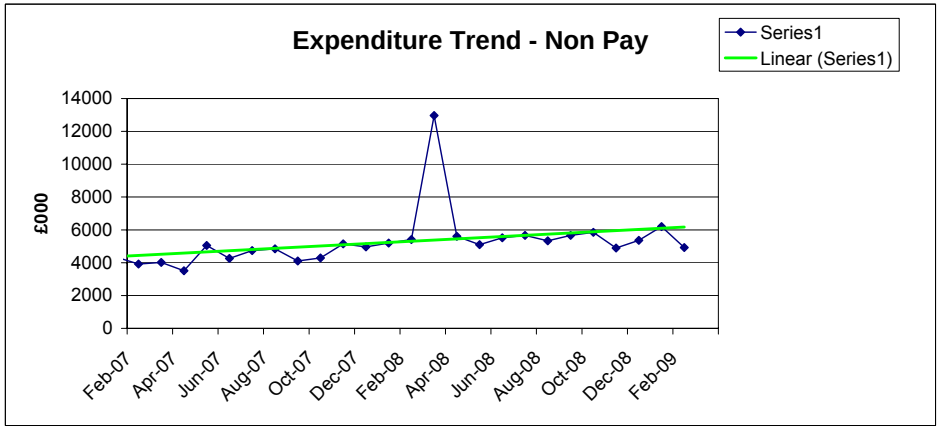
Current Year

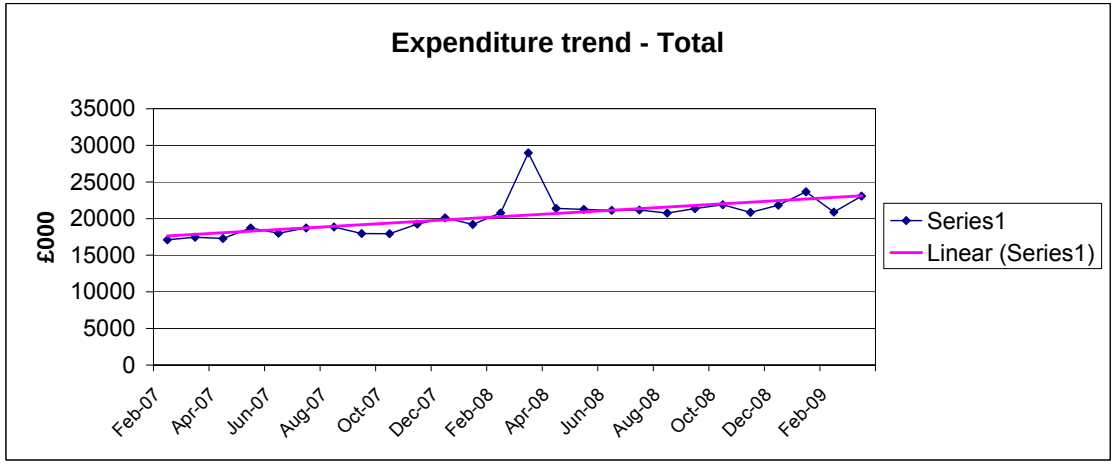
	March	April	May	June	July	August	September	October	November	December	January	February	March
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**25,743**	**21,086**	**21,218**	**21,128**	**21,147**	**21,219**	**22,551**	**23,328**	**19,982**	**22,955**	**22,728**	**22,590**	**21,790**
Pay Expenditure													
A&E Operational Staff	8,677	9,087	9,030	8,936	8,790	8,779	8,912	9,011	9,070	9,471	10,430	9,517	9,154
Overtime	1,764	1,910	1,994	1,897	1,647	1,566	1,620	1,739	1,601	1,712	1,710	1,495	1,735
A&E Management	911	942	940	945	966	949	967	979	970	1,024	1,001	980	1,001
EOC Staff	946	977	978	979	1,006	982	985	948	962	918	965	1,007	990
PTS Operational Staff	459	450	475	468	468	476	454	485	468	470	464	448	479
PTS Management	88	81	80	86	87	91	83	88	93	60	80	74	79
Corporate Support	3,154	2,345	2,672	2,304	2,539	2,581	2,690	2,791	2,781	2,687	2,804	2,431	3,600
Sub Total	**15,999**	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**	**15,946**	**16,342**	**17,455**	**15,952**	**17,038**
Average Daily	*516*	*509*	*522*	*521*	*500*	*514*	*507*	*517*	*532*	*527*	*582*	*515*	*550*
Non-Pay Expenditure													
Staff Related	386	223	251	369	207	258	260	355	223	186	326	219	430
Subsistence	209	343	44	149	193	200	195	152	167	222	149	147	336
Training	258	64	1	129	54	85	65	226	10	131	167	120	262
Drugs	28	37	25	9	9	49	9	47	49	26	34	51	41
Medical Consumables & Equipment	1,814	450	537	410	499	433	547	486	374	494	526	463	272
Fuel & Oil	417	415	455	440	450	399	400	427	392	421	403	357	378
Third Party Transport	173	213	183	76	142	89	105	95	115	125	153	121	173
Vehicle Costs	2,895	1,114	1,039	943	1,083	948	1,013	1,128	1,017	1,153	1,225	836	1,507
Accommodation & Estates	1,702	783	807	750	927	833	874	926	938	1,052	1,013	1,018	1,091
Telecommunications	2,129	558	517	718	397	510	749	582	613	537	973	615	926
Depreciation	706	597	597	695	630	611	611	609	609	596	608	606	712
Other Expenses	2,051	476	442	585	766	574	540	813	394	477	621	392	750
Profit/(Loss) on Disposal FA	29	0	0	12	0	1	0	0	2	67	0	0	0
Sub Total	**12,797**	**5,273**	**4,810**	**5,261**	**5,356**	**4,987**	**5,366**	**5,845**	**4,897**	**5,489**	**6,197**	**4,942**	**5,664**
Average Daily	*413*	*170*	*155*	*175*	*173*	*166*	*173*	*189*	*163*	*177*	*207*	*159*	*183*
Financial Expenditure	**170**	**328**	**289**	**256**	**313**	**342**	**299**	**310**	**366**	**337**	**360**	**362**	**363**
Average Daily	*5*	*11*	*9*	*9*	*10*	*11*	*10*	*10*	*12*	*11*	*12*	*12*	*12*
Monthly	**28,966**	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**	**21,210**	**22,168**	**24,012**	**21,256**	**23,064**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends over the last 24 months as at 31st March 2009 (month 12)







LAS Capital Expenditure for 2008/09 at 31st March 2009.			
Category	**Expenditure**	**Budget**	**Variance**
Equipments	-21,030	1,426,792	1,447,822
Estates	3,307,299	1,988,211	-1,319,088
IM&T	5,467,559	4,629,933	-837,626
Vehicles	5,872,414	5,285,064	-587,350
Grand Total	**14,626,241**	**13,330,000**	**-1,296,241**
Additional Funding from SHA		1,500,000	
Additional Funding from HART		1,035,000	
CRL		15,865,000	
2008/09 Actual Capital Expenditure		14,626,241	
Variation to CRL		1,238,759	
Additional Capital funding of £2,535,000 was received during the year.			

LONDON AMBULANCE SERVICE NHS Trust

Forecast Balance Sheet
For the Month Ending 31 March 2009 (Month 12)

	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*	*Actual*	*Actual*	*Actual*	
Intangible assets	3,765	4,511	4,523	3,784	3,854	3,797	3,790	4,016	4,043	4,530	5,046	5,046	6,683	
Tangible assets	119,652	123,612	123,179	123,607	124,108	123,640	123,778	123,755	124,225	124,654	124,353	127,345	107,130	
	123,417	128,123	127,702	127,391	127,962	127,437	127,568	127,771	128,268	129,184	129,399	132,391	113,813	
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	1,948	2,600	Trade Debtors
NHS Trade Debtors	1,628	821	1,194	1,717	11,611	6,563	3,768	4,744	3,673	5,879	2,372	9,122	2,832	A&E £36k > 60 days (1.59%), Feb - £42k > 60 days (0.47%)
Non NHS Trade Debtors	93	139	244	207	105	112	108	78	88	105	112	105	0	PTS £430k > 60 days (18.98%), Feb - £541k > 60 days (5.94%)
Other Debtors	4,337	388	578	452	401	491	232	385	279	299	325	520	901	
Accrued Income	247	2,117	4,028	5,676	2,466	3,760	5,120	10,010	9,491	8,785	11,418	262	1,473	
Prepayments	5,237	5,060	4,334	4,629	4,246	3,510	3,361	3,357	3,134	4,035	795	2,967	3,088	
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	10,364	9,435	2,533	
Total Current Assets	22,437	23,523	25,782	25,520	28,988	28,567	24,445	27,364	27,483	26,457	27,324	24,359	13,427	
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	6,009	6,113	7,531	NHS PSPP - This month (97%), Feb (100%), Ytd (89%)
Other Creditors	1,772	7,066	7,145	7,275	7,663	6,974	6,437	6,505	6,590	7,643	10,170	9,954	3,887	Non NHS PSPP - This month (94%), Feb (88%), Ytd (85%)
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	170	282	1,926	
Accruals	618	2,145	1,914	1,595	1,388	1,673	1,291	1,262	1,779	1,691	1,471	1,083	956	
Deferred Income	152	193	554	586	5,605	4,747	2,654	3,393	3,649	3,274	3,889	2,136	44	
Total Current Liabilities	16,958	18,457	20,402	20,058	24,187	22,708	17,461	19,776	21,611	20,690	23,180	21,407	14,344	
Net Current Assets	5,479	5,066	5,380	5,462	4,801	5,859	6,984	7,588	5,872	5,767	4,144	2,952	(917)	
Long Term Debtors	9,875	9,893	9,910	9,858	9,903	9,926	9,870	9,981	9,994	9,998	10,177	10,201	4,488	
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	143,720	145,544	117,384	
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	18,242	17,699	12,246	
Total Assets Employed	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	125,976	126,762	125,478	127,845	105,138	
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	57,523	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	33,128	
Donated Asset Reserve	68	50	30	9	9	9	9	9	9	9	9	8	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	14,124	15,457	14,897	
Total Taxpayers' Equity	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	125,976	126,762	125,478	127,845	105,138	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement

For the Month Ending 31 March 2009 (Month 12)

	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*	*Actual*	*Actual*	*Actual*	
EBITDA after exceptionals	619	836	936	918	1,417	2,082	2,050	(254)	1,787	(316)	2,300	(195)	12,180
Excluding Non cash I&E items	(18)	(20)	(21)	0	0	0	0	0	0	0	(1)	1	(59)
Movement in working capital													
Stocks & Work in Progress	4	(1)	0	(7)	6	5	(3)	1	3	0	10	(652)	(634)
NHS Trade Debtors	807	(373)	(523)	(9,894)	5,048	2,795	(976)	1,071	(2,206)	3,507	(6,750)	6,290	(1,204)
Long Term Debtors	(18)	(17)	52	(45)	(23)	56	(111)	(13)	(4)	(179)	(24)	5,713	5,387
Non NHS Trade Debtors	(46)	(105)	37	102	(7)	4	30	(10)	(17)	(7)	7	105	93
Other Debtors	49	(190)	126	51	(90)	259	(153)	106	(20)	(26)	(195)	(381)	(464)
Accrued Income	(1,870)	(1,911)	(1,648)	3,210	(1,294)	(1,360)	(4,890)	519	706	(2,633)	11,156	(1,211)	(1,226)
Prepayments	177	726	(295)	383	736	149	4	223	(901)	3,240	(2,172)	(121)	2,149
Trade Creditors	(3,079)	1,319	(621)	(1,879)	(94)	(592)	1,390	415	(1,672)	(838)	104	1,418	(4,129)
Other Creditors	4,990	(14)	255	415	(902)	(596)	(231)	(86)	469	3,250	(2,911)	(5,750)	(1,111)
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)	(220)	(388)	(127)	338
Deferred Income	41	361	32	5,019	(858)	(2,093)	739	256	(375)	615	(1,753)	(2,092)	(108)
Provisions & Liabilities	(57)	(19)	(257)	(20)	88	28	(213)	32	29	55	(543)	(5,453)	(6,330)
Net Cashflow from operating activities	2,525	(455)	(3,161)	(2,872)	2,895	(1,727)	(4,443)	3,031	(4,076)	6,764	(3,459)	(2,261)	(7,239)
Returns on Investments & Servicing of Finance													
Interest received	54	92	125	68	39	82	71	15	44	21	19	18	648
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	21	19	18	648
Capital Expenditure													
Tangible fixed assets acquired	(2,981)	(46)	(456)	(787)	(386)	(511)	(741)	(767)	(1,154)	(1,521)	(823)	(2,258)	(12,431)
Tangible fixed assets disposed	3,900	0	0	0	0	0	0	0	0	0	0	0	3,900
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)	(823)	(2,258)	(8,583)
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)	4,948	(1,964)	(6,902)	(7,467)
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	1,035	0	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	1,035	0	1,035
Increase/(decrease) in cash	4,099	407	(2,565)	(2,673)	3,966	(2,280)	(3,063)	2,027	(3,467)	4,948	(929)	(6,902)	(6,432)
Closing cash balance	13,064	13,471	10,906	8,233	12,199	9,919	6,856	8,883	5,416	10,364	9,435	2,533	2,533

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 30th April 2009 (Month 01)
£000s

	M01 Actuals	M12 Actuals	Var		Notes
Income	**-22,954**	**-21,790**	**-1,164**	F	£2.2m is the increase in A&E Services contract for 0910. Offset by M12 bunkered fuel income of £500k. E&D Income 100k less than M12, M12 Elective bets income higher than M01 by 100k due to YE adjustment of BETS income. 280k reduction in PTS income from M12. 100k Provision for reduction in E&D Payment
Pay Expenditure					
A&E Operational Staff	9,143	8,880	263	F	22 Extra Trainee Paramedics and 9 new A&E Support have started in M01. Also inflationary increase has occurred in M01 of 2.4%.
Overtime Incentive	443	274	169	U	M12 Incentive difficult to achieve, now in M01 target is easier to achieve thus has there has been higher spend.
Overtime	1,695	1,735	-40	F	Fine
A&E Management	1,046	1,031	16	U	Fine
EOC Staff	1,008	990	18	U	Fine
PTS Operational Staff	491	479	12	U	Fine
PTS Management	59	50	9	U	Fine
Corporate Support	2,855	3,600	-745	F	332k Payroll adjustments in M12, 228k FY reallocation of Prof Agency Staff done at YE due to Cap to Rev realloc. 80k Saving on PTS agency staff due to cost reductions. M12 YTD adj from Consultancy to Agency staff £50k.
Sub Total	**16,740**	**17,037**	**-298**	F	
Non-Pay Expenditure					
Staff Related	371	430	-59	F	£54k Stab Vest testing in M12, not spent in M01.
Subsistence	167	-336	502	U	M12 Subsistance included 500k reduction due to movement from reserves at YE
Training	131	262	-131	F	60k extra in M12 due to 0809 university invoices hitting ledger, 50k for courses in M12 not repeated in M01
Medical Consumables & Equipment	517	-272	788	U	M12 661k Stock adjustment thus spending back in line with expectations
Drugs	-3	41	-43	F	Feb & March high drugs purchases thus used stock in M01
Fuel & Oil	367	378	-11	F	Fine
Third Party Transport	154	173	-19	F	Fine
Vehicle Costs	902	1,507	-605	F	M12 Increase of 270k due to YE adjustments for: Increase in Provision of Ambulance Remount costs (358k) Offset by increase in stock levels (88k).
Accommodation & Estates	1,018	1,091	-73	F	M12 had additional spending for Security systems maintenance(23k) and Deptford redecoration costs (17k). Also more Reactive building repairs were done in M12 (23k).
Telecommunications	592	926	-334	F	Under accrual of BT Bill in March of 27k gone through in April. M12 128k spent on MDT Equipment. M12 CMS Invoices for 0809 of £125k.
Depreciation	623	712	-89	F	Year end write downs of CTAK, depreciation now back in line with trend.
Other Expenses	727	750	-23	F	Fine
Profit/(Loss) on Disposal FA	-1	-0	-1	F	Fine
Sub Total	**5,566**	**5,664**	**-98**	F	
Financial Expenditure	**362**	**363**	**-1**	F	fine
Monthly Expenditure	**22,667**	**23,064**	**-397**	F	
Monthly Net	**-287**	**1,274**	**-1,560**	F	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 30th April 2009 (Month 01)

	January *Actual*	February *Actual*	March *Actual*	April *Actual*
Income	**-22,728**	**-22,589**	**-21,790**	**-22,954**
Pay Expenditure				
A&E Operational Staff	8,677	8,624	8,880	9,143
Overtime Incentive	1,753	893	274	443
Overtime	1,710	1,495	1,735	1,695
A&E Management	1,001	980	1,031	1,046
EOC Staff	965	1,007	990	1,008
PTS Operational Staff	464	448	479	491
PTS Management	80	74	50	59
Corporate Support	2,804	2,431	3,600	2,855
Sub Total	**17,455**	**15,952**	**17,037**	**16,740**
Average Daily	*563*	*570*	*559*	*525*
Non-Pay Expenditure				
Staff Related	326	219	430	371
Subsistence	149	147	-336	167
Training	167	120	262	131
Medical Consumables & Equipment	526	396	-272	517
Drugs	34	51	41	-3
Fuel & Oil	403	357	378	367
Third Party Transport	153	121	173	154
Vehicle Costs	1,225	836	1,507	902
Accommodation & Estates	1,013	1,085	1,091	1,018
Telecommunications	973	615	926	592
Depreciation	608	606	712	623
Other Expenses	621	376	750	727
Profit/(Loss) on Disposal FA	0	-0	-0	-1
Sub Total	**6,197**	**4,927**	**5,664**	**5,566**
Average Daily	*200*	*176*	*167*	*176*
Financial Expenditure	**360**	**378**	**363**	**362**
Average Daily	*12*	*13*	*12*	
Monthly Expenditure	**24,012**	**21,256**	**23,064**	**22,667**
Monthly Net	**1,284**	**-1,333**	**1,274**	**-287**

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board
19 May 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 by the LAS since my last report in March.

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

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

40 alerts were received from17th March to 30th April 2009. All alerts were acknowledged; three required action, two relating to battery powered wheelchairs and one relating to blood collection tubes. These actions are complete.

Since 30th April the LAS has received regular alerts on Swine Flu. Our response to these is detailed under Domain 7 (Public Health)

Occurrence Report – Controlled Drugs Concerns
In our quarterly report to the Local Intelligence Network (LIN) the LAS reported **no concerns** regarding its management or use of controlled drugs during the period January to April 2009. The LAS has negotiated a reporting mechanism through Richmond and Twickenham PCT, as the lead Commissioner, rather than providing reports to each of the LINs across London.

Healthcare Commission report on Mid Staffordshire Foundation NHS Trust
A summary of the issues raised in this report, with particular emphasis on the possible parallels and lessons for the LAS will be presented for discussion.

2. Second domain – Clinical and Cost Effectiveness

NICE guidance
NICE have released guidelines for the assessment and management of diarrhoea and vomiting in children under the age of 5 years. This advice is most relevant to Emergency Care Practitioners and Clinical Telephone advisers and will be considered by the Joint Royal Colleges Ambulance Liaison Committee Guidelines subcommittee for inclusion in the next (2010) edition.

Two Team Leader Conferences are planned for later this month providing an excellent opportunity to brief staff on the most recent clinical issues, including the proposed field triage decision tool to enable staff to decide whether to convey trauma patients to a Major Trauma Centre (MTC) or Trauma Centre (TC). Team Leaders will also have the chance to consider amended resuscitation guidelines and to be introduced to the new shock boxes and monitor defibrillators to be rolled out across the Trust from 2010.

Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit:
Appendix 1 contains a summary of the CPI report. This document summarises the findings from the Clinical Performance Indicator process between April 2008 and March 2009. It highlights the impact of redirecting Team Leaders' activities to managing demand, but stresses the positive elements of continuing to provide feedback and the generally high standard of documentation achieved by staff.

3. Third Domain – Governance

The Trust submitted the Annual Health Check Declaration for 2008/09 to the Care Quality Commission (CQC).

The Trust has declared compliance with all the core standards, except for the standard C4d - Medicines are handled safely and securely, for which the Trust declared "not met" for the fourth quarter of 2008/09, but compliant by 31st March 2009. This is based on some of the control issues identified by the internal auditors for which immediate actions were put in place. CQC will start the process of cross checking on our declaration with all the other data available to them (eg: feedback from Staff Satisfaction Survey, Patient Survey, DH, NPSA etc.) to decide whether the Trust is selected for a follow up inspection.

The core standards assessment contributes to the "Quality of Service" part of the overall Annual Health Check performance rating. The Trust is expecting to achieve a score of "Fully Met" on our core standards for 2008/09.

4. Fourth Domain – Patient Focus

Update from Urgent Operations Centre (UOC)
The Assistant Medical Director (Control Services) and the Urgent Operations Centre AOM have instigated a number of initiatives within UOC.

- A clinical working group to review cases and try to improve training and teaching;
- Further interviews next week, including some external applicants eg Physician Assistants;
- Working with the Patient Experiences Department to review calls passed to NHS Direct on a weekly basis, clarifying where the governance lies relating to complaints and who takes primacy in answering them;
- A review of all the maternity calls where the new pathway has been used;
- A review of falls patients to see how long it is before they get a response and whether it is appropriate;
- On-going work to review calls that are passed to urgent care to ensure they are appropriate.

Update on the Clinical Support Desk

The monthly workload of the team appears to have reached a plateau at around the 1000 call mark, although the emergence of swine flu may lead to an increase in the figures over the next few months.

- **The calls:**

April has seen the desk accessed 989 times, with calls from Urgent Care staff creating a significant amount of the workload. Additionally we have seen 2 calls direct from the Police and two direct from the VAS – both sources that have not previously been identified as direct referees (the Clinical on call number has been available to police custody suites since before the desk went live).

The staffing of the desk remains under established and we are very grateful to the AOMs who have cooperated in allowing Team Leaders to be trained and released to work on the desk. Shifts are covered both through rostering and overtime.

Recruitment continues to be very disappointing. A further round of adverts has generated little interest. Anecdotal information suggests that staff are reluctant to travel to Waterloo. A recruitment and retention premium may be considered if full establishment is not achieved.

- **Examples of work:**

The team are becoming more adept at arranging referrals – often liaising with senior medical staff at receiving facilities. Now that the existence of the desk is becoming known outside of the LAS, we are being permitted to facilitate referrals where previously we met closed doors. The Patient Experience Department has assisted greatly in this, as have some of the Mental Health and social service teams who have benefitted from direct contact. This has without doubt saved significant numbers of journeys which are not fully reflected in the figures.

The introduction of MPDS V12 would appear to have had an impact on our workload. The accuracy of call prioritisation would appear to have risen significantly, and the number of calls where we are required to intervene and upgrade calls has notably dropped.

One change that has led to a lot of queries was the introduction of aspirin to the PDIs. This led to a lot of calls from VCS, and also to questions from call handlers about the benefits of giving aspirin.

Staff are being called away from the desk to treat members of the public less frequently. A much better working relationship with staff in the control rooms has developed with arrangements to facilitate the release of other members of staff so that the desk is not left unmanned for extended periods of time, to cover meal breaks and emergency clinical duties.

13 staff members have been assessed by the team. This is an inappropriate use of the staff on the Desk. Although in a few of these cases it was wholly appropriate to request a paramedic to attend, most could have been dealt with by a competent first aider. Discussions with EOC Resources are ongoing to see if we can identify at any given time who is competent to administer basic first aid and can be released to do so if needed.

A drop in the number queries relating to Patient Specific Protocols is probably related to the work being done by members of the Medical Directorate to ensure that all the PSPs currently held are up to date.

- **Looking Forward:**

With the planned reconfiguration within EOC there is the potential for both disruption and improvement. The current temporary location of the desk has met with a lot of positive feedback – especially due to the additional space that is available. Staff will have to continue to be flexible in working practices until the new base is set up.

As a result of CSD intervention 187 ambulance journeys have been saved. Most of these are where Urgent Care crews have been able to leave a patient at home safely – often with a referral for ongoing care facilitated by the desk. Work is in progress with UOC and the Medical Directorate to reduce the number of calls that Urgent Care vehicles are being sent to and where the patient has required a second resource to be sent before agreeing that the patient can be safely left (most are those where a 12 lead ECG has been looked at, or where there have been capacity issues).

Graphs relating to work load are included under Appendix 2.

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Recommendation

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Fionna Moore,
Medical Director
10th May 2009

Appendix 1.

Clinical Audit & Research Summary Report for the Trust Board

Summary of Clinical Performance Indicator (CPI) Figures 2008/09

Authors: Brendan Bradley and Gurkamal Virdi, Clinical Audit & Research Unit

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

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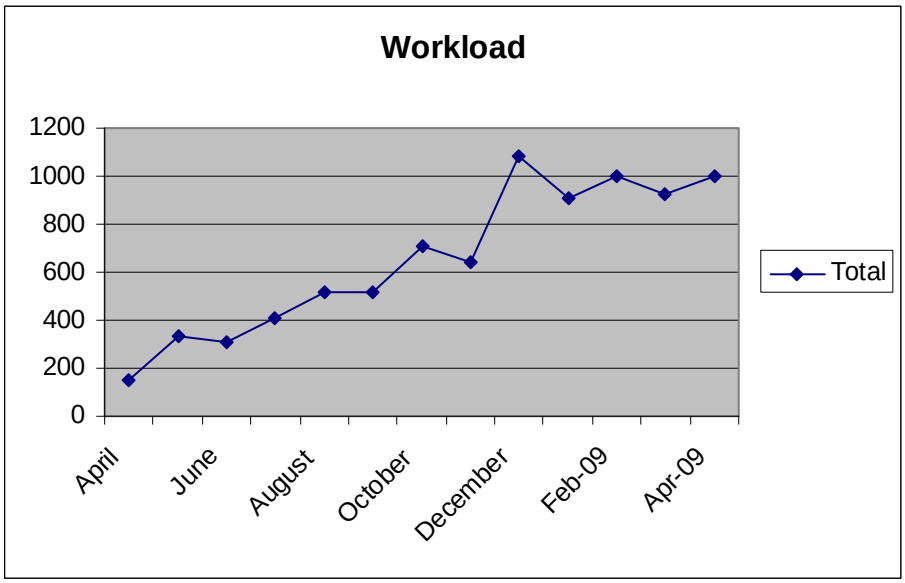
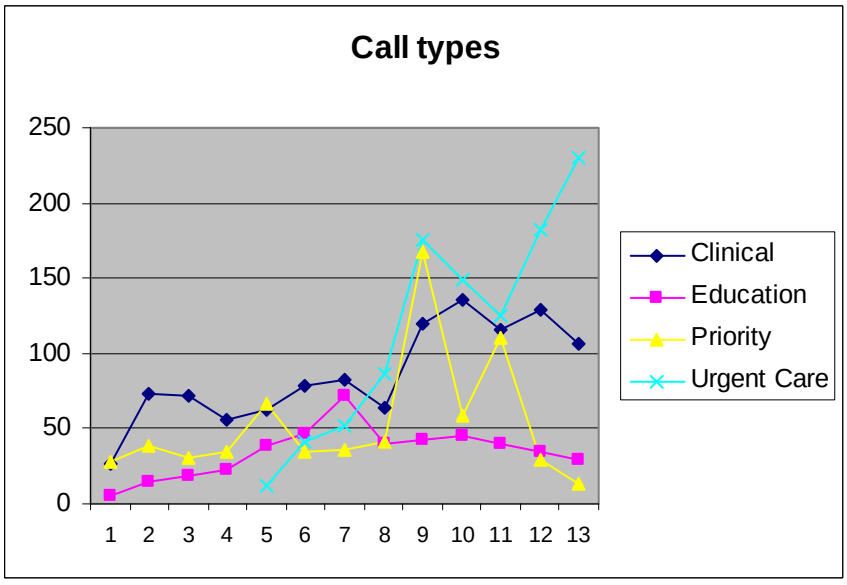
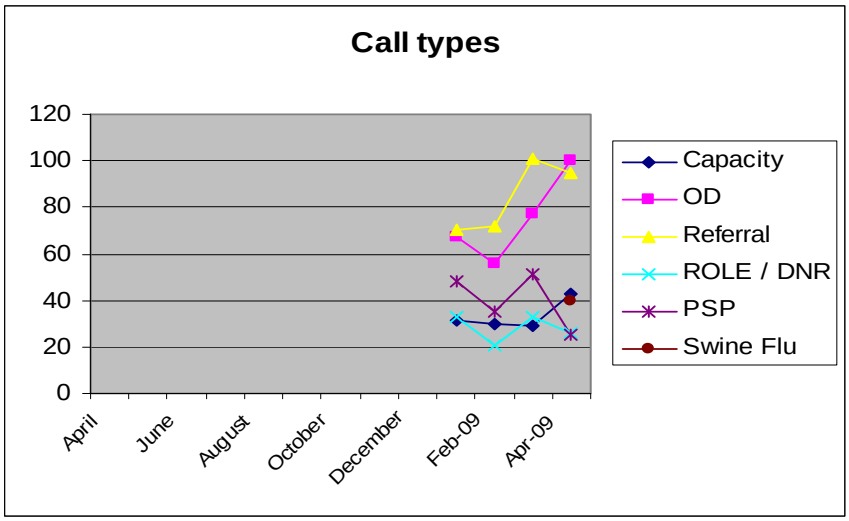


Call types April 2008 – April 2009



Call types Feb 2009 – April 2009


Call types
120
100
80
60
40
20
0
April
June
August
October
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Capacity
OD
Referral
ROLE / DNR
PSP
Swine Flu

Appendix 3

Referral Pathways Update

A key objective for the NHS is the reduction of unnecessary A&E admissions. This has been highlighted as a priority in national policy, particularly in "Healthcare for London: A Framework for Action" which prioritizes the delivery of more care in the community.
Unnecessary A&E admissions currently cost the NHS in London around £2.3billion. Around 60% of the patients we convey to A&E are not admitted, representing a cost of around £29million annually.
We know our patients prefer treatment in the community and are less likely to be repeat callers if they access a service which can manage their condition in the long term.
The Service currently has 56 referral pathways, all of which can be located on *the Pulse.* Pathways include those to MIUs, district nursing, WICs, palliative care, mental health teams, falls teams and crisis teams for the homeless. However the utilisation and number of pathways available varies significantly across London.

Referral pathways in the LAS

Developing a new pathway

Two new pathways have been developed in the South.
Southwark SLIPS
A falls service for Southwark residents who have fallen, are at risk of falling or have a fear of falling. Available Monday to Friday 0900-1700hrs.
Lambeth Falls Service
An integrated service for older fallers in Lambeth. Available Monday to Friday 0830-1700hrs.

New Referral Pathways

• Hillingdon complex has highest non-conveyance rate • New falls pathways in the South • Developing new pathways

Frontline staff are best placed to identify services in their local area which are likely to be used by patients in their local area. Pathways are most successful when they are developed by staff on station who can encourage their colleagues to utilise the pathway and build relationships with the service provider.
A template referral guideline can be accessed here. The Policy, Evaluation & Development team are available for support in the development of pathways.
Once a pathway has been developed and has approval from local management and the service receiving the referrals, formal sign off is required from the Service's Medical Director. Pathways are then uploaded to *the Pulse* but it is key that they are also launched on station. Posters, memos, articles in newsletters and regular discussion on station all help to ensure crews are aware of new pathways.

Referral pathway implementation on a NWoW complex

Julie Carpenter, Community Involvement Officer; Barnehurst

Since being at Barnehurst I have worked very hard trying to get crews to use alternative pathways and have issued every member of staff a copy of all the relevant pathways in the south east. I'm also producing a booklet for all vehicles on our complex which includes all the pathways, and I have given a copy of these to Bromley and Greenwich for their vehicles.

I also organised a seminar where Dr Daryl Mohammed came and spoke to staff about documentation, so that they are confident about leaving patients at home and satisfactorily completing the paperwork .

When a new pathway comes in I send out individual copies for the crews patient referral folder and put a poster on each station so they are aware of the new referral pathway.

Referral pathway utilisation in the LAS

The average tariff for an A&E patient is around £78. Our commissioning PCTs have recognised that every patient we keep out of A&E results in a saving to the PCT. Therefore we have negotiated a 'split the difference' agreement. For every alternate pathway we utilise, we are remunerated £38. This income is does have a cap, but is based on a cumulative increase in the number of saved A&E attendances. Therefore in order to reach the maximum level of funding we need to increase the number of referrals we make by 20% each year.

London Central & West Care Collaborative (LCWCC) have established a single point of access communications hub for health professionals wanting to refer patients to primary care within Westminster and Kensington & Chelsea PCTs. There is also a telephone line for patients to call directly into the hub. The hub provides primary care over the telephone, with face to face with home visits, or by booking surgery appointments.

This pathway has been utilised by CTA and EBS staff since December 2008 and has resulted in 134 referrals to GPs and district nurses in two months. A formal guideline for road staff has been developed and is available on Pulse.

LCWCC are also developing the pathway to enable referrals to mental health and social care within the next 6 months with a view to extending the opening hours to 24/7.

"I am delighted that phase one has gone so smoothly and it's success ensures that patients are directed seamlessly to the most appropriate part of the Health Service to deal with their needs" Tim Ladbrooke, Medical Director, Kensington & Chelsea PCT

Successful development of out of hours primary care hub

This newsletter is a new initiative and your feedback would be much appreciated. We will distribute the newsletter quarterly. We are currently investigating the potential for complexes with the greatest cumulative increase in pathway utilisation to receive financial rewards into a training budget. Thoughts on this are also welcome.

Referral pathways newsletter

Questions or comments? For advice in development of new referral pathways contact claire.garbutt@lond-amb.nhs.uk or call 0207 463 3116

Complex	Not conveyed	Conveyed to alternate destination	Referred, left on scene	Cumulative percentage of patients not conveyed to A&E
Isleworth	16.97%	1.79%	1.85%	20.60%
Hanwell	15.83%	1.72%	1.55%	19.10%
Hillingdon	22.27%	1.63%	1.93%	25.84%
Pinner	15.03%	1.64%	1.34%	18.00%
Friern Barnet	13.54%	1.85%	0.97%	16.36%
Brent	14.64%	2.05%	0.98%	17.68%
Camden	14.54%	1.90%	0.78%	17.22%
Fulham	15.85%	2.71%	1.09%	19.64%
Islington	16.52%	1.95%	0.68%	19.15%
Homerton	15.67%	3.16%	0.79%	19.62%
Chase Farm	14.55%	2.00%	0.53%	17.08%
Edmonton	12.92%	1.62%	0.48%	15.02%
Whipps Cross	13.38%	1.84%	0.65%	15.86%
Tower Hamlets	14.71%	2.67%	0.88%	18.26%
Newham	14.29%	1.87%	0.87%	17.03%
Romford	14.16%	1.75%	1.36%	17.26%
Barnehurst	12.45%	1.30%	0.78%	14.53%
Greenwich	11.67%	1.23%	0.94%	13.84%
Bromley	11.37%	1.90%	1.12%	14.40%
Croydon	12.44%	2.11%	1.13%	15.69%
Deptford	13.37%	3.18%	0.74%	17.29%
Waterloo	17.98%	3.01%	0.69%	21.67%
Oval	16.23%	2.24%	0.75%	19.22%
St Helier	14.41%	3.04%	0.82%	18.27%
Wimbledon	13.30%	2.44%	1.17%	16.90%
New Malden	12.96%	2.73%	1.28%	16.97%
Other	0.00%	0.03%	0.03%	0.07%

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board
19 May 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 by the LAS since my last report in March.

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

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

40 alerts were received from17th March to 30th April 2009. All alerts were acknowledged; three required action, two relating to battery powered wheelchairs and one relating to blood collection tubes. These actions are complete.

Since 30th April the LAS has received regular alerts on Swine Flu. Our response to these is detailed under Domain 7 (Public Health)

Occurrence Report – Controlled Drugs Concerns
In our quarterly report to the Local Intelligence Network (LIN) the LAS reported **no concerns** regarding its management or use of controlled drugs during the period January to April 2009. The LAS has negotiated a reporting mechanism through Richmond and Twickenham PCT, as the lead Commissioner, rather than providing reports to each of the LINs across London.

Healthcare Commission report on Mid Staffordshire Foundation NHS Trust
A summary of the issues raised in this report, with particular emphasis on the possible parallels and lessons for the LAS will be presented for discussion.

2. Second domain – Clinical and Cost Effectiveness

NICE guidance
NICE have released guidelines for the assessment and management of diarrhoea and vomiting in children under the age of 5 years. This advice is most relevant to Emergency Care Practitioners and Clinical Telephone advisers and will be considered by the Joint Royal Colleges Ambulance Liaison Committee Guidelines subcommittee for inclusion in the next (2010) edition.

Two Team Leader Conferences are planned for later this month providing an excellent opportunity to brief staff on the most recent clinical issues, including the proposed field triage decision tool to enable staff to decide whether to convey trauma patients to a Major Trauma Centre (MTC) or Trauma Centre (TC). Team Leaders will also have the chance to consider amended resuscitation guidelines and to be introduced to the new shock boxes and monitor defibrillators to be rolled out across the Trust from 2010.

Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit:
Appendix 1 contains a summary of the CPI report. This document summarises the findings from the Clinical Performance Indicator process between April 2008 and March 2009. It highlights the impact of redirecting Team Leaders' activities to managing demand, but stresses the positive elements of continuing to provide feedback and the generally high standard of documentation achieved by staff.

3. Third Domain – Governance

The Trust submitted the Annual Health Check Declaration for 2008/09 to the Care Quality Commission (CQC).

The Trust has declared compliance with all the core standards, except for the standard C4d - Medicines are handled safely and securely, for which the Trust declared "not met" for the fourth quarter of 2008/09, but compliant by 31st March 2009. This is based on some of the control issues identified by the internal auditors for which immediate actions were put in place. CQC will start the process of cross checking on our declaration with all the other data available to them (eg: feedback from Staff Satisfaction Survey, Patient Survey, DH, NPSA etc.) to decide whether the Trust is selected for a follow up inspection.

The core standards assessment contributes to the "Quality of Service" part of the overall Annual Health Check performance rating. The Trust is expecting to achieve a score of "Fully Met" on our core standards for 2008/09.

4. Fourth Domain – Patient Focus

Update from Urgent Operations Centre (UOC)
The Assistant Medical Director (Control Services) and the Urgent Operations Centre AOM have instigated a number of initiatives within UOC.

- A clinical working group to review cases and try to improve training and teaching;
- Further interviews next week, including some external applicants eg Physician Assistants;
- Working with the Patient Experiences Department to review calls passed to NHS Direct on a weekly basis, clarifying where the governance lies relating to complaints and who takes primacy in answering them;
- A review of all the maternity calls where the new pathway has been used;
- A review of falls patients to see how long it is before they get a response and whether it is appropriate;
- On-going work to review calls that are passed to urgent care to ensure they are appropriate.

Update on the Clinical Support Desk

The monthly workload of the team appears to have reached a plateau at around the 1000 call mark, although the emergence of swine flu may lead to an increase in the figures over the next few months.

- **The calls:**

April has seen the desk accessed 989 times, with calls from Urgent Care staff creating a significant amount of the workload. Additionally we have seen 2 calls direct from the Police and two direct from the VAS – both sources that have not previously been identified as direct referees (the Clinical on call number has been available to police custody suites since before the desk went live).

The staffing of the desk remains under established and we are very grateful to the AOMs who have cooperated in allowing Team Leaders to be trained and released to work on the desk. Shifts are covered both through rostering and overtime.

Recruitment continues to be very disappointing. A further round of adverts has generated little interest. Anecdotal information suggests that staff are reluctant to travel to Waterloo. A recruitment and retention premium may be considered if full establishment is not achieved.

- **Examples of work:**

The team are becoming more adept at arranging referrals – often liaising with senior medical staff at receiving facilities. Now that the existence of the desk is becoming known outside of the LAS, we are being permitted to facilitate referrals where previously we met closed doors. The Patient Experience Department has assisted greatly in this, as have some of the Mental Health and social service teams who have benefitted from direct contact. This has without doubt saved significant numbers of journeys which are not fully reflected in the figures.

The introduction of MPDS V12 would appear to have had an impact on our workload. The accuracy of call prioritisation would appear to have risen significantly, and the number of calls where we are required to intervene and upgrade calls has notably dropped.

One change that has led to a lot of queries was the introduction of aspirin to the PDIs. This led to a lot of calls from VCS, and also to questions from call handlers about the benefits of giving aspirin.

Staff are being called away from the desk to treat members of the public less frequently. A much better working relationship with staff in the control rooms has developed with arrangements to facilitate the release of other members of staff so that the desk is not left unmanned for extended periods of time, to cover meal breaks and emergency clinical duties.

13 staff members have been assessed by the team. This is an inappropriate use of the staff on the Desk. Although in a few of these cases it was wholly appropriate to request a paramedic to attend, most could have been dealt with by a competent first aider. Discussions with EOC Resources are ongoing to see if we can identify at any given time who is competent to administer basic first aid and can be released to do so if needed.

A drop in the number queries relating to Patient Specific Protocols is probably related to the work being done by members of the Medical Directorate to ensure that all the PSPs currently held are up to date.

- **Looking Forward:**

With the planned reconfiguration within EOC there is the potential for both disruption and improvement. The current temporary location of the desk has met with a lot of positive feedback – especially due to the additional space that is available. Staff will have to continue to be flexible in working practices until the new base is set up.

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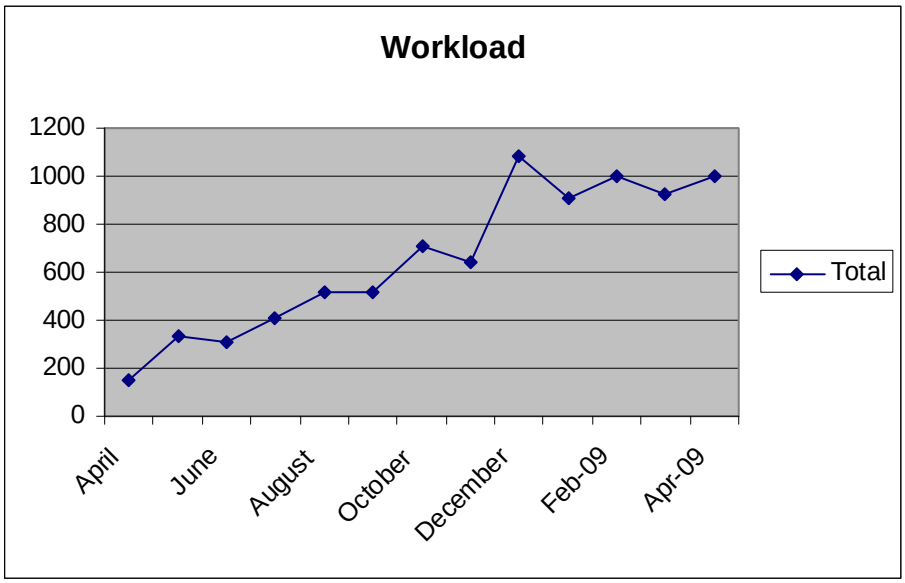

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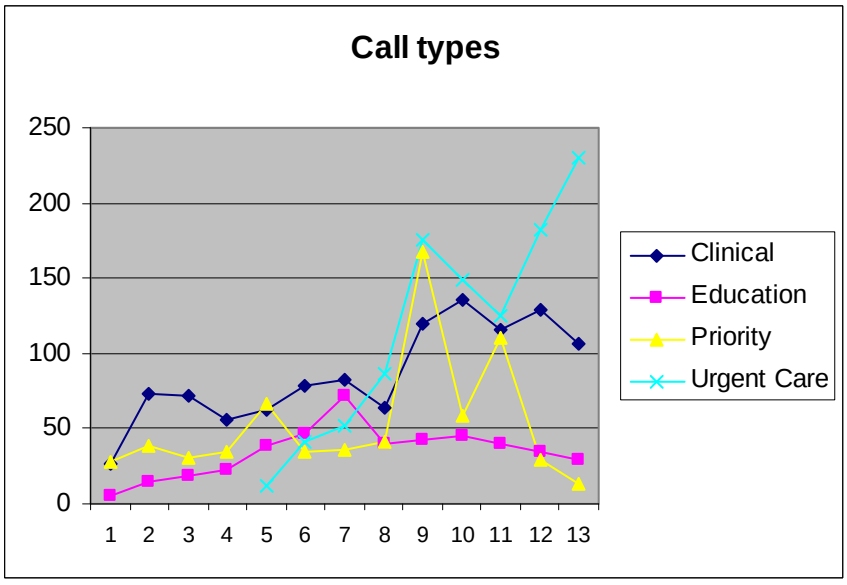

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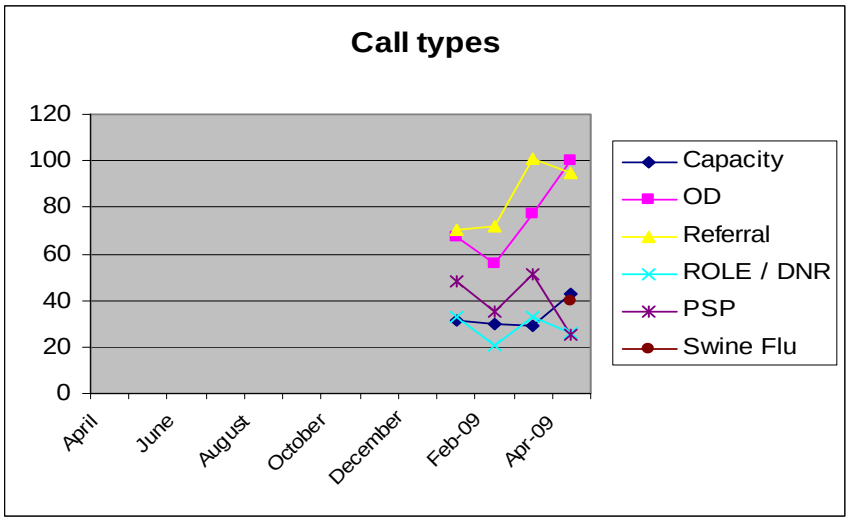
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Referral pathways in the LAS

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Two new pathways have been developed in the South.
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A falls service for Southwark residents who have fallen, are at risk of falling or have a fear of falling. Available Monday to Friday 0900-1700hrs.
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An integrated service for older fallers in Lambeth. Available Monday to Friday 0830-1700hrs.

New Referral Pathways

• Hillingdon complex has highest non-conveyance rate • New falls pathways in the South • Developing new pathways

Frontline staff are best placed to identify services in their local area which are likely to be used by patients in their local area. Pathways are most successful when they are developed by staff on station who can encourage their colleagues to utilise the pathway and build relationships with the service provider.
A template referral guideline can be accessed here. The Policy, Evaluation & Development team are available for support in the development of pathways.
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Referral pathway implementation on a NWoW complex

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LONDON AMBULANCE SERVICE NHS TRUST

Trust Board
19 May 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 by the LAS since my last report in March.

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

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

40 alerts were received from17th March to 30th April 2009. All alerts were acknowledged; three required action, two relating to battery powered wheelchairs and one relating to blood collection tubes. These actions are complete.

Since 30th April the LAS has received regular alerts on Swine Flu. Our response to these is detailed under Domain 7 (Public Health)

Occurrence Report – Controlled Drugs Concerns
In our quarterly report to the Local Intelligence Network (LIN) the LAS reported **no concerns** regarding its management or use of controlled drugs during the period January to April 2009. The LAS has negotiated a reporting mechanism through Richmond and Twickenham PCT, as the lead Commissioner, rather than providing reports to each of the LINs across London.

Healthcare Commission report on Mid Staffordshire Foundation NHS Trust
A summary of the issues raised in this report, with particular emphasis on the possible parallels and lessons for the LAS will be presented for discussion.

2. Second domain – Clinical and Cost Effectiveness

NICE guidance
NICE have released guidelines for the assessment and management of diarrhoea and vomiting in children under the age of 5 years. This advice is most relevant to Emergency Care Practitioners and Clinical Telephone advisers and will be considered by the Joint Royal Colleges Ambulance Liaison Committee Guidelines subcommittee for inclusion in the next (2010) edition.

Two Team Leader Conferences are planned for later this month providing an excellent opportunity to brief staff on the most recent clinical issues, including the proposed field triage decision tool to enable staff to decide whether to convey trauma patients to a Major Trauma Centre (MTC) or Trauma Centre (TC). Team Leaders will also have the chance to consider amended resuscitation guidelines and to be introduced to the new shock boxes and monitor defibrillators to be rolled out across the Trust from 2010.

Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit:
Appendix 1 contains a summary of the CPI report. This document summarises the findings from the Clinical Performance Indicator process between April 2008 and March 2009. It highlights the impact of redirecting Team Leaders' activities to managing demand, but stresses the positive elements of continuing to provide feedback and the generally high standard of documentation achieved by staff.

3. Third Domain – Governance

The Trust submitted the Annual Health Check Declaration for 2008/09 to the Care Quality Commission (CQC).

The Trust has declared compliance with all the core standards, except for the standard C4d - Medicines are handled safely and securely, for which the Trust declared "not met" for the fourth quarter of 2008/09, but compliant by 31st March 2009. This is based on some of the control issues identified by the internal auditors for which immediate actions were put in place. CQC will start the process of cross checking on our declaration with all the other data available to them (eg: feedback from Staff Satisfaction Survey, Patient Survey, DH, NPSA etc.) to decide whether the Trust is selected for a follow up inspection.

The core standards assessment contributes to the "Quality of Service" part of the overall Annual Health Check performance rating. The Trust is expecting to achieve a score of "Fully Met" on our core standards for 2008/09.

4. Fourth Domain – Patient Focus

Update from Urgent Operations Centre (UOC)
The Assistant Medical Director (Control Services) and the Urgent Operations Centre AOM have instigated a number of initiatives within UOC.

- A clinical working group to review cases and try to improve training and teaching;
- Further interviews next week, including some external applicants eg Physician Assistants;
- Working with the Patient Experiences Department to review calls passed to NHS Direct on a weekly basis, clarifying where the governance lies relating to complaints and who takes primacy in answering them;
- A review of all the maternity calls where the new pathway has been used;
- A review of falls patients to see how long it is before they get a response and whether it is appropriate;
- On-going work to review calls that are passed to urgent care to ensure they are appropriate.

Update on the Clinical Support Desk

The monthly workload of the team appears to have reached a plateau at around the 1000 call mark, although the emergence of swine flu may lead to an increase in the figures over the next few months.

- **The calls:**

April has seen the desk accessed 989 times, with calls from Urgent Care staff creating a significant amount of the workload. Additionally we have seen 2 calls direct from the Police and two direct from the VAS – both sources that have not previously been identified as direct referees (the Clinical on call number has been available to police custody suites since before the desk went live).

The staffing of the desk remains under established and we are very grateful to the AOMs who have cooperated in allowing Team Leaders to be trained and released to work on the desk. Shifts are covered both through rostering and overtime.

Recruitment continues to be very disappointing. A further round of adverts has generated little interest. Anecdotal information suggests that staff are reluctant to travel to Waterloo. A recruitment and retention premium may be considered if full establishment is not achieved.

- **Examples of work:**

The team are becoming more adept at arranging referrals – often liaising with senior medical staff at receiving facilities. Now that the existence of the desk is becoming known outside of the LAS, we are being permitted to facilitate referrals where previously we met closed doors. The Patient Experience Department has assisted greatly in this, as have some of the Mental Health and social service teams who have benefitted from direct contact. This has without doubt saved significant numbers of journeys which are not fully reflected in the figures.

The introduction of MPDS V12 would appear to have had an impact on our workload. The accuracy of call prioritisation would appear to have risen significantly, and the number of calls where we are required to intervene and upgrade calls has notably dropped.

One change that has led to a lot of queries was the introduction of aspirin to the PDIs. This led to a lot of calls from VCS, and also to questions from call handlers about the benefits of giving aspirin.

Staff are being called away from the desk to treat members of the public less frequently. A much better working relationship with staff in the control rooms has developed with arrangements to facilitate the release of other members of staff so that the desk is not left unmanned for extended periods of time, to cover meal breaks and emergency clinical duties.

13 staff members have been assessed by the team. This is an inappropriate use of the staff on the Desk. Although in a few of these cases it was wholly appropriate to request a paramedic to attend, most could have been dealt with by a competent first aider. Discussions with EOC Resources are ongoing to see if we can identify at any given time who is competent to administer basic first aid and can be released to do so if needed.

A drop in the number queries relating to Patient Specific Protocols is probably related to the work being done by members of the Medical Directorate to ensure that all the PSPs currently held are up to date.

- **Looking Forward:**

With the planned reconfiguration within EOC there is the potential for both disruption and improvement. The current temporary location of the desk has met with a lot of positive feedback – especially due to the additional space that is available. Staff will have to continue to be flexible in working practices until the new base is set up.

As a result of CSD intervention 187 ambulance journeys have been saved. Most of these are where Urgent Care crews have been able to leave a patient at home safely – often with a referral for ongoing care facilitated by the desk. Work is in progress with UOC and the Medical Directorate to reduce the number of calls that Urgent Care vehicles are being sent to and where the patient has required a second resource to be sent before agreeing that the patient can be safely left (most are those where a 12 lead ECG has been looked at, or where there have been capacity issues).

Graphs relating to work load are included under Appendix 2.

5. Fifth Domain – Accessible and Responsive Care

Referral pathways

The first edition of a new quarterly internal LAS newsletter relating to the use of referral pathways has been published. The newsletter demonstrates the use of existing pathways and quotes examples of good practice from the Barnehurst Complex around establishing new pathways.

This bulletin is included under Appendix 3.

6. Sixth Domain – Care Environment and Amenities

Infection Control

The Trust's annual infection prevention and control report is presented, along with a presentation on a 'Board to On Board Approach – how to embed a culture of HCAI prevention in acute Trusts' as a separate agenda item.

7. Seventh Domain – Public Health

Following the outbreak of swine flu initially in Mexico and the USA, the Medical Directorate, Emergency Planning Unit, and the LAS Infection Control Coordinator have worked closely with NHS London, the HPA, South East London HPU and the Communications Department. At the time of writing three bulletins have been circulated electronically to all staff, in addition to being made available through the Pulse. Our intention has been to circulate accurate and up to date information to advise staff how to identify possible cases and the infection control measures appropriate to protect themselves and manage their patients.

The LAS is working closely with the National Ambulance Infection Control Group and the DH to produce practical advice for staff around infection control guidance specific to WHO phase 5 and in the longer term a more detailed piece of work around actions appropriate to WHO phase 6.

Recommendation

- That the Board notes the report

Fionna Moore,
Medical Director
10th May 2009

Appendix 1.

Clinical Audit & Research Summary Report for the Trust Board

Summary of Clinical Performance Indicator (CPI) Figures 2008/09

Authors: Brendan Bradley and Gurkamal Virdi, Clinical Audit & Research Unit

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

This document summarises the findings from the Clinical Performance Indicator process between April 2008 and March 2009.

CPI Completion

CPI completion is a percentage figure used to monitor how many PRFs were audited by Team Leaders compared to the expected number of PRFs that were eligible for audit. To encourage the completion of CPI audits, the LAS has set a 95% CPI completion target.

In 2008/09, the overall CPI completion rate was 45%. From April to July 2008, the completion rate ranged from 60% to 69%. However, from August onwards it decreased considerably with rates ranging from just 31% to 39% until March 2009.

The main reason behind this decrease in CPI completion was the severe operational pressures experienced by the LAS last year, which resulted in Team Leaders undertaking operational duties in place of their CPI audits.

CPI Compliance

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

The table below displays the compliance rates achieved by the LAS in 2008/09:

Clinical Performance Indicator (CPI)	Average LAS Compliance1
1 in 20 (Basic documentation audit)	95%
Acute Coronary Syndrome	94%
Cardiac Arrest	93%
Difficulty in Breathing	93%
Glycaemic Emergencies	96%
Obstetric Emergencies	92%
Non-Conveyed Patients	92%
Overall	93%
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Non-Conveyed Patients	92%
Overall	**93%**

Overall, LAS staff complied with 93% of clinical care standards in 2008/09, which represents an increase of 2% compared to the previous year. The largest improvement was seen in compliance to clinical care standards for non-conveyed patients, which improved from 88% in 2007/08 to 92% in 2008/09.

This improvement in clinical performance can be attributed to the impact of CPI feedback that was delivered to staff by Team Leaders in 2007/08 and in 2008/09 (see below).

CPI Feedback

Team Leaders use information generated from the CPI audits to provide feedback sessions to staff about their clinical performance. Each member of staff should receive feedback twice a year and, to ensure this, a Service-wide target number of 5737 feedback sessions was set for Team Leaders to undertake in 2008/09.

[1] Please note, compliance data is based on the 45% sample of PRFs audited.
[2] Please note, compliance data is based on the 45% sample of PRFs audited.

Team Leaders undertook 3099 feedback sessions for the year, which, although short of the feedback target, contributed towards the above improvement in compliance to clinical care standards.

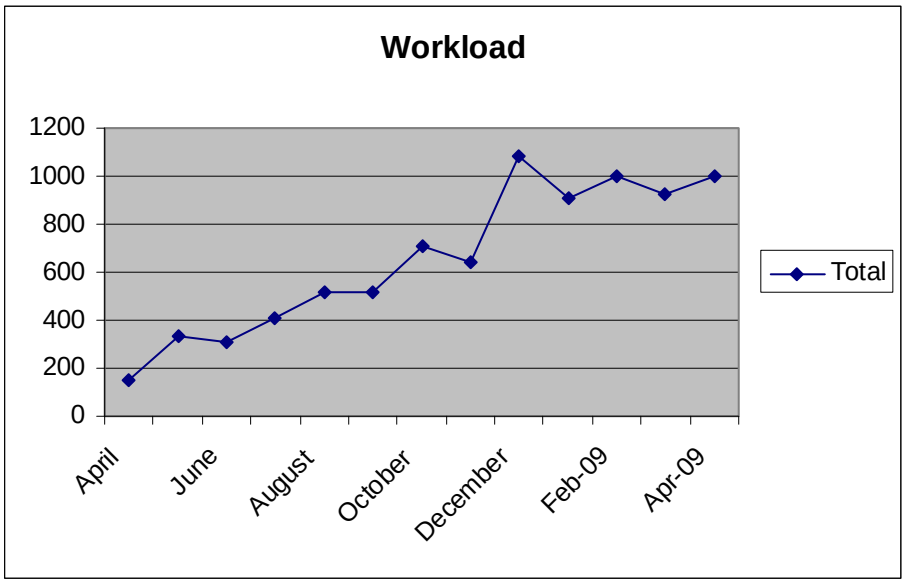
Summary

It is clear that the completion of CPIs was affected considerably by the severe operational pressures. However, it is reassuring that both a high standard of clinical care was maintained by the LAS and that Team Leaders continued to make efforts to provide CPI feedback to their staff during these pressures.

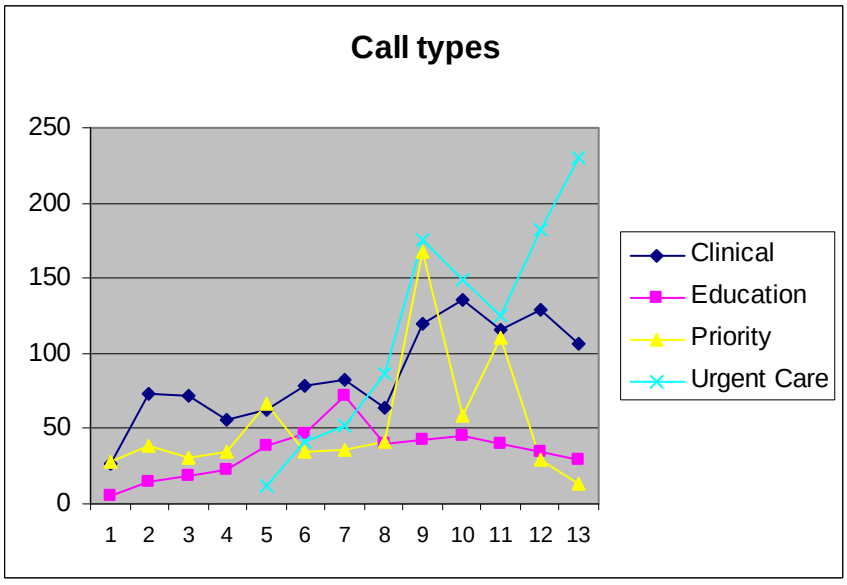
The CPIs are an important tool in evidencing the quality of care the LAS provides to its patients and, as such, efforts need to be made to ensure that Team Leaders are fully supported in their CPI duties. To assist this, the Clinical Audit & Research Unit is currently developing an updated version of the CPI database that will automatically select and provide Team Leaders with electronic images of PRFs for auditing. This will reduce the workload on Team Leaders and enable the LAS to achieve higher rates of CPI completion.

Appendix 2.

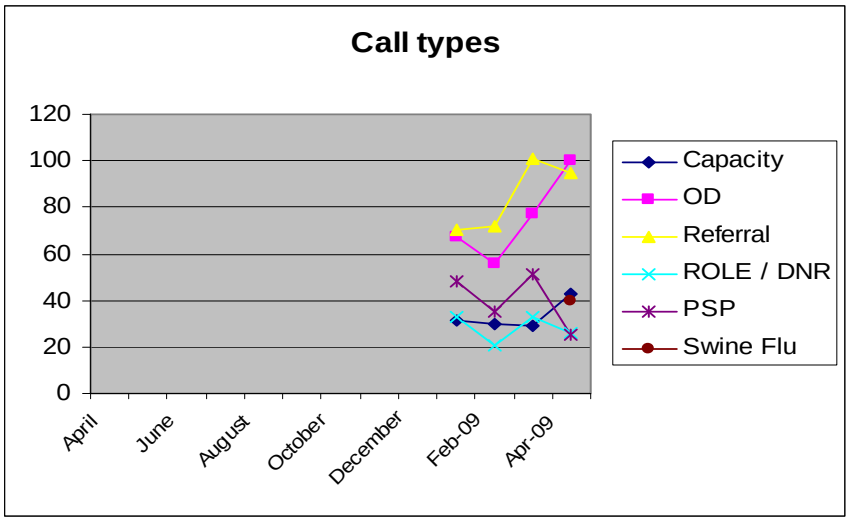
Clinical Support Desk data: workload April 2008 - 2009



Call types April 2008 – April 2009



Call types Feb 2009 – April 2009



Appendix 3

Referral Pathways Update

A key objective for the NHS is the reduction of unnecessary A&E admissions. This has been highlighted as a priority in national policy, particularly in "Healthcare for London: A Framework for Action" which prioritizes the delivery of more care in the community.

Unnecessary A&E admissions currently cost the NHS in London around £2.3billion. Around 60% of the patients we convey to A&E are not admitted, representing a cost of around £29million annually.

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London Ambulance Service NHS TRUST

TRUST BOARD 19th May 2009

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: *For noting.*

3. Summary

The report provides an update on progress in implementing the Service Improvement Programme (SIP2012).

The following reporting procedure to Trust Board and SDC was approved by the Board in September 2007:

- Trust Board – every meeting;
- SDC – one of the 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

TRUST BOARD MEETING, 19th May 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.

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*. Work is underway to consolidate these programmes into three larger ones which will be better configured to meet then needs of the Trust and the changing environment it is operating in. The new structure of SIP2012 will be:

- *Clinical Development, Leadership and Workforce* led by the Deputy Chief Executive focused on patients and staff, covering New Ways of Working, Organisation Development and People, Healthcare for London and new service development arising from Foundation Trust status;

- *Performance and Service Delivery* led by the Director of Human Resources and Organisation Development covering performance in its widest sense and the tangible infrastructure and operating systems which enable staff to provide patient care;

Version: 1.1
Date: 15 January 2009

- *Preparing for the Olympics* led by the Deputy Chief Executive which is unchanged.

4. Exceptions

This section provides commentary on those projects (not individual milestones) identified as being of red status (i.e. not on track and cause for concern).

Corporate Processes and Governance

Asset Tracking

The project has been on hold due to capacity constraints on power to the server room in headquarters. Information Management and Technology department have taken steps to address this issue which currently is one of competing priorities to migrate to the new server hosted at an external location. A schedule of priorities is being developed and at the appropriate time this project will be able to progress.

Organisation Development and People

Individual Performance Management

There has been no further progress with this project due to the operational commitments of the project manager. An audit of current practice of performance management has been concluded with Senior Management Group members interviewed regarding their views of the processes and policies available to staff. A discussion paper has informed a few small workshops to develop an understanding of the performance management concept in the LAS and to explore its use and areas for improvement. Some initial recommendations have come out of this work

Operational Model

Vehicle Fleet Procurement

Progress is very slow with the AEU contract and as of 6th May the supplier has completed a total of 11 AEU's (including the prototype build). There are a further 19 chassis with assembled bodies in various stages of build. Delivery of LAS vehicles is being impacted upon by the North West Ambulance Service contract with the supplier for 56 AEU's which should have been completed by mid March. Manufacturing defects identified in the early units have been troublesome to resolve impacting on the overall output volumes expected. Fleet are in constant contact with the supplier to expedite progress.

5. Recommendation

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

Kathy Jones
Director of Service Development

Infection Prevention and Control

Annual Report 2008/09

Executive Summary

Infection prevention and control continues to be a key quality measure for the London Ambulance Service and is reportable to the Trust Board on an annual basis. This report shows the progress made in infection prevention and control (IPC) over the period 2008 / 09.

The visit in November from the NHSLA highlighted a number of issues around IPC which were of concern. Following the appointment of an IPC lead various measures have been put in place to support the implementation of IPC within the LAS.

In early 2009 the Trust was required to register with the Care Quality Commission and show compliance with 9 criteria which form the new Health & Social. Care Act 2008. The trust has identified areas to develop and has acknowledged that there is an overall compliance to the Act. Further development is needed in coming months to reach the standard that is required by the CQC should they undertake an inspection.

Recommendation:

THAT the Trust Board approves recommendations 1 to 6 contained in the Report.

Infection control arrangements

Fionna Moore as the Medical Director is the designated Director ofIinfection Prevention and Control (DIPC). Each Trust is required under the Health and Social Care Act 2008 to have a designated person that reports IPC issues at board level and takes responsibility for IPC across the organisation.

The London Ambulance Service was unable to recruit an infection control coordinator in the last financial year due to lack of suitable candidates and as a result Trevor Hubbard, Ambulance Operations Manager for Edmonton complex agreed as the operational lead to undertake this role on a part time basis from October 2008 subject to operational demand and this has remained in place until 1st May 2009 when he takes up the role full time for an initial 6 month secondment as the infection prevention and control lead. Trevor has a nursing background in critical care and an interest in infection prevention and control and has been the operational lead on the Infection Control Steering Group for the past 5 years.

Chris Vale, Head of Operational Support chairs the Infection Control Steering Group which is made up of representatives from across the organisation from estates to training and A&E to PTS with staff side representation included. Safety and Risk feed in specific IPC issues to the group, receiving regular reports on inoculation injuries and infectious risks. This forum meets on a quarterly basis. Regular reports are provided to the Trust board via the DIPC.

Members of the group also sit on the Clinical Governance Group and Corporate Health & Safety Group, feeding in infection prevention and control issues accordingly. The DIPC chairs the clinical groups which oversee prescribing by the Emergency Care Practitioners but this is also determined by local prescribing practice across differing boroughs in London.

The IPC lead sits on the National Ambulance Infection Prevention and Control Group and reports Trust activity into this group and feeds back national initiatives to the DIPC on a monthly basis. The IPC lead is also the infection control lead for the DH Pandemic Flu Ambulance Steering Group and feeds this back into the National group.

From May 2009 the London Ambulance Service will be recruiting infection control champions from across the organisation to deliver key messages, improve clinical practice and feed into local infection control networks across London. These champions will also undertake cleanliness and infection control audits at complex level and feed these back in to the steering group.

Recommendations:

1. The Trust Board adopts a board to ward (‘on board’) approach recommended by the Department of Health in providing best infection prevention and control practice across the organisation in accordance with 1a of the Health and Social Care Act 2008.

2. The Trust Board endorses the development of the IPC champions network, has a non executive member as champion and allows adequate resource to ensure that the champions can support IPC at complex or department level.

DIPC reports to the Trust board

The DIPC should report quarterly to the Trust Board and provide an annual report outlining the progress in infection prevention and control. The IPC lead will develop an action plan in accordance with DH and CQC policy to deliver infection prevention and control issues across the organisation in order to comply with government requirements and these should be agreed by the Trust board.

Recommendations:

3. There will be an infection control programme incorporating an action plan in place to ensure compliance with national guidance and policy which is agreed by the Trust board.

Budget allocation to infection control activities

Currently there is 1 WTE budgeted within the operational support directorate for infection prevention and control.

An SPPP was agreed in April for the procurement of additional equipment required to meet the DH Ambulance Guidelines 2008.

Recommendation:

4. The Trust board recognises the importance of the IPC agenda and ensures adequate resources are allocated to support the delivery of effective IPC.

HCAI statistics

The Trust is not required to report mandatory statistics in MRSA and Clostridium Difficile infection (CDI) due to the nature of our work. It is recognised however that both of these infections are easily acquired in the community and acute Trusts are now required to produce root cause analysis (RCA) for each case. This has led to some ambulance Trusts having to isolate vehicles and undertake detailed analysis of their activities to identify potential risk. This process will increase in the future as hospital associated risks fall. There have been no occasions in the past 12 months where the LAS has been approached to provide evidence for the RCA in relation to MRSA or CDI.

The safety and risk department produce statistics on sharps / inoculation injuries and issues with infectious patients where staff have been put at risk.

Lightbridge Support Services who provide our make ready service undertake random swabbing of vehicles. No MRSA or Clostridium Difficile (C. Diff) positive results have been returned.

Hand Hygiene and Aseptic Protocols

The London Ambulance Service has adopted the National Patient Safety Agency (NPSA) 'clean your hands campaign' and all areas within the service should have hand washing posters above each hand washing sink and general hand hygiene posters that are displayed in staff areas to highlight good hand hygiene.

Links on the Pulse have been included for hand hygiene and recent articles on infection control and hand hygiene have been produced for the LAS News to highlight this to staff groups.

A Hand Hygiene policy has been written to ensure best practice in accordance with DH guidance and in response to the NHS Litigation Authority visit in November 2008 which highlighted the need for the policy linked to the Infection Control policy and manual.

In September 2008 the DH issued the Ambulance Guidelines which highlighted the need for good hand hygiene practice, a bare below the elbows policy and for all operational staff to be issued with alcohol gel to allow adequate decontamination of hands at the patients' side as well as in the back of the ambulance. The London Ambulance Service is currently reviewing the dress code policy to deliver this and an SPPP has been agreed for personal issue alcohol gel for point of care delivery and sleeve protectors for road side protection.

The Trust will adopt a cannulation pack to reduce the risk of HCAI and ensure aseptic practice where possible in the insertion of peripheral lines. Changes have been made to the paramedic training package to ensure this is incorporated for the future and an SPPP has been agreed for the pack which will include a sterile field and chloraprep skin preparation to disinfect the skin prior to insertion.

A catheter care policy has been developed and is undergoing final review before being sent out nationally to be adopted by all ambulance Trusts. The ECPs do not currently catheterise patients and the policy is for the care of patients with an indwelling catheter and their safe transportation to reduce the risk of HCAI.

A generic wound care policy has also been agreed in conjunction with the gluing and suturing policy.

Decontamination

The designated lead for decontamination is Chris Vale as Head of Operational Support.

The Trust has adopted single use items where possible and all products are approved at the Infection Control Steering Group and Vehicle Equipment Working Group following trials where required.

The Trust does not currently sterilise any equipment or undertake invasive operations which require sterilisation of surgical equipment.

Cleaning services

1. Premises cleaning

Premise cleaning is contracted out to Lightbridge Support Services and this is due for review with the Make Ready contract within the next 18 months. Cleaners undertake premises cleaning Monday to Friday at complex level and audits should be completed at station level by the local management team and reported back to Lightbridge Support Services.

The London Ambulance Service will adopt the NPSA guidance on premises cleaning (March 2009) and undertake regular audit by the IPC Champions. Lightbridge will provide cleaning schedules which are more explicit for cleaning staff and allow improved monitoring.

Cleaning at other premises should be monitored by designated leads for each building that will provide audits in conjunction with health and safety premises inspections.

2. Ambulance cleaning

Ambulance cleaning is the responsibility of crew staff in ensuring that the vehicle is cleaned in between patient use and in the event of a significant spillage.

Lightbridge provide a make ready service which should clean the exterior of the vehicle on a daily basis and then fully clean the interior daily and restock the vehicle. A deep clean should take place each 6 weeks. The current contract does not include cars or patient transport vehicles which remain the responsibility of operational staff. Current policy does not encourage the routine transportation of patients in cars and therefore the risk of HCAI is reduced. An SPPP has been approved for 2009/10 for the deep cleaning of PTS and FRU vehicles by LSS.

Following release of the DH Ambulance Guidelines 2008 the London Ambulance Service is adopting new cleaning materials for vehicles to comply with standards to eradicate infection and in particular spores and improve cleanliness. Detergent wipes are being introduced to enable hand hygiene and the cleaning of areas that have been in patient contact and equipment between patients by crew staff. An SPPP has been agreed to purchase detergent wipes.

Patient Environment Action Group (PEAG)

The NPSA guidance recommends the development of a PEAG to monitor environmental cleanliness across the service and report its findings to the Trust board. This should be led by the DIPC or their deputy and will be set up in 2009 to meet quarterly to review the patient environment from an ambulance trust perspective.

Audit

The LAS introduced infection control audits which were undertaken alongside the premises inspections by health and safety stewards and station / area management. This audit tool was adapted from a tool used by SECAMB but was thought to require further adaptation to meet our needs. It was agreed to await the launch of the NPSA framework before changing the tool and that in future the tool would be used by IPC champions to monitor cleanliness and infection control at a clinical level.

In Q1 of 08/09 23 infection control audits were undertaken across all premises in the LAS

In Q2 of 08/09 18 audits were undertaken

In Q3 of 08/09 11 audits were undertaken

Hand hygiene audits are due to be introduced at hospitals in June 09 for our staff and will be reported quarterly to the Trust Board and form part of the key performance indicators (KPI) for the National Ambulance Contract. The initial audit will form a baseline prior to the roll out of additional equipment to staff to improve hand hygiene.

Targets and Outcomes

In November 2008 the NHSLA visit was undertaken and prior to this all of the relevant policies relating to infection prevention and control had been reviewed and updated. As a result of the visit a further policy on hand hygiene was written and approved by the SMG and following their recommendations firm systems were put in place for the management of IPC within the organisation.

In February 2009 the LAS registered with the Care Quality Commission and declared our compliance with the Health and Social Care Act 2008 and each of the 9 criteria required with the exception of criteria 6 and 7 which were not applicable to ambulance trusts. A number of points were declared as partially compliant and information was provided to the CQC to support our application. This has been accepted by the CQC and all ambulance trusts accept Yorkshire Ambulance Service were compliant with the Act.

As part of the National Ambulance contract it has been agreed that the LAS will provide KPIs in relation to infection prevention and control to be agreed by the infection control steering group and to be reported quarterly to the Trust board.

Training

All new staff entering the organisation have an infection prevention and control session as part of their induction package. This session has recently been revised and updated in line with current practice.

The Trust has subscribed to the NHS e-learning package on infection control for both clinical and non-clinical staff and staff are able to access this programme on line from any PC.

A proposal has been put forward for infection prevention and control to be an integral part of the CPD programme for clinical staff and a recommendation that this should be mandatory.

Changes have been made to the paramedic training programme to incorporate amendments in line with the DH Ambulance Guidelines 2008 in aseptic technique and cannulation. The infection control element of the student paramedic programme is being updated in line with other ambulance trusts.

The department of education and development is investigating the possibility of providing a bespoke programme to the infection control champions from a partner learning organisation. Both the IPC operational and training leads will be accessing further education in IPC this year (2009).

Recommendations:

5. The Trust board agrees to the delivery of mandatory training in infection prevention and control to all clinical staff as part of the CPD programme

6. The Trust board ensures that sufficient resources are provided for the training of staff in IPC.

Trevor Hubbard
Ambulance Operations Manager for Infection Prevention and Control

Fionna Moore
Director of Infection prevention and Control
May 2009

London Ambulance Service NHS TRUST

TRUST BOARD 19th May 2009

PATIENT EXPERIENCE HALF YEARLY REPORT

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: *For noting.*

3. Summary

The report provides a summary of the activity of the Patient Experiences department from Sept 08 to March 09 . With the advent of the new legislation (The Local Authority Social Services and NHS Complaints Regulations 2009) which came into force in April 2009 we have been merging PALS and Complaints and SUI activity under the Making Experiences Count programme. As such this report now summarises both PALS and Complaints activity for the period and describes some emerging themes.

In addition to the high level data and trends a large number of individual cases are briefly summarised to gives the Board tangible examples of the issues being raised and the actions taken as a consequence.

4. Recommendation *That the Trust Board:*

- *Notes the report*

London Ambulance Service NHS Trust
Trust Board Meeting 19th May 2009

Patient Experiences Department half yearly report

Introduction

The merger of PALS and complaints as distinct entities has been undertaken as part of the *Making Experiences Count* programme, with new legislation (the Local Authority Social Services & NHS Complaints Regulations 2009) coming into effect from 1 April 2009. We continue to work towards combining the data to relation to the volume of enquiries across all the work streams the department now has responsibility for.

Significant changes in practice in relation to safeguarding, High Risk Register management and Incident Reporting are being embedded and an outline of these will be made available to the Trust Board in due course

Emerging themes:

(a) Call management:

- Referrals to NHSD. These incidents are under investigation and a report will be prepared when enquiries have been concluded.
- EOC call management via GPs. The calls were evidently not recorded which has meant that it has been difficult to review the call management although enquiries relating to several incidents continue.
- Continuing examples of delays in relation to lower priority calls, often exacerbated by poor resourcing.
- A significant inter-agency review has been conducted in collaboration with a mental health Trust in relation to the management of patients who are prescribed Clozapine.

(b) Maternity Cases
Continuing reports (mostly from acute Trusts) suggesting a poor interface between the LAS, community and hospital midwives, in particularly in relation to hospital destination.

Improvements have been put into place for EOC to better triage maternity calls by using enhanced information guidelines.

(c) Staff attitude & behaviour
Continuing reports of poor examples of staff attitude, including an increase is incidents reported by other health and social care professionals. A staff survey is being designed to test the possible correlation between corporate messages and incidents of poor staff behaviour. We also continue to promote reflective practice as a learning tool to address this consideration.

(d) Availability of S136 suites
Following an incident in which a patient was forced to remain in an ambulance for a prolonged period, the CEO has initiated a review by all the agencies involved towards improving availability of provision and improved inter-agency liaison.

(d) Patient Property

A themed report will be made available to CGC, analysing trends since the establishment of the patient property scheme across the Trust.

(e) Safeguarding

As a generic theme arising from safeguarding cases, we will be approaching London Safeguarding Board towards achieving improved sharing of information between local authorities and the LAS in relation to children identified as being 'at Risk' and seeking the introduction of a standard safeguarding enquiry format across London.

Complaints by Subject (primary) and Service grouped by First received

	EOC	E	NOP	NOS	PTS	S	W	Total
08/09 Q3	**20**	**13**	**1**	**6**	**8**	**12**	**13**	**73**
Clinical Incident	0	0	0	0	1	0	0	1
Conveyance	0	0	0	0	1	1	0	2
Delay	16	0	1	0	2	0	0	19
Non-conveyance	1	2	0	0	1	1	0	5
Not our service	0	0	0	6	0	0	0	6
Non-physical abuse	3	5	0	0	1	7	7	23
Road handling	0	2	0	0	1	1	1	5
Treatment	0	4	0	0	1	2	5	12
08/09 Q4	**20**	**19**	**0**	**2**	**4**	**19**	**11**	**75**
Aggravating Factors	0	0	0	0	0	1	1	2
Clinical Incident	0	1	0	0	0	0	1	2
Delay	12	0	0	0	1	1	0	14
Non-conveyance	4	0	0	0	1	1	2	8
Not our service	0	0	0	2	0	0	0	2
Non-physical abuse	4	9	0	0	2	7	6	28
Road handling	0	1	0	0	0	2	0	3
Treatment	0	8	0	0	0	7	1	16
Totals:	40	32	1	8	12	31	24	148

PALS by Subject (primary) 01 October to 31 December 2008

Subject	Numbers
Access	6
Appreciation	234
Physical Violence	2
Clinical Equipment	6
Clinical	26
Communication	27
Conveyance	14
Delay	25
Non-physical abuse	2

Non - Clinical Equipment	1
Frequent Callers	26
Information/Enquiries	669
Lost Property	109
Medical Records	23
Other	3
Policy/ Procedure	19
Road Traffic Collision/RTC	1
Social Services	48
Totals:	1241

PALS by Subject (primary) 01 January to 31 March 2009

Subject	2009 Q1
Access	7
Aggravating Factors	1
Appreciation	15
Clinical Equipment	6
Clinical	27
Communication	27
Conveyance	12
Delay	12
Non-physical abuse	5
Explanation of Events	7
Non - Clinical Equipment	1
Frequent Callers	22
Information/Enquiries	579
Lost Property	126
Medical Records	56
Non-conveyance	2
Other	12
Policy/ Procedure	7
Road Traffic Collision/RTC	6
Social Services	41
Totals:	971

(Reduced due to re-allocation of Appreciation letters to the Corporate Induction and Awards Department)

Case Examples

Case 1
An ambulance was requested for Child A who had been placed at a residential respite care facility; his mother subsequently refused to agree admission to hospital. The child was taken home but died the next day. An Independent Management Review was carried out as part of the Serious Case Review which resulted in a

number of recommendations including improved liaison between LAS crews and the Clinical Support Desk.

Case 2
A child's family who had been subject of a CP Plan arising from concerns relating to harm and neglect were the subject of a Serious Case Review following the death of their baby. An Independent Management Review was conducted which supported the recommendation that information about children identified as being 'At Risk' should be held on our system which in turn could be passed to the attending ambulance staff in the event of a 999 call.

Case 3
Child B suffered a cardiac /respiratory arrest in relation to choking/airway obstruction. An IMR was carried out at the request of the Local Safeguarding Children's Board and found that there was no ostensible reason for a safeguarding referral to have been made by the attending ambulance staff as it is considered a common occurrence for the LAS to be requested to attend children experiencing choking/vomiting and no suspicious circumstances were apparent. However, the Trust believes that it could be better involved in safeguarding practice if information about children designated as being 'At Risk' was made available pan-London

Case 4
An elderly female who lives alone, confined to bed and deemed to have capacity placed over 250 x 999 calls. She has a full care package with good support from Social Worker, GP and Community Matron plus Linkline call facility and no immediate clinical needs. Local liaison meetings resulted in an Individual Dispatch Protocol (IDP) put in place, GP to deal with 999 calls during surgery hours. The patient has not significantly reduced her call volume despite these measures and is now to be assessed towards Cognitive Behaviour Therapy. The possibility of the issue of a fixed penalty notice has been raised by the Met Police Community Liaison Officers.

Case 5
An elderly female with poor mobility who lives alone and is deemed to have capacity began falling and phoned 999 with up to 12 calls per month. To address matters, liaison was affected with the GP involving an analysis of the times of day the patient called 999. Her care plan has now been increased and a home hoist fitted. The patient is no longer placing 999 calls.

Case 6
A patient with mental health problems deemed to have capacity she has called 999 6-8 times per month with various issues since 2006; underpinning these calls is anxiety. Contact was made with patient's Key worker which resulted in a telephone number for the supported housing team being placed above patient's telephone. No further 99 calls have been received.

Case 7
A 46 year old wheelchair user who lives alone has various health problems arising from a recent stroke. He is deemed to have capacity and receives 30 hours of care a week. The patient has called in excess of 250 times in past year for falls from his wheelchair (anecdotally crews state patient is often not out of wheelchair on their arrival). Patient fails to engage with GP and has been verbally abusive to both staff at GP practice and crews. GP intervention had not proved successful. A case conference was held and resulting from that the patient's soc wkr is applying for additional funding from the Independent Living Fund and a request has been made

for the GP to arrange psychiatric evaluation. The patient has failed to pay for his community alarm and this matter is being taken forward by Social Services.

Case 8
An obese 68 year old male with poor mobility who has a live-in carer, suffers from COPD and is deemed to have capacity. He has called over 125 times, 25 of these conveyed to A&E. He often makes calls whilst carer is on scene in relation to chest pain, breathing difficulties and anxiety. The patient's house is unsecure and strangers have been known to take money from him (a Vulnerable Adult referral had been placed by a crew). The GP was contacted with details of the call volume and a case conference was held involving Social Services. His care package was increased to two full time live-in carers and the house was secured with new locks. The call volume provided to Social Services proved significant evidence of the patient's care needs and towards achieving the maintenance of the increased care package. Call volume has been reduced to one call every 2-3 months.

Case 9
An elderly patient is cared for by her niece who has a learning difficulty. They have been frequent callers to LAS as the patient falls out of bed or her wheelchair when transferring. Following discussion with local Adult social care services, a hospital type bed has been supplied and the number of calls has reduced significantly.

Case 10
A large hostel for homeless and rough sleepers was the source of a large number of calls. These calls were often being made on the mobile phones of residents and were not always in relation to serious or life threatening situations. The hostel is staffed 24/7 so we met with the hostel staff team and have now agreed that, although we will dispatch to any 999 call we will follow up by contacting the hostel staff to verify the requirement. – an arrangement which is clearly of mutual benefit. We are also exploring the possibility of a making an on-site defibrillator available, together with appropriate training for the staff. This activity has also led to establishing contact with the London region of 'Homeless Link' so that by joining their network the LAS can discuss similar arrangements with other similar service providers.

Case 11
A 50 year old male with chronic depressive illness who frequently calls 999 asks to be conveyed to hospital because he 'cannot cope'. Also calls again from A & E to ask for a lift home. We have liaised with local mental health outreach team to visit the patient together and encourage him to consider calling alternative numbers when he is depressed.

Case 12
Referral from CSD regarding a patient noted to be calling increasingly. Call logs were checked and it was ascertained that most calls were via the police. It is documented that the patient is frequently verbally abusive to ambulance crews when they arrive and is known to refuse all treatment. Contact was made with social services, GP, MPS Community Safety officer and DSO. A Strategy meeting was arranged for follow up.

Case 13
A large care home in North London has been the source of over 200 calls so far this year, many from resident's own phones. Contact made with Manager and visit arranged together with DSO from local station to agree a joint management protocol.

Case 14
One of the service's most frequent callers, a homeless man who is incontinent of urine and also has a colostomy has historically called the service from many different street locations in London seeking help to be cleaned up and have his stoma bag replaced or attended to. Following much liaison with one London Borough's Vulnerable Adults Team they have accepted financial responsibility for him and he has recently been placed in a residential care home where he is receiving daily visits from a district nurse and his drinking is being monitored.

Case 15
The Department received concerns raised by a scheme manager of a residential care home about concerns about comments made to resident's relatives by ambulance crews about the care home, which were viewed as very negative about the care home staff processes and procedures. The scheme manager felt the ambulance staff should have discussed their concerns with her before speaking to the family. An approach was made to the local complex management team and a Duty Station Officer attended a meeting at the care home. Agreement was reached to devise a template for the type of information ambulance staff require when called to the care home and resuscitation training is to be provided by the LAS to care home staff.

This case exemplifies the MEC programme by engendering closer liaison with service users and health and social care colleagues.

Case 16
A patient's relatives were unhappy with the long delay in an ambulance attending, which was due to the high demand for ambulances being experienced at the time and a reduction in resourcing availability. Whilst the delay was very disappointing the relatives felt that our response included too much corporate information. The relatives were invited to visit the Emergency Operations Centre.

A positive outcome was achieved, the relatives finding their visit to EOC helpful in understanding the pressure caused by demand. The relatives complimented the Trust on it 'open door' policy.

Case 17
A hospital A&E consultant required details of ambulance activity to support a forthcoming inquest into a patient's death from 2007. Although an ambulance had been dispatched shortly after the first call, work colleagues elected to convey the patient to hospital shortly after the dispatch of the ambulance. The Department was able to confirm the availability of ambulance resources and HEMS and other statistical information to support the forthcoming inquest.

The case demonstrated the importance of information sharing between Trusts.

Case 18
A hospital CCU requested the ECG taken by the attending crew as the patient (who had suffered a cardiac arrest on scene) of the incident, remained seriously ill at CCU and the hospital wanted to further understand the patient's ECG rhythm history. Although a simple request, this case exemplifies the importance of information sharing towards on going care and treatment.

Case19

Concerns were expressed from a member of the public who attended the recent protests outside the Israeli Embassy regarding the delay in an ambulance attending an injured protestor. Whilst it was accepted that there was a very disappointing response in an ambulance arriving there were mitigating circumstances as a consequence of civil disorder breaking out within the area. This case highlighted the detailed work that is required in gathering information from across the Trust to provide a detailed response.

Case 20
A request was received from a patient's relatives who sadly later died in hospital whether any last words had been recorded and the presenting patient's mood and behaviour. We were able to discuss this matter with the staff concerned and offer a response. This case illustrates our ability to supporting families who have experienced bereavement.

Case 21
The attending crew delivered a pre term infant. The Midwifery Unit raised concerns that the crew had washed the baby in warm water. This was unnecessary, even if the baby was very soiled as in a pre term infant there would be a risk of chill factor; the baby was cold on presentation although we were able to confirm that this is not unexpected in a preterm BBA. The Maternity Advisor is issuing guidance that crews should not wash a baby prior to removal from the scene. The Midwifery Unit were satisfied with the learning and action point initiated.

Case 22
A review was undertaken after an incident involving a maternity patient BBA, the patient was bleeding with a placenta in situ. The crew gave Syntometrine to control bleeding PV and requested midwife but the patient continued bleeding. The hospital had no staff free from Labour ward to send. The review confirmed that the crew were correct to elect to go straight to the maternity unit and not wait for a midwife as post partum bleeding is a life threatening event. Another issue arising from the review included the poor handover as the midwives were not prepared for and a significant delay occurred. It transpired that a priority blue call had not been made. A local Team Brief was issued.

Case 23
A patient raised concerns at the delay in an ambulance attending. Her baby was later born with neurological damage which she believed was attributable to the delay. We ascertained that the patient had consulted with her midwife who believed that her heavy PV haemorrhage was attributable to a 'show' and the patient's subsequent 999 call was triaged as an Amber call. Quality Assurance advised that the EMD should have "shifted" to the appropriate response determinant which would have given the call a "Category A" response. The response time of the ambulance from the call start time was 17 minutes. An EOC Training Officer has discussed the call management with the call handler involved, towards enhancing future practice. EOC have been approached to advise whether there are any means of improving the software systems so that we may more easily categorise an emergency call of this nature, reconciling the differences in interpretations described. The local PCT were informed of our response as the patient has shared her concerns with the Acute Trust about the community midwife and the Maternity Department of her local Hospital.

Case 24
GP surgery raised concerns at the BM equipment used by attending crew. The reading obtained by the crew was not matched by that later obtained by the GP. The local station were alerted and initially believed that the BM reading may have been

contaminated. The equipment was taken out of operation and checked as well as the BM of other patients treated that day. All of this verified matters; the surgery was informed and thanked the LAS for our timely response.

Case 25
A patient was concerned at the non arrival of ambulance when there was exceptionally poor weather. The patient was informed that a national media bulletin had been placed to alert callers that only life-threatening calls would be responded to. An apology was offered and the patient was advised that senior operational managers and our emergency planning department are evaluating the service we were able to provide during February to identify any lessons that can be learned.

Case 26
A GP attended a patient and asked a carer to phone 999 for an ambulance as he believed patient was at risk at home as he kept falling. The GP was aware that the patient did not want to go to hospital but considered that he did not have capacity to make this decision. The GP did not wait on scene. The crew treated the patient and deemed him to have the capacity to make a decision not to travel to hospital. The GP was advised of our capacity policy. This case has contributed to the review of the capacity tool being undertaken by the Medical Directorate.

Case 27
An incident occurred involving an ambulance that running out of fuel while transferring a patient in labour. A second ambulance was called which resulted in a 20 minute delay. The ambulance crew concerned believed that they had half a tank of fuel on leaving the origin hospital but broke down halfway to destination hospital. The RAC attended and confirmed the vehicle had a faulty fuel gauge. The ambulance was taken out of operational service and the hospital advised that this was an isolated incident and that no systematic issues had been identified..

Case 28
Enquiry received from member of the public who received *LAS info* text messages on his private mobile phone. The messages consisted of call signs and times (resourcing info) and were received several times daily. The enquirer was unable to reply to them. The Resource Centre were informed and immediately removed the number from the SMS system

Case 29
A crew expressed concern at the level of care provided by A&E staff towards a patient with a potentially life-threatening episode of asthma. The patient suffered a delay of an hour before her condition was brought under control and she was taken to ITU. A review indicated that it would have been more appropriate to have called the anaesthetist at the time of the blue call; advice was also provided to both the crew and hospital staff on best practice management; Guidance was also issued on ensuring that patients who are at risk of sudden deterioration have a clear escalation plan with their GP or chest clinic. This case exemplifies 'governance in action'. By bringing together all the involved clinicians to consider the totality of the patient care pathway.

Case 30
A patient disputed a number of matters that had been recorded on the PRF, notably, that she had consumed alcohol, that her date of birth had been wrongly documented and that she disputed some the clinical observations. The patient placed a formal request under section Section 10 of the Data Protection DPA Act (1998). A meeting

was facilitated with the patient, her legal advocate and ICAS. An explanatory letter was provided to the patient's satisfaction.

Case 31
A 999 call on Christmas Day was placed to attend an elderly gentleman who was unable to get up out of a chair, despite the help of visiting friends. The call was processed as an 'assist only' and after a delay a PTS crew were dispatched. Once on scene it transpired that the expectation was that the patient would be taken to hospital for assessment as his friends were concerned that he would not be able to manage at home on his own. This incident highlighted that the lines into UOC are not recorded as are those into EOC. IM&T have been asked to look into this matter. The incident also highlighted the need to explain our social care referral system and the role we have to play in the social care pathway.

Case 32
A patient who had been assaulted and sustained a facial injury felt unable to converse with the attending ambulance staff and elected to respond to their questions by writing in his notebook. The reason for the patient's limited responses was misunderstood by the ambulance staff and the ensuing breakdown in communications resulted in the ambulance staff and the patient interpreting each other's actions in a completely different way. The ambulance staff concerned subsequently engaged in a reflective practice exercise and a request was made to the Education and Development department to consider placing an article in the Trust's in-house magazine in relation to best assessment practice where a patient is unable to communicate.

Case 33
The family of an elderly patient with a history of mental health problems called for an ambulance as they were unable to cope with her increasingly erratic behaviour. Based on the information provided during the 999 call, the ambulance crew were asked by EOC staff if they required police attendance at the address. The ambulance staff declined but they did make mention of this while on scene which prompted a breakdown in communication with the patient's family. A full explanation of the practice of seeking police assistance was offered to family. The case is being referred for use, in an anonymised form, as part of the 'Excellence in Patient Communications' training.

Case 34
A Patient suffered burns from hot oil; the FRU felt the burns were superficial and the patient was not conveyed; later the patient underwent surgery and skin grafts. The patient had signed the Patient Report Form (PRF) as consent of non conveyance. The Medical Director advised that all crews should use the capacity tool and document any concerns. It was also suggested that a review of non conveyed patients be considered to ascertain whether the capacity tool was used and how any discussions with the patients were recorded. Clinical Audit and Research are at present reviewing non conveyed PRFs including aspects of care on consent and capacity.

Gary Bassett
Head of Patient Experiences

May 2009

London Ambulance Service NHS TRUST

TRUST BOARD 19 May 2009

ANNUAL EQUALITY REPORT 08-09

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

2. Purpose: For noting.

3. Summary

This report provides information on the LAS workforce profile for 08-09, includes a progress update on recommendations made in the previous report (07-08) submitted to the Trust Board on January 27 2009 and sets out further recommendations for actions to be taken over the coming year to promote best practice on equality & diversity.

The full report containing all the reporting data can be accessed electronically and will be published on the Trust's public website.

4. Recommendation

Trust Board are asked to:

- *Note the Executive Summary report, which highlights the progress on equality & diversity issues in the year April 1 2008 – 31 March 2009, detailed in the attached report.*

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD BOARD MEETING 19 MAY 2009

EXECUTIVE SUMMARY OF ANNUAL EQUALITY REPORT 2008/2009

1 INTRODUCTION

This report provides an executive summary of the 2008/2009 Annual Equality Report , which will be available on the Trust's website.

The last Annual Equality Report, covering the period from April 1 2007 to March 31 2008 retrospectively, was received by the Trust Board on 27 January 2009.

2. PROGRESS SINCE LAST REPORT

A number of recommendations were made in the last report, which have been progressed as follows:

- A standard monitoring template for the collection of equalities monitoring data is being drafted, to be used by each service area across all its functions, activities, employment & training & engagement practices. A report on this will go to SMG in the summer and thereafter the Trust Board.
- A survey questionnaire has been drawn up to seek the views of staff on the possible establishment of new staff diversity networks.
- LAS has now joined the Employers Forum on Age and the Employers Forum on Belief; discussions have also been held with the Employers Forum on Disability, which LAS had joined previously, to promote dissemination of best practice on recruitment and retention of disabled people.
- An initial meeting has been held with Stonewall and an application for assessment of LAS against the Stonewall Workplace Equality index of the top 100 UK employers will be made this year before the deadline in September 2009.
- Management information processes are being improved to ensure the information provided in the Annual Equality Reports is as comprehensive and qualitatively robust as possible and that any action necessary for the identification and improvement of management information systems can be identified and planned for.
- Benchmarking with other ambulance services is currently underway through involvement in the National Ambulance Association Diversity Forum and also through a questionnaire survey of other Ambulance Trust practice on equality monitoring.
- The Equality & Diversity Team is meeting with the Recruitment Manager, PPI Manager and Communications Team to devise a strategy of initiatives targeting under-represented groups, including use of advertising media and involvement in recruitment events, schools & careers days and other external initiatives.
- An initial meeting has been held with communications to discuss a PR campaign aimed at promoting the service as an employer of choice for black

and minority ethnic people, disabled people and women and members of other under-represented groups and this campaign will be launched later this year

I. LAS will be taking up the option of a free profile in the Stonewall "Starting Out" free recruitment guide, aimed at students and people wishing to follow a new career; this guide goes out to all universities, secondary schools, career services and youth groups across the UK.

3. OTHER KEY INITIATIVES

- To ensure the Trust's ongoing compliance with its duties under existing equalities legislation and its preparedness for the requirements of the forthcoming Single Equality Act, a new generic Single Equality & Diversity Strategy is being drawn up, which will take forward the work from the previous Race, Disability & Gender Equality Schemes and build in the three new additional strands of age, religion and belief and sexual orientation. A report on the new strategy, which will be extensively consulted on, will go to the Trust Board later in the year.
- All current equality impact assessments are being published on the LAS website and a new three-year schedule of equality impact assessments of LAS policies, procedures, strategies & functions will be published shortly.
- A review of all the current equality & diversity training programmes within the Trust will be undertaken, covering induction, managers' and team leaders' training and recruitment & selection training, with a view to integrating and mainstreaming this training wherever possible and to identifying any further essential training required
- A report has been presented to SMG in May proposing a new strategic approach to LAS's involvement in key equalities initiatives

4. CONCLUSION

- Within the two months' gap from the previous report every effort has been made to obtain more robust statistics, quantitatively and qualitatively, on each of the key functions and service areas of the Trust. However, given the necessity of a fundamental systems review of how data is collected and monitored within the Trust, some of the major improvements required are not expected to take effect until the coming year.
- The LAS 07-08 Workforce Profile comprised 8.6% BME staff and 39.7% women, with no statistics available on disabled staff. The LAS 08-09 Workforce Profile comprises 9% BME, a slight increase on the previous year's figure, though well below the Census 2001 estimate of 28.8%, and 41% female, which again represents a slight increase on the previous year, but is also not representative of the Census estimate of 51%, with again no statistics available on disabled staff. The Healthcare Commission's "Tackling the challenge – Promoting race equality in the NHS in England" report (March 2009) estimated that BME staff represented 16% of the total workforce, with fewer than 10% of senior managers being BME staff. The 08-09 LAS profile shows that although representation of BME staff in LAS is still well below the NHS-wide estimated figure, there are considerably more higher-graded BME staff in LAS – 15.3% - than the NHS- wide estimate. Only 11.1% of women staff are at senior grade level in LAS, less than the equivalent percentage of

BME staff. The full Annual Equality Report 08-09 provides detailed information on the LAS profile, including breakdown by grade/rank, staff group, length of service, pay band, age, starters and leavers, promotions, employee relations activity and applications and uptake of training as well as information on take-up of key services.

- There has been substantial PPI activity and engagement with patients and key stakeholders and several key equality and diversity initiatives are in planning, which will support and extend this activity, outlined in a separate report.
- The Trust has undertaken some major steps to benchmarking its performance on equality & diversity, through its ongoing involvement in the National Ambulance Diversity Network and its application later this year for assessment against the Stonewall Diversity Champions Workplace Equality Index of top 100 employers.
- The 2009-10 Annual Equality Report should see the productive conclusion of a host of equality & diversity initiatives, outlined in this and the previous reports.

5. RECOMMENDATIONS

1. Where there are any I.T. systems currently in place which are not sufficient to provide comprehensive and qualitatively robust data (as highlighted in the report), these be urgently reviewed, amended or changed by the departmental Director, to ensure the Trust is able to report on its workforce profile, service usage and engagement & decision-making practices across all six equality strands for the future (this will ensure LAS compliance with the Core Standard 7e – discrimination and prepare LAS to meet the requirements of the new Equality Act.
2. All service managers and function holders throughout the Trust monitor and review the information on take-up of or access to their function or service across equality strand groups, in accordance with existing and forthcoming equalities legislation, to ensure that any barriers faced by people from disadvantaged groups when accessing services or employment and training can be identified and removed; this should form an intrinsic part of the equality impact assessments service managers and function holders are required to undertake on their service or function, along with any policy or procedure, **before** these are implemented (with any equality impact assessment of three years' standing needing to be reviewed immediately as a matter of course);
3. As the responsibility for the review of the systems used in the collection of monitoring and reporting data lies with the department in which the service or function is based, the specific recommendations for enhancement in data collection and reporting made by individual service managers in this report be considered and an action plan put in place to take immediate action to address any barriers to equalities monitoring, review and reporting, to ensure that the information required for the 2009-2010 report can be easily provided;
4. A comprehensive data refresh be carried out, to update disability status & other equality strand data of staff, either through self-serve or a manual survey; this needs to be accompanied by advanced publicity, reinforcing the Trust's commitment to employing disabled people, as a "Two Ticks – Positive about Disabled People" employer;

5. A systematic review of all equality & diversity training in the Trust, including induction, managers' and team leaders' training and recruitment & selection be undertaken by the Equality & Diversity Team, in conjunction with other relevant colleagues, to ensure the Trust's visions and values on equality & diversity are inculcated in and embodied by all staff;
6. Exit surveys be conducted systematically throughout the Trust to identify reasons for staff leaving the organization, in particular staff from under-represented groups; the surveys should be conducted by a trained member of staff other than the individual's line manager;
7. Future staff surveys include questions on staff satisfaction with the Trust as an employer, including questions around career development and diversity; these questions should be able to be evaluated to identify responses and satisfaction by equality strand groups;
8. To ensure that the publications/media used by LAS in recruitment exercises are the most appropriate for attracting candidates from under-represented groups, the Recruitment Team track this through the relevant section on the application form asking where applicants were made aware of the job advertisement, so that application routes can be broken down by equality strands and the success of specific media can be assessed.

Janice Markey
Equality and Diversity Manager
11 May 2009

BACKGROUND PAPERS
Annual Equality Report 2008-09

London Ambulance Service NHS TRUST

TRUST BOARD DATE 19 May, 2009

PTS Strategy

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

PTS Strategy has been reviewed over the last six months by both SMG and the Trust Board.

At the SDC away day in April 2009, an update on the business and a revised strategy was presented to the Trust Board.

After this review, the attached strategy paper is presented to the Trust Board for approval.

4. Recommendation

The Trust Board approves the strategy to maintain the current PTS business as a profitable, separate business unit.

PTS Strategy 2009/2010

1. Introduction

The current PTS market environment is unclear as the NHS in London is faced with a series of complex changes. In particular restructuring in the provision of services and the drive for financial stability is affecting the way PTS is commissioned and delivered.

An NHS London procurement framework was introduced in the last financial year to bring about a consistent procurement process. Given that the main drive was to place the financial risk of PTS onto the providers, at this time it would be debatable that either of these goals have been achieved.

From 1 April 2009 PCTs became responsible for the commissioning of PTS. Funding for PTS is no longer included in the PTS tarrif. The impact of this is still unclear but it is expected that PCTs will take a more active role in commissioning PTS services, either individually or on a consolidated basis. Given the fragmented nature of the current PTS market in London (40 + contracts), this change in commissioning will take some time to come into effect..

The restructure of services under Healthcare for London could potentially bring about a division in procurement with better definitions of more complex clinical transport as opposed to more routine local transport required for Polyclinics. With potential increase in the number of patients requiring transport it is likely the size of the market will increase at the more unscheduled bottom end of the market, whilst the more complex journeys will see a slower, linear, increase in demand.

The current financial climate is likely to affect all three parts of the patient transport relationship (patients, customers and providers). Increasingly, the economic downturn will affect patients' ability to afford access to healthcare. Although provision of PTS is based purely on medical need it is likely that there will be an increase in numbers as social factors come into play.

Funding for the NHS has been guaranteed for the next 2 years. However, pressure will increase on costs during this period in the expectation of wide ranging cuts to follow. This of course could be accelerated with a change of government in the intervening period.

With the hardening on credit coupled with pressures to reduce cost by the customer, there is potential that the financial viability of PTS providers to be stretched.

PTS Income was £10m in 2008/09 and achieved a small surplus after a difficult financial year.

2. Current Strategic Position

LAS PTS currently provides a range of services. This includes the more clinically needy patients, such as those with chronic heart conditions and stroke; to patients with little medical need such as those attending appointments for anticoagulant. This range in services has been driven by customer requirements and a focus to find a "one stop shop" transport solution.

Consideration in tendering has therefore centred around ability to provide a range of quality, cost effective, services. In this respect the LAS has not differentiated itself from the competition and in some cases has struggled to compete against smaller competitors with lower overheads and unit costs.

PTS is perceived as a middle of the road provider with little strategic differentiation from other competitors in the market place. It has also suffered from an uneven investment strategy from the LAS in terms of both management and financial investment.

From a financial perspective, it is estimated that at least £700k of additional corporate overhead should be attributed to PTS. As we develop our Service Line Reporting, this analysis will be updated.

Consequently over the past 2 years PTS has strived to take advantage of its pan-London coverage, using scale and known infrastructure to differentiate us from the competition. To increase efficiency and reduce costs to supplement this, PTS has developed a new operating

model around formation of two Transport Operations Centres and mobile communications solutions.

To support these developments PTS requires a more commercial focus and business centred approach in how it promotes and operates its business. This will become increasingly important with rapid changes to services likely to happen in the near future on existing contracts and in an environment where disputes are more likely to arise between PCTs and Acutes of payment for particular patient journeys.

Under current market conditions we are working towards being able to continue to provide a total range of transport services. However, dependent on the changes which Healthcare for London will bring about LAS is ideally placed to review its current strategy to specialise into more high dependency/clinical type journeys which will arise from specialist treatment centres or increase lower skills to deploy more drivers for provision of journeys for GPs, PCTs and polyclinics.

It is probable that many of our competitors will compete for the lower end of the market with less competition at the higher end. However, the new operational model will allow PTS the option to decide to narrow its focus if required. Additionally, we are placed to consider other opportunities which may arise from the changes to PCT provider arms. We remain a competent operation in the provision of patient transport services and there may be scope, with greater commercial awareness, to provide other mobile healthcare services.

Increasingly, PTS is supporting the core A&E function in a limited capacity on specific events and in undertaking some PTS suitable Cat C and green calls. In occupying this space PTS is able to minimise the use of other providers who may see this as a potential growth area and consequently potential risk to income for the larger organisation.

Increasingly PTS is positioned to provide additional support in this area and this strengthens the links with the core business across the service.

3. Strategic Review

Against the current strategic position, PTS has reviewed the 4 following options:

- Maintain market position;

  This option considered continuing the current opportunistic strategy and would be demonstrated though:
  - Profitable, standalone PTS Business
  - Improved portfolio of contracts each making a viable contribution
  - Producing sustainable annual net profits in excess of £500k

- Grow Market Share

  This could be achieved through dramatic reduction of prices, however, to make this meaningful in the short term, PTS would need to reduce cost quickly which is not achievable given that 80% of overheads is attributable to staff costs.

  Although in the short term quick growth could mask current inefficiencies in the operational model, the medium to long term position would lead to wide scale monetary losses.

- Joint Venture/Partnership with other Provider

  The current range of potential PTS partners would require extensive market intelligence. Given the current economic climate it would be more appropriate to consider this as a potential future option.

  If the conditions remove some of the current providers this may encourage other larger brands to either increase their market share or open the door to other larger transport companies to enter.

In seeking a joint venture or partnership the LAS would need to be confident that the other party was viable and that practices could not compromise the LAS brand.

- Exit the Market

  LAS could adopt one of two exit strategies:

  - Managed withdrawal: give notice to contracts over a defined timescale;
  - "Lose" contracts: Do not bid for contracts once they come due for renewal.

  In both cases could the current group of other providers take on an additional 20% of the market? There is potential that a number of providers could over extend their ability to deal with additional work and would customers look to the LAS to assist in providing services if they failed? What would our response be?

  Given very recent investment in PTS (PTS planning system, mobile data solution and vehicles) and the organisations ability to remove all surplus PTS staff from the organisation: it is conservatively estimated that an exit from the market would cost approximately £1m.

  If LAS were to adopt the "lose contract" option the final contract would be Barnet, Enfield and Haringey Mental Health Trust, which would cease in 2013.

4. Conclusions

The current PTS market outlook is unclear both in terms of the services to be provided in the future and the commissioning arrangements.

There will be a drive in the near future to see further reduction in price and with increasing operation costs there is likely to be a decline in the number of operators in London.

Healthcare for London restructuring is likely to bring about clearer definitions in the provision of high end ambulance transport as opposed to low end taxi type services.

Current development of the LAS PTS is moving to a new operational model to increase flexibility in resources and to reduce cost through efficiencies of scale by using its pan-London infrastructure and mobile data solutions.

LAS is well placed to be opportunistic in the type of contracts it bids for in future, given its broad range of services which it currently provides. As the market place develops future consideration can be given to specialisation of services or to consider additional services which could become available from the divestment of PCT Provider arms.

There is a requirement for more commercial focus both in terms of brand awareness and, more importantly, management of existing contracts.

To develop the brand the LAS must ensure consistent investment both in terms of resources and senior management time. In return, PTS should become more resilient, both commercially and from an organisational perspective.

PTS continues to support the core business through events and delivery of PTS suitable Cat C calls. That there is an opportunity to develop this further which draws closer links between PTS and the core. This potentially defends the bottom end of the A&E workload from predatory third party providers and ensures maintaining income into the future.

To maintain the current market position strategy the PTS business must become standalone and profitable. It must generate a sustainable net profit of £500k and will be achieved through current development activity and better contract portfolio management.

Wholesale market growth is untenable given that it can only be achieved through rapid price and cost reduction. This would lead to a failure of the operation or to financial loss.

Further market intelligence would be required to consider a partnership. However, given the fractured nature of the market there currently is no one provider who could guarantee provision of service. This may change as the financial impact of the current recession moves through the market and either strengthens the position of one of the other current providers or allows a bigger national transport provider enter the market.

An exit from the market is achievable although at a cost to the LAS. Questions remain about whether there would be capability within the marketplace to take on all the work the LAS currently undertakes. In addition would the LAS be expected to step in if any of the other providers fail.

5. Recommendations

- The LAS maintains its current market position by adopting an opportunistic strategy when tendering for work and considering more profitable work. The recent changes to the business will bear fruit in 2009/10 and deliver a profitable , more stand alone business unit.

- That PTS focus on being profitable across the whole contract base.

- Take advantage of any opportunities arising from HfL consistent with PTS core business competence.

- Improve operational effectiveness and flexibility

- Extend services provided to A&E to increase connectivity between core business and PTS; limit opportunities for competitors to enter Cat C/green call market.

- Review strategy again in Q4 2009/10.

London Ambulance Service NHS TRUST

TRUST BOARD DATE 19 May, 2009

IFRS Update

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

This paper provides a background to the introduction of International Financial Reporting Standards to the LAS and summarises the key changes which affect financial reporting.

4. Recommendation

The Trust Board note the report

LONDON AMBULANCE SERVICE NHS TRUST
INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRS)

FROM THE DIRECTOR OF FINANCE

1. Introduction

1.1. This paper provides a background to the introduction of International Financial Reporting Standards to the LAS and summarises the key changes which affect financial reporting.

2. Background

2.1. International Financial Reporting Standards (IFRS) refer to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that include accounting standards, interpretations and established accounting practice. It has long been recognised in the corporate sector that there is a demand for a single set of accounting standards as both business and the financial markets become global.

2.2. The Chancellor's 2008 Budget announcement introduced IFRS-based financial reporting for the government and public sector accounting from 2009/10.

2.3. The reasons for introducing IFRS include enhanced consistency and comparability between financial reports in the global economy and to follow private sector best practice.

2.4. Annual accounts for the NHS will need to be prepared using IFRS for the year ending 31 March 2010. The Trust is required to prepared an opening balance sheet as at 1 April 2009 which complies with IFRS . In addition, comparative financial statements for 2008/09 will be prepared and the opening balance sheet at 1 April 2008 will be restated. The Trust prepared its financial plans for 2009/10 and work on Foundation Trust application under IFRS.

2.5. The implementation of IFRS is a significant piece of work . In the private sector the size of the published accounts have on average increased by 60%.

3. Areas of work to complete

3.1. The significant areas of change for London Ambulance Service NHS Trust are shown in APPENDIX 1.

4. Financial Impact 2009/10

4.1. Ambulance Leases

Resulting from a change in the classification of leases for existing vehicles from operating to finance leases the effect on the balance sheet is to increase borrowings by £29m. This is because the financing of the Mercedes leases are shown as debt in the balance sheet with a corresponding increase in fixed assets. The fixed asset value will be depreciated over the life of the lease with the finance element shown as interest. The effect in the I&E is to reclassify lease expenditure to depreciation .There is no effect on the bottom line in the I&E over the life of the lease. Costs reclassified as a result of this amount to £4.9M.

4.2. Holiday pay

No impact on I&E actuals. Any adjustments will be to Prior Year profits through reserves in the Balance Sheet.

4.3. Mercedes Remount

Further analysis is ongoing with the Audit Commission and Baker Tilley.

4.4. EBITDA

As the operating leases are now included in depreciation, planned EBITDA increased by £4.9m.

5. RECOMMENDATION

5.1. The Board is asked to note this paper.

Mike Dinan

Director of Finance

May 2009

APPENDIX 1

Area of Change	Impact on the Trust	Trust Action required	Teams affected
Property Leases	Significant components of assets that have different useful economic lives for depreciation purposes are required to be recorded , valued and depreciated separately within the accounts. In practice this means that land and buildings will be recorded separately and with more detailed disclosure requirements on all leases that the Trust holds. The number of assets held on the fixed asset register which require to be administered each year will increase.	All lease arrangements must be scrutinised to ensure we account for each one correctly. This will be led by the finance and estate teams.	Finance, Estates and Capital
Segmental reporting	The Trust needs to disclose the carrying amount of each segment's assets and liabilities associated cash flows.	Trust Board to agree upon which segments it wishes to report for this new requirement. It is recommended that the Trust agree with its external auditors which parts of the Trust constitute separately reportable segments.	Executive Directors
Financial Instruments	Long term contracts where there are variables to the amount paid in year (e.g. if there is an RPI element to payments).	Full review of Trust-wide long term contracts.	Finance, HR, IM&T, Procurement, Estates and Capital
Annual leave carried forward accruals	The Trust must accrue expenditure to account for staff carrying forward annual leave across financial years. This data is currently not collected centrally therefore this will be sought for the first time. It will also need to be available to allow the 2008/09 accounts to be prepared as a comparator.	All directorates will be required to submit a return for the end of March 2008 and March 2009 detailing the number of days annual leave team members will be carrying forward at the year end.	All Directorates
Accounting Policies	The Trust needs to include the new accounting policies within its accounts. It is required to make an explicit and unreserved statement of compliance with IFRS.	The Board is required to formally adopt the new accounting policies under IFRS	Executive Directors
Ambulance Leases	The issue is to determine where the risks and rewards of ownership of an asset held under a lease lie. The test under UKGAAP allows the Trust to treat ambulance leases as operating leases. Under IFRS the test is more onerous with more lease arrangements likely to be treated as finance leases. The significance for the Trust is that finance leases will require the ambulances to be	All lease arrangements must be scrutinised to ensure we account for each one correctly. The final accounting treatment needs to be agreed with our Auditors.	Finance, Procurement and Operations

	treated as fixed assets with the financing shown as a debt obligation in the balance sheet. This treatment will require a greater quantum of funding to be available to the Trust.		
Inventory	The Trust currently uses the last in first out (LIFO) method of valuation of its inventory. This method is not permitted under IFRS.	The inventory needs to be valued using the first in first out (FIFO) or weighted average valuation techniques.	Finance, Procurement and Operations

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
MINUTES OF THE ANNUAL GENERAL MEETING

Tuesday 30th September 2008 at 2.30pm
Held in the Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Present:

Sigurd Reinton	Chairman
Peter Bradley	Chief Executive
Non Executive Directors	
Caroline Silver	Non Executive Director
Sarah Waller	Non Executive Director
Beryl Magrath	Non Executive Director
Roy Griffins	Non Executive Director
Barry McDonald	Non Executive Director
Ingrid Prescod	Non Executive Director
Executive Directors	
Caron Hitchen	Director of Human Resources & Organisation Development
Mike Dinan	Director of Finance
Fionna Moore	Medical Director
Martin Flaherty	Director of Operations

In Attendance:

Peter Suter	Director of Information Management & Technology
Kathy Jones	Director of Service Development
Margaret Vander	Patient, Public Involvement Manager
Angie Patton	Head of Communications
Alan Hay	Emergency Bed Service
Leyla Strutt	Emergency Bed Service
Christine McMahon	Trust Secretary (Minutes)
Malcolm Alexander	Member of the LAS Patients' Forum
Mark Mitten	Member of the LAS Patients' Forum
John Larkin	Member of the LAS Patients' Forum
Sr. Josephine	Member of the LAS Patients' Forum
Gary Orris	Member of LAS Patients' Forum
Richard Rees	Member of the Public
Catherine Gustav	Member of the Public
Owen Cock	Member of the Public
Mary O'Dwyer	Member of the Public
Michael English	Lambeth Link
Mark Jones	RSM Bentley Jennison
Clare O'Neill	British Heart Foundation
Katherine Peel	British Heart Foundation
John Walker	Assistant to Simon Hughes, MP
Wendy Mead	Health & Scrutiny Committee, City of London Corporation
Tracey Tyer	Just Communication (British Sign Language Interpreter)
Zane Hema	Just Communication (British Sign Language Interpreter)

1/08 Minutes of Annual General Meeting held on 26th September 2007

The minutes were **agreed** as a correct record and **signed** by the Chairman.

2/08 Chairman's Introduction

The Chairman welcomed the audience to the twelfth annual public meeting of the London Ambulance Service NHS Trust. He introduced the main speakers, Peter Bradley (Chief Executive), Mike Dinan (Director of Finance), Dr Fionna Moore (Medical Director) and Kathy Jones (Director of Service Development).

The Chairman said that 2007/08 had been an exceptionally successful year for the Trust with a number of improvements made in the care given to patients including the direct transport of patients suffering a STEMI attack to specialist stroke cardiac care units. The establishment of Clinical Telephone Advice has meant that many calls are resolved on the telephone without the need to send an ambulance or transport patients unnecessarily to Accident & Emergency departments.

The Healthcare Commission recently published a report on 'Urgent and Emergency Care across England' in which the LAS was cited as being one of the best ambulance services in the United Kingdom. The Healthcare Commission acknowledged that the LAS' position regarding Thrombolysis, for which it had been criticised in 2006/07, had been vindicated.

The Trust received additional funding in the latter part of 2007/08 to implement initiatives that would enable the Trust to achieve greater efficiencies in how it provided support to the front line operations. The Trust was currently negotiating with Commissioners on securing funding for a three year period as part of the Foundation Trust application process.

Lord Darzi's report, Healthcare for London, was warmly welcomed by the LAS. Senior personnel have been actively involved in the different Programmes (Stroke, Unscheduled Care etc) to implement the vision of the Healthcare for London.

3/08 Report of the Chief Executive

The Chief Executive thanked the Communications Department who had produced the 2007/08 Annual Report; this year's theme was the development of the Service over the last six decades as part of this year's commemoration of the NHS' 60th anniversary.

The Chief Executive said that the LAS was one of the busiest ambulance services in the world, with demand in 2007/08 increasing by 3%. It received 1.4 million 999 calls in 2007/08 which was an increase of ten thousand on the number of calls received in 2006/07. There have been improvements in the speed at which calls are answered, two seconds is the average length of time for a call to be answered. Of the 100,000 calls received by the Urgent Operations Centre in 2007/08, approximately 50,000 were deemed appropriate to receive telephone advice rather than a vehicle to transport to A&E.

The Chief Executive said that there had been 2.5 million patient contacts in 2007/08, with the Trust receiving thousands of letters of support, expressing thanks for the assistance and care received from members of staff. The Trust also received 550 letters of complaint, which although each letter was taken seriously, reflected well on the Service given the volume of work undertaken.

To ensure it can provide the best service possible the Trust has recruited an additional 270 members of staff in 2007/08 and was planning to recruit a further 400 members of staff in 2008/09.

The Trust has made a very good start in planning for the accident and emergency service to be provided to athletes and people who are otherwise associated with the Olympics so as to ensure that the service provided to London is not affected. The LAS is co-ordinating provision of accident and emergency response to the Olympics through close liaison with other ambulance services. Additional funding for the planning work being undertaken by the LAS has yet to be confirmed.

The new control system (CAD 2010) for the Emergency Operations Centre will be installed in the next 18 months and will provide the Service with modern technology to answer calls and despatch vehicles.

4/08 <u>Finance Director's Report</u>

The Director of Finance presented the accounts to the meeting. The Trust fulfilled all four of its statutory financial duties in 2007/08:

- On income and expenditure the Trust reported a surplus of £397,804 for the year and therefore did better than the break even target set for it by the Department of Health for 2007/08;
- The Trust achieved its EFL (external financing limit) for the year.
- A return on assets (the capital cost absorption duty) of 3.7% was achieved. This was within the permitted range of 3.0% – 4.0 %.
- As part of the Trust's capital programme £10.8m was spend on arrange of projects such as the purchase of fast response vehicles (£3m); improvement of the Trust's estate (£3m), the introduction of technology (£4m).

The Director of Finance said that in respect of the Trust's income of £236m, 90% of it was from the Primary Care Trusts in London who commissioned the accident and emergency service. In terms of expenditure, 73% of the Trust's income was spent on salaries and the percentage spent on management costs was 6.8%.

The Director of Finance confirmed that since the end of the financial year, 3rd April 2008, there were no impact events occurring after the year end that had a material effect on the 2007/08 accounts.

Noted: That the 2007/08 Financial Statements were presented to the Annual Public Meeting by the Director of Finance

5/08 Presentations on key LAS developments:

Clinical developments within the LAS, presentation by the Medical Director

The Medical Director said that on an average day the LAS receives 1: 4 of all ambulance calls made in England and Wales, which amounts to approximately 3,500 999 calls per day requiring the despatch of 2,500 responses. Of those responses 850 of the 2,500 were to patients assessed as being Category A (incidents that are immediately life threatening) and 73% of these patients were reached within 8 minutes.

The Medical Director highlighted the following developments and initiatives undertaken during the year.

<u>Patient Care Issues</u>

- The development of alternative care pathways for patients who do not need to be in hospital e.g. the introduction of Clinical Telephone Advisers;
- The delivery of training modules on resuscitation, patient assessment and manual handling;
- The development of new training modules on Obstetrics, ECGs and Mental Health developed;

- The development of the Student Paramedic training course which will be implemented in 2008/09;
- Improved staff support with the appointment of an Assistant Medical Director (Control Services); a Consultant Midwife and the establishment of a Clinical Support Desk offering around the clock advice;
- The introduction of improvements in the way that Clinical Performance Indicators (CPIs) are used to audit patient care as documented on the Patient Report Form. Front line crews can now access data about their own clinical performance so as to enhance their learning opportunities and identify areas of care that might be addressed through a complex's refresher training programme.

New Drugs & Equipment

- Oral morphine and Clopidogrel have been introduced to improve pain management.

Infection Control:

- PTS vehicles and Fast Response Units will be included in the Trust's existing Make Ready Scheme;
- Intravenous canulae packs will clearly identify when out of hospital canuale have been undertaken;
- Haemorrhage control, this is undertaken when catastrophic haemorrhaging is taking place, e.g. railway, traffic, gun or knife wounds.

Innovative practice

- All patients suffering heart attacks are now taken directly to London Chest Hospital (East London);
- A feasibility study is being undertaken in West London in cooling cardiac arrest patients; this approach is widely used in Scandinavia and parts of USA and. The objective of the treatment is to minimise neurological damage and maintain brain function;
- Non invasive ventilation (CPAP) for hear failure patients (Whipps Cross); this is based on treatment pioneered in the USA.

The LAS' involvement with the implementation of 'Healthcare for London': Presentation by the Director of Service Development

The Director of Service Development shared the following vision statement for the LAS as "an organisation of well trained, enthusiastic, caring people who are **all** recognised for their dedication to meeting the needs of **all** our patients".

Approximately 10% of the LAS' patients require emergency treatment; the remainder need something else, and often have complicated health issues. The LAS is endeavouring to deliver appropriate care to all its patients, whether by despatching a Fast Response cars to a life threatening incident or by treating on the telephone and advising other courses of action e.g. visiting local GP or Walk in Centre. Patients requiring specialist care e.g. in the event of cardiac arrest, trauma or stroke will be transported longer distances in order to ensure that they receive the appropriate treatment. Studies have shown that patients have better outcomes when they are treated at specialist centres.

As part of Healthcare for London specialist centres will be established in London to treat cardiac arrest, stroke or trauma; they will be relatively few in number and this will be something that the public may find challenging. From the LAS' point of view it is important that front line crews feel confident in transporting patients for longer distances in order that they receive appropriate care at the specialist centres.

For many patients hospital is not the best or preferred option as they would like to be treated, if possible, in their homes; work is being undertaken to facilitate this through the introduction of telephone advice, the use of community matrons, etc.

Healthcare for London is currently considering a new telephone number that Londoners will use to access healthcare. Currently people can phone NHS Direct, the LAS via the 999 emergency system and Out of Hours Doctors. Ideally information will be shared between the different facets of the system to ensure that the patient receives optimum level of care.

6/08 Questions from the audience

Members of the public asked questions concerning the following subjects:

1. ***Duplication of services by the LAS and NHS Direct:*** The Director of Service Development said that work was being undertaken with the NHS Direct to develop links between the two organisations to minimise the danger of duplicating services.
2. ***Transporting of patients to specialist centres:*** Patients will be taken to the most appropriate treatment centre e.g. trauma or stroke and, if the patient has a long term condition and is receiving treatment at a specific hospital, he/she will be taken there unless there is a good reason why they cannot be. Alternative care pathways are in development and not all of them are available 24 hours a day/7 days a week and so for some patients there may be no option but to take them to the nearest A&E.
3. ***The service received by sufferers of Sickle Cell:*** The Medical Director said London was not unique in having a large number of patients with Sickle Cell; cities such as Birmingham also have a high number of patients with Sickle Cell. The LAS contributes evidence to national fora, providing evidence of best practice and giving feeding back on local experiences.
4. ***The service received by patients with Mental Health issues****:* Work is ongoing to develop alternative care pathways. One NHS Trust has the facility to directly admit patients with mental health issues rather than the patient having to be admitted via the general A&E route. Internally, the Trust has improved the training given to staff when they join the Trust and as part of the development of front line staff educational modules on mental health will be introduced. The Director of Service Development said the Trust received very positive feedback when the 1990 Trust facilitated black focus groups about their experience of the LAS.
5. ***Measures taken by LAS to encourage people to call A&E service appropriately?*** The Trust has undertaken various campaigns to encourage members of the public to use the Service wisely (e.g. the recent poster campaign '*break glass in an emergency'*) and will continue to do so. There are a small number of patients who frequently and inappropriately call the Service, often because they do not have the right care package in place. The Trust's Patients Advice Liaison Service (PALS) has had a number of successes during the year working with colleagues in Social Services and local mental health teams to develop a care package to support these individuals. More recently the Trust has employed a Social Worker to liaise with Local Authorities.
6. ***Cardiac attack Survival rate:*** Of the calls deemed to require a response within eight minutes, approximately 10% were life threatening. Success is measured not necessarily by resuscitation, which the front line crews undertake on patients suffering heart attacks, but whether the patient was discharged from hospital and was able to return to a 'normal' life. A patient's resumption of a normal life brings in a number of factors beyond the control of the LAS. In 2007/08, 80 to 90 people who suffered a cardiac attack who would otherwise be dead survived to lead a normal life.

7. ***In response to a question concerning delays***, the Chief Executive said that the Trust has a target of 75% for Category A calls that require a response within 8 minutes and 85% for those calls deemed to require a response within 19 minutes (Category B19 minute).

   The Chief Executive said that although delays were experienced in despatching ambulances it was predominantly at the weekend and did not involve life threatening incidents. The Trust's Management Information department produced data for recent months that showed the longest delay in any one month was an average of 10-20 minutes and did not involve any incidents where there were life threatening situations or vulnerable patients such as elderly fallers.

   To address the issue of delays the Trust has introduced initiatives such as Cycle Responders who were stationed in the West End or the City to respond to calls quickly and, as had previously been stated was in the process of recruiting additional front line staff to improve staffing resources in order to minimise delays.

   Claire O'Neill of the British Heart Foundation congratulated the Trust on the work undertaken by the Community Response Team (as described on page 10 of the Annual Report) who have been responsible for the distribution of defibrillators in public places in London and training members of the public on how to use them. The project's objective was to improve survival rates for out of hospital cardiac arrest events.

   The Chairman said that he was hopeful that the Greater London Authority could be persuaded to support a greater degree of training of Londoners in Basic Life Support so as to improve cardiac survival rates.

In closing the Chairman thanked the management team of the LAS on behalf of the Non Executive Directors.

The meeting closed at 15.40 hours.

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Chairman

Enclosure 13a

London Ambulance Service NHS TRUST

SUMMARY OF THE DRAFT MINUTES
CLINICAL GOVERNANCE COMMITTEE 23 February 2009

1. **Chairman of the Committee** **Beryl Magrath**

2. **Purpose:** **To provide RCAG with summary of proceedings of Clinical Governance Committee meeting on 23 February 2009**

3. **Agreed**

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- Head of Clinical Audit and Research to give update on scanners and cards at CGC meeting in August (now revised to July).
- That future Area Governance reports include graphic comparisons with previous reports/ years and concentrate on exception reporting
- ADO East to conduct an annoymised case study and place on the Pulse once completed. and to ensure that Internal Auditors conduct a morphine audit
- That Dr. Tom Evans to be invited to the CGC meeting in August (now revised to July)) to discuss V.A.S. (Voluntary Ambulance Services), in particular governance, quality assurance, education and training and any other issues of significance.
- That the discussion required around CGC planning should take place outside the Committee meetings and be reported to the next CGC meeting in August 2009 (revised to a date in July).
- The August meeting would take place in July 09

4. **Approved**

- OP/045 procedure for Patients Suspected of Alcohol and/ or drug Intoxication subject to agreement being received from staff-side
- TP/008 Policy n the Supply and Administration of Medicines under Patient Group Direction subject to minor amendments by the Assistant Director of Organisational development.

5. **Noted**

- A presentation on Healthcare for London
- PPI Action Plan 2008-2012
- A presentation on Community First Responders (CFR)
- HCC: 2008/09 Final Declaration - The Trust would be able to declare compliant on all standards by 31 March 2009 – though at present C4-d "Medicines are not handled safely and securely" was not met , but all actions will be completed by 31March 09
- Updated NHSLA Standards and Assessments - Preparing for achieving Level2 standard in 2010

6. **Minutes Received**

PPI Committee
Infection Control Steering Group
Standards for Better Health Group
Risk Compliance & Assurance Group
Clinical Steering Group
Training Services Group

7. **Recommendation** **THAT the RCAG note the draft minutes of the Clinical Governance Committee, 23rd February 2009.**

LONDON AMBULANCE SERVICE NHS TRUST

CLINICAL GOVERNANCE COMMITTEE
(Core meeting)

Minutes of the meeting held on Monday 23 February 2009
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	Beryl Magrath	Chair
	Fionna Moore	Vice-Chair
	Sarah Waller	Non Executive Director
	Kathy Jones	Director of Service Development
	Richard Webber	Deputy Director of Operations
	Nicola Foad	Head of Legal Services
	Bill O'Neill	Assistant Director, Organisation Development
	Stephen Moore	Head of Records Management & Business Continuity
	Margaret Vander	PPI Manager
	Phil Flower	ADO Control Services
	Paul Tattam	AOM D Watch
	Jason Killens	ADO East
	Tony Crabtree	Assistant Director, Employee Support Services
	Phil de Bruin	PIM South (for ADO South)
	Jon Knott	PIM West (for ADO West)
	Gary Bassett	Head of Patient Experiences
	John Selby	Senior Health and Safety Adviser
	Pat Billups	Educational Governance Manager
	Daniel Adams	Corporate Logistics Manager (for Head of Operational Support)
	Gurkamal Virdi	(for Head of Clinical Audit and Research)
	Barry Silverman	Patients Forum (for Malcolm Alexander)
	John Ellman-Brown	Trust Secretary
Apologies	Ingrid Prescod	Non Executive Director
	Fenella Wrigley	Assistant Medical Director, Control Services
	Peter McKenna	ADO West
	Paul Woodrow	ADO South
	Lizzy Boville	ADO
	Rachael Donohoe	Head of Clinical Audit and Research
	Chris Vale	Head of Operational Support
In attendance:	Chris Hartley-Sharpe	AOM i/c Community First Responder Project

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01/09 Apologies

The Chair noted apologies had been received from Ingrid Prescod, Fenella Wrigley, Peter McKenna, Lizzy Boville, Rachael Donohoe and Chris Vale.

02/09 Minutes

After review and due consideration by the Committee:

IT WAS RESOLVED THAT the minutes of the Clinical Governance Committee meeting held on 12 November 2008 be and are hereby confirmed as a true record of the meeting.

03/09 Matters Arising

1. ***Minute 56/08(2):*** It was confirmed that the data collected concerning the audit of CTA calls had been shared with CARU;
2. ***Minute 56/08(4):*** Some information in respect of the findings arising from the recent general review of the CTA function (that included the random review of PSIAM) was incorporated within the ADO Control Services Report. More detailed information was required and would be included as a separate Agenda item for the next meeting;
   Action: ADO Control Services
3. ***Minute 57/08(1)*:** The Trust Secretary confirmed that 5 job titles within the Committee's Terms of Reference had been changed as required;
4. ***Minute 57/08(2)*:** It was noted that all clinical groups acting for LAS as 3rd party agencies have CG arrangements in place. All these groups would be asked to submit a short annual report to the CGC;
5. ***Minute 60/08:*** The following policies were agreed for ratification by the Trust Board:
   - Policy & Procedures for the Management of Frequent Callers;
   - Policy for Pre-Hospital Blood Taking;
   - ECP Policy for Health, Safety & Risk Management Training & Provision of H&S information.
6. ***Minute 60/08(7)*:** The reference to the legal duty of LAS to attend calls where key symptoms had been reported was confirmed as deleted from the Frequent Callers Policy.

04/09 Area Governance Reports

The Committee received the following Area Governance Reports:

- **Control Services**
  - CSD staff took on some of the CTA work over Christmas and the New Year;
  - Community Involvement Officers were working hard to raise the profile of CSD;
  - EBS took GP calls from CTA in the previous 3 months, saving 85 hours of CTA call-takers time;
  - EBS-GP referral service numbers were low and Commissioners had requested a 15% increase in activity during 2009;
  - CTA is trying to recruit a designated Training Officer, to help identify training and development needs.

- **South Area**
  - CPI completion rate had fallen from a peak of 77% last May to 18% at present. The high REAP levels and use of Team Leaders and managers as operational staff or to manage acute hospital pressure were largely to blame;
  - 5 staff members in South Area were responsible for 18 vehicle accidents; these are being investigated;
  - South Area ADO has concerns and stated that improvements need to be made to satisfy the new reforms coming into force in October 2009 (Ministry of Justice Response to Consultation on Personal Injury Claims Process & Case Track Limits**:** **t**he new process will apply to RTA claims only).

- **East Area**
  - Two useful case studies were presented, highlighting once again the difficulties disseminating information and learning in a large organisation such as the LAS.

- **West Area**
  - The need to recruit more Practice Placement Educators onto vehicles in a 3rd manning or supernumerary position was highlighted. The West Area employs 146 at present, which will need to increase to 200;
  - The Brent Complex has introduced 2 new means of communication with staff:
    1. A monthly Complex Newsletter on all topical information; all staff are encouraged to submit articles;
    2. An electronic notice board.

The Committee thanked all presenters for their reports, which provided detailed and very useful information. It requested all future reports included graphical comparisons with previous reports/years and concentrated on exception reporting etc. where this was not done already.
Action: ADOs

05/09 **Medical Directorate Update**

The Committee received and noted the update presented by the Medical Director.

06/09 **Clinical Risks**

The Committee reviewed the Clinical Risks update, noting in particular that at its meeting on 16 February 2009, RCAG had reviewed the controls in place and agreed the following:

- ID71 be downgraded to Mod/6;
- Approval of the Risk Register process and new Risk Register Layout.

The Committee then reviewed the risks in detail as follows:

- 269: Likely to be downgraded once new staff are recruited;
- 31: Obstetrics data will be shared with Bill O'Neill for NWOW;
- 138: To be rolled out in May 2009;
- 22: Likely to remain permanently high risk;
- 207: Update on scanners and cards to next CGC meeting;
  Action: Head of Clinical Audit and Research
- 20: To be reverted to RCAG;
- 296: Wording in respect of staff exposed to risk at an incident to be reworded;
  Action: ADO East
- 301: "Anonymous" case study to be conducted and placed on The Pulse
  Action: ADO East
- 211: Agreed for Team Leaders to report anonymously. ADO East to take on at ADO level;
  Action: ADO East
- 138: Noted;
- 165: Noted;
- 179: Re-wording might be required due to new Race Relations Act;
  Action: Diversity and Equality Manager
- 305: Morphine audit to be conducted by Internal Auditors and presented to the Audit Committee;
  Action: ADO East
- 71: ADO Group to take responsibility;
  Action: ADO East
- 295: Noted.

07/09 **Clinical Policies and Procedures**

The Committee considered the draft of a new procedure for Patients suspected of Alcohol and/or Drug Intoxication as well as a revised policy on the supply and administration of medicines under Patient Group Directions, and received briefings on both.

After due consideration and debate:

- **OP/045 Procedure for Patients suspected of Alcohol and/or Drug Intoxication** was approved subject to agreement being received from staff-side;
- **TP/008 Policy on the Supply and Administration of Medicines under Patient Group Directions** was approved subject to minor amendment by the Assistant Director, Organisational Development.

08/09 **New Strategies/Developments**

The Committee received a presentation on Healthcare for London from the Director of Service Development.

It was noted by the Patients Forum representative that the consultation document made no mention of LAS. Ms Jones confirmed that the LAS was being funded for Stroke but had received no promises in respect of Trauma. Accordingly, no response had been made by LAS as no assurances had been provided by H*f*L.

09/09 **PPI**

The Committee was reminded of the PPI Action Plan 2008-2012 previously presented to them (a copy of which was included in the papers) and received a presentation from the PPI Manager.

10/09 **Special Reports**

The Committee received a presentation on CFR ("Community First Responders") from Chris Hartley-Sharpe, who took questions on completion. The Committee thanked Mr Hartley-Sharpe for his presentation.

The Committee requested that Dr Tom Evans be invited to the CGC meeting in August 2009 to discuss V.A.S. (Voluntary Ambulance Services), in particular governance, quality assurance, education and training, and any other issues of significance.
Action: Deputy Director of Operations

11/09 **CGC Planning Discussion**

The Committee agreed that this discussion should take place outside the Committee meetings and be reported to the next CGC meeting in August 2009.
Action: Trust Secretary

12/09 **Annual Health Check 2009/10**

The Committee received an update on the progress of the SfBH declaration due on 30 April 2009.

The Committee noted that it was likely the Trust would be able to declare itself compliant with all core standards by March 2009. However considerable work remained to be done especially on 3 new standards. At present **C4d "Medicines are not handled safely and securely"** was not met, but an Action Plan was in place to ensure that compliance would be met by 31 March 2009.

The Committee noted the report.

13/09 **NHSLA**

The Trust achieved NHSLA level one Standard following an improvement period. The report recommends to review the document management processes for approval and rectification and also to accurately describe the systems and processes in the documents. An action plan is developed for achieving compliance with the standards where LAS did not meet the minimum requirements. The Trust has agreed with the assessor to have informal visits on a quarterly basis to ensure that the Trust is on track with the progress of the action plan and on track for progress towards Level 2 by 2010.

The Committee noted the report.

14/09 **Reports from Groups/Committees**

The Committee noted minutes and reports from the following Groups and Committees:

- PPI Committee;
- Infection Control Steering Group;
- Standards for Better health Group;
- Risk Compliance & Assurance Group;
- Clinical Steering Group;
- Training Services Group

The Committee noted that the CARSG, Race Equality Strategy Group and Feedback, Learning and Improvement Group (superseding the Complaints Panel) had not met since the last CGC meeting.

15/09 **Next Meetings**

It was noted that the next CGC meetings were scheduled as follows:

- 27 April 2009 at 2:00 pm (core meeting)
- 10 August 2009 at 2:00 pm (full meeting)

Due to the August meeting falling within the school summer holidays, the Committee agreed that the August meeting be reprogrammed for a date in July.
Action: Trust Secretary

16/09 **Any Other Business**

The Assistant Director, Organisation Development reported that several of his roles were being taken over by Gill Heuchan, an example being Clinical Education. This would allow him to concentrate on other issues within his responsibilities. He would introduce her to the next meeting of the Committee.
Action: Assistant Director, Organisation Development

There being no further business, the Chair declared the meeting closed at 17:50.

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Chair

Enclosure 13b

London Ambulance Service NHS TRUST

SUMMARY OF THE DRAFT MINUTES
CLINICAL GOVERNANCE COMMITTEE 27th April 2009

1. Chairman of the Committee **Beryl Magrath**

2. Purpose: **To provide RCAG with summary of proceedings of Clinical Governance Committee meeting on 27 April 2009**

3. Agreed

- **Clinical Policies/Procedures**
  All clinical policies/procedures to be presented to staff-side for review/comment before presentation to CGC for approval/ratification.
- **Staff Education and Training**
  That of current staff is lagging behind that for new staff. To become SMG standing item. NEDs to take forward at TB level.
- **Clinical Risks**
  1. Following new risks approved for recommendation to RCAG for addition to Risk Register:
     - Required drugs/equipment not being available in drug packs/on vehicles leading to patients not receiving appropriate treatment;
     - Similar packaging of Glucose and Sodium Chloride may result in administration of incorrect drug, causing patient harm;
  2. Re-packaging of Glucose or Sodium Chloride to be considered to ensure easy identification and prevent administration of incorrect drug.
- **Risk Information Report**
  "Audit trail" to be created for all SUIs. Head of Patient Experiences to propose mechanism for reporting incidents as part of SUI policy.
- **"Six Lives" Report**
  Director of Service Development to comment on "Six Lives" report prior to Committee agreeing to recommendations.

4. Noted

- Infection Control Update-it was noted that no infection control audits had taken place in the last year. A full time appointment as Infection Control Manager was starting on 1st May
- Area Governance Reports-all reported poor levels of CPI audit, East Area reported only 14%
- Internal Audit Action Plans
- New National Targets 2008/09
- HCC: 2008/09 Final Declaration
- Updated NHSLA Standards and Assessments
- PPI Update
- CARU Update
- Patient Experiences Update

5. Minutes Received

- Infection Control Steering Group: 10 February 2009
- Risk Compliance & Assurance Group: 16 February 2009
- Clinical Audit and Research Steering Group: 13 March 2009
- Standards for Better Health Group: 26 March 2009
- Clinical Steering Committee: 20 October 2008

6. Recommendation **THAT the RCAG note the draft minutes of the Clinical Governance Committee, 27 April 2009.**

LONDON AMBULANCE SERVICE NHS TRUST

CLINICAL GOVERNANCE COMMITTEE
(Core meeting)

Minutes of the meeting held on Monday 27 April 2009 at 2:00 p.m.
in the Disney Room, The Union Jack Club, Sandell Street, London, SE1 8UJ

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Present:	Beryl Magrath	Non Executive Director: Chair
	Fionna Moore	Medical Director: Vice-Chair *(until 3:55 p.m.)*
	Sarah Waller	Non Executive Director *(from 2:15 p.m.)*
	Martin Smith	Head of Corporate Services *(from 2:30 p.m.)*
	Nicola Foad	Head of Legal Services
	Stephen Moore	Head of Records Management & Business Continuity
	Fenella Wrigley	Assistant Medical Director, Control Services *(until 3:55 p.m.)*
	Gary Bassett	Head of Patient Experiences
	Chris Vale	Head of Operational Support *(until 3:55 p.m.)*
	Laila Abraham	Head of Governance (Interim)
	Andrew Stainthorpe	Head of Clinical Audit and Research (Interim)
	Peter McKenna	ADO West *(until 3:55 p.m.)*
	Paul Woodrow	ADO South
	John Selby	Senior Health and Safety Adviser
	Paul Tattam	AOM Control Services
	Sue Watkins	(for ADO Control Services) *(until 3:55 p.m.)*
	Margaret Vander	PPI Manager
	Malcolm Alexander	Patients Forum
	John Ellman-Brown	Capita Company Secretarial Services (Minutes)
Apologies:	Ingrid Prescod	Non Executive Director
	Kathy Jones	Director of Service Development
	Richard Webber	Deputy Director of Operations
	Bill O'Neill	Assistant Director, Organisation Development
	Phil Flower	ADO Control Services
	Jason Killens	ADO East
	Paul Gates	PIM East
	Tony Crabtree	Assistant Director, Employee Support Services
	Pat Billups	Educational Governance Manager
	Lizzy Bovill	ADO

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17/09 Apologies

Apologies were noted as having been received from Ingrid Prescod, Kathy Jones, Richard Webber, Bill O'Neill, Phil Flower, Jason Killens, Tony Crabtree, Paul Gates, Pat Billups and Lizzy Bovill.

18/09 Minutes

After review and due consideration by the Committee, subject to minor amendment:

IT WAS RESOLVED THAT the minutes of the Clinical Governance Committee meeting held on 23 February 2009 be and are hereby confirmed as a true record of the meeting, and that they be signed by the Chair.

19/09 Matters Arising

1. ***Minute 03/09(4):*** *Previous Minute: 57/08(2)* All clinical groups acting for LAS as 3rd party agencies were to be asked to present a written report to the CGC on an annual basis.
   Action: Head of Governance (Interim)
2. ***Minute 03/09(5):*** *Previous Minute: 60/08* The Policy for Community First Responders was noted as having been published, however it was very short of purpose and therefore was to be completely rewritten.
   Action: AOM i/c Community First Responder Project
3. ***Minute 06/09:*** **Risk No. 207: S**taff uptake of scanners and cards was noted as being only 16%, and ways to increase this were discussed. The issue would be considered at the next meetings of both the ADOs and the Information Governance Group.
   Action: ADOs/Head of Records Management & Business Continuity
4. ***Minute 06/09:*** **Risks Nos. 71, 179, 211, 296, 301 and 305**: Discussion of these issues was deferred until the next meeting.
   Action: ADO East
5. ***Minute 08/09***: The Medical Director confirmed that LAS was now being funded in respect of Trauma, but that the funding was not included within the Trust's budgets.
6. ***Minute 11/09***: The CGC Planning Discussion was noted as not yet having been held. As previously indicated, the results of the discussion would be reported to the full CGC meeting in August 2009.
   Action: Trust Secretary/Head of Governance (Interim)
7. ***Minute 15/09:*** It was agreed that the full CGC meeting currently programmed for 10 August 2009 be rescheduled for 13 July 2009.
   Action: ALL

20/09 Clinical Policies and Procedures

The Committee considered drafts of the following new policies and procedures for approval or ratification:

- **OP/32: Alternative Response Procedure**;
- **TP/03: Policy Statement of Duties to Patients;**
- **OP/10: Procedure for the Maintenance of the High Risk Address Register**

It was noted that none of the drafts had been presented to staff-side for review/comment. Accordingly, it was agreed that all three policies/procedures be referred to staff-side first and then presented to the CGC for approval/ratification. This process was also approved for all such actions in the future.

Action: Head of Records Management & Business Continuity

21/09 Medical Directorate Update

The Committee received a briefing from the Medical Director who expressed her concern that LAS was losing its clinical focus and needed to concentrate on patient care.

Whilst there was new and improved training being provided for **new** staff, training for **current** staff was out of date and official training time insufficient – both needed to be updated and built in to ensure **all** staff were up to date. She confirmed that this was to

become a standard item on the SMG agenda. The Non Executive Directors agreed to take the issue forward at Trust Board level.
Action: Medical Director/Non Executive Directors

22/09 **Infection Control Update**

The Medical Director reported that the Trust was registered with the CQC and was in process of implementing the Ambulance Guidelines and applying for necessary funding.

The major issue at the present time was swine flu. Although the current threat to the UK was very small, pandemic planning was well advanced. It was reported that calls transferred to CTA from the EOC did not include pandemic advice; however it was possible that, following a meeting later in the afternoon, Card 36 could be introduced.

The Medical Director reported that no Infection Control Audits had been carried out within the Areas. In addition, with effect from 1 May, there would be one member of staff employed fulltime on Infection Control. Trevor Hubbard would be providing a report to the Trust Board on an annual basis.

23/09 **Area Governance Reports**

The Committee received the following Area Governance Reports:

- **Control Services**

Paul Tattam presented the report on behalf of Control Services:

- Within CTA, reviewers were currently being reviewed;
- CSD workload remained high with access reported per month between 900 and 1000 times (although February had been significantly underreported);
- Paul Tattam to ascertain EBS Medical Referee who validates their practise and report at the next meeting.
  Action: AOM Control Services

- **South Area**

Paul Woodrow presented the report on behalf of South Area:

- CPI completion rates were noted. From 1 May 2009, the Area had committed to release Team Leaders for clinical audit and PRF feedback;
- RT Collision Forms had been reviewed and were now in use across the Area. It was considered that 12 hour shifts had an influence on both staff attitude and the number of RTAs, but was not proven.

- **East Area**

No-one was available to report but the following points were noted:

- CPI completion (14%) continued to be a challenge due to operational pressures;
- An Area Risk Register was to be developed which would highlight specific risks germaine to the Area. It was noted as imperative that **all** risks be able to be seen by the Trust Board and relevant Managers; Ms Abraham would ensure this occurred.
  Action: Head of Governance (Interim)

- **West Area**

Peter McKenna presented the report for the West Area. There were no comments or questions arising from his report.

The Committee thanked all presenters for their reports, which provided detailed and very useful information and which the Committee considered to be much improved. ADOs were requested to continue with the improvement.
Action: ADOs

24/09 **Internal Audit Action Plans**

The Committee reviewed the papers presented, noting that the Audit Committee was responsible for **all** risks. The CGC saw all Clinical Risks first; these were then reviewed and graded by the RCAG before being put to the Audit Committee for final review.

ADOs were requested to impress upon staff that technician and paramedic packs **must** be returned at the ends of shifts.

The issue of encouraging staff to admit to making errors were discussed at length. The Trust was aiming to develop a "no blame" culture, to encourage staff to come forward to report errors and mistakes they have committed in their working day, by ensuring that no disciplinary action would be taken against them (unless the incident was extremely serious). Ms Abraham would discuss the issue with Andrew Stallard and report back to the Committee.

Action: Head of Governance (Interim)

25/09 **New National Targets 2008/09**

The Committee reviewed the paper presented that gave an overview of the scoring system for the New National Targets (and the predictions for the Trust) for 2008/09. These targets (some of which had a greater clinical focus than others) were part of the CQC's Annual Health Check of ambulance trusts, and the report outlined the 8 indicators used to assess their performance against existing commitments and national priorities based on the outlined point system.

The Committee questioned why Target 6 "Repair and Safe Environment of Ambulances" had been withdrawn. Ms Abraham would confirm and report back at the next meeting.

Action: Head of Governance (Interim)

26/09 **HCC: 2008/09 Final Declaration**

Ms Abraham confirmed that the LAS would be compliant with the requirements of the HCC, and would therefore be able to sign and deliver the final declaration for 2008/09, by the deadline.

NHSfL had provided feedback on draft declarations only to certain organisations with whom they were experiencing difficulties – this did **not** include the Trust. Ms Abraham had attempted to obtain written confirmation from NHSfL that the Trust's declaration was acceptable, but had only managed to obtain verbal confirmation.

Once completed, the Declaration would be circulated to Committee members.

Action: Head of Governance (Interim)

27/09 **Updated NHSLA Standards and Assessments**

Ms Abraham reported that the Action Plan (Level 1) had been approved. An assessor from the NHSLA would be visiting the Trust on 20 May for the agreed informal quarterly visit to ensure that the Trust is on track with the progress of the action plan and on track for progress towards Level 2 by 2010 and she would be discussing the progress with them.

Action: Head of Governance (Interim)

28/09 **Patient & Public Involvement Update**

The Committee received an oral update from Margaret Vander who reported on the PPI Committee meeting held on 16 April 2009. A number of very positive items had come out of that meeting, amongst which were the following:

- Beverley Jeal had been appointed as PPI & Public Education Co-ordinator and started work on 20 April 2009;
- The Patient Care Conference was scheduled for 15 September 2009, the focus of which would be on 'engagement';
- A pilot Staff Development Programme evaluation was underway, as was planning for the next programme for the summer;
- The possibility of secondments with the Prince's Trust had been viewed positively. An Open Day had been held on 21 April 2009; 41 people had attended and there had been a waiting list for places;
- The Resources sub-group of the Public Education Strategy Steering Group had been busy designing and circulating new items such as Oyster Card holders and leaflets; banners were on order and materials for 10/11 year olds were being developed;
- A new knife crime initiative was underway in East London. ADO South requested more information in respect of this in order to feed into the London Weapons Forum. **Action: PPI Manager**

Further to the above, confirmation had been received that morning of agreement to continue discussions on the development of a Joint Emergency Services Museum. This had the backing of the GLA, however funding had not yet been discussed.

The Committee thanked Ms Vander for a most positive report.

29/09 **Clinical Audit and Research Unit ("CARU") Update**

The Committee received an oral update from the Interim Head of CARU, Andrew Stainthorpe who reported on a restructuring of the Unit that had occurred prior to Rachael Donohoe departing on Maternity Leave. The Unit would be at full strength by May 2009 with less agency staff employed.

30/09 **Clinical Risk Update**

The Committee received an update on progress made with action plans in place to mitigate clinical risks on the Risk Register, and reviewed the risks involved.

After due consideration:

IT WAS RESOLVED THAT Risk ID31 "Misuse of the LA4H Single Responder Handover Form" be recommended for amendment on the Risk Register from its current grading and level of ***12 – significant*** to a new grading and level of ***3 – low***.

IT WAS FURTHER RESOLVED THAT the following new risks as presented be recommended for addition to the Risk Register:

- That required drugs/equipment may not be available in drug packs leading to patients not receiving appropriate treatment;
- That the similar packaging of Glucose and Sodium Chloride may result in the administration of the incorrect drug, causing patient harm.

It was agreed that, due to the absence of ADO East, consideration of Risk ID71 "Not learning and changing practice, following receipt of complaints, due to inadequately trained officers or any other cause" be deferred until the next meeting of the Committee.
Action: Head of Governance (Interim)

It was further agreed that the re-packaging of either Glucose or Sodium Chloride be recommended to the manufacturers to ensure the drugs are easily identifiable and to prevent the administration of the incorrect drug.
Action: Medical Director

31/09 **Risk Information Report ("RIR")**

The Committee reviewed the regular RIR, intended to demonstrate the effectiveness of clinical governance arrangements, and received a briefing from John Selby, the Senior Health and Safety Advisor, who reported that the figures contained therein were correct. Categories of incidents were considered and the Committee noted that delays featured prominently throughout the report.

The Committee agreed that an "audit trail" be created for all Serious Untoward Incidents ("SUIs"). As part of this, the Head of Patient Experiences intended to propose a mechanism for reporting such incidents as part of the updated SUI policy.

32/09 **"Six Lives": the provision of public services to people with learning disabilities**

The Committee reviewed a paper on the "Six Lives" report, published on 24 March 2009 by the Health Service and Local Government Ombudsman. It had focussed on investigations into the death of six individuals and called for an urgent review of health and social care for people with learning disabilities.

The Committee was being asked to agree to the recommendations within the report. However, after due consideration, it was agreed to approach the Director of Service Development in the first instance for comment.

Action: Medical Director

33/09 **Reports from Groups/Committees**

The Committee noted minutes and reports from the following Groups and Committees:

- Infection Control Steering Group: 10 February 2009;
- Risk Compliance & Assurance Group: 16 February 2009;
- Clinical Audit and Research Steering Group: 13 March 2009;
- Standards for Better Health Group: 26 March 2009;
- Clinical Steering Committee: 20 October 2008

34/09 **Patient Experiences**

A paper was circulated by Gary Bassett, the Head of Patient Experiences, who apologised to the Committee for the late delivery. He asked that Committee members review the paper and revert to him with any questions.

35/09 **Next Meeting**

Following the change to the August date agreed earlier in the meeting, it was noted that the next CGC meeting (full) would now be held on 13 July 2009 at 2.00 pm.

36/09 **Any Other Business**

There being no further business, the Chair declared the meeting closed at 17:10.

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Chair

Enclosure 14

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD
19 May 2009

Report of the Trust Secretary
Use of the Trust Seal

1. Purpose of Report

i. The Trust's Standing Orders require that tenders received be reported to the Board. Set out below are those tenders received since the last Board meeting.

ii. It is a requirement of Standing Order 32 that all sealings entered into the Sealing Register are reported at the next meeting of the Trust board. Board Members may inspect the register after this meeting should they wish.

2. Use of Seal

There have been 2 entries, 130 and 131 since the last Trust Board meeting. The entries relate to:

- Engrossment of deed of surrender relating to Crooked Billet Roundabout, Wadham Road, Walthamstow, between LAS and Transport for London.

- Section 106 agreement for Park Royal Ambulance Station, London NW10.

3. Recommendation:

THAT the Board NOTE this report regarding the use of the seal.

Mike Dinan
Director of Finance