LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING
28 JULY 2009

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD

Tuesday 28 July 2009 at 10:00 am
Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

Present:	Richard Hunt	Chairman
	Sarah Waller	Non-Executive Director - Vice Chairman
	Peter Bradley	Chief Executive Officer
	Martin Flaherty	Deputy Chief Executive
	Mike Dinan	Director of Finance
	Caron Hitchen	Director of Human Resources & Organisation Development
	Fionna Moore	Medical Director
	Roy Griffins	Non-Executive Director
	Brian Huckett	Non-Executive Director
	Beryl Magrath	Non-Executive Director
	Caroline Silver	Non-Executive Director
In attendance:	Richard Webber	Director of Operations
	Kathy Jones	Director of Service Development
	Sandra Adams	Director of Corporate Services & Trust Secretary
	Peter Suter	Director of Information Management & Technology
	Angie Patton	Head of Communications

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- Trust Board: 29 September 2009

London Ambulance Service NHS Trust

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 19 May 2009 at 10:00 a.m.
in the 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 Officer
	Martin Flaherty	Deputy Chief Executive Officer
	Mike Dinan	Executive - Director of Finance
	Roy Griffins	Non Executive Director
	Caron Hitchen	Executive - Director of Human Resources & Organisation Development
	Brian Huckett	Non Executive Director
	Beryl Magrath	Non Executive Director
	Fionna Moore	Executive - Medical Director
	Caroline Silver	Non Executive Director
In attendance:	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	Angie Patton	Head of Communications
	Richard Webber	Director of Operations
	Gary Bassett	Patient Experiences Manager (*Minute 55/09 only)*
	Janice Markey	Equality & Diversity Manager (*Minute 56/09 only)*
	Malcolm Alexander	Patients Forum
	John Ellman-Brown	Capita Company Secretarial Services

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43/09 Welcome and Apologies

The Chairman welcomed everyone to the meeting noting that, with the exception of Ingrid Prescod, all Directors were in attendance.

44/09 Resignations and Retirements

The Board formally acknowledged the resignation of Dr. Prescod as a Non Executive Director of the Trust with effect from 30th April 2009, noting that she had decided to step down as she could see no let up in the travel and time commitments required with her new responsibilities as global head of learning at DHL Logistics. The Chairman had invited her to attend the meeting at 1.00 p.m. at which time he would, on behalf of the Board, express his thanks to her for her work as a Director, and make a small presentation.

The Board also noted the forthcoming retirement of the Chairman himself with effect from 30 June 2009, and expressed its deep gratitude to him for his 10 years of inspired leadership and management of the Trust. There would be an appropriate occasion to thank him less formally but Directors wished their thanks to be formally recorded. The Chairman thanked the Board for its kind words, and expressed his hopes for the future success of the Trust, noting that its leadership was now in good hands to take it forward into an exciting and challenging future.

45/09 Minutes: 31 March 2009

The draft minutes from the Part I meeting of the Trust Board held on 31 March 2009 were circulated. It was noted that the draft minutes had not been produced in time to be included within the Board papers. Directors had thus had no opportunity to review them; however, they were now requested to do so and to pass any comments/amendments to the Chief Executive for inclusion. The updated version would then be circulated for final approval.

46/09 Trust Board Meeting 31 March 2009: Part II Synopsis

It was noted that, as indicated in minute 45/09 above for the draft minutes of the Part I Trust Board meeting of 31 March 2009, no draft minutes had been produced for the Part II meeting of the same date in time to be included within the Board papers. Accordingly, no synopsis had been produced.

47/09 Matters Arising

There were no Matters Arising from the last meeting for discussion.

48/09 Chairman's Update

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

- He apologised to Malcolm Alexander for the non-receipt of the papers for this meeting. This was not deliberate, as he himself had not received the papers either. There had simply been a mix-up with the circulation which had meant non-receipt by certain Directors and Attendees;
- Sandra Adams had been appointed to replace Martin Smith as Director of Corporate Services, formally commencing at the end of July 2009. She would join part-time during July and would hopefully be able to attend the SDC meeting at the end of June;
- The Provider Agency would cease to exist at the end of May. A letter from Lord Warner had been received to that effect although this had not originally been sent to the LAS!;
- FT commissioning arrangements divided London into six sectors and the LAS had traditionally been aligned with the Richmond sector. However, various issues were now arising in this regard so a decision as to which sector the Trust wished to be connected needed to made;
- In terms of the FT Public Consultation, two responses received (from Richmond and City & Hackney sectors) clearly indicated that the consultation document had not been read properly. Invitations extended to the 31 London PCTs had seen 27 of them visit the Trust, and leave with a clearer understanding of its role and purpose.

49/09 Chief Executive's Report

The Board considered the report of the Chief Executive.

The Board congratulated management on the extremely good performance by the Trust on achieving the call connect Cat A response time standard for the year. The Board also recognised the extenuating circumstances in the final Cat B figure of 84.5%. They noted the intention to concentrate on ensuring Cat B figures were achieved in the current year but requested assurance that this concentration would not impact on the achievement of Cat A; this assurance was given.

The graphs provided were reviewed and discussed at length.

The CEO also advised that the new AirWave Radio project would be going live during June before the next SDC meeting. He would provide a report for that meeting.

After further discussion:

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

50/09 Report of Finance Director: Month 12 2008/09 Finance Report and M1 2009/10 Finance Flash Result

The Report of the Finance Director for March 2009 (month 12), and the M1 2009/10 Finance Flash Result, were reviewed.

Directors noted that the unaudited Month 12 08/09 results showed a £723k surplus, well within the NHS London control range, and the M1 09/10 flash result showed a surplus of £287k for the month.

This had been a challenging audit but Mr Dinan confirmed that this was not specific to LAS but across the NHS as a whole.

Mr Dinan agreed to produce for the next meeting of the Audit Committee on 8 June 2009 a list of all the risks to be tracked by the Board.

After further discussion:

IT WAS RESOLVED THAT the Finance Report for March 2009 (month 12 2008/09), together with the M1 2009/10 Finance Flash result, be and are hereby received and noted.

51/09 Report of Medical Director

The Report of the Medical Director was reviewed and discussed, and Dr. Moore confirmed that a "No Concerns " report had been submitted to Richmond PCT regarding incidents involving controlled drugs.

The Board discussed the outbreak of swine flu and how the Trust's staff felt about the Trust's response to it; Dr. Moore confirmed that this would be done via The Pulse, and also at the forthcoming staff conference. She noted that this had been a mild version within the UK but that it might be much worse if it returned during the winter.

After due consideration:

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

52/09 Healthcare Commission Investigation into Mid Staffordshire NHS Foundation Trust

The Medical Director made a presentation on the Healthcare Commission's report of its investigation into the Mid Staffs NHS Foundation Trust. The investigation had brought to light major and catastrophic failures within that FT. Complaints about conditions and working practices had not been acted upon and it was clear that there was a culture of fear within the Trust itself, with staff feeling threatened and "leant upon" by Senior

Managers. This culture had pervaded all areas of the Trust's operations, which had therefore led to the failures reported.

In terms of lessons that could be learned, the Board undertook a discussion of the issues highlighted and agreed that:

- the Trust's processes needed to be reviewed but not by the expedient of box-ticking;
- LAS staff required more opportunities to undertake training; Team Leaders required protected time to undertake CPI checks and provide feedback; and
- there was an advantage in NEDs conducting more "ride-outs" with LAS staff.

53/09 Service Improvement Programme ("SIP") 2012 Update

The Board considered the SIP 2012 Update report, presented by the Director of Service Development.

Ms Jones advised that specific reports on the Olympics, Clinical Development and the Performance Delivery Programme would be presented to the next meeting of the Board on 28 July 2009.

After due consideration:

IT WAS RESOLVED THAT the SIP 2012 Update report, as presented, be and is hereby received and noted.

54/09 Infection Prevention and Control: Annual Report 2008/09

The Board reviewed the paper presented by Dr. Moore who confirmed that she would be making a presentation on this subject to the June 2009 meeting of the SDC. However she was able to advise that considerable progress had been made on the subject by Trevor Hubbard, the newly appointed AOM for IPC.

The Board noted that it was being asked to approve the six recommendations contained within the report, but Directors expressed their reluctance to do so, especially in respect of recommendations 2 ("a specific NED as champion" – this was considered a whole Board responsibility), 4 and 6 ("ensuring adequate resources" – this was a responsibility of the Executive Management). The Board agreed that it was not able to approve the recommendations as presented but did agree to be guided by said recommendations.

Accordingly:

IT WAS RESOLVED THAT the Trust Board agree to be guided by the six recommendations in respect of Infection Prevention and Control, as presented.

55/09 Patient Experience Department: Half Yearly Report

Directors considered the paper presented by Gary Bassett, giving a summary of activity of the Patient Experience department in the period September 2008 - March 2009.

The Local Authority Social services and NHS Complaints Regulations 2009 came into force in April 2009; to ensure compliance, the PE Department had merged PALS, Complaints and SUI activity under the "Making Experiences Count" programme. Accordingly the report provided a summary of both PALS and Complaints activity

during the period and described some of the themes emerging. A significant number of individual cases were also summarised to give Directors examples of issues being raised and actions taken as a consequence.
The Board noted confusion in figures indicating letters of appreciation received in Q4 2008 compared to Q1 2009; Mr Bassett advised that the reporting of these figures had been moved from one department to another but that in future he would combine the figures for greater accuracy. The Board agreed to provide any layout suggestions to the CEO that would assist the Board in drawing the correct conclusions from the information provided.

After due consideration:

IT WAS RESOLVED THAT the Patient Experience Department Half Yearly Report be and is hereby received.

56/09 **Annual Equality Report 2008/09**

The Board considered the Annual Equality Report 2008/09 presented by the Director of Human Resources & Organisation Development and the Equality & Diversity Manager.

The report presented was a summary of the full report (to be loaded onto The Pulse) and provided information on the Trust's workforce profile for 2008/09 including a progress update on recommendations made in the previous report for 2007/08 submitted to the Board at its January 2009 meeting, and set out further recommendations for actions to be taken over the coming year to promote best practice on equality and diversity within the Trust.

The Board noted that movement was in the right direction with BME staff representation improving from 8.6% to 9%, and the number of female employees increasing from 39.7% to 41%. However, these figures were below the national census, so there was more work to be done in this area.

Directors recognised the sensitivities around gathering information relating to the equality strands such as religion and sexuality. Ms. Markey agreed and reported ongoing work to draw up an equality-monitoring document in order to meet the requirements of the incoming law. She noted staff might experience some discomfort to the new law and such disclosures (as had been the case in the 1960s and 1970s), so it fell to her and her team to get the message across to staff; to this end, they were working ahead of time to ensure they were as prepared as possible and that appropriate systems were in place.

After due consideration therefore:

IT WAS RESOLVED THAT the Equality and Diversity Report for the year 2008/09, and the eight recommendations contained therein, be and are hereby received, noted and approved.

57/09 **PTS Strategy**

The Board reviewed and considered the PTS Strategy presented by Mr. Dinan for approval.

Both the Trust Board and the SMG had reviewed the strategy during the previous six months. In addition, at the Trust Board Away Day during April 2009, an update on the

business and a revised strategy had been presented to Directors for review. This led to the current strategy paper presented to the Board with recommendations for approval.

The Board requested that recommendation 4 be quantified and measures formulated; Mr. Dinan agreed to do so and circulate to Directors. He also advised that a review of the strategy would be conducted during Q4 2009.

Subject to the changes being made to recommendation 4 therefore:

IT WAS RESOLVED THAT the PTS Strategy and associated six recommendations be and are hereby approved.

58/09 IFRS Update

The Board considered the paper from the Finance Director on the introduction of International Financial Report Standards within the LAS, and noted the key changes that would affect the Trust's financial reporting.

The standards would be applied from Month 2 for financial year 2009/10, and Mr. Dinan confirmed the net cost of implementing the change would be approximately £50,000. The Audit Committee would monitor the effective operation of the new standards.

IT WAS RESOLVED THAT the introduction of International Financial Reporting Standards to the LAS financial reporting, be and is hereby noted.

59/09 Board Effectiveness Review

The Board received a presentation from the CEO on a recent review conducted on Directors' views of the effectiveness of the Trust Board and how it operated. It was noted that the question that elicited the lowest score was that considerably more time needed to be spent on the risks faced by the Trust, how they were monitored and how they could be mitigated.

Mr. Bradley confirmed that "freehand" comments and scores would be passed to all Directors. He also advised that a similar review of the Board Committees would shortly be undertaken and the results reported to the Board in due course.

60/09 Annual Public Meeting: Draft Minutes 30 September 2008

The Board reviewed the draft minutes of the Annual Public Meeting of the Trust held on 30 September 2008.

After due consideration, and subject to minor amendment:

IT WAS RESOLVED THAT the draft minutes of the Annual Public Meeting of the Trust held on 30 September 2008, be and are hereby approved for presentation to the Annual Public Meeting of the Trust to be held in 2009.

61/09 Clinical Governance Committee ("CGC") Meetings: Draft Minutes

The Board reviewed the draft minutes of the CGC held on 23 February 2009 and 27 April 2009, and received a briefing from the Committee Chair, Beryl Magrath. She draw the Board's attention in particular to the following minutes:

- **20/09:** The Committee had decided not to approve 3 new policies and procedures until review and comment by staff-side;

- **32/09:** The Committee had deferred agreement to recommendations contained in the "Six Lives" report in respect of the provision of public services to those with learning disabilities, until the Director of Service Development had commented on the report.

In response to a question from Mr. Alexander, the Medical Director advised that the packaging of both Glucose and Sodium Chloride were very similar. Accordingly, in order to prevent the incorrect administration of the drugs, the CGC had agreed that the manufacturers be requested to re-package the drugs, and that she would be following up with the manufacturers.

62/09 Report of the Trust Secretary: Tenders received and Use of the Trust Seal

Directors noted that there had been no tenders received since the previous Board meeting.

Use of Seal

There had been 2 entries, Nos. 130 – 131, since the last Trust Board meeting. The entries related to:

No. 130 Engrossment of deed of surrender relating to Crooked Billet Roundabout, Wadham Road, Walthamstow, between LAS and TfL;

No. 131 Section 106 agreement for Park Royal Ambulance Station, London NW10.

IT WAS RESOLVED THAT the Report of the Trust Secretary concerning Tenders received and the Use of the Trust Seal since the previous Board meeting, be and is hereby noted.

63/09 Questions from Members of the Public

There were no questions received from Members of the Public

64/09 Next Meeting

It was noted that the next meeting of the Trust Board would be held at 10:00 am on Tuesday 28 July 2009 in the Conference Room at LAS HQ.

65/09 Any Other Business

- On behalf of the Patients' Forum, Mr. Alexander expressed his grateful thanks to the Chairman for his efforts for the Trust. He had been an excellent Chairman and would be missed. He wished him well for the future. The Chairman thanked Mr Alexander for his kind words.
- The Chairman reported that he had written to TfL requesting the provision of a painted road "box" at the junction of Waterloo Road and Morley Street, which was a dangerous junction due to traffic trying to enter and exit Morley Street from Waterloo Road. However, to date he had received no reply.

There being no further business, the Chairman declared the meeting closed at 12:45.

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Chairman

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 19 May, 2009
in the Conference Room, LAS HQ,
Waterloo, London

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

Child N Serious Case Review: Action Plan

The Medical Director briefed the Board on the current status of the Child N Serious Case Review.

An Action Plan to deal with such incidences had been formulated and put in place by Bexley PCT, in whose area the case had occurred. In addition, the LAS policy in respect of the deployment of staff with an interest in a patient had been reviewed and amended, so as to ensure that the member of staff with the interest did not conduct the clinical assessment of the patient. In such instances, a First Responder with such interest would **always** be backed up by a secondary unit who would then assume responsibility for the relevant management of the case.

HSE Prosecution

The Deputy CEO referred to the incident that occurred on 8 June 2006 at St Barnaby's Church, Ealing which resulted in the tragic death of a young child, and briefed Directors on further developments in the case.

The LAS had appeared before Isleworth Crown Court, pleading guilty to the charge brought against it under the Health and Safety at Work Act. The Case Judge had been highly critical of the LAS, but had then commended it on the quality of its SUI Report and the fact that it had shared its report nationally.

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 28th JULY 2009
CHIEF EXECUTIVES REPORT

1 SERVICE DEVELOPMENT

LAS clinical and policy staff continue to be engaged in all of the Healthcare for London workstreams to an appropriate extent.

Current position:

Stroke & Major Trauma

The Joint Committee of PCTs (JCPCT) met to consider the feedback from the public consultation on Monday 20th July. Fionna Moore and Claire Garbutt/Nick Lawrance were in attendance.

LAS has detailed implementation plans for both stroke and major trauma. These plans are on track and will ensure the LAS is prepared to convey acute stroke and major trauma patients to specialist centres on the planned go live dates. A communications plan for the LAS has also been developed.

Stroke

HASU implementation.
London requires c.130 HASU beds. HfL recommends that these be split across eight Hyper Acute Stroke Centres (HASUs). Availability of HASU beds will go from c65 in Mar 2010 to c120 in April 2010. Good coverage will be offered throughout London apart from in South East London where the HASU at Princess Royal University Hospital (PRUH at Bromley) will not be fully up and running until 2011. Transition in South East London will therefore require the support of the unit at Guys and St Thomas'Trust (GSTT), which will then be decommissioned as PRUH builds capacity.

In order to maximise use of available resources whilst opening up HASU capacity in a manageable manner, LAS will commence conveyance to HASUs (excluding PRUH) from their catchment area in two stages.

Stage one (early February 2010): All FAST+ patients who can be conveyed to a HASU to arrive within 2 hours of onset of symptoms.

Stage two (early April 2010): All FAST+ patients conveyed to HASU, regardless of inset time.

LAS crews are already trained in FAST and the latest version AMPDS triages potential strokes as Category A. Therefore staff do not require additional training, however clear

communications will be provided to ensure staff are aware of the appropriate pathway for stroke patients.

Trauma

HfL's proposed major trauma centres at Royal London, South West London & St George's and King's College Hospital will open during April 2010. St Mary's major trauma centre is scheduled for October 2010. Plans for North West London major trauma patients are yet to be agreed after LAS expressed dissatisfaction with proposals that they are simply conveyed to their local A&E department during the transition phase.

In order to deliver the LAS's preferred model of delivering major trauma expertise via Team Leaders, Team Leader updates have been scheduled to run in September, October and November. Team Leaders and Training Officers will attend. This will ensure that frontline staff have access to clinical and scene management support when attending major trauma patients. Also, all staff will require familiarisation with a new decision support tool that they will use to determine which patients should go to a major trauma centre.

Unscheduled Care

The unscheduled care workstream has developed a commissioning toolkit for urgent care. The focus is on commissioning for quality, and making urgent care pathways easy to navigate for patients with links between service providers.

Response Hubs
OfCom launched a national consultation which was announced 10th July for a national three digit number for accessing non-emergency (urgent) care. The 111 number has been proposed and the LAS will provide a formal organisational response to the consultation.

There will be pilots in various areas of the UK and the LAS is maintaining close links with HfL regarding any plans for a pilot in London.

Urgent Care Centres
The LAS has established pathways for direct conveyance of patients to Bexley Urgent Care Centre. We are currently working with the London Central West Care Collaborate to establish pathways into the Urgent Care Centre at Hammersmith Hospital and planned primary care front ends at Chelsea & Westminster and St Mary's. A key priority for the LAS in development of these new pathways is to ensure some consistency across London to best facilitate ease of use for crews.

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

2 SERVICE DELIVERY

A&E Operations (graphs 1 – 10)

Category A performance for the year to date up to and including 12th June was very much on track at 74.5%. However there then followed a period of sustained and unprecedented demand during the latter part of June and throughout July which has seen the year to date Cat A performance fall to 72.7%.(as at 20th July)

This increased demand was driven partly by the heatwave experienced at the beginning of July and partly by an increasing incidence of Swine Flu. July has seen a pronounced and sustained increase in Category A volumes of circa 14% and Cat B volumes of circa 17% when compared with July 08 making it the second busiest period in our history only surpassed by December 08.

We have now agreed with the Strategic Health Authority and our commissioners that the principal objective is to continue to provide a safe service to the public of London and to concentrate our efforts on reaching life threatened patients as quickly as possible. We will therefore be concentrating on recovering the Cat A year to date position across the summer period.

Performance recovery plans and revised trajectories have been agreed with the SHA and Commissioners and the Trust is implementing a series of actions to stabilise and improve response time performance across the summer. The levels of performance improvement achieved will be dependant on a number of assumptions around demand being met and feedback is being provided to the SHA and Commissioners daily against these assumptions. It should be noted that the assumptions agreed around demand have been exceeded daily during the last ten days.

Category B performance continues to be an area of significant challenge for the Trust given the increasing demand and the Cat B performance year to date is currently 84% for the period April to 20th July09. As indicated above whilst the Trust is doing everything in its power to improve Category B performance we have agreed with the SHA and our Commissioners that our priority over the next 8 weeks is to recover the Cat A position whilst also achieving the best possible Cat B performance.

The Airwave radio rollout was successfully implemented in part of the West Area on Tuesday 14th July and new technologies have been exploited from Airwave following the implementation in June for MRUs and CRUs. We can now utilise Airwave handsets to provide live tracking of resources without MDTs and automatically dispatch emergency calls to these resources via SMS text message.

The Trust hosted a delegation from the Emergency Care Intensive Support Team (ECIST) team that is facilitated by NHS Interim Management and Support (IMAS) on 7th July. The visit explored current plans to stabilise and improve performance and the actions already underway to do so. An interim report from the assessment team has been received by the Trust. The report is broadly positive and states "*It was clear from our discussions and from the information provided in your completed diagnostic tool that the LAS believe that the current performance position is temporary. This current position, particularly an underperformance against category B response standard, has been exacerbated by a short*

fall in front line resources that will, broadly be rectified with the cadre of staff commencing active roles in September 2009. As discussed at the meeting, we were impressed with the work programmes already undertaken by the LAS and the commissioning teams. We were also impressed with your vision for the long term development and provision of ambulance services for the people of London". We are currently setting out an action plan to deliver the recommendations made. Further follow up visits have already taken place and are planned in the coming weeks to provide some additional focused support in specific areas. These actions will further support the extensive arrangements already in place within the Trust to improve performance in the coming months.

During the period since the last board report the Trust has twice raised its Resource Escalatory Action Plan (REAP) level to level four 'Critical'. The latest of these occurred on 27th June and the Trust currently remains at REAP level four as a result of the sustained increases in demand. This will be reviewed weekly by the Director of Operations and should the incoming demand reduce consideration will be given to reducing the current REAP level.

We have also re-established Assistant Director level scrutiny and support to all aspects of performance delivery on an on-duty basis 24hours per day, 7 days a week. The Central Support Unit (CSU) has been re-established with the GOLD Suite at Headquarters and is now monitoring and assisting in the delivery of real time performance improvement. It is envisaged at this stage that these arrangements will need to remain in place until end September 2009.

Technical improvements have been made to responding to 999 calls from mobile phones which allows a crew to be dispatched to the approximate location of the incoming mobile phone call whilst the exact address is being confirmed by the call taker. This allows for a faster dispatch and the exact address and details of the type of call are then subsequently sent to the responding vehicle whilst it is en route to the call.

The refurbishment of the Emergency Operations Room (EOC) has now been completed and will be further enhanced by work already underway that will introduce wallboard information on call taker performance in the call handling area of the control room.. This will provide a dynamic picture of each call takers work activity during a shift and improve the overall call handling performance.

There has been continued work to improve the tasking of Emergency Care Practitioners including the examination of the new version 12 of AMPDS to identify ECP-specific determinants to improve dispatch and utilisation. The aim is also to increase the number of calls ECPs attend as a single responder (all green, most amber calls), requesting ambulance backup only as required, in order to enable ambulances to be utilised more effectively. In addition, a biannual review of the ECP Patient Group Directions has been completed to allow ECPs to dispense additional medications.

The Emergency Bed Service continues to work on improvements in line with the EBS development strategy. These include working with other agencies to develop the design, piloting and subsequent operation of a Text Emergency Access Service for the Speech and Hearing Impaired Patient (TEASHIP) and assisting the cross-government CBRN program

with the development of an information service to support the national response to radiation events.

The hospital turnaround project has continued over the previous two months. Assessments have now been made of all the A&E Departments with the worst handover times and action plans have been agreed to improve matters. In addition, well performing Emergency Departments have also been visited to ensure that best practice can be learnt and shared. Ambulance complexes are still being assessed on a monthly basis on their reduction in hospital handover times and Ambulance Operations Managers are charged with working with their local A&E departments to drive down handover times month on month.

The Trust produced circa 242,600 Ambulance hours in May and June this year. FRU hours produced for May/June 09 decreased by circa 5.6% to 116,265hrs compared to 123,191hrs for the same period as last year. This decrease in hours produced is caused by a 23% reduction in take up of overtime despite the "Bonus Initiative". Overtime hours for the same period last year were circa 135,000hrs and this year 104,000hrs.

The "Bonus Incentive" scheme has continued in May, June and July. All operational staff were required to have 100% attendance to be eligible. Bonuses have been targeted to improve overall FRU hours throughout the week and to improving Ambulance hours at the weekends. It is envisaged that a similar bonus scheme will continue to be required during August .

ProMis (resourcing software) will shortly replace the Station Operating System (SOS) across the Trust and manage all aspects of staff pay, annual leave and attendance. We have requested our external auditors, Bentley Jennison, to carry out an audit on the New Time and Attendance reporting system to ensure that it is robust and enhances the functionality already available to station administrators.

The Emergency Preparedness Department has continued to plan for a number of large events during the period. These have included a series of concerts in Hyde Park, the Biggin Hill Airshow and Wimbledon tennis championships. In addition, the department has responded to spontaneous demonstrations outside The Palace of Westminster on a number of occasions. The department is currently planning for the Notting Hill Carnival at the end of August.

At the time of writing, I can also report that the Trust declared a major incident in response to a large fire in a high-rise residential building in South East London on 3rd July. Over sixteen ambulances together with numerous single responders and the Hazardous Area Response Team (HART) were committed to the incident.

The Trust has begun a replacement programme of our Public Order personal protective equipment to ensure that staff working at pre-planned events or spontaneous demonstrations where disorder erupts are equipped with the very latest safety equipment. In conjunction with the Public Order branch of the Metropolitan Police Service we have developed a training package for staff in this connection and have begun its delivery to a specific group of staff.

Since the onset of the Swine Flu pandemic the department has been working closely with the Medical Directorate and others to ensure the Trust is able to respond to the pressure

associated with a flu pandemic whilst protecting core services. The Head of Emergency Preparedness is the responsible officer in the Trust for all flu related matters. We have formed a flu group made up of representatives from operations, medical directorate, Communications, HR, infection control, emergency preparedness, logistics and procurement. This group now meets bi-weekly to ensure that all necessary actions are taken to ensure business continuity arrangements are maintained.

To date we have issued a regularly updated Medical Director's Bulletins to all frontline staff giving advice on dealing with callers/patients with flu like symptoms. A flow chart is available on the Pulse setting out how such patients should be managed. We have carried out a Trust wide audit of facemasks 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.

Following a robust external recruitment process involving externally facilitated selection centres two new Assistant Directors of Operations (ADO) have been appointed. One will be posted to East Area and the other will be centrally based at Headquarters supporting the performance delivery unit.

The delivery of new Mercedes ambulances has been disappointingly slow in recent months with only 29 ambulances out of 35 being delivered so far. Intensive support and scrutiny of the manufacturer has however led to some improvements in recent weeks.

I am pleased to be able to report that we have now submitted an application under the 'extenuating circumstances' provisions to the Healthcare Commission/CQC in relation to Category B performance during the winter period of 2008/09 where performance was adversely affected by significant hospital delays. This application has been fully supported by the Strategic Health Authority.

Accident & Emergency service performance and activity

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

	CAT A8	**CAT A19**	**CAT B19**
Standard	**75.0%**	**95.0%**	**95 %**
2009/10 YTD	72.7%	98.1%	84%
May 2009	73.4%	98.2%	85.7%
June 2009	71%	97.9%	82.9%
July 2009 (to 20th)*	70.3%	97.9%	78.7

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

- Overall activity rose in the first quarter by 3.4% in April, 1.7% in May and 4.5% in June compared to the same periods last year. The greatest increase in volume remains in Category B workload.

- Resource utilisation rose in June with 70% of the fleet being engaged in call cycle activity on over 50% of the total available time. This has continued through July to date and overall utilisation remains excessive.
- Call answering performance has remained reasonably resilient despite the huge increases in demand falling to 93% in 5 secs for the month of June . Week ending the 5th July saw 999 calls increase to 33,000 which is an unprecedented level of 999 demand.
- We have continued to use NHS Direct to manage some of our Green call demand and are now routinely transferring some 200 to 250 calls per day to NHSD. The return rate on these calls following further assessment by NHSD is approximately 18% and therefore 72% are being managed without a traditional ambulance response.

2.1 PATIENT TRANSPORT SERVICE

Commercial

We have been advised that Door 2 Door have been successful in their bid for the London and Barts renal work. The LAS will continue to provide this service until 31 August 2009 when the contract will transfer to the new provider. Although this contract made a substantial loss in the last financial year, it had been operating at a profit since April when a renegotiated price was agreed. This loss will affect 10 Ambulance Personnel.

We are aware London Procurement Programme (LPP) personnel are talking to numerous hospitals in London about a second phase of tenders. However, the LPP framework has been called into question with the instigation of the National Ambulance Contract and they are currently considering how this will affect this years tendering process.

The new South London NHS trust has advised the LAS that they will be part of this second phase of tendering which will affect our existing contracts that we held with Bromley Hospitals, Queen Mary's Sidcup and Queen Elizabeth hospitals.

Other hospitals that are due to take part in this next phase of tendering will include:

- Imperial College Hospitals
- North West London Hospitals
- Epsom and St Helier University Hospitals

Operations

Personal Digital Assistants have been trialled successfully in South East London. Roll out to all contracts will commence from the end of July 2009. The introduction of these devices will provide controllers with real time data over vehicle location and the number of patients on board. This will enable them to adjust and adapt their delivery plan throughout the day to meet changing circumstances as the day unfolds.

The final phase of the Meridian, the new planning system, will look to introduce e-booking for customers. This will allow them to make bookings on line and remove the requirement to fax bookings across to LAS staff.

Both initiatives will have an effect on the operational efficiency of the Transport Operations Centres and speed up the production of monthly management information packs and invoices for customers.

Performance

Performance and activity data is shown at the end of my report graphs 12-15. The Trust Board will note a significant increase to workforce over the first quarter, the majority of this can be attributed to the opening of the new renal unit at Barts.

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

3. INFORMATION MANAGEMENT & TECHNOLOGY

AIRWAVE DIGITAL RADIO SYSTEM

The London Airwave Radio Project, known as LARP, has gone live. Airwave is the new digital radio system that is being implemented nationally by the Department of Health for all UK Ambulance Services. It is also used by all UK Police forces and will be used by the Fire Service.

As the Trust Board will be aware this has been a difficult project with substantial delays at a national level. However a huge amount of work has been put in over more than three years by Airwave and the Department of Health teams and the LAS support teams. As a result of which the LAS finally achieved the substantial milestone of SC1 (Service Commencement 1) on 19 June, that subsequently allowed the live roll out to commence on 23 June with implementation on motorbikes and cycle units. Implementation has now started in the west area and over the coming months will progress across the Trust. Full implementation should be completed by October.

Electronic Patient Report Form (ePRF)

As part of the national Connecting for Health (CfH) programme, BT as the Local (London) Service Provider (LSP), is contracted to provide the LAS with the Electronic Patient Report Form (ePRF) solution and associated infrastructure services.

The Trust is adopting the standard increments business case approach and the Strategic Outline Business Case was approved by the SMG in March 2009. At a high level it detailed the case for the ePRF solution to be deployed to all emergency response vehicles to replace the paper-based PRF system and to provide a foundation for the wider development of clinical IT capability within the Trust. The indicative capital cost is considerable at £7.25m over three years and revenue costs will exceed those for the paper system by around £0.57m per annum. As a result, the SMG have approved that the project should complete the full business case, the definition of a detailed set of system functional requirements and the completion of contract negotiations by LPfIT and BT. This will be presented to the SMG in October and subsequently the Trust Board for full approval prior

to signing the Declaration of Intent that commits the Trust to the capital and revenue expenditure and the project timescale detailed in the contract.

CAD 2010

Work continues well with the CAD 2010 supplier Northrop Grumman (NG). Jackie Nostaja (NG Project Manager) and Steve Watson (NG Technical Manager) have relocated to London for the duration of the project. They are supported by teams based in the US, who participate in meetings via teleconference and visit the UK as required.

The key activities during this stage are the design and development of the modifications required to meet those LAS requirements not fully met by the off-the-shelf CommandPoint product. To achieve this, NG have produced Functional Design Documents (FDDs), each of which describes how one or more of the LAS requirements will be satisfied. To date, 41 of 43 Functional Designs have been finalised by NG, 38 of which have been approved by the LAS. Following approval of each FDD, Northrop Grumman are carrying out the associated development work, after which they will conduct Factory Acceptance Testing. The outstanding designs are currently under development. In parallel with the NG design and development work, the LAS are carrying out internal design and development activities to enable integration between CommandPoint and legacy LAS applications.

A number of Requests for Change (RfCs) to the original requirements have been raised and are currently awaiting consideration and approval by the Project Board before formal submission to NG. In order to remove the risk of further delays to go-live, a number of these RfCs may be deferred until a later release of CommandPoint several months after the initial go-live.

The Test and Training Premises at 32 Southwark Bridge Road are now operational and are used by both LAS and NG personnel. The accommodation includes two classrooms, a testing room, a meeting room and a number of offices. It was formal opened by the Chief Executive on 15 June.

During the week of 13 July, 4 members of the Project Team (the Senior User, Head of Training, Lead Training Officer, Staff Side appointed CAD 2010 Lead) visited a EMS Command Point customer in the USA. The objective of the visit was to discuss training and implementation planning. The output from the visit will inform the overall training plan for the LAS implementation.

4 HUMAN RESOURCES

Workforce Plan implementation

In the first quarter of the year the Trust has appointed 150 new staff (115 Student paramedics and 35 A&E Support). In the same period, 122 staff have completed their initial training and been posted to their operational posts.

Recruitment activity is currently on track to achieve full establishment of A & E staff by January 2010. Recruitment continues to progress well with all Student Paramedic training places full up to the course commencing 7 September 2009 (72 places). For the same period 39 places (out of 48) have currently been filled for A&E Support.

During the second quarter, 159 additional staff are expected to complete initial training and be posted to operational roles. In addition, we are in the process of appointing newly qualified university graduates (c52 recruits expected) with start dates around September to be confirmed. These staff will be operational immediately.

Recruitment to Emergency Operations Centre staff is on track to deliver the increased establishment for 2009/10 in preparation for the implementation of the CAD 2010 project.

All other general recruitment is also continuing as required.

Workforce information

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

Trust sickness levels for May show a further reduction on previous months to 4.07% with another marked reduction in PTS from 6.51% in April to 4.84% in May.

Staff turnover has also reduced again to 5.77% as at June 2009 continuing the downward trend.

Current A&E staff in post shows a vacancy level of 320 wte. A full update on recruitment activity is provided above.

Development of the MPET funding SLA

Following lengthy negotiations the LAS has been awarded an aggregated total of £9.2 million (8.2 million allocation and 1 million offset again last years funds) by NHS London (NHSL) to support the workforce transformation plans. This funding will in the main support the training and development of 377 student paramedics and 121 A & E support workers. Currently the LAS is working with the education commissioning team to agree the service level agreement, performance and finance reporting for the service level agreement. This was due to be available at the end of June 2009, but is still being prepared by NHSL.

The Workforce Advisory Forum

The Workforce Advisory Forum has been established by NHSL to progress the implementation of the workforce for London strategy which underpins the delivery of Health Care for London. Some 24 members, including the Assistant Director for Professional Education Development from the LAS, were selected from applicants across the capital. The forum exists to provide expert advice and support from both a workforce and clinical perspective to the Workforce for London (WfL) programme to ensure solutions and implementation plans are fit for purpose.

The WAF will inform the development of the WfL programme and support the WfL Programme Board in delivering high quality, evidence based, clinically effective services. WAF members are expected to act as ambassadors of the WfL programme, communicating when required the rationale for change to relevant audiences and provide leadership on

implementation across London. WAF members are required to make recommendations which are based on a balanced view of the full picture and not only reflective of their professional group or employing organisation's individual context.

The LAS benefits from having a member on this forum as it will further enhance the profile of the organisation and its work through the contacts and networks which are being created. The Assistant Director of Professional Education and Development is able to influence solutions and advise on the implications of proposals on and for the LAS. Membership of the forum also builds on the skills and knowledge base of the Assistant Director, enhancing her contribution to the transformational programmes the Trust is engaged in.

Clinical Education Update

The Clinical Education Team have responded enthusiastically to the challenges of delivering the new accelerated recruitment programmes, introduction of new modules as well as continuing with some of the provision of business as usual in other areas with limited resources. Recruitment and realignment of roles and courses are currently under way to ensure continuous quality improvement and to refine the new programmes which have been developed. The clinical education team are also working towards delivering all paramedic training at a minimum of Diploma level by 2011.

With the cohorts of trainees being released into operations the ability of the organisation to release staff to training will improve the combination of improved programmes and improved release provides a very positive model for moving clinical education forward.

A training plan for the period 1.10.09 to 31.3.11 is currently being developed for approval by SMG in August. Plans are also being finalised to provide all Team Leaders with a comprehensive clinical and leadership update to commence in October 2009.

A review of driver training is being undertaken to ensure compliance with the new legislation which becomes effective in January 2011 and to ensure that the organisation is delivering this training efficiently and effectively.

The clinical education team are actively engaged in the delivery of two key programmes of work for operations namely the delivery of the London Ambulance Radio Project and the CAD 2010 project, both of which are critical to optimising productivity and performance for operations.

Partnership working, staff engagement and joint consultative arrangements

The Trust's approach to joint partnership working has been recognised at both local and national level.

A successful funding bid was submitted to NHS London under the "Engaging for Quality and embedding partnership locally" initiative to promote partnership working by training a combination of staff representatives and managers as focus group facilitators. The aim is to engage staff in informing the work to find innovative new ways to measure LAS performance, identify potential new patient pathways and improve patient care. A formal report will be published including feasibility assessments and recommendations to take

forward to the LAS SMT and to be communicated externally to other ambulance trusts to enable shared learning. The expected outcomes of the project are:

- A measurable increase of staff engagement
- A measurable increase of staff advocacy
- Identification of new patient pathways
- A pool of staff and managers trained to lead focus groups for future research

The bid also provided the funds to support the Partnership Conference held at the ExCel centre in Docklands in May.

Nationally, the NHS Social Partnership Forum has commended the Trust's approach to joint partnership working over a number of years by way of inclusion as an examplar case study on its website, and achievement that was also brought to the attention of the NHS at large via the regular Workforce Bulletin published by NHS Employers.

A steering group has been established to lead and co-ordinate the corporate review of the staff survey, identifying key actions to improve staff engagement and satisfaction. All operational areas and support Directorates are to be included and represented, and Trust-wide and local action plans will be produced and progress against key milestones monitored. An overarching employee engagement strategy is to be prepared for consideration of the Strategic Steering Group (SSG) in the Autumn.

The Staff Council arrangements agreed in partnership in 2008 have been reviewed to take account of changes in senior management roles. The Operational Partnership Forum has been reconstituted, and will be the focus of the work to review and modernise operational working practices. Membership of the terms and conditions of service sub-group has been confirmed, and this group will be convened within the coming weeks.

HR Pandemic Flu Planning

The Trust is closely involved in the work commissioned by NHS London to establish a Workforce/HR framework for potential adoption across NHS organisations in London, and is also leading and facilitating similar work on behalf of all ambulance trusts nationally. A number of HR flu planning workshops have been conducted both locally and nationally. Local planning has involved trade unions and health and safety representatives.

Disciplinary Appeals and Employment Tribunals

Since the last Trust Board meeting 5 appeals against dismissal have been heard with the following timescales:

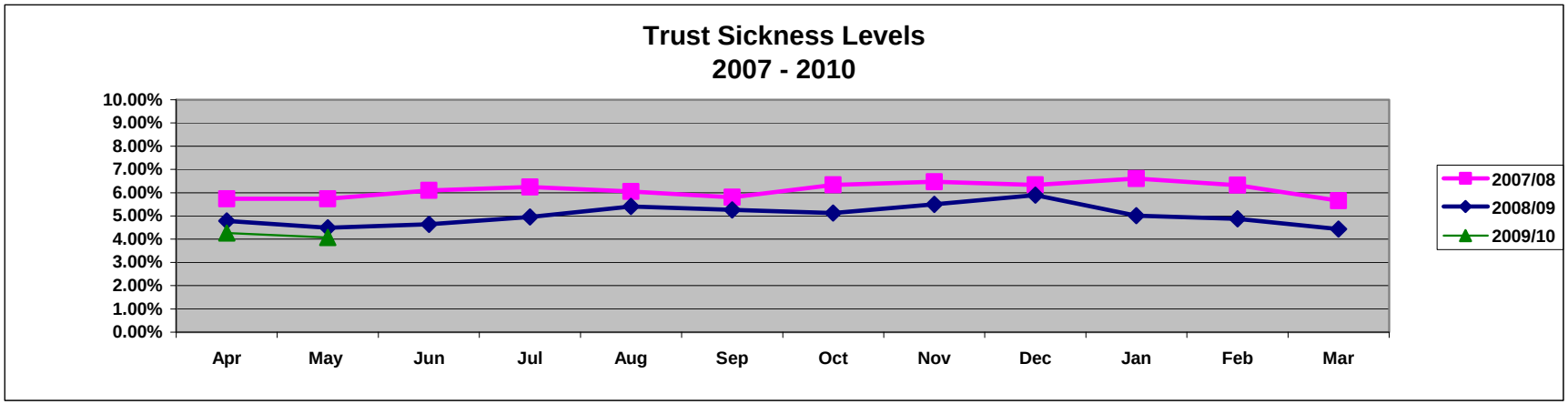
Case No.	Date of appeal letter	Hearing date	Further comments
1	2.2.09	29.7.09	Original hearing scheduled for 15 June 2009. Original date then postponed by appellant

			on 27 May due to lack of representation.
2	5.3.09	22.7.09	Original hearing commenced on 30 April. Objection to the constitution of the appeal and the appeal was rescheduled.
3	12.3.09	5.6.09	
4	8.4.09	24.6.09	
5	14.5.09	3.7.09	

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

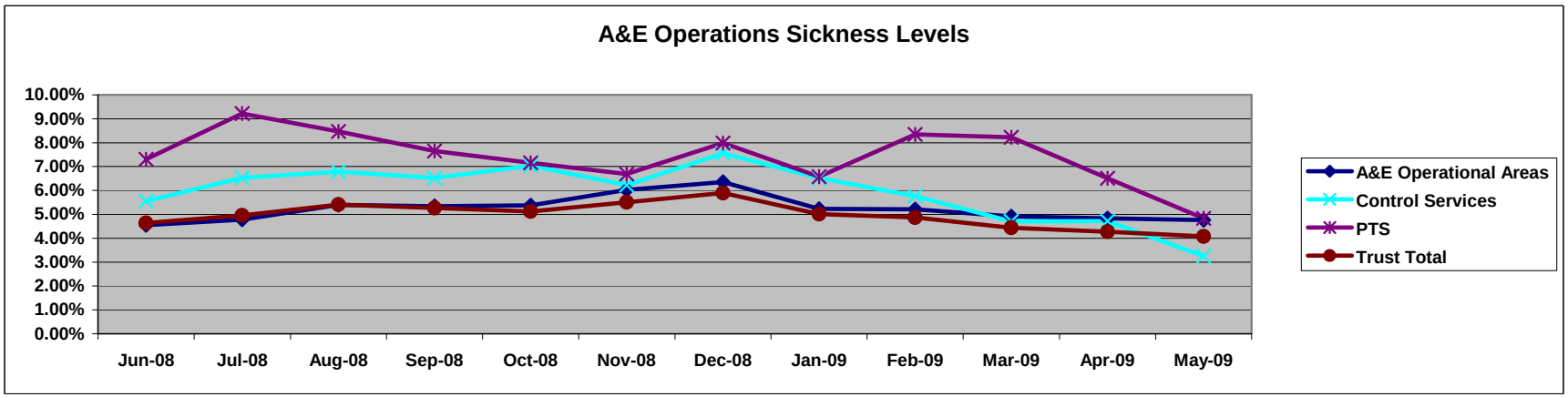
Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%
2009/10	4.27%	4.07%										



A&E Ops Sickness Levels

	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09
A&E Operational Areas	4.55%	4.78%	5.40%	5.34%	5.37%	6.02%	6.35%	5.23%	5.21%	4.91%	4.84%	4.76%
Control Services	5.55%	6.53%	6.78%	6.52%	7.04%	6.23%	7.55%	6.52%	5.76%	4.70%	4.71%	3.25%
PTS	7.30%	9.22%	8.47%	7.65%	7.16%	6.69%	7.98%	6.57%	8.35%	8.23%	6.51%	4.84%
Trust Total	**4.64%**	**4.96%**	**5.41%**	**5.26%**	**5.12%**	**5.50%**	**5.89%**	**5.01%**	**4.87%**	**4.44%**	**4.27%**	**4.07%**



Staff Turnover

Staff Groups	Aug-07/Jul-	Sep-07/Aug	Oct-07/Sep	Nov-07/Oct	Dec-07/Nov	Jan-08/Dec	Feb-08/Jan	Mar-08/Feb	Apr-08/Mar	May-08/Apr	Jun-08/May	Jul-08/ Jun-09
A & C	14.79%	13.35%	14.59%	15.38%	15.27%	15.76%	15.14%	14.51%	14.06%	12.62%	12.30%	11.56%
A & E	5.58%	5.47%	5.44%	5.64%	5.60%	5.58%	5.51%	5.45%	5.10%	4.99%	4.86%	4.50%
CTA	8.51%	10.87%	8.51%	9.09%	9.52%	7.14%	6.97%	7.32%	7.69%	2.50%	2.56%	2.44%
EOC Watch Staff	12.57%	12.20%	12.87%	13.31%	13.55%	11.70%	11.52%	11.47%	10.76%	9.97%	10.00%	9.55%
Fleet	13.21%	7.55%	5.66%	11.32%	14.00%	14.00%	14.00%	13.46%	13.21%	10.53%	8.62%	8.47%
PTS	12.34%	11.97%	12.61%	12.55%	11.86%	12.45%	12.98%	12.13%	10.92%	9.27%	9.39%	9.05%
Resource Staff	2.08%	2.08%	2.13%	2.13%	0.00%	0.00%	0.00%	2.04%	4.26%	4.17%	4.17%	4.17%
SMP	7.36%	7.32%	7.37%	6.88%	6.61%	6.99%	6.77%	6.75%	6.94%	5.84%	5.47%	5.24%
Trust Total	**7.57%**	**7.27%**	**7.35%**	**7.57%**	**7.50%**	**7.39%**	**7.30%**	**7.18%**	**6.82%**	**6.32%**	**6.14%**	**5.77%**

A&E Establishment as at June 2009

Position Titles	Funded Est	Staff in pos	Variance	Leavers
Team Leader Paramedic	175.00	161.82	13.18	0.00
ECP	86.00	68.17	17.83	0.00
Paramedic	802.00	852.66	-50.66	4.00
EMT	1198.00	1230.70	-32.70	0.00
Student Paramedic	600.00	420.00	180.00	1.00
A&E Support	330.00	208.06	121.94	1.00
EMD1	84.00	112.75	-28.75	3.00
EMD2	86.55	106.97	-20.42	0.20
EMD3	96.76	57.97	38.79	0.00
EMD Allocator	60.00	70.69	-10.69	0.00
CTA	48.00	50.00	-2.00	0.00
Total	**3566.31**	**3339.79**	**226.52**	**9.20**

5 COMMUNICATIONS

Communications

Swine flu: Internal communication about swine flu continues, emphasising in particular the need for all staff to maintain good standards of hand hygiene. Clinical guidance continues to be updated through the Medical Director's bulletin and news and advice are published on the intranet. A recent Evening Standard report featured the number of calls the Service is receiving about swine flu, and the work being done to minimise the number of admissions to hospital of patients with the virus.

Media issues

2008-09 performance: The Service's success in achieving the target of reaching 75 per cent of Category A patients within eight minutes during 2008-09 was reported positively in the Evening Standard, which mentioned the use of initiatives such as motorcycle paramedics to help reach patients more quickly. There was also some positive coverage from local newspapers about the performance of local ambulance complexes.

Alcohol-related issues: The Service's 'booze bus' initiative was identified as good practice in a report on young people and drinking, which was widely reported in the media in June.

Team Leader Brian Hayes gave evidence at a London Assembly inquiry into young people and drinking - 'Too much too young?' at City Hall, and James Cleverly, the Chair of the Health and Public Services Committee which conducted the investigation, spent an evening with the 'booze bus'.

Figures show that young drinkers aged 11- 21 years old cost the Service around £1.3 million a year. The final report also found that 11-15 year olds in London now consume 180,000 bottles of lager every week. Recommendations within the report include reducing the supply of alcohol to under 18s, improving education and information through a London-wide marketing campaign, and helping young people who are misusing alcohol with more early intervention work.

As well being mentioned in the Evening Standard and other newspapers, the 'booze bus' featured on ITV's This Morning programme where the report's findings were discussed with Secretary of State for Children, Schools and Families Ed Balls.

Fatal fire in Camberwell: A fatal fire in a block of flats in South London at the beginning of July, in which six people tragically died, led to a large number of media enquiries. Details about the Service's response and casualty figures were released and updated throughout the incident, and Assistant Director of Operations Paul Woodrow attended the scene, accompanied by a communications officer, to act as a media spokesperson. Interviews were given to ITV News, BBC News 24, Sky News and Radio 5 Live, with details also given to a number of print journalists who were there.

Response to an emergency call in south London: An emergency call to a patient in Morden, who subsequently died after there was a delay in a member of staff entering the address, was picked up by The Sun newspaper before also being covered by the Daily

Mail, The Times, ITV London and LBC radio. The incident is now the subject of an internal investigation.

7 July anniversary: The fourth anniversary of the London bombings was marked by the unveiling of a memorial to the victims in Hyde Park. Assistant Director of Operations Paul Woodrow and Edmonton Emergency Medical Technician Jessica Ashford attended the event on behalf of the Service.

Hot weather: A proactive media campaign was launched when warm weather in June and the subsequent heatwave in early July led to increased demand on the Service.

Messages focused on how people should take extra care in the heat and when to use the 999 service. Coverage was achieved through the issue of news releases and statistics as well as a number of broadcast interviews. Nineteen national and six London media (press, radio and TV) reported on the issue, reaching an estimated 32 million people. The London Ambulance Service was mentioned 17 times across all media, and a total of over 20 minutes of airtime was given to the issue.

Other stories: A collision involving a manager in a response car and a police car in Hampstead was covered by both the Evening Standard and the local paper. The Standard also ran a story in June about crews being off the road because their vehicles were needing to be repaired.

Filming

Blue Peter: The Service featured in an episode of Blue Peter in May when the BBC children's programme highlighted what happens when somebody dials 999. Training Officer Jules Lockett, Emergency Medical Dispatcher Rachel Taylor, Team Leader Brian Hayes and Clinical Support Desk Manager Stephen Hines joined presenter Andy Akinwolere as he went behind the scenes in the Emergency Operations Centre. The short film showed the valuable work of control staff while explaining to children how the Service handles emergency calls.

Staff engagement

GoWalk Challenge: The internal promotion of the Service's GoWalk challenge, which encouraged staff to get fit ahead of 2012, prompted over 600 staff to sign up for the initiative. Between them they clocked up over 60,000 miles in June.

PPI activity report

Public education:

- The development programme for staff involved in public education activity is being planned for October and November 2009. There have been some alterations to the programme following the evaluation. In order to ensure staff commit to the entire programme (a total of 8 days), there will be an application process, which will include line manager approval and commitment to releasing staff to attend.

- New opportunities to convey our public education messages are being explored through joint working with the London Fire Service and use of the Life Channel, a community TV channel which broadcasts in schools, GP surgeries and community centres.

Museum:

- The Trust is having discussions with the GLA and the other emergency services in London about the development of a joint blue light services museum. While this exciting project is in the development phase, the museum at Ilford remains closed and essential restoration and preservation work is being undertaken on some of the museum's vehicles.

Insight into Management:

- For the second year, the Trust recently hosted sixth form students from Barking & Dagenham to undertake a work experience project. They carried out an evaluation of the Trust's "Go Walk" campaign, which was very thorough and provided very useful information to help the Olympic Games Planning Team plan similar initiatives in the future. The LAS group won second prize for their report, against 14 groups of other students from across four schools in the borough.

Learning disabilities:

- Daryl Mohamed, Assistant Medical Director (Primary Care), is leading on a new project to improve our service for people with learning disabilities. This is likely to encompass staff development on this topic – possibly involving service users in training – and working with service users to develop resources and materials to remind them what to do in an emergency or when they have a health problem.

Category C Service User Survey:

- In 2008 Picker Europe were commissioned to assess how changes in the way Category C calls are managed have affected patients' perceptions of ambulance care.

- The national picture was very positive and the LAS also performed well overall. However, the scores were generally lower than those for other ambulance services and the free text comments highlighted a number of areas where improvements could be made.

- A small group is being established to explore the findings of the survey in more detail, and take forward actions and recommendations arising from it.

6 Olympic Funding

The Department of Health has asked all Trusts to use the Olympic Investment Appraisal Monitoring Board (OIAMB) business case template for submission of bids for 2012

funding. OIAMB is responsible for the approval and authorisation of multi agency spends under the Olympic Safety and Security Programme (OSSP).

The funding process for the LAS revolves around a jointly developed and agreed business case with NHS London and Richmond and Twickenham PCT. The business case when complete will be presented to the London PCT Chief Executive Group prior to submission to the Department of Health.

The current target is to present a joint business case to the NHS London CEOs meeting on 24/9/09 with a planned approval by NHS London on 7/10/09. The LAS will work on the required agreements with London PCTs, NHS London and the DH before submission to the Trust Board in Q4 as part of the Business Planning Process.

A draft LAS business case has now been developed and outlines approximately £23m of updated costs including almost £1m in opportunity costs for the period 2009/10 – 2012/13. A number of assumptions surrounding these costs have been noted and these are included in this report. Since the requirements of LOCOG are changing further operational costs may be incurred in the run up to the Games period and the business case will be updated as required.

The LAS has further developed an internal model to support its bid analysis. This model has updated previously submitted bids as part of the Comprehensive Spending Review Process.

Peter Bradley CBE
Chief Executive Officer

21 July 2009

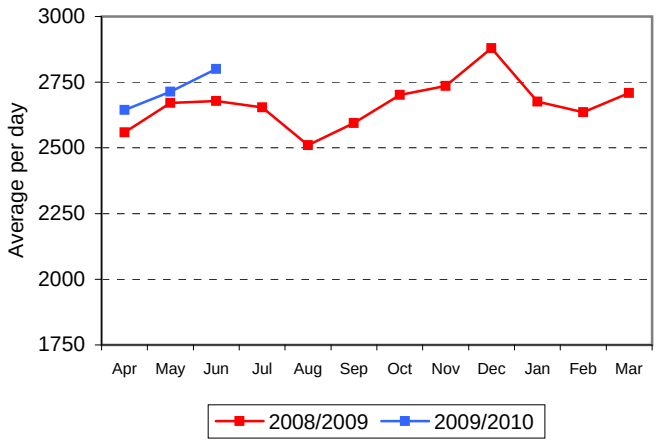
London Ambulance Service
NHS Trust

Information Pack for Trust Board

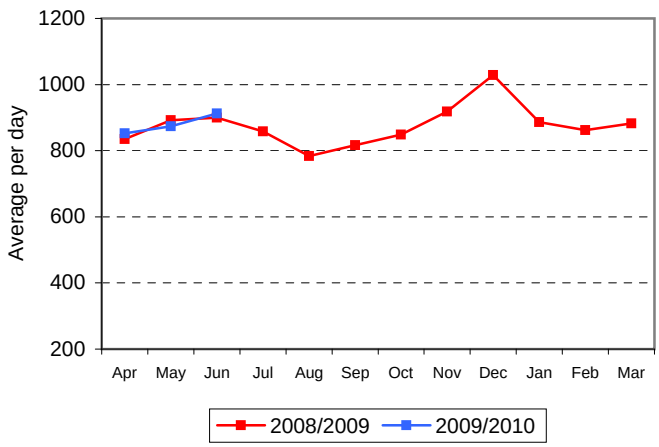
June 2009

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

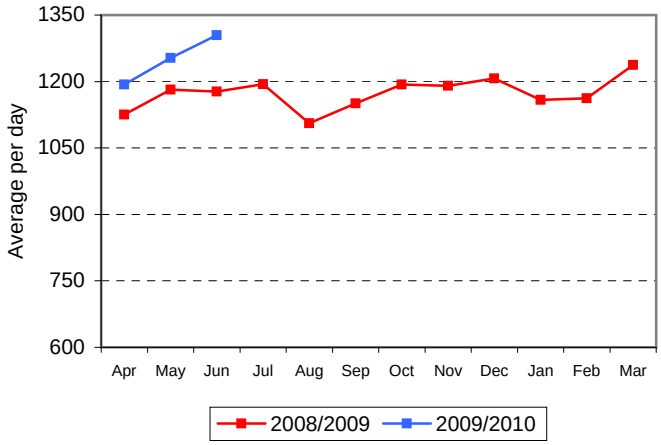
Graph 1
Average number of Cat A, B & C incidents per day



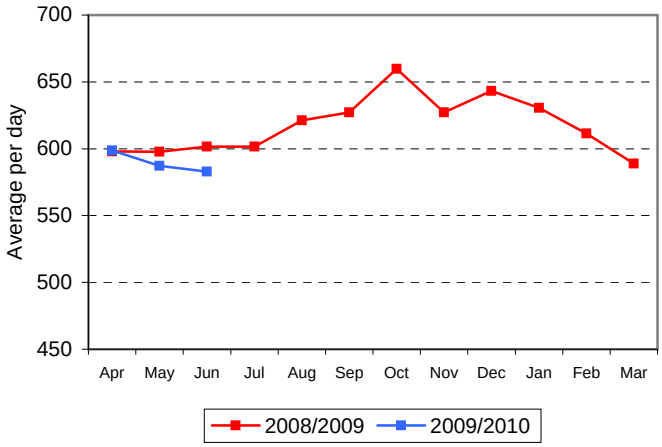
Graph 2
Average number of Cat A incidents per day



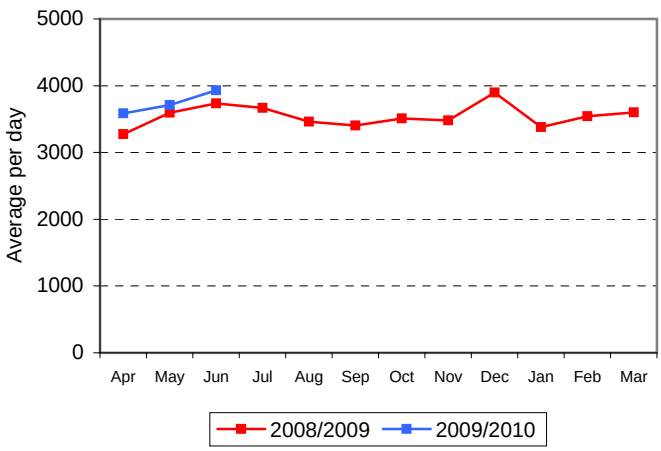
Graph 3
Average number of Cat B incidents per day



Graph 4
Average number of Cat C incidents per day

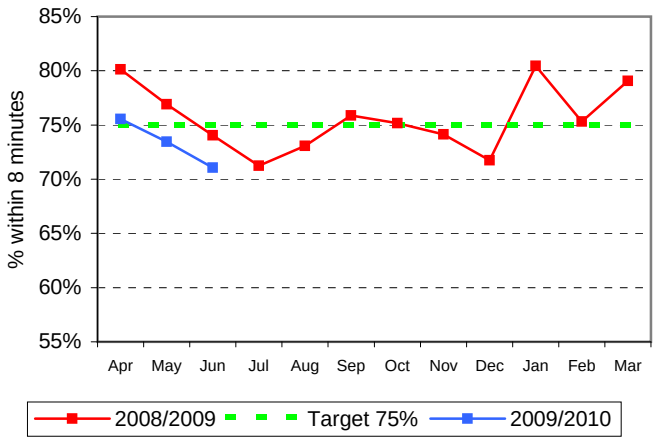


Graph 5
Average number of 999 calls received per day

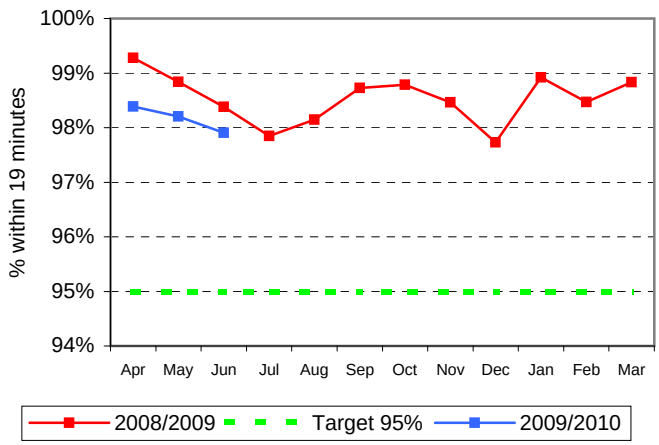


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - June 2009

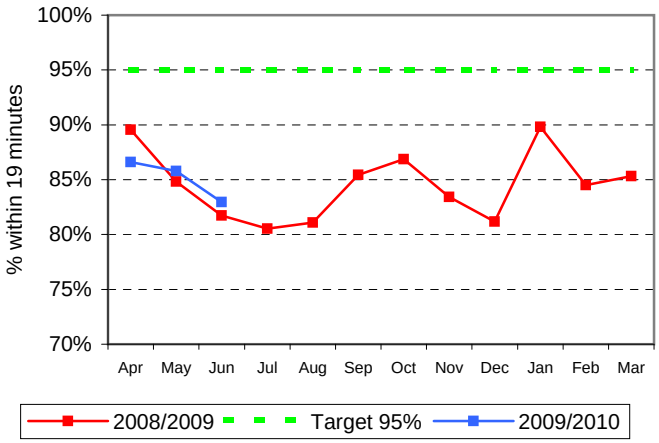
Graph 6
Category A 8 minute performance



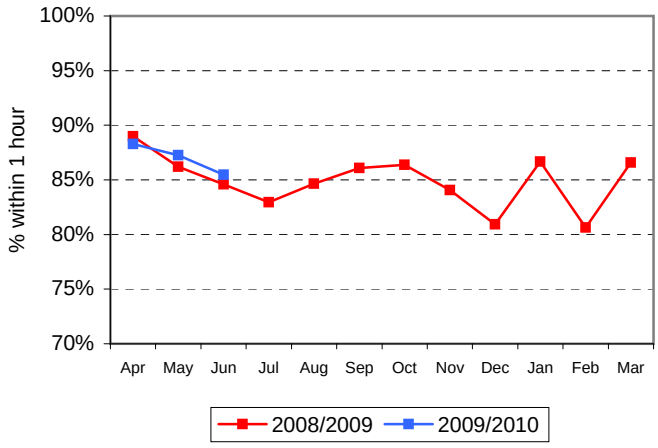
Graph 7
Category A 19 minute performance



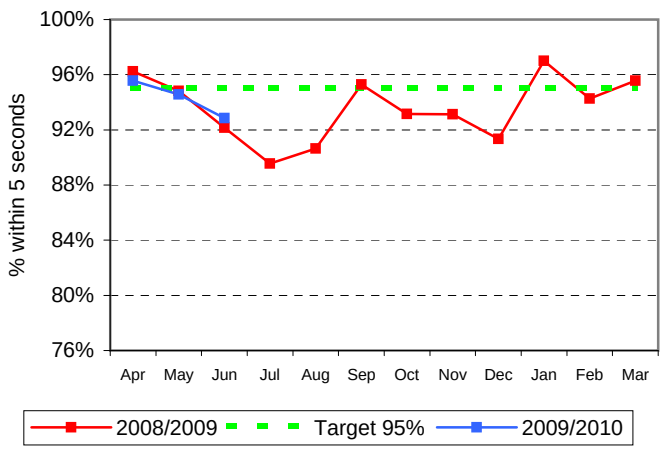
Graph 8
Category B 19 minute performance



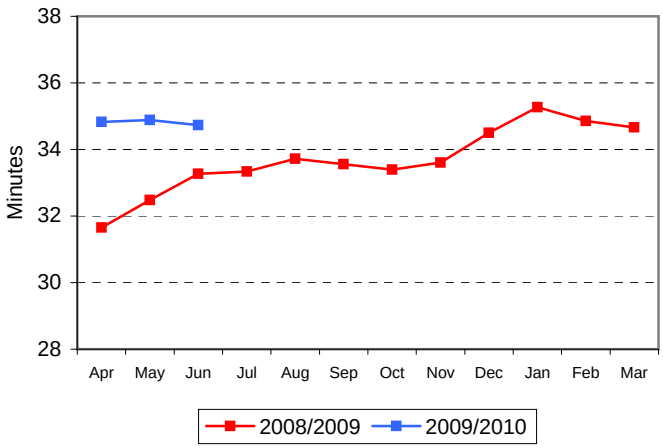
Graph 9
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)



Graph 10
Percentage of calls answered within 5 seconds

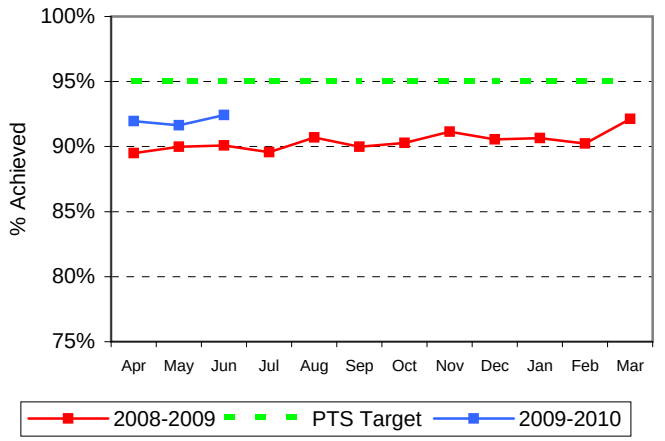


Graph 11
Average hospital turnaround time

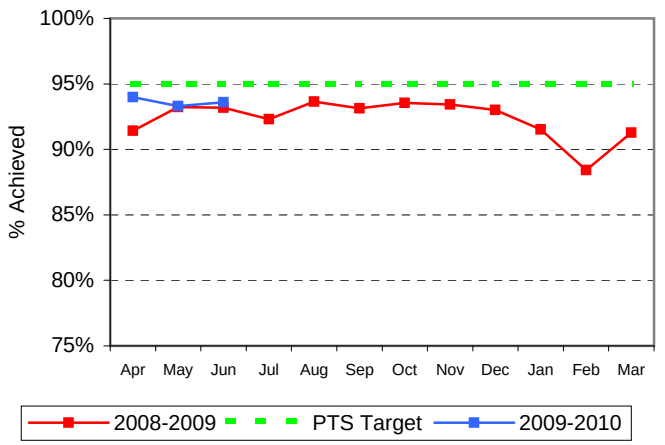


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - June 2009

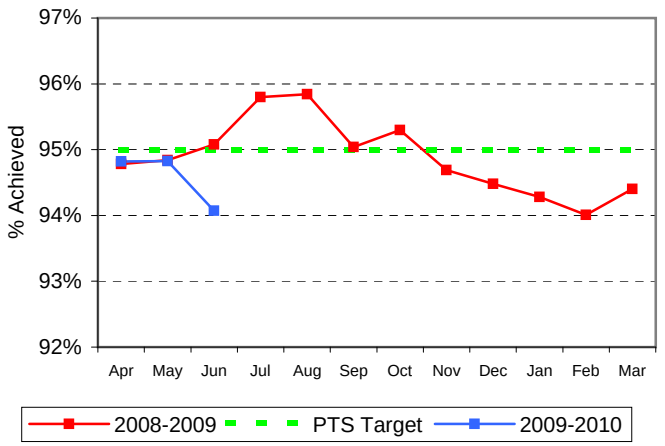
Graph 12
Arrival at Hospital Against Appointment Time



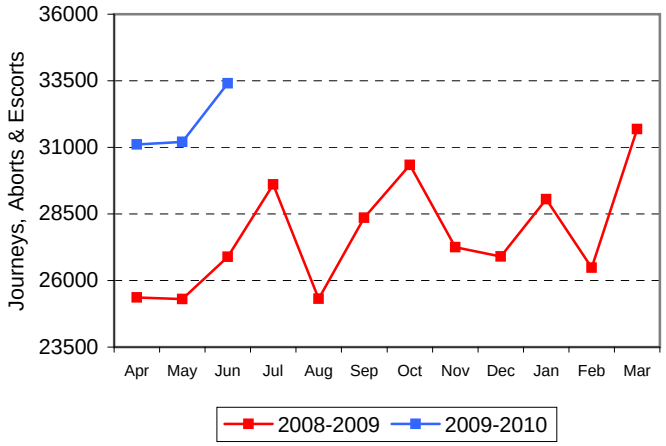
Graph 13
Departure Against Ready Time



Graph 14
Time spent on Vehicle

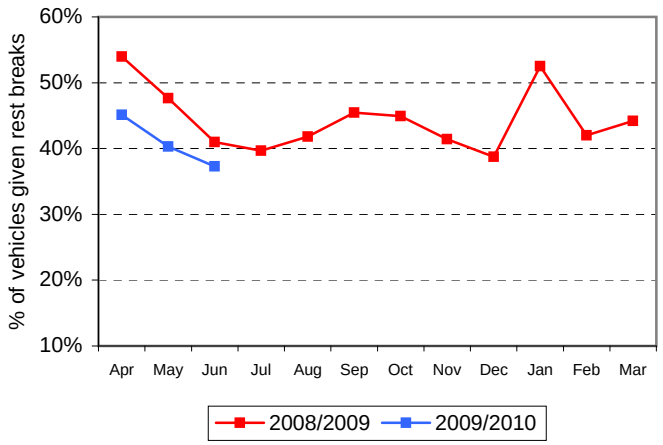


Graph 15
PTS Total Activity

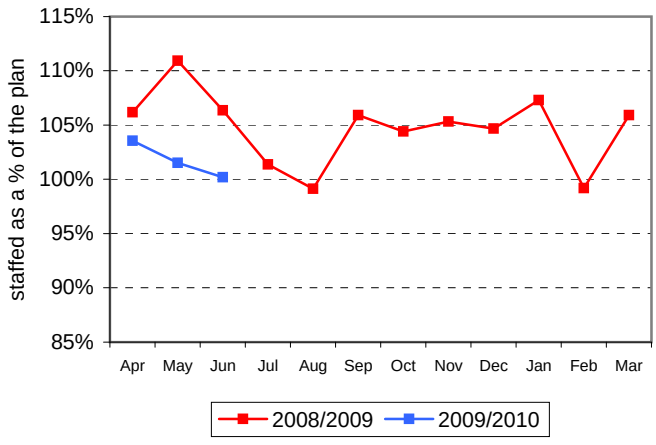


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - June 2009

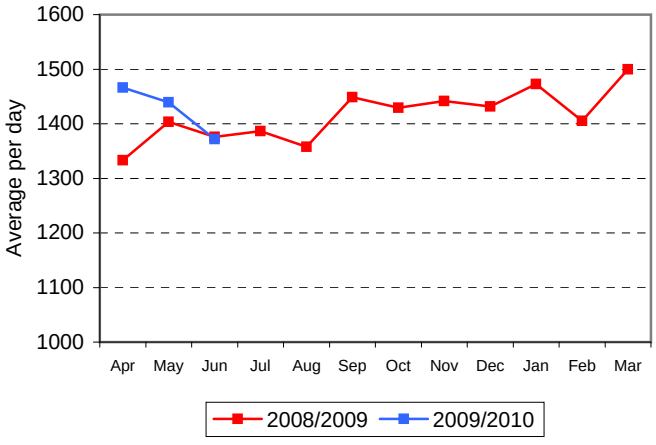
Graph 16
% of vehicles given a rest break



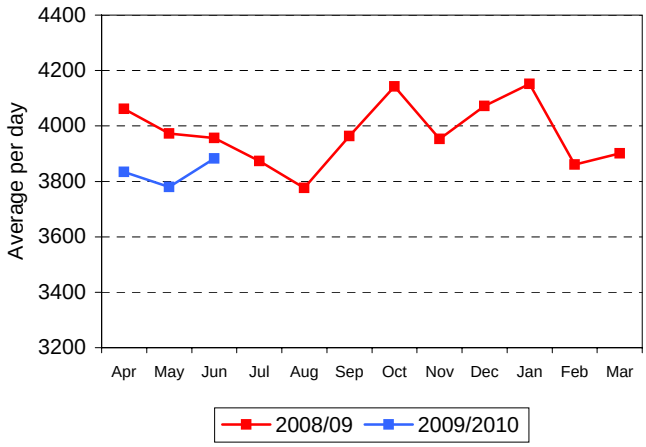
Graph 17
EOC Staffing as a % of the plan



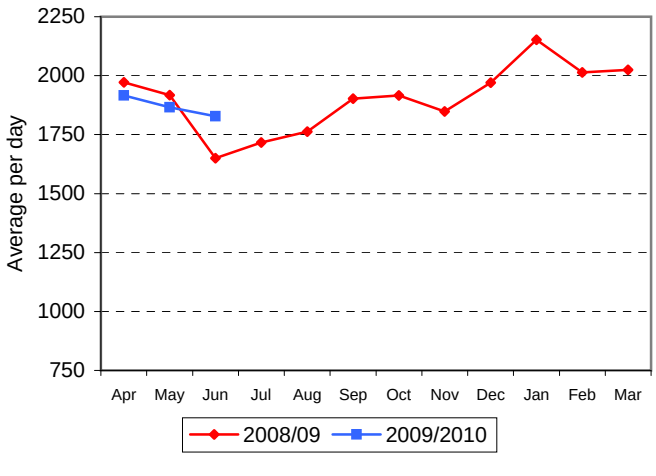
Graph 18
EOC hours staffed per day



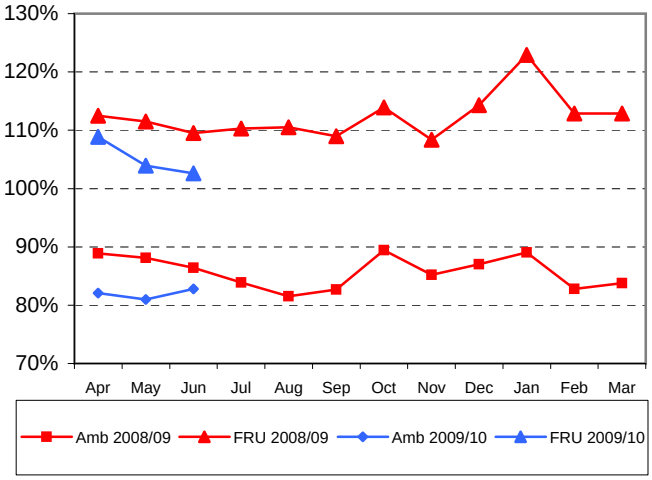
Graph 19
Ambulance hours available per day



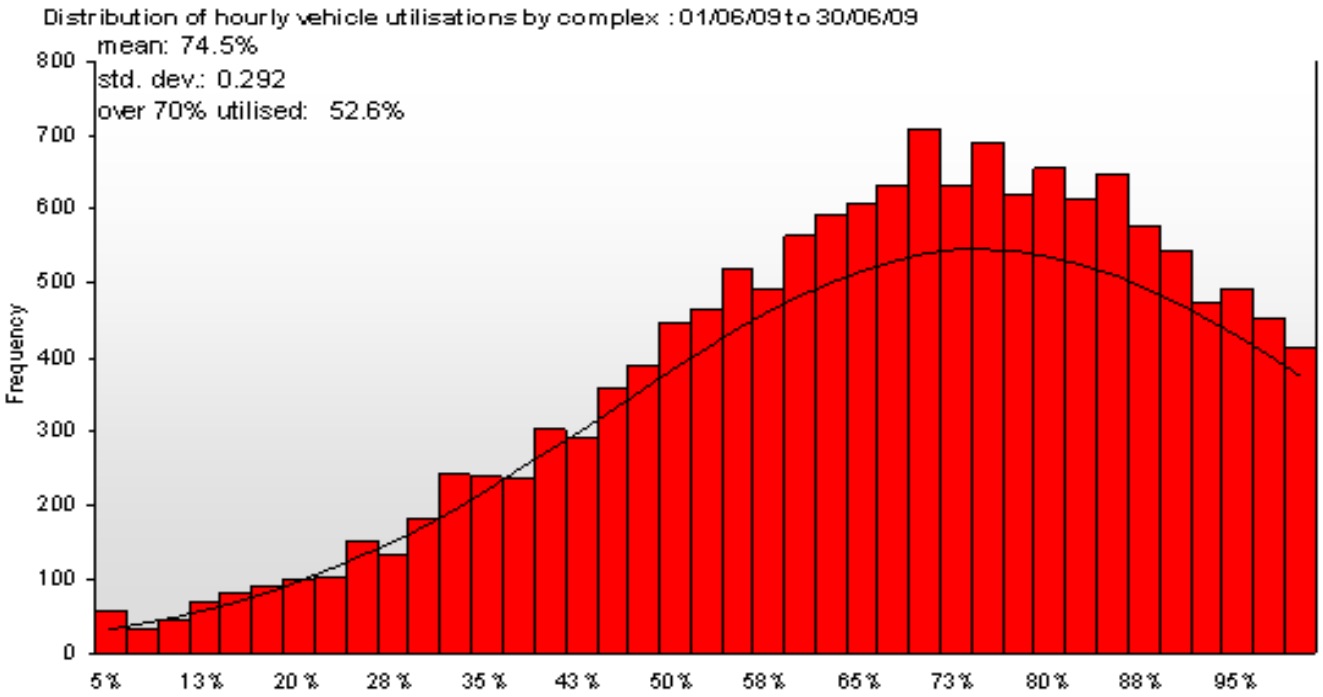
Graph 20
FRU hours available per day



Graph 21
Vehicle availability as a percentage of the plan



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



London Ambulance Service
NHS Trust

Trust Board Meeting Front Sheet

Title: Final 2008/09 Audited Accounts	**Agenda Item: 7** **Enclosure: 4**

Purpose:

To inform the Trust Board on the financial performance of the Trust for the year ending 31st March 2009.

Summary:

Financial Performance - The retained surplus for the year was £725k.

Capital Cost Absorption Rate – The Trust is required to make a 3.5% financial return on average net relevant assets. The actual rate of return in 2008/09 was 4.2%; this was above the permitted range of 3.0% to 4.0%. The variance from 3.5% is due to the fall in value of land & buildings attributable to the current economic downturn.

External Financing Limit (EFL) – The Trust achieved its External Financial Limit (EFL) target of £7,467k for the year.

Capital Resource Limit (CRL) – The Trust is given a CRL which it is not permitted to overspend. The CRL was under spent by £1,247k against the limit agreed with the London Strategic Health Authority of £15,865k.

Public Sector Payment Policy (PSPP) – The PSPP performance for Non-NHS trade invoices was 85% and for NHS invoices 89% (in numbers of invoices); the target set by the Strategic Health Authority is 95%.

The Trust is required to submit its audited accounts to the Department of Health on or before the 12 June 2009.

Recommendations/and or actions required:

The Trust Board is asked to ratify the final 2008/09 audited accounts for the year ending 31 March 2009.

Author and Date:

Michael Dinan – 14 July 2009

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board Meeting – 28 July 2009

Report on behalf of the Executive Trust Director Finance

Audited Annual Accounts for the year ending 31 March 2009

1. **Annual Accounts**

   The Audited Annual Accounts for the year ending 31 March 2009 are attached.

2. **Audit Committee**

   The audit committee approved the accounts on the 8 June 2009.

3. Audit Commission

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

4. **Statutory Duties (Note 24, pages 36 & 37)**

   Performance against the four statutory duties was as follows:

   - **Breakeven performance – achieved**

     The retained surplus for the year was £725k.

   - **Capital Cost Absorption Rate – not achieved**

     The Trust is required to make a 3.5% financial return on average relevant net assets. The actual rate of return in 2008/09 was 4.2%; this was above the permitted range of 3.0% to 4.0%. The variance from 3.5% is due to the fall in value of land & buildings attributable to the current economic downturn.

   - **External Financing Limit – achieved**

     The Trust achieved its External Financial Limit (EFL) target of £7,467k for the year.

   - **Capital Resource Limit – achieved**

     The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend. The CRL was underspent by £1,247k against the

limit agreed with NHS London of £15,865k.

5. **Accounts Completion**

The Annual Accounts were completed by the 23 April 2009 target date and submitted to the NHSE, Audit Commission and NHS London.

6. **Public Sector Payment Policy (PSPP) (Note7.1, page 22)**

The PSPP performance for Non-NHS trade invoices was 85% and for NHS invoices it was 89% (in numbers of invoices), the target set by the NHS London was 95%.

7. Auditors Local Evaluation (ALE)

The ALE assessment for 2008-09 has not been completed at the time of this report. Last year the Trust achieved a 'Good' rating out of a possible Excellent, Good, Fair or Weak rating. The table below shows the current position, the highest score achievable for any category is 4:

ALE	2007-08	2008-09	Comments
Financial Management	3	4	Provisional - To be confirmed
Internal Control	3	3	Provisional - To be confirmed
Value for Money	3	3	Provisional - To be confirmed
Financial Standing	4	4	Provisional - To be confirmed
Financial Reporting	3	3	Provisional - To be confirmed
Final Overall Score	3	4	Provisional - To be confirmed

8. **Other Matters**

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

The Trust Board are asked to approve the audited annual accounts for the year ended 31st March 2009.

Michael Dinan
Director of Finance
13th July 2009

Definition of Statutory Duties

External Financing Limit (EFL)

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

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

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

For 2008/09 the Trust achieved its EFL.

Capital Resourcing Limit (CRL)

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

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

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

For 2008/09 the Trust achieved its CRL.

Capital Cost Absorption Rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £4,414,000, bears to the average relevant net assets of £106,096,000 that is 4.2%.

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

Break-even duty

The Trust is required to break-even each year. For 2008/09 the Trust exceeded this requirement and generated a surplus of £725k. (See board report for details).

BALANCE SHEET AS AT 31 March 2009

	NOTE	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS			
Intangible assets	10	**6,752**	3,765
Tangible assets	11	**107,061**	119,652
Financial assets	14	**0**	0
TOTAL FIXED ASSETS		**113,813**	123,417
CURRENT ASSETS			
Stocks and work in progress	12	**2,600**	1,930
Debtors	13	**12,467**	21,417
Investments		**0**	0
Other financial assets	14	**0**	0
Cash at bank and in hand	19.3	**2,651**	10,478
TOTAL CURRENT ASSETS		**17,718**	33,825
CREDITORS: Amounts falling due within one year	15.1	**(14,462)**	(18,471)
Financial liabilities	16	**0**	0
NET CURRENT ASSETS/(LIABILITIES)		**3,256**	15,354
TOTAL ASSETS LESS CURRENT LIABILITIES		**117,069**	138,771
CREDITORS: Amounts falling due after more than one year	15.2	**0**	0
Financial liabilities	16	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(11,931)**	(18,589)
TOTAL ASSETS EMPLOYED		**105,138**	120,182
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	23	**57,523**	56,488
Revaluation reserve	18	**32,810**	50,605
Donated asset reserve	18	**9**	68
Government grant reserve	18	**0**	0
Other reserves*	18	**(419)**	(419)
Income and expenditure reserve	18	**15,215**	13,440
TOTAL TAXPAYERS' EQUITY		**105,138**	120,182

The financial statements on pages 1 to 43 were approved by the Audit Committee on 8th June 2008 and signed on its behalf by:

Signed: ……(Chief Executive) Date: ……

Signed: ……(Audit Committee Chair) Date: ……

London Ambulance Service NHS TRUST

TRUST BOARD **DATE 28 July, 2009**

M3 Finance Board Pack

1. **Sponsoring Executive Director:** Mike Dinan

2. **Purpose:** *Information*

3. **Summary**

The result for the month is a deficit of £208k, the year to date shows a surplus of £314k .The full year surplus is forecast to be £1,690k.

The forecast profile has changed to reflect the activity undertaken to support performance. The full year forecast has been maintained .

The key risks are around the achievement of the Cost Improvement Plan, the receipt of all budgeted income and the financial impact of responding to increased demand.

4. **Recommendation**
Board to note

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD
June 2009/10 (MONTH 03)

Contents:

Page 3: EBITDA Summary
Page 4: Commentary
Page 5: Summary of financial position
Page 6: Forecast by Month
Page 7: Comparison of Forecast to Forecast.
Page 8: IFRS Impact on I&E
Page 9: Financial performance graphs
Page 10: Analysis by Expense type
Page 11: Analysis by Function
Page 12: Analysis of income
Page 13: Income & Expenditure trends over the last year
Page 14: Income & Expenditure trend graphs
Page 15: Capital Expenditure Forecast
Page 16: Balance Sheet
Page 17: Cashflow

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 30th June 2009 (Month 3)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	23,606	23,513	93F	69,800	70,706	(906)U	(1.3%)U	277,881	281,930	(4,049)U
Total Operational Costs	22,416	22,288	(127)U	65,354	66,609	1,254F	1.9%F	259,021	267,371	8,350F
Total Expenditure	23,814	23,343	(471)U	69,486	69,772	286F	0.4%F	276,191	280,024	3,833F
EBITDA	**1,190**	**1,225**	**(35)U**	**4,445**	**4,097**	**348F**	**0F**	**18,860**	**14,559**	**4,301F**
EBITDA Margin	***5%***	***5%***	**0%**	***6%***	***6%***	**1%**		***7%***	***5%***	**2%**
Depreciation & Interest	1,398	1,054	(343)U	4,131	3,163	(968)U	(30.6%)U	17,170	12,653	(4,518)U
Net *Surplus/(Deficit)*	**(208)**	**171**	**(378)U**	**314**	**934**	**621**	**31.2%F**	**1,690**	**1,906**	**(217)U**
Net Margin	***-0.9%***	***0.7%***	***-0.2%***	***0.4%***	***1.3%***	***-0.9%***		***0.6%***	***0.7%***	***0.1%***

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending June 30th 2009

Year to Date

• For the year to date, income exceeds expenditure by £314k. The budgeted position is for income to exceed expenditure by £934k, hence there is a year to date adverse variance of £621k.
• This is mainly due to the fact that Income is lower than plan by £906k due to provisions for Cat B and MPET.
• PTS is reporting a profit to date of £189k against a planned surplus of £100k which reflects higher than planned activity.

Month

• In the month there is a £208k loss against a planned surplus of £171k resulting in an unfavourable movement of £378k.
• The loss is a result of increased spend on overtime incentives, overtime usage and subsistence due to ongoing operational demand pressures.
• PTS reported a surplus of £44k which results from increased activity.

Forecast

• The year end forecast is £1,690k surplus against a planned surplus of £1,906k.
• Forecast Income has reduced against plan by £4,049k due to a CAT B Penalty provision of £3.6m and a Reduction of MPET Funding of £1,000k. There is a partial offset caused by an increase in variable income.
• Forecast Pay expenditure increased by £2,651k against budget due to additional forecast Overtime Incentive £2,557k
• Forecast Non Pay is less than plan by £5,686k mainly due to unidentified CIP savings required.

Key Items

• The Forecast profile has changed significantly between M02 and M03 Forecasts mainly due to a rephasing of £1.7m Overtime and Incentive Costs across the year

Cashflow

• The forecast year-end cash balance is £5,081k.
• The Trust's cashflow assumes that the sale and lease back of 100 new ambulances will occur November 2009 and the lease of 65 vehicles will occur in March 2010.
• The Trust will be taking out a £10m loan facility with the Department of Health. The trust will be making its first drawdown of £1m in July against the loan facility.
• The PDC dividend is paid to the Department of Health in September and March of each year.

Balance Sheet

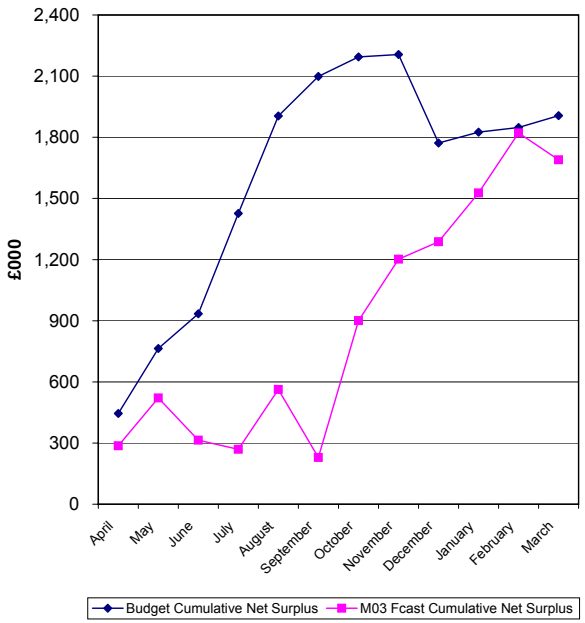
• Property, Plant & Equipment – The Trust is planning to £10m on new ambulances and £16m on technology, equipment, property and vehicles.
• Provisions - The Trust is negotiating with the HMRC to resolve the outstanding subsistence liability, when concluded this will result in a reduction of £1m in the provision. The Trust is also expecting to utilise the £2.2m Mercedes Ambulances conversion provision before the year end.

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 30th June (Month 03)

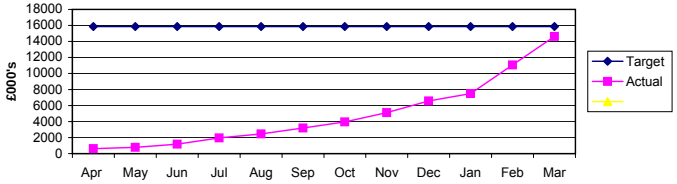
Income and Expenditure

Cumulative Net Financial Position

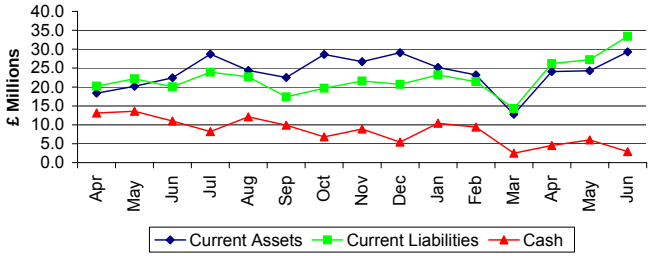


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	April	May	June	
Asset turnover ratio	2.42	2.62	2.16	●
Debtors % > 90 days	5.3%	17.8%	-1.7%	●
PSPP NHS	96%	100%	89%	●
PSPP Non NHS	88%	91%	81%	●

Key Financial Indicators

	April	May	June
A&E Overtime (£000) / Day (Month)	56	50	56
A&E Overtime (% of paybill)	10.12%	9.03%	9.87%
Subsistence (£000) / Day (Month)	5.56	5.89	6.82
Subsistence per head £	39.30	42.27	46.99
Third Party Transport expenditure / Day (Month)	5,142	7,112	6,540
Total operational cost per incident	273	253	267
A&E Gross Surplus (YTD) (% of Income)	24.9%	25.5%	24.9%
A&E Net Margin (YTD) (% of Income)	0.9%	0.3%	0.1%
PTS Gross Margin (YTD) (% of Income)	12.4%	8.00%	7.54%
Cat B performance (cumulative)	86.60%	86.17%	85.07%

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 30th June 2009 (Month 3)

£000s

	MONTHLY SPEND												
	April *Actual*	May *Actual*	June *Actual*	July *Forecast*	August *Forecast*	September *Forecast*	October *Forecast*	November *Forecast*	December *Forecast*	January *Forecast*	February *Forecast*	March *Forecast*	Total
Income	**22,954**	**23,240**	**23,606**	**23,673**	**23,393**	**23,320**	**23,340**	**23,081**	**22,936**	**22,840**	**22,802**	**22,695**	**277,881**
Pay Expenditure													
A&E Operational Staff	9,143	9,201	9,318	9,697	9,825	10,114	10,209	10,347	10,352	10,464	10,480	10,401	119,549
Overtime	1,695	1,552	1,680	1,591	1,195	1,199	969	971	973	723	698	724	13,969
Overtime Incentives	443	781	513	690	600	529	0	0	0	0	0	0	3,557
A&E Management	1,023	1,024	1,072	1,058	1,061	1,060	1,060	1,060	1,060	1,060	1,060	1,060	12,659
EOC Staff	1,008	1,044	1,039	1,074	1,037	1,065	1,040	1,065	1,040	1,089	1,040	1,089	12,631
PTS Operational Staff	491	527	511	506	506	531	531	531	531	531	531	531	6,259
PTS Management	82	76	78	77	77	77	77	77	77	77	77	77	927
Corporate Support	2,855	2,965	2,813	2,819	2,875	2,877	2,896	2,893	2,882	2,874	2,862	2,897	34,508
Sub Total	**16,740**	**17,168**	**17,025**	**17,512**	**17,177**	**17,452**	**16,783**	**16,943**	**16,915**	**16,818**	**16,748**	**16,779**	**204,059**
Average Daily	*558*	*554*	*567*	*565*	*554*	*582*	*541*	*565*	*546*	*543*	*598*	*541*	*559*
Non-Pay Expenditure													
Staff Related	371	341	303	339	338	349	333	307	322	298	291	290	3,882
Subsistence	167	183	204	186	143	123	115	115	103	111	96	102	1,649
Training	131	158	70	198	199	211	193	202	202	212	212	214	2,200
Medical Consumables & Equipment	517	450	498	736	589	739	579	579	530	426	426	423	6,492
Drugs	3	33	44	38	38	38	38	38	38	38	38	38	412
Fuel & Oil	367	375	389	380	382	384	384	384	384	384	384	384	4,586
Third Party Transport	154	220	196	156	156	136	136	136	136	136	136	136	1,838
Vehicle Costs	902	107	1,004	775	715	715	712	685	685	682	685	685	8,353
Accommodation & Estates	1,018	1,019	1,082	1,086	1,098	1,098	992	993	993	993	993	993	12,357
Telecommunications	592	617	800	479	513	620	643	664	824	807	849	808	8,217
Depreciation	623	1,255	976	1,023	1,023	1,116	1,135	1,150	1,165	1,223	1,223	1,223	13,137
Other Expenses	727	584	803	501	422	367	321	278	245	165	120	97	4,629
Profit/(Loss) on Disposal FA	1	0	2	0	0	0	0	0	0	0	0	350	347
Sub Total	**5,566**	**5,343**	**6,367**	**5,897**	**5,617**	**5,896**	**5,581**	**5,532**	**5,628**	**5,475**	**5,453**	**5,743**	**68,099**
Average Daily	*186*	*172*	*212*	*190*	*181*	*197*	*180*	*184*	*182*	*177*	*195*	*185*	*187*
Financial Expenditure	**362**	**493**	**422**	**308**	**306**	**306**	**305**	**305**	**307**	**307**	**307**	**305**	**4,033**
Average Daily	*12*	*16*	*14*	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*11*	*10*	*11*
Monthly Expenditure	**22,668**	**23,004**	**23,814**	**23,717**	**23,100**	**23,654**	**22,668**	**22,780**	**22,850**	**22,600**	**22,508**	**22,827**	**276,191**
Cumulative	**22,668**	**45,672**	**69,486**	**93,203**	**116,303**	**139,957**	**162,625**	**185,406**	**208,256**	**230,856**	**253,364**	**276,191**	
Monthly Net	**286**	**235**	**(208)**	**(45)**	**293**	**(334)**	**672**	**301**	**86**	**240**	**294**	**(132)**	**1,690**
Cumulative Net	**286**	**521**	**314**	**269**	**563**	**229**	**901**	**1,202**	**1,288**	**1,527**	**1,821**	**1,690**	

LONDON AMBULANCE SERVICE NHS TRUST

Comparison of annual forecasts at Month 3 and Month 2
As at 30th June (Month 3)

	Forecast			
	Month 3	Month 2	Variance	
Income	**277,881**	**276,767**	**1,114F**	**HART (Hazardous Area Response Team) income decreased by 250k due to change to start date of funding. PTS income increase by 200k due to higher expected activity. PTS forecast Income increased by £1.1m.**
Pay Expenditure				
A&E Operational Staff	119,549	119,995	446F	Based on revised workforce plan
Overtime	13,969	15,504	1,536F	Overtime reduced in months 6 to 12 to offset increase in Incentive £1,800k. PTS Overtime increased by £300k in line with projected usage
Overtime incentives	3,557	1,774	(1,783)U	Incentive extended to M06 in line with month 1 to 3 expenditure. Additional spend is expected to be offset by reduced spend on Overtime from Months 6 to 12
A&E Management	12,659	12,564	(95)U	Additional management resource forecast
EOC Staff	12,631	12,841	210F	Forecast reduced in line with review of EOC training plan.
PTS Operational Staff	6,259	5,631	(627)U	PTS additional spend, Offset by Savings in agency Staff, and increase in income.
PTS Management	927	871	(55)U	
Corporate Support	34,508	33,553	(955)U	Adjustment in realisable savings in Corporate support. Previously included £1m primarily for agency savings. This is now largely offset by filling permanent posts being covered by agency
Sub Total	**204,059**	**202,735**	**(1,324)U**	
Non-Pay Expenditure				
Staff Related	3,882	3,855	(27)U	
Subsistence	1,649	1,649	1F	
Training	2,200	2,357	156F	Lower spend forecast reflects reduced spend on training due to operational demand pressures
Drugs	412	426	14F	
Medical Consumables & Equipment	6,495	5,837	(658)U	£600k projected increase in Pandemic Flu spend (e.g. Masks etc.)
Fuel & Oil	4,586	4,514	(72)U	PTS extra fuel forecast due to extra vehicles on the road and reflect current trend.
Third Party Transport	1,838	1,253	(585)U	Third party increase due to increase in PTS activity
Vehicle Costs	8,353	9,754	1,401F	£1,053k reduction in Vehicle Costs due to New 100 amb leases reforecast as Finance rather than Operating Leases. £634k reduction in Vehicle costs relating to existing leases adjusted for IFRS. £214k increase on forecast for maintenance on LDV vehicles as
Accommodation & Estates	12,353	11,690	(663)U	Additional Make Ready VRC Driver Costs
Telecommunications	8,217	8,491	274F	£130k reduction in spend on IPT phones as estimated will be in stock at M12, £93k Capital Reallocation
Depreciation	13,137	11,653	(1,485)U	£927k New 100 amb leases previously forecast as operating leases now forecast as finance leases. £530k increase due to IFRS adjustment for existing leases
Other Expenses	4,629	4,702	73F	Contains unidentified CIP of £7.8m. Finance working with individual direcotrates to resolve.
Profit/(Loss) on Disposal FA	347	350	3F	
	68,099	**66,531**	**(1,568)**	
Dividends	3,538	5,370	1,832F	Revision of PDC Dividend based on Balance Sheet.
Financing Costs and Interest Payabe	513	281	(232)U	Increase of £127k for new 100 amb leases previously forecast as operating leases now forecast as finance leases. £105k increase due to IFRS adjustment for existing leases.
Other Financial Expenditure	18	161	179F	
Financial Expenditure	**4,033**	**5,811**	**1,779F**	
Total Expenditure	**276,191**	**275,077**	**(1,114)U**	
Net	**-1,690**	**-1,690**	**0F**	

London Ambulance Service NHS Trust

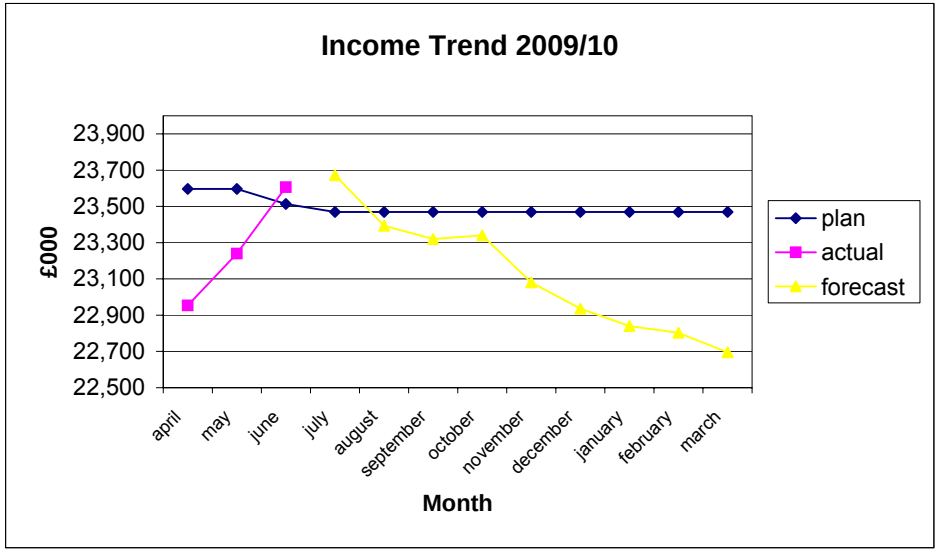
Month 03 Trust Board report - Effect of IFRS on I&E

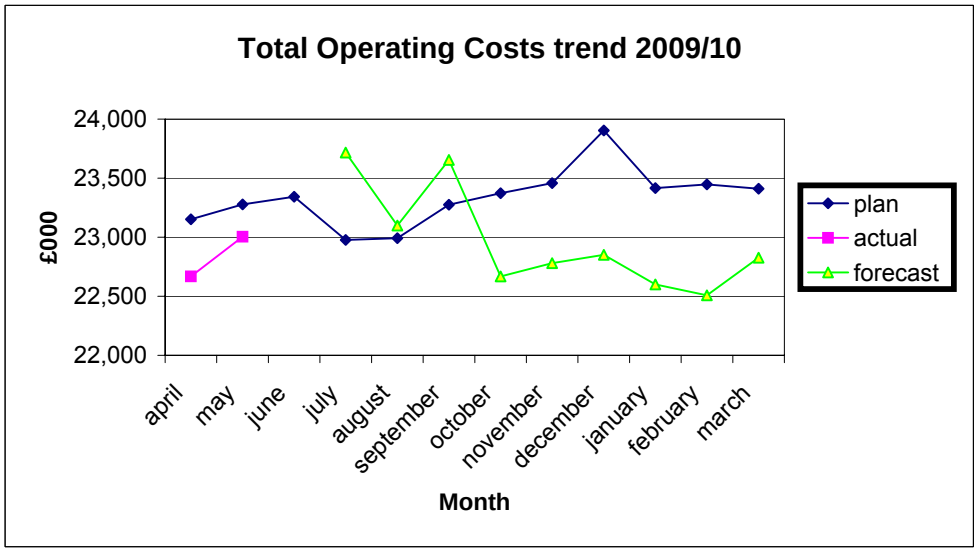
YTD	UK GAAP	IFRS	Variance
	£000	£000	£000
Vehicle Costs	3,079	2,013	1,066
Depreciation	1,980	2,855	-875
Financial Expenditure	1,086	1,277	-191
Total	**6,144**	**6,144**	**0**

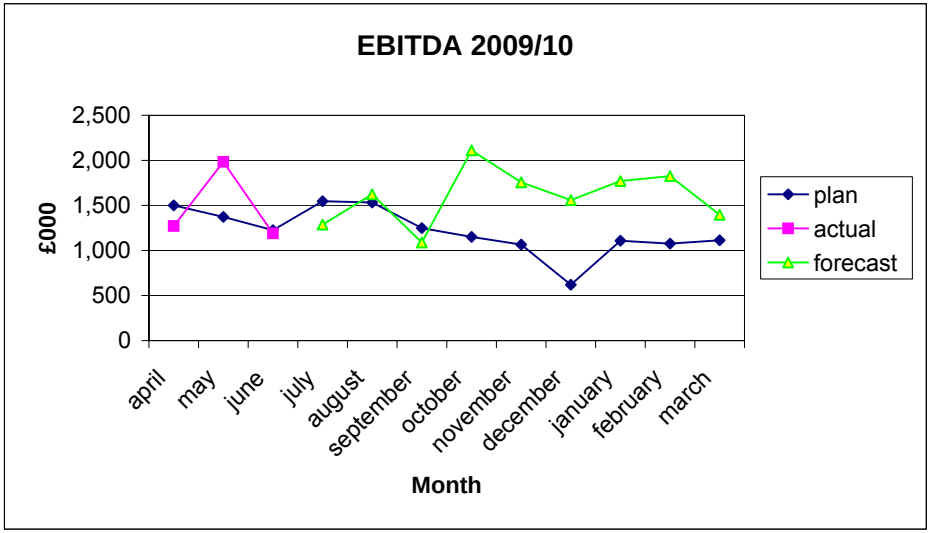
FYE	UK GAAP	IFRS	Variance
	£000	£000	£000
Vehicle Costs	14,306	8,353	5,953
Depreciation	8,140	13,137	-4,997
Financial Expenditure	3,077	4,033	-956
Total	**25,523**	**25,523**	**0**

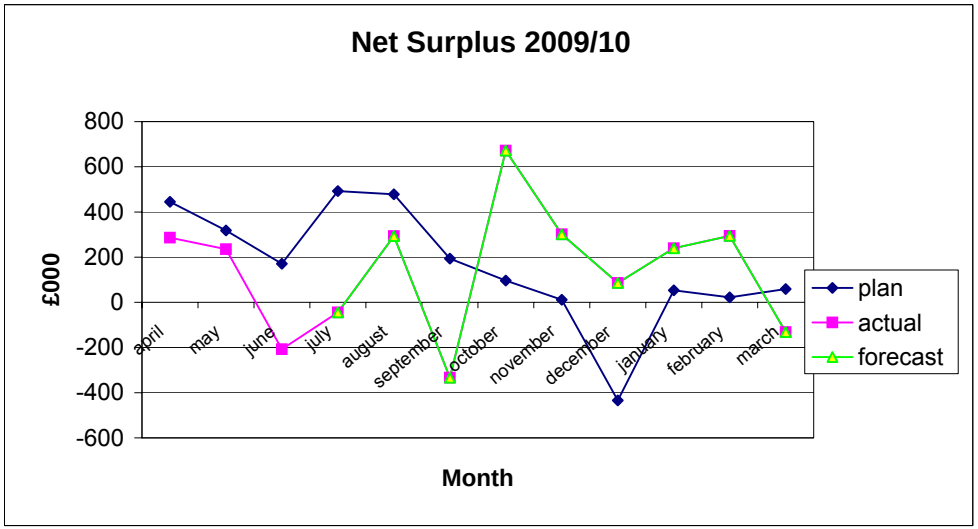
London Ambulance Service NHS Trust

Month 03 Trust Board report - forecast data









LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 30th June 2009 (Month 3)

£000s

	IN THE MONTH			*YEAR TO DATE*			*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Pay Expenditure									
A&E Operational Staff	9,318	9,559	241F	27,662	28,294	633F	119,549	119,869	319F
Overtime	1,680	1,477	(203)U	4,927	4,441	(485)U	13,969	15,505	1,536F
Overtime Incentives	513	333	(180)U	1,737	1,000	(737)U	3,557	1,000	(2,557)U
A&E Management	1,072	1,013	(59)U	3,119	3,031	(88)U	12,659	12,152	(507)U
EOC Staff	1,039	1,045	6F	3,091	3,145	54F	12,631	12,797	166F
PTS Operational Staff	511	471	(40)U	1,528	1,501	(27)U	6,259	5,534	(725)U
PTS Management	78	105	27F	236	323	87F	927	1,268	342F
Corporate Support	2,813	2,782	(31)U	8,633	8,346	(287)U	34,508	33,285	(1,223)U
	17,025	**16,787**	**(238)U**	**50,933**	**50,083**	**(850)U**	**204,059**	**201,409**	**2,650**
Non-Pay Expenditure									
Staff Related	303	321	18F	1,015	965	(50)U	3,882	3,856	(26)U
Subsistence	204	120	(84)U	554	360	(194)U	1,649	1,441	(208)U
Training	70	207	137F	358	620	262F	2,200	2,482	282F
Drugs	44	35	(9)U	74	105	31F	412	420	8F
Medical Consumables & Equipment	498	487	(11)U	1,468	1,460	(8)U	6,495	5,839	(656)U
Fuel & Oil	389	380	(9)U	1,131	1,142	10F	4,586	4,534	(52)U
Third Party Transport	196	88	(108)U	571	264	(307)U	1,838	1,054	(784)U
Vehicle Costs	1,004	1,265	261F	2,013	3,812	1,799F	8,353	15,149	6,795F
Accommodation & Estates	1,082	874	(208)U	3,115	2,621	(494)U	12,353	10,484	(1,870)U
Telecommunications	800	707	(93)U	2,009	2,123	113F	8,217	8,485	268F
Depreciation	976	652	(324)U	2,855	1,955	(899)U	13,137	7,822	(5,316)U
Other Expenses	803	989	186F	2,115	2,967	852F	4,629	11,868	7,239F
Profit/(Loss) on Disposal FA	(2)	29	31	(3)	88	91F	347	350	3F
	6,367	**6,153**	**(213)U**	**17,276**	**18,481**	**1,205F**	**68,099**	**73,783**	**5,684F**
Financial Expenditure	**422**	**403**	**(20)U**	**1,277**	**1,208**	**(69)U**	**4,033**	**4,831**	**798F**
Total Trust Expenditure	**23,814**	**23,343**	**(471)U**	**69,486**	**69,772**	**286F**	**276,191**	**280,024**	**3,833F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 30th June 2009 (Month 3)

£000s

	IN THE MONTH			*YEAR TO DATE*			*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income	22,706	22,712	(6)U	67,107	68,136	(1,029)U	267,179	272,543	(5,364)U
Sector Services	13,646	13,664	18F	40,415	40,815	400F	165,399	165,703	304F
A&E Operational Support	1,596	1,277	(319)U	4,265	3,832	(434)U	17,048	15,281	(1,767)U
Control Services	1,842	1,500	(341)U	5,059	4,501	(558)U	19,696	18,158	(1,538)U
Planning and Specialised Ops	244	367	123F	661	1,101	440F	4,120	4,318	198F
Total Operations Cost	**17,328**	**16,808**	**(519)U**	**50,401**	**50,249**	**(152)U**	**206,263**	**203,461**	**(2,803)U**
A&E Gross Surplus/(Deficit)	**5,378**	**5,904**	**(525)U**	**16,706**	**17,886**	**(1,180)U**	**60,915**	**69,082**	**(8,167)U**
Gross Margin	23.7%	26.0%	(2.3%)U	24.9%	26.3%	-1.4%	22.8%	25.3%	-2.5%
Medical Directorate	104	100	(4)U	256	300	43F	1,213	1,203	(10)U
Service Development	73	98	24F	232	293	61F	820	1,174	353F
Communications	241	197	(44)U	608	590	(18)U	2,270	2,362	92F
Human Resources	1,897	1,924	26F	5,720	5,564	(156)U	21,908	21,497	(411)U
IM&T	1,249	1,196	(54)U	3,555	3,587	32F	14,587	14,348	(239)U
Corporate Services	23	38	15F	67	113	46F	2,637	452	(2,185)U
Finance	1,937	2,113	176F	5,859	6,340	481F	14,837	25,361	10,524F
Chief Executive	128	126	(3)U	349	378	28F	1,534	1,510	(24)U
Total Corporate	**5,653**	**5,791**	**138F**	**16,649**	**17,165**	**517F**	**59,806**	**67,906**	**8,100F**
A&E Net Surplus/(Deficit)	**(274)**	**113**	**(387)U**	**57**	**721**	**(664)U**	**1,109**	**1,176**	**(67)U**
A&E Net Margin	(1.2%)	0.5%	(1.7%)U	0.1%	1.1%	-1.0%	0.4%	0.4%	0.0%
Patient Transport Service	**44**	**20**	**24F**	**189**	**100**	**89F**	**620**	**278**	**342F**
Trust Result *Surplus/(Deficit)*	**(231)**	**133**	**(364)U**	**246**	**821**	**(575)U**	**1,729**	**1,454**	**275F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 30th June 2009 (Month 3)

£000s

	IN THE MONTH			*YEAR TO DATE*			*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
A&E Income									
A&E Services Contract	19,919	20,219	(300)U	59,757	60,657	(900)U	239,026	242,626	(3,600)U
HEMS Funding	11	11	0F	33	33	0F	131	131	(0)U
Other A&E Income	20	92	(73)U	274	276	(3)U	1,108	1,105	3F
Foundation Trust Income	20	39	86F	38	117	(80)U	197	470	(273)U
CBRN Income	1,008	1,008	0F	3,023	3,023	0F	11,842	12,092	(250)U
ECP Income	0	0	0F	0	0	0F	0	0	0F
BETS & SCBU Income	114	53	61F	145	159	(14)U	586	634	(48)U
A & E Long Distance Journey	42	33	9F	91	100	(9)U	350	400	(50)U
Stadia Attendance	91	85	6F	267	255	13F	1,024	1,019	5F
Heathrow BAA Contract	44	44	0F	133	133	0F	532	532	0F
Resus Training Fees	0	6	(6)U	6	17	(11)U	55	68	(13)U
MPET	1,142	851	291F	2,418	2,554	(136)U	8,616	10,217	(1,601)U
	22,410	**22,441**	**74**	**66,185**	**67,323**	**1,139**	**263,466**	**269,294**	**(5,828)U**
PTS Income	900	775	125F	2,693	2,490	202F	10,702	9,067	1,635F
Other Income	296	297	(2)U	922	892	30F	3,713	3,569	144F
Trust Result	**23,606**	**23,513**	**93F**	**69,800**	**70,706**	**(906)U**	**277,881**	**281,930**	**(4,049)U**

LONDON AMBULANCE SERVICE NHS TRUST

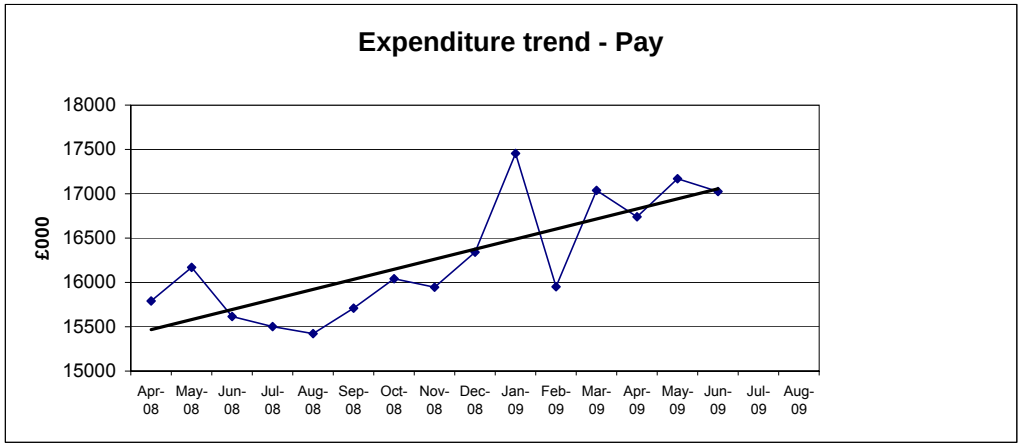
Expenditure Trends Including Last Year
As at 30 June 2009 (Month 3)

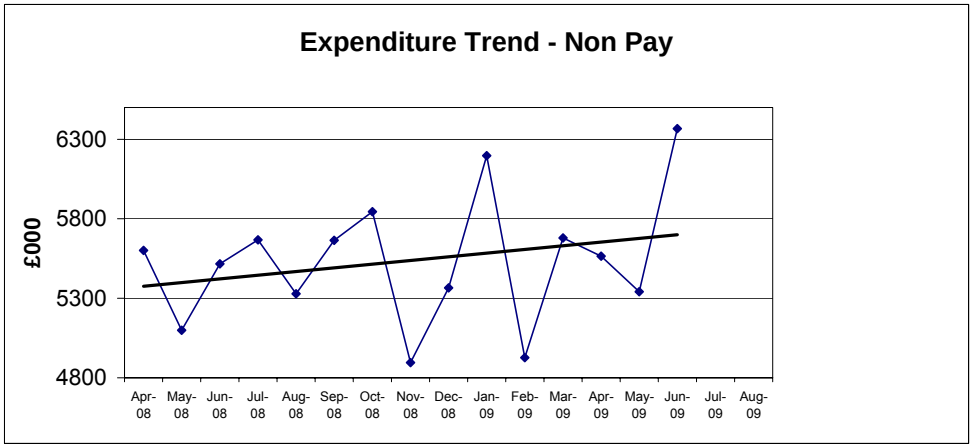
Current Year

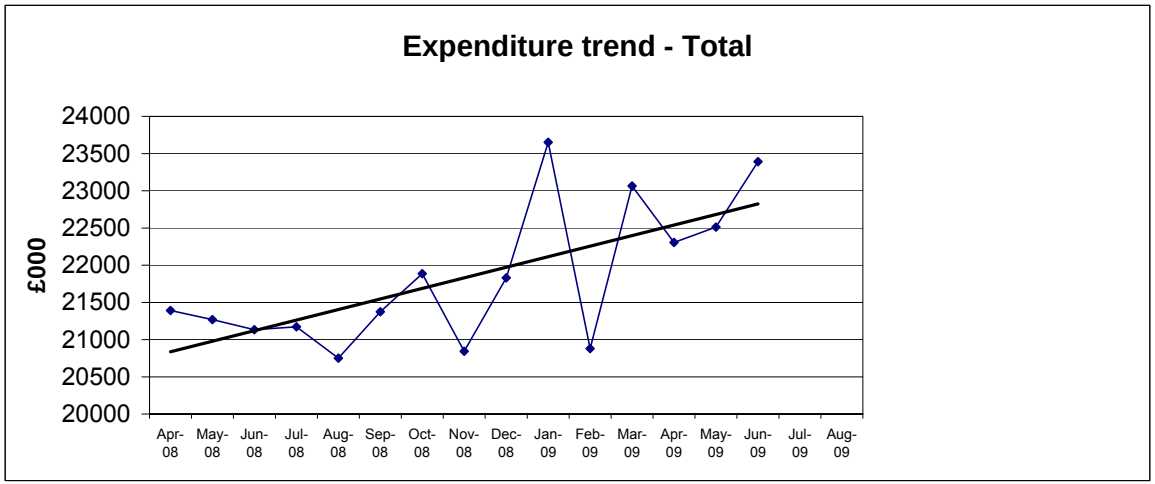
	June	July	August	September	October	November	December	January	February	March	April	May	June
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**21,128**	**21,147**	**21,219**	**22,551**	**23,328**	**19,982**	**22,955**	**22,728**	**22,590**	**21,790**	**22,954**	**23,240**	**23,606**
Pay Expenditure													
A&E Operational Staff	8,280	8,314	8,249	8,329	8,471	8,474	8,624	8,677	8,624	8,880	9,143	9,201	9,318
Overtime	1,897	1,647	1,566	1,620	1,739	1,601	1,712	1,710	1,495	1,735	1,695	1,552	1,680
Overtime Incentives	656	476	530	584	541	596	848	1,753	893	274	443	781	513
A&E Management	945	966	949	967	979	970	1,024	1,001	980	1,001	1,023	1,024	1,072
EOC Staff	979	1,006	982	985	948	962	918	965	1,007	990	1,008	1,044	1,039
PTS Operational Staff	468	468	476	454	485	468	470	464	448	479	491	527	511
PTS Management	86	87	91	83	88	93	60	80	74	79	82	76	78
Corporate Support	2,304	2,539	2,581	2,690	2,791	2,781	2,687	2,804	2,431	3,600	2,855	2,965	2,813
Sub Total	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**	**15,946**	**16,342**	**17,455**	**15,952**	**17,038**	**16,740**	**17,168**	**17,025**
Average Daily	*504*	*500*	*498*	*524*	*517*	*532*	*527*	*563*	*532*	*550*	*558*	*554*	*549*
Non-Pay Expenditure													
Staff Related	369	207	258	260	355	223	186	326	219	430	371	341	303
Subsistence	149	193	200	195	152	167	222	149	147	336	167	183	204
Training	129	54	85	65	226	10	131	167	120	262	131	158	70
Drugs	9	9	49	9	47	49	26	34	51	41	3	33	44
Medical Consumables & Equipment	410	499	433	547	486	374	494	526	463	272	517	454	498
Fuel & Oil	440	450	399	400	427	392	421	403	357	378	367	375	389
Third Party Transport	76	142	89	105	2,855	115	125	153	121	173	154	220	196
Vehicle Costs	943	1,083	948	1,013	1,128	1,017	1,153	1,225	836	1,507	902	107	1,004
Accommodation & Estates	750	927	833	874	926	938	1,052	1,013	1,018	1,091	1,018	1,015	1,082
Telecommunications	718	397	510	749	582	613	537	973	615	926	592	617	800
Depreciation	695	630	611	611	609	609	596	608	606	712	623	1,255	976
Other Expenses	585	766	574	540	813	394	477	621	392	750	727	584	803
Profit/(Loss) on Disposal FA	12	0	1	0	0	2	67	0	0	0	1	0	2
Sub Total	**5,261**	**5,356**	**4,987**	**5,366**	**5,845**	**4,897**	**5,489**	**6,197**	**4,942**	**5,664**	**5,566**	**5,343**	**6,367**
Average Daily	*170*	*173*	*161*	*179*	*189*	*163*	*177*	*200*	*165*	*183*	*186*	*172*	*205*
Financial Expenditure	**256**	**313**	**342**	**299**	**310**	**366**	**337**	**360**	**362**	**363**	**362**	**493**	**422**
Average Daily	*8*	*10*	*11*	*10*	*10*	*12*	*11*	*12*	*12*	*12*	*12*	*16*	*14*
Monthly	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**	**21,210**	**22,168**	**24,012**	**21,256**	**23,064**	**22,668**	**23,004**	**23,814**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends over the last 24 months as at 30th June 2009 (Month 3)







CAPITAL PLAN JUNE 2009

Cost Category	Actuals YTD M03	Forecast M4-12	FYE Forecast YE	2009/10 BUDGET
	£000	£000	£000	£000
Fleet	2,870	20	2,890	2,907
IM&T	599	9,229	9,828	9,817
Equipment	62	1,725	1,787	1,787
Estates	71	1,917	1,988	1,989
Total:	**3,602**	**12,891**	**16,493**	**16,500**

Current CRL:	16,500
Note: With the new ambulance leases being treated as finance leases under IFRS additional CRL	16,587
Revised CRL	33,087

LONDON AMBULANCE SERVICE NHS Trust

Statement of Financial Position
For the Month Ending 30 June 2009 (Month 3)

	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Non-Current Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Intangible assets	6,752	9,564	9,603	8,989	8,989	8,989	8,989	8,989	8,989	8,989	8,989	8,989	8,989
Property, Plant and Equipment	121,789	117,135	109,296	109,857	111,947	113,247	118,096	118,264	118,364	122,579	121,856	121,133	126,466
Trade and Other Receivables	12,462	12,484	12,507	12,654	12,654	12,654	12,654	12,654	12,654	12,654	12,654	12,654	12,654
Total Non-Current Assets	141,003	139,183	131,406	131,500	133,590	134,890	139,739	139,907	140,007	144,222	143,499	142,776	148,109
Current Assets													
Inventories	2,600	2,547	2,508	2,510	2,510	2,510	2,510	2,510	2,510	2,510	2,510	2,510	2,510
NHS Trade Receivables	2,773	4,339	1,680	8,978	8,279	4,251	4,244	4,246	4,220	4,205	4,195	4,191	4,180
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Receivables	6,140	5,769	5,629	5,659	5,289	5,289	5,289	5,289	5,289	5,289	5,289	5,289	5,289
Accrued Income	0	3,619	5,638	6,034	5,705	4,367	4,626	4,588	4,847	5,106	5,057	4,731	4,152
Prepayments	4,561	3,329	2,843	3,221	3,076	3,021	2,966	2,911	3,130	3,075	3,020	2,965	2,910
Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash and Cash Equivalents	2,533	4,513	6,013	2,924	1,582	4,606	3,125	1,069	11,799	11,916	12,029	12,721	5,081
Current Assets	18,607	24,116	24,311	29,326	26,441	24,044	22,760	20,613	31,795	32,101	32,100	32,407	24,122
Non-Current Assets Held for Sale	0	1,700	1,700	1,709	1,709	1,709	1,709	1,709	1,709	1,709	1,709	1,709	1,709
Total Current Assets	18,607	25,816	26,011	31,035	28,150	25,753	24,469	22,322	33,504	33,810	33,809	34,116	25,831
Total Assets	159,610	164,999	157,417	162,535	161,740	160,643	164,208	162,229	173,511	178,032	177,308	176,892	173,940
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0
Trade Payables	7,531	6,518	6,333	6,851	6,240	5,907	6,065	5,749	5,652	5,727	5,524	5,481	5,275
Other Liabilities	3,887	9,845	9,869	9,728	7,083	6,942	7,057	6,776	6,843	6,831	6,290	5,761	286
PDC Dividend Liabilities	0	350	820	1,230	1,487	1,744	0	257	514	771	1,028	1,285	0
Capital Liabilities	1,926	132	149	162	1,775	848	2,463	516	1,516	1,896	1,896	1,896	2,064
Accruals	4,139	4,858	5,873	5,732	5,732	5,732	5,732	5,732	5,732	5,732	5,732	5,632	4,934
Deferred Income	0	930	561	6,171	5,830	5,489	5,148	4,807	4,466	4,105	3,714	3,323	3,623
DH Capital Loan Principal Repayment	0	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	3,602	3,602	3,602	3,562	3,562	3,562	3,562	3,562	3,562	3,562	3,562	3,562	3,562
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Current Liabilities	21,085	26,235	27,207	33,436	31,709	30,224	30,027	27,399	28,285	28,624	27,746	26,940	19,744
Net Current Assets/(Liabilities)	(2,478)	(419)	(1,196)	(2,401)	(3,559)	(4,471)	(5,558)	(5,077)	5,219	5,186	6,063	7,176	6,087
Total Assets less Current Liabilities	138,525	138,764	130,210	129,099	130,031	130,419	134,181	134,830	145,226	149,408	149,562	149,952	154,196
Non-Current Liabilities													
DH Capital Loan Principal Repayment	0	0	0	0	1,000	1,000	5,000	5,000	5,000	10,000	9,937	9,937	9,687
Borrowings	25,002	25,002	25,002	24,141	24,141	24,141	24,141	24,141	34,141	34,141	34,141	34,141	40,879
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	11,931	11,884	11,832	11,789	11,766	11,861	11,957	11,934	12,029	11,125	11,102	11,198	9,083
Total Non-Current Liabilities	36,933	36,886	36,834	35,930	36,907	37,002	41,098	41,075	51,170	55,266	55,180	55,276	59,649
Total Assets Employed	101,592	101,878	93,376	93,169	93,124	93,417	93,083	93,755	94,056	94,142	94,382	94,676	94,547
Financed By Taxpayers' Equity													
Public Dividend Capital	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523
Revaluation Reserve	32,810	33,129	24,394	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348	24,348
Donated Asset Reserve	9	9	8	8	8	8	8	8	8	8	8	8	8
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Retained Earnings	11,669	11,636	11,870	11,709	11,664	11,957	11,623	12,295	12,596	12,682	12,922	13,216	13,087
Total Taxpayers' Equity	101,592	101,878	93,376	93,169	93,124	93,417	93,083	93,755	94,056	94,142	94,382	94,676	94,547
Control Total	0	0	0	0	0	0	0	0	0	0	0	0	0

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 June 2009 (Month 3)

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
Operating surplus/(deficit)	648	847	281	334	670	43	1,048	677	464	618	672	595	6,897
Depreciation and amortisation	623	1,255	976	1,023	1,023	1,116	1,135	1,150	1,165	1,223	1,223	1,223	13,135
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	0	(129)	(62)	(109)	(109)	(109)	(109)	(109)	(109)	(109)	(109)	(109)	(1,172)
Dividend Paid	0	0	0	0	0	(2,001)	0	0	0	0	0	(1,537)	(3,538)
(Increase)/Decrease in Inventories	53	39	(2)	0	0	0	0	0	0	0	0	0	90
(Increase)/Decrease in NHS Trade Receivables	(1,566)	2,659	(7,298)	699	4,028	7	(2)	26	15	10	4	11	(1,407)
(Increase)/Decrease in Long Term Receivables	(22)	(23)	(147)	0	0	0	0	0	0	0	0	0	(192)
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	371	140	(30)	370	0	0	0	0	0	0	0	0	851
(Increase)/Decrease in Accrued Income	(3,619)	(2,019)	(396)	329	1,338	(259)	38	(259)	(259)	49	326	579	(4,152)
(Increase)/Decrease in Prepayments	1,232	486	(378)	145	55	55	55	(219)	55	55	55	55	1,651
Increase/(Decrease) in Trade Payables	(1,013)	(185)	518	(611)	(333)	158	(316)	(97)	75	(203)	(43)	(206)	(2,256)
Increase/(Decrease) in Other Payables	5,944	(440)	456	(2,659)	(155)	101	(295)	(9,947)	(26)	(555)	(543)	(5,489)	(13,608)
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	719	1,015	(141)	0	0	0	0	0	0	0	(100)	(698)	795
Increase/(Decrease) in Deferred Income	930	(369)	5,610	(341)	(341)	(341)	(341)	(341)	(361)	(391)	(391)	300	3,623
Increase/(Decrease) in Provisions & Liabilities	(47)	(52)	(43)	(23)	95	96	(23)	95	(904)	(23)	96	(2,115)	(2,848)
Net Cash inflow/outflow from operating activities	4,253	3,224	(656)	(843)	6,271	(1,134)	1,190	(9,024)	115	674	1,190	(7,391)	(2,131)
Cashflows from Investing Activites													
Interest received	2	0	(6)	1	3	3	4	4	2	2	2	1	18
(Payments) for property, plant & equipment	(2,275)	(1,724)	(1,569)	(1,500)	(3,250)	(4,350)	(3,250)	(250)	(5,000)	(500)	(500)	(7,738)	(31,906)
Proceeds from disposal of property, plant & equipment	0	0	3	0	0	0	0	10,000	0	0	0	1,000	11,003
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(2,273)	(1,724)	(1,572)	(1,499)	(3,247)	(4,347)	(3,246)	9,754	(4,998)	(498)	(498)	(6,737)	(20,885)
Net Cash inflow/outflow before financing	1,980	1,500	(2,228)	(2,342)	3,024	(5,481)	(2,056)	730	(4,883)	176	692	(14,128)	(23,016)
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	1,000	0	4,000	0	0	5,000	0	0	0	10,000
Loans principal repaid to DH	0	0	0	0	0	0	0	0	0	(63)	0	(250)	(313)
Capital element of finance lease	0	0	(861)	0	0	0	0	10,000	0	0	0	6,738	15,877
Net Cashflow inflow/(outflow) from financing	0	0	(861)	1,000	0	4,000	0	10,000	5,000	(63)	0	6,488	25,564
Increase/(decrease) in cash & cash equivalents	1,980	1,500	(3,089)	(1,342)	3,024	(1,481)	(2,056)	10,730	117	113	692	(7,640)	2,548
Cash, cash equivalents and bank overdrafts at 1.4.09	2,533												2,533
Cash, cash equivalents and bank overdrafts at 31.3.10	4,513	6,013	2,924	1,582	4,606	3,125	1,069	11,799	11,916	12,029	12,721	5,081	5,081

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th July 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):

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

14 alerts were received from 30th April to 10th July 2009. All alerts were acknowledged; one requires action, relating to the risk of not using the NHS Number as the national identifier for all patients. Completing this action will be a very significant challenge for all areas within the Health Service, and especially for ambulance services, as only a very small minority of patients either know or have immediate access to their NHS Number. In the first instance the LAS is looking at how this information could be recorded, if known, on the Patient Report Form.

Occurrence Report – Controlled Drugs Concerns

Two x 10mg vials of Morphine Sulphate were lost during a shift on either the 6th or 7th July 2009, by a paramedic based at the Bromley Complex of the London Ambulance Service NHS Trust (LAS).

The morphine was correctly signed out on the Monday morning (6th July), was *possibly* lost on that shift, but the loss was not realised until the paramedic went to sign the ampoules back in at the subsequent end of the Tuesday (7th July) shift. This therefore was in direct contravention of LAS policy and procedure that categorically states that staff must sign all drugs (whether controlled or otherwise), back into the respective drug stores at the end of each shift. There is no exception to this either by virtue of rank, role, position or shift pattern.

Theft is not being considered as the cause of the loss. There is one call on the 6th July that it might be likely that the morphine was misplaced and / or discarded by accident as "contaminated sharps". As of 9th July this was still being investigated / considered

Actions taken:

Investigation undertaken starting 7th July 2009.Police informed 7th July 2009. Home Office informed 9th July 2009. AOM informed 7th July 2009 .Paramedic initially interviewed 7th July 2009 by Duty Station Officer to establish the facts and to try and establish exactly where the ampoules may have been lost. Paramedic has been informed that in this instance formal action may be taken as *de facto* LAS policies and procedures have not been adhered to.

By 08:30 on 8th July 2009 the Medical Director had ensured that the LAS procedure for dealing with this incident had been followed and instructed that an LA52 (LAS Incident Report Form) be completed. The Senior Clinical Adviser to the Medical Director was asked to undertake a review of the whole incident to establish any organisational learning points. Mr. Whitmore also undertook to contact Ms. Dianne Adams, Chief Pharmacist for Richmond and Twickenham PCT and Chair of the LIN Group to whom LAS report, and to also complete and send Ms. Adams a LIN Report.

Immediately prior to this incident Mr. Whitmore had placed a notice, to run for three weeks, in the LAS Routine Information Bulletin (RIB), reminding all paramedics of their legal obligations with regard to morphine. In addition to this a more wide ranging review of the carriage of morphine by LAS staff will be undertaken. Initial actions are to contact the Vehicle and Equipment Working Group to raise the subject in that forum. Colleagues in other UK Ambulance Services will be contacted to see if lessons can be learnt, in terms of the carriage of the ampoules by ambulance staff. The current system was introduced following negotiations with the staff, the Home Office and looking at other systems used across the UK. (There is no laid down national policy on this aspect). In particular we will consider the method used by West Midlands Ambulance Service where morphine is carried on a belt pouch.

2. Second domain – Clinical and Cost Effectiveness

Medical staffing update

I am delighted to report that the LAS has successfully recruited two additional Assistant Medical Directors, bringing our establishment up to four. Ms Peta Longstaff, a very experienced Consultant in Emergency Medicine will join the West Area Management and Governance Team, and Dr Neil Thomson, who currently works for the Coventry and Warwickshire Air Ambulance Service, the East. As with the existing Assistant Medical Directors, each will have a portfolio of responsibilities in addition to their Areas.

I will officially take up the part time appointment of London Trauma Director on 1st October.

The two Team Leader conferences held at the end of May provided the opportunity to hold a series of clinical workshops, briefing staff on the field triage decision tree for major

trauma, updated resuscitation guidelines, the new JRCALC Guidelines on pelvic trauma and sickle cell emergencies, introduce the new Automated External Defibrillator and Lifepak 15 and discuss issues around drug and medicines management. The Medical Directorate also sought feedback on subjects for inclusion in the planned clinical refresher courses planned for all Team Leaders commencing in October.

Update on Patient Specific Protocols (PSPs)

A review has been completed of all 200 of the current PSPs. This has involved contacting each of the patients' supervising clinicians, almost all of whom have now replied.

Currently up to 12 new PSP requests arrive each week, providing a workload which we will now seek additional administrative support. The Clinical Support Desk staff can now only provide limited support with the processing these forms in the light of their increasing workload. We are experiencing a growing interest in PSPs from clinicians looking after patients with very specific long term conditions (often citing the Darzi recommendations regarding long term conditions and individual care plans). These include a contact from spinal injury support group looking at using PSP to flag to crews the risks of autonomic dysreflexia in patients with complete cord injury who may present with symptoms relatively minor such as urine retention and constipation.

We have also been contacted by the Commissioners who look after a specialist haematology service to ensure haemophilia patients have individual protocols so they are conveyed direct to their known treatment centre. (Circa 400 patients).

The Palliative Care Handover form is increasingly used (up to 60 a week). We are making contact with PCTs where the form is not in regular use. We have developed good case studies of where having the form has worked and are trying to use these to convince the PCTs that information sharing with LAS provides real benefit to patients.

Update on Maternity Issues

Andrew Lingen Stallard, the LAS' Consultant Midwife Adviser, now routinely attends the London Heads of Midwifery (HOM) Group. This group is also attended by the midwifery advisor at NHS London and the LSA midwifery officer. Issues which he has highlighted with them include the lack of a dedicated phone line for pre alert calls from the LAS, problems around deploying midwives to patients, concerns around responsibility for 'out of area' patients and cross cover and attitude. The HOM have agreed to take these issues back to their units. Progress will be reported following the next meeting in December.

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

Appendix 1 contains the findings of summary of cycle one and two of the national CPI report. This demonstrates LAS compliance against the national figures for the five indicators measured (STEMI, stroke, cardiac arrest, hypoglycaemia and asthma)

Appendix 2 contains both 'an overview of the LAS Research & Development year and examples of impact on health and social care', the yearly report submitted to DH, along with 'Changes to the mechanism for funding research in the NHS'. These are presented for information.

3. Third Domain – Governance

Care Quality Commission
Consultation on 'compliance guidance' for new registration standards

Background

From April 2010, providers of health and adult social care in England, including NHS Ambulance Trusts which provide regulated activities, must be registered with the Care Quality Commission (CQC) to operate. The registration timetable requires NHS trusts to apply for registration with the CQC from January 2010 with registration by 1 April 2010.

To register and to remain on the CQC register, providers must comply with new registration standards / requirements of safety and quality. (The final detail on the registration requirements regulations are still to be finalised, though any changes from the draft regulations are likely to be limited).

The CQC has produced a draft 'compliance guidance' document, which makes clear to providers what they need to do to comply with each registration standard / requirement and what service users should expect to experience if the standards are met.

The CCQ has launched a consultation on the 'compliance guidance' to develop the guidance further. The Ambulance Service Network (ASN) has asked members to consider how practical the suggested steps to meet the registration standards and will be collating responses.

The consultation was launched on Monday 1 June and will run to Monday 24 August 2009.

The final version of the 'compliance guidance' will be published in December 2009.

Summary of the CQC compliance guidance

The CQC draft 'compliance guidance' document sets out *generic guidanc*e on compliance applicable to all providers. In addition, for some providers, which provide certain types of services there is *specific guidance* on meeting certain registration standards. The latter will apply to transport services provided by an NHS provider, which may include patient transport services, and emergency vehicles transporting patients including ambulances and air ambulances

The CQC draft guidance sets out its *generic guidance* on compliance with the registration standards under six themed sections, which relate to the care pathway that a person may follow when they begin to use a service. The themed sections are:

Involvement and information
Personalised care, treatment and support
Safeguarding and safety
Suitability of staffing
Quality and management
Suitability of management

Each section includes details of the registration standards / requirements for compliance, information on what providers must do to comply with the registration standards and Intended outcomes for service users.

In addition to the generic guidance on compliance with the registration standards applicable to all providers, for some providers, which supply certain types of services, there is also specific guidance on meeting particular registration standards and the expected outcomes for service users. This is likely to apply to patient transport services, and emergency vehicles transporting patients including air ambulances.

4. Fourth Domain – Patient Focus

Update from Urgent Operations Centre (UOC)

Subject: 'Selecting the Right Care Pathway for every Call' – a trial extending the use of alternative pathways for selected Green and Amber calls.

Authors: Phil Flower & Dr Fenella Wrigley

1. Introduction

The public generally call the LAS to ask for an ambulance for a patient (including themselves) when *they* perceive there is a medical emergency. That gives rise to an expectation that is often not justified in the circumstances, and frustration when there is a delay in the arrival of an ambulance. Research has consistently shown that only a relatively small proportion of the emergency calls received by the LAS justify an emergency response (circa 250 - 350 calls a day out of 4000). Public education programmes have had little impact on reducing demand, and some have actively encouraged the public to call. With a steady and continuous growth in demand there is now a pressing need to reconsider the way lower priority calls are managed to continue to provide a robust emergency response to those with a genuine need

An internal review of LAS call handling protocols and systems has determined that alternative call routing within and out of the LAS is likely to result in a more efficient use of LAS resources and enhance overall patient care. To this end it is proposed to decline some callers an ambulance as soon as MPDS triage categorises their condition as one that does not need such a high level of service, to build on and expand the current successful trial of NHS Direct (NHSD) dealing with Green (category C) calls, and to route selected calls currently graded as Amber to LAS Clinical Telephone Advisers.

2. Case for change

The evidence to support this proposal comes from a review of the use of the 'GPs in EOC' project conducted in the LAS from December to March 2009, current CTA and NHSD usage and review of non conveyance by LAS crews.

Since February 2009 NHSD has accepted and dealt with 106 categories of Green calls on behalf of the LAS. To date they have dealt with circa 20,150 calls in total, and have achieved a high 'No Send' rate. In February an average of 847 calls per week were transferred to NHSD with a return rate of 124 (14%) equating to approximately 120 calls transferred per day with 4 returns. In April an average of 1152 calls were transferred per week to NHSD with a return rate of 217 (19%) equating to approximately 160 calls transferred per day with 7 returns The 'no send' rate is particularly important as it increases the number of ambulances available to respond to serious and life threatening conditions across London.

3. Proposal

The three elements of this trial are linked to one another. Firstly, a group of Green calls have been identified by the Medical Directorate as being suitable for immediate referral to NHS Direct or Primary Care e.g. General Practitioner, and a 'No Send' decision at that point ***(Group 1).*** Secondly, the list of Green calls identified as suitable for transmission to NHSD has been reviewed and expanded ***(Group 2).*** These two measures would, if implemented, create additional capacity in CTA to manage a third set of calls classed as Amber that have been identified by the Medical Directorate as being suitable for retriage by Clinical Telephone Advisers.

The overriding objective of this trial is to ensure that the maximum number of patients receive the most appropriate response.

It is recommended that this new system of call handling be adopted subject to close monitoring and review. Further expansion of this initiative will be dependant on the outcome of the review process and the identification of an unacceptable level of risk or adverse patient outcome. Since the introduction of transfer of calls to NHSD in February 2009 there have been a number of enquiries to the Patient Experiences Department, several relating to the caller's concern that they were unaware that their call to the ambulance service might be routed to NHSD. As a result call handlers now inform patients if their call is being passed to NHSD.

4. Management of Green Calls

To improve effective handling of low priority calls two key changes to the handling of Green calls are proposed. (The following changes do <u>not</u> apply to any patient who is under the age of 16 years and who is not in the presence of a responsible adult)

MPDS Determinants in Group 1.

Call takers refer callers with minor conditions directly to alternative care pathways without an ambulance being dispatched.

All calls will be triaged through MPDS in the normal way. For those calls deemed suitable ***(Group 1)*** the caller will be advised by the call taker that:

> *"The assessment of your condition indicates that you do not need an ambulance at this time. If you want medical advice relating to this condition and how to manage it you should speak to a health adviser at NHS Direct on 0845 4647 or your GP. If your / the patient's condition worsens in any way you should ring us back immediately".*

MPDS Determinants in Group 2.

The second element of this revised approach involves expanding the categories of calls being dealt with by NHSD by a further 27 determinants. In these cases the caller will be told that they may be called back by a telephone adviser. The call will then be referred to CTA who will determine whether or not the call can be handled by NHSD. If the call falls within the list of calls (designated as ***Group 2),*** the call will be referred to NHSD to be dealt with by them. On completion of these calls the caller will be advised as follows:

> *"The assessment of your condition indicates that you do not need an immediate ambulance response. I am transferring details of your call to a Clinical Adviser who will contact you shortly by telephone to undertake a more detailed assessment of your condition. The adviser who contacts you may be from the LAS or NHS Direct. An ambulance is not being sent to you at this time however, if your / the patient's condition worsens in any way you should ring us back immediately".*

CTA handle circa 150 – 200 green calls a day. In addition the team is estimated to have the capacity to accept up to circa 50 Amber calls a day for triage and review through the PSIAM system. Passing a further 27 call types to NHSD potentially provides additional capacity for CTA to handle selected Amber calls.

Of the remaining Green calls dealt with by CTA a small number have been identified as being suitable for referral to a hospital / clinic. In some cases patients do not have access to transport and cannot afford a taxi but do have a clinical need to have a face to face consultation. In these cases the LAS will explore the possibility of CTA arranging a taxi for the patient, initially at our expense.

4.1. Avoiding circular calls

If a call that has been reviewed by NHSD is identified as requiring an ambulance response it will be dealt with under the provisions of card 35 to avoid it entering a loop of telephone advice. To achieve this NHSD will telephone 999 back to the LAS with the patient still on a conference call. When the call is answered by the LAS the NHSD adviser must announce who they are and that the call is being referred back for an ambulance response.

4.2 Alternative transport

A group of patients are identified may need ambulance transport but often do not need the high level of care provided by LAS crews. As such, it is suggested that the additional use of private ambulance transport is considered.

5. Telephone advice for selected Amber calls

Currently the DH requires ambulance services to send ambulances to all Category A and Category B calls. However, part of the implementation of the Ambulance Service Review was to replace the Category B 19 minute response time measure with clinical indicators and outcome measures. As a step along the way to this the DH have agreed in principle that the LAS pilot, on behalf of English ambulance services, specific category B determinants for clinical telephone advice. Following evaluation a recommendation will be made to the DH sponsored Emergency Call Prioritisation Advisory group on specific Category B calls that may be re classified as Category C, with effect from 1st April 2010.

The Medical Directorate have reviewed all calls that MPDS grades as Category B (Amber) and has determined that there are 22 determinants, subdivided into three tranches, that are potentially suitable for CTA to handle. These have been subdivided into three so that they can be progressively phased into those calls handled by CTA. After each tranche has been added to the list of call suitable for CTA the system will be monitored by QA to ensure clinical standards are maintained and will be subject to review before the next group of Amber calls is included to ensure clinical safety is not be compromised by this process. Adjustments will be made to the process as necessary. The evaluation will not only monitor patient outcomes but also 'No Sends' so that the overall cost benefit analysis can be conducted.

The Alternative Response Procedure (OPO 32) will be reviewed and amended in accordance with this policy.

As these calls will have been triaged by MPDS there is the assurance that any call requiring an emergency response will continue to receive one, e.g. calls where the patient has crushing chest pain, difficulty in breathing etc. In effect the MPDS triage acts as an effective risk management tool supported by a clear understanding that if an Amber call is passed to CTA and later determined to require a response, it will receive one.

These selected calls will be passed for CTA to process. This will require a small change to CTAK so that the call is routed in the first instance to CTA. This is relatively straightforward to achieve. A more complicated change to CTAK will be needed to allow CTA staff to log in and see these Amber calls as currently they are only able to view Green calls. This will need support from IM&T.

This group of Amber calls must be rung back within 15 minutes. If a ring back cannot be made within 15 minutes the call will be dispatched in the normal way. If after one of these Amber calls has been dispatched on, a ring back is made and the need for an ambulance no longer exists, the unit dispatched may be stood down.

All calls passed to CTA including these Amber calls must be subject to a full PSIAM triage.

If after review and triage using PSIAM it is determined that an ambulance should be sent the call must be upgraded to at least Amber 1 or higher as appropriate.

If an ambulance dispatch becomes necessary an Amber call passed through this system is unlikely to receive a response within the B19 minute target. It is anticipated that this will affect a relatively small number of calls.

All calls from Health Care Professionals will be dealt with by card 35 and dispatched on to ensure that they do not enter a loop of telephone triage. (See 4.1 above)

6. Risk Management.

Clearly there is a balance to achieve in the provision of ambulance services which involves ensuring patients with life threatening conditions receive the quickest response within the resources available. Inevitably utilising telephone triage and advice rather than the dispatch of an ambulance may involve an increased risk. However the categories of call are based on the medical advice that it is at an acceptable level. This approach will result in more ambulance resources being available overall and therefore ensures a quicker response to those patients with the greatest need.

This increased flexibility in call handling forms another part of the plan to provide the most effective care pathway for patients at the earliest opportunity. CTA will be able to determine with greater accuracy the precise needs of the patient, give advice and make referrals that better meet the patient's needs.

To provide effective Quality Assurance to underpin this work a bid has been submitted for an additional four (4) QA staff to ensure regular monitoring of the work of CTAs on both the designated Amber and Green calls. Additional work on measuring the patient / caller experience of those calls subject to QA will further enhance the data collected from this work. This will ensure that key lessons from a patient's perspective help shape the future direction of call handling regimes.

The criteria for success will be the clinical outcome not the response time for the call.

7. Clinical Governance, Complaints and Learning

A detailed Service Level Agreement (SLA) will be agreed between the LAS and NHSD in due course covering the operational and clinical governance arrangements.

Clinical Governance for this proposal will be provided by the LAS Medical Directorate. This will include review of a sample of calls, particularly those where there is a complaint or concern raised either by patients, LAS staff, NHSD or other Health Care Professionals.

CTA staff will be supported by the Medical Directorate and encouraged to report concerns openly, and provided with regular feedback.

Patient views / concerns will be accessed through the Patients' Forum and post contact questionnaires / web site submissions. This element forms a further part of Control Services bid for additional staff in QA.

Complaints and matters falling within the remit of Patient Experience will be dealt with in accordance with the new NHS governance arrangements for such matters. When a complaint relates exclusively to actions taken by or matters falling exclusively within the response to a call provided by the LAS it will be dealt with by the LAS complaints / Patient Experience Department.

If the complaint or concern relates to actions taken or matters falling exclusively within the response provided by NHSD or any other part of the NHS it will be the responsibility of that business unit to respond.

Where the complaint touches more than one NHS business area i.e. the LAS and NHSD the body most directly concerned with the matters raised will lead on the case. Where there are various issues that touch or affect more than one part of the NHS equally the recipient of the complaint / concern raised will lead. Each part of the NHS engaged in this process will be responsible and liable for the actions of their staff systems and processes and any outcomes that they produce.

8. Communication

This proposal will need to be complimented by a communication strategy that informs the public and our staff of the new approach to responding to emergency calls. This will help manage expectation and remove the potential for disappointment on the part callers who do not automatically receive an ambulance response.

External communication about this project will need to take place with NHS London, PCTs and the Chief Executive of PDC, Dr Jeff Clawson.

9. Diversity

Time constraints mean that this policy has not yet been be subject to a full diversity. Impact assessment but one will be completed if it is approved.

5. Fifth Domain – Accessible and Responsive Care

Nothing further to report

6. Sixth Domain – Care Environment and Amenities

Infection Control

The Infection Prevention and Control Coordinator is hosting a conference for the newly recruited IPC Champions on 21st July. To date 36 champions have been recruited, including 5 PTS, representatives from the training department, 2 from EOC and 5 department leads (estates, patient experience, facilities, logistics etc). From Operations there is a clinical mix

from A&E support staff through Team Leaders and DSOs, 1 from each of the complex areas but 6 still left to nominate.

The Care Quality Commission has undertaken inspections at both South West Ambulance Service NHS Trust and West Midlands Ambulance Service NHS Trust. Minimal prior warning was provided. The LAS are expecting an inspection at the end of July and are working closely with both the Trusts under inspection and the National Ambulance Infection Prevention and Control Group to gain feedback.

7. Seventh Domain – Public Health

Pandemic Flu Update

Personal Protective Equipment

We have ordered 4030 Reusable FFP3 respirators which we hope to take full delivery of by the end of August. We have already taken delivery of 30 fit testing kits which will be used to fit test the respirators to every frontline member of staff. This process will take some time and the interim solution has been to fit test all HART staff with disposable FFP3 respirators so that a 24hr response to confirmed swine flu patients needing aerosol generating procedures can be provided.

The HART team have now been trained and will be asked to respond to convey confirmed cases who may require an aerosol generating procedure (hospital transfers of ITU / HDU patients who are intubated or undergoing CPAP etc.) and in the rare cases of a cardiac arrest in the community where staff have had to intubate a patient who later turns out to be a confirmed case then anti viral medication has already been offered in these circumstances. This has occurred on at least one occasion already with our staff.

We have in stock 150,000 disposable FFP2 respirators which will be introduced into Infectious kits on vehicles and response bags as stocks of N95 respirators diminish.
A list of the top consumables used by frontline staff is being developed in order that we may be able to increase stocks of these items to prepare for possible supply chain problems further into the pandemic.

Antiviral medicines

LAS have been designated a supply of antiviral medicines from the old GLA stock. The legalities of moving this stock into the national stockpile and subsequently out to us are still being explored with no timeframe as to when we can expect delivery. LAS staff that need antiviral treatment will access this through public avenues i.e. their GP.

Information dissemination

Staff responded well to the Pandemic Flu Awareness Workshops held in May. We are currently planning another Pandemic Flu event for the end of July, specifically aimed at identifying lessons from the pandemic response to date and planning for subsequent waves by walking through table top scenarios. This will include addressing issues such as; staff

absence, current actions and procedures that could safely be curtailed should the need arise and identifying gaps in planning.
We have been keeping staff regularly updated with current information using 'the Pulse', LAS news, Medical Directors Bulletins and Swine Flu newsletters.
It has been agreed to publish all Pandemic Flu related information via an Influenza Bulletin in order to have information coming from a single source.

Medical Directorate Bulletins and Patient Management Flowcharts

Version 4 of the Medical Directorate Bulletin was published on 19 June and is the most up to date version. Information for the management of patients presenting with flu like illness has been published in version 7 of the flowchart. The information on this flowchart has been developed from HPA guidance which is not expected to change rapidly; as such we will be putting a laminated copy of the flowchart along with guidance on leaving patients at home on each frontline vehicle for ease of reference.

Recommendation

- That the Board notes the report
- That the Board approves developing the proposal for 'Selecting the Right Care Pathway for every Call' to take forward passing certain selected determinants identified through AMPDS to alternative providers, and to pass selected Amber calls for Clinical Telephone Advice.

Fionna Moore,
Medical Director
18th July 2009

Appendix 1

Clinical Audit & Research Summary Report for the Trust Board

Summary of Findings from Cycle One and Two of the National Clinical Performance Indicators

Author: Stephen Gadd & Gurkamal Virdi
Clinical Audit & Research Unit, Medical Directorate

Background

The National Clinical Performance Indicator (CPI) programme was developed by the National Ambulance Clinical Audit Steering Group (NACASG) to allow the comparison of clinical performance between ambulance services in England, with the overall aim of improving patient care. Currently, five clinical areas are evaluated: ST-elevation Myocardial Infarction (STEMI), Cardiac Arrest, Stroke, Hypoglycaemia and Asthma.

Each National CPI is repeated in six month cycles during each financial year, allowing performance to be compared over time. This report presents LAS performance across Cycle One and Two of the National CPIs in comparison to the national average.

Method

For each CPI area, Ambulance Services audited the first 300 cases (or all available cases if there were fewer than 300) from a given month (between May 2008 and March 2009). Data were entered onto specifically designed audit templates with each Trust auditing against the same standards and using the same exception criteria. Audit results were sent to the National CPI Coordinator at East Midlands Ambulance Service NHS Trust who compiled and disseminated the results to Audit leads, Medical Directors and Chief Executives of each Trust.

Results

The table below presents LAS compliance against each of the five CPI areas from Cycle One and Two of the National CPI programme and the national average for each cycle. Aspects of care audited are ordered according to the area of clinical care. Compliance is defined as documentation that a particular aspect of care was delivered to a patient, or that there is a documented valid exception to that aspect of care.

Indicator	Cycle One		Cycle Two	
	LAS Compliance	National Average Compliance	LAS Compliance	National Average Compliance
STEMI				
Initial pain assessment	98%	69%	95%	84%
Final pain assessment	87%	55%	87%	68%
Aspirin administration	98%	83%	89%	86%
GTN administration	94%	77%	78%	81%
Analgesia given	61%	44%	68%	54%
Stroke				
FAST assessment	94%	86%	97%	87%
Blood glucose measurement	97%	85%	97%	82%
Blood pressure measurement	100%	98%	99%	98%
Cardiac Arrest				
ROSC on arrival at hospital	25%	26%	27%	17%
Defibrillator on scene	100%	100%	100%	99%
Time to respond ≤ 4 minutes[$]	16%	22%	15%	20%
Hypoglycaemia				
Blood glucose measured before treatment	100%	99%	98%	97%
Blood glucose measured after treatment	99%	91%	97%	96%
Treatment recorded	100%	95%	99%	98%
Asthma				
Respiratory rate recorded	100%	96%	100%	97%
Peak flow recorded	61%	30%	55%	31%
Oxygen saturation recorded	78%	81%	79%	85%
Beta 2 agonist treatment given	98%	93%	96%	94%
Oxygen administered	99%	89%	96%	89%

$: Call start to arrive scene

Discussion

In Cycle One, LAS compliance was greater than or similar to the national average compliance for 18 of the 19 aspects of care assessed. The only aspect of care where LAS performance was clearly lower than the national average was in responding to cardiac arrest patients in less than or equal to 4 minutes (16% of

LAS cases versus 22% nationally). However, on examining the data for this measure the LAS's performance is still well within acceptable performance limits (defined as 2 standard deviations). Furthermore, for 8 aspects of care LAS compliance was at least 10 percentage points above the respective national average figure.

In Cycle Two, the LAS maintained its performance against the national average. LAS compliance to 18 of the 19 aspects of care was greater than or similar to the national average and 7 aspects of care were at least 10 percentage points above the respective national figure. As for Cycle One, the only aspect of care clearly lower than the national average was in response times for cardiac arrest patients, but again performance was within acceptable limits.

Comparing LAS performance between Cycle One and Cycle Two, compliance to the majority of the aspects of care was generally similar. It can be seen from the table above, compliance to three aspects of care decreased in Cycle Two; these were aspirin and GTN administration to STEMI patients and peak flow measurements for asthma patients. The Clinical Audit and Research Unit are exploring reasons for these decreases; however, it may be that the clinical significance of these changes will become clear with further audit cycles.

The most notable finding was for analgesia administration to STEMI patients which showed an improvement in compliance between Cycle One and Two. This is encouraging as analgesia administration to STEMI patients was promoted in the October 2008 Clinical Update following the Cycle One National CPI audit. A poster campaign is due to be launched across LAS ambulance stations, with the aim of further improving this aspect of care.

A summary report of Cycle One and Two data will be disseminated across the Trust.

Appendix 2

Overview of R&D year and examples of impact on health and social care
Key R&D developments & achievements:

The LAS continued to build on last year's activity of developing protocols for research and submitting proposals for research to organisations offering funding. The LAS portfolio of research projects has continued to develop with a number of notable achievements. This has included securing funding from The Stroke Association for an LAS-led, NIHR Portfolio adopted research study of stroke assessment techniques. This, and other success with joint research applications, has enable the LAS to:

- develop its capacity to lead and take part in research
- enhance income from the NIHR
- strengthen its reputation in research as a partner of choice in emergency care research nationally and overseas.

Feedback from the 2007/08 Annual Report recognised and supported initiatives taken to adapt to the research environment of Best Research for Best Health. The LAS initiatives to seek external funding for research and to reduce own account activities were also acknowledged. This programme was continued successfully throughout 2008/09.

The amount of transitional funding used to support research with no other external sources of funding has been significantly reduced over the year with a number of the projects completed and no new projects funded in 08/09. New research questions were taken forward as proposals for external funding rather than supporting them as own account projects.

In 2008/09 the LAS was notified of the success of research proposals submitted to external funding bodies last year and took steps to ensure the work would be taken forward effectively. Staff changes limited the number of new proposals that could be developed in 2008/09. However, funding proposals put forward for research:

- investigating procedures to cope with pandemic flu (developing a system to triage patients with suspected pandemic flu), and
- to work with The British Heart Foundation a national review of community resuscitation initiatives

both of which were funded.

The LAS has taken an active role in NIHR initiatives to develop partnerships supporting research, service and education and training including; the South West London Academic Health and Social Care Network and the Northwest London Collaboration for Leadership in Applied Health Research and Care.

LAS staff led and contributed to six publications in peer-reviewed and two in non-peer reviewed journals, up slightly compared to last year.

The LAS continues to make a significant contribution to the research base in pre-hospital care and work cooperatively to assist other UK Ambulance Services

develop structures and capacity to support research. The LAS makes a leading contribution to the National Ambulance Research Group, and is working to develop a Special Interest Group focussing on Pre-hospital and Ambulance Research in London. This work continues the LAS aim of contributing to goals of Best Research for Best Health and expanding capacity for, and activity in, pre-hospital research. Research capacity in The LAS has continued to increase. Staff in the Clinical Audit and Research Unit (CARU) both lead research projects and provide guidance to those wishing to develop research. The CARU team has expanded to five professionals (three at the post-Doctorate level) and many clinical staff gained skills in research during 2008/09.

Key impacts of our research:

Listed below are six examples which illustrate the ways in which the LAS uses research to change practice, grouped under themed headings.

Coronary Heart Disease (CHD):
The LAS has an active programme of research and audit investigating performance in, and ways to improve support for, heart attacks and survival following cardiac arrest. Research has shown that paramedics can accurately identify specific types of heart attacks including patients with suspected ST Segment Elevation MI (STEMI). Based on this evidence the LAS developed models of care which direct ambulance crews caring for STEMI patients to a specialist cardiac unit which provide patients with immediate treatment. In 2008, 1,280 STEMI patients (86% of total) were taken directly to a specialist unit, a considerable increase over 2007. The LAS has built the most extensive database of out of hospital cardiac arrest events held by any ambulance service in the UK. This provides an excellent platform for research, for the study of success of initiatives to improve care and to guide new developments in patient care. (Contact: Gurkamal Virdi, London Ambulance Service. Gurkamal.virdi@lond-amb.nhs.uk)

The LAS and organisations such as the British Heart Foundation (BHF) make a considerable investment in support of Community Resuscitation. The LAS will conduct research funded by the BHF looking at the impact of community resuscitation initiatives. This research will report in 2010 contributing information to guide the future development of resuscitation support. (Contact: Dr Andy Stainthorpe, London Ambulance Service. Andrew.Stainthorpe@lond-amb.nhs.uk)

Contribution to National Guidelines
Research within the LAS contributed to the 2009 revisions of the guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). In particular, LAS staff provided input to the revision of the British Thoracic Society's guideline on emergency oxygen provision which included a systematic review of the existing evidence. The BTS review now forms the basis of the JRCALC oxygen guideline (revised April 09). Emergency oxygen provision to patients by LAS crews in now in line with the JRCALC guidelines.

A review within the LAS in 2008 also contributed to updating the JRCALC

treatment option guidance for sickle cell patients. The LAS review brought together expert input from haematologists across London to develop guidelines to deliver the best care for patients in sickle cell crisis.
(Contact: Gurkamal Virdi, London Ambulance Service. Gurkamal.virdi@lond-amb.nhs.uk)

Care for older people
The LAS has worked in partnership with the Universities of Kingston and Swansea to research the potential to develop and an effective decision-making tool to guide ambulance crews attending older people who have fallen. A key aim of such a tool is to assist crews with the complex decision of whether to convey a patient to the emergency department or not to convey them but refer them to an alternative care pathway. Initial research identified many complexities in this decision-making process. A joint research proposal developed in 08/09, funded through the Health Technology Assessment programme, aims to take this work forward looking at the development of:

- practical guidance for emergency care teams to follow when making decisions about conveyance
- appropriate alternative care pathways
- education and training for frontline staff in decision-making about the best care for fallers.

(Contact: Dr Rachael Donohoe, London Ambulance Service. Rachael.donohoe@lond-amb.nhs.uk)

Service Developments
The LAS has reviewed operational approaches to a number of significant issues facing ambulance service staff. One issue reported in 2008, concerned the dangers presented by carbon monoxide. Evidence from this LAS study was included as input to the House of Commons All Party Parliamentary Gas Safety Group report. The study found that ambulance crews attending calls to assist unconscious subjects were unable to assess the potential threat to patient and crew posed by CO. A review of cases attended by the LAS where carbon monoxide had been found to be a contributing factor illustrated that there were indicators which could have alerted the emergency services to the potential CO poisoning hazards. The LAS is currently investigating the ways call handlers could prompt callers to provide relevant cues which could indicate the potential risk of CO involved. (Contact: Dr Andy Stainthorpe, London Ambulance Service. Andrew.Stainthorpe@lond-amb.nhs.uk)

Repeat Callers
A review of repeat caller behaviours (those who make more than ten calls in one month), prompted the LAS to lead the development of a coordinated approach involving other health and social care providers to identify causation of repeat caller behaviour and to address any underlying care needs they might have. The study contributed to the development of LAS policy and the Patient Experiences Department taking a lead with other service providers to coordinate services to address the care needs of repeat callers. This approach has enabled the LAS to lead the development of care plans addressing the needs of a number of patients and stop their repeat calling. (Contact: Gary Bassett, London Ambulance Service.

Gary.Bassett@lond-amb.nhs.uk)

Mental Health:
Research completed in 2008 further developed our understanding of emotional regulation by ambulance service staff when faced with stressful situations. The outcome of this and earlier work continues to inform the LAS occupational health practices and are included in training packages for frontline staff. A new study, funded by a programme grant from the Wellcome Trust, also started in 2008/09 which will contribute further to the understanding of this complex area.
(Contact: Dr Jennifer Wild, Institute of Psychiatry. Jennifer.wild@IOP.kcl.ac.uk)

Changes to the Mechanism for Supporting Research in the NHS

1 R&D Support Funding

1.1 2008/09 was the last years NHS Trusts received R&D Support Funding on a historic basis. The new research strategy – Best Research for Best Health - put in place a new mechanism to remunerate Health Trusts taking part in NHS endorsed R&D and this has been taking shape since April 2006.

1.2 Last year the LAS received £65,000 of R&D Support Funding and the final Annual Report to the Department of Health – which details how this money was used – is attached at annex 1. The focus this year was to highlight areas where research had been directly translated into improvements in service to patients.

2 The new mechanism for R&D Support Funding and the LAS

2.1 The new mechanism provides remuneration to NHS Trusts based on research activity as measured by patients recruited into studies – accrual. The more participants involved in National Institute for Health Research (NIHR) approved studies the greater the income to the Trust.

2.2 This income is routed through the Comprehensive Local Research Networks (CLRN). Currently the LAS leads on one NIHR approved study (The ROSIER Project), and contributes to a number of others.

2.3 The new system provides funding to organisations with NIHR approved studies both:

- directly - linked to patients accrued and
- Indirectly - for management and governance and for capacity development (flexibility and sustainability funding).

2.4 More research activity leads to a greater income from the NIHR. If an organisation hosts no activity it will receive a minimum allocation for Research Management and Governance (RM&G) to handle any new proposals it might take forward.

2.5 In 2009/10 the allocation to LAS for RM&G is £9,500 with £15,000 Flexibility and Sustainability funding - based on one short listed (but unsuccessful) research application in 2008.

2.6 The Rosier project will accrue patients in 2009/10 but this will most likely not have associated income until 2010/11.

2.7 To increase income from the NIHR CLRNs, the LAS will need to succeed in gaining funding for research studies from NIHR approved funders and develop capacity to maintain and build activity in partnership with other organisations.

London Ambulance Service NHS TRUST

TRUST BOARD 28th July 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 sub-programmes which make up the Service Improvement Programme will be presented to each of the 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, 28th July 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 sections for each of the three sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A list of projects giving project progress status using a Traffic Light reporting system;
- 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 has up to June 2009 consisted of seven sub-programmes:

- Access and Connecting (the LAS) for Health;
- Improving our Response (known as the "Operational Model");
- Organisation Development and People;
- Preparing for the Olympics;
- Corporate Processes and Governance.;
- New Ways of Working;
- Foundation Trust Application.

There has also been a supporting Stakeholder Engagement and Communications Strategy.

As reported to the Trust Board in May work has been 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 is as follows:

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

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

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

This is the first Trust Board meeting to which a progress report is submitted using the new programme structure.

4. Exceptions

This section provides commentary on those projects (not individual milestones) identified as being of red status (i.e. not on track and cause for concern). This month there is only one project in this category, however it should be noted that several projects are of green status because they are in the process of being scoped, an activity which has itself been influenced by performance pressures diverting operational managers' attention.

Clinical development programme

e-learning project - This has been put on hold due to the loss of both team members to LARP training (3 months) and driving training (5 weeks). The successful recruitment of an e-learning manager due to start in the summer (once satisfactory reference have been received) will mean that he will be given the priority task of developing a recovery plan for the project and working with IM&T to develop a solution to the current technical issues.

5. Recommendation

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

Kathy Jones
Director of Service Development

London 2012 Olympic and Paralympic Programme Board Progress Report

PROGRAMME: London 2012 Olympic and Paralympic Programme

REPORTING PERIOD: 10/06/09 – 07/07/09

PROJECT STATUS SUMMARY: 6 ▲ 0 ▲ 0 ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

Programme Summary

The following projects are currently live;

Organisation Development & People – Tranche 1	
Operational Planning (Alan Palmer/Lewis Tasker) ▲	
Workforcece Management Framework (Sandy Thompson) ▲	
Skills Acquisition (Alan Taylor) ▲	
Infrastructure and Support (Anna Kilpin) ▲	
Communication and Involvement (Liz McAndrew) ▲	
Commissioning Process (Anna Kilpin) ▲	

OLYMPIC PROGRAMME TRANCHE 2 OVERVIEW

T2P1: Operational Planning
Project Executive: Peter Thorpe; Project Manager: Alan Palmer/Lewis Tasker
This project is focused on the operational components of LAS Olympic and Paralympic Games preparations. Incorporated in this project is the development of the Operational Plan and associated Contingency Plan for the London 2012 Olympic and Paralympic Games. Also encompassed within this project is the development of plans for implementation during the construction phase. A key area of focus will be the modelling of demand: in the Olympic and Paralympic venues, in relation to cultural events during the lockdown period, and that attributable to the 'Olympic effect' on London. The creation of the LAS Scenario Testing and Exercise Programme (STEP) sits within this project, and LAS participation in external STEP activity.

T2P2: Workforce
Project Executive: Peter Thorpe; Project Manager: Sandy Thompson
This project is focused on the refinement of workforce numbers and groups building on the work undertaken in Tranche 1. In response to the demand modelling undertaken in T2P1, this project will explore the supply options, considering Voluntary Aid Services, private providers, first responders etc, and determine how the LAS will meet the demand on its workforce during the Olympic and Paralympic Games. In addition, gold and silver officers will be 'selected' and a 'selection process' for the other staff groups required will commence.

T2P3: Skills Acquisition
Project Executive: Anna Kilpin; Project Manager: Alan Taylor
This project will build on the work undertaken in the Tranche 1 Clinical Skills Acquisition/Training Project further refining the areas where additional skills will be required for the Olympic and Paralympic Games. Operational, event management and clinical skills will be explored within this project. Furthermore, consideration of other training needs will occur with identification of the preferred mode/s of training provision and commencement of the skills acquisition programme.

T2P4: Infrastructure and Support
Project Executive: Peter Thorpe; Project Manager: Anna Kilpin
This project is comprised of three areas: Information Management and Technology (IM&T), Estates and Operational Support. Fundamental to the project is the development of additional event control capacity for the Olympic and Paralympic Games and the building/refurbishment of an Olympic complex. This will include the identification of sites for both, the building and equipping of the event control (including IM&T functionality) and the production of detailed plans for the Olympic complex. Also incorporated in the project is the finalisation of vehicle numbers/types, and the commencement of any procurement/ tendering process required.

T2P5: Communication and Involvement
Project Executive: Anna Kilpin; Project Manager: Liz McAndrew
This project focuses on communication with and involvement of staff, local communities and patients/public in London, including the development of a Stakeholder Management Strategy and a Communication and Engagement Strategic Plan. This project will oversee and co-ordinate the communication activity across Tranche 2 ensuring a joined-up and streamlined approach.

T2P6: Commissioning Process
Project Executive: Peter Thorpe; Project Manager: Anna Kilpin
This project focuses on the commissioning process, which the LAS is undertaking in conjunction with NHS London and the lead commissioner, Richmond and Twickenham PCT. Central to this project is the alignment of the LAS programme with the revised OSD programme structure and the production of a business case, including costings for submission via the Olympic Investment and Appraisal Monitoring Board (OIAMB) process.

LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

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

2009

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
T2P1: OPERATIONAL PLANNING **Project Executive: Peter Thorpe** **Project Manager: Alan Palmer** **Status:** ✓	▲ Complete project initiation	▲ Approach to LAS involvement in external exercising and testing	▲ Venue specific contingency plans for construction phase v.1 ▲ Influencing of external exercising/ testing programmes commenced	▲ Olympic effect - urban domain (core:999 calls): modelling profile ▲ Event demand in urban domain during lockdown period v.1	▲ Olympic venue demand: modelling profile		△ LAS Command and Control structure designed △ Initial understanding of of special operations requirements (e.g. CBRN/HART)		△ Complete end stage review + scope next stage			
T2P2: WORKFORCE **Project Executive: Peter Thorpe** **Project Manager: Sandy Thompson** **Status:** ✓	▲ Complete project initiation	▲ Staff engagement strategy agreed *(request for change)*					▲ Process for identifying gold/silver	△ Feasibility/role of private providers/ VAS/volunteers/ co + 1st responders △ All LAS workforce/ groups/nos identified (options appraisal v.1) △ HR issues relating to LAS staff	△ High level support structure for staff identified △ Decision regarding use of mutual aid △ Complete end stage review + scope next stage		△ HR issues with regard to mutual aid identified and Action Plan produced △ Identification of policy change required Olympic Specific △ Staff engagement plan produced (inc. specification for reward and recognition scheme)	
T1P3: SKILLS ACQUISITION **Project Executive: Anna Kilpin** **Project Manager: Alan Taylor** **Status:** ✓	▲ Complete project initiation				▲ Content of Olympic skills acquisition programme further refined ▲ Consideration of scope for skills acquisition re paralympians 2012 requirements current LAS provision: gap analysis	▲ Authority to recruit an additional Training Officer for e-learning ▲ Authority to recruit an additional Training Officer to develop training packages ▲ End of stage review and scope next stage		△ Fully scoped approach for training delivery e.g. train the trainer? △ Commencement of training/educational session development	△ Approach for LAS provision of training for mutual aid (including overseas) △ Approach for LAS provision of training for volunteers		△ Timetable for *all* Olympic training required △ Timetable for training training the trainers (if preferred approach)	△ Timetable for induction/training provision for mutual aid △ Timetable for induction/training provision for volunteers △ End of stage review and scope next stage
T1P4: INFRASTRUCTURE AND SUPPORT **Project Executive: Peter Thorpe** **Project Manager: Anna Kilpin** **Status:** ✓	▲ Complete project initiation ▲ Decision re: bespoke event control and outline brief ▲ Decision re: superstation and outline brief	▲ Start search for 'event control' OR site for displaced staff ▲ Start search for for Olympic complex	▲ IM&T high level requirements and main planning assumptions	▲ IM&T baselining ▲ Final agreement reached re: vehicle types & additional key equipment needed	▲ Requirements analysis ▲ Agree funding streams: A&E fleet ▲ End stage review/ scope next stage		▲ Site identified for event control or displaced staff △ Gap analysis and option analysis	△ Risk and priority analysis	△ Commence tendering for vehicle framework		△ Specification, procurement, secure internal resource	▲ Site identified for complex △ End stage review and scope next stage
T1P5: COMMUNICATION AND INVOLVEMENT **Project Executive: Anna Kilpin** **Project Manager: Lewis Tasker** **Status:** ✓	▲ Complete project initiation ▲ Clarify definitions: staff, local community and patients/public	▲ Write Tranche 2 Communication & Engagement Strategic Plan inc. key messages ▲ Review of Transfer of Knowledge: v.2 ▲ Write Stakeholder Management Strategy: v.2	▲ Timetable/plan for involvement of, and engagement with staff - Tranche 2 ▲ Timetable/plan for involvement of, and engagement with, local community, patients/public ▲ Produce Strategic Plan for liaison with other UK ambulance services			▲ Determine scope for development of community defibrillators for Olympics ▲ Complete end stage review + scope next stage	△ Establish initial contact (Olympic specific) with LINks within boroughs	△ Determine scope of LAS teams e.g. Events & Schools teams re: Health Promotion	△ Carry out EIA for Olympics/Paralympics			△ Complete 2nd Staff Survey
T1P6: COMMISSIONING PROCESS **Project Executive: Peter Thorpe** **Project Manager: Anna Kilpin** **Status:** ✓ OIAMB Business Case Development + LAS Programme alignment with 2012 Safety and Security Strategy *						▲ Complete project initiation ▲ Initial scoping meeting with OSD ▲ Meet with OSD to review LAS submission to CSP + ▲ LAS Programme (re) aligned with 2012 Safety and Security Strategy *	△ OIAMB Business Case v1 submitted to NHSL/R&TPCT + △ Challenge process: NHSL/ R&TPCT complete + △ OIAMB Business Case v2 submitted to NHSL/R&TPCT /DH +		△ Conduct End Project Review			

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

PROGRAMME PROGRESS REPORT FOR CLINICAL DEVELOPMENT, LEADERSHIP & WORKFORCE

PROGRAMME: CLINICAL DEVELOPMENT, LEADERSHIP AND WORKFORCE PROGRAMME

REPORTING PERIOD: 10/06/2009 – 08/07/2009

PROJECT STATUS SUMMARY: 7  5  1 

Key

 **On track**

 **Not on track but in control**

 **Not on track and not in control**

Programme Summary

The following projects are currently live;

Organisation Development & People – Tranche 1		
Recruitment & Induction (Jo Davis)		
Performance Management Framework (Steve Sale)		
Talent Management (Johnny Pigott)		
Training restructure (Bill O'Neill)		
E-learning (Johnny Pigott)		
Team Briefings (Alex Bass)		
Learning Management Systems (Johnny Pigott)		
New Ways of Working		
Clinical Leadership (Jane Worthington)		
Leadership Development (Jo Anthony)		
Team based working (Hazel Smith)		
Communications (Alex Bass)		
Healthcare for London		
Stroke (Nick Lawrance)		
Major Trauma (Claire Garbutt)		
Referral Pathways (Grenville Gifford)	being scoped	
Directory of Clinical Services (Grenville Gifford)	being scoped	

OD & PEOPLE WORKSTREAM OVERVIEW

Recruitment & Induction
Project Executive: Ann Ball **Project Manager: Jo Davis**

This initiative will revise the recruitment process to enable the organisation to assess and recruit candidates for values, attitudes and behaviours. This project will also help LAS to deliver diversity targets for achieving a more representative workforce and insuring fairness and equity for all candidates. The induction process will also be revised to reflect these same themes.

Leadership Development – project closed
Project Manager: Jo Anthony

This initiative is to establish and support new styles of leadership at all levels underpinned by the right skills; through continuing the current leadership programmes available and developing new leadership programmes. The programme will be comprised of a number of courses and qualifications aimed at specific groups within the organisation to support both the NWoW and OD & People Programmes.

Individual Performance Management
Project Executive: Ann Ball **Project Manager: Steve Sale**

The aim of this initiative is to develop a comprehensive performance management process that is accepted and used by all staff members. This performance management framework will enable all staff to accept responsibility and accountability for their personal performance, rewarding and recognising good performance, whilst identifying and supporting staff with poor performance, and where necessary enabling appropriate exit strategies.

Workforce Re-Configuration – project closed
Caron Hitchen

The aim of this initiative is to develop the workforce plan that supports the Operational Model and implements a staff profile that is representative of the population of London.

Modularised Training – project closed
Project Manager: Keith Miller

The aim of this initiative is to provide all staff with access to appropriate professional development through training and development packages delivered through a variety of media. There are currently three training modules in operation with the intention to develop a number more, prioritised by clinical need.

Talent Management
Project Executive: Bill O'Neill **Project Manager: Johnny Pigott**

The aim of this initiative is to provide a clear career development framework for all staff that allows staff to progress their career according to their choice and their own pace, whilst recognising and providing the opportunity for talented staff, anticipating and targeting opportunities for talented individuals and ensuring equality of access.

Staff & Union Engagement – project closed
Project Manager: Tony Crabtree

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

PROGRAMME PROGRESS REPORT FOR CLINICAL DEVELOPMENT, LEADERSHIP & WORKFORCE

Training Restructure
Bill O'Neill

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

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

E-Learning
Project Executive: Bill O'Neill **Project Manager: Johnny Pigott**

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

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

Team Briefings
Project Executive: **Project Manager: Alex Bass**

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

Learning Management Systems
Project Executive: Greg Masters **Project Manager: Johnny Pigott**

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

Workforce Plan Implementation – project closed
Project Manager: Ann Ball

The project is stage 2 of the workforce re-configuration with the scope to recruit 350 student paramedics by 31st of March, and deliver the student paramedic course. The project has been split into three mainstreams, the sourcing and operationalisation of additional external training facilities, the recruitment of the 350 staff, and the running of the student paramedic training course.

NEW WAYS OF WORKING WORKSTREAM OVERVIEW

Clinical Leaderships
Project Manager: Jane Worthington

This project aims to identify the clinical training requirements in order to achieve a fully trained staff base (including management) on New Ways of Working Complex sites.
Initially a training need analysis will be performed manually, based on information provided by IM. This will then be analyzed to develop training development plans for each member of staff, in conjunction with the Team Based Working project and Non-clinical Training Needs Analysis project and integrated with local clinical requirements

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Leadership Development
Project Manager: Jo Anthony

Major change, such as New Ways of Working, requires highly effective leadership and this project aims to align the management on each Complex with the requirements and intent of NWoW. Capacity and capability will be assessed on each Complex and identified development areas will be addressed. This might take the form of formal training, 1-1 coaching and feedback or team development work, as well as making recommendations for the ideal configuration of the individual management teams. Psychometric analysis and preference auditing will further inform this work and assist in creating a benchmark for ideal management/leadership skills. The project will also respond to any identified non-clinical development required for staff on Complex – e.g.: chairing forum meetings.

Team Based Working
Project Manager: Hazel Smith

This project involves working with staff and management at New Ways of Working Complexes in the formation and development of a team based working environment. Fundamental to this will be the need to move away from fixed rota systems towards more flexible working practices. Teams will be created and given the responsibility for providing the cover required to meet demand along with organisational objectives. The creation of teams and development of a team based working environment will enable communication and access to training/development to be improved and more focused. A teamwork culture will also be beneficial to the organisation in terms of improved attendance and performance.

Communications
Alex Bass

The NWoW Communications strategy has been developed by the communications department. It is currently awaiting feedback from Senior Management.
The communications strategy aims to integrate with other projects and form a holistic approach to communications to and from NWoW Complex staff and Complex / senior management.

HEALTHCARE FOR LONDON WORKSTREAM OVERVIEW

Stroke
Project Executive: Fionna Moore **Project Manager: Nick Lawrance**

The aim of this project is to scope, develop plans for implementation and respond to the regionalization of stroke services requiring LAS crews to convey FAST positive patients directly to one of eight hyper-acute stroke units in London.

Major Trauma
Project Executive: Fionna Moore **Project Manager: Claire Garbutt**

The aim of this project is to scope the implications of the regionalisation of trauma care in London for the LAS, and ensure we are best placed to effectively respond to the service changes. This will require LAS crews to identify, and convey major trauma patients directly to one of four major trauma centres in London.

Referral Pathways
Project Executive: tbc **Project Manager: Grenville Gifford**

Documented alternative and referral pathways were introduced from 2007 – 2008 as a project within the Operational Model programme however statistical evidence indicates that take up and the consequent reduction in traditional A&E conveyance has not yet been realised.

The objective of this project is to deliver increased and sustained utilisation of alternatives to A&E conveyance that is clinically safe and that aligns both with patients' expectations for treatment at home or in the community and needs of the service to improve efficient use of resources.

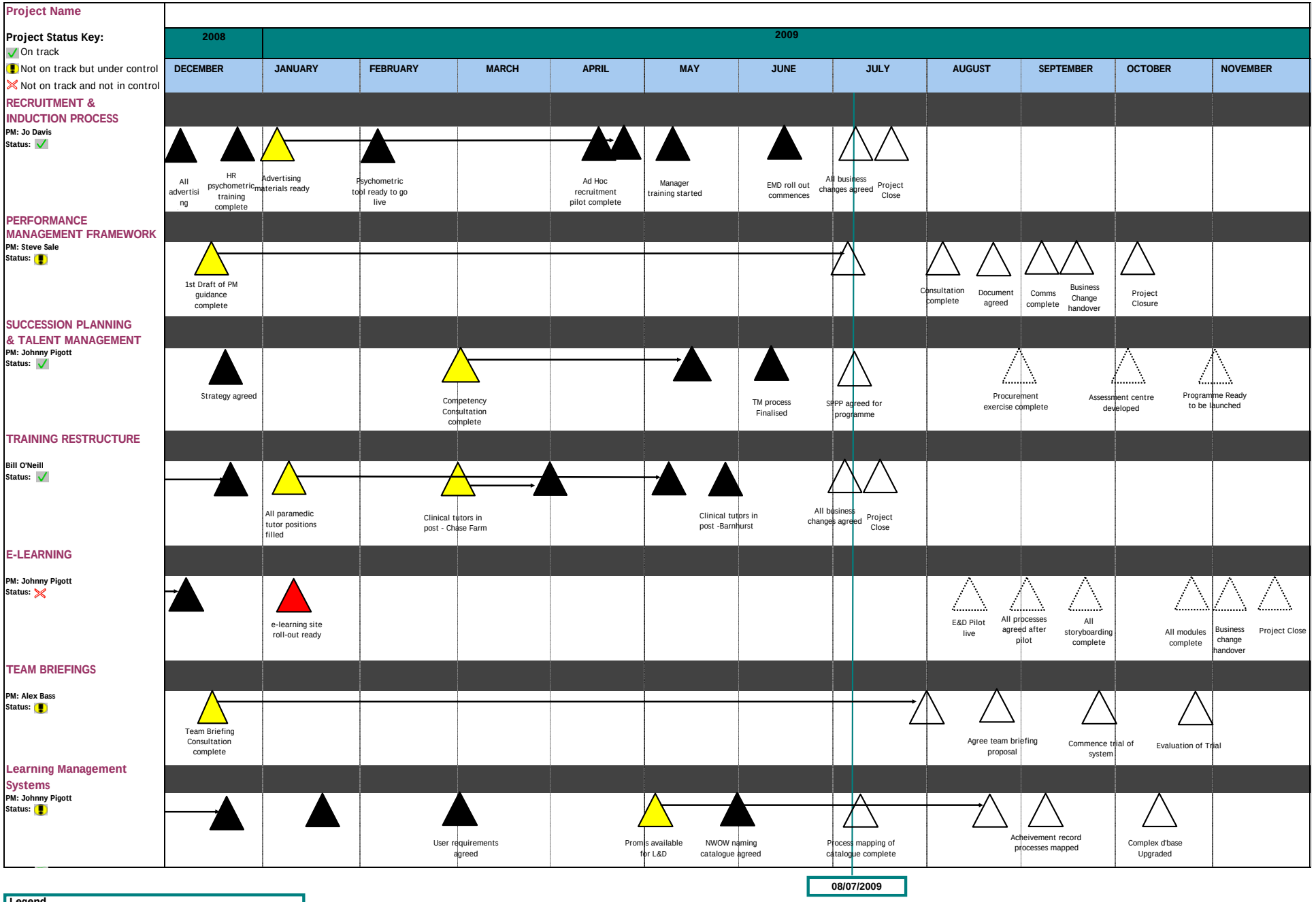
The approach shall be to identify and remove barriers to greater utilisation, to build crews confidence to select alternatives and where necessary to adapt the pathway's parameters to align with prevailing needs of both the service and patient.

Directory of Clinical Services
Project Executive: tbc **Project Manager: Grenville Gifford**

As well as collecting and collating real time data about hospital capacity there is an emerging need to assess and track the capability and capacity of clinics and clinical services offering an alternative care pathway to those offered at A&E departments. For A&E departments this is currently done by EBS, which in liaison with acute trusts prepares and disseminates London Critical Capacity information, reflecting pressure on emergency treatment services at A&E departments across London to inform conveyance decisions. To extend the service will involve collecting and collating capacity data from a much larger number of service providers.

The purpose of the project is to identify and implement a computerized system to streamline this administrative task that will support reliable operational decision making with accurate, up to date and comprehensive management information.

ORGANISATION DEVELOPMENT AND PEOPLE - Workstream Summary



Legend

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

New Ways of Working : Transforming Clinical Leadership

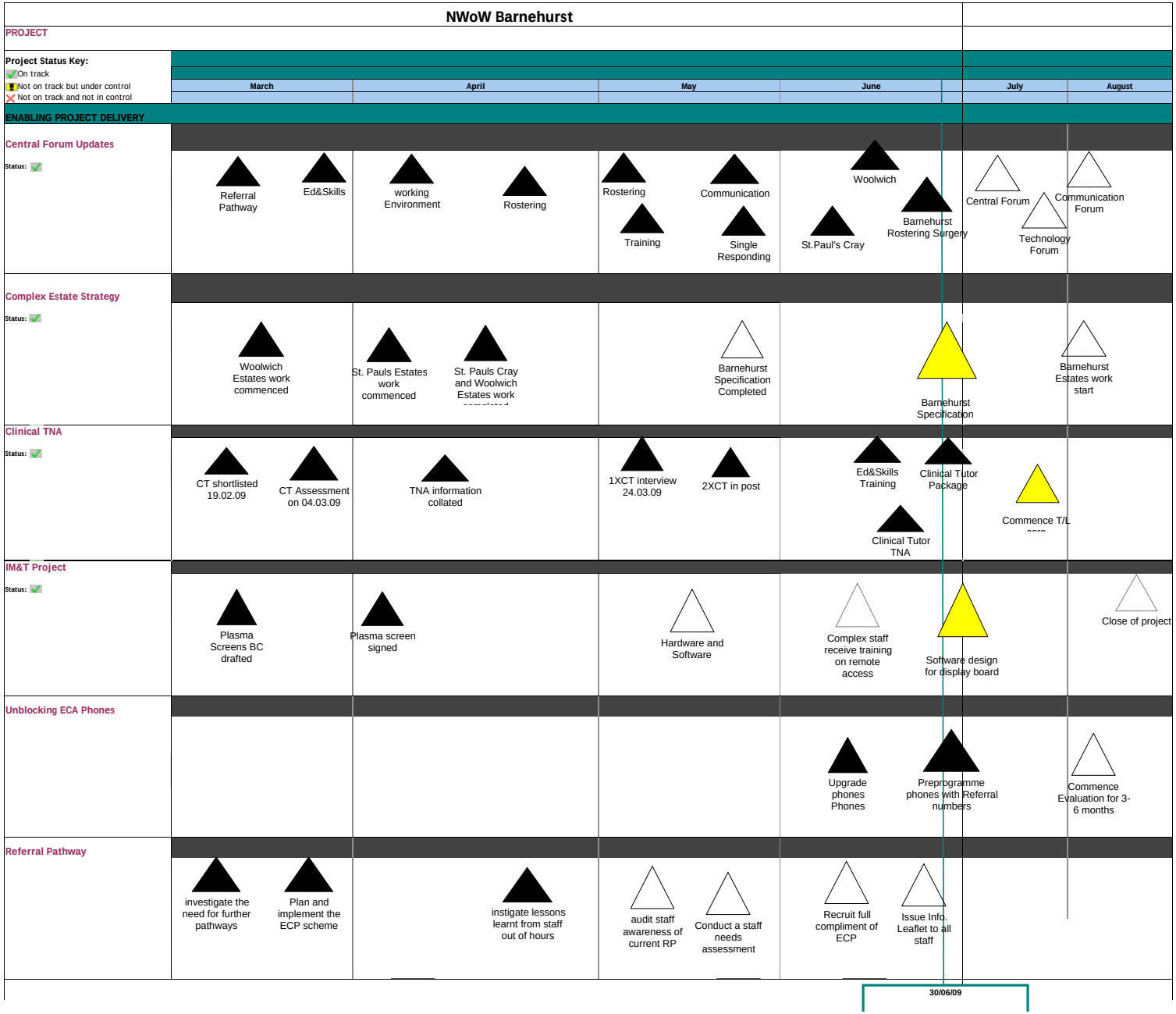
Project

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

	January	February	March	April	May	June	July
ENABLING PROJECT DELIVERY							
Estates	Chase Farm Estates work completed; St. Paul's Cray and Woolwich Estates commenced	St Paul's Cray and Woolwich completed		Barnehurst Estates work specification	Barnehurst Estates Work specification completed		Barnehurst Estates work commence
Staff Structure and Training	E-Learning available for use	2X Chase Farm CT in Feb; TNA letters returned; BH CT advert closing date 17.02.09	BH CT interview on 24.03.09	2XChase Farm CT in April 09; TLs Increased Establishment form signed off	CHFand BH CT in post	CF TLs interview	CF 2XTLs in post
Leadership Development	Managem ent style questionna; Training chairs at Barnehurst; Position audit conduted at CF &BH				Self and Peer assessment commenced		Self and Peer assessment completed
IM&T	Commence IM&T work	Plasma Screen submitted and agreed		1st meeting with Cisco re: software; BH IM&T cable and Networking	2nd Meeting with Cisco to agree software design and cost; IM&T cabling and Networking completed		Meeting to agree software design; Display screen installation completed
Team Based Working		ORH Modelling released on 26.02.09	Skill Mix model for signed off 20.03.09; CH TBW away day 13.03.09	BH TBW Surgery April 09; TBW meeting to sign off roster options	Skill mix Response Model	BH TBW surgerys; BarneuurstTBW surgery to review ORH model and discuss options	Barnehurst Capacity/demand report; Barnehurst Capacity/demand paper signed off
Communications		CIO article featured in LAS	ECPs article in LAS News Mar 09	BH&CH agreed Roster options		NWoW progress made	CF TBW Roster options

30/06/2009

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


NWoW Barnehurst
PROJECT
Project Status Key:
On track
Not on track but under control
Not on track and not in control
March
April
May
June
July
August
ENABLING PROJECT DELIVERY
Central Forum Updates
Status:
Referral Pathway
Ed&Skills
working Environment
Rostering
Rostering
Training
Communication
Single Responding
Woolwich
St.Paul's Cray
Barnehurst Rostering Surgery
Central Forum
Technology Forum
Communication Forum
Complex Estate Strategy
Status:
Woolwich Estates work commenced
St. Pauls Estates work commenced
St. Pauls Cray and Woolwich Estates work
Barnehurst Specification Completed
Barnehurst Specification
Barnehurst Estates work start
Clinical TNA
Status:
CT shortlisted 19.02.09
CT Assessment on 04.03.09
TNA information collated
1XCT interview 24.03.09
2XCT in post
Ed&Skills Training
Clinical Tutor Package
Clinical Tutor TNA
Commence T/L
IM&T Project
Status:
Plasma Screens BC drafted
Plasma screen signed
Hardware and Software
Complex staff receive training on remote access
Software design for display board
Close of project
Unblocking ECA Phones
Upgrade phones Phones
Preprogramme phones with Referral numbers
Commence Evaluation for 3-6 months
Referral Pathway
investigate the need for further pathways
Plan and implement the ECP scheme
instigate lessons learnt from staff out of hours
audit staff awareness of current RP
Conduct a staff needs assessment
Recruit full compliment of ECP
Issue Info. Leaflet to all staff
30/06/09

New Ways of Working : Transforming Clinical Leadership

PROJECT

Project Status Key:						
On track						
Not on track but under control	**March**	**April**	**May**	**June**	**July**	**August**
Not on track and not in control						

NWoW Chase Farm Milestones

Project

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

January | February | March | April | May | June | July

ENABLING PROJECT DELIVERY

Complex Staff updates

Status:

- Clinical Support Forum
- Community Engagement Forum
- Resourcing Forum
- Ed&Skills forum
- Technology Forum
- Staff Welfare
- Referral Pathway
- Ed&Skills
- Working Environment
- Rostering
- Education and Welfare
- Rostering
- Referral Pathways
- Chase Farm Away Day

Complex Estate Strategy

Status:

- Cabin Carpeting completed
- Refurbishment Mess Room
- Estates and IM&T work completed

Clinical TNA

Status:

- 2XCT in post Feb
- 2XCT in Post
- 2XClinical Tutors in post
- Collate information i.e Ed and Skills
- Commence T/L core competencies
- Complete Ed&Skills competencies

Management Traning

- Self and Peer Assessment
- AOM development

Referral Pathway

- Brief staff on relaunch of Magnolia unit
- Circulate information to staff
- Meeting with Providers brief on objectives and monitoring guidelines
- Brief staff on relaunch of Magnolia unit
- Circulate information to staff
- Meeting with Providers to brief on objectives and monitoring
- Evaluate Pathway
- Evaluation of Pathway ends

IM&T Networking

- Cabling Site Survey Conducted
- Authorisation of Networking and Cabling POs
- Relocation of the BT circuit box
- Installation of Networking and Cabling
- Delivery and installation of PC
- Networking and installation of PCs completed
- Installation of Networking and cabling completed

30/06/2009

HEALTHCARE FOR LONDON - Workstream Summary

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

	2009						2010					
	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	AUGUST	SEPTEMBER
STROKE PM: Nick lawarance Status:		Comms plan agreed & implemented		Transition Plan agreed			Full Implmentation Plan agreed					
MAJOR TRAUMA PM: Claire Garbutt Status:	Development of training plan agreed	Comms plan agreed & implemented	Trauma database developed	Start team leader training	Start all staff training		Complete team leader training	Agree transition plan for Phase 2	All staff trained	Phase 1 - Go Live		
DIRECTORY OF CLINICAL SERVICES PM: Grenville Gifford Status: being scoped												
REFERRAL PATHWAYS PM: Grenville Gifford Status: being scoped												

08/07/2009

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

PROGRAMME PROGRESS REPORT FOR PERFORMANCE AND SERVICE DELIVERY PROGRAMME

Programme Highlight Report

PROGRAMME: Performance and Service Delivery Programme

REPORTING PERIOD: Period End 29 June 2009

PROJECT STATUS SUMMARY: 29 ▲ 10 ▲ 0 ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

PROGRAMME SUMMARY

The following projects are currently live:

Workstream 1 – Technology		
CAD2012 (Nick Evans)	▲	
Data warehouse (James Cook)	▲	
LARP (Rony Zaman) (London Ambulance Radio Project)	▲	
PTS system upgrade (Robert Utchanah)	▲	
TEASHIP (Grenville Gifford) (Text Emergency Access for Speech or Hearing Impaired People)	▲	
Workstream 2 – A&E Capacity Production		
First and co-responders (Chirs Hartley-Sharpe)	▲	
Hospital turnaround projects (Helen Lew)	▲	
Roster reviews (Gary Hunt)	▲	
Annual leave (Steve Sale)	▲	
Resourcing to ORH plan across 168 hours (Gareth Hughes)	▲	
Mobile office (Michael McGinn)	▲	
Workstream 3 - A&E Resource Distribution		
Performance oversight (Andy Heward)	▲	
Single responders (Jason Killens)	▲	
Urgent care despatching (Paul Woodrow)	▲	
Ambulance activation reduction (30secs) (Peter McKenna)	▲	
FRU activation reduction (15 secs) (Jon Knott)	▲	
Active area cover (Andy Heward)	▲	
Rest breaks (Andy Heward)	▲	

Workstream 4 – A&E Infrastructure		
Vehicle fleet procurement (Nick Pope)		
Event control rooms (Gary Hunt)		
Logistics and fleet review (Chris Vale)		
Emergency preparedness review (John Pooley)		
New workshop commissioning (Chris Miles)		
Control rooms (Julia Hilger-Ellis)		
Real time fleet management information (Chris Miles)		
Workstream 5 - PTS		
Workstream 6 – Corporate processes		
Staff administration (Jonathan Nevison)		
Performance measurement phase 2 (David Hodgkinson)		
VRC process improvement (David Hodgkinson)		
The Intelligent Trust (Stephen Moore)		
Electronic expenses (Steve Martindale)		
Inventory management (David Hodgkinson)		
Incident data records (Jonathan Nevison)		
Workstream 7 – Foundation Trust and corporate governance development		
Finance (Reuven Vazan)		
Governance and membership (John Wilkins)		
Business strategy and marketing (Stewart Chandler)		
Commissioning engagement (Stewart Chandler)		
Business Plan (Kerrie Martsch)		
Workforce development (Caron Hitchen)		
Consultation and communication (Angie Patton)		

TECHNOLOGY WORKSTREAM OVERVIEW

CAD 2010
Project Manager: Nick Evans
The purpose of this project is to replace the core Call Taking and Dispatch capabilities within Control Services, including replacement or development of any interfaces with existing systems, applications or services.

Data Warehousing
Project Manager: James Cook
Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse information. Information is not available from outside the LAS network and therefore it is not accessible to our partners and stakeholders.
To address these issues a data warehouse will be developed that stores LAS data.
Eventually this data warehouse will encompass the whole of the LAS, including A&E and PTS data, resources, fleet, finance, estates, staff, recruitment and more. This project is the first step towards that goal and will limit the scope of its data to A&E data and vehicle manning and availability.

LARP (London Ambulance Radio Project)
Project Manager: Rony Zaman
As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable radios, EOC / UOC dispatcher equipment and the integration with CTAK

PTS System; Meridian Mobile Technology
Project Manger: Robert Utchanah
The intension of this project is to introduce handheld information terminals to build upon the functionality of the upgraded Meridian booking, billing and management reporting system used to support Patient Transport Services operations.
The system eliminates paper-based dispatching. The use of handheld terminals to receive and feed back operational and management information related either to the patient or of relevance to the customer in a more timely manner and in a secure technological environment, is expected to deliver efficiency savings over time and a more flexible operation on a day-to-day basis.

TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)
Project Manager: Grenville Gifford
The objective is to provide the capability to respond to patients or their carers who have a speech or hearing impairment that prevents use of the normal '999' facility.
A method piloted by several U.K. police services is to use texting from mobile telephones and at present this would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.
Our intention is to adopt this solution for call taking and this was initially expected to be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up during 2008.
Because of continuing delay and uncertain surrounding the national initiative the project is also investigating the feasibility of establishing an in-house solution that would deliver text messages directly to ambulance control rooms.

PRODUCTION WORKSTREAM OVERVIEW

First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe
Project Executive: martin Flaherty

The LAS is looking to revise and expand existing responder schemes which broadly fall into one of three categories: Static defibrillator sites where staff who work in the vicinity are trained to provide Emergency Life support, Co-responders that work for established organisations and who respond to selected emergency calls as part of their work, and community responder who are groups of local people who volunteer to share the provision of a single responder within their local area.

Hospital Turnaround
Project Manager: Helen Lew
Project Executive: Lizzy Bovill

There are 3 projects within the scope of the 'Hospital turnaround projects portfolio' which aim to provide central enablers to support the business change to reduce hospital turnaround times through local implementation.

Project 1: Hospital process project:
To process map eight hospitals across London (Mayday, Princess Royal, Ealing, West Middlesex, Barnet, Chase Farm, Queens & Whipps Cross) with lengthy hospital turnaround times and identify bottlenecks and issues which are affecting the hospital processes and causing delays to the LAS. This work will allow the hospitals to be benchmarked against hospitals that have shorter turnaround times, and to share best practice. The output of this project will be a detailed report of the study and recommendations to improve the clinical and patient handover, which will require local implementation.

Project 2: Hospital escalation policies
Working with NHS London, this project aims to obtain Trust bed escalation policies (for Acute and Foundation Trusts) to establish how the Trust communicate bed issues to the LAS. The project aims to identify similarities and differences, best practice and make recommendations for the potential development of a Pan London policy.

Project 3: Marketing & Communication project
This project is focused internally within the LAS, and aims to scope the wider marketing and communication activities which are required to achieve a cultural change and reduce crew turnaround times (from handing over the patient to going green).

Please note it is through the development of central enablers which will support local implementation, that a reduction in hospital turnaround time will be achieved. The reduction in hospital turnaround time will be as a consequence of the business change.

Roster Reviews
Project Manager: Gary Hunt (support)
Project Executive: Paul Gates

This project will review all the rotas in the Trust by station and then changes will be made to bring them in line with the ORH recommendations as funded by commissioners.

The project already has reviewed the rotas in the East and South areas and changes have been identified to local managers. The local managers will then work with their staff on complex to change the rota's so as the cover is improved when demand required it. The West area will have completed this piece of work by the end of July 09.

The first 40% of stations in each area have been identified against the highest demand. These rotas will be the ones changed first so as the performance gains and benefits can be realized readily.

The plan will have 40% or changes made by December 09 with a further 40% changed by the end of the financial year with the final 20% completed by the end of the first quarter next financial year.

The project is managed by area leads so as to keep the changes identified locally led.

Annual Leave
Project Manager: Steve Sale

The Annual leave review project is currently in the process of being scooped, the current policy is a trust wide document; however the greatest impact of the current policy falls on A&E operations.

The current annual leave year is in the process of transition from the traditional annual leave year April through to March to an individualised annual leave year based upon an individual staff members start date with the Trust. This change is being introduced to reduce the log jam of annual leave requests within the last quarter of the annual leave year which coincides with the peak demand time within operations. Also by staggering the annual leave year for individuals it should reduce the amount of annual leave carry over which in itself compounds the impact on resourcing.

The change of annual leave year has been agreed with our staff side who are actively supporting this change, a draft communication has been agreed and the intention is to implement the change from the 1st of September back dated to the 1st of April.

Resourcing to ORH Plan across 168 hours
Project Manager: Gareth Hughes
Project Executive: Richard Webber

ORH have now supplied the Trust a comprehensive Staffing plan for Ambulances' and FRU's.
The plan covers all 168 hours of the week by hour of day, day of week.
This initiative is to supply the tools to allow the Trust to monitor the Resourcing compliance from ProMis against the plan.
This will be broken down by Service, Area, Complex and Station.
Relief staff, overtime and finally AAC will be targeted to areas where compliance is not met.

Mobile Office
Project Manager: Michael McGinn
Project Executive: Jason Killens

This project is tasked with equipping DSO vehicles with laptops to enable staff to work remotely, giving them immediate access to information whilst also allowing them to spend more time out in the field. The project will establish hardware and software requirements, examine security concerns and establish the best way to transport the laptops in the vehicles.

DISTRIBUTION WORKSTREAM **OVERVIEW**

Performance Oversight (CDU/EOC)
Project Manager: Andy Heward
Project Executive: Phil Flower

This workstream will scope and set up the performance management arrangements to give robust 24/7 oversight. It is currently envisaged that the CDU arrangements will be replaced by a robust set up in EOC

Single Responders
Project Manager: Jason Killens

This initiative will review the effective utilisation of single responders. It will cover FRUs, MRUs and CRUs and will oversee the tasking regime of these resources. The early intentions are that the responders will be moved the control of an individual allocator and a performance matrix produced to ensure that there is effective tasking and a reduction in dual dispatching.

Urgent Care Dispatching
Project Manager: Paul Woodrow

The purpose of this initiative is to review the dispatching regime for urgent care resources. The early intention of this project is to trial moving the dispatch of urgent care resources from UOC to the allocators in EOC whilst considering carefully the need to overview pre-planned work.

Ambulance Activation Reduction of 30 Seconds
Project Manager: Peter McKenna

This initiative will take forward the ORH recommendations whereby the activation time of ambulances is to be reduced by at least 30 seconds.

FRU Activation Reduction of 15 Second
Project Manager: Jon Knott

This initiative will review the tasking regime for FRUs and produce a reduction in activation of at least 15 seconds.

Active Area Cover (AAC)
Project Manager: Andy Heward
Project Executive: Paul Webster

This initiative will review both the current AAC arrangement and ensure increased and appropriate usage of AAC deployments.

Rest Breaks
Project Manager: Andy Heward
Project Executive: Paul Webster

This initiative is to review the allocation of breaks to maximize the allocation across all shifts with the intention of improving to over 80% allocation by year end.

INFRASTRUCTURE WORKSTREAM OVERVIEW

Vehicle Fleet Procurement
Project Manager: Nick Pope
Project Executive: Chris Vale

This project is responsible for delivering a 5 year fleet procurement and policy plan which was agreed by the Trust Board on 20th May 2008. This includes; ambulances, PTS, bariatric and training vehicles.

Event Control Rooms
Project Manager: Gary Hunt
Project Executive: Jason Killens

This project comprises the setting up and full implementation of an Event Control facility at Bow to manage major events (including the Olympic Games) until such time that new Control Room facilities for London have been established.

Logistics and Fleet Review
Project Manager: Chris Vale
Project Executive: Richard Webber

The Operational Support Department (OSD) is in the process of implementing a new 3 year strategy to implement and consolidate the further business changes necessary to provide world class logistical support. The strategy has required that a further review of logistical and fleet services is carried out to ensure services are customer focused and robust. An agreed strategy will then be implemented by a delivery plan, setting milestones for each year.

A number of substantive projects sit under the umbrella of the strategy. These include the reconfiguration of Fleet Workshops, vehicle procurement, enhanced logistics support, the retendering of Make Ready, and performance and quality improvements. A number of these projects sit in the LAS Corporate Governance and Process Programme.

The infrastructure workstream seeks to ensure all aspects of the OSD portfolio is fully reviewed, also that business change is effected in a considered and measured fashion to support improvements in operational performance and clinical care.

Emergency Preparedness Review
Project Manager: John Pooley
Project Executive: Jason Killens

This is work already underway within the Emergency Preparedness Unit and will ensure that the Unit is fit for purpose and that consideration is given to training and development of staff to further enhance the Trust's response to pre-planned events, major incidents and the Olympics.

New workshop Commissioning.
Project Manager: Chris Miles
Project Executive: Chris Vale

This project is a continuation of the Workshop Reconfiguration in tranche 1, and is delivering a new large scale workshop on premises to be identified in West London.

Control rooms
Project Manager: Julia Hilger-Ellis
Project Executive: Martin Flaherty

This project will scope, plan and then deliver 2 purpose built control rooms with sufficient capacity to provide resilience.

Real-Time Fleet Management Information
Project Manager: Chris Miles

The project consists of implementing TranMan across the whole of Fleet Support and ensuring that all business changes are implemented.

CORPORATE PROCESSES WORKSTREAM OVERVIEW

Staff Administration
Project Manager: Jonathan Nevison

The project consists of a review and redesign of staff administration processes at complex level. Previous process mapping indicates that an interface between ESR and ProMis could substantially improve efficiency by reducing duplication and hard copy paper flows and the project is tasked with exploring this further. There is also an urgent need to replace the Station Operating System, which is becoming increasingly difficult to support.

Performance Measurement Phase 2
Project Manager: David Hodgkinson

This project is to implement Performance Accelerator, which will provide a repository for all the evidence required by external agencies, e.g. Healthcare Commission.

VRC Process Improvement
Project Manager: David Hodgkinson

This project is to review the processes used by the VRC with the intention of streamlining then and allowing faster resolution of problems. The intention is to provide information and capacity to solve potential problems proactively.

The Intelligent Trust
Project Manager: Stephen Moore

This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement SharePoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

Electronic Expenses
Project Manager: Steve Martindale

Select and implement an electronic system for claiming and authorising staff expenses. The systems must interface with ESR to eliminate manual input of data into the payroll system.

Inventory Management
Project Manager: David Hodgkinson

This project is to develop electronic stock management in the Trust enabling better management of stock levels and real-time stock information. This is being done using a new module within the Trust's accounting package. The initial stage is to roll-out a paper-based stock control system which will subsequently be automated.

Incident Data Records
Project Manager: Jonathan Nevison

This project is a continuation of the IDR project to roll out collision investigation and IDR download skills and technical capability to more DSOs.

FOUNDATION TRUST WORKSTREAM OVERVIEW

Finance

The objective of this Workstream is to produce information to feed into the IBP to prove that the London Ambulance Service is financially stable and able to remain financially viable and ultimately self sustaining in the long term through the use of trend analysis, forecasting and historic data. Finance also plays a key role in other Workstreams specifically in aligned Strategy

Historical Data and forecasting will provide a clear view of how we have performed and can expect to perform, enabling opportunities to improve efficiency across the business.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Providing Financial information for the Integrated Business Plan, such as
  - Historical Performance Analysis (2 year)
  - Income and Expenditure 5 year projection (best and worst case scenarios)
  - Income and Expenditure Historic Data (2 year)
  - Capex 5 Year Plan (best and worst case scenario)
  - Capex Historic Data (2 year)
  - Cash flow and Balance sheet 5 year Projections
  - Breakdown of Income Historic last 5 years per source/service
- Providing Benchmarking KPIs and Balanced Scorecard
- Developing Financial Models
- Participating in Business Risk Review and Performance Management (Workforce)

Governance & Membership

Governance and Membership is the largest Workstream in the Programme.

The Governance objective of this Workstream is to define how the Organisation will function following FT approval and specifically how the Organisation will be managed.

The Membership objective of this Workstream is to define the population of London, actively seek public buy-in (through the Consultation and Communication Workstream), and set up a mechanism for controlling membership interest.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Preparing the framework for a public 'owned' organisation
- Review the Organisation Structure
- Gathering information on the population of London, with a view to creating a membership base
- Maintaining a membership database after Foundation Trust status has been awarded
- Provide the means to create a membership database

Provide a contact point for Membership enquiries

PROGRAMME PROGRESS REPORT FOR PERFORMANCE AND SERVICE DELIVERY PROGRAMME

Business Strategy & Marketing

The objective of this Workstream is to assess the market place in which London Ambulance Service plays a major role, identify opportunities and competition, thereby defining a strategy upon which the Organisation can strengthen its base.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Analysis of the market place in terms of opportunities and competition
- Prepare a Business Strategy which will give direction to the services we provide and aid decision making for the future
- Analysis of business risks, based on opportunities, competition and strategy.
- Prepare a Relationship Management Strategy, based on the above

Commissioning Engagement

The objective of this Workstream is to work with the PCTs to gain agreement and approval on the Foundation Trust application, ensuring that as an FT we can meet (and exceed) supplier-customer expectations.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Working with the Commissioners and building relationships with the Commissioners
- Develop a Payment by Results strategy
- Model Activity Projections.

Business Plan

The objective of the Business Plan Workstream is to collaborate and collate all the outputs from the other Workstreams to produce a robust Integrated Business Plan ensuring exceptional quality through use of action plans and reviews.

Scope:

The scope of work is to facilitate the Foundation Trust Application by:

- Developing the Integrated Business Plan
- Working with the other Workstreams to provide input to the IBP
- Submission of the IBP and supporting information to Monitor

Work Force Development

The objective of this Workstream is to enable the organisation to function efficiently and effectively by implementing strategy which reflects the changes being made to the organisation, the services we provide and how the organisation is managed.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Development of the Trust Board through a development plan
- Development of a workforce expansion programme
- Staff training

Consultation & Communication

The Consultation and Communication Workstream is to ensure that the Public and Staff are engaged in the Consultation process to facilitate membership to the Trust should the application be successful.

Scope:
The scope of work is to facilitate the Foundation Trust Application by:

- Communicating the desire to achieve Foundation Trust status to the Public, Staff, union, partners
- Preparation of communications for Public Consultations and Staff Briefings
- Make available relevant documentation, such as the Consultation Document, in a variety of formats.

WORK STREAM: PRODUCTION

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

2008 | 2009

NOV | DEC | JAN | FEB | MAR | APRIL | MAY | JUNE | JULY | AUGUST | SEPTEMBER

FIRST AND COMMUNITY RESPONDERS
PM:Chris Hartley Sharpe
PE: Martin Flaherty
Status: ✓

- 8 trial sites live
- 2nd Trainer recruited
- Remainder 103 BHF defibs phased to be delivered
- 79 AEDs for static sites
- 12 Community Responder schemes live
- 2nd Trainer recruited

HTA:Hospital Processes Project
Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Site visits complete (x8 hospital)
- HLO role scoped / benefits identified.
- Report production
- Action plan produced
- Present report & action plan

HTA: Escalation matrix project
Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Deadline for Acute escalation policies
- Final cut-off deadline (Acute & FT)
- Escalation policies analysed
- 1st draft of matrix complete
- Finalise matrix
- Finalise report
- Finalise action plan & consult
- Present report & action plan

HTA: Marketing & Communication Project
Project Executive: Lizzy Bovil
Project Manager: Helen Lew
Status: ✓

- Project Initiation
- Marketing research complete
- Stakeholder profile
- Approach scoped
- Communication channels identified
- Possible incentives identified
- Local projects underway identified
- Finalised report
- Finalise action plan & consult
- Present report & action plan

ROSTER REVIEWS
PM: Gary Hunt (supporting)
PE: Paul Gates
Status: ✓

- Agree milestones
- Initiate project board
- PID produced
- Review each station rota against ORH Recommendations
- Commence Rota Implementation

ANNUAL LEAVE
PM: Steve Sale

Status: Being scoped

- Project Board
- PID Produced
- Recommendation to A&E SMT
- Operation consultative forum agenda

RESOURCING TO ORH PLAN ACROSS 168 HOURS
PM: Gareth Hughes
PE: Richard Webber
Status: Being scoped

- Plan Produced
- Area Plan
- Complex Presentation

MOBILE OFFICE
PM: Michael McGinn
PE: Jason Killens
Status: ✓

- PID complete
- Laptops selected
- Phase 1 trial starts
- Phase 1 trial ends

30/06/09

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

WORK STREAM: DISTRIBUTION

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

2008		2009								
NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER

PERFORMANCE OVERSIGHT
PM: Andy Heward
PE: Phil Flowers
Status: Being scoped

SINGLE RESPONDERS
PM: Jason Killens
Status: Being scoped

- East and South MRU desk operations merged (E/T Only
- Request CTAK changes via change board
- Airwave goes live on MRU desk
- Trial new APL tracking at 100 metres or 1 minute refresh rate on MRU's
- Exploit full use of Airwave with new APL (tracking) with refresh Rate of 100 meters or 1minute
- 1. Dispatch staff rationalised to 1 paramedic 0630/1830, 1 Paramedic1130/2330 plus 1 EMD 24/7
- 2. Activation of CFR's, Co responders and static defibrillator sites transferred to single responders desk
- 3. Develop a dispatch protocol for static defibrillator sites
- 4. Develop an education piece for staff in EOC about what does not improve awareness of targets and action to deliver them
- 5. Switch CRU's from FREDA activation on codes similar to but to identical to FRU's
- 6. Develop performance management matrix for single responders within this work stream and ensure delivery of data from MI
- Develop automatic telephone dispatch system with automated message to all static defibrillator sites (similar to airport omni-crash system)

URGENT CARE DESPATCHING
PM: Paul Woodrow
Status: Being scoped

AMBULANCE ACTIVATION REDUCTION (30 SECONDS)
PM: Peter Mckenna
Status: Being scoped

FRU ACTIVATION REDUCTION (15 SECONDS)
PM: Jon Knott
Status: Being scoped

ACTIVE AREA COVER
PM: Andy Heward
PE: Paul Webster
Status: Being scoped

- PID Completed
- Baseline Completed
- Initial Trajectories completed and released
- Revised Monthly targets Released
- 8000AAC Deployments per Month

REST BREAKS
PM: Andy Heward
PE: Paul Webster
Status: Being scoped

- PID Completed
- Baseline Completed
- Initial Trajectories completed and released
- Revised Monthly targets Released
- 50% resource allocated Rest Breaks

30/06/09

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

WORK STREAM: INFRASTRUCTURE

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

2008: NOV, DEC
2009: JAN, FEB, MAR, APRIL, MAY, JUNE, JULY, AUGUST, SEPTEMBER

VEHICLE FLEET PROCUREMENT

PM: Nick Pope
PE: Chris Vale
Status:

- Prototype MSV completed
- Mercedes complete chassis builds
- First converted A & E ambulances delivered
- Approx 30 ambulances delivered
- Orders placed for 35 + 65
- *123* ambulances funding/qty to be confirmed
- Completed PTS Bariatric vehs
- 25 Vehicles delivered

Event Control Rooms

Project Executive: Jason Killens
Project Manager: Gary Hunt
Status:

- IM&T Specs costed for Business Case
- Business Case finalised for Presentation and approval to SMG Board

LOGISTICS & FLEET REVIEW

PM: Chris Vale
PE: Richard Webber
Status: Being scoped

- Paper Produced

EMERGENCY PREPAREDNESS REVIEW

PM: John Pooley
PE: Jason Killlens
Status: Being scoped

NEW WORKSHOP COMMISSIONING

PM: Chris Miles
PE: Chris Vale

Project Has been running for 2 years and Reporting under CPG

- Submit planning requests and prepare specification
- Agree design and layout
- Agree specification of mobile workshops
- Staff agreement to pay and relocation package
- Staff Agreement to shift rosters
- Communication of new working arrangements to all fleet and operational staff
- Staff Agreement to shift rosters

Control Rooms

PM: Julia Hilger Ellis
PE: Martin Flaherty

REAL TIME FLEET M/INFO

PM: Chris Miles
Status:

- Training
- Testing
- Implementation
- Post Implementation Review

30/06/09

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

London Ambulance Service NHS TRUST

TRUST BOARD DATE 28 July, 2009

Business Case 65 Ambulances

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: Board Approval

3. Summary

The Business Case is for the acquisition of 65 new ambulances as part of the strategic fleet plan and the 2009/10 Trust Business Plan.

This acquisition will allow an additional 40 ambulances to be procured as part of the agreed 2009/10 commissioning agreement and 25 will complete the replacement of the LDV fleet. In additional, the additional new ambulances will add some additional operation flexibility to allow the remount of the existing Mercedes fleet.

The business case follows the DH model (GEM)

The current business plan has plans for 142 additional ambulances. The increase to 165 is affordable.

The total purchase cost of the 65 ambulances is £7.1M. Current analysis shows that a lease option is more appropriate but this will be confirmed after further discussions with the Audit Commission viz. finance/operating leases.

4. Recommendation

The Trust Board approves the Business Case.

A&E AMBULANCE REPLACEMENT PROJECT 2009/10

BUSINESS CASE

Authorisation:

Proposed by:

Head of Operational Support **Date**

Concurrence:

Director of Operations **Date**

Director of Finance **Date**

Approved By:

Chief Executive **Date**

Document Control

Author: Karen Walker

Address: Finance Dept

Level 3
42 Loman Street
London
SE1 0EH

 0207 463 6647

 Karen.walker@lond-amb.nhs.uk

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Christopher Vale
Nick Pope
Asif Islam

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1 EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The purpose of this Combined Business Case (CBC) is for internal London Ambulance Service (LAS) use where combining the Outline and Full Business case requirements can save time and effort, and the overall cost is within the LAS financial approval authority. This business case draws upon both the LAS Strategy Plan 2006/7 to 20012/13 and the Fleet update presented to the Trust Board in March 2008. It refers to recent independent research on fleet size and an urgent requirement to address an ageing fleet of front line ambulances.

1.1.2 This CBC draws the conclusion that the Trust should buy 41 new ambulances to increase fleet size due to additional staff numbers recruited during 2008/09 and 2009/10, and replace 24 of the oldest ambulances with new ones because:

- The need to replace old and worn out vehicles remains strong
- Costs to repair vehicles will become higher as the age of vehicles increases
- The need to provide buffer capacity whilst 240 ambulance units from older ambulances are remounted onto new chassis

The preferred option arising from this analysis of costs and benefits is that 65 new ambulances should be purchased through a lease during the 2009/10 financial year. The 2009/10 budgeted forecast figures have taken into account the purchase of an additional 141 ambulances, thus the affordability of an additional 24 ambulances is illustrated in 2009/10 and thereafter the affordability impact of the 65 ambulances on years 2 through to 5 (All other items remaining constant). A trust surplus is maintained throughout.

1.1.2 This CBC also confirms that the Trust has the capability to manage the project as evidenced by recent projects, the procurement of 148 RRUs during 2006 and 2007/8, and the rollout of the new Mercedes ambulances from the 2008/09 Business Case. Other members of the project team were involved in previous deliveries of the 260 Mercedes AEU's since 2004/5.

1.2 Strategic Case

1.2.1 The Trust has an ageing fleet because of under-investment in the 1990s. The age profile of the fleet is improving, but as at March 2008, 35% of the fleet was greater than 6 years old and 20% of the fleet is more then 9 years old. Older ambulances are costly to maintain, increase overall vehicle downtime and reduce the capacity to achieve performance targets, with a consequent impact on patient care. The 2008/09 100 ambulance business case seeks to address this need, but there will still remain a further 24 LDV vehicles that need to be replaced.

1.2.2 A number of drivers for the replacement of ambulances have been identified including meeting Government performance targets, improving staff health and safety, reducing vehicle downtime due to defects and repairs and reducing running costs.

1.2.3 This business case proposes that 65 of the latest LAS specification, CEN compliant, A&E ambulances are procured. These vehicles will grow the fleet by 41, and replace the 24 oldest vehicles in the fleet. The ambulances will be Mercedes diesel vehicles

with a removable box body and tail lift. This will be the sixth batch of this vehicle type that the Trust has procured

1.2.4 The Trust's fleet replacement strategy specifies that ambulances should be replaced after 6 years. The Trust is procuring vehicles in batches of 65 to achieve a more even spread in the age profile of ambulances to avoid too many vehicles needing to be replaced at one time in the future. However, the requirement for a sensible age spread needs to be balanced against the risks posed by the ageing fleet.

1.2.5 For this reason, this Combined Business Case has been prepared for Trust Board approval in July 2009 in order to allow 65 ambulances to be procured and put into service by the end of the 2009/10 Financial year.

1.3 Economic Case

1.3.1 There are five investment objectives and targets for this business case:

- Provide 65 CEN Compliance ambulance vehicles designed to the latest LAS Specification ready for deployment within the 2009/10 Financial year.
- To improve the availability of A&E Ambulances by increasing the fleet by 41 vehicles, and by reducing instances of off-the-road downtime (VOR) caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- Meet Health & Safety requirements to reduce back injuries caused by manual trolley bed vehicle loading; by up to 50% like for like by installing mechanical tail-lifts
- To meet the aims of the Strategic Plan 2006/7 to 2012/13 by responding to our patient's needs with the appropriate service.

1.3.2 This business case has considered three options open to the LAS - Do Nothing, Buy New with Capital, and Buy New with a lease. It has been found that the preferred option is the Buy New with a lease, this is largely due to the Weighted Benefit Score applied to both Buy New options. The Lease option is more favourable due to the estimate by the Lessor of the residual value at the end of the lease, equating to lower lease payments to the LAS.

1.3.3 The financial case uses figures consistent with the economic case but with VAT and non-cash elements (such as depreciation) included.

1.3.4 The financial case shows that there is a net cost in all years of the project, starting at £1.4 million in year 1 this is comprised of interest, depreciation and PDC effect. Years 2 through to 5 see a decline in the net cost mainly due to interest cost decreasing. An overall Trust surplus position is maintained however, throughout the period of investment.

1.3.5 This business case has been shown to be affordable and is within the Trust's delegated limits, thus commissioner support has not been sought.

1.4 Commercial Case

1.4.1 The contract for build of ambulance bodies has been tendered and awarded via the newly awarded PASA NHS framework agreement. A formal tender evaluation

group was formed and reviewed each supplier's submitted tender response using criteria such as price, quality, compliance to the specification, and ability to meet the vehicle delivery schedule.

1.4.2 This contract was let to UV Modular following a further competition exercise against the PASA framework. Scope was included in this procurement exercise for future vehicle requirement over two years and as per EU guidelines has been awarded with sufficient scope within the contract life for this Business cases additional build requirements. Approval for this business case is sought on the basis that final prices are per the UV modular quoted prices and these prices have been included within the financial analysis of this document.

1.5 Management Case

1.5.1 This project will be managed by the Operational Support Fleet Project Manager using the PRINCE 2 methodology. This model is the NHS standard and has been used by the LAS for many successful procurement projects since 2002.

1.5.2 The stakeholders' expectations are that vehicles commence operational deployment following on from the current 100 ambulance business case of 2008/09 and that all vehicles are in service by the end of the 2009/10 financial year. This is an ambitious and challenging schedule to achieve. However, these timeframes cannot be confirmed until contracts are placed with the individual equipment suppliers and their production schedules are known.

1.5.3 Staff involvement is of course critical to the success of this project, the ambulance being the key resource of the Trust. The design of the new ambulance has had the direct involvement of staff through the A&E Vehicle and Equipment Working Group. Equally importantly, all staff have had the opportunity to make direct suggestions for changes to the vehicle design. Where practicable, these have been incorporated into the specification for these vehicles.

2 STRATEGIC CASE

2.1 LAS Organisational Overview

2.1.1 Summary of LAS Organisation

2.1.1.1 The London Ambulance Service NHS Trust provides ambulance-related services to the public in the Greater London area. The service is provided to some 7.5 million residents, which are increased by approximately 700,000 per day when commuters and visitors are taken into account. The London Ambulance Service is the largest ambulance service in the world and by far the busiest.

2.1.1.2 The 31 Primary Care Trusts commission the A&E services on behalf of the residents of London.

2.1.1.3 The main functions of the Trust are to:

- Receive and process 999 calls from the public and dispatch A&E vehicles to the patients based upon their priority.
- Convey patients, declared by a clinician to be urgent, on a scheduled basis to hospital and/or between hospitals.
- Provide both emergency planning and responses to major incidents, e.g. bombings, train crashes, and to plan and provide services for events such as Notting Hill carnival, anti globalisation marches, etc.
- Provide the Emergency Bed Service.
- Provide transportation services to and from hospitals for non-urgent patients.

2.1.1.4 The Trust works from 77 locations around the London area. It has its main control facilities at its Waterloo HQ with fallback facilities in East London. There are 71 stations across the Metropolis from which paramedics and technician crew staff are dispatched to calls processed through its control centre.

2.1.2 Business Goals

2.1.2.1 The primary National target is to reach 75% of Category "A" (life-threatening) calls within eight minutes of the call being connected to the LAS EOC. Other targets include reaching Category B (not immediately life-threatening) calls within 19 minutes,

2.1.2.2 The business goals for the LAS are set out in its Strategic Plan to 2013. This plan was approved by the Trust Board and has the support of both commissioners and London Strategic Health Authority. These goals encompass National Performance targets, stakeholder requirements, LAS improvement and efficiency goals.

2.1.2.3 At the time of writing and in terms of the LAS' primary performance measure set by the DH, as at 6th of July 2009 the LAS are tracking at 72.5% of all Category A calls reached within 8 minutes and 84.2% of all Category B calls. The timely delivery of this resource is considered a key contributor to the Trust's ability to achieve the targets set for the year.

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2.2 Investment Overview

2.2.1 Current Facilities

2.2.1.1 The core front line ambulance fleet comprises 397 vehicles, up to 14 of which are used by the training department on an ad-hoc basis.

2.2.1.2 The higher than normal maintenance costs associated with maintaining a disproportionately aged fleet is of concern to the Trust. These costs are currently unavoidable and detract from other areas of the service.

2.2.1.3 During 2003, the LAS commenced a replacement programme of 121 of its frontline A&E ambulances with 130 new vehicles, however these are now 5 years old and the Trust is still heavily reliant upon the 124 older LDV vehicles to maintain its performance. Table 1 illustrates the current age distribution of frontline ambulances. As the new vehicles are introduced (Both from this business case and the 2008/09 Business case for 100 Ambulances), the fleet will grow by 41 vehicles and 24 of the remaining LDV vehicles will be replaced.

2.2.1.4 To meet the changing response criteria and increasing demands on the service, alternative operating models and fleet sizes have been proposed by ORH, (external consultants). Over the past few years the funding stream was directed to procure greater numbers of RRUs which was in line with one of the preferred operating models proposed by ORH. This has proved to have several deficiencies. In addition, more recently, the Urgent Care operations have increased and these have absorbed any spare AEU capacity, thus putting additional demands on the existing fleet. Variants of the ORH models have been adopted with the Training fleet being incorporated into the daily deployment. Table 1 demonstrates that in 1997 to 1999 and in 2002 to 2006 the Trust undertook an effective replacement programme. The Trust must therefore resume the replacement programme to prevent falling into the situation as described in 2.2.1.3 and being exposed to external probity.

Table 1

Vehicle Age	**11-12 Years**	**10-11 Years**	**9-10 Years**	**8-9 Years**	**7-8 Years**	**6-7 Years**	**5-6 Years**	**4-5 Years**	**3-4 Years**	**2-3 Years**	**1-2 Year**	**<1 Year**	
(Financial Year Vehicles in service)	**(1997 / 1998)**	**(1998 / 1999)**	**(1999 / 2000)**	**(2000 / 2001)**	**(2001 / 2002)**	**(2002 / 2003)**	**(2003 / 2004)**	**(2004 / 2005)**	**(2005 / 2006)**	**(2006 / 2007)**	**(2007 / 2008)**	**(2008 / 2009)**	**TOTAL:**
Ambulance Numbers July 2008	13	50	0	61	0	8	121	65	60	1	0	0	379
2008/09 100 Amb Business Case Effect:	-13	-50	0	-37	0	0	0	0	0	0	0	100	0
Total:	**0**	**0**	**0**	**24**	**0**	**8**	**121**	**65**	**60**	**1**	**0**	**100**	**379**

2.2.1.5 The remaining older vehicles, some of which are over 8 years of age are becoming increasingly unreliable. This inevitably leads to lower response and vehicle availability, lower morale for those having to use these vehicles but also higher running and maintenance costs.

2.2.1.6 The Trust knows that vehicle reliability/availability is a large factor in providing the

level of patient care required of it and that this naturally deteriorates as vehicle age profiles increase further. The older LDVs are recorded as those with the highest VOR, are repeatedly faulted and putting greater pressures on the workshops. Since the demise of LDV, parts are scarce and difficult to obtain.

2.2.1.7 The LAS adopted CEN as the standard, known as BS EN 1789:2007 – for its A&E Vehicles and their equipment. CEN is a voluntary standard; however, due to the importance of the requirements for ensuring the safety of both patients and crew staff, the LAS view this as a purchasing requirement for new ambulances.

2.2.1.8 The major justification for updating vehicles to CEN includes:

- One specific standard to choose for an industry benchmark.
- Ambulance crews will have a safer working environment.
- Patients are transported in vehicles proven to be as safe and comfortable a vehicle as possible.
- Provides a level of protection to the Trust against legal action, during vehicle accident inquests.

2.2.2 Proposed Facilities

2.2.2.1 In 2001, the LAS researched and designed the next generation of A&E ambulances to replace the existing fleet. This constituted 14 months worth of work before the specification/designs were finalised. Since deployment of these vehicles in 2003, the LAS, through the Vehicle and Equipment Working Group, has evaluated the build design and performance of the vehicle. Whilst minor changes to the specification have been made, (which is a natural part of a product's lifecycle) this vehicle is the core design for all new LAS ambulances.

2.2.2.2 This Business Case sets out the argument for replacing 24 of the remaining LDV vehicles with new CEN compliant vehicles built to the latest LAS Specification dated June 2008, this has been up-dated from the original 2003 designed vehicles encompassing minor changes to reflect enhancements in medical treatment. The vehicles shown in Table 1, which are in years 8-9, will be the target for these replacements. This will ensure the last of the LDV vehicles are off the road.

2.2.2.3 The remaining 41 vehicles are to be procured to increase the vehicles available for operational use. This increase in fleet size is funded by additional funding received from our commissioners to achieve Cat A and Cat B targets in 2009/10 by increasing our core establishment.

2.2.2.4 This case also seeks to demonstrate that the need for this investment enables the Trust to better balance the age of the fleet by resuming the practice of a continuous replacement cycle. It is only through annual replacements that the Trust can ensure reliable, cost effective, appropriate and efficient vehicles are available to patients and staff.

2.2.2.5 Automatic tail-lifts will be fitted to the vehicles as part of the standard ambulance build. They are designed to improve crew and patient safety when loading on and off the vehicle. Since their introduction the LAS health & safety department report a back injury reduction of 20% year on year.

2.2.2.6 The Trust will always seek to be as cost-efficient as possible. A significant benefit

of the 24 replacement ambulances is the reduced fuel costs achieved. The reduction in fuel costs through use of a cheaper fuel alternative with greater economic consumption is achieved by using diesel. Evidence from the latest vehicles has shown that they provide us with improved miles per gallon rate of 16.5mpg verses 9mpg.

2.3 Investment Objectives and Targets

2.3.1 Five investment objectives and targets have been identified for this business case:

- To provide 65 CEN compliant ambulance vehicles designed to the latest LAS specification ready for deployment within the 2009/10 financial year.
- To improve the availability of A&E Ambulances by increasing the fleet by 41 vehicles, and by reducing instances of off-the-road downtime (VOR) caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- To reduce back injuries caused by trolley bed vehicle loading by up to 50% like for like through installing mechanical tail-lifts
- To meet the Strategic Plan 2006/7 to 2012/13 in responding to our patients' needs with the appropriate service.

2.4 Scope of Investment

2.4.1 The scope of this project includes the investment in 24 vehicles to replace the oldest and/or most unreliable vehicles in the current fleet. In addition, to increase the fleet by 41 new vehicles.

2.4.2 The high-level scope of this project includes the chassis, saloon, communications and clinical equipment.

2.4.3 A thorough review and agreement of the vehicle specification has already taken place and made available to the tender process. This was a significant milestone as it was identified as the first critical path activity in the plan.

2.4.4 The critical success factors of this investment centre on:

- Successful & timely approval of the business case.
- Successful tender process leading to identification of a suitable vehicle constructor.
- Keeping change requests to a minimum (avoid scope creep).
- The ability to minimise the delay between CTS communications installations & Fleet PDI activities.
- Timely availability of LAS personnel to support the controlling (implementation) phase of the project.

2.4.5 The success of this investment will be shown by:

- Reduction in annual fuel costs for replacement vehicles.
- Reduction in maintenance costs for replacement vehicles.

- Reduction in instances of staff sick leave caused by back injuries when loading or unloading trolleys on vehicles.
- Improved patient care through improved vehicle availability and on-board medical facilities.
- Staff satisfaction with the new vehicle.

2.5 Constraints and Dependencies

2.5.1 Constraints

Constraints identified for this investment include:

- Adherence to the final specification.
- The constructor's capacity to deliver to the agreed schedule.
- Availability and input of project stakeholders and work package managers, in particular IM&T with manpower availability and utilising obsolete technology and Purchasing with tender support.

2.5.2 Dependencies

2.5.2.1 The major dependencies identified for this project are:

- Approval of the business case.
- Controlling the scope of the project to avoid scope creep and delays.
- Successful tender evaluation and satisfactory supplier performance.
- This investment places a significant amount of work/risk with the prime contractor and is dependent upon their professional engineering and management ability to deliver vehicles to the schedule at the agreed level of quality.

3 ECONOMIC CASE

3.1 Objectives

3.1.1 The investment objectives set out in paragraph 1.3.1 are repeated here:

- To provide 65 CEN compliant ambulance vehicles designed to the latest LAS specification ready for deployment within the 2009/10 financial year.
- To improve the availability of A&E Ambulances by increasing the fleet by 41 vehicles, and by reducing instances of off-the-road downtime (VOR) caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- To reduce back injuries caused by trolley bed vehicle loading by up to 50% like for like through installing mechanical tail-lifts
- To meet the Strategic Plan 2006/07 to 2012/13 in responding to our patient's needs with the appropriate service.

3.2 Benefits

3.2.1 From the investment objectives, a list of benefits has been developed and categorised into financial, non-financial and non-quantifiable groups as follows:

Financial Benefits

- Less overtime costs through cover of back injuries
- Achieving a better fuel consumption thus reducing running costs for replacement vehicles.
- Reduced maintenance costs for replacement vehicles due to parts for newer vehicles being cheaper, and the expectation that less maintenance will be required due to vehicles being younger.
- Enhanced operational capability with a reduction in unscheduled breakdowns of vehicles, and an increase in fleet size.
- Fitment of Incident Data recorders with overall benefit to reduce accident rate and therefore repair costs, benefit realisation dependent upon other projects.

Non-Financial Benefits

- Improved trolley bed equipment, (intention that it will be more durable – less prone to breakdown) coupled with a greater tail-lift capacity would give a Bariatric capability
- Improved patient care through increased vehicle reliability/availability
- Greater number of CEN compliant ambulances
- Reduced CO2 emissions in line with the Kyoto agreement

Non-Quantifiable Benefits

- Corporate kudos for being environmentally responsible
- Improved public image
- Improved staff morale

3.2.2 A detailed explanation of the benefits can be found in Appendix A.

3.2.3 The non-financial benefits listed above have been grouped into benefit criteria, which are listed in Table 2 below in rank order:

Table 2

Benefit Criteria
a) Improved Patient Care
b) Improved Vehicle Availability
c) Improved Staff Safety
d) Improved Trolley Bed Equipment
e) Environmental Responsibility
f) Meeting Operational Objectives

3.3 Generating Options

3.3.1 Long List and Short List of Options

For this business case, there are only two viable options - to replace the vehicles or to extend the life of the existing vehicles.

As there are only two options, the long list and the short list are the same:

- **Do Minimum** - No replacement vehicles would be purchased for another three years with repairs being carried out and vehicle equipment being replaced only in the event of failure, accidents or breakages. Disadvantages of this option include high vehicle maintenance costs, vehicle downtime and high fuel costs due to petrol rather than diesel engines. The potential lack of availability and poor reliability of vehicles carries a higher risk of lower staff morale, under-performance against targets and a lower quality of patient care.
- **Procure 65 new A&E ambulances (Option 1)** - Procure 65 Mercedes chassis and 65 bodies of similar type to the Mercedes vehicles currently on lease. This option assumes 65 Mercedes chassis would be procured along with 65 bodies of similar type to the 2005/06 procurement. A new trolley bed will be included. New MDT and communications equipment may be included as part of the work to be completed by the LAS on receipt of approved vehicles from the converter.

3.3.2 Option Ranking

The benefit criteria, derived from the objectives, which had been ranked, were then given percentage weights through the pairing comparison techniques. The options were ranked as per Table 3 below:

Table 3

Benefit Criteria	Rank	Pairings					Raw Weights	% Weights
		1st	2nd	3rd	4th	5th		
a) Improved Patient Care	1	100					100	27.14
b) Improved Vehicle Availability	2	85	100				85	23.07
c) Improved Staff Safety	3		80	100			68	18.46
d) Improved Trolley Bed Equipment	4			75	100		51	13.84
e) Environmental Responsibility	5				73	100	37	10.11
f) Meeting Operational Objectives	6					73	27	7.38
							368	100.00

3.3.3 Each option was then scored out of 10 as to how close it came to achieving the benefits. The results are shown in Table 4 below; the reasoning for each score is given in Appendix B.

Table 4

Benefit Criteria	Weight (w) %	Options			
		Do Minimum		Purchase Vehicles	
		Score (s)	Weighted Score (w) x (s)	Score (s)	Weighted Score (w) x (s)
a) Improved Patient Care	27.14	0	0.0000	7	190.0068
b) Improved Vehicle Availability	23.07	0	0.0000	9	207.6503
c) Improved Staff Safety	18.46	0	0.0000	9	166.1202
d) Improved Trolley Bed Equipment	13.84	0	0.0000	8	110.7468
e) Environmental Responsibility	10.11	0	0.0000	8	80.8452
c) Improved Staff Safety	7.38	1	7.3771	7	51.6399
Total	100.00		**7.3771**		**807.0091**
0rder of options		**2nd**		**1st**	

3.3.4 As can be seen in table 4, Option 1 (purchase of vehicles) clearly offers the greatest benefit.

3.4 Identification and Quantification of Option Costs

3.4.1 Opportunity Costs

There is no opportunity cost identified for either of the options.

3.4.2 Residual Identified Value Costs

The current book value of the existing ambulances (LDVs) is zero. There is no expected income from the disposal of these assets, in fact, it is likely that a disposal cost will be incurred.

3.4.3 Capital Costs

There are no capital costs associated with the 'Do Minimum' option. The capital costs associated with Option 1 are set out in Table 5.

Table 5

Option 1 - Purchase 65 vehicles	Number of Units =				65
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Saloon Build	56,000	8,400	64,400	3,640,000	4,186,000
Lifecycle Costs					
Purchase of chassis	26,583	3,987	30,570	1,727,895	1,987,079
Purchase of trolley bed	7,523	1,128	8,652	489,011	562,363
Technology fit (MDT and radio)	5,000	750	5,750	325,000	373,750
Totals	**95,106**	**14,266**	**109,372**	**6,181,906**	**7,109,192**

3.4.3.1 The costs shown in Table 5 have been derived using the following information:

- **Saloon Build** – Costs have been provided by Operational Support and are based on a recent tender exercise.
- **Purchase of Chassis** – Costs have been based on recent purchases of Mercedes chassis.
- **Purchase of Trolley Bed** – This cost is from the tender application received from Supplier A in July 2008 for the supply of a trolley bed and the associated CEN compliant fixings. Supplier B trolley beds are cheaper to purchase but are likely to incur higher maintenance costs. For prudence, the trolley bed cost from Supplier A has been included in this analysis until the outcome of the tender exercise is known.
- **Technology Fit (MDT and Radio)** – MDT and the service radio equipment, this is estimated at an average cost of £5k per vehicle.

3.4.4 **Revenue Costs**

3.4.4.1 The DH guidance requires that all relevant costs are included in the economic analysis. For the purposes of this business case, the costs associated with running the vehicles have been included but crew, dispatch costs and other general costs have not as they remain the same irrespective of which vehicles are used.

3.4.4.2 The costs for the 'Do Minimum' option reflect the costs built into existing (2008/09) forecasts for retaining 65 vehicles and estimates for maintaining 65 vehicles for a further period. These costs are shown in Table 6.

Table 6

Do Minimum - Retain Existing Vehicles (for 3 yrs)							
	Unit Cost	**Cost Driver**	**Cost Driver Units**	**Annual Cost per Vehicle**	**Cost for GEM**	**VAT (or other taxes)**	**Total Cost per annum**
No of Vehicles to Keep On Road	**24**						
Existing Recurrent							
Fuel	0.4173	per mile	19,500	8,137	195,299	29,295	224,594
Vehicle maintenance (including labour)				4,944	118,653	17,798	136,451
Trolley bed maintenance				1,126	27,024	4,054	31,078
				14,207	340,976	51,146	392,123

3.4.4.3 In developing the 'Existing Recurrent Costs' shown in Table 6 the following assumptions have been made:

- **Fuel** – The existing LDV based vehicles operate at just over 9 mpg. The price paid by the Trust, during May 2009, for Cleaner Unleaded petrol was 96.94 pence per litre (incl. VAT). On average, the vehicles are expected to cover 19,500 miles per annum.
- **Vehicle Maintenance** – The costs of maintaining the existing vehicles is calculated with reference to existing fleet records and the professional judgement of fleet managers.
- **Trolley Bed Maintenance** – The costs of maintaining the current trolley bed have been calculated with reference to existing fleet records and the professional judgement of fleet managers and finance.

3.4.4.4 The revenue costs associated with Option 1 is shown in Table 7.

Table 7

Option 1 - Purchase 65 vehicles	**Unit Cost**	**Cost Driver**	**Cost Driver Units**	**Cost per Vehicle**	**Cost for GEM**	**VAT (or other taxes)**	**Total Cost per annum**
Non Recurrent (Year 0 Costs)							
Initial Clinical Equipment					415,774	62,366	478,140
Trolley Bed Extra Batteries				120	7,800	1,170	8,970
Commissioning costs of vehicles				289	18,798	2,820	21,618
				409	442,372	66,356	508,728
Recurrent							
Fuel	0.2450	per mile	19,500	4,777	310,512	46,577	357,089
Vehicle maintenance (including labour)				2,604	169,238	25,386	194,624
Trolley bed maintenance				925	60,125	9,019	69,144
Taillift Maintenance				337	21,905	3,286	25,191
				8,643	561,781	84,267	646,048

3.4.4.5 The forecast revenue costs of Option 1, shown in Table 7 have been derived using the following assumptions:

- **Fuel** – The current Mercedes ambulances operate at 16.5 mpg. The price paid by the Trust, during May 2009, for diesel was 103.3 pence per litre (Incl. VAT). On average, the vehicles are expected to cover 19,500 miles per annum.
- **Vehicle Maintenance** – The cost of maintaining the proposed vehicles is calculated with reference to existing fleet records for Mercedes ambulances and the professional judgement of fleet managers. The maintenance cost used in the calculation is the average cost over the 5-year life of the vehicle. These costs do not fall evenly over the life of the chassis. Table 8 below sets out an analysis of the vehicle maintenance costs over the life of the vehicles.

Table 8

Option 1 - Purchase New Vehicles	2009/10	2010/11	2011/12	2012/13	2013/14
One off costs (not covered by warranty) - Major Repairs	**15.0**	**18.3**	**82.2**	**118.3**	**140.0**
General Service Maintenance Costs					
Air conditioning			2.5		
General Maintenance (Parts only)	37.2	37.2	37.2	37.2	37.2
Labour costs	55.8	57.5	59.2	61.0	62.8
Brakes	54.2	54.2	54.2	54.2	54.2
Battery	32.5	32.5	32.5	32.5	32.5
Minor one off repairs	2.0	2.0	2.0	2.0	2.0
General Service Costs including labour	**181.7**	**183.3**	**187.5**	**186.8**	**188.7**
TOTAL - PURCHASE NEW VEHICLES	**196.7**	**201.7**	**269.7**	**305.2**	**328.7**

- **Trolley Bed Maintenance** – The costs of maintaining the new Supplier A trolley bed have been calculated with reference to the existing tender document held by LAS and assumptions on repair needs.
- **Tail Lift Maintenance** – The costs of maintaining the tail lifts have been calculated with reference to existing fleet records and the professional judgement of fleet managers. The estimates include the cost of annual certification of the tail lift equipment.

3.4.5 Transitional Costs

There are no transitional costs associated with the 'Do Minimum' option. Option 1 incurs transitional costs associated with decommissioning the old vehicles (estimated at £2,484 each, excl VAT), the new Vehicles will need to be disposed of at the end of their expected life (estimated at £2,484 each, excl VAT).

3.4.6 External Costs

There are no external costs associated with any of the options.

3.5 Discounted Cashflow Analysis of Options

3.5.1 The costs identified in section 3.4 have been entered into the DH's Generic Economic Model (GEM), applying the HM Treasury discount rate of 3.5%. HM Treasury guidance requires the use of the Equivalent Annual Cost (EAC) where the appraisal periods for each option are not of the same duration. Appraisal is based on all 65 ambulances being in use by the end of 2009/10 financial year.

Table 9

SUMMARY	Appraisal Period	EAC
		£'000
OBC Do Minimum	4 Years	560.8
Retain Existing Vehicles (for 3 yrs)		
OPTION 1	5 Years	1,708.4
Purchase 65 vehicles		
Leasing Test	5 Years	1,588.0
5 Year Lease of preferred option		

3.5.2 Table 9 above indicates that the 'Do Minimum' option provides the lower EAC.

3.6 Option Cost Benefit Analysis

3.6.1 Cash Releasing Benefits

The costs and the calculated EAC include an element of cash releasing efficiency savings. These include:

- **Fuel** - The change of engine type and the consequent increase in miles per gallon of the diesel engine is estimated to save £115,214 (ex VAT) per annum.
- **Vehicle Maintenance** - The change of engine type and body type is estimated to save £50,585 (ex VAT) per annum.
- **Trolley Bed Maintenance** – The change from the current supplied trolley beds to Supplier A trolley beds and the younger age of the trolley beds would save approximately £33,101 (ex VAT) per annum.

3.6.2 Non-Cash Releasing Benefits

There are numerous Non-Cash Releasing Benefits associated with Option 1; these have been addressed in section 3.2 above.

3.6.3 Quantifiable Benefits

The non-financial quantifiable benefits are shown in Table 4.

3.6.4 Non-Quantifiable Benefits

Option 1 has the added non-quantifiable benefit of improving staff morale as they see the Trust continuing its vehicle replacement programme. This is not measurable and, therefore, has not been included in the cost benefit analysis.

3.6.5 Summary of Option Cost Benefit Analysis

At this point in the analysis, the EAC totals shown in Table 9 are adjusted by the benefit scores from Table 4 to result in a value of EAC per weighted benefit score. The effect of which is illustrated below in Table 10.

Table 10

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score
		£'000		£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	560.8	7	76.01
OPTION 1 Purchase 65 vehicles	5 Years	1,708.4	807	2.12
Leasing Test **5 Year Lease of preferred option**	5 Years	**1,588.0**	**807**	**1.97**

3.6.6 The calculations above show that Option 1 has a lower cost per weighted benefit score. The risk adjusted EAC per weighted benefit score indicates that the leasing alternative coupled with Option 1 is the preferred choice.

3.7 Assessing Risk

3.7.1 Risk Identification

The Capital Investment Manual requires the Preferred Option to be subjected to a risk assessment. The tables overleaf summarise the assessment of risk for the short listed options. Assessment of risk is a continual process and is managed by the Project Manager. Risk Reviews will be carried out by the Project Board and may involve other LAS staff if their expertise is required. Risk severity is measured using the Safety & Risk Department; risk log and its associated scoring matrix.

Business level risks identified during document completion are logged in the risk register found within the PID. The Safety and Risk Department will carry out a detailed operational risk assessment during the project lifecycle as appropriate.

3.7.2 Risk Transfer

There is just one risk that can be transferred (by default) to the supplier for the purchasing option. This is the risk of vehicle and/or equipment loss associated with the point of storage and transit to LAS.

3.7.3 Optimism Bias

Most of the costs used in the option appraisal are based on tendered prices or actual costs already incurred by the Trust. Consequently, there is no justification for including an optimism bias in the comparison of options.

3.7.4 Assessing the Impact of Risk on Option Ranking

Table 11 below summarises the assessment of risk for the do minimum option

Table 11

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
The business case is not approved.	5%	Fleet ages and becomes less reliable. Maintenance Costs and potential legal liabilities of up to £1,000,000	£50,000	Close liaison with stakeholders to ensure the business case is clear, concise and falls within the guidelines for approval.
Maintenance costs are higher than expected	10%	The service incurs higher than expected maintenance costs increasing the running costs of the vehicles at £450 per vehicle. (£29,250)	£2,925	Assign a financial threshold on vehicle maintenance costs before making a decision on the vehicles operating viability.
Spare parts become increasingly scarce for old vehicles, suppliers charge premium.	70%	More vehicles are off the road due to parts shortage and the service has higher parts costs; increasing costs by £350 per vehicle. (£22,750)	£15,925	Close liaison with suppliers, and create strategy to stock up on parts known to be low or earmarked for deletion from supply.

3.7.5 Table 12 below summarises the assessment of risk for Option 1.

Table 12

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
The business case is not approved.	5%	Fleet ages and becomes less reliable. Maintenance Costs and potential legal liabilities of up to £1,000,000	£50,000	Close liaison with stakeholders to ensure the business case is clear, concise and falls within the guidelines for approval.
New contractor may have lack of LAS specific knowledge which may result in Project schedule	30%	Delayed start (2 months) meaning old vehicles requiring longer life and extra maintenance at £250 per vehicle (£16,250)	£4,875	Assign high priority. Pressure supplier to perform

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
over-runs				
Maintenance costs are higher than expected	10%	The service incurs higher than expected maintenance costs increasing the running costs of the vehicles at £100 per scheduled maintenance period. (£58,500 pa)	£5,850	Assign a financial threshold on vehicle maintenance costs before making a decision on the vehicles operating viability.

3.7.6 The table below summarises the assessment of risk for Option 1 (Lease Purchase)

Table 13

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
The business case is not approved.	5%	Fleet ages and becomes less reliable. Maintenance Costs and potential legal liabilities of up to £1,000,000	£50,000	Close liaison with stakeholders to ensure the business case is clear, concise and falls within the guidelines for approval.
New contractor may have lack of LAS specific knowledge which may result in Project schedule over-runs	30%	Delayed start (2 months) meaning old vehicles requiring longer life and extra maintenance at £250 per vehicle (£16,250)	£4,875	Assign high priority. Pressure supplier to perform
Maintenance costs are higher than expected	10%	The service incurs higher than expected maintenance costs increasing the running costs of the vehicles at £100 per scheduled maintenance period. (£58,500 pa)	£5,850	Assign a financial threshold on vehicle maintenance costs before making a decision on the vehicles operating viability.
Mileage estimates are exceeded	15%	Extra charge by lessor 14p per mile (average as quoted by PASA). Assessed at 2000 miles per vehicle £18,200	£2,730	Rotate vehicles to avoid risk and pool mileage in contract.
Risk of not meeting lessor return conditions	30%	The service may have to fund remedial works to bring vehicles up to the residual value standard. £5,000 per vehicle	£97,500	Vehicle inspections carried out in the last 18 months of lease, to determine state of repair/Or include all

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
		(£325,000)		known outcomes in the lease agreement residual value insurance.

3.7.7 The risks set out above have been quantified for each option and discounted to produce an EAC. The impact of the risk analysis on the discounted cashflow is shown below.

Table 13

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjustment	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score	Ranking
		£'000		£'000	£'000	£'000	£'000	
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	560.8	7	76.01	27.0	587.8	79.67	3
OPTION 1 Purchase 65 vehicles	5 Years	1,708.4	807	2.12	15.3	1,723.8	2.14	2
Leasing Test 5 Year Lease of preferred option	5 Years	1,588.0	807	1.97	33.6	1,621.6	2.01	1

3.8 Preferred Option Analysis

Table 13 calculates a risk-adjusted EAC per Weighted Benefit Score for each option. This again demonstrates that Option 1 provides the better value for money and as such, is the preferred option.

3.8.1 Funding Route Option

The preferred option (Option 1) can be funded either using NHS capital, if the Trust can secure additional capital funds, or as illustrated above by the use of an operating or finance lease.

3.9 Sensitivity Analysis

A sensitivity analysis has been carried out to identify the robustness of the preferred option.

A number of scenarios have been considered which are listed below with the findings of each. These are summarised in Table 14.

Table 14

SENSITIVITY ANALYSIS	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjustment	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score
		£'000		£'000	£'000	£'000	£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	560.8	7	76.01	34.5	595.3	80.69
OPTION 1 - No Changes Purchase 65 vehicles	5 Years	1,708.4	807	2.12	16.7	1,725.1	2.14
OPTION 1 - Only Half Fuel Saving Purchase 65 vehicles	5 Years	1,749.4	807	2.17	16.7	1,766.1	2.19
OPTION 1 - No Vehicle Maintenance Savings Purchase 65 vehicles	5 Years	1,887.2	807	2.34	16.7	1,903.9	2.36

- **Option 1 (Fuel Savings Achieved)** – This test assumes that the fuel savings achieved will only be half the £115,214 assumed in the base case. The risk-adjusted EAC would increase by £161k to £1,749.4k giving a risk-adjusted EAC per weighted benefit score of 2.17. This is still substantially lower than the 'Do Minimum' option.
- **Option 1 (Maintenance Savings Not Achieved)** – This test assumes that the vehicle maintenance savings estimated in the base case will not be achieved. In this scenario, the risk-adjusted EAC would increase to £1,887.2k giving a Risk Adjusted EAC per Weighted Benefit Score of 2.34. Again, this is still substantially lower than the 'Do Minimum' option.

3.10 Summary of the Economic Case

In summary, the above analysis has shown that procurement of new vehicles through a lease coupled with the significant non-financial benefits associated with this replacement would be the most cost-effective option.

4 FINANCIAL CASE

4.1 Financial Position

4.1.1 The LAS has a track record of meeting all of its statutory financial duties each year. It is expected that this position will be maintained in the current year. The proposed investment will partly be funded from the savings generated from reduced fuel, trolley bed maintenance and vehicle maintenance costs. The investment will proceed on the basis that it will have no material impact on the Trust's financial standing. The financial effects of Option 1 (Lease buy), have been illustrated in the Tables below. Coupled with this, the effect of treating the Lease as an Operating or Finance Lease is also illustrated.

4.2 Impact on Income and Expenditure Account

4.2.1 The table below sets out the net impact of the proposed investment on the Trust's Income & Expenditure (I&E) Account. The 2009/10 budgeted forecast figures have taken into account the purchase of additional 141 ambulances. This affordability model thus only takes into account the effect of an additional 24 ambulances in 2009/10 thereafter the full effect of the additional 65 ambulances is shown for years 2010/11 to 2013/14. As demonstrated below there is a net cost in all years of the project, starting at £0.5 million in year 1, with the largest increase taking place in year 2 and then cycling down in years 3 to 5 due to decreasing interest charges. An overall Trust surplus position is maintained throughout the period of investment.

Table 15

	Income & Expenditure Account				
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	£m	£m	£m	£m	£m
FINANCE LEASE	-	-	-	-	-
Finance Lease Depreciation	-0.37	-1.00	-1.00	-1.00	-0.42
Finance Lease Interest Payable	-0.16	-0.36	-0.28	-0.21	-0.11
PDC dividend	0.00	-0.01	-0.01	-0.01	0.00
Total Business Case effect on Profit and Loss	-0.53	-1.37	-1.30	-1.22	-0.53
Current forecasted surplus	1.93	3.32	9.17	9.49	9.82
Adjusted forecasted surplus/(deficit)	**1.40**	**1.94**	**7.87**	**8.27**	**9.30**
OPERATING LEASE					
Non-Pay (Op Lease) Costs - CHANGE IN P&L	-0.49	-1.33	-1.33	-1.33	-0.66
Total Business Case effect on Profit and Loss	-0.49	-1.33	-1.33	-1.33	-0.66
Current forecasted surplus	1.93	3.32	9.17	9.49	9.82
Adjusted forecasted surplus/(deficit)	**1.44**	**1.99**	**7.84**	**8.16**	**9.16**

4.3 Affordability Gap

4.3.1 A conservative estimate of savings from the investment have been made and included in both the economic case and the income and expenditure statement above.

4.3.2 Given the current control total requirements and the impact of the investment on the overall Trust surplus, it would be prudent to identify further cost improvements or savings to restore the surplus back to its planned levels.

4.4 Balance Sheet

Table 16

	Balance Sheet				
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	£m	£m	£m	£m	£m
FINANCE LEASE					
ASSETS					
Finance Lease Asset Value	1.97	4.33	3.33	2.32	1.90
LIABILITIES					
Finance Lease - Long Term Liability	-2.07	-4.63	-3.58	-2.46	-1.90
Total Net Effect on Assets Employed	-0.10	-0.30	-0.26	-0.14	0.00
Current Forecasted Assets Employed	103.46	106.82	116.00	128.53	142.17
Adjusted Forecast Assets Employed	**103.37**	**106.53**	**115.75**	**128.39**	**142.17**
OPERATING LEASE					
Operating Lease would have no impact on Assets Employed	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

4.4.1 The table above sets out the net impact of the proposed investment on the Trust's Balance Sheet. This demonstrates that there is a minor impact on total assets employed if the Lease Option is treated as a finance lease and no impact on total assets employed if the Lease Option is treated as an Operating Lease.

4.5 Cashflow Statement

Table 18

	Cash Flow				
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	£m	£m	£m	£m	£m
The Cash Outflow would be the same for a Finance or Operating					
Lease.					
FINANCE LEASE					
Net Cash Outflow	-0.49	-1.33	-1.33	-1.33	-0.66
Current Forecasted Cash in Hand	5.05	3.36	14.60	23.78	34.03
Adjusted Forecast Cash in Hand	**4.56**	**2.03**	**13.27**	**22.46**	**33.37**

4.5.1 The table above sets out the net impact of the proposed investment on the Trust's Cashflow Statement. Whether the Lease Option is treated as a Finance Lease or an Operating Lease the effect on Cash Flow's would be the same.

5 COMMERCIAL CASE

5.1 Assessment of the Market

5.1.1 In the 2003/04 financial year, the LAS acquired (via a lease option) 130 A&E ambulances. At the time and due to both the CEN and tail-lift requirements, only one company was suitable (UVM) and this gave them a significant market advantage over their competitors.

5.1.2 The market has since matured and there are now four companies that are both CEN compliant and on the PASA framework. These are:

- S. MacNeillie Fully certified and authorised to supply
- UV Modular Fully certified and authorised to supply
- VAS Gmbh Fully certified and authorised to supply
- Wilker Fully certified and authorised to supply

5.1.3 This business case has been based on the premise that the current contract in place will have spare capacity to produce this demand. This contract was let to UV Modular following a mini competition exercise against the PASA framework. Scope was included in this procurement exercise for future vehicle requirement over two years and as per EU guidelines, suppliers were evaluated in line with the original framework tender.

5.1.4 The current successful contractor is sufficiently experienced and is able to produce CEN compliant vehicles.

5.2 Alternative Procurement Methods

5.2.1 It has been demonstrated in the Economic Case that replacing the existing vehicles is the most cost-effective option. The Financial Case shows that this proposal is affordable.

5.3 Concurrent Contracts

5.3.1 There are no concurrent contracts associated with this procurement, although the prime contractor is likely to sub-contract elements of work to other parties.

5.4 Procurement Options/Strategy

5.4.1 The procurement of the vehicles will not involve OJEU tenders but use the Current NHS PASA approved agreement in place for the procurement of the Ambulance Chassis and saloon work. As the supplier on this Framework has already been tested through OJEU, and the contract awarded after a mini competition, no further tendering requirements are needed.

5.4.2 The LAS has an up to date and approved ambulance build specification based around the Mercedes 515 Sprinter chassis with Modular saloon, which will be used for this procurement.

5.5 Bid Criteria

5.5.1 The following Evaluation criteria was applied to the successful contractor in accordance with the LAS Standing Orders (SOs):

- Compliance to specification
- CEN compliance certification
- Financial Standing of the company
- Ability to manufacture to the defined schedule
- Cost of work
- The level of after sales support and parts supply availability
- Project Management Expertise
- References are taken up on short listed companies
- Evidence of and commitment to innovation
- Short-listed companies are asked to reconsider areas of non or partial compliance and if appropriate a meeting is held with each company
- The LAS will award the contract to the company which offers the most advantageous tender and may not necessarily be the cheapest

5.6 Evaluation Model Used to Assess Successful Contractor

5.6.1 In accordance with the Standing Orders, bids are received electronically via the Bravosolution e-tendering portal. Every entry including supplier submission and buyer receipt are given an electronic time and date stamp, which cannot be altered. The technical envelope of the tender response is opened by Purchasing. Late tenders will only be admissible if technically late due to unforeseen circumstances or the Chief Executive and Director of Finance believe significant advantage would accrue to the Trust and the Bona Fides of the company are not in question.

Until the qualification and technical envelopes of the tender submission have been evaluated, the commercial envelope will remain locked. When the technical evaluation has been completed, the purchasing officer and the Trust Secretary will open the commercial envelope, and a record of the prices submitted will be recorded.

5.6.2 The Bids are opened and recorded.

5.6.3 The criteria defined in 5.6.1 above are checked to provide the shortlist.

5.6.4 The immediate tender evaluation team consists of:

- Nick Pope Project Manager
- Richard Deakins Head of Procurement
- Kitty Whitehead Contracts Manager
- Chris Vale Head of Operational Support
- Colin Jolly Head of Fleet

5.6.5 As this is a mini competition under a PASA framework, the evaluation criteria has to reflect that used in the award of the framework: Quality, Service, Price (40%), Environmental & Sustainability, Innovation & Flexibility.

5.6.6 For this business case, the group will use the last tender submission and evaluation as the basis for supplier selection but will continue to focus on areas listed in 5.6.5.

5.7 Key Principles for Contract Type

5.7.1 The contracts placed will be procured using the PASA contractual conditions

5.7.2 The contracts are of short duration and therefore will not require any breakpoints.

5.8 Initial Assessment of the Transfer of Risk

5.8.1 The risks, which can be transferred to the vehicle suppliers, are considered minor and these are covered during normal contractual arrangements during build and post build.

5.8.2 On acceptance, each vehicle is checked to ensure it conforms to the LAS Specification and that the title of ownership is transferred to the approved Lessor through an invoice (where applicable).

5.8.3 The LAS has full control of vehicle build until ownership is transferred to the Lessor (if applicable).

5.9 Procurement Timetable

5.9.1 From approval of the Business case, the contractor can produce the required vehicles within the following time constraints:

- 13 weeks for start of chassis delivery
- 6 weeks for acceptance of first off vehicle
- 12-14 weeks to complete full delivery of vehicles to the LAS

5.9.2 Separate orders will be generated by the LAS for the chassis, saloon, medical equipment and trolley bed against the approved LAS vehicle and trolley bed specifications (currently under trial for an alternative to the Current product).

6 MANAGEMENT CASE

6.1 Project Management

6.1.1 The project will be managed by Nick Pope, Fleet Projects Manager in the Operational Support/Fleet Department and follows the structures and controls of PRINCE 2.

6.1.2 Chris Vale has responsibility of being Executive of the Project Board to oversee the project management arrangements.

6.1.3 The Project Board will also include a joint Senior Technical arrangement with Colin Jolly/Nick Pope (Fleet) and John Downard (IM&T department). The End User representative is Ian Lee.

6.1.4 The Project Manager will be supported by Team Managers who will control the concurrent stages of the project under the direction of the Project Manager. The Project Manager will ensure that Team Managers (Shreekant Buch, David Selwood) deliver their stages and components to the required cost, timescale and quality criteria.

6.1.5 Project Assurance is the responsibility of each Project Board Member, and no formal external Quality Assurance function has been nominated. However, the PID draws to each Project Board Member's attention the facility to delegate this function to an appropriate person (not the Project Manager) if necessary.

6.1.6 Roles and Responsibilities of the project team are detailed in the Project Initiation Document.

6.1.7 The project will be managed at the three levels of Project Board, Project Management and Team Management through formal assessment controls as follows:

Table 19

Management Monitoring	Responsibility	Triggering Event
Project Board Management		
Project Initiation	Project Board	Authorisation of Project by Chief Executive & Project Executive.
Project Assessments	Project Board	Planned at mid project or when an exception plan is required.
Project Closure	Project Board	All products have been delivered.
Project Management		
Highlight Reports	Project Manager	Monthly, or as determined by the Project Board.
Checkpoint meetings	Project Manager/Team Manager	Weekly or as determined by the Project Manager.
Stage Quality Management		
Quality Reviews	Quality Chairman	A product has been completed.

6.2 Resources

6.2.1 The resources for the project will be confirmed when the project is initiated.

6.3 Change Management

6.3.1 To control unplanned situations concerning the vehicle and trolley bed specification, performance, delivery of products etc., the project will be subject to configuration and exception control.

6.3.2 The PRINCE 2 change-control approach will be used to ensure that all changes are properly managed during the project. All specification changes, queries and off specifications can be raised by anyone working on the project as a Project Issue with the author indicating their priority for the query. All Project Issues are passed to the Project Manager for assessment and will be progressed through the PRINCE 2 change-control approach.

6.4 Project Plan

6.4.1 The detailed tasks of the project are defined in the Project Plan, which forms part of the Project Initiation Document.

6.5 Risk Management

6.5.1 A Project Risk is defined as a situation, which may have a negative or positive impact on delivering the project.

6.5.2 Business risks will be assessed and monitored during the lifecycle of the project. An operational risk assessment will also be carried out during the tender evaluation period and vehicle build and approval phases. Once the project is initiated, any risks that are identified will be entered into the project Risk Log. The identified "project risks" are monitored and managed by the Project Manager as part of the Checkpoint Meetings. The Project Manager also monitors the other identified risks during the course of the project for changes in terms of probability. Risk assessment is an on-going process and changes are reported by means of Risk Reports. The Project Manager will take initial action on all Risk Reports and all actions are recorded in the Risk Log. At project closure, the register of remaining risks is handed over to the User Director for continued monitoring.

6.5.3 For the duration of the project, the Project Board will examine the Risk Log at each of its meetings to ensure risk is under control and that where necessary, appropriate actions have been taken.

6.5.4 The Project Board will consider if any risks could arise post-project and these will be handed over to the appropriate Senior Manager for monitoring on project closure.

6.6 Security and Confidentiality

6.6.1 There is no involvement with the patient during or post-project and therefore there are no security or confidentiality issues regarding Caldicott or the Data protection Act.

6.7 Benefits Realisation Plan

6.7.1 The responsibility for ensuring that benefits within this business case are optimised and measured sits with the Project Board.

6.7.2 The Project Board will monitor the benefits as vehicles are introduced into service. The nature of the benefits listed below means a reasonable amount of time must pass before they can be accurately measured.

6.7.3 On Project Closure, the responsibility for monitoring and managing achievement of individual benefits will be transferred to those nominated in the Benefits Realisation table.

6.7.4 The benefit criteria from Table 2 have been brought forward and included in Table 20. This table illustrate the performance indicators and the person responsible for monitoring and reporting back on the benefit.

Table 20

Benefit	**Performance Indicator**	**Responsibility**
Financial Benefits	***How will we know it is achieved?***	***Who is responsible for monitoring achievement?***
Less back injuries & lower resulting overtime cost	A full year total or moving annual total (mat)[1] comparison on back injuries and overtime costs associated with patent vehicle loading with figures obtained from Health & Safety and Management Information,	Senior Health and Safety Advisor
Achieve a better fuel consumption and reduced fuel cost	Analysis of fuel reports measured like for like as moving annual total (mat)	Head of Operational Support
Potentially reduced maintenance costs	Analysis of job card information taken from workshops	Head of Operational Support
Enhanced Operational Capability with a reduction in unscheduled breakdowns of vehicles	Reduction in breakdowns can be recorded through EOC/ fleet logistics.	Head of Operational Support
Reduced workload on fleet dept	Less maintenance hours spent on new vehicles versus old. This data can be captured from vehicle maintenance history on FleetPlan.	Head of Operational Support
Improved trolley bed equipment	Achieved by default of deploying ambulances with the new trolley bed.	Head of Operational Support
Improved patient care	Achieved by default of deploying all 65 ambulances.	Head of Operational Support
Greater proportion of the fleet will be CEN compliant	Achieved by default of deploying all 65 ambulances.	Head of Operational Support
Reduced CO2 Emissions	Recorded by reduction in fuel consumed	Management Accounts

[1] M.A.T (Moving Annual Total)= comparison of 12 months from current period versus same period last year i.e. comparing 12 months June 03-June 04.

Non-Quantifiable Benefits	***How will we know it is achieved?***	***Who is responsible for monitoring achievement?***
Corporate kudos for being environmentally responsible	Non-measurable, however statements on our diesel vehicles should be made where possible by Press dept. Discuss with Press number of occasions this has happened. In addition, meeting controls assurance standards by default of vehicle deployment for fleet & transport management.	Head of Operational Support
Improved public image	Anecdotal evidence or through letters.	Director of Communications
Improved staff morale	Difficult to measure without staff surveys, however A&E working group can be the forum to present staff feedback. This can be captured via a web forum similar to that used for MDT.	Director of Communications

6.7.5 A more detailed explanation of the benefits can be found in Appendix A.

6.8 Training

6.8.1 Training will be appropriate and limited to any significant new additions on the vehicle.

6.8.2 If required, staff will receive training and their training record will be updated and signed. No staff will be allowed to use the new vehicles unless their training record has been checked and approved.

6.9 Contract Management

6.9.1 The main external delivery contracts will be managed by the Project Manager who may delegate responsibility for any separately funded procurement activities to various Team Managers.

6.9.2 The Technical, User Acceptance and delivery aspects of all the products are controlled by the Project Manager who will advise the Lessor when financial payment can be made for full or part delivery of completed products (where appropriate).

6.10 Post Project Evaluation

6.10.1 During the three months following delivery of the vehicles, the Project Manager will undertake a Post-Project Evaluation Review and present the report at the Project Closure Meeting.

6.10.2 In particular, it will look at:

- What went right?
- What went wrong?
- Lessons learnt.

6.10.3 The Project Closure Meeting will also set dates for a Benefits Realisation Meeting described in Section 6.7.

6.10.4 Finally, it will be ensured that a Senior Manager is formally nominated with the responsibility for post-project reviews and continuous benefits reappraisals.

7 APPENDIX A - BENEFITS EXPLAINED

7.1.1 *Improved Patient Care* - This benefit focuses on the LAS' ability to serve its patients with a greater level of patient care. This is achieved by increasing the fleet size by 41 vehicles, and reducing the number of vehicles off the road at any one time and ensuring equipment is up to date and in working order.

7.1.2 *Increased proportion of the fleet will be CEN compliant* - This benefit will be achieved through vehicle replacement and fleet growth.

7.1.3 *Reduced Fleet workload*- This benefit focuses on the increased reliability and lower maintenance times achieved with new vehicles.

7.1.4 *Improved Trolley bed equipment*- This benefit highlights the improved trolley bed equipment that the new vehicles will be fitted with. At this time, options for equipment with bariatric capabilities are being explored.

7.1.5 *Less back injuries and lower resulting overtime costs* - This benefit highlights the evidence that automatic tail-lifts have reduced incidences of back injury and subsequent overtime costs. New Tail-lifts will also have a greater lift capacity to cater for bariatric patients.

7.1.6 *Achieving a better fuel consumption thus reducing running costs* - This benefit highlights that through use of diesel fuel engines on the new ambulances, the LAS can expect to reduce both fuel price and volumes.

7.1.7 *Potentially reduced maintenance costs* - with newer vehicles and the expectation that less maintenance will be required.

7.1.8 *Environmental responsibility* - This benefit addresses the impact on the environment, with vehicles producing less CO2 emissions.

7.1.9 *Improved staff morale* - This benefit focuses on improved morale through use of newer, smarter and more reliable vehicles, measured via annual staff survey.

7.1.10 *Improved public image* - This benefit focuses on the public perception of the LAS. Newer vehicles better position the LAS towards being a word class ambulance service, measured through public feedback.

8 APPENDIX B - BENEFITS SCORE REASONING

Explanation of weighted benefit analysis

The weighted benefit analysis table demonstrates support for the selection of option 1 – Purchase Vehicles.
An explanation for scores awarded is given against each benefit listed below:

Improved Patient Care

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
27.14	0	0	27.14	7	190
A score of 0 was awarded as this option as by keeping the status quo we add no value to improving patient care.			A score of 7 was awarded as new ambulances are better equipped, safer and designed for more comfortable transportation of patients.		

Improved Vehicle Availability

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
23.07	0	23	23.07	9	207
A score of 0 was awarded to this as the current vehicle availability is unacceptable, due to high levels of breakdowns, and staff reluctance to use vehicles.			A high score of 9 was awarded as by default the LAS can expect an immediate improvement in vehicle availability with newer vehicles and less vehicle off the road lost hours.		

Improved Trolley Bed Equipment

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
13.84	0	0	13.84	9	27
A score of 0 was awarded as the old ambulances cannot accommodate the latest style design trolley beds.			A score of 9 was awarded as new design trolley beds could offer a bariatric capability, and will give an enhanced usability through a powered lift.		

Improved Staff Safety

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
18.46	0	0	18.46	9	147
A score of 0 was awarded as the old ambulances cannot accommodate the latest style design trolley beds.			A score of 9 was awarded since the new vehicle employes higher levels of vehicle stability, thus making driving safer.		

Environmental Responsibility

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
10.11	0	0	10.11	8	70
A score of 0 was awarded as fuel economy will further decrease with the ageing fleet which increases cost and the level of pollution the vehicles produce.			A score of 8 was awarded as the transition to diesel powered engines meeting euro 4 compliance reduces both fuel consumption and vehicle pollution.		

Meeting Operational Objectives

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
7.38	1	0	7.38	7	59
A score of was 1 awarded as by not replacing ambulances we do not meet the operational objectives and also the Wells report recommendations nor the vehicle replacement strategy recommendations.			A score of 7 was awarded to reflect the achievement of the operational objective.		

London Ambulance Service NHS TRUST

TRUST BOARD DATE 28 July, 2009

Defibrillator Business Case

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: *Board Approval*

3. Summary

The Business case is for the replacement of 140 older Lifepack 12 defibrillators with 140 newer versions. The capital cost in year 1 amounts to £1.7M . The capital and the associated revenue cost are within the 2009/10 Business Plan. The business case shows the incremental financial effects in subsequent years.

The business case follows the DH model (GEM)

The purchase is shown to be affordable in each of the five years of the useful life of the assets.

4. Recommendation
Board to Approve

DEFIBRILLATOR REPLACEMENT PROJECT 2009/10

BUSINESS CASE

Authorisation:

Proposed by:

Finance	**Date**

Concurrence:

Director of Operations	**Date**

Finance Director	**Date**

Approved By:

Chief Executive	**Date**

Document Control

Author: Karen Walker

Address: Finance Dept

Level 3
42 Loman Street
London
SE1 0EH

 0207 463 6647

 Karen.walker@lond-amb.nhs.uk

Distribution:

Action:
Christopher Vale
Nick Pope
Mark Whitbread
Asif Islam

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1. Executive Summary

The purpose of this Business Case is for internal London Ambulance Service (LAS) use, where combining the Outline and Full Business case requirements can save time and effort, and the overall cost is within the LAS financial approval authority. This business case draws upon both the LAS Strategic Plan 2006/7 to 20012/13.

This Business Case draws the conclusion that the Trust should buy 140 new Defibrillators to replace on a one to one basis the old LIFEPACK 12 (Not including 'SHOCK BOXES') defibrillators. This is required because:

- The need to replace old and worn out Defibrillators is paramount for patient care.
- Costs to repair the current Defibrillators will become higher as the age of these increases.

This report looks at the non-financial benefit of procuring new Defibrillators to replace existing equipment. The benefits are then weighted against the Economic Annual Cost (EAC) to give a preferred financial option. The preferred option from this analysis is for the LAS to buy New Defibrillators. The overall effect of buying these defibrillators is as follows:

	REVENUE	CAPITAL	CASH
	£'mill	£'mill	£'mill
YEAR 1	-	-	-
YEAR 2	- 0.60		- 0.26
YEAR 3	- 0.57		- 0.23
YEAR 4	- 0.55		- 0.21
YEAR 5	- 0.53		- 0.18
TOTAL	**- 2.25**	**-**	**- 0.88**

The Tender Process has commenced for this, and we are currently awaiting Business Case approval to award the contract. The 2009/10 budgeted forecast figures have taken into account the purchase of an additional 140 defibrillators.

1.1 Strategic Case

1.1.1 Older defibrillators are costly to maintain, increase overall equipment downtime and reduce the capacity to achieve performance targets, with a consequent impact on patient care.

1.1.2 The New Defibrillators will be the most up to date models in the market, and will thus have extra functionality, which will assist in monitoring the patient's condition.

1.2 Economic Case

1.2.1 From the investment objectives, a list of benefits has been developed and categorised:

- To improve A&E services by replacing old outdated defibrillators with 140 new defibrillators. In doing so meeting the aims of the Strategic Plan 2006/7

to 2012/13 by responding to our patient's needs with the appropriate service and equipment.

- To reduce reactive maintenance of our defibrillators, caused by aged unreliable equipment.

1.2.2 The benefit criteria, derived from above, have been ranked, and then given percentage weights through the pairing comparison technique. The two options were then ranked. Each option is scored out of 10 as to how close it came to achieving the benefits. The results are shown in Table 1 below.

Table 1

Benefit Criteria	Weight (w) %	Options			
		Do Minimum		Purchase Defibrillators	
		Score (s)	Weighted Score (w) x (s)	Score (s)	Weighted Score (w) x (s)
a) Improved Patient Care	54.05	1	54.0541	8	432.4324
b) Lower reactive maintenance	45.95	2	91.8919	5	229.7297
Total	100.00		**145.9459**		**662.1622**
0rder of options		**2nd**		**1st**	

1.2.3 Financial Analysis has been done on both options appraising each option over a 5-year period. Options analysed are Buy new and Retain existing equipment. This appraisal has been done using the Generic Economic Model (GEM) to find a NPC for each project this has then been discounted to provide an Economic Annual Cost (EAC) per option. Please see table 2 below.

Table 2

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score	Ranking
		£'000		£'000	£'000	£'000	
OBC Do Minimum	5 Years	191.70	145.95	1.31	191.70	1.31	2
Retain Existing Defibrillators							
OPTION 1	5 Years	484.75	662.16	0.73	484.75	0.73	1
Purchase 140 Defibrillators							

1.2.4 From the above table we are able to show that Option 1 Purchase new Defibrillators is the preferred option for the London Ambulance Service.

1.3 Financial Case

1.3.1 **Financial Position**:

1.3.2 The LAS has a track record of meeting all of its statutory financial duties each year. It is expected that this position will be maintained in the current year. The investment will proceed on the basis that it will have no material impact on the Trust's financial standing. The financial effects of Option 1 (Buy New) have been illustrated in the Tables below.

1.3.3 **Impact on Income and Expenditure Account**

1.3.4 The table below sets out the net impact of the proposed investment on the Trust's Income & Expenditure (I&E) Account. The 2009/10 budgeted forecast figures have taken into account the purchase of an additional 140 defibrillators. This affordability model thus only takes into account the effect on affordability for years 2010/11 to 2013/14. This demonstrates that there is a net cost in all years of the project excluding year 1, and that this cost remains relatively static for years 2 to 5 due to the main element of this cost being depreciation. A Trust surplus position is maintained throughout the period of investment.

Table 3

	Income & Expenditure Account				
	2009/10	2010/11	2011/12	2012/13	2013/14
	£m	£m	£m	£m	£m
PURCHASE OF DEFIBRILLATORS					
Consumables	-	- 0.14	- 0.14	- 0.14	- 0.14
Maintenance and Repairs	-	- 0.03	- 0.03	- 0.03	- 0.03
Depreciation	-	- 0.34	- 0.34	- 0.34	- 0.34
PDC dividend	-	- 0.08	- 0.06	- 0.04	- 0.01
Total Business Case effect on Profit and Loss	-	- 0.60	- 0.57	- 0.55	- 0.53
Current forecasted surplus	1.93	3.32	9.17	9.49	9.82
Adjusted forecasted surplus/(deficit)	1.93	2.72	8.60	8.94	9.30

1.3.5 **Impact on Balance Sheet**

Table 4

	Balance Sheet				
	2009/10	2010/11	2011/12	2012/13	2013/14
	£m	£m	£m	£m	£m
PURCHASE OF DEFIBRILLATORS					
ASSETS					
Defibrillators	-	1.03	0.68	0.34	-
Total Net Effect on Assets Employed	-	1.03	0.68	0.34	-
Current Forecasted Assets Employed	103.46	106.82	116.00	128.53	142.17
Adjusted Forecast Assets Employed	103.46	107.85	116.69	128.87	142.17

1.3.6 The table above sets out the net impact of the proposed investment on the Trust's Balance Sheet. As the 2009/10 forecast has correctly taken into account the purchase of 140 new defibrillators, the impact on capital is illustrated for years 2010/11 to 2013/14. As illustrated, this is affordable under our capital budgets.

1.3.7 **Impact on Cashflow**

Table 5

	Cash Flow				
	2009/10	2010/11	2011/12	2012/13	2013/14
	£m	£m	£m	£m	£m
PURCHASE OF DEFIBRILLATORS					
Net Cash Outflow	-	- 0.26	- 0.23	- 0.21	- 0.18
Current Forecasted Cash in Hand	5.05	3.36	14.60	23.78	34.03
Adjusted Forecast Cash in Hand	5.05	3.10	14.37	23.58	33.85

1.3.1 The table above sets out the net impact of the proposed investment on the Trust's Cashflow Statement. This shows the Trust has enough Cash to fund the Capital investment, and associated maintenance and consumable costs.

1.4 Commercial Case

1.4.1 The contract for supply of defibrillators has been tendered. A formal tender evaluation group was formed and reviewed each supplier's submitted tender response using criteria such as price, quality, compliance to the specification, and ability to meet the delivery schedule.

1.4.2 The tender evaluation has been completed for the supply of new defibrillators, this business case has been drafted using the prices from the tender, and current costs the LAS incurs. Approval for this business case is sought on the basis that final prices are within reasonable proximity of the quoted prices in the financial analysis of this document.

1.5 Management Case

1.5.1 This project will be managed using the PRINCE 2 methodology. This model is the NHS standard and has been used by the LAS for many successful procurement projects since 2002.

1.5.2 The stakeholders' expectations are that the 140 defibrillators will be purchased and installed within the 2009/10 financial year. However, these timeframes cannot be confirmed until contracts are placed with the individual equipment suppliers and their production schedules are known.

London Ambulance Service NHS TRUST

TRUST BOARD

28 July 2009

Compliance With DH Response Time Data Reporting Requirements

1 Sponsoring Director: Peter Bradley

2 Purpose: For Noting

3 Summary Synopsis of what the report is about

This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with the guidance issued by the DH Information Centre for the KA34 yearly return (version 09/10 final guidance). It also confirms that LAS reporting procedures conform with the additional operational clarification provided by the National Directors of Operations Group (NDOG). There are four appendices to this paper:

Appendix1:	Glossary of Terms
Appendix 2:	Technical specifications
Appendix 3:	KA34 Guidance 09/10
Appendix 4:	NDOG Operational Clarification

While the basis of the document remains the same as in previous years, a significant amount of work has gone into ensuring it more accurately describes the rules that we apply. One objective is to remove ambiguity at year end and ensure that we keep on top of the performance stats during the year to reflect our current position.

The main changes are that the industry standard approach to data validation and verification has been applied, more clarification given on which calls are counted and those that are not. Some technical information has been moved into the appendices.

4 Recommendation The Trust Board are asked to;

- Note the contents of this paper.

Compliance with DH Response Time Data Reporting Requirements (KA34 2009/10) V1.1

1 Background

This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with the guidance issued by the DH Information Centre for the KA34 yearly return (version 09/10 final guidance). It also confirms that LAS reporting procedures conform with the additional operational clarification provided by the National Directors of Operations Group (NDOG). There are four appendices to this paper:

Appendix1: Glossary of Terms

Appendix 2: Technical specifications

Appendix 3: KA34 Guidance 09/10

Appendix 4: NDOG Operational Clarification

2 Compliance with KA34 2008/09 Guidance

The 08/09 compliance paper was presented and approved by the Trust board in May 2008. The compliance details, as specified within this paper, were met. Additionally, work was undertaken to refine the data with a greater level of granularity. This included detailed validation and verification against the KA34 and NDOG guidance. Examples include;

- All test calls were removed,
- All dropped calls and calls where the caller was not with patient and unable to give details, that were missed were re-categorised as Cat C as per the KA 34 guidance.
- All language line calls that were missed were individually validated to ascertain if there were delays in obtaining the call details. Those calls where there was clearly a delay associated with the caller's inability to give details were re-categorised as Cat C.
- Where there was no automatic timestamp and the call was missed a detailed analysis of the call was undertaken

This work has formed the basis for this paper for the reporting year 2009/10.

3 Clock synchronisation

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

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

4 Call connect time

The call connect time is taken from when the call hits the telephone switch. CTAK detects the call arrival and time stamps it instantly. This process is an accepted industry standard. The time stamp is stored by the Calling Line Identity (CLI) process.

Approximately 2% of calls do not go through the main incoming 999 lines (and hence the CLI process) or are not public calls. These calls do not have a call connect time so the start time (call answer time) is used where necessary.

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

5 Clock start times (call connect)

- **Calls generated by a 999 call**

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

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

- **Running calls (LAS emergency responder who comes across an incident)**

  The clock start time for running calls is when the LAS responder contacts the control room to inform them that they are dealing with a running call. The time is when the call is answered either from telephone or radio by EOC. The time is taken from the clocks on the EOC wall, synchronised to the national time standard currently broadcast from Anthorn in Cumbria (formerly Rugby). There are no seconds displayed.

- **Calls taken during CTAK downtime**

  The time is taken from the clocks on the EOC wall, synchronised to the national time standard currently broadcast from Anthorn in Cumbria (formerly Rugby). There are no seconds displayed.

6 Arrival times

- Arrival times for all categories of calls are generated from automatic status reporting at scene based on a vehicle being within 200m of the original incident location (NDOG).

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

- PRF times are used for those calls which are not generated from a 999 call e.g. “footprint” calls. These calls will be added into the database manually within Management Information, based entirely on data from the PRF.

- Currently the LAS does not operate the front end model where they wait for confirmation from the initial responder that an ambulance is required. An ambulance routinely forms part of the initial response and is not requested as described in the KA34 guidance.

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

7 Changing incident attributes such as AMPDS code or system generated time stamps

There are no facilities in the CTAK software to make any changes to the record once the call taker completes the call. This has been confirmed by the CTAK System Manager, George Dervis. A call can be upgraded or downgraded if further information is supplied

regarding a call. This up/down grading is recorded but it doesn't overwrite the original categorisation.

8 MPS calls

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

9 Calls during CTAK downtime.

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

10 Cross border calls

The KA34 return states the following:

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

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

Calls transferred to the LAS from other ambulance services are excluded from the performance calculations.

11 KA34 Return

The IM&T Management Information Department is responsible for providing statistical returns and ensuring that the LAS complies with the KA34 and NDOG guidance. On a monthly basis, there will be a two stage process of conformance checking the data in terms of validation and verification as defined in the following two sections:

Stage 1: Data Validation - for data to be valid it must obey given rules.

CAT A & CAT B calls recorded in the performance database must conform to the rules (i.e. what a CAT A & CAT B call is) as defined in the 09/10 KA34 guidance. By this process of checking;

- Test calls will not be counted.
- Equipment pick-up calls will not be counted.
- Critical inter-hospital transfer calls made by a health care professional that have not gone through AMPDS will be categorised as Category A.
- Non-critical inter-hospital transfer calls made by a health care professional that have not gone through AMPDS will be categorised as Category C.
- Calls made by a healthcare professional that have not gone through AMPDS (that should be Card 35) will be categorised as a Category C.

- Running calls (hence do not go through AMPDS) will be categorised as Category A. ***(***NDOG).

- The KA34 guidance explicitly allows certain types of calls to be re-categorised as Cat C for reporting purposes. Clearly this approach was to acknowledge the difficulty of hitting a response time in certain circumstances. In particular;

    - Hang-ups before coding is complete (i.e. before the determinant is obtained)

    - Caller not with patient and unable to give details

    - Caller refuses to give details (the definition of refuses is taken from the Oxford English dictionary to mean unwillingness or inability)

  Current LAS dispatching regimes allow calls to be despatched immediately on basic information, reducing the impact of these problems. Therefore in the spirit of the guidance this rule is only applied to these three types of calls not met within the target.

- Where a call is via a translation bureau (e.g. language line or hearing impaired access service), the rule defined above applies. In addition each call suitable for re-categorisation to Cat C will be individually validated to ascertain if there were delays in obtaining the call details. Only those calls where there is clearly a delay associated with the caller's inability to give details will be re-categorised as Cat C.

- City police arrival times are added to the database for Category A calls as an approved first responder equipped with a defibrillator (KA34).

- Calls with AMPDS code 1C4 (Female 12-50 fainting with abdominal pain) will be categorised as Category B (from C) from 15/06/09 following a change from DH.

- Calls with AMPDS code 24B1 (Labour delivery not imminent, over five months) will be categorised as Category C whilst research is carried out by the LAS. This dispensation to report these as Cat C applies only to the LAS in order to continue the trial for a further 6 months.

<u>All calls within the KA34 performance database will be validated in this way.</u>

Stage 2: Data Verification – the process to ensure that valid data is correct and accurate.

With regard to the KA34, this is to ensure that the stated times are accurate and can be substantiated from a defined source. The process will be to verify the database in the following sequence:

<u>Stage 2.1: Zero response</u> - the following groups of **Category A** calls will have a zero response applied to them.

- Static defibrillator locations including hospitals, GP surgeries. airports, railway and underground stations, prisons, police stations, leisure centres, museums, theatres, stores and other locations where a healthcare professional is at the location of the incident, equipped with a defibrillator and deemed clinically appropriate to respond by the trust (KA34, NDOG).

- Events – all calls within event footprints and calls attended by designated event call signs (NDOG).

- Running calls (NDOG).

- Transported transfer - calls to meet helicopters or other modes of transport where a health care professional is already on board, arriving with a patient to be transferred on to a hospital (NDOG).

- BETS calls –calls to a hospital to collect and transfer a baby to another hospital (KA34, NDOG).

Stage 2.2: RVPs – rendezvous point

For Cat A & Cat B a RVP location is a pre-arrival rendezvous point deemed appropriate for the safety of the ambulance crew.

- Arrival times are adjusted to be the arrival at RVP (KA34).

- Arrival times to calls where the crew waits for the police are adjusted to be the arrival at RVP (KA34).

- Where there is a call to an incoming aircraft, train, coach or boat providing the ambulance service approved response is at the RVP by the ETA of the aircraft, train, coach or boat the response will be zeroed (NDOG).

Stage 2.3: Automatic Time stamp

All remaining Cat A& CAT B calls that have been automatically time stamped will not be further verified regardless of whether they meet the target (Cat A 8 minute & Cat B 19 minute). The basis for this decision is that as there is no human intervention in this process, the room for error is deemed negligible.

Stage 2.4: Manual Time stamp

All remaining Cat A & Cat B calls that are either MDT button pressed or manually entered (for whatever reason) will be further verified. This will be irrespective of whether or not they are within the performance target and manually adjusted (within KA34 and NDOG guidance) if errors are found. The basis for this decision is to remove possible errors introduced by human intervention.

Records will be kept of any adjustments that are made.

Recommendation.

The Trust Board to note the contents of this paper.

Sue Meehan
Head of Management Information

Peter Suter
Director of IM&T
July 2009

APPENDIX 1: GLOSSARY OF TERMS

CLI Calling Line Identity

Details of the telephone number are passed from the caller, via the telephone company (e.g. BT) to the LAS.

KA34

DH guidance for completion of KA34.

LAS emergency responder

Emergency vehicle (includes car or bike), approved LAS first responder equipped with a defibrillator.

MSF ("Rugby time")

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

NDOG

Best practice set of guidelines agreed by the National Directors of Operations Group.

NTP Network Time Protocol

This is the system by which internet servers synchronise each other to UTC. Every computer connected to the internet can synchronise its clock with this signal, using a number of public time servers run by the American military. All our servers are using this method to keep in synch.

UTC Universal Time Co-ordinated

The internationally agreed time standard set by synchronised atomic clocks run by several countries.

APPENDIX 2: TECHNICAL SPECIFICATIONS

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

APPENDIX 3

AMBULANCE SERVICES:

DATA REPORTING REQUIREMENTS FOR THE COMPLETION OF KA34, 2009-10

1. INTRODUCTION

1.1 The information obtained from the KA34 is analysed by individual ambulance service provider to show volume of service and performance against required standards. This information is published each year by the Information Centre (IC), most recently in the statistical bulletin "Ambulance services, England: 2007-08", available on the IC website. (www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/ambulance)

1.2 The KA34 reporting template for 2009-10 is enclosed. It is planned to publish information derived from the returns in June 2010.

Important note: The principal changes to the guidance for 2009-10 are:

A) Amendments to the collection form 'Part 1 – Emergency and Urgent Calls' to include an additional field in the KA34 dataset to measure the number of calls resolved by the Trust through telephone advice. Detailed definitions for this change can be found in section 3.2 of this guidance.

B) Amendments to the collection form - 'Part 2 – Patient Destinations: Emergency and Urgent' and changes to section 3.4.2 of the guidance to include the measurement of the number of emergency and urgent ambulance journeys into the following three categories:

a. Patient journeys to Type 1 and 2 A&E

b. Patient journeys to a destination other than Type 1 and 2 A&E.

c. Treatment at the scene

Please note that the heading for Part 2 of the KA34 dataset template has been amended from 'Patient Journeys' to 'Patient Destinations' to take into account these new dataset fields.

Detailed definitions for this amendment can be found in 3.4.2 section of this guidance.

C) To note: that some re-numbering of sections has been required to allow amendments and changes to be made to this guidance.

D) Annual reported data is no longer required for line 04 column 3 of the KA34 dataset template ('Number of calls where following the arrival of an emergency response no ambulance is required' for Category C calls).

1.3 NHS Ambulance Trusts use different types of technical solutions to quickly identify the location of a caller, to dispatch an emergency response and to record electronically the various stages of the call management cycle, including the stopping of the clock.

1.4 It is expected that ambulance services will have robust governance arrangements, including data management protocols, in place to assure their Board and independent auditors that all performance data submitted as part of this return is measured and recorded in accordance with this guidance.

2. AMBULANCE RESPONSE TIME REQUIREMENTS

2.1 National response times standards for emergency and urgent ambulance services have been set since 1974. The NHS Executive Review of Ambulance Performance Standards introduced revised standards following publication in July 1996. The following revised targets were issued to ambulance services in Executive Letter EL(96)87, as amended by the Department of Health's letters to all Chief Executives dated 10 September 2004, 28 September 2004 and 2 March 2006.

2.1.1 **Category A:** presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. Presenting conditions, which require a fully equipped ambulance vehicle to attend the incident, must have an ambulance vehicle arrive within 19 minutes of the request for transport being made in 95% of cases, unless the control room decides that an ambulance is not required.

2.1.2 **Category B:** presenting conditions, which though serious are not immediately life threatening and must receive a response within 19 minutes in 95% of cases.

2.1.3 **Category C:** presenting conditions which are not immediately serious or life threatening. For these calls the response time standards are not set nationally but are locally determined.

2.1.4 **Urgent Cases:** in addition to emergency 999 calls, ambulance services are required to take patients to hospital where a doctor, midwife or other health care professional identifies the need as urgent. From 1 April 2007, these calls were prioritised and classified in the same way as emergency 999 calls and since April 2007 should have been included in parts 1 and 2 of the KA34 Ambulance Services data template.

3. DEFINITIONS FOR COMPLETION OF KA34

3.1 Emergency calls:

3.1.1 The MPDS and CBD codes that comprise Categories A, B and C are reviewed annually and, if appropriate, revised lists will be issued each year in advance of 1st April.

3.1.2 Although the vast majority of calls can be categorised using the Annexed list, some calls remain that the Annex does not deal with:

(a) Duplicate or multiple calls to an incident where a response has already been activated. <u>All</u> of these calls should be categorised in the same way as the original call that activated the response

(b) Hang-ups before coding is complete
Caller not with patient and unable to give details
Caller refuses to give details
Hoax calls where response not activated
Response cancelled before coding is complete (e.g. patient recovers)
<u>All</u> of these should be counted as category C calls

3.1.3 Once a category (A, B, C) is determined and a response is activated, the priority given should not subsequently be altered <u>for reporting purposes</u>. For operational reasons, a service may subsequently upgrade or downgrade the category, but reporting should remain against the <u>original</u> category.

3.1.4 In line 01 on KA34, all emergency calls are to be counted, even if multiple calls are received for a single incident (see also 2.1.4)

3.2 Resolving Category C calls through telephone advice

3.2.1 Where a call is determined as Category C and the most appropriate response is through clinical advice to be provided over the phone (with no ambulance response required), and calls are dealt with by a healthcare professional accountable to the Trust or passed to another organisation working with the Trust through an agreed contract or Service Level Agreement (agreed and governed through the Trust Board) and recorded in line 07 of the KA34 return. Calls defined under section 3.1.2 of this guidance should be excluded when recording in line 07.

3.2.2 Only successfully completed calls that have been dealt with by the healthcare professional, to whom the call was transferred to, should be recorded in line 07 of the KA34 return. A successfully completed call is one where advice has been given with any appropriate action being agreed with patient and where no further response is required from the ambulance service.

3.3 Incidents

3.3.1 For purposes of reporting performance, each incident responded to should be counted only once (except for line 01), regardless of how many ambulances or other emergency responses are despatched to the incident.

3.4 Patient Destinations and Patient Journeys

3.4.1 Each patient conveyed is counted as an individual patient destination. Similarly, each patient who is treated at the scene of an incident without requiring onward conveyance is counted as an individual treatment at the scene.

Part 2 – Patient Destinations: Emergency and Urgent

3.4.2 **Disaggregation of emergency patient destinations** - include only those patients conveyed as a result of a 999 call made by a member of the public or organisation, or as a result of being categorised as an emergency following a referral by a health care professional.

3.4.3 **Emergency patient journeys to Type 1 and 2 A&E** (as defined in the NHS Data Dictionary) – include those emergency patient journeys provided by the Trust where a patient is transported to a Type 1 or Type 2 A&E department only.

3.4.4 **Emergency patient journeys to a destination other than Type 1 and 2 A&E** – include those emergency patient journeys provided by the Trust where a patient is transported to all other destinations other than Type 1 or 2 A&E departments. An example of this could be conveying a patient to a minor injuries unit or a Walk-in Centre, a specialist stroke or cardiac centre, GP service or any other health or social care service.

3.4.5 **Treatment at the scene** – include those patients who were treated at the scene by the ambulance service and as a result of that treatment did not require onward transportation for further treatment. If, as part of that treatment, the ambulance trust staff arranged, for example, an appointment for the patient at a GP surgery or a follow-up home visit from a health professional that should also be counted as treatment at the scene. Responses where ambulance trust staff attended an incident and advice was given but no clinical intervention was necessary with no onward transportation required, then that should also be included as treatment at the scene.

Part 3 – Patient Journeys: Non-urgent

3.4.6 The following provides a more detailed clarification of what should be included in Part 3 'Patient Journeys: Non-Urgent' section of the KA34 return:

3.4.7 **Special patient journeys -** include those patient journeys provided by the Trust where punctuality is of paramount importance and late arrival beyond the prescribed time could be detrimental to the patient's medical condition. An example of this is a transfer between hospitals

3.4.8 **Planned/ non-emergency patient journeys -** include all other patient journeys by the Trust. These are for any patients not given emergency or special priority (e.g. most journeys for outpatient appointments, hospital admissions and discharges of a routine nature, including transport to and from other healthcare facilities).

3.5 Timing of emergency response times – clock start and stop

3.5.1 In order to calculate the response time the "clock starts" when the call is presented to the control room telephone switch. This will be the case for all calls received on control room telephone lines; from dedicated 999 lines or otherwise. For calls that are electronically transferred to the computer aided dispatch (CAD) system from another CAD the clock starts immediately when that call record is first received by an ambulance trust system.

3.5.2 The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. To clarify, a legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room. For example, a rendezvous point could be agreed for the following situations:

- Information has been received relating to the given location that the patient is violent and police or other further assistance is required.
- Information has been received that the operational incident because of its nature is unsafe for ambulance staff to enter.

3.5.3 A response within 8 minutes means 8 minutes 0 seconds (i.e. 480 seconds) or less. Similarly, 19 minutes means 19 minutes 0 seconds or less.

Category A 19-minute transport request

3.5.4 Whichever is the earlier, the clock starts when either

- the initial responder makes a request for transport to the control room, or
- the information received from the 999 caller indicates that transport is needed, in which case the clock starts as per 3.5.1.

3.6 Emergency response

3.6.1 For the purposes of the Category A 8-minute standard, an emergency response may only be by:

- An emergency ambulance; or
- A rapid response vehicle equipped with a defibrillator to provide treatment at the scene; or
- An approved first responder equipped with a defibrillator, who is accountable to the ambulance service; or when a healthcare professional is at the location of the incident, equipped with a defibrillator and deemed clinically appropriate to respond by the trust. A first responder is not a substitute for an ambulance response and an ambulance response should be dispatched to all calls attended by an approved first responder.

3.6.2 For the purposes of the Category A 19-minute standard, transport is defined as a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

3.6.3 For the purposes of the Category B 19-minute standard, a permitted response is a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner. This may be a car or ambulance as determined by the information received by the caller.

3.7 Cross-border Calls

3.7.1 A cross-border call/incident should be reported by only one Ambulance Service.

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

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

3.7.4 Where an NHS Ambulance Service asks another NHS Ambulance Service to undertake a call on its behalf, the responsibility for dealing with the call in the most appropriate way passes to the Ambulance Service once it has accepted it.

4. COMPLETING THE KA34 RETURN

4.1 Part 1: Emergency and urgent calls

Line 01 on KA34: Total number of emergency and urgent calls

4.1.1 Record in column 1 on KA34 the total number of emergency and urgent calls where the incident is classified as immediately life-threatening (Category A), in column 2 on KA34 the total number of emergency calls where the incident is classified as being Category B and in column 3 the total number of emergency calls where the incident is classified as category C.

4.1.2 If there have been multiple calls to an incident, all calls should be recorded in this line. Include urgent and non-urgent transport requests, which, after interrogation and the agreement of the caller, are treated as either Category A, B or C calls.

Lines 02 to 07 on KA34: Emergency responses

4.1.3 In **Line 02** on KA34 record the total number of incidents, which resulted in an emergency response arriving at the scene. **If there have been multiple calls to a single incident, only one incident should be recorded.** A separate entry should be made for each of the categories A, B and C.

4.1.4 In **Line 03** on KA34 record the total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less. Note that this detail is not required for category B or C incidents.

RESPONSE PERFORMANCE FOR CATEGORY A INCIDENTS AT 8 MINUTES IS CALCULATED AS FOLLOWS:

$$\frac{\text{Emergency responses within 8 minutes (Line 03)}}{\text{Total number of incidents with an emergency responses (Line 02)}}$$

4.1.5 In **Line 04** on KA34, record the total number of incidents where, following the arrival of a rapid response vehicle or an approved responder at the scene, the control room **subsequently** decided that a fully equipped ambulance vehicle would not be required for category A calls. Note that this detail is not required for categories B and C.

4.1.6 In **Line 05** on KA34, record the total number of incidents that resulted in the arrival of a fully equipped ambulance vehicle (car or ambulance) able to transport the patient. Note that this detail is not required for category C.

NOTE: The number of emergency incidents resulting in the arrival of an emergency response (line 02) can be split into

(i) those where an emergency response arrived and the control room subsequently decided that a fully equipped ambulance vehicle (car or ambulance) was not need

(ii) those where a fully equipped ambulance vehicle (car or ambulance) able to transport the patient was needed (line 05 on KA34).

For Category A, the total of lines 04 and 05 on KA34 should therefore equal the number recorded in line 02 on KA34.

4.1.7 In **Line 06** on KA34, record the total number of incidents that resulted in the arrival within 19 minutes of a fully equipped ambulance vehicle (car or ambulance) able to transport the patient. For Category A incidents, the timing starts when a request for transport is made (see 3.5.4); for Category B incidents the timing starts when the call is received (see 3.4.1). Note that this detail not required for category C

NOTE: only the first fully equipped ambulance vehicle (car or ambulance) to arrive at the scene of the incident should be included in lines 05 or 06 where more than one fully equipped ambulance vehicle has been despatched.

RESPONSE PERFORMANCE FOR CATEGORY A INCIDENTS AT 19 MINUTES IS CALCULATED AS FOLLOWS:

$$\frac{\text{Total number of incidents with ambulance vehicle arriving within 19 minutes (Line 06)}}{\text{Total number of incidents with ambulance vehicle arriving (Line 05)}}$$

RESPONSE PERFORMANCE FOR CATEGORY B INCIDENTS AT 19 MINUTES IS CALCULATED AS FOLLOWS:

$$\frac{\text{Total number of incidents with ambulance vehicle arriving within 19 minutes (Line 06)}}{\text{Total number of incidents with ambulance vehicle arriving (Line 05)}}$$

4.1.8 In **line 07** on KA34, record the total number of successfully completed Category C calls that have been resolved by a designated healthcare professional providing telephone advice (see section. 3.2.)

4.2 Parts 2 and 3: Patient Destinations and Patient Journeys

4.2.1 Count each patient conveyed as an individual patient destination (part 2) or as an individual patient journey (part 3).

Part 2: Patient Destinations – Emergency and Urgent

4.2.2 Record the number of patient journeys separately for Categories A, B and C arising from emergency and urgent calls into the following three destination categories (see section 3.4.2):

- Patient journeys to Type 1 and 2 A&E
- Patient journeys to a destination other than Type 1 and 2 A&E.
- Treatment at the scene

Part 3: Patient Journeys - Non-urgent

4.2.3 Record here the total number of patient journeys other than emergency, include special and planned journeys.

ANNEX

The MPDS and CBD codes that comprise Categories A, B and C are set out at

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare/EmergencyCareArticle/fs/en?CONTENT_ID=4136003&chk=jPlVJe

The code lists are reviewed annually and, if appropriate, revised lists will be issued each year in advance of 1st April.

Compliance with DH Response Time Data Reporting Requirements (KA34 2009/10) V1.1

TEMPLATE OF FORM

Ambulance Services - KA34

	1	2	3
	Category A: Immediately Life Threatening Calls	Category B: Serious Not Life Threatening	Category C
Part 1 - Emergency and Urgent Calls			
1. Total number of emergency and urgent calls			
2. Number of calls resulting in an emergency response arriving at the scene of the incident			
3. Number of calls resulting in an emergency response arriving at the scene of the incident within 8 minutes			
4. Number of calls where following the arrival of an emergency response no ambulance is required			
5. Number of calls resulting in an ambulance able to transport a patient arriving at the scene of the incident			
6. Number of calls resulting in an ambulance able to transport a patient arriving at the scene of the incident within 19 minutes			
7. Number of calls resolved through telephone advice only			
Part 2 - Patient Destinations: Emergency and Urgent			
8. Total number of emergency and urgent patient journeys to Type 1 and 2 A&E destinations			
9. Total number of emergency and urgent patient journeys to a destination other than Type 1 and 2 A&E			
10. Total number of patients treated at the scene only			

	Special Journeys	Planned Journeys
Part 3 - Patient Journeys: Non-urgent		
11. Total number of special/ planned journeys		

Please record in the box below any factors that may have significantly increased or decreased the figures from the previous year

APPENDIX 4: NDOG OPERATIONAL CLARIFICATION

Stopping the clock for category A and B calls in a consistent way in all English Ambulance Services.

Background -

When the Directors of Operations and performance leads met on the 19th January 2007 it was apparent that ambulance services were treating some operational incidents in a different way regarding clock start/stop.

Organisations were reporting clock start and stop within the guidance issued by the DH; however they were often presented with other Operational incidents which required a common and consistent approach around clock start/stop.

The Director of Operations and Performance leads for Ambulance Services have therefore recommended in this document a number of clock start/stop points for ambulance Trusts to put in place with immediate effect.

The group also recommended that existing performance data for ambulance Trusts is retrospectively adjusted from 1st July 2006 to reflect the suggested clock start/stop points in this document.

Suggested Clock start/stop-

Please note: that 01 refers to validated ambulance service response/responder at the location given by the caller and therefore call within the 8/19 minute standard will be met.

1. Patients in Transit

   This refers to patients travelling in bound to a location by train, coach, boat and aircraft and providing the ambulance service approved response is at the RVP of the location given by the estimated time of arrival of the patient the clock starts when the patient arrives and is stopped with a 01 code.

2. Special Events

   When the NHS Ambulance Service has been asked to provide medical cover at a special event and has trained personnel at the location of the event in the use of a defibrillator, the 01 code may be applied to all calls received within the event itself. Those calls which fall outside of the perimeter of the special event are to be responded to normally by the local ambulance service.

   Calls which arise from a special event should be entered on a Patient Report Form and retrospectively prioritised before being entered into the CAD system. The CAD record must be made within 36 hours of the event closing.

3. Inter-hospital transfers

   When a request is received through the 999 system to transfer a patient from one Healthcare facility to another and the ambulance service has confirmed that the centre requesting the transfer has a defibrillator at the location and someone is trained in its use, MPDS card 33 should be used and the 01 code applied to the call.

4. GP surgeries/Walk in Centres/Minor Injury Units

   As above, but without the use of card 33.

5. Prisons/Secure Detention Units

   If the ambulance service receives a call through the 999 system to attend a Prison or secure unit the clock stops when the ambulance response arrives at the agreed RVP.
   If the ambulance service have trained personnel within the unit and have provided a defibrillator and have confirmed at the time of the call that both are present then the 01 code can be applied to the call.

6. Running Calls

   To default to a Category A and the 01 code is applied.

Hayden Newton
National Ambulance Performance Implementation Lead
20th January 2007.

London Ambulance Service NHS TRUST

TRUST BOARD DATE 28 July, 2009

CAD2010 £10m Loan approval

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: *Approve CAD 2010 £10m loan application*

3. Summary

Approval is requested from the Trust Board for the London Ambulance Service NHS Trust to enter into a Capital Loan Agreement with the Department of Health. The loan principal will amount to £10m and the interest charge will be £1.094m. The loan is affordable and is already included in LAS financial plans.

The need for a capital loan to purchase the new CAD2010 asset was set out in the CAD2010 Full Business case which was approved in July 2008.

The loan has also been included in the 2009/10 Business Plan approved by the Trust Board and submitted to NHS London

NHS London have changed their processes and asked that the LAS Trust Board approve the specific loan application again despite it already being part of the approved CAD 2010 FBC.

To align with DH timelines for 2009/10 and to allow a drawdown of £1m on 15/7/09, we have submitted an application on 24/6/09 subject to full LAS Trust Board approval.

Documentation included is as follows:-

Extract from CAD2010 Business Case- Pages 52 – 55
Capital Loan agreement
Affordability schedules

.

4. Recommendation

The Trust Board approve the loan application for £10m

FINANCIAL CASE

1. FINANCIAL POSITION

.279 The LAS has a budgeted turnover for the financial year 2008/09 of £252.6m, of which £180m (72%) represents pay costs and £72m (28%) represents non-pay costs.

.280 The LAS has a track record of achieving all its statutory financial duties each year and SHA control totals.

.281 The Auditors' Local Evaluation (ALE) assesses how well NHS Trusts manage and use their financial resources it involves external auditors making scored judgements on key areas of financial performance. In the areas of Financial Management, Financial Standing and Value for Money the LAS has consistently scored at least a 3 out of a maximum of 4. This score indicates recognition by the Audit Commission that the LAS is consistently above minimum requirements and performing well in these areas and is rated as "Good".

.282 The FBC indicates that the investment will increase the Trust's capital and revenue costs. The Financial Case sets this position out in detail and demonstrates how the Trust intends to fund these costs.

2. IMPACT OF PREFERRED OPTION

.283 The financial impact of the preferred option (Option 2) has been analysed in detail and the Capital and Revenue costs are shown at Appendix 21. These costs include those items excluded from the GEM revenue costs used for the Economic Case, such as depreciation, capital charges and taxation.

.284 Based on the numbers shown in Appendix 21 (Affordability Gap), the investment will have a recurrent impact on the Trust's revenue expenditure of between £1.6m in the year 2008/09 and £4.2m during the year 2011/12. The average impact per year is £3.3m.

.285 Appendix 22 projects the Trust's complete income and expenditure account, balance sheet and cash flow forward over the life of the project, taking into account the financial impact of the preferred option. This demonstrates that the Trust can undertake and sustain the contract without adversely affecting its financial position and while continuing to meet its statutory financial duties.

3. SOURCES OF FUNDING – CAPITAL

3.1. FUNDING ROUTE OPTIONS

.286 The LAS has the following funding routes in seeking capital funding for the project:

- LAS planned cash resources
- Department of Health financing
- Private sector partner

3.2. PREFERRED FUNDING ROUTE

.287 The capital costs of the project will be funded from planned LAS resources and may use Department of Health financing. These funding routes have been selected for the following reasons:

- The LAS has reviewed its capital programme to 2011 in the light of capital resources internally available, such as depreciation, working capital and capital receipts. It has concluded that £8.5m of the capital cost is affordable within the total resources available. These internal resources, in addition to the funding already earmarked have been generated by:
  - Internally Generated Cash - EBITDA was £10m in 2007/08. It is planned to be £12.9m in 2008/09. This is a good indicator of how the LAS generates cash from internal sources and how this is planned to grow.
  - Cash Resources - The year-end cash balance is planned to be £4m after funding a capital plan of £14.8m in 2008/09.
  - NHS Capital Allocation - The new NHS Capital Regime permits new capital to be committed based on a Trust's annual depreciation. Depreciation is planned to be £7.8m is 2008/09. This is the minimum capital that the LAS will be able to spend annually
  - Capital Capacity - Overall Capital Employed is currently forecast to be £126m in 2008/09. The gap is approximately 11% of this.
- The remaining £10m of the capital cost may need to be funded through the Department of Health capital financing which is only available in the form of interest-bearing debt at National Loans Fund rates (currently in excess of 5% per annum). This loan, if required, will be taken out in 2009/10 and repaid over the remaining appraisal period of the business case which is 9 years. Assuming an interest rate of 5.5% the loan will cost £2.2m in interest.
- The PFI route is not normally suitable for NHS IM&T projects of this type and has not been regarded by the Department of Health as an appropriate procurement route since publication of the Treasury's report PFI: Meeting the Investment Challenge in 2003.

.288 The capital costs identified in Appendix 21 will therefore be financed by the Trust's planned internal resources and, if required, Department of Health financing.

4. SOURCES OF FUNDING - REVENUE

4.1. FUNDING ROUTE OPTIONS

.289 The LAS has the following funding routes in seeking revenue funding for the project:

- LAS currently planned income
- Additional income contribution from PCT commissioners

4.2. PREFERRED FUNDING ROUTE

.290 Funding the revenue costs of the project from planned LAS resources has been selected for the following reasons:

- Total revenue costs to 2017/18 are estimated to be £33.4m with an average cost of £3.3m annually. The maximum cost in any one year is £4.2m (2011/12).

- Existing budgets had an estimated cost excluding savings of £17.4m for CAD2010, leaving a 'gap' of £16.0m or £1.6m average cost p.a. This equates to 0.6% of the 2008/09 revenue budget.
- To date, PCT commissioners have not agreed to provide additional funding and the FBC prudently assumes no additional funding at this stage.
- Both the OBC and FBC state that the LAS can afford CAD2010 through additional internal savings. This is based on the proven ability of the LAS to deliver Cost Improvement Programmes:
- - 2006/07 £4.6m
- - 2007/08 £10.6m
- - 2008/09 £7.2m (Planned & on track)
- The current 2008/09 business plan (excl PTS) has total planned staffing of 3,863 and a planned payroll of £175m.
- Additional savings of £1.6m p.a. would equate to 0.9% of total payroll or approximately 32 staff.
- It is expected that the introduction of CAD2010 will provide a more stable operating environment where such savings should be more than achievable. Whether they come from a reduction in control room staff, frontline operations or support functions has yet to be determined.
- This calculation excludes non-pay savings at this stage.

.291 Appendix 22 is based upon the trust's financial plan submitted to the London Provided Agency (LPA) on 6 May 2008 and approved by the SHA. This plan assumes that LAS income will increase by 2.3% pa as a result of inflation. No account has been taken of any potential increase in income from commissioners. These financial assumptions will be revised as part of the annual planning process, in conjunction with commissioners. The 2.3% increase in income is a pessimistic assumption. The costs and internally generated sources of funding have been added to the plan. Appendix 22 demonstrates that the impact of this investment does not inhibit the Trust's ability to meet its statutory financial duties.

5. FINANCIAL RISK AND OPTIMISM BIAS

.292 The financial impact of risk and Optimism Bias was assessed in the Economic Case. In the Financial Case, the economic valuation of risk is replaced by the budgeted contingency reserves for the project. Optimism Bias, at 9% for the preferred option, is included in the Financial Case capital costs.

.293 The arrangements for the management of risk, including financial risk, are set out in the Management Case.

6. COMMISSIONER SUPPORT

.294 Richmond and Twickenham PCT is the lead PCT commissioner for the LAS and acts on behalf of all London PCTs. Discussions have taken place with the PCT and a letter of support for the CAD 2010 Project has been received. The letter is attached as Appendix 23.

7. BALANCE SHEET

.295 An analysis of the costs of the contract between capital and revenue elements has been undertaken, in accordance with relevant accounting standards, and shared with the Trust's external auditors.

.296 The capitalised element will sit on the Trust's balance sheet to be depreciated over the life of the contract (7 years) and attract capital charges on the reducing net book value accordingly. Depreciation and capital charges are set out in more detail in Appendix 24. These are included in the Financial Case revenue costs shown in Appendices 21 and 22.

.297 A short impact assessment of the move from UK GAAP (Generally Accepted Accounting Practices) to IFRS (International Financial Reporting Standards) has been undertaken. No material impact is anticipated.

8. PAYMENT BY RESULTS

.298 At the present time, ambulance services are excluded from the *Payment by Results* system and the national tariff. The LAS is participating in national pilot work to assess how ambulance services may be brought within a more transparent, tariff-based system of funding. As this work is at an early stage, it is not possible to predict the effect that any such change may have on the future income of the Trust.

.299 Therefore no specific allowances have been made for this impact within the financial assumptions underpinning the Full Business Case, other than those made in the existing contingency reserves and Optimism Bias already accounted for in the revenue costings.

9. SUMMARY OF THE FINANCIAL CASE

.300 The Financial Case has projected the financial impact of the preferred option on the Trust's future I&E, balance sheet, capital and cash flow plans. It has demonstrated that the preferred option is affordable to the Trust and how the Trust proposes to manage the impact on its capital and revenue financing over the life of the contract.

DATED 24 JUNE 2009

CAPITAL INVESTMENT LOAN

between

LONDON AMBULANCE SERVICE NHS TRUST
(as "Borrower")

and

THE SECRETARY OF STATE FOR HEALTH
(as "Lender")

TEN MILLION POUNDS

8 YEARS 2 MONTHS TERM

LOAN FACILITY AGREEMENT

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1 DEFINITIONS AND INTERPRETATION

Definitions

In this Agreement:

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Facility" means the term loan facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means **[£10,000,000]** at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as the case may be) under this Agreement.

"Final Repayment Date" means **[15 September 2017]**].

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Interest Payment Date" means the last day of an Interest Period.

"Interest Rate" means the National Loan Fund rate prevailing on the day the Loan is utilised.

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

“National Loans Fund” means the government's main borrowing account set up under the National Loans Act 1968

"Party" means a party to this Agreement.

"Repayment Schedule" means the repayment schedule set out in Schedule 5.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, being the date on which a drawing is to be made under the Facility.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower a sterling term loan facility in an aggregate amount equal to the Facility Amount.

3. PURPOSE

3.1 Purpose

The Facility shall be utilised by the Borrower for the purposes of financing capital expenditure.

4. UTILISATION

4.1 Delivery of a Drawdown Request

The Borrower may utilise the Facility through 3 drawdowns only, as detailed in Schedule 2. The Borrower may drawdown on 15 July 2009 by delivery to the Lender not later than 6 July 2009 of the duly completed Drawdown Request at Schedule 4. The Borrower may drawdown on 15 September 09 by delivery to the Lender not later than 7 September 09 the duly completed Drawdown Request at Schedule 5. The Borrower may drawdown on 15 December 09 by delivery to the Lender not later than 7 December 09 the duly completed Drawdown Request at Schedule 6.

4.2 Currency and amount

4.2.1 The currency specified in the Drawdown Request must be sterling.

4.2.2 The amount of each proposed Loan must be an amount that is not more than the Available Facility and which is a minimum of £250,000 or, if less, the Available Facility.

4.3 Repayment

The Borrower shall repay:

4.3.1 each Loan by equal instalments in accordance with the Repayment Schedule; and

4.3.2 each Loan and all other amounts outstanding under the Finance Documents in full on the Final Repayment Date.

4.4 Reborrowing

The Borrower may not reborrow any part of the Facility that is repaid or prepaid.

5. PREPAYMENT

5.1 Voluntary prepayment of Loans

The Borrower may, if it gives the Lender not less than fourteen days' (or such shorter period as the Lender may agree) prior notice, prepay the whole or any part of any Loan (being a minimum amount of £250,000 where part repayment), on the September Repayment Date in any financial year. Prepayments of the whole or any part of any Loan on the March Repayment Date in any financial year will be permitted only at the discretion of the Lender.

5.2 Restrictions

5.2.1 Any notice of prepayment given by any Party under this Clause 5 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify

the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that prepayment.

5.2.2 Any proposals for prepayment that are accepted will require the borrower to pay a sum calculated by the Department of Health in addition to the interest payable up to the day before the loan is prematurely repaid. This sum represents the present value of future payments of principal and interest, which would have been paid if the original repayment schedule had been met. The present value is calculated by discounting the future payments at a rate of discount equal to the rate of interest currently being charged on new loans of a similar type to that being prepaid, with a life equal to the remaining life of the loan being prepaid. The relevant rate being the one prevailing on the day formal notice is given of the intention to repay. Notwithstanding, the Lender and Borrower may by agreement waive the payment and receipt of any payments due upon early repayment.

5.2.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

5.2.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

5.3 **Automatic Cancellation**

At 31 March 2010 the undrawn part of the Available Facility will be cancelled.

6. INTEREST

6.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate. The Interest Rate is determined by reference to the National Loan Fund rate prevailing on the day the Loan is utilised.

6.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the Interest Payment Date.

7. INTEREST PERIODS

7.1 **Interest Period**

The Interest Period for each Loan shall be a maximum of six months and will end on 15 September and 15 March of each financial year, regardless of the Utilisation Date.

8. PAYMENT MECHANICS

8.1 **Payments**

8.1.1 On each date on which the Borrower is required to make a payment under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary at the time for settlement of transactions in the relevant currency in the place of payment.

8.1.2 Payment shall be made by Internal Direct Debit to the Health General Cash Account 5957 at the Office of the Paymaster General (OPG) from the Borrower's OPG Account.

8.2 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may, at its discretion, decide.

8.3 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

SCHEDULE 1

CONDITIONS PRECEDENT

1. Finance Documents

1.1 This Agreement (original).

1.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

2. General

2.1 A copy of any other Authorisation or other document, opinion or assurance which the approving Strategic Health Authority ("SHA") or Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

SCHEDULE 2

DRAWDOWN SCHEDULE

15 JULY 2009:	£1,000,000
15 SEPT 2009:	£4,000,000
15 DEC 2009	£5,000,000

(zero if not drawing, otherwise minimum £250,000 to a maximum of the available facility)

SCHEDULE 3

BUSINESS CASE FOR APPROVAL OF NHS TRUST CAPITAL INVESTMENT LOAN

Sections 1 and 2 to be prepared by the NHS Trust and approved by SHA at section 3. All forms to be forwarded to DH for approval.

1.Please explain briefly the reason/need for a loan and how repayment will be supported.

The NHS Trust and SHA confirm that:

a) the loan is required to finance capital expenditure;

b) the loan is affordable in terms of cash to meet principal and interest repayments;

c) the loan is affordable in terms of revenue to cover interest charges and additional running costs;

d) an appropriate term for the loan has been chosen, taking into account the life of the asset(s) the loan is to fund; and

e) the Trust's plans for 2009-10 and beyond take into account the impact of the repayments of this loan on the financing available to fund future capital expenditure.

The loan will fund a new capital asset which is currently under development. The new asset called CAD2010 will replace the existing twelve year old Call Taking and Dispatch system (CTAK). The procured asset will include :-

- server hardware
- database management system
- CAD application software
- interface software.

The total capital outlay for the new asset is expected to be £18.5m. Of this figure, £8.5m will be met through the Trust's own internal resources. The loan will secure funding for the additional £10m.

The loan term will be for a period of 8years. (7 years for the economic life of the asset plus 1year for the period for which the asset is under construction.)

The affordability of the capital loan is set out in the CAD2010 Business Case at Appendix 22 a copy if which has been sent to the Department of Health.

DH Notes

2. Period of Loan: [8] Years [2] Months

Length of borrowing:

Date from: 15 [July] 2009 to 15 [September] 20[17]

DH Notes

- Repayments of principal will be by equal instalments over the period of the loan, due on 15 March and 15 September of each year.
- Interest will be paid in arrears commencing from 15 September 2009

3. Confirmation from SHA

The SHA has scrutinised the capital investment loan requirement and overall cash position of the Trust with the Trust Director of Finance.

The SHA is satisfied that:

a) the loan is required to finance capital expenditure;

b) the loan is affordable in terms of cash to meet principal and interest repayments;

c) the loan is affordable in terms of revenue to cover interest charges and additional running costs;

d) an appropriate term for the loan has been chosen, taking into account the life of the asset(s) the loan is to fund; and

e) the Trust's plans for 2008-09 and beyond take into account the impact of the repayments of this loan on the financing available to fund future capital expenditure.

Name: Paul Baumann **SHA Code:** Q36

Contact Tel Number: 0207 932 3853

Date: 25th June

DH Notes

SCHEDULE 4

FORM L2

APPLICATION FOR FUNDING FORM - CAPITAL INVESTMENT LOAN FACILITY – JUNE 09 DRAWDOWN

Trust: LONDON AMBULANCE SERVICE NHS TRUST **Org Code: RRU**

Date loan required: 15 July 09

Amount Required: **£ [1,000,000]**
(minimum of £250,000 and in round thousands)

Amount in words: [ONE MILLION] pounds

Repayment Period: [8] Years [2] Months

TERMS AND CONDITIONS

Please sign below to confirm that this drawdown is in accordance with the Term Loan Facility Agreement.

1st Authorised Signature ……

Print name: Mr Michael Dinan…….. Date: 02/07/09

2nd Authorised Signature: **……**

Print name Mr Asif Islam…….. **Date: 02/07/09**

Contact Name: Susan Logan
Contact Telephone: 0207 463 6649

Contact Email: susan.logan@lond-amb.nhs.uk
(This email address will be used to issue the repayment schedule to the borrowing organisation)

OPG Account details

Full Account Name: London Ambulance Service **Account Number: 97156**

NB - THIS FORM MUST BE RETURNED TO THE LENDER BY CLOSE OF PLAY MONDAY 6 JULY 2009

For CF Team use only	Checked	Authorised

SCHEDULE 5

FORM L2

APPLICATION FOR FUNDING FORM - CAPITAL INVESTMENT LOAN FACILITY – SEPT 09 DRAWDOWN

Trust: **LONDON AMBULANCE SERVICE NHS TRUST** **Org Code:** **RRU**

Date loan required: 15 September 09

Amount Required: **£ [4,000,000]**
(minimum of £250,000 and in round thousands)

Amount in words: **[FOUR MILLION]** pounds

Repayment Period: **[8] Years [0] Months**

TERMS AND CONDITIONS

Please sign below to confirm that this drawdown is in accordance with the Term Loan Facility Agreement.

1st Authorised Signature: **[SIGN HERE……]**

Print name: **[PRINT NAME HERE……..]** Date: **[DD/MM/YY]**

2nd Authorised Signature: **[SIGN HERE……]**

Print name **[PRINT NAME HERE……..]** Date: **[DD/MM/YY]**

Contact Name: **[ENTER CONTACT NAME]**

Contact Telephone: **[ENTER CONTACT TELEPHONE NUMBER AND EXTENSION]**

Contact Email: **[ENTER CONTACT EMAIL ADDRESS]**

(This email address will be used to issue the repayment schedule to the borrowing organisation)

OPG Account details

Full Account Name: **[ENTER ACCOUNT NAME]** **Account Number:** **[ACCOUNT NUMBER]**

NB - THIS FORM MUST BE RETURNED TO THE LENDER BY CLOSE OF PLAY MONDAY 7 SEPTEMBER 2009

For CF Team use only	Checked	Authorised

SCHEDULE 6

FORM L2

APPLICATION FOR FUNDING FORM - CAPITAL INVESTMENT LOAN FACILITY – DEC 09 DRAWDOWN

Trust: **LONDON AMBULANCE SERVICE NHS TRUST** **Org Code:** **RRU**

Date loan required: 15 December 09

Amount Required: **£ [5,000,000]**
(minimum of £250,000 and in round thousands)

Amount in words: **[FIVE MILLION]** pounds

Repayment Period: **[7] Years [9] Months**

TERMS AND CONDITIONS

Please sign below to confirm that this drawdown is in accordance with the Term Loan Facility Agreement.

1st Authorised Signature: **[SIGN HERE……]**

Print name: **[PRINT NAME HERE……..]** Date: **[DD/MM/YY]**

2nd Authorised Signature: **[SIGN HERE……]**

Print name **[PRINT NAME HERE……..]** Date: **[DD/MM/YY]**

Contact Name: **[ENTER CONTACT NAME]**

Contact Telephone: **[ENTER CONTACT TELEPHONE NUMBER AND EXTENSION]**

Contact Email: **[ENTER CONTACT EMAIL ADDRESS]**

(This email address will be used to issue the repayment schedule to the borrowing organisation)

OPG Account details

Full Account Name: **[ENTER ACCOUNT NAME]** **Account Number:** **[ACCOUNT NUMBER]**

NB - THIS FORM MUST BE RETURNED TO THE LENDER BY CLOSE OF PLAY MONDAY 7 DECEMBER 2009

For CF Team use only	Checked	Authorised

Schedule 7

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	RRU
Trust Name	London Ambulance Service NHS Trust
DH Reference Number	XXX/XXX
Loan Value	£1,000
NLF Interest Rate	2.73%
Date of Loan	15-Jul-09
Period - Years	8yrs 2mths
First Repayment	15-Sep-09

Date	Advance Recovered	Interest	Total Recovered	Future Recovery	Days in Period
15-Sep-09	£59	£5	£64	£941	62
15-Mar-10	£59	£13	£72	£882	181
15-Sep-10	£59	£12	£71	£823	184
15-Mar-11	£59	£11	£70	£764	181
15-Sep-11	£59	£10	£69	£705	184
15-Mar-12	£59	£10	£69	£646	182
15-Sep-12	£59	£9	£68	£587	184
15-Mar-13	£59	£8	£67	£528	181
15-Sep-13	£59	£7	£66	£469	184
15-Mar-14	£59	£6	£65	£410	181
15-Sep-14	£59	£6	£65	£351	184
15-Mar-15	£59	£5	£64	£292	181
15-Sep-15	£59	£4	£63	£233	184
15-Mar-16	£59	£3	£62	£174	182
15-Sep-16	£59	£2	£61	£115	184
15-Mar-17	£59	£2	£61	£56	181
15-Sep-17	£56	£1	£57	£0	184
Total	**£1,000**	**£114**	**£1,114**		

Schedule 8

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	RRU	
Trust Name	London Ambulance Service NHS Trust	
DH Reference Number	XXX/XXX	
Loan Value	£4,000	
NLF Interest Rate	2.65%	
Date of Loan	15-Sep-09	
Period - Years	8yrs	
First Repayment	15-Mar-10	

Date	Advance Recovered	Interest	Total Recovered	Future Recovery	Days in Period
15-Mar-10	£250	£53	£303	£3,750	181
15-Sep-10	£250	£50	£300	£3,500	184
15-Mar-11	£250	£46	£296	£3,250	181
15-Sep-11	£250	£43	£293	£3,000	184
15-Mar-12	£250	£40	£290	£2,750	182
15-Sep-12	£250	£37	£287	£2,500	184
15-Mar-13	£250	£33	£283	£2,250	181
15-Sep-13	£250	£30	£280	£2,000	184
15-Mar-14	£250	£26	£276	£1,750	181
15-Sep-14	£250	£23	£273	£1,500	184
15-Mar-15	£250	£20	£270	£1,250	181
15-Sep-15	£250	£17	£267	£1,000	184
15-Mar-16	£250	£13	£263	£750	182
15-Sep-16	£250	£10	£260	£500	184
15-Mar-17	£250	£7	£257	£250	181
15-Sep-17	£250	£3	£253	£0	184
Total	**£4,000**	**£451**	**£4,451**		

Schedule 9

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	RRU
Trust Name	London Ambulance Service NHS Trust
DH Reference Number	XXX/XXX
Loan Value	£5,000
NLF Interest Rate	2.65%
Date of Loan	15-Dec-09
Period - Years	7yrs 9mths
First Repayment	15-Mar-10

Date	Advance Recovered	Interest	Total Recovered	Future Recovery	Days in Period
15-Mar-10	£313	£33	£346	£4,687	90
15-Sep-10	£313	£63	£376	£4,374	184
15-Mar-11	£313	£57	£370	£4,061	181
15-Sep-11	£313	£54	£367	£3,748	184
15-Mar-12	£313	£49	£362	£3,435	182
15-Sep-12	£313	£46	£359	£3,122	184
15-Mar-13	£313	£41	£354	£2,809	181
15-Sep-13	£313	£38	£351	£2,496	184
15-Mar-14	£313	£33	£346	£2,183	181
15-Sep-14	£313	£29	£342	£1,870	184
15-Mar-15	£313	£25	£338	£1,557	181
15-Sep-15	£313	£21	£334	£1,244	184
15-Mar-16	£313	£16	£329	£931	182
15-Sep-16	£313	£12	£325	£618	184
15-Mar-17	£318	£8	£326	£300	181
15-Sep-17	£300	£4	£304	£0	184
Total	**£5,000**	**£529**	**£5,529**		

SIGNATORIES

Borrower

Signed for and on behalf of

London Ambulance Service NHS Trust

By: **NAME:** MICHAEL DINAN

POSITION: DIRECTOR OF FINANCE

SIGNATURE:

Address: London Ambulance Service NHS Trust

220 Waterloo Road

London

SE1 8SD

Phone: 0207 463 2585

Lender

Signed for and on behalf of

The Secretary of State for Health

By: **NAME:** **Robert Yates**

POSITION: **Deputy Director – Group Financial Reporting and Cash Management**

Finance and Operations Directorate

SIGNATURE: _____

Address: Department of Health,
Group Financial Reporting and Cash Management Branch
4W57 Quarry House
Quarry Hill
Leeds
LS2 7UE

Phone: 0113 254 5425

CAD 2010 FBC Financial Projections

Balance Sheet (Annexe B)

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£m	£m	£m	£m	£m	£m	£m	£m	£m
FIXED ASSETS									
Tangible and Intangible Fixed Assets	121.1	117.1	119.2	121.2	123.2	125.2	129.3	130.8	133.9
CAD 2010 - Tangible Fixed Assets (at cost)	15.1	18.6	18.6	18.6	18.6	18.6	18.6	18.6	18.6
CAD 2010 - Tangible Fixed Assets (depreciation)	(0.4)	(0.6)	(3.2)	(5.8)	(8.3)	(10.9)	(13.5)	(16.0)	(18.6)
Long Term Revenue Receivables	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8
Total Fixed Assets	**148.6**	**147.9**	**147.3**	**146.8**	**146.3**	**145.7**	**147.2**	**146.2**	**146.6**
CURRENT ASSETS									
Inventories	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
NHS Trade Receivables	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9
Non NHS Trade Receivables	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Other Receivables	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4
Prepayments	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
Cash at bank and in hand	5.8	4.9	4.8	4.8	4.9	5.1	3.4	4.2	4.3
Total Current Assets	**16.6**	**15.7**	**15.6**	**15.6**	**15.7**	**15.9**	**14.2**	**15.0**	**15.1**
CURRENT LIABILITIES (amounts due in less than one year)									
Trade Payables	(9.2)	(6.3)	(6.4)	(6.5)	(6.6)	(6.7)	(6.7)	(6.8)	(6.9)
Other Payables	(3.9)	(4.6)	(4.3)	(4.0)	(3.7)	(3.4)	(3.1)	(2.8)	(2.5)
PDC dividend payable	(0.2)	(0.1)	(0.0)	(0.0)	(0.1)	(0.3)	(0.6)	(1.0)	(1.5)
Capital Payables	(1.1)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)
Interest payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Finance lease	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)
Other Liabilities	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)
Deferred Revenue	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Total Current Liabilities	**(20.7)**	**(18.2)**	**(17.9)**	**(17.7)**	**(17.6)**	**(17.6)**	**(17.7)**	**(17.9)**	**(18.1)**
NET CURRENT ASSETS/(LIABILITIES)	**(4.1)**	**(2.5)**	**(2.3)**	**(2.1)**	**(1.9)**	**(1.7)**	**(3.5)**	**(2.8)**	**(3.0)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**144.5**	**145.4**	**145.0**	**144.7**	**144.4**	**144.0**	**143.7**	**143.4**	**143.7**
Finance Leases	(21.6)	(21.6)	(18.6)	(15.6)	(12.6)	(9.6)	(6.6)	(3.6)	(0.6)
Provision for Liabilities and Charges	(12.2)	(10.4)	(10.4)	(10.4)	(10.4)	(10.4)	(10.4)	(10.4)	(10.4)
CAD 2010 Capital Loan	(9.3)	(8.1)	(6.8)	(5.6)	(4.3)	(3.1)	(1.9)	(0.6)	0.0
Total Assets Employed	**101.4**	**105.3**	**109.2**	**113.1**	**117.0**	**120.9**	**124.8**	**128.8**	**132.7**
Financed by Taxpayers Equity:									
Public Dividend Capital	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5
Income and Expenditure Reserve	11.2	15.1	19.0	22.9	26.8	30.8	34.7	38.6	42.5
Revaluation Reserve	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1
Donated Asset Reserve	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Other Reserves (Government Grant Reserve etc)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Total Taxpayers Equity	**101.4**	**105.3**	**109.2**	**113.1**	**117.0**	**120.9**	**124.8**	**128.8**	**132.7**

CAD 2010 FBC Financial Projections

Income & Expenditure Account (Annexe A)

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£m	£m	£m	£m	£m	£m	£m	£m	£m
A&E Income	243.8	261.4	261.4	261.4	261.4	261.4	261.4	261.4	261.4
PTS Income	9.5	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9
Other Income	29.8	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7
Total Income	**283.1**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**
Baseline Pay	(203.7)	(210.4)	(210.4)	(210.4)	(210.4)	(210.4)	(210.4)	(210.4)	(210.4)
CAD 2010 - Pay Costs	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
CAD 2010 - Pay Savings	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3
Baseline Non-Pay (Drug Costs)	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)
Baseline Non-Pay (Other Costs)	(60.3)	(56.6)	(56.6)	(56.6)	(56.6)	(56.6)	(56.6)	(56.6)	(56.6)
CAD 2010 - Non-Pay Costs	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
CAD 2010 - Non-Pay Savings	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Total Costs	**(263.7)**	**(266.8)**	**(266.8)**	**(266.8)**	**(266.8)**	**(266.8)**	**(266.8)**	**(266.8)**	**(266.8)**
EBITDA	**19.4**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**
Profit/Loss on Asset Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Asset Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation & Amortization	(11.3)	(13.1)	(10.8)	(10.8)	(10.8)	(10.8)	(10.8)	(10.8)	(10.8)
Interest receivable/(payable)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)
Loan Interest Payable	**(0.1)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.2)**
PDC Dividend	(4.6)	(4.3)	(4.3)	(4.4)	(4.5)	(4.6)	(4.7)	(4.8)	(4.9)
CAD 2010 - Depreciation	(0.2)	(0.2)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)
CAD 2010 - PDC dividend	(0.4)	(0.6)	(0.6)	(0.5)	(0.4)	(0.3)	(0.2)	(0.1)	(0.0)
Retained Surplus/(Deficit) for the Year	**2.11**	**3.91**	**3.91**	**3.91**	**3.91**	**3.91**	**3.91**	**3.91**	**3.91**

CAD 2010 FBC Financial Projections

Cash Flow (Annexe C)

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£m	£m	£m	£m	£m	£m	£m	£m	£m
EBITDA	**19.4**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**	**23.2**
Excluding Non cash I&E items	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in working capital:									
Inventories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NHS Trade Receivables	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non NHS Trade Receivables	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Receivables	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Prepayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Trade Payables	1.7	(2.9)	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other Payables	(16.0)	(4.3)	(5.3)	(5.3)	(5.3)	(5.3)	(7.3)	(4.8)	(6.3)
Finance Leases	3.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Deferred Revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions & Liabilities	0.0	(1.8)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CF from Operations	**8.4**	**14.2**	**18.0**	**18.0**	**18.0**	**18.0**	**16.0**	**18.5**	**17.0**
Capital Expenditure									
Capex Spend	(8.6)	(7.9)	(7.8)	(7.8)	(7.8)	(7.8)	(7.8)	(7.8)	(7.8)
CAD 2010 - Capex Spend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cash receipt from asset sales	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CF before Financing	**(0.2)**	**6.4**	**10.2**	**10.2**	**10.2**	**10.2**	**8.2**	**10.7**	**9.2**
Movement in LT debtors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in LT Creditors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest (paid)/ received	(0.8)	(0.8)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.0)	(1.0)
Loans Interest Payable - CAD 2010	(0.1)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.0)	(0.0)
Loan received from DH - CAD 2010	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans repaid to DN - CAD 2010	(0.7)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.6)
Finance leases	0.0	0.0	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)
Public Dividend Capital received	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Public Dividend Capital repaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in Other grants/Capital received	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends paid	(4.8)	(5.0)	(5.0)	(4.9)	(4.8)	(4.7)	(4.6)	(4.5)	(4.5)
CAD 2010 - PDC Dividend paid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net cash inflow/(outflow)	**3.4**	**(0.9)**	**(0.1)**	**0.0**	**0.1**	**0.2**	**(1.7)**	**0.8**	**0.1**
	2.35	5.76	4.86	4.77	4.78	4.89	5.08	3.36	4.19
	3.41	-0.90	-0.09	0.01	0.11	0.19	-1.71	0.83	0.09
	5.76	4.86	4.77	4.78	4.89	5.08	3.36	4.19	4.28

London Ambulance Service NHS TRUST

TRUST BOARD

28 July 2009

Balanced Scorecard Report

1 Sponsoring Director: Mike Dinan

2 Purpose: For Noting

3 Summary Synopsis of what the report is about

This presentation will briefly set out the background to the development of the Trust's Balanced Scorecard since the content was agreed in October 2008. This will be followed by a demonstration of Performance Accelerator (the Trust's on-line governance tool) during which there will be an opportunity to discuss the measures contained in the balanced scorecard. The final part of the presentation will explain the next steps.

The attached report, taken from Performance Accelerator, and circulated for information shows the balanced scorecard measures as currently entered on the system.

4 Recommendation The Trust Board are asked to;

- Note the contents of this report and presentation.

London Ambulance Service NHS Trust

PI Target Report 09/10

Balanced Scorecard Report showing Target, Milestone name, Milestone Target, Actual Value, RAG status, Variance Indicator and Comments

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
A. OUTCOMES																														
A1.1 Cardiac arrests survival rates (Utstein)	14		14		14		14		14		14		14		14		14		14		14		14		Jul 09	14		?	▷ ?	-
A2.1 The proportion of suitable completed patient episodes managed through Clinical Telephone Advice/urgent care	80	100	80	100	80		80		80		80		80		80		80		80		80		80		May 09	80	100	?	▷ G	
A2.2 Income received for non emergency care (increase)	30971		30971		30971		30971		30971		30971		30971		30971		30971		30971		30971		30971		Jul 09	30971		?	▷ ?	-
A2.3 A&E non conveyance	2599.92	21570	2599.92	26971	2599.92		2599.92		2599.92		2599.92		2599.92		2599.92		2599.92		2599.92		2599.92		2599.92		May 09	2599.92	26971	?	△ G	
B. CUSTOMERS / STAKEHOLDERS																														
B1.1 ALE scores and number of targets met	4		4		4		4		4		4		4		4		4		4		4		4		Jul 09	4		?	▷ ?	-
B2.1 Healthcare core standards met		100		100	100						100						100						100		Qtr 1 09/10	100	100	G	▷ G	LA 2009-06-02 All standards are compliant
B2.2 Achievement of the Health and Social Care Act 2008					100						100						100						100		Qtr 2 09/10	100		?	▷ ?	-
B2.3 Compliance on Infection Control Audit	95		95		95		95		95		95		95		95		95		95		95		95		Jul 09	95		?	▷ ?	-
B3.1 Number of pathways developed by each PCT	250	71	250	73	250		250		250		250		250		250		250		250		250		250		May 09	250	73	R	△ R	NL. 2009 June 25th. 4 in development.
B3.2 Number of meetings/events with the local involvement networks (LINks)	1		1		1	1	1		1		1		1		1		1		1		1		1		Jun 09	1	1	A	▷ G	Meetings with LINks beginning to happen but depend on AOMs being able to attend.

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
B4.1 Complaints, comments or letters of appreciation (by type e.g. attitude, timeliness, quality of care etc)																									Jul 09			?	?	-
B4.2 Number of times an alternate pathway was used		3757																							Apr 09		3757	?	?	
B4.3 Number of PALS queries						504																			Jun 09		504	A	?	GB 2009-07-01 Commentary to follow in quarterly report to CGC.
B5.1 Column inches in the media and other health related journals - positive and negative																									Jul 09			?	?	-
B5.2 Number of community consultation / PPI events	6	3	6	10	6	20	6		6		6		6		6		6		6		6		6		Jun 09	6	20	?	G	
B6.1 Successful FT application - % Plan complete					75		75	75																	Jul 09	75	75	G	G	SDC feedback on proposed change to timeline
C. INTERNAL PROCESSES																														
C1.1.1 Staffing as a % of plan: EOC	100		100		100		100		100		100		100		100		100		100		100		100		Jul 09	100		?	?	-
C1.1.2 Staffing as a % of plan: Back office	100		100		100		100		100		100		100		100		100		100		100		100		Jul 09	100		?	?	-
C1.1.3 Staffing as a % of plan: Frontline	100		100		100		100		100		100		100		100		100		100		100		100		Jul 09	100		?	?	-
C1.2 Response per incident compared with the plan (Cat A)	1.70	1.42	1.70	1.42	1.70		1.70		1.70		1.70		1.70		1.70		1.70		1.70		1.70		1.70		May 09	1.70	1.42	?	R	

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
C1.3.1 Utilisation by vehicle type: Cars	35		35		35		35		35		35		35		35		35		35		35		35		Jul 09	35				-
C1.3.2 Utilisation by vehicle type: AEU	67.20		67.20		67.20		67.20		67.20		67.20		67.20		67.20		67.20		67.20		67.20		67.20		Jul 09	67.20				-
C1.4 % hours employed compared with hours delivered (frontline only)	100	96.60	100		100		100		100		100		100		100		100		100		100		100		Apr 09	100	96.60			
C1.5 % of workload undertaken by cars instead of ambulances	27		27		27		27		27		27		27		27		27		27		27		27		Jul 09	27				-
C10.1.1 The number of contacts with PCTs and SHA: Team managers																									Jul 09					-
C10.1.2 The number of contacts with PCTs and SHA: SMG members																									Jul 09					-
C10.2 Feedback from PCTs and SHA.																									Jul 09					-
C11.1 Level of income received for non emergency care activity													400		400		400		400		400		400		Oct 09	400				-
C2.1 Call answering times (less than 5 seconds)	95	95.70	95	94.60	95		95		95		95		95		95		95		95		95		95		May 09	95	94.60			

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
C2.2 Quality Assurance – evaluation of call handling and call categorisation (% completed in first year, then quality in subsequent years)	95		95	94.60	95		95		95		95		95		95		95		95		95		95		May 09	95	94.60	A	R	PW- 2009/06/29 investigation as QA figure higher than MI's
C2.3 Average AEU activation times (seconds)	234		234		234		234		234		234		234		234		234		234		234		234		Jul 09	234		?	?	-
C2.4 Average FRU activation times (seconds)	126		126		126		126		126		126		126		126		126		126		126		126		Jul 09	126		?	?	-
C3.1.1 Response times: Cat A (8 mins)	75	75.53	75	72.16	75		75		75		75		75		75		75		75		75		75		May 09	75	72.16	?	R	
C3.1.2 Response times: Cat B (19 mins)	95	86.05	95	85.14	95		95		95		95		95		95		95		95		95		95		May 09	95	85.14	?	R	
C3.1.3 Response times: Cat B (19 mins)	95		95		95		95		95		95		95		95		95		95		95		95		Jul 09	95		?	?	-
C3.1.4 Response times: Cat C																									Jul 09			?	?	-
C3.2 Number of PCTs whose CatA is <72%		6		17																					May 09		17	?	?	
C3.3 % of CatB workload (FRU)	30		30		30		30		30		30		30		30		30		30		30		30		Jul 09	30		?	?	-
C4.1 Completion of clinical audits (CPI vs plan) also by implementation and collecting of data	95		95		95		95		95		95		95		95		95		95		95		95		Jul 09	95		?	?	-
C4.2 Compliance with guidelines as a % of all.	100		100		100		100		100		100		100		100		100		100		100		100		Jul 09	100		?	?	-

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
C4.3 % of staff who have an operational workplace performance review twice per year																									Jul 09			?	?	-
C4.4 % of feedback sessions that are being undertaken compared to the target																									Jul 09			?	?	-
C5.1.1 Time spent at hospital per episode: Cat A	18.27	35.97	18.27	35.95	18.27		18.27		18.27		18.27		18.27		18.27		18.27		18.27		18.27		18.27		May 09	18.27	35.95	?	R	
C5.1.2 Time spent at hospital per episode: Cat B	20.51	34.13	20.51	34.19	20.51		20.51		20.51		20.51		20.51		20.51		20.51		20.51		20.51		20.51		May 09	20.51	34.19	?	R	
C5.1.3 Time spent at hospital per episode: Cat C	18.55	34.68	18.55	34.66	18.55		18.55		18.55		18.55		18.55		18.55		18.55		18.55		18.55		18.55		May 09	18.55	34.66	?	R	
C5.2.1 Job cycle time: Cat A	65	57.75	65	58.03	65		65		65		65		65		65		65		65		65		65		May 09	65	58.03	?	G	
C5.2.2 Job cycle time: Cat B	73	59.47	73	59.78	73		73		73		73		73		73		73		73		73		73		May 09	73	59.78	?	G	
C5.2.3 Job cycle time: Cat C	66	72.62	66	74.25	66		66		66		66		66		66		66		66		66		66		May 09	66	74.25	?	R	
C6.1 Process cycle time for PRFs from submission to database	14		14		14		14		14		14		14		14		14		14		14		14		Jul 09	14		?	?	-
C6.2 % PRFs available for management use in seven calendar days	95		95		95		95		95		95		95		95		95		95		95		95		Jul 09	95		?	?	-

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
C9.1 Number of plans reviewed and updated						3																			Jun 09		3	G	▷ ?	JP 2009-07-01 A total of three plans have been updated:- Pandemic Flu, Contingency Plans & Heatwave Plan.
C9.2 Number of training exercises delivered tabletop or physical						0																			Jun 09		0	R	▷ ?	JP 2009-07-01 None due to REAP level.
D. RESOURCES, LEARNING AND GROWTH																														
D1.1.1 Number of planned training day opportunities available per staff member: Operational				0																					May 09		0	G	▷ ?	KM 2009-06-22. No CPD training has been requested for this month as all training resources are committed to the accelerated recruitment of student paramedics.
D1.1.2 Number of planned training day opportunities available per staff member: Non-operational				0																					May 09		0	G	▷ ?	KM 2009-06-22 There has been no CPD activity planned for this month due to the pressure of the accelerated recruitment of Student paramedics.
D1.2.1 Number of training days undertaken per staff member: Operational																									Jul 09			?	▷ ?	-
D1.2.2 Number of training days undertaken per staff member: Non-operational																									Jul 09			?	▷ ?	-
D1.3 % of staff who complete re-registration																									Jul 09			?	▷ ?	-

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
D1.4.1 Frontline staff in post as a % of establishment: Registered		46		1085.85		1081.65																	1273		Jun 09		1081.65	G	▷?	
D1.4.2 Frontline staff in post as a % of establishment: Other		0		1859.48		1892.69																	2038		Jun 09		1892.69	G	▷?	
D1.5 Number of staff recruited					168	142					184						116						204		Qtr 1 09/10	168	142	G	▷R	AB 2009-07-02 SP courses 13 below capacity - no cause for concern AB 2009-07-02 A&E Support courses 13 below capacity - no cause for concern at this stage
D2.1 Crew hours with no available vehicle																									Jul 09			?	▷?	-
D2.2 Vehicles activated from 'stand by' positions (not from station)	7650		7905		7650		7905		7905		7650		7905		7650		7905		7905		7140		7905		Jul 09	7905		?	▷?	-
D2.3.1 Average vehicle hours per week a) AEU	32786	119471	32786		32786		32786		32786		32786		32786		32786		32786		32786		32786		32786		Apr 09	32786	119471	?	▷G	
D2.3.2 Average vehicle hours per week b) FRU	13600	59128	13600		13600		13600		13600		13600		13600		13600		13600		13600		13600		13600		Apr 09	13600	59128	?	▷?	
D2.3.3 Average vehicle hours per week c) AESU	3327	14778	3327		3327		3327		3327		3327		3327		3327		3327		3327		3327		3327		Apr 09	3327	14778	?	▷G	

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
D2.3.4 Average vehicle hours per week d) Total	49713	193377	49713		49713		49713		49713		49713		49713		49713		49713		49713		49713		49713		Apr 09	49713	193377	?	G	
D2.4 Average weekly Paid Hours/produced hours	67.97		67.97		67.97		67.97		67.97		67.97		67.97		67.97		67.97		67.97		67.97		67.97		Jul 09	67.97		?	?	-
D3.1 Staff sickness levels (vs plan and include PTS)	5		5		5		5		5		5		5		5		5		5		5		5		Jul 09	5		?	?	-
D3.2 Staff turnover																									Jul 09			?	?	-
D3.3 % of staff with PDRs (Op staff only)																									Jul 09			?	?	-
D5.1 No. of days vehicles are off the road (average VOR per day)	65	36	65	45	65		65		65		65		65		65		65		65		65		65		May 09	65	45	?	G	
D5.2 Mercedes AEU in fleet	240		240	240	240		240		240		240		240		240		240		240		240		240		May 09	240	240	G	G	JB 2009-06-03 The target for the month has been met
D6.1.1 System down time and frequency (% and hours - planned and unplanned): CAD - System	99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		Jul 09	99.80		?	?	-
D6.1.2 System down time and frequency (% and hours- planned and unplanned): Environoment	99		99		99		99		99		99		99		99		99		99		99		99		Jul 09	99		?	?	-

PI Target Report 09/10

PI	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual					
PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
D6.2.1 Impact on other disruption: CAD - System e.g. slow down of systems across the CTAK and the CTAK environment	99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		99.80		Jul 09	99.80		?	▷ ?	-
D6.2.2 Impact on other disruption: Environoment	99		99		99		99		99		99		99		99		99		99		99		99		Jul 09	99		?	▷ ?	-
D6.3 User/customer satisfaction and view of perceived impact of a system breakdown	100	99.90	100	99.90	100		100		100		100		100		100		100		100		100		100		May 09	100	99.90	?	▶ R	
D6.4 % of systems backed up and tested	100		100		100		100		100		100		100		100		100		100		100		100		Jul 09	100		?	▷ ?	-
D6.5 Airwave implementation - % of units operational					24.21	15	46.51		75.21		89.18		100												Jun 09	24.21	15	A	▶ R	RZ 2009-07-06 Delay to the start of the rollout due to pending release of a new software version. It was decided to stay with the current version to commence rollout. The slippage will be recovered over the next two weeks are the suppliers are operating a double shift over night. Target by 14th July is 25%.
D6.6 CAD 2010 Milestones - % complete																									Jul 09			?	▷ ?	-
D6.7 Estates plan - % complete	100	90	100	90	100		100		100		100		100		100		100		100		100		100		May 09	100	90	?	▶ R	

PI Target Report 09/10

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PI Target Name	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	PI Milestone Name	TRG	Actual	R	V	Comments
D7.1 Staff feedback (from a survey)																									Jul 09			?	?	-
D8.1 Cash flow – actual vs forecast	2355		2355		2355		2355		2355		2355		2355		2355		2355		2355		2355		2355		Jul 09	2355		?	?	-
D8.2.1 Five financial measures from Monitor and LPA: EBITDA Margin	4.60		4.60		4.60		4.60		4.60		4.60		4.60		4.60		4.60		4.60		4.60		4.60		Jul 09	4.60		?	?	-
D8.2.2 Five financial measures from Monitor and LPA: EBITDA % Achieved	91.70		91.70		91.70		91.70		91.70		91.70		91.70		91.70		91.70		91.70		91.70		91.70		Jul 09	91.70		?	?	-
D8.2.3 Five financial measures from Monitor and LPA: ROA	4.20		4.20		4.20		4.20		4.20		4.20		4.20		4.20		4.20		4.20		4.20		4.20		Jul 09	4.20		?	?	-
D8.2.4 Five financial measures from Monitor and LPA: I&E surplus margin	0.40		0.40		0.40		0.40		0.40		0.40		0.40		0.40		0.40		0.40		0.40		0.40		Jul 09	0.40		?	?	-
D8.2.5 Five financial measures from Monitor and LPA: Liquid Ratio	-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		-0.80		Jul 09	-0.80		?	?	-
D8.3 Result by entity/department (PTS profit)	89		89		89		89		89		89		89		89		89		89		89		89		Jul 09	89		?	?	-
D8.4 CIP plan					2340						3000						3120						3223		Qtr 2 09/10	3000		?	?	-
D8.5 A&E price per head of population within 5% of nat. avg	5		5		5		5		5		5		5		5		5		5		5		5		Jul 09	5		?	?	-

PI Target Report 09/10

Legend

RAG Status

- Red RAG Status represents a high level of concer
- Amber RAG Status represents a possible issue for concern
- Green RAG Status represents on track
- RAG Status Not Set

PI Variance

- Red Variance Indicator
- Amber Variance Indicator
- Green Variance Indicator
- Variance Not Set

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD
28th July 2009

Report of the Trust Secretary
Tenders Received

1. Purpose of Report

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

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

2. Tenders Received

There have been 2 tenders received since the last Trust Board meeting.

Coaching, mentoring and worklife balance programme

Coaching on Call	Tavistock & Portman NHS Fnd Trust
Davidson Nicklen & Assoc	The Performance Coach
Lane 4 Management Group	

Refurbishment of Bounds Green

Sibmar	Lakehouse Contracts
Caniston	TCL Granby

3. Recommendations

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

…….
Michael Dinan
Director of Finance