LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 29th January 2008 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Apologies & Declarations of Further Interest.		
2.	Opportunity for Members of the Public to ask Questions.		
3.	Minutes of the meeting held on 27th November 2007 Part 1 and synopsis of the Part II meeting held on 27th November 2007.		Enclosure 1 & 2
4.	Matters arising		
5.	Chairman's remarks	SR	Oral
6.	Report of the Chief Executive	PB	Enclosure 3
7.	Presentation: National Emergency Preparedness Audit	MF	Oral
8.	Financial Report, Month 9 2007/08,	MD	Enclosure 4
9.	Report of the Medical Director	FM	Enclosure 5
10.	Note Three Year Service Plan	MD	Enclosure 6
11.	Approve Human Resources Strategy	CH	Enclosure 7
12.	Appointment of the chairmen of the Board's committees and proposed future Board development.	MD	Enclosure 8
13	Receive presentation on Payment by Results	MD	Oral
14	Receive update on the Service Improvement Programme 2012	KJ	Enclosure 9
15	Draft Minutes of Clinical Governance Committee, 18th December 2007	BM	Enclosure 10
16	Draft minutes of the Service Development Committee, 18th December 2007	SR	Enclosure 11
17	Report from Trust Secretary on tenders opened since the last Board meeting	CMc	Enclosure 12
18	Opportunity for members of the public to ask question		Oral
19	Date of next meeting: 10.00am on 18th March 2008, Conference room, LAS HQ, Waterloo Road.		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 27th November 2007

Held in the Conference Room, LAS HQ
220 Waterloo Road, London SE1 8SD

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Ingrid Prescod	Non Executive Director
	Roy Griffins	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Caroline Silver	Non Executive Director
	Barry MacDonald	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Martin Flaherty	Director of Operations
	Caron Hitchen	Director of Human Resources & Organisation Development
In Attendance:		
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Martin Brand	Head of Planning and Programme Management
	Malcolm Alexander	Chairman of the LAS Patients' Forum
	John Wilkins	Head of Governance
	Sarah Mawson	Cardiac Data Officer
	Alex Bass	Acting Head of Communications
	Christine McMahon	Trust Secretary (Minutes)

118/07 Declarations of Further Interest

There were no declarations of further interest.

119/07 Opportunity for Members of the Public to ask Questions

There were no questions from members of the public.

120/07 Minutes of the Meeting held on 25th September 2007

Agreed: The minutes of the meeting held on 25th September 2007 with the amendment to Minute 105/07, 'that the proposed tolerance of 80% for the Service Improvement Programme would be kept under review by the Senior Management Group'.

121/07 Synopsis of the Trust Board's Part II meeting held on 25th September 2007

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

122/07 Matters arising from the minutes of the meeting held on 25th September 2007

Noted: Minute 106/07: the HR Director said that the title of the Management of Change Policy and Procedure had been changed to emphasise its status as a staff related policy and it was now entitled 'Management of Change, HR Policy and Procedure'

123/07 Chairman's remarks

The Chairman thanked Barry MacDonald for his eight years of service as a member of the Trust Board and Chairman of the Trust's Audit Committee. The Chairman said that Barry MacDonald had brought a level of professionalism to the Audit Committee that had been sorely needed at the time of his appointment. Barry MacDonald had worked tirelessly to ensure that proper controls and processes were in place for the proper management of risk in the Trust.

Due to Barry MacDonald's retirement a vacancy has arisen on the Trust Board. The Chairman said that the Appointments Commission had received 69 applications applicationshad been received from the Appointments Commission; short-listing would take place this week, with interviews taking place on 11th December 2007. The new Member of the Board was expected to attend the Trust Board's meeting on 29th January 2008.

The Chairman has accepted the uncontested re-appointment as Chairman of the LAS for a third term until 31st March 2009. The Chairman said this was in the clear expectation that the Trust would prepare for Foundation Trust status during the next 18 months. Assurances of the required financial support for the LAS to become a Foundation Trust have had accordingly been sought and received from Malcolm Stamp (NHS London Provider Agency) and Paul Corrigan (NHS London's Director of Strategy & Commissioning).

The Chairman said he had resigned from the NHS Confederation's National Council after ten years and had stepped down as the NHS Confederation's Lead for London, though he hoped to continue attending membership meetings.

The Ambulance Service Association (ASA) and the NHS Confederation (NHSC) merger was proceeding. An Ambulance Services Network (ASN) would be formed within the NHSC with a Board of 11 members. It has been proposed that the Chairman of the Network Board should be one of the existing Ambulance Services Chairmen.

The Chairman said there had been much media interest recently in the Ambulance Service in England e.g. the impact that the extended licensing hours has had on the ambulance service; the need for stronger infection control measures and the call for stab vests to be issued to all front line ambulance crews. The Chairman said he would be writing to the BBC, voicing concern on how the 'Today' Programme had inaccurately broadcast the stab vest story, unlike Radio 5 Live which had reported that the LAS introduced stab vests four years ago. The recent publicity concerning infection control had highlighted that the LAS had introduced the Make Ready Scheme a few years ago as part of its infection control process.

124/07 The Chief Executive's report

The Chief Executive said that the Trust had achieved the highest level of performance ever for all categories of calls. The number of incidents attended in October 2007 rose 3.9% compared to the same month last year. There had been a

sharp increase in demand the week commencing 19th November 2007 and this had affected Category A 'Call Connect' and Category B performance.

The Board's attention was drawn to the various graphs included in the Chief Executive's report illustrating that November had been the busiest month in the last three years. Category B [1] performance in October was 86.5%. The Category A[2] performance against the current target was 80.5%, in 8 minutes; as measured by 'Call Connect' standards, it was 64.4%. October was the first month that the Trust had fallen below the trajectory for reaching 75% of Category calls in 8 minutes from 'Call Connect[3] by April 2008. Work was in hand to get back on trajectory.

A number of technical innovations would be introduced in the Control Room during the next few weeks. FRED (the automatic dispatching of ambulances) had been delayed but would be in place by mid December; the Dynamic Deployment of cars would be implemented in early December and Caller Line Identification for calls from Cable & Wireless would be implemented by mid December.

Discussions were being held with Staff Side to ensure robust staffing arrangements are in place during the Christmas and New Year period.

Discussions were being held with the Commissioners in regard to 2008-09 performance targets and funding; the Trust has made it clear that a substantial amount of funding would be required to ensure that the Service achieves the national targets for Category B in 19 minute and Category A in 8 minutes measured from 'Call Connect'.

In respect to the 2007-08 Category B performance target, the discussion with Commissioners has been constructive and an agreement should be finalised by mid December. The Commissioners have recognised the significant improvement that has taken place.

A bid for workforce funding for 2008/09 would be submitted to the NHS London as the Trust proposed to deliver a lot of its future training through Higher Education institutions.

The Trust's risk rating by the London Provider Agency has been revised downwards, resulting in a lighter regulatory touch, i.e. quarterly as opposed to monthly submissions.

The Board's attention was drawn to the various types of activity reported under the Communications section of the Chief Executive's report. The Chief Executive thanked Alex Bass, Acting Head of Communications, who was covering for the Head of Communications whilst she was on a six month sabbatical.

In conclusion, the Chief Executive said that call answering performance has been excellent despite the recent rise in demand; 2,638 999 calls were received on Sunday, 25th November. During the last two months 90% of calls have been answered in less than 5 seconds despite an increase in the number of calls. The Manager of the 999 Service at British Telecom recently wrote congratulating the Service in reducing the number of 999 calls waiting for more than two minutes from 1300 in November 2006 to 48 in November 2007.

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[1] Category B: presenting conditions which though serious are not immediately life threatening and must receive a response within 19 minutes.

[2] 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.

[3] Call Connect: ambulance response times are currently measured from a point when 3 pieces of key information has been obtained (location, telephone number and chief complaint). From 1 April 2008, the clock will start earlier - when the call is connected to the ambulance control room.

It was noted that:

In October 2007 16.5% of calls related to enquiries as to when a response would be arriving (ETA Calls). It was recognised that this figure would be addressed through faster responses by front line vehicles to patients with potentially life threatening conditions. Call Takers were unable to state how long it would be for an ambulance to arrive and sometimes people became impatient or needed to inform the Service that there had been a change in the patient's condition.

A double response was sent to patients requiring a Category A 8 minute response time in line with established medical protocols. The Director of Operations said that 1.6 of Category A 8 responses involved a fast response car and an ambulance. It was accepted that this figure was high and needed to be lowered whilst adhering to established clinical protocols.

The Board wished to receive a graph showing performance against the Category B 19 response target, as currently presented for the Category A 8 performance target (graph 2), in recognition of the funding implications associated with Category B 19 performance. **ACTION: Director of Operations**.

Discussions were being held with the new occupational health provider, Atos Healthcare, concerning the quality of information contained in Clinician's reports which were considered at capability hearings. The HR Director said that Atos Healthcare itself regularly reviews the Clinician's reports. This was an area that would be closely monitored by the HR team.

The LAS Patients' Forum would be continuing as an independent organisation, it would be recruiting new members and seeking to establish a nationwide network comprised of similar organisations. The Chairman said that during the recent discussions concerning Foundation Trust status there had been recognition that the Trust would need to work closely with the LAS Patient Forum and the new borough based organisations, LINks[4], as part of its preparation for Foundation Trust status. The Chairman said that the views of the Chairman of the LAS Patients' Forum would be sought as to how the Trust could take this work forward.

The Board was pleased that there had been a successful test of the Fall Back Control Room in October 2007. A further test of the Fall Back Control Room would be undertaken in February 2008.

Every complex management team had recently been provided with a new 'ideal' staffing picture for their complex. The Director of Operations said that there was a significant gap between the actual and 'ideal' particularly at weekends. This was being addressed by rostering extra vehicles at times of peak demand. Discussions were ongoing with Staff Side as to revising rotas to ensure that sufficient staffing was available at times of high demand.

During the last ten days there had been significant delays experienced at hospitals across London and this was being closely monitored.

The Director of Communications circulated an article featured in the Daily Mirror concerning an alternative response and two DVDs on recent television and radio programmes and the ITV documentary series, 'London Ambulance'.

Agreed: 1. In recognition of the good healthcare ratings achieved by the Trust, to thank the Head of Governance for doing a

[4] LINks: under the Department of Health's proposals for replacing Patients' Forums (sic) it is intended that Local Involvement Networks will gather and analyse information from patients and make recommendations to commissioners, providers and Overview and Scrutiny Committees.

sterling job in co-ordinatinged the Trust's submission of the Annual Declaration to the Healthcare Commission.

2. **That the Chairman would write to Laurie Strugnell, formerly Emergency Planning Adviser, who retired from the Service after 37 years of service. ACTION: The Chairman**

125/07 <u>Month 7 Finance Report</u>

The Director of Finance reported that for month 7 the Trust had a surplus of £1.5m and was forecasting a year end surplus of £647k. The forecast assumes receipt of income (£3,000k) relating to the achievement of Category B performance targets. Expenditure was forecasted to increase in future months for spend on 'Call Connect' initiatives.

Income was higher than planned in the month due to funds being made available to meet the 'Call Connect' response time targets. This resulted in a higher than planed EBITDA[5] of 12% compared to the intended 5% in the month.

Expenditure was lower than expected due to a lower than planned expenditure on various internal projects and credits received relating to the BT and CTS contracts.

Salary expenditure in Month 7 was £17.9m, which was broadly in line with Month 6. Month 8 would include the payment of £400k back pay to members of staff as part of the staggered pay increase to public sector employees. A&E staffing was broadly in line with the recent increase in 25 Emergency Medical Technicians, grades 2 and 3. The overtime forecast remained unchanged. There was an increase in Emergency Operations Control staffing during the year.

There was an increase in expenditure on medical consumables and equipment. The depreciation figure rose from £6,387 to £6,576k in line with planned projects.

It was noted that:

There was a discussion as to how the Trust would best utilise its financial resources to support A&E operations in the rest of the financial year. A range of additional measures were under active review by the Senior Management Group.

Although the expenditure on overtime was less than budgeted, the Director of Operations expected this to rise in the forthcoming weeks. The availability of staffing at weekends continues to be of concern.

The majority of third party spend was with St John Ambulance and the Red Cross. The Director of Finance said he expected the use of third party to decrease with the introduction of Alternative Response Vehicles.

The Finance Director said discussions were on-going with Commissioners in respect of the 2007/08 Category B 19 performance targets (92% for the year and 95% in quarter four). The Commissioners had recognised that Category B 19 performance had significantly improved; efforts were continuing to meet the performance targets.

The LAS submitted a bid to NHS London for non-recurrent funding of £8.2m which would be shared between operational support and improved outcomes. The Finance Director intended to establish a separate programme to oversee the projects; he would be the Senior Responsible Officer and Martyn Salter would manage the programme. The duration of the programme would be 3rd December

[5] EBITDA (earnings before interest, taxation, depreciation and amortisation) is a measure of an organisation's operational cash flow.

2007 to 22nd March 2008. Projects would be undertaken only if they were deliverable within that timeframe and could demonstrate specific benefits.

Although Patient Transport Service (PTS) vehicles were not part of the Make Ready Scheme they were regularly 'deep' cleaned. The Medical Director said there was no objective evidence that there was any greater risk of infection on PTS vehicles than A&E vehicles; vehicles were regularly swabbed for the presence of infectious bacterium and to date there has been no evidence of MRSA or Clostridium difficile.

126/07 **The Medical Director's report**

The Medical Director highlighted the following from her report to the Trust Board:

Serious Untoward Incident (SUI): a robust system has been implemented whereby any event flagged up as a potential SUI would be reported to the Assistant Chief Ambulance Officer who would then convened a discussion of the case with the Director of Operations and the Medical Director. To date, three of the 42 incidents that have been reviewed in this way have been declared Serious Untoward Incidents. The most recent incident involved a patient at an addressed flagged as high risk on the Metropolitan Police Register; this resulted in a significant delay while the ambulance crews awaited attendance of the police.

Feasibility study into the provision of therapeutic hypothermia: A feasibility study in providing therapeutic hypothermia would commence in February 2008 and would involve patients in the catchment areas of Hammersmith and Charing Cross Emergency Departments and the LAS crews from Fulham and Hanwell Complexes. Therapeutic hypothermia involved cooling obtunded (non-responsive) patients who have a return of spontaneous circulation following resuscitation from cardiac arrest. There was substantial evidence for improved neurological outcomes through the use of therapeutic hypothermia. Although the intervention is practiced widely in Scandinavia and increasingly in the United States, few Emergency Departments in the UK routinely undertake this treatment.

Pilot of emergency transfers for non STEMI patients: the London Chest Hospital has commenced a pilot whereby non STEMI patients presenting to Newham and the Royal London Emergency Departments with ongoing chest pain would be booked into the next available slot for angiography. These patients would be transferred as an emergency rather than waiting as in-patients for a routine appointment to become available.

Update on Stroke Care: Representatives from the Service Development and Medical Directorates met with Mr Chris Streather, Medical Director of St George's Healthcare NHS Trust, the NHS London lead on Stroke, to agree a potential way forward to co-ordinate Acute Stroke Care in London. The LAS would be implementing a bypass protocol from 1st April 2008, to ensure that FAST[6] positive patients are expedited to units offering acute stroke care either 12 or 24 hours a day.

The arrangements in place with University College London Hospitals in respect of Stroke patients were progressing well; nine patients had been thrombolysed in the first ten weeks since implementing the new arrangements.

Clinical Update Newsletter is published monthly on the Pulse. The newsletter highlights topical issues such as national guidance, (e.g. the rising incidence of measles), trends in clinical incidents and any changes to protocols or procedures.

[6] FAST: Face, Arms, Speech Test

The newsletter includes an 'ECG[7] of the month', reinforcing the need to capture, and file, ECG records and demonstrating some of the more interesting and challenging examples. Examples of the Newsletter were circulated for information.

Two revised procedures were presented to the Trust Board: TP1018, Suspected Cases of Child Abuse Procedure, and TP1019, Suspected Abuse of Vulnerable Adults Procedure. The procedures were approved by the Clinical Governance Committee on 15th October 2007 and the Board was asked to ratify this decision.

The Department of Health document giving guidance on the ambulance response in the event of a pandemic influenza epidemic was still out for consultation. As part of the LAS internal plan a Flu Co-ordinator has been appointed and a working group set up. The next print of the Patient Report Form (PRF) would include a 'suspected flu' diagnostic code.

Approved: The procedures, TP1018 Suspected Cases of Child Abuse Procedure and TP1019 Suspected Abuse of Vulnerable Adults Procedure.

127/07 <u>Infection Control Policy</u>

The Infection Control Policy had been revised and updated to reflect the requirements of the Code of Hygiene. The Policy provided the Board with assurance that the organisation was compliant with the core standards (C1a, C1b) relating to patient safety for the period from 1st April 2007 to 31st March 2008. The Policy set out the duties and responsibilities of all members of staff, from the Trust Board to front line members of staff, for infection control. Responsibility has been devolved for infection control at Complex level to Ambulance Operation Managers. The Trust would be recruiting a full time Infection Control Co-ordinator.

It was noted that:

An action plan had been drafted in response to the recommendations set out in the Healthcare Commission's report of the Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust. The plan would be taken forward by the Infection Control lead (the Medical Director) and would be sent by the Chief Executive to the NHS London in response to the letter dated 15th October 2007 from the NHS Chief Executive, David Nicholson.

The recent publicity concerning infection control would reinforce with front line staff the importance of adhering to infection control procedures. It was hoped that the publicity might also encourage members of staff to volunteer to be local champions for infection control. The Director of Finance said that additional audits would be undertaken to evidence the implementation of the infection control policy.

When NHS London recently gave the Trust funding in respect of infection control it raised a concern regarding pre-hospital canulation as a source of infection. The Trust would be introducing labels on cannulae that clearly identify patients cannulated prior to their admission to A&E.

Approved: The Infection Control Policy.

[7] ECG: Electrocardiogram, measures the electrical activity of the heart.

128/07 **Interim Assurance Framework**

The Interim Assurance Framework was presented as a mid term report on compliance with the core standards for the Annual Health Check 2007/08. The Assurance Framework was the process that links clinical governance, controls assurance and risk management systems to enable the Board to meet the challenge of Governance.

In preparation for the next Statement of Internal Control and the Final Declaration of the Annual Health Check 2007/08 this Interim Assurance Framework has been produced from the previous Assurance Framework and included the twenty-five most strategic (risks with the highest risk score) risks currently held on the Trust's Risk Register.

The report to the Board included: an analysis sheet illustrating the risks mapped on the framework to the Healthcare Standards and the principal objectives of the Trust and the interim assurance framework. In addition, there was a report concerning the Healthcare Standards that were not included in the Interim Assurance Framework as there were no risks currently on the Risk Register to which they related to. These Standards were kept under review by the Standards for Better Health Group who update the controls.

It was noted that:

The Framework and the Trust Wide Register would be updated and presented to the Board in March 2008 as evidence of compliance supporting the Final Declaration of the Annual Health Check and the Statement of Internal Control for 2007/08. **ACTION: Director of Finance**

Approved: The Interim Assurance Framework as the first part of compliance evidence with the core standards of the annual health check for 2007/08

129/07 **Update re. workforce strategy 2008**

The HR Director summarised the context of the strategy together with proposed strategic elements and aims, which included the development of a flexible and adaptive workforce.

The HR Director said that much of the Strategy was contained in the Organisation Development and People Programme. A presentation on that Programme was scheduled to be given to the Service Development Committee in December as part of the update on the Service Improvement Programme 2012.

130/07 **Alternative Response Policy**

A 'no send policy' has been in operation in the Trust since November 2003, but although approved in principle by the Trust Board, it was not formally adopted. Clinical decision support software for Clinical Telephone Advisers has led to this 'policy' being revised. In practice, Clinical Telephone Advisers and Call Takers have only rarely refused point blank to send an ambulance.

The Medical Director said that the introduction of clinical software decision support meant Clinical Telephone Advisers were able to advise patients of the most appropriate way to access help in the event that an ambulance was not required. This was done either by reassuring them that there was no need for an ambulance, suggesting that they make an appointment to see their General Practitioner or make their own way to the Local Emergency department or Walk in Centre.

It was noted that:

That the Board would receive a report in six months time on the implementation of the Policy. **ACTION: Medical Director**

Approved: The Alternative Response Policy, subject to the undertaking of an Equality Impact Assessment.

131/07 Cardiac Arrest Annual Report

Sarah Mawson, Cardiac Data Officer, presented the Cardiac Arrest Annual Report to the Trust Board. She outlined the process for obtaining the outcome data from hospitals on LAS conveyed cardiac arrest victims and highlighted the improvements that have been made which have enabled information to be accessed within 1-2 months as opposed to the previous 6 months.

Data analysis has shown that

- crews reached patients faster (on average by 1 minute);
- measured on the Utstein[8] template, the percentage of patients that survived a cardiac arrest to discharge from hospital rose from 10.9% in 2005/06 to 15.8% in 2006/07[9].
- the overall survival rate rose from 3.2% in 2003/04 to 5.3% in 2005/06 and levelled out in 2006/07.

The Clinical Audit and Research Unit (CARU) produce a monthly Cardiac Care Pack. It contains data on cardiac arrests and STEMI[10] on a Complex, Area and London wide basis. The pack also contains trend reports that allow changes to be tracked over the time.

It was noted that:

Cardiac Arrest data for April to September 2007 would be available in late December 2007; being able to access data in such a short period of time was very helpful.

Acquiring the survival to hospital discharge data required members of CARU to work hard to maintain good relations with the 24 A&E hospitals in London. Some hospitals being were more co-operative than others. The Chairman asked for a list of those hospitals that were helpful and those that were not, as he would like to thank or raise an issue with the relevant chairs when he had the opportunity. It was recognised that the planned introduction of the electronic Patient Report Summary Care Record would mean the above data being more readily available to the LAS. Quicker access to information would enable crews to routinely receive feedback on their treatment of patients, thereby improving the quality of care given. The Chairman said when he had been a member of the Ministerial Taskforce on the introduction of the Summary Patient Care Records, he had successfully argued that patients' data should not be anonymised on transfer to the data warehouse since it was important that clinical auditors should be able to track patients through the system in order to ascertain outcomes.

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[8] Utstein: The internationally agreed Utstein calculation is based on patients suffering a witnessed cardiac arrest with the initial rhythm being diagnosed as either ventricular fibrillation (VF) or ventricular tachycardia (VT).

[9] This means that 3 in every 20 people we resuscitate following a bystander witnessed cardiac arrest (with VF/VT) are leaving hospital alive.

[10] STEMI: ST-Segment Elevation Myocardial Infarction. It is a heart attack caused by a prolonged period of blocked blood supply.

There was an increasing use of primary angioplasty, with over 75% of patients with STEMI being transported directly for primary angioplasty.

132/07 Update re. Healthcare for London

The Director of Service Development said that the consultation paper, "Healthcare for London: consulting the capital", would be published on 30th November. It reflected the LAS' potential role in the new organisation of health. Consultation would be led by the Primary Care Trusts and the Overview and Scrutiny Committees of each of the 32 London Boroughs. The organisers of the consultation would be seeking the general public's views by means other than traditional public meetings, e.g. by inviting people to attend day long events where there would be stalls and people would have the opportunity to ask questions. LAS members of staff would be involved in these events.

The Director of Service Development said that some members of staff have expressed anxiety regarding the proposal to decrease the number of trauma centres; following discussions with members of staff an article would be appearing in the next LAS News outlining the proposals and seeking views.

NHS London has established a separate organisation to oversee the delivery of 'Healthcare for London' and has appointed a programme manager. During the consultation period, and without prejudging the outcome of the consultation, work would be taking place regarding Stroke; Polyclinics; Local Hospital Feasibility; Major Trauma and Unscheduled Care. The LAS would be working with the Healthcare for London team in respect of the Stroke, Polyclinics, Major Trauma and Unscheduled Care.

The issue of reconfiguration would be on hold during the consultation period with the exception of the reconfiguration discussions in South East of London which were expected to be concluded by December/January. The reconfiguration of acute services in Barnet Enfield and Haringey had been concluded and it was decided that Chase Farm would become an elective-only site; the LAS would receive funding for two additional ambulances in that area to ensure that performance is maintained.

It was noted that:

Concern was expressed by Dr Beryl Magrath that the reconfiguration of Barnet Enfield and Haringey had ignored the recommendations of a clinician, Lord Ara Darzi, in respect of co-location of consultant and midwife led maternity services.

The Trust's formal response to the NHS London's consultation would address the opportunities that the polyclinics present and what they should be capable of delivering. The issues surrounding the introduction of a hub pilot would be followed up separately as well as in the response.

Agreed: That the Trust should make a formal submission in response to the Consultation paper on 'healthcare for London'.

133/07 Annual Clinical Governance Report

The Annual Clinical Governance Report recorded clinical governance activity trust-wide for the period October 2006-October 2007. The activity has been classed using the domains of the Annual Health Check and highlights the achievements in clinical governance that have been reported to the Board via the Clinical Governance Committee's minutes and the Medical Director's reports. The Report provided evidence to corroborate compliance with the Healthcare Standards which would be included in the Final Declaration of the Annual Health

Check 2007/08. The Clinical Governance Committee, at its meeting on 15th October 2007, approved the Report subject to minor amendments

It was noted that:

The Chairman of the Clinical Governance Committee commended the efforts of the Head of Governance and the Governance Development Unit under the leadership of the Medical Director in producing this report. She also commended the pan London and Area Governance reports presented by the Deputy Director of Operations and the Assistant Director of Operations to the Clinical Governance Committee. These reports have provided evidence that the quality of clinical care delivered to patients was seen to be the responsibility of all front line staff.

Approved: 1. The Annual Clinical Governance Report.

Agreed: 2. That the Annual Clinical Governance Report be presented to NHS London's lead for clinical governance as the Trust's formal record of clinical governance achievements for the period from October 2006 to October 2007.

134/07 Annual report of the Charitable Funds Committee

Noted: The annual report of the Charitable Funds Committee 2006/07.

135/07 Update re. Service Improvement Programme

The Director of Service Development presented an update on the Service Improvement Programme. The Board's attention was drawn to the milestone charts included for all of the programmes except Access, which was still being scoped. The Director of Service Development requested feedback as to whether the report gave enough information without too much unnecessary detail.

It was noted that:

The £8.2m bid to the NHS London included funding for projects such as the management of frequent callers which would enable the Trust to save money and improve performance. The Director of Service Development said that projects were being reviewed to identify those that, with additional resources, could be accelerated and benefits realised this financial year.

There had been a delay with the LARP[11] project which was outside the Trust's control; the LARP project was a national project managed by the Department of Health. The Service Development Committee would receive an update on the project in December. **ACTION: Director of IM&T**.

136/07 Draft minutes of the Annual Public Meeting, 25th September 2007

The Chairman presented the draft minutes of the Annual Public Meeting, 25th September 2007.

Noted: The draft minutes of the Annual Public Meeting, 25th September 2007.

[11] LARP: London Airwave Radio Project

137/07 **Draft minutes of the Audit Committee, 10th September and 19th November 2007, and the Annual Audit & Inspection Letter, 2006/07**

Barry MacDonald presented the draft minutes of the Audit Committee's meetings held in September and November 2007. The meeting in September considered reports from the Internal Auditors and the Audit Commission, and the Risk Register. It also discussed the implications of the possible introduction of National Reference Costs for ambulance services. In November, the Committee met with the senior Finance team and a Resource Centre manager, and received evidence of how the finance team and A&E were now more closely integrated. The Chairman of the Audit Committee said that there was evidence that the financial management systems were working much more efficiently than in the past.

It was noted that:

The handover note from Barry MacDonald, in preparation for his retirement as Chairman of the Audit Committee, would be circulated to all members of the Audit Committee. **ACTION: Chairman of the Trust Board.**

The NHS London's deadline of 15th January 2008 for a draft 2008/09 budget would precede the agreement of the budget by the Trust Board on the 29th January 2008. The Director of Finance said that NHS London may provide an update on the planning timetable at the Trust Chief Executives meeting taking place on 28th November 2007. The Service Development Committee would receive an initial draft of the 2008/09 budget when it meets on 18th December. The Chairman said he was confident a sensible way forward would be negotiated concerning the submission of the draft budget to the SHA in January.

The Director of Finance presented the Annual Audit & Inspection Letter 2006/07. He drew the Board's attention to the recommendations contained within the Annual Audit & Inspection letter, 2006/07.

138/07 **Draft minutes of Clinical Governance Committee, 15th October 2007**

Beryl Magrath, the Chairman of the Clinical Governance Committee presented the minutes to the Board.

Noted: The draft minutes of the Clinical Governance Committee, 15th October 2007.

139/07 **Draft minutes of the Charitable Funds Committee, 30th October 2007**

Caroline Silver, Chairman of the Committee, said that the Committee had agreed, with effect from January 2008 to decrease the length of time required for long service awards for retirees from 20 to 10 years. This was in recognition that the changing the length of service from 20 to 10 years would recognise long service by non-front line staff. The LAS' Charitable Funds was shown to have generous arrangements in place when compared with the charitable arrangements in place at other NHS and PCT Trust.

The Trust Board briefly discussed its policy of running down the Fund. It was recognised that if disbursements relied on the income generated by interest received from the Funds there would be an insubstantial amount of funds available, hence the decision to run down the fund.

Noted: The draft minutes of the Charitable Funds Committee, 30th October 2007.

140/07 **Report from Trust Secretary on tenders opened since the last Board meeting**

Two tenders have been opened since the last Trust Board:

Real Time Software	EADS Defence & Security Systems Ltd Northgate The Optima Corporation
Conversion of Vauxhall Zafiras for Rapid Response Units and ECPs	Wilker Papworth MacNellie Bluelite AES

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

Noted:
1. **The report of the Trust Secretary on tenders received**
2. **That the Trust's seal has not been used since the last Trust Board meeting.**

141/07 **Any Other Business**

The Chief Executive said a letter had been received from the Healthcare Commission following its receipt of 25 complaints from members of the public, 12 of which have been returned in the expectation that the LAS would achieve a local resolution. The return rate of 48% was much higher than the English average of 28%. The Trust has been given ten days to respond the Healthcare Commission's letter concerning the returned 12 complaints. A report on this matter would be presented to the Trust Board in January 2008. **ACTION: Chief Executive**

142/07 **Opportunity for members of the public to ask questions**

There were no questions asked by members of the public.

143/07 **Date of next meeting**

Tuesday, 29th January 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 12.35

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 27th November 2007
held in the Conference Room, LAS HQ, London SE1

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

On the 27th November 2007 in Part II the Trust Board received a brief update regarding the progress of the CAD 2010 project; how the a technical problem encountered in the Control Room was being managed and there was further discussion regarding the Trust's £8.2m bid for one off revenue funding from the SHA.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 29 JANUARY 2008

CHIEF EXECUTIVE'S REPORT

1. ACCIDENT & EMERGENCY SERVICE

999 Response Performance

The tables below set out the A&E performance against the key standards for November and December of 2007 and for the year to date. Please note that call connect is not a cumulative target and has therefore been omitted in terms of ytd values.

	CAT A8 (current)	CAT A8 (call connect)**	CAT B19
Standard	75.0%	75.0%	90.0%
November 2007	78.8%	62.9%	84.8%
December 2007	75.5%	60.3%	81.8%
YTD*	79.1%	n/a	84.5%

* Accurate as at 21st January 2008
** Applicable from April 2008

Key highlights

i. November and December 2007 have been the two busiest months in the history of the Trust. In that context I am pleased to report that the Trust is continuing to perform well against the current Category A target of 75%, achieving 78.8% in November and 75.5% in December. This provides strong evidence that the systemic changes introduced over the past 18 months have been effective. The year to date position remains in excess of 79%.

ii. Call connect performance has not remained so resilient to the increase in demand particularly as this was coupled with a reduction in the Ambulance and FRU hours produced during December.

Control Services have continued to perform well and call answering has remained very resilient with only a small drop during December to 89.5% of calls answered within 5 seconds despite the steep increase in incoming 999 calls. Long waits for 999 calls to be answered remained negligible.

A number of technical problems also impacted on performance during December and these are discussed in more detail in section 1.4 below.

Call connect performance fell back to 62.9% in November and 60.4% in December which whilst disappointing when compared to the trajectory target of 70% for December was still a reasonable level of performance given the unprecedented demand levels. This is borne out by performance against the

current Cat A 8 minute target being 79% for Christmas week and 78.2% for the week after which represents some of the best performance delivered across this difficult period in some years.

iii. Category A volumes have risen steadily over the last five months to a peak of 977 per day in December which is the highest level the trust has ever seen. The previous busiest month had been Feb 07 at 953. Once again to add perspective, performance in December 07 showed a +13.6% improvement in call connect and a +3.9% improvement in current A8 when compared with February 07against a background of a higher Cat A and overall demand profile.

iv. Category B performance proved more challenging during November and December in the context of the high Category A workload. We are currently at 84.5% ytd and November delivered 84.8% however December, with the higher workload and with fewer ambulance hours produced, delivered a disappointing 81.8%. Weekends are still difficult due to the lower number of rostered ambulance hours. Whilst in overall terms current Cat B performance is the best the Trust has ever achieved it is clear that there is still much improvement required. Good ambulance staffing and fast activation is the key to this improvement and we are concentrating on improving both in the coming weeks.

v. The Trust moved to REAP level 3 'Severe Pressure' during this period and the associated actions from the escalation plan were implemented.

1.2 Activity

- The number of incidents attended in December 07 rose 5.7% compared to the same month last year and the Trust faced the busiest month in its history.
- Overall workload, year to date, is up 3.1% on the same period in 2006/7

1.3 Resourcing

- Overall staffing fell during December when compared with November in line with the usual seasonal trend as staff enter the peak Christmas holiday period but hours produced remained at just above those levels seen in 2006.

- Staffing during Christmas week was predicted to be very poor due to Christmas Day and Boxing Day falling on a Tuesday and Wednesday respectively, when we have minimal relief cover (as relief rotas are mainly focussed on weekend working) however, resourcing was boosted over the Christmas and New Year period by an innovative incentive scheme allowing the payment of a Christmas bonus to staff members who worked at least 72 hours over the whole period and at least 24 hours over Christmas Eve/Christmas Day, Boxing Day and New Year's Eve/New Year's Day. The bonus was dependant on no sickness, lateness or absence over the whole period. A large number of staff took advantage of this opportunity, boosting our overall staffing over the period.

- Formal consultation has now concluded on the future of the 'Resourcing' function in the Trust. The Trust will now move to two resource centres, which will be based at Ilford and Croydon. In two years time we expect to reconfigure down to one resource centre but this decision will be kept under review whilst we understand the full resourcing implications of moving to the 'New Ways of Working ' on complexes.

- Work continues on making some resourcing functions 'self service'. Staff will soon be able to access the resourcing database from station computers (and possibly home) and book overtime, annual leave and training courses.

- In our ongoing programme to improve weekend resourcing we have recently advertised 'weekend-only working' to existing staff and have secured 11 crews and 10 individuals for these duties.

1.4 Emergency Operations Centre (EOC)

- The Automatic Dispatching of Ambulances (FREDA) underwent final testing across a number of closely monitored trials in late November. There were a number of modifications made following detailed feedback from staff and it went live on the 7th of December. Whilst the increase in workload has masked some of the benefits, there has been an improvement noted in dispatch times of Ambulances for Category A and Category B calls. It has also resulted in a small reduction in the number of dual assignments to calls. The resultant increased capacity in the FRU fleet is supporting further increases in performance under Call Connect.

- The number of Category A calls activated within 2 minutes in December was 27,548 as compared to 25,876 in November. The number of Activations on Category B calls within 2 minutes has also improved. December 2007 achieved 64.8% and dispatched 26,663 calls within 2 minutes which compares very favourably with December 2006 when only 51.2% was achieved with 18,970 calls dispatched in 2 minutes.

- There were a number of other improvements implemented in November. The improvements include changes to the information provided by the Met Police via the CAD Link with crews now automatically receiving all updates from the police in cases where they have been requested. The updates include whether or not Police are en route and their estimated time of arrival.

- Caller Line identity for Cable and Wireless calls was implemented in early December. It now gives the address where all fixed line calls are being made from and also gives an area in which Mobile Phone calls are being made. This has reduced the time taken to take these calls and also ensures a greater degree of accuracy for these calls which make up about 20% of our overall incoming call volume.

- The staffing levels in EOC for November and December have continued to be above 100%, which has greatly assisted in achieving the necessary levels of

performance. The staffing for the first 9 months of the year stands at 100.6% of the agreed plan. Work is now underway to ensure that the skill levels of staff at work consistently meets the needs of the new structure across the entire week. Discussions are now reaching a conclusion with staffside to amend the core rota to include weekends in the relief week which currently only covers Monday to Friday. Clearly whilst there is some opposition to the increased weekend working the need to provide an effective service to the public consistently across the entire week is compelling support for the changes. An amendment to the current relief rota is also going to be implemented. This has received strong support from our newer staff and will ensure that whilst providing cover at the times of greatest need, their working pattern will more closely mirror the core rotas. This will provide these staff with more consistent management support in their first 18 months and should ensure an increased compliance with call taking standards.

- Call taking is now stabilising at over 90% of calls being answered in under 5 seconds each month. There have also been 3 weeks where the 95% target was attained. November attained the highest level with the month delivering 91.5% and a slight deterioration in December to 89.5%. However there were significant issues that caused the deterioration, such as a technical failure in early December that caused a loss of Caller Line Identity for a few days and a failure of the Met police cad link which required all of those calls to be taken manually. This resulted in nearly 117,000 calls being taken in December as compared to 105,000 in November and 102,000 in December 2006. It is also worth noting that the call taking performance for last December was 56.6%. This means there has been a 32% improvement in performance against a backdrop of an increased workload of 14% when compared to the same period last year. The calls where there is a wait of over 2 minutes is now consistently coming below the 0.5% agreed level with November at 0.2% and December at 0.3%.

- In terms of the quality of call handling, the level of compliance within AMPDS has remained satisfactory with compliance levels of 96.5% for November and 96.7% for December against a Centre of Excellence level standard requirement of 95%. Several members of staff have now received a detailed assessment of their call taking with a follow up review taking place a month later to identify improvements and areas still requiring improvement. This is now being rolled out to all other members of staff in call taking with completion anticipated by the end of February.

- A change in the order in which questions are asked in call taking has now been implemented, following a detailed trial which showed the benefits of the changes. This is reducing the time to obtain certain key parts of information and is resulting in faster activation of resources.

- The second phase of the EOC reorganisation paper has been completed. It has been discussed with staffside and the final document shared with staff for comment. Responses are due by mid February and anticipated implementation will occur in mid March. The new structure will ensure that the EOC structure in dispatch more closely mirrors the operational structure across the three

operational areas. There will also be an enhanced managerial overview of call taking as well as providing an improved career structure for staff who wish to remain in call-taking.

- A project Board has been formed to implement a Clinical Support desk in EOC. The desk will be staffed by experienced Paramedics who are going to be supported by access to a team of clinicians for those instances that require it. The desk will be used to provide clinical support to both operational crews on the road as well as Control room staff and will be operational by the spring. The intention is to provide support in terms of a real-time Governance overview and mitigate some of the risks currently faced by EOC when holding calls.

- A new Gazzeteer is scheduled to be implemented in late March. Accompanying it will be more detailed mapping. Together these will provide a much greater degree of support to call-handling staff in cases where the location of help required is difficult to pinpoint. Once pinpointed the exact co-ordinates will then be sent to the MDT to guide crews to the precise location where help is required; as opposed to a vague location which is what currently occurs in public places such as parks.

- A number of other improvements are scheduled for EOC in the next quarter which includes a new switch for the phone system, some recabling and the replacement of the desk tops, carpet and chairs. The environment will be further enhanced as plans are underway to upgrade the lighting and décor in the room.

1.5 Urgent Operations Centre (UOC)

- Recruitment for A&E Support Crews has been successful to date, and it is anticipated that we will be on target to achieve 162 staff employed by 31st March 2008. Some EMT1's will go on to Technician training during 2008, and therefore the recruitment strategy continues to back fill the expected vacancies. Urgent Care, in the mean time, continues to be supplemented by the Voluntary Aid Societies and by an ASA accredited private ambulance company.

- Since the middle of November there has been a steady increase in the volume of work carried out buy Urgent Care Crews, and this is expected to rise again with the improved availability of A&E support crews as the training courses finish.

- At the end of 2007 we had a head count of 49 CTA staff. As secondments come to an end, further training courses are planned up to March 2008, with a target to employ 70 staff. An open evening is being planned, where staff can come in and meet the management team and CTA staff. They will be able to discuss the role in depth with current CTA staff in an attempt to continue to boost the numbers of applicants.

- CTA call volumes continue to improve. The target for March 2008 is 1600 calls per week. It is pleasing to report that week ending 30/12/07, CTA answered 1604 calls, the highest week on record. There is however still some fragility in these numbers and more work needs to be done to stabilise the figures.

- A number of Control staff from the Emergency Operations Centre (EOC) requested secondments to UOC, and they have now transferred. This has made for a more robust operating regime, and is in anticipation for the increased numbers of A&E support crews.

- UOC management continue to focus on all aspects of attendance management, and a number of staff have and will be seen formally around their attendance. More robust screening of attendance management issues will be introduced at the recruitment and secondment stage.

- Overall work load for UOC has gone up from 35% in September 2007 to 39.7% in December 2007. This overall improvement is down to improved Urgent Care Crew staffing levels, more robust management of work load, more staff on duty in CTA and improved Quality Assurance compliance.

1.6 Emergency Preparedness

- The Board will recall that at the beginning of September the Trust underwent an extensive audit of its emergency preparedness by a team from the Department of Health. The team were with the Trust for a period of 4 days. During this period they had the opportunity to examine all our documentation, visit operational sites and interview external partners and Trust staff.

  The full report has now been delivered. It is very positive and rates the Trust as the best prepared in the country, as we would expect. The LAS is held up as an example of best practice in five specific areas, including the new Major Incident Plan.

- The new Major Incident Plan and associated 'Action cards' are currently being printed and will be issued at the end of February to each station. It is anticipated that we will then issue personal copies to staff. The plan has been extensively re-written to incorporate lessons learned following the 7th July Bombings.

- In November the new plan was tested when the service declared a major incident at the O2 Dome. This was a chemical incident involving a leak of chlorine. The service HART team assisted and we took 30 patients to hospital.

- Extensive planning for the Trust's response to the New Year celebrations in central London worked well on the night and the Trusts coped well with our busiest night of the year managing over 1825 calls in the period between midnight and 4am. The Trust worked closely with St John and Red Cross to ensure that the 700,000 capacity crowd in Central London were well cared for

and the impact on front line ambulance resources was minimised wherever possible. There were still some problems experienced with the capacity of the Airwave network and these issues are currently being addressed. The service response this year was very well led by ADO Killens.

- In January the service declared a further major incident following our attendance at a fire at the Royal Marsden Hospital in Fulham. We moved 80 patients to various hospitals in the area. The service received positive feedback from the hospital and politicians, as well as good media coverage. Several of our staff were amongst those from the NHS to meet both the Prime Minister and Prince William in the following days.

- The new Gold Command Suite is currently under construction on the site of the old communications department offices on the first floor at HQ. Completion date is mid February. This facility will be specifically for the management of Gold level issues, including performance and major incidents.

2. PATIENT TRANSPORT SERVICE

2.1 Commercial

Announcements of the successful bidders for Kingston Hospital (existing business) and Darrent Valley Hospital (new business) have been made. These have been awarded to OSL and an in-house bid respectively. Feedback in both cases has shown that we have scored highly in respect of quality and tender submissions, however, we have lost out on price. In the case of Kingston the winning bid was 30% lower than the bid submitted by the LAS.

Whipps Cross University Hospital (existing) is still to announce their award which is expected following their Trust Board meeting this January. The LAS is one of the final two bidders being considered for this contract.

A tender and subsequent presentation has been made to Richmond and Twickenham PCT (new) and we wait to be advised of their decision.

A further expression of interest has been made to Lambeth PCT following their recent tender notification in the European Journal.

2.2 HR

TUPE consultations have commenced with staff and new providers at UCLH and Kingston hospitals. The new providers will commence operation on 1 April 2008 in both cases. These consultations affect a total of 34 LAS staff in total.

2.3 Performance

Performance for Arrival Time, Departure Time and Time on Vehicle remained static in December at 88%, 91% and 93% respectively even though activity for the month increased.

3. HUMAN RESOURCES

3.1 Occupational Health and Counselling Services

On 1 December 2007 the contract for provision of occupational health and counselling services switched to Atos Healthcare. The new service includes a formal telephone assessment by a qualified occupational health advisor to determine whether a face to face to appointment is needed, and with whom. The transfer of services is still in the early, transitional stage, and was complicated by the Christmas and New Year holiday period, with some expected "teething problems". However, regular contract management meetings have been instigated, and the feedback from the representative of operational management at the first of these was that the initial reports on staff referrals have been positively received and have been very helpful.

3.2 Partnership arrangements

Following the review and renewal of the Partnership Agreement in the Autumn, a programme of joint events was launched with a Partnership Conference attended by around 100 managers and staff representatives in October. From this, an Operational Consultation Forum has been established involving senior management and staff side representatives. Initial meetings have been held fortnightly, and progress has been made on a range of issues including the agreement of a framework for the review of working patterns. Area level events have been held, hosted jointly by Assistant Directors and Senior representatives, and further presentations at station complex level are being planned.

3.3 Policy development

Minor amendments to the Trust's Disciplinary Policy and Procedure have been agreed with staff side.

In summary, the amendments are:

- Clarifying rights of representation for staff subject to investigation/disciplinary action;
- Improved guidance on matters to consider when deciding whether to suspend staff;
- Amending HR responsibilities in regards to staff being given a verbal warning;
- The right of dismissal being delegated to Assistant Director level;
- Improved guidance on the interface of the Disciplinary Policy with the responsibilities of individuals and the Trust in regards to professional bodies (specifically the Health Professions Council).
- The revised Policy will be published shortly.

3.4 Move to Higher Education

Plans to move to Higher Education Paramedic training are currently being developed through the Trust's Training Services Group. These plans are currently in the early stages and the Trust Board will be updated on progress through the training report to the Board in March 2008.

3.5 Healthcare for London

The Human Resources Director is currently a member of the NHS London Workforce and Education Strategy Reference Group and is fully involved in workforce development discussions progressing in light of potential developments in healthcare in London. She is working with NHS London on the workstream looking at out of hospital care together with a specific workstream concentrating on the LAS. The Trust is awaiting NHS London's response to our submission on training and education funding pressures though discussion continues to be positive.

3.6 Workforce Information

Sickness levels for November show a further rise in year and continue to be higher than levels last year. This raises cause for concern and priority will be given to the continuing monitoring of causes of absence and robust management. We will work closely with our new providers of Occupational Health to ensure timely and effective support for those absences requiring referral. The Trust Board will continue to receive regular updates on levels of sickness absence and any specific management issues.

Staff suspensions are being well managed and issued resolved within appropriate timescales. The Trust currently has two members of staff suspended from duty, both of whom are currently under police investigation.

Vacancies within A&E Operations have increased and are within the anticipated numbers. We are currently advertising externally to fill vacancies in addition to inviting bank staff to apply for permanent positions. The workforce plan for the year 2008/09 is being reviewed and will determine recruitment activity for the next financial year. This will be presented to the Trust Board in March 2008.

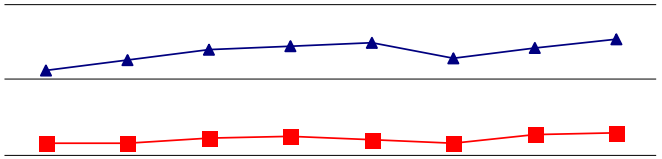
INTERIM WORKFORCE INFORMATION

Staff Turnover Jan/Dec 2007	
Staff Group	**Turnover %**
A & C	11.93%
A & E	4.64%
CTA	10.26%
EOC Watch Staff	12.38%
Fleet	12.73%
PTS	7.94%
Resource Staff	2.04%
SMP	6.42%
Grand Total	**6.32%**

A&E ESTABLISHMENT REPORT - December 2007				
Title	**Funded Establishment**	**Staff in post**	**Variance**	**Leavers**
Team Leader	169.50	162.19	7.31	0.00
ECP	56.00	53.56	2.44	0.00
Paramedic	910.89	814.40	96.49	3.43
EMT4	713.48	856.51	-143.03	5.00
EMT3	682.75	449.17	233.58	2.00
EMT2	0.00	146.91	-146.91	1.00
EMT1	30.00	33.00	-3.00	0.00
Total	**2562.62**	**2515.74**	**46.88**	**11.43**

Absence 2007	**Sept**	**Oct**	**Nov**
A & E Ops East	5.31%	6.78%	7.03%
A&E Ops South	6.35%	6.39%	6.58%
A&E Ops West	6.12%	6.32%	6.23%
Control Services	7.25%	7.19%	7.27%
PTS	6.76%	8.43%	8.24%
Trust Total	**5.80%**	**6.33%**	**6.47%**

Trust Sickness Levels
April/Nov 06 cf April/Nov 07



	April	May	Jun	July	Aug	Sept	Oct	Nov
2006/07	4.87%	5.59%	5.94%	6.00%	6.38%	5.62%	5.84%	6.20%
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%

SUSPENSIONS as at 07.01.08		**Date of Suspension**	**Reason**	**Stage in Investigation**	**Investigating Officer**	**Hearing Date**
East	1	11.9.07. Reviewed by letter 28.09.07. Told suspension remains in place while Police investigation progresses. Review letter 13.11.07 in view of being bailed.	Police Investigation.	Seen by Police 12.11.07 and rebailed until January 08.	To be confirmed.	
South	0					
West	0					
Control Services	0					
HQ/Fleet/Others	1	11.1.08	Police Investigation			

4. Communications

Media issues

Alcohol-related calls: Coverage at the end of November to mark the second anniversary of new licensing laws was followed by a number of local newspaper stories about the impact on crews in different boroughs across the capital. Subsequent to this, work was also carried out ahead of Christmas and New Year to once again raise awareness of the pressure placed on the Service by alcohol-related calls during the festive season.

A series of media ride-outs on the relaunched 'Booze Bus', as well as visits to special initiatives at Liverpool Street station and Croydon town centre, resulted in widespread coverage.

The main features included:

- Double page stories in the Daily Mail and The People newspapers
- News items on BBC London, ITV London Tonight and Five News
- Live radio interviews on BBC Five Live, the BBC London Breakfast Show and LBC
- A three-quarter page story in the Evening Standard.

Additionally, a number of local newspaper journalists also spoke to and observed crews in their local area, resulting in coverage in places such as Croydon, Poplar, Islington, Richmond and Twickenham and Kingston.

New Year: A Sky News reporter and camera crew also accompanied the 'Booze Bus' on the Service's busiest night of the year. The resulting coverage, in conjunction with a news release issued early on New Year's Day, subsequently led the channel's early morning news bulletins, while Assistant Director of Operations Jason Killens also attended their studios for a live interview about the impact of alcohol on the Service. He also carried out radio interviews with BBC London and LBC, and the story was covered extensively in national papers – including The Times, Daily Telegraph and the Daily Mail – as well as the Metro, Evening Standard and some local London papers.

Use of single responders: A BBC story about plans by ambulance services across the country to increase their use of single responders led to interest from London media. As well as coverage in the Evening Standard, Director of Operations Martin Flaherty also spoke to LBC radio as part of phone-in they were holding on the issue.

Serious incidents: There was significant media interest in a serious fire at the Royal Marsden Hospital earlier this month. Two members of the Communications Department attended the scene to support Deputy Director of Operations Russell Smith, who read a prepared statement to the assembled media about the Service's role in helping with the transfer of up to 80 patients to other hospitals, before giving live interviews to BBC 5 Live and LBC radio.

Arrangements were also subsequently made for staff to be present when both Prime Minister Gordon Brown and HRH Prince William made separate visits to the Brompton Hospital in the following two days.

A media statement was also issued following the deaths of three teenagers in a road traffic collision in south east London on New Year's Day.

Cardiac care: Reunions with two cardiac arrest patients were held in early December, and local newspaper coverage was subsequently secured – including one front page article – along with articles in the ambulance trade press.

Local news stories: Other media coverage has included an article about a member of staff based at Greenwich completing 40 years with the Service, the opening of the new base for Wembley Ambulance Station, a delayed response to an elderly patient who had fallen over on a bus in Hounslow and a piece about response times in Haringey.

NHS reconfiguration: The start of public consultation on reconfiguration proposals affecting hospitals in south east London has led to an increase in media enquiries about the potential impact on the Service. Support will also be given to local managers who will be attending public meetings in their areas.

Internal communication

New Ways of Working: Communications support has been provided to preparations for the launch of the 'New Ways of Working' clinical leadership initiative, including the design and production of an information booklet for distribution across the Service.

Patient and Public Involvement

Public Education Strategy

In November the Public Education Strategy Steering Group organised two workshops for staff involved in public education, which were attended by a total of 34 participants. There were four main sessions in the workshops: setting the context, targeting priority groups, effective communication, and materials and resources.

There were table discussions about (a) priority groups to target and (b) how to reach them, including the development of specific materials and resources for different groups. Participants had some good ideas and found the discussions useful.

One crucial element of the Public Education Strategy is the appointment of a Public Education Co-ordinator. Once it is known whether or not this post will be funded in 2008-09, the Steering Group will ensure that activities within the Strategy are planned using the ideas identified at the workshops.

London South Bank University have expressed an interest in supporting the development of the Public Education Strategy and the staff involved in this work. Discussions are currently taking place with them in order to take this idea forward.

Patients' Forum

The Director of Human Resources attended the December Patients' Forum meeting to discuss diversity in the LAS workforce. In January the Olympic Games Planning Manager attended the Forum meeting to present information about how the Service is planning for the 2012 Olympics and Paralympics.

Picker Europe Category C Survey

Following a number of focus groups and one-to-one interviews with patients who have received a Category C response, Picker Europe has now developed a national survey of Category C patients which will be carried out in May 2008. The LAS has been chosen to be one of the pilot sites for this survey; the pilot will be conducted in February. Through this work, Picker Europe aims to find out about patients' views and experiences of receiving a non-emergency response from the ambulance service.

Peter Bradley CBE

Chief Executive Officer

29th January 2008

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th January 2008

REPORT OF THE MEDICAL DIRECTOR

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

Since my last update to the Board four SUIs have been declared. Investigations are ongoing in three and have been completed in one, where the cause was established as human error. In this case an action plan has been completed and approved by SMG. One of the incidents has been downgraded in view of the clinical outcome for the patient but in view of the potential to learn lessons from the case the investigation is still ongoing.

The investigation into an SUI highlighted in my report to the November Board is still ongoing. We continue to work closely with the Metropolitan Police on this case.

Safety Alert Broadcasting System:

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

Twenty alerts were received during the period from 21st November to 15th January 2007. All alerts were acknowledged, seventeen required no action, action has been completed and the matter resolved in two and a further alert remains under investigation to ascertain its relevance to the Trust, as detailed below:

Date issued: 26/11/2007
Completion deadline: 26/02/2008; Rapid Response Report 4:

Fire hazard with paraffin based skin products on dressings and clothing (National Patient Safety Agency)

The three alerts deemed to be of relevance to the Trust in my November report have all been investigated and require no further action.

2. Second domain – Clinical and Cost Effectiveness

Update on Cardiac Care

i) Feasibility study into the provision of therapeutic hypothermia

The protocols for cooling obtunded patients who have a return of spontaneous circulation following resuscitation from cardiac arrest have been agreed with the receiving units (the Emergency Departments at Charing Cross and Hammersmith Hospitals). Training for the staff involved has taken place and the study will commence on 4th February 2008.

ii) Extension of ECG criteria for transfer to 'Heart Attack Centres'

All nine 'Heart Attack Centres' have agreed that patients with the 12 lead ECG appearance of left bundle branch block (LBBB) and a classical history suggesting myocardial infarction should be transferred for consideration of angioplasty, rather than taken to the nearest Emergency Department. This is a departure from previous practice as the presence of LBBB makes ECG interpretation difficult, and crews cannot generally determine whether the change is new or pre existing. This should increase the numbers of patients receiving primary angioplasty.

Update on Stroke Care:

Consultant Neurologists with an interest in acute stroke care will meet on 23rd January to discuss a pan London response. Dr Chris Streather, the NHS London lead on Stroke and members of the LAS Medical Directorate will also attend.

Clinical Update Newsletter

The December edition (issue 4) of the Clinical Update Newsletter focuses on Obstetric emergencies. It also includes information about and contact details for the Consultant Midwife Adviser to the LAS, who assisted in compiling this bulletin.

Copies of this bulletin will be available at the meeting.

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

A summary of the LAS Annual ST Elevation Myocardial Infarction Report (2006/07) is presented under Appendix 1. Points to highlight are the increased number of patients receiving primary angioplasty through conveyance direct to a cardiac catheterisation suite, the generally high, and increasing number of patients receiving appropriate therapy, including pain relief and the reduced in patient stay for this group. We are continuing to stress the importance of good documentation and the need to pass copies of 12 lead ECGs on to the Clinical Audit Unit, as well as the receiving units.

2. Third Domain – Governance

No items to report

4. Fourth Domain – Patient Focus

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

5. Fifth Domain – Accessible and Responsive Care

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

6. Sixth Domain – Care Environment and Amenities

Infection Control

Baseline Trust wide Infection Control Audit

The National Infection Control Policy 'Clean, safe care. Reducing infections and saving lives' was published on 9th January 2008. It includes the following requirements for all NHS Trust Boards:

- That they must ensure that they have effective systems in place to assure themselves that infection prevention and control is well managed in their organisations
- That there is a new mandatory requirement for quarterly reporting to Boards by matrons and clinical directors on cleanliness and infection control.

Following work with the DH and Healthcare Commission a Trust wide baseline audit has been undertaken. A snapshot of the findings, listing the areas audited and broken down by complex is included under Appendix 2 and 3.

This audit has previously been trialled in another ambulance service; it measures compliance against ten standards, including waste management, sharps disposal and vehicle cleanliness. Of the standards used only one, vehicles, addresses the environment that directly interfaces with patient care. However the spirit of the audit reflects the need expressed in 'Clean safe care,' to highlight the importance of cleanliness and infection control in all aspects of LAS activity.

The results of the audit will be discussed at the forthcoming meeting of the Infection Control Steering Group, to look at ways of improving compliance on every complex. Work has already commenced to identify common areas where compliance is poor and to address these. Further audits will be undertaken four times a year and we would hope to suggest ways of refining the current tool to increase its relevance to ambulance services.

Other Infection Control issues.

Recruitment of an Infection Control Coordinator is ongoing. This has proved a greater challenge than anticipated and the post is being advertised externally.

Labels are being purchased for cannulae sited by LAS staff outside hospital. This will allow hospital staff to re site these as appropriate, given the concern expressed over higher rates of MRSA bacteraemia associated with intravenous lines placed under less than ideal conditions.

7. Seventh Domain – Public Health

Pandemic Flu

The LAS Pandemic Flu plan is currently being updated in light of the DH 'Pandemic Flu – Guidance for Ambulance Services and their staff,' published in November 2007. The existing plan is largely focused on business continuity and requires more clinical detail. The Assistant Medical Director (Primary Care) is working with the LAS Flu Coordinator to expand this area.

Recommendation

THAT the Board notes the report

Fionna Moore,
Medical Director
20th January 2008

Appendix 1.

Summary of the ST Elevation Myocardial Infarction Annual Report: 2006/07

Authors: Dr Rachael Donohoe and Debbie Evans, Clinical Audit & Research Unit.

Introduction

Between 1st April 2006 and 31st March 2007 the LAS treated 808 ST-elevation myocardial infarction (STEMI) patients. Information for each of these patients was collected by the Clinical Audit & Research Unit (CARU) from Patient Report Forms (PRFs), Mobile Data Terminals and Emergency Operations Centre records. Where possible, patient outcomes were obtained from hospital records and national databases.

Key findings from the 2006/07 Annual Report are presented below. Further information can be found in the full version of this report which is available on request from CARU.

Key Findings

Patient details

The average age of the STEMI patient was 64 years (ranging from 20-98 years). The majority of patients were male (74%), who were on average 12 years younger than females (61 vs. 73 years respectively).

Response times

78% of STEMI patients were attended within the 8 minute target, an increase of 4% from 2005/06.

Time Interval	Average Time (minutes)	Range (minutes)
999 call* – arrival on-scene	7	1 - 29
Arrival on scene – arrive patient	1	0 - 41
Arrival on scene – leave scene	30	11 - 86

The average time spent on scene has increased progressively over the last 3 years from 25 minutes in 2004/05, to 27 minutes in 2005/06 and 30 minutes in 2006/07.

Pain assessment

An initial (pre-treatment) pain assessment was recorded on 96% of PRFs. A final (post treatment) pain assessment was recorded for only 86% of patients.

Aspirin

LAS crews administered aspirin to 81% (n=654) of STEMI patients. A further 17% (n=139) were not eligible to receive aspirin (7% had already taken it prior to LAS arrival and it was contraindicated for 10%).

2% of patients should have received aspirin, but did not - and there were no reasons for non-administration reported on the PRFs.

GTN

GTN was not administered to 26% of patients (n=28) and there were no reasons for this documented.

Conveyance Destination

All STEMI patients should be taken directly to a Cardiac Catheter Laboratory (Cath Lab) for primary angioplasty or have a clearly documented reason why this care pathway is not appropriate.

74% (n=598) of STEMI patients were taken directly to a Cath Lab. A further 12% were appropriately transported directly to A&E instead. However, 55 patients (7%) were taken to A&E when, according to PRF documentation, they should have gone directly to a Cath Lab.

Direct to Cath Lab	Unsure if taken to Cath Lab or A&E	Direct to A&E	
		With valid reason	Without valid reason
74% (n=598)	7% (n=61)	12% (n=94)	7% (n=55)

Conveyance Response Times

When patients were taken directly to a Cath Lab the journey times were, on average, only 6 minutes longer than the journey times to A&E.

	Number of patients^	Average Time (minutes)	Range (minutes)
999 call – arrival at Cardiac Cath Lab	587	53	21 - 104
999 call – arrival at A&E (call to door)	146	47	17 - 88

^ *Number of patients with both times available.*

Reperfusion Times

273 STEMI patients (34%) received primary angioplasty at hospital. The average time from the 999 call to receiving angioplasty was 101 minutes, 51 minutes of which were attributable to the hospital.

Seven STEMI patients received thrombolytic treatment. The National Service Framework for Coronary Heart Disease states that thrombolysis should be given within 60 minutes of the call for professional help. Three patients (43%) received thrombolysis within the 60 minute target. The average time from 999 call to receiving thrombolysis was 84 minutes.

Patient Outcome

Hospital outcome data was available for 354 patients, of which 89% (n=316) were discharged alive. The average length of hospital stay for patients who survived to discharge was 6 days.

Points for Action

Crews must be encouraged to facilitate data collection and the reporting of clinical care by:

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

Station:

Appendix two

SECTION ONE: KITCHEN STANDARD: Kitchen will be maintained to reduce the risk of cross infection	Yes	No	Comments
1. Evidence of a periodic inspection by the local manager (check signage/schedule).			
2. Separate dedicated hand washbasin is present.			
3. Liquid soap in the form of single use cartridge dispensers for Handwashing is available.			
4. Disposable paper towels and dispenser are available for hand drying.			
5. There are no nail brushes in use.			
6. All opened food is stored in pest proof containers.			
7. There is a clear policy to ensure out of date food is removed from the fridge.			
8. Fridge/Freezers are clean and free from ice build up.			
9. There is evidence that daily temperatures are recorded & appropriate action is taken if standards are not met. Fridge temp must be less that 8˚ C, freezer - 18˚ C.			
10. There are no inappropriate items stored in the kitchen.			
11. There is no evidence of infestation or animals in the kitchen.			
12. All cooking appliances are visibly clean.			
13. The kitchen surfaces and floor are clean and dry.			
14. Fixtures and fittings are in a good state of repair.			
15. Disposable paper towelling is used for cleaning and drying equipment and surfaces – not tea towels.			
16. Dish cloths or 'J' cloths are disposed of daily and pan scrubbers are routinely changed. All are stored correctly to dry & air.			

17. Food temperature probe is present and is clean and stored correctly.			
18. Waste bins are foot operated, clean and in good working order.			
19. All kitchen appliances are well maintained.			

SECTION TWO; ENVIRONMENT **STANDARD: The environment will be maintained appropriately to reduce the risk of cross infection.**	**Yes**	**No**	Comments
1. Evidence of a station cleaning schedule in place.			
2. The crew room is clean and uncluttered with no inappropriate items of equipment stored.			
3. Crew room floor surfaces are clean, dry and washable.			
4. All Crew room furniture is washable and in good state if repair (i.e. covers intact). Meal tables are not wooden surface.			
5. The allocation of locker/changing rooms is fit for purpose, uncluttered, clean and tidy.			
6. Fluorescent coats are clean and not visibly soiled & stored separately to personal clothing.			
7. All shower cubicles are clean and in good working order and the shower curtains are clean and free from mould. Tiles are intact and not broken or cracked			
8. Wooden equipment in wash areas such as chairs and **c**ork bath mats are not in use.			
9. Staff have their own personal wash equipment with no communal equipment in use.			
10. Liquid soap for handwashing is available, not bar soap.			
11. Nail brushes are not available for use.			
12. Paper towels for hand drying is available and stored in a wall-mounted dispenser.			
13. Female sanitary bins are well maintained and clean.			
14. Toilet areas are not being used to store items of clothing or equipment.			
15. Toilets and surrounding areas are visibly clean with no body substance, dust or lime scale stains, deposits or smears – including underneath toilet seats.			
16. All fixtures and fittings are serviceable and equipped.			
17. Water cooling machines are visibly cleaned and on a planned maintenance programme.			

SECTION THREE: WASTE DISPOSAL **STANDARDS: Waste will be disposed of safely without the risk of contamination or injury and within current guidelines.**	**YES**	**NO**	**Comments**
1. Foot operated bins are lidded, clean and in working order.			
2. Clinical waste bags/bins are used for the disposal of clinical waste only.			
3. There is evidence that staff segregate clinical waste and domestic waste correctly and not decanted from one bag to another.			
4. Full waste bags are less than 2/3 full and securely tied.			
5. Clinical waste is stored in a designated area prior to disposal.			
6. The clinical waste storage bin is clean, locked and inaccessible to unauthorised persons and pests.			
7. The clinical waste storage bin is large enough to contain the amount of waste generated.			
8. Clinical waste bags are labelled with source (station name) and dates.			
9. Collection of clinical waste is undertaken at least fortnightly with a registered company and consignment ticket kept available on station.			
10. Bag less general waste bins are emptied regularly, clean and are not over flowing.			
11. The general waste skip is not overflowing and the lid is closed and the area is clean.			
12. Re-cycling is undertaken and managed efficiently to reduce general waste.			

SECTION FOUR: SHARPS **STANDARD: Sharps will be handled safely to reduce the risk of inoculation injuries.**	**YES**	**NO**	**Comments**
1. Sharps boxes are available for use and conform to British standards BS7320 (1990)/ UN3291.			
2. Staff are aware of the sharps Policy & Procedures and can explain and demonstrate its content (ask staff).			
3. Staff are aware of the accidental Inoculation section of the Infection Control Reference Manual ask staff).			
4. Sharps boxes stored on station are free from dirt, dust and moisture.			
5. Sharps boxes are the correct size for use and assembled correctly – check lid is secure.			
6. Sharps containers are available at the point of use i.e. drugs and grab bags, also located within easy reach in vehicles.			
7. When in use, the appropriate sharps boxes are stored using correct facilities with lids secured properly using the temporary closure mechanism.			
8. Sharps containers are visibly clean with no body substances, dust, dirt or debris.			
9. There are no inappropriate items e.g. packaging or swabs in the sharps containers.			
10. Sharps are disposed of directly into sharps box following use by the practitioner only.			
11. When in use, sharps boxes are less than 2/3rds full with no protruding sharps.			
12. When in use, sharps boxes are correctly labelled with (station name, fleet number and/or bag number), dates and signed.			
13. There is no evidence of sharps boxes being decanted from one container to another.			
14. There are no used sharps boxes left around the site awaiting disposal.			

SECTION FIVE; SLUICE ROOM **STANDARD; The sluice room environment will be well maintained to reduce the risk of cross infection and contamination.**	**YES**	**NO**	**Comments**
1. The sluice room is clean, dry and free from spillages.			
2. All items of equipment are stored above floor level and if likely to become dirty, wet or dusty are stored in lidded containers.			
3. No clean laundry present.			
4. Equipment used for decontaminating is disposable, well maintained, and suitably stored.			
5. Disposable paper towels are provided for hand drying and to dry equipment.			
6. Personal Protective Equipment is supplied for staff to wear when decontamination equipment e.g. plastic aprons, disposable gloves and eye protection.			
7. Liquid soap and alcohol hand rub in the form of single use cartridge dispensers for Hand hygiene is available.			
8. There is no evidence of single use items being reused.			
9. Data sheets are available for detergent/disinfectant in use with appropriate dilution chart.			
10. Enclosed foot operated bins are in good working order and surface area is clean.			
11. Mop & Bucket colour coding information sign displayed.			
12. Evidence of Mop & Bucket colour coding system being followed.			
13. Mops and Buckets are stored clean, dry and inverted.			

SECTION SIX: CLEANERS CUPBOARD STANDARD: The cleaners Cupboard environment will be well maintained to reduce the risk of cross infection and contamination	YES	NO	Comments
1. The cleaner's cupboard is clean and free from spillages.			
2. All items of equipment likely to become dirty, dusty or wet are stored in lidded containers and above floor level.			
3. Equipment used by the cleaner is clean, well maintained and suitably stored.			
4. Mops and buckets are stored clean, dry and inverted.			
5. The cleaner has supplies of Personal Protective Equipment and is stored separately from personal clothing.			
6. The cleaner is aware of the infection control Policy and the Infection Control Reference Manual			
7. The cleaner is following best hand hygiene practices.			
8. The cleaner has a copy of the COSHH reports on the chemicals they will be coming across and using.			
9. The cleaner has a copy of the Mop & bucket colour coding system in place.			
10. Evidence that the Mop & Bucket colour coding system is being used throughout the Station.			
11. There is a cleaning schedule for the site and is in use.			

SECTION SEVEN: LINEN **STANDARD: Linen is handled appropriately to prevent contamination and cross infection.**	**YES**	**NO**	**Comments**
1. Used linen is segregated into appropriate bags e.g. soiled in alginate bag.			
2. Bags are less than 3/4 full and are capable of being secured.			
3. Full used laundry bags are stored in the utility room/sluice or garage area prior to disposal.			
4. Used linen is not re-handled by staff once bagged.			
5. Clean linen is stored in a suitable clean area (not utility/sluice room).			
6. Hand washing is carried out by staff after handling used linen.			
7. Evidence of Personal Protective Equipment when handling used linen, such as disposable gloves, plastic aprons are available for staff.			
8. Clean linen is put into clean storage on arrival at the station and not left sitting in the garage/sluice room or corridors.			
9. Clean linen when in storage is appropriately covered to prevent getting dusty/dirty.			
10. Alginate stitched bags are readily available.			
11. Disposable red plastic bags are readily available.			
12. Appropriate linen signage with information for staff to follow is adequately displayed.			

SECTION EIGHT: GARAGE **STANDARD: The garage & vehicles will be maintained appropriately to reduce the risk of cross infection and contamination.**	**YES**	**NO**	**Comments**
1. The garage is clean, tidy and well maintained.			
2. Clinical waste is disposed of in a correctly identified, foot operated enclosed bin.			
3. General waste is disposed of in a correctly identified, foot operated enclosed bin.			
4. Mops & Buckets being used are to the colour coding system.			
5. Mops and Buckets used to clean vehicles are clean and in good condition.			
6. Mops and Buckets are stored clean, dry and inverted.			
7. Fresh clean solution for mopping is used for each vehicle.			
8. Consumable stores are put away and not left out gathering dust.			
9. The garage is free from infestation of birds and pests.			
10. Oil & fuel spills are dealt with directly.			
11. The garage is not being used to store Inappropriate items.			
12. Different sized yellow clinical waste bags are available for garage bins and vehicle bins.			
13. The vehicle wash area is clean and tidy and the drains are clear.			

SECTION NINE: GENERAL **STANDARD: These criterions will be maintained to reduce the risk of cross infection and contamination.**	**YES**	**NO**	**Comments**
1. Equipment is clean and in good state of repair. Defective equipment is logged and where appropriate, stored correctly and safely.			
2. Single use items are not reused.			
3. There is evidence that staff are aware of decontamination being completed before sending equipment/vehicle away for repair or maintenance.			
4. There is evidence that staff are aware of Defecting equipment, sending for repair/maintenance & the decontamination certificate being attached.			
5. Equipment being stored is visibly clean with no visible body substances, dust, dirt or debris.			
6. Patients transported by crews are done so following precautions as per standard (universal) precautions. (Ask crews)			
7. Staff are aware of the correct procedures when dealing with blood/body fluid spillages. (Ask Crews).			
8. Staff have received training on the principles of hand hygiene. (Ask Crews).			
9. Appropriate disinfection and dilution charts are available to deal with blood/body fluid spillages.			
10. Blood/body fluid **s**pillage (Bio-Hazard) kits are available.			
11. Disposable gloves, plastic aprons and face protection are readily available.			
12. Signage demonstrating a good hand washing technique is available at strategic points around Trust site.			
13. Hand moisturisers that are pump operated are in place for clinical staff to use at hand washing facilities.			
14. There are fully operational foot operated bins for waste paper towels in close proximity to hand wash sinks.			

SECTION TEN: VEHICLES **STANDARD: These criterions will be maintained to reduce the risk of cross infection and contamination.**	**YES**	**NO**	**Comments**
1. All vehicles are clean; dust free and the interior is well maintained, in good condition to ensure the fabric of the environment and equipment smells fresh and pleasant.			
2. The floor, including edges and corners are visibly clean with no visible body substances, dust, dirt or debris. Floor coverings are washable and impervious to moisture.			
3. Alcohol hand rub is available on all vehicles at the point of care.			
4. Skin cleansers (wet wipes) are available for visibly soiled hands prior to using alcohol hand rub.			
5. Stretcher mattresses and chair covers are clean and free from rips and tears.			
6. Stretcher mattresses are regularly cleaned with both warm water and detergent or appropriate wet wipes between patient use. (Ask Crews).			
7. When used, linen is changed after every patient. (Ask Crews).			
8. All items of equipment are stored away clean, dry and correctly during and at the end of the shift.			
9. Suction equipment is visibly clean and dry with no visible body substances, dust or debris.			
10. Clinical waste bags are renewed as appropriately after every patient and definitely at the end of the shift.			
11. Sharps boxes are readily available in grab bags and designated areas of vehicle.			
12. Sharps box lids are closed and stored above floor level & Safely out of the publics reach.			
13. Sharps boxes are not more than 2/3rds full.			
14. Sharps boxes are correctly labelled with start date, Station name, Fleet and/or bag number.			
15. Vehicles are equipped with blood/body fluid spillage (Bio-Hazard) kits.			
16. Detergent spray & surface wet wipes are stored on the vehicle.			

17. Disposable paper towels are evident on the vehicle.			
18. Disposable protective hooded overalls are stored on the vehicle.			
19. Disposable plastic aprons are stored on the vehicle.			
20. Disposable face masks are stored on the vehicle.			
21. Disposable medical gloves are stored on the vehicle.			
22. All tubing and equipment designed to come into contact with blood/body fluid is single patient use and disposable.			
23. Ventilator and Entonox equipment Bacterial filters are used.			
24. Body bags are stored on the vehicle.			
25. Rinse Wash Rinse kit is stored on the vehicle and package intact.			
26. Mop & Bucket colour coding system is evidenced as being followed by staff when cleaning vehicles.			

London Ambulance Service
NHS Trust

INFECTION CONTROL AUDIT TOOL

AUDIT SUMMARY

STATION NAME: ……DATE:…../……../……..

AUDIT UNDERTAKEN BY: ……..

NAMED PERSON RESPONSIBLE FOR INFECTION CONTROL:……..

1. KITCHEN	**……% COMPLIANCE**
2. ENVIRONMENT	**……% COMPLIANCE**
3. WASTE MANAGEMENT	**……% COMPLIANCE**
4. SHARPS	**……% COMPLIANCE**
5. SLUICE ROOM	**……% COMPLIANCE**
6. CLEANERS CUPBOARD	**……% COMPLIANCE**
7. LINEN	**……% COMPLIANCE**
8. GARAGE	**……% COMPLIANCE**
9. GENERAL	**……% COMPLIANCE**
10. VEHICLES	**……% COMPLIANCE**

ACTION PLAN
To be completed by:
Date: ……

Overall Compliance	**%**

Note: To calculate your score, multiply the numbers of 'yes' answers by 100. Then divide this number by the number of questions in the audit section to reach compliance %. Overall compliance is to multiply the totals scored by 100 and divide by 10.

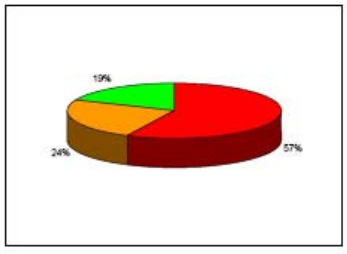
Overall Compliance compared across 3 areas, East, West and South

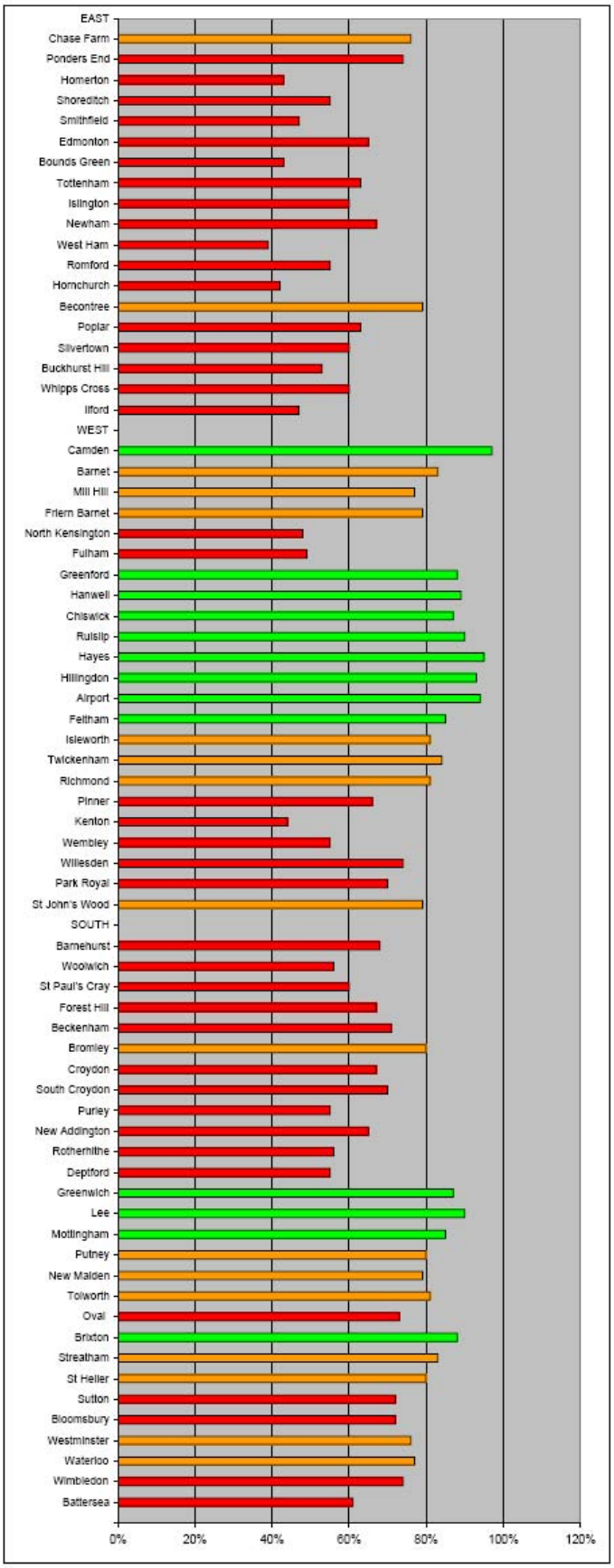
Appendix Three

Overall Compliance

EAST	
Chase Farm	76%
Ponders End	74%
Homerton	43%
Shoreditch	55%
Smithfield	47%
Edmonton	65%
Bounds Green	43%
Tottenham	63%
Islington	60%
Newham	67%
West Ham	39%
Romford	55%
Hornchurch	42%
Becontree	79%
Poplar	63%
Silvertown	60%
Buckhurst Hill	53%
Whipps Cross	60%
Ilford	47%
WEST	
Camden	97%
Barnet	83%
Mill Hill	77%
Friern Barnet	79%
North Kensington	48%
Fulham	49%
Greenford	88%
Hanwell	89%
Chiswick	87%
Ruislip	90%
Hayes	95%
Hillingdon	93%
Airport	94%
Feltham	85%
Isleworth	81%
Twickenham	84%
Richmond	81%
Pinner	66%
Kenton	44%
Wembley	55%
Willesden	74%
Park Royal	70%
St John's Wood	79%
SOUTH	
Barnehurst	68%
Woolwich	56%
St Paul's Cray	60%
Forest Hill	67%
Beckenham	71%
Bromley	80%
Croydon	67%
South Croydon	70%
Purley	55%
New Addington	65%
Rotherhithe	56%
Deptford	55%
Greenwich	87%
Lee	90%
Mottingham	85%
Putney	80%
New Malden	79%
Tolworth	81%
Oval	73%
Brixton	88%
Streatham	83%
St Heller	80%
Sutton	72%
Bloomsbury	72%
Westminster	76%
Waterloo	77%
Wimbledon	74%
Battersea	61%

Minimal Compliance (75% or less)	46
Partial Compliance (76% - 84%)	17
Compliant (85% or above)	13





Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 29th January 2008

THREE YEAR SERVICE PLAN

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

On 15/1/08, the LAS submitted the first draft of the Three year Service Plan to NHS London. The final submission is due to the SHA on 29/2/08. The plan currently is under internal review with an objective to submit a final plan for review at the Service Development Committee on 26/2/08.

4. Recommendation

THAT the Trust Board

1. NOTE the contents of the first draft of the Three year Service Plan submitted to NHS London.
2. DELEGATE approval of the final draft of the 3 year Service Plan to the Service Development Committee on 26th February 2008.

Appendix 2
Annual Plan Commentary Template

NHS London

Provider Agency

1. Past year performance
   1.1. Chief executive's summary of the year
   1.2. Summary of financial performance
   1.3. Other major performance issues
2. Future business plans
   2.1. Strategic overview
   2.2. Achievement of FT status
   2.3. Service development plans
   2.4. Operating resources required to deliver service development
   2.5. Service Line Reporting
   2.6 Investment and disposal strategy
   2.6. Summary of key assumptions
3. Risk analysis
   3.1. Financial risk
   3.2. Governance risk
   3.3. Risk to services provided
   3.4. Quality and safety risk
   3.5. Other risks
4. Declarations and self-certifications
   4.1. Board statements

1. Past year performance

1.1. Chief Executive's summary of the year

Chief executive's summary of the year

1.1.1 **Introduction**

1.1.2 This Service Plan for 2008/09 identifies what the London Ambulance Service NHS Trust (LAS) will strive to deliver for its patients and the public of London during the year. Alongside immediate performance challenges this is the third year of the seven year Strategic Plan for the organisation. The Strategic Plan sets direction in the wider context of developments in the NHS in the fields of emergency, urgent and out of hours care. It outlines what the LAS will strive to deliver for its key stakeholder groups, following extensive consultation with them, culminating when the Olympics come to London.

In order to drive forward service improvement and modernisation in the future the Strategic Plan maps the route to achieving the LAS Vision, Purpose and Values, translating these into tangible outcomes and programmes of work to deliver them:

A world class ambulance service for London

*An organisation of well-trained, enthusiastic, caring people who are **all** recognised for their dedication to meeting the needs of the public and **all** our patients*

The focus of the year 2007-08 has been to maintain and in some cases improve performance while preparing for the change to call connect time that comes into force in April 2008 (see section 2.1). This Service Plan aims to ensure sustainable category A and B performance building on a track record of achieving Category A but not Category B in the context of having been resourced to achieve the former but not the latter. Additionally a long term growth in call volumes of circa 3% to 4% per annum and the continuing need to prepare for terrorist attacks on the Capital places increasing demands on the Service. Only by developing alternative responses can the LAS manage a growing number of 999 calls, meet commissioners' requirements and existing and new response time targets in a tight financial environment..

The Service Plan aims to carry forward Government policy for the provision of emergency, urgent and out of hours care, specifically building on the NHS core principles documented in the Government's 10 year NHS Plan published in 2000, the NHS planning and governance framework "Standards for Better Health" published in July 2004, the Department of Health's National Ambulance Review "Taking Healthcare to the Patient: Transforming NHS Ambulance Services" published in June 2005 and the Health White Paper "Our Health, Our Care, Our Say" published in February 2006 and most recently Lord Darzi's 2007 report "Healthcare for London: A Framework For Action".

The key stakeholder groups who have been consulted are: patients and public; Primary Care Trusts; NHS partners; police and fire services; LAS staff; Department of Health and the Strategic Health Authority ; the Greater London Authority and London Boroughs; and key suppliers. Discussions with patients, unions, commissioners and other stakeholders are ongoing while the feedback received during the Chief Executive's consultation meetings with staff is influential in planning

for the forthcoming year. This broad consultation has helped the Board identify priorities for future years.

1.1.2 Review of 2007/08 - achievement against the Service Plan

The 2007/08 Service Plan was focused on delivery of two aspirations for the London Ambulance Service:

- To improve the delivery and outcomes of services for our patients and the public;
- To ensure that change is sustainable through investment in Organisational Development.

These aspirations informed the key objectives for the Senior Management Team and definition of the five component parts of the overall Service Improvement Programme (SIP2012) through which the Strategic Plan is being implemented (see sections 2.1 to 2.3). The remainder of this section reviews achievement against key objectives for 2007/08.

In year Performance

1. Response time targets

High levels of demand continued in 2007/08 forecast to out turn for the year at circa. 10.3% above the overall demand for 2004/05. Category A demand is forecast to be 48% higher than in 2004/05. These increases in Category A demand are especially challenging as they place more and more calls in the 8 minutes response bracket. With the advent of the new call connect target in April 08 the response time clock effectively starts some two minutes earlier which further adds to the complexity of the task)

During 2007/8 PCTs also provided part year funding for the new call connect target and the LAS has made good progress against the trajectory submitted to DH for this target raising performance on this measure from 43%in Dec 06 to 64% in October 07.

Performance against the main response time targets for 2007/08 year to date is:

	Response Time Target	Actual As At: 14/01/08
Current A8	75% in 8 minutes of address & key determinant	79.1
Connect A8	75% in 8 minutes of telephone operator call connect to control room (From April 2008)	60.7%
Current A19	95% in 19 minutes of address & key determinant	98
Connect B19	95% in 19 minutes of telephone operator call connect to control room	84.5

For many years the London Ambulance Service has worked under pressure. There have been occasions, e.g. winter pressures, when the LAS has produced a specific plan to deal with anticipated capacity issues. The response by the LAS to the threat to performance levels was to produce a new Capacity Plan which triggers specific measures when the Service is operating at 'over capacity' with a variety of tactical options that are considered most suitable to deal with the over-capacity situation.

The tactical options that may be considered are identified in the Resourcing Escalatory Action Plan (REAP) which is designed to increase operational resourcing in line with demand, to cope with periods of high pressure and maintain the quality of patient care. The REAP plan is in operation at all times. In general the organisation will operate at REAP level one, when the Service is at a steady state.

There are varying REAP levels reflecting increasing pressure on the Service, up to level five, where there is the potential of Service failure. Each level is triggered by intelligence from inside the Service or from the external environment. The triggers are detailed in the LAS Capacity Plan. The REAP plan and the REAP levels apply to the whole organisation. The prevailing level is widely publicised.

Each operational manager and head of department has a responsibility to understand the plan and to have a corresponding implementation plan for their area of operation. All areas of the Service are required to take meaningful action, with the appropriate urgency, as the plan escalates. During 200/08 the Service has at varying times been operating at REAP levels 2 and 3 to address the threat to performance.

The Category B19 target remains very challenging and inevitably progress against this has been hampered by the need to maintain Category A performance in the face of significant demand growth. That having been said the service has made some significant improvements in this area and these are expected to improve still further during the final quarter.

2. Financial Balance

A surplus of £1.1m is for 2007/08 is currently being forecast by the Trust.

In addition, the Trust has received an additional £8.3m in Dec, 2007 from NHS London to invest in a range of Invest to Save projects in Q4 2007/08.

Preparing for the Future – The Service Improvement Programme

The implementation programme to prepare the LAS for the challenges of the longer-term future comprises of five sub-programmes and an enabling Stakeholder Engagement and Communications Strategy which is described in section 2.3. Developments during the year in relation to each of these are as follows:

Access and Connecting (the LAS) for Health –

The focus of this programme was on progressing work to procure a new Computer Aided Despatch system. To date, a shortlist of two suppliers has been identified and work is underway to select the final supplier for presentation of a Business Case in the next Financial Year. A second key project has been the development of the digital radio project in response to shortcomings in communications identified in the

aftermath of the terrorist attacks of July 2005. Work has commenced to scope requirements for improving access to the Service for people with hearing and speech difficulties or for whom English is not their first language. Work has also commenced on a project to develop a Data Warehouse for the Trust to better manage trust data and provide a platform for other infrastructure enhancements.

Improving our Response: Operational Model -

A large number of projects has been undertaken during the year to place the Trust in a better position to maintain response time performance when Call Connect changes come into being in April 2008. In particular, initiatives have been undertaken to make the fleet more mobile through dynamic deployment, positioning vehicles in location where it is anticipated calls will be made rather than starting from station and increasing the number of solo response units. Other key projects have been the automatic despatch of Fast Response Units and Ambulances upon identification of address and key complaint determinant which has had a significant impact on activation time of vehicles and hence made a contribution to response time.

Organisation Development And People -

Focus this year has been on identifying and scoping those initiatives necessary to bring about culture change and new ways of working for implementation in 2008/09. Particular focus has been on agreeing a new Partnership Agreement with the unions with the aim of enabling agreement on a number of initiatives progressed through the other programmes, for example the Dynamic Deployment of all vehicles and staff.

Corporate Processes and Governance -

A number of projects aimed at improving efficiency and effectiveness in support functions have been initiated, aimed at achieving the Cost Improvement programme agreed for the Trust. A variety of Governance initiatives have also commenced, specifically an approach in tandem with Commissioners to pilot an approach to Payment By Results and consideration of the implications of applying to become a Foundation Trust and the necessary action to be taken in preparation.

Preparing for the 2012 Olympics –

As a key player in supporting the London Olympics games in 2012. the LAS has initiated a programme to gear itself up for the substantial increase in demand for its services anticipated as a consequence of the huge influx of people to London during the run up to, during and in the aftermath of Games time. Scoping work has led to thirty projects being initiated during 2007/09 and a lot of effort has been put into working with the Olympic and security authorities on behalf not just of the ambulance services involved, but also to represent the voice of Health.

Stakeholder Engagement and Communications Strategy -

Clearly such a large programme of work requires interaction with a wide variety of stakeholders. Among other initiatives two major PPI events in March 2008 are planned. Ongoing consultations have taken place with staff, other emergency services and parts of the NHS as well as the SHA and Department of Health.

Plans have also been influenced by a major research project carried out by IPSOS Mori into public views of the Service.

The key tasks for the Trust in 2008/09 remain: to meet the call connect target from April and throughout the year; to maintain financial balance while increasing efficiency; to progress the new

Service Improvement Programme in circumstances of financial stringency and ever increasing demand - in particular the Trust is planning to embark on the most major organisational change activity it has undertaken to implement "New Ways of Working" on the first three ambulance complexes (see section 2.3). This involves not only changes to the response regime but also how the front-line workforce is managed and operated in teams. This will roll out to the remaining twenty three complexes over the period up to 20010/11.

The Trust is actively considering Foundation Trust status in conjunction with The Department of Health, Monitor and the London Provider Agency.

Also, the Trust is progressing strategic discussions with NHS London on a range of reconfiguration issues for the capital, including the setting up of co-ordinated response hubs for emergency health needs.

1.2. Summary of financial performance

Summary of financial performance: commentary

The Trust is currently forecasting a surplus of £1.1m for 2007/08.

Income is higher than plan due to Call Connect (£6.8m), Invest to Save (£8.2m), HART (£1.3m) and Olympics 2012 funding (£0.6m)

On cost, the comparison in the table is based on the original plan submitted to the LPA last year. This plan had an incorrect split between Pay and Non Pay. In reality, both the Call Connect and HART funding received were invested in increased staffing (£8m). The balance of the increase in costs relates to Invest to Save projects in Q4 2008/09.

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

£m	**2007/08 plan**	**2007/08 forecast***	**Variance**
Income			
Clinical income	216.2	223.3	7.1
Non-clinical income	1.1	0	-1.1
Other income	1.7	12.7	11.0
Total income	219.0	236.0	17
Expenses			
Pay costs	166.6	168.84	2.24
Non-pay costs	41.4	56.44	15.0
Other costs	0.0	0.0	0.0
Total costs	**208.0**	**225.3**	**17.3**

EBITDA	11.0	10.7	-0.3
Exceptional items	11.0	9.6	-1.38
Net surplus/(deficit)	0.0	1.1	1.1

*Based on month 9 actual plus 3 months forecast initially

1.3. Other major performance issues

Other major issues

1.3.1 Staff Engagement

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

The seventh annual series of Chief Executive consultation meetings face to face with staff at each complex took place in April - June 2007. A new Partnership Agreement with the unions was agreed following a Partnership Conference held in October. Regular internal conferences for managers and team leaders continue to be used to share key messages and information and to reiterate the importance of the LAS values.

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

1.3.2 Diversity and Public and Patient Involvement

The London Ambulance Service is committed not only to meeting its statutory obligations to equality and public and patient involvement legislation, but also to the spirit behind these and wants to go beyond mandatory obligations.. The Trust has particular challenges in engaging public and patients generally within the various diverse communities in the geographical area it covers given that it is the only London-wide Trust. These are challenges are pro-actively and creatively being addressed (see section 2.3).

2. Future business plans

2.1. Strategic overview

Strategic overview, incorporating turnaround and reconfiguration

2.1.1 Drivers for Change

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

Policy drivers

The LAS has a key role to play in supporting the NHS in achieving the Government objectives and targets identified in the various published policy documents (see section1). Many of these depend on taking a whole system approach, with each organisation – including the LAS - playing its part in delivery, with local sharing of performance and financial data and involving front-line staff.

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

The key national target for the LAS remains maintaining response time performance of reaching 75% of patients with conditions prioritised as Category A in eight minutes. The LAS must also concentrate on other national targets (Category A19, Category B19) as well as improve performance against clinically focused indicators. However as a consequence of the National Ambulance Review it has been decided by Government that:

- as from April 2008 for the purposes of measuring 999 Category A and Category B response times the clock should start when the call is connected to the ambulance control room to more closely match the patients' experience and to ensure consistency across the country;
- by April 2009 national performance requirements for Category B response times should be replaced by clinical and outcome indicators against which performance should be managed locally;
- as from April 2007 the performance requirements for responding to patients whose GP calls an ambulance on their behalf (GP Urgents) should be the same as for 999 calls.

These changes on top of the existing national targets present challenges for the LAS to achieve. In November 2005 the difference between existing and new Category A performance was about 25-30% percentage points (ORH Modelling November 2005). A comprehensive programme of activities is in place to improve performance against the new target and include improvements in the control room processes involved in taking and managing the call as quickly as possible coupled with many improvements to the operational response regime. Subject to securing appropriate ongoing funding we are confident that these will place the trust in a position to reach

the new targets for the month of April 08 and to be able to maintain this for the 2008/09 year and beyond. (see section 2.3).

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

- High case completion at point of both telephone contact and physical contact;
- Reduced duplication;
- Localisation - embedded with primary care and community services;
- Flexible and highly empowered workforce as the key to cost efficiency.

The implications for the LAS are that approximately 200,000 fewer patients per annum will be taken to hospital Accident and Emergency departments than would otherwise have been taken. A new approach to patients, callers and the public is necessary, requiring changes in vehicle, skill and workforce mix (with increasing focus on solo first responders), training and education, roles, responsibilities and relationships, information management and technology as well as structure and operating arrangements. This Service Plan for 2007/08 progresses the approach the LAS is taking to these challenges in order to realise in London the benefits defined by the National Ambulance Review.

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

Significant aspects of the White paper potentially are:

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

a re-think on the closure of community hospitals;

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

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

Lord Darzi's autumn 2007 report "Healthcare for London: A Framework For Action" proposes fundamental change in the pattern of acute trust service provision. This will have an effect on the ambulance service and the LAS is also crucial to the success of the reforms which are currently out to consultation. The LAS welcomes the recommendation that seriously ill and injured patients be treated at a smaller number of specialist centres – which carries further the LAS' existing policy of taking patients with confirmed myocardial infarctions to regional heart attack centres. Doing the same for patients with strokes and serious injuries will lead to better clinical outcomes. It may also have resource implications for the ambulance service if response times are to be maintained. At the same time, there will be more

community-based options for patients in or near their homes, to which the LAS hopes to have access. The LAS also hopes to be involved in work to bring more coherence to the systems for patients to access urgent help by phone.

This Service Plan, and many core activities, link to these principles, policy objectives and targets. It is designed not only to maintain performance against the Core Standards documented in "Standards for Better Health" but also to make demonstrable progress against the Developmental Standards. These are used by the Healthcare Commission to determine the Trust's annual performance rating and as such are essential to move towards Foundation status should this be required (see section 2.2). For 2005/06 the LAS was given a scoring of Weak on quality of care the 2006/07 rating was good on quality of care and good on use of resources, the LAS being the only ambulance service in the country to be rated "good and good"..

Operating environment drivers

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

1. *Stakeholder feedback to the Trust* on what they want it to deliver to them over the forthcoming years (see section 2.1.2);
2. *The requirements of Primary Care Trust commissioners* that the LAS:
    - assist them in preventing unnecessary hospital attendances through alternative methods of responding to 999 calls;
    - assist in the management of chronic diseases outside of hospital and meet response time targets in an environment of zero growth in funding;
    - provide more equitable performance across London;
    - more effectively integrate with the wider health economy and play a full part in local emergency care networks.
3. *The consequences of demand growth and the impact of developments in Out of Hours (OOH) provision as a consequence of GPs no longer being required to provide OOH cover, following on from new GP contracts;*
4. *The need to respond to population and visitor growth, particularly in the Thames Gateway area and the substantial increase in passenger throughput at Heathrow as a consequence of Terminal 5. Three main issues arise from this: the impact on relative PCT contributions to the LAS; resource requirements; and the potential to develop new models of care;*
5. *Opportunities for co-location with PCT facilities when they consider new builds to realise service and cost benefits and the potential for new models of care;*
6. *The need to further develop and deliver new locally agreed Category C outcome measures for specific disease groups in response to abolition of the national response time target for Category C patients;*
7. *Any possible requirement for PCTs to divest themselves of their provider functions presents a potential opportunity to form closer association with other healthcare professionals such as District Nurses who bring the NHS into peoples homes and external providers;*

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

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

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

Internal LAS drivers

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

A balance needs to be struck between focus on current performance and development for the future. The challenge for the Trust is to move to a position as quickly as possible whereby it manages demand differently. The Strategic Plan 2006/07-2012/13 maps the long-term route. This Service Plan maps the steps in 2007/08 along the way.

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

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

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

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

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

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

- co-ordinate response to additional Out of Hours demand (that is undertake a wider call taking and tasking role for other healthcare providers) and/or;
- manage services currently provided directly by Primary Care Trusts which have synergies with the current service portfolio, should the latter decide or be required to relinquish management of such provision;
- be in a position to apply for Foundation Trust status (see section 2.2).

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

- re-define itself as a provider of urgent care in London as much as it is a provider of emergency care, and demonstrate to partners and the public that it is of equal significance to the health service in this respect;
- develop an organisation which "responds appropriately to all our patients" whether their need is of an emergency or urgent nature.

The strategic direction will be implemented through the five programmes that make up the overall service improvement programme "SIP 2012" as outlined in section 2.3 and this Service Plan is intended to progress these programmes and other identified objectives in 2007/08.

High-level financial and investment implications of the proposed strategy

See sections 2.4. 2.5 and 2.6

2.2. Achievement of FT status

Actions identified to achieve FT status

The LAS is actively considering an FT application at Trust Board level.

Preparatory analysis is being undertaken to assist an application process, particularly in the area of membership and financial planning.

The LAS has been selected to be a pilot site for the FT process for ambulance trusts. The LAS is also running a pilot for PbR for ambulance trusts in 2008/09.

2.3. Service and workforce development plans

Service development plans

2.3.1 Transformational Change - implementation programme 2006/07

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

Programmes

1. *Access and Connecting (the LAS) for Health* - covers not only access to LAS services by patients and the public but also Connecting for Health. Access/connectivity/information flows within the LAS and between it and partners, led by the Director of Information Management and Technology. In 2008/09 the focus will continue to be development and implementation of the large infrastructure projects CAD2012, digital radio (LARP), Data Warehouse along with improved computer network enhancements for resilience and Access for Speech and Hearing Impaired People (see section 1.1.2).

   The focus of this programme has been work to procure a new Computer Aided Despatch system. The current status of the procurement is that two suppliers have been invited to participate in the final stage of the competitive dialogue process. It is anticipated that a preferred supplier will be selected, the Full Business Case approved by the SHA and a contract placed by the Trust Board in the next financial year. A second key project has been the development of the digital radio project. Its full implementation will address the shortcomings in communications identified in the aftermath of the terrorist attacks of July 2005. In support of a national initiative, work has commenced on a project to improve access for people with hearing and speech difficulties. Other projects will be developed to enhance the Data warehouse (improved use of data within the Trust), network enhancements, support Operational initiatives for new ways of working and improve the IT infrastructure.

2. *Improving our Response: Operational Model* - covers the comprehensive review of our operational response regime. It includes significantly improving processes and management within our emergency Control Rooms, coupled with the introduction of additional Fast Response Units and also improving the way in which all our vehicles are deployed to ensure that they are always geographically placed in the optimum positions to reach patients as quickly as possible. Finally it also involves developing a comprehensive clinical telephone advice system backed up by an urgent care fleet designed to minimise unnecessary emergency responses.(see section 1.1.2 and 2.3.2).

3. *Organisation Development And People* - covers Organisation Development, culture, HR strategy, education and training (clinical and non-clinical), Diversity and workforce skill mix (including recruitment and retention) and IR, led by the Human Resources Director. In 2008/09 the focus will be on defining and starting the implementation of the changes to working practices envisaged to go alongside the shift to more solo responding under the Operational Model, in particular moving to a genuine team based watch system (see section 2.3.2).

4. *Corporate Processes and Governance* - covers Corporate and Clinical Governance and development of all corporate management processes, led by the Director of Finance. In 2008/09 the focus will be on implementation of the work started in 2007/08 regarding Governance of the Trust (e.g. Payment By Results pilot, preparation for Foundation Trust status and development of a Balanced Scorecard method for performance management) along with new cost saving initiatives to achieve the efficiency savings expected through the Cost Improvement Programme (see section 1.1.2).

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

Enabling Support Strategy

6. *Stakeholder Engagement and Communications Strategy* - covers relationships with external stakeholders and their involvement with the LAS especially Patients and the Public (PPI) but also other healthcare professionals, emergency services, social services, key suppliers etc., led by the Director of Communications. In 2008/09 the focus will be on PPI and other communication and engagement activity associated with the Operational Model and Organisation Development work collectively know as "New ways of Working: Clinical Leadership on Complexes" (see this section and section 2.3.2 following).

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

2.3.2 Managing Demand - high Impact changes

During 2004/05 call volumes rose at a rate of 7.5%, at 5.9% in 2005/06 and 4.2%? in 2006/07.. These years have all been in excess of the historic long-term rate of annual growth of approximately 3%. In terms of responses, growth of 2.9% was experienced in 2005/06 over 2004/05 and is anticipated to be 3.6% in 2006/07 over 2005/06 (Total responses: 1,173,24).. These numbers however mask the changing pattern of calls with Category A constituting a greater proportion of the total, growing at 48% over the two year period with, correspondingly, Category A responses growing at 47.5%.

Given the context of capacity constraints, increasing demand and the potential impact on response time performance of the clock start changes, the Trust decided that a new operational model is required. It is necessary to continue with further "High Impact Changes" during 2008/09 such as solo responding except where it is known at the outset that the patient definitely will need to be transported lying down. This will be managed through the Operational Model Programme but form part of a wider Organisation Development initiative known as "New Ways of Working: Clinical Leadership on Complexes" which is intended to simultaneously bring in a genuinely team based watch system way of working with enhanced clinical leadership given to staff. This will be rolled out over three years to all complexes in London, the first three "exemplar" stations going live in 2008/09.

The “High Impact Changes” are designed to deliver fundamental change across the service in terms of how the LAS organises its processes to deliver on both the challenging new performance targets and high quality patient care. They have been developed by thinking carefully about what needs to be different in A&E Sectors, the Emergency Operations Centre, the Urgent Operations Centre and within Patient Transport Services. In doing so, the Service has considered the whole system and has worked to ensure that the changes are complementary and improve the whole system rather than individual departments.

2.3.3 Delivery of Core and Developmental Standards and the Diversity agenda

A key requirement for the Trust is to meet the requirements of the NHS planning and governance framework “Standards for Better Health” published in July 2004. This Service Plan is designed not only to maintain performance against the Core Standards but also to make demonstrable progress over 2007/08 against the Developmental Standards. These will be used by the HealthCare Commission to determine the Trust’s annual performance rating, along with delivery against national targets, the Information Governance Toolkit and achieving financial balance.

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

The Trust has an established Diversity team and in accordance with legislation is in the process of carrying out Equality and Diversity Impact Assessments on its relevant policies, procedures, functions and practices. The actions arising from these assessments will be incorporated into the Trust’s existing Equality Schemes and their associated action plans.

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

2.3.4 Organisation Development

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

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

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

However, many patients need a caring response more than they need a quick one. They need the Service to spend time with them – understanding their situations and resolving their problems. The skills needed will often be less “technical” and will require skilled communication alongside education in assessment and understanding of underlying causes and chronic illnesses as well as the ability to

work with other health professionals in the community to secure the right next step for the patient.

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

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

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

2.3.5 Workforce Development Plans

Workforce development plans

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

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

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

2.3.6 Clinical Income and Clinical Activity

Comparison between historical achievement and current plan*

Clinical income

£m	**Plan**	**Forecast**	**Current plan**		
	2007/08	**2007/08**	**2008/09**	**2009/10**	**2010/11**
A&E	206.8	213.34	234.5	239.2	244.0
PTS	9.4	10.0	8.3	8.3	8.3
Other	2.8	12.7	9.5	9.8	10.1
Other activity	0.0	0.0	0.0	0.0	0.0

Total	219.0	236.0	252.3	257.3	262.4

Clinical activity					
Activity numbers (000s)	**Plan**	**Forecast**	**Current plan**		
	2007/08	**2007/08**	**2008/09**	**2009/10**	**2010/11**
Elective					
Non-elective					
Outpatients					
Other activity					
A&E – Incidents	946	949	986	1017	1047

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

2.4. Operating resources required to deliver service development

Resources required to deliver service development

The revenue impact of implementing Call Connect in full is estimated to be £17.7m for 2008/09. This investment is currently under review with the LAS Commissioning Group. This cost relates mainly to additional staff (318) working in an improved, more efficient operating environment.

The LAS is working with NHS London on developing a significant change in how training and development of staff is delivered. NHS London asked the LAS to bid for MPET funds to fund this change. A bid of £18m was submitted for 2008/09, covering improved paramedic training, additional investment in ECPs and an enhanced e-Learning capability. To date no answer has been received from the SHA and for planning purposes, we have assumed income of £5m to cover the initial phase of this project. Costs matching this funding have also been included in the plan

Current discussions with the SHA indicate that at least two HART teams will be required in London. We are finalising how these teams will be delivered and funded. In the plan, we have assumed that income of £5m will be provided from the Deprtament of Health to support this requirement. Costs matching this income have also been included in the plan.

As part of the recent CSR submission, planning costs for the 2012 Olympics of £1.5m have been included for 2008/09. It is assumed in the plan that this activity will be funded centrally, with associated costs also planned.

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

Gross capital investment of £11.9m is included in the plan for 2008/09 covering additional vehicles, CAD2010 investment and a range of estates projects

The current capital plan is planned to be funded from internal resources

Comparison between historic achievement and current plan

Operating expenses*					
£m	**Plan**	**Forecast**	**Current plan**		
	2007/08	**2007/08**	**2008/09**	**2009/10**	**2010/11**
Pay costs	166.6	168.8	189.3	194.2	198.7
Drug costs	0.6	0.4	0.6	0.6	0.6
Other operating costs	40.8	56.0	49.3	48.3	47.2
Total	208.0	225.3	239.2	243.0	246.5

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

Cost improvement plans					
Pay/Productivity	7.9	8.0	5.7	5.8	6.0
Non Pay	3.5	2.9	1.4	1.5	1.5
Total	11.3	10.9	7.2	7.3	7.5

Commentary on cost improvement plans

A significant Cost Improvement programme has been largely delivered in 2007/08.

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

For 2008/11, this is planned to continue using the SIP Programme methodology. In particular, the Corporate Processes & Governance programme is looking at all key processes within the LAS to identify further efficiencies. Areas such as procurement, logistics and staff administration are a key focus.

Turnaround and reconfiguration plans	
Initiative 1	
Initiative 2	
Initiative n	
Total	

Commentary on turnaround and reconfiguration plans

2.5. Service Line Reporting

Plans for implementation of service line reporting
The LAS currently splits out its business into A&E and PTS. Further analysis will be completed in 2008/09 as part of preparation work for FT status.

2.6. Investment and disposal strategy

Plans for investment and disposal
Key areas of investment over the next 3 years include CAD2010, new ambulances and a reconfigured estate. Estimates have been made regarding the split for capital and revenue for these projects. The Estates strategy for the Trust is currently being updated. In 2007/08, a major disposal of a site is forecast to be complete. In 2008/09, further disposals are planned for some smaller sites

Comparison between historic achievement and current plan Investment and disposal strategy					
£m	**Plan**	**Forecast**	**Current plan**		
	2007/08	**2007/08**	**2008/09**	**2009/10**	**2010/11**
Investment in fixed assets (non-maintenance)	3.0	2.3	1.2	0.6	0.6
Investment in fixed assets (maintenance)	1.4	1.5	1.4	3.2	0.7
Investment in other assets	11.3	8.1	12.2	8.8	5.8
Asset disposals	-3.26	-3.26	-1.5	0.0	0.0

2.7. Summary of key assumptions

Key assumptions			
	2008/09	**2009/10**	**2010/11**
A&E Incidents	4.0%	3.0%	3.0%
A&E Income (Base)	2.3%	2.0%	2.0%
Other Income	2.0%	3.0%	3.0%
Pay Inflation	2.5%	2.5%	2.5%
Non pay Inflation	2.0%	2.0%	2.0%
CRES	2.5%	2.5%	2.5%
AfC Drift (£m)	1.0	1.1	1.1

3. Risk analysis

3.1. Financial risk

3.1.1. Commentary on financial risk rating

Financial commentary

The provisional rating is 2. This is primarily driven by both the net margin and liquid ratio indicators each scoring a 2, which automatically results in a overall financial risk of 2 despite a weighted average score of 3.1.

As the 2008/09 net margin is planned to be 0.4%, To achieve a score of 3, the net margin would need to be at least 1% which will not be possible in a challenging year. In the calculation, the interval between a score of 2 and 3 is a net margin range of a loss of 2% to a surplus of 1% i.e the LAS would get the same score with a deficit of £5m as with a surplus of £1m

The Liquid ratio also scores a 2. The requirement on the LAS to reduce net cash balances to £1.6m at year end results in a lower score. Historically, one of the mechanisms to reduce cash balances is to increase prepayments. In the Liquid ratio calculation, prepayments are excluded, resulting in a lower score.

The current financial projections include assumptions on income not yet finally agreed with both A&E commissioners and other funding providers. The LAS has planned cost in line with these projection and in the vent of not receiving the required income, the cost base can be adjusted to ensure **financial** balance

The comparison between the original submitted plan for 2007/08 and the the current forecast is skewed by the fact that Call Connect (£6.8m), Invest to Save (£8.3m), HART (£1.5m) and the Olympics (£0.6m) were not included in the original LPA plan, both from a revenue and a cost perspective

3.2. Governance risk

3.2.1. Commentary on governance and associated risks

Governance commentary

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

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

Compliance with operational and financial requirements used by the Agency

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

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

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

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

Compliance with the Agency Board's rights to participate in key appointments

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

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

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

Effective risk and performance management

The LAS fulfils its responsibility for ensuring that its statutory obligations are met at all times. The Trust uses a risk-based approach to management receiving exception reports where there is an intensified risk of failure to meet national targets. This is known internally as the REAP system. In addition to this the Assurance Framework reports to the Board on the management of low risks that threaten the achievements of its principal objectives, using the domains of the Annual Healthcheck.

The Trust uses a transparent method for risk assessing set out in a performance management framework underpinned by its Risk Management policy and the Statement of Internal control.

Implementation of national policy and guidance on planning for an incident

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

Maintaining an up to date Business Continuity Plan

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

3.3. Risk to services provided

3.3.1. Commentary on services provided and associated risks

Commentary on services provided

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

This is contingent on securing the funding required from London commissioners to cover the increased investment required for Call Connect as well as non-PbR uplifts for volume and inflation.

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

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

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

3.4. Quality and safety risk

3.4.1. Commentary on quality and safety performance and associated risks

Commentary on quality and safety
The LAS will provide high quality and safe services in line with current performace.The LAS has a well developed risk management framework which identifies both generic and specific risk with associated action plans to manage these risks. Further activity is planned with our stakeholders to ensure that both the public and our patients receive the required service in line with both national and local guidelines.

3.5. Other risks

3.5.1. Commentary on any other risks

Commentary on other risks

4. Declarations and self-certifications

4.1. Board statements

Commentary
The LAS Senior Management Team has reviewed and agreed the submission of this plan. The LAS Board has agreed the basic planning assumptions used and will review further and approve the required the self certification document at the planned Trust Boards in Jan and Feb 2008, prior to final submission of the plan. The Chairman, Chief Executive and Director of Finance have reviewed and approved this submission.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 29 January 2008

HUMAN RESOURCES STRATEGY

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

2. Purpose: For approval

3. Summary

The HR Strategy outlines the key direction of travel for Human Resources within the London Ambulance Service in recognition of the main external and internal drivers and in particular the Trust wide Strategic Plan with the supporting Service Improvement Programme.

The document sets out the Strategic aims for Human Resources and intentions for the implementation of the strategy over the next five years.

4. Recommendation

THAT the Trust Board APPROVE the Human Resources Strategy

London Ambulance Service NHS
NHS Trust

Human Resources Strategy

2008 -2013

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1. Introduction

The London Ambulance Service NHS Trust (LAS) is the busiest emergency ambulance service in the world providing healthcare that is free to patients at the point of delivery.

The LAS is the only London - wide NHS Trust and is at the frontline of the NHS in the Capital

The Trust currently has two principle functions: to provide an accident and emergency service (including urgent care) in response to 999 calls and a patient transport service which performs an important role by taking non emergency patients to and from their hospital appointments.

As an integral part of the NHS in London, the LAS works closely with hospitals and other healthcare professionals, as well as with other emergency services. The Trust is also central to the emergency response to major and terrorist incidents in the Capital.

The LAS serves a resident population of more than seven million people in an area of approximately 620 square miles.

In 2007, the Trust handled more than 1.3 million emergency calls from across London and attended more than 865,000 emergency incidents.

The LAS is committed to developing and improving the service it provides to the people who live, work in, or visit London with the vision of being an organisation of well trained enthusiastic, caring people who are **all** recognised for their dedication to meeting the needs of the public and **all** our patients.

2. Context

There are a number of key drivers which influence the future direction of the LAS and in particular that of its HR strategy. This section outlines this context (as it currently exists) in relation to both the external and internal drivers.

External

- *"Taking Healthcare to the Patient: Transforming NHS Ambulance Services"* - published in 2005 sets the vision for the future provision of services delivered by Ambulance Trusts in England. It identifies fourteen specific national workforce recommendations covering recruitment, diversity, skill mix and future developments in training, education and leadership development. (Appendix 1).

- *Commissioning a Patient led NHS* – has seen the development of NHS London and associated infrastructure of NHS services within London. This provides a new focus to healthcare provision within the

Capital in terms of future strategic plans and requires the development of new productive relationships with our stakeholders. The LAS will have a greater profile within this new framework and is seen as key to the delivery of both emergency and urgent care in the Capital.

- *"Healthcare for London: A Framework for Action"* – currently out to public consultation, outlines the proposal for reshaping healthcare in London through which the majority of healthcare will be provided at:

  - Home
  - Polyclinic
  - Local hospital
  - Elective centre
  - Major acute hospital specialist hospital

  This places a greater emphasis on the associated reshaping of services and responses delivered by the LAS in providing the right care in the right place to patients in London.

- *Foundation Trust application* – with Ambulance Trusts having the opportunity to apply for foundation status from April 2009 the Trust is mindful of the associated requirements for Human Resources and the workforce. As stated in "*NHS Foundation Trusts: A guide to developing HR systems and practices"* (DoH, July 2007), *"As high performing, knowledge and learning based organisations, NHS foundation trusts are expected to be model employers – maintaining and progressing high standards of employment practice and securing a culture which reflects their new organisation and delivers added value for the direct benefit of NHS patients"*. Integrated Business Plans of foundation trusts are expected to cover the following HR elements:

  - Management arrangements
  - Leadership and Board development
  - Legal requirements
  - Workforce plan
  - Organisation development
  - HR arrangements

  This is the standard which will be applied irrespective of the foundation status of the organisation.

- *National performance targets* – require us to have a flexible, responsive and skilled workforce providing a timely, appropriate response to our patients, making best use of public funding and offering value for money.

- *Healthcare Commission* – conducts an annual health check on all Trusts on the use of resources and quality of services. The results of these health checks have a significant bearing on the reputation and

public perception of the organisation together with the “feel good” factor of our staff.

- *Employment legislation* – remains dynamic with regular changes to existing legislation and the introduction of new. It is vital that Trust policies and practice reflect these changes, together with developing best practice in all aspects of employment.

Internal

- *Finance* – The period of significant funding growth is now over with the focus now on financial stability, efficiency and productivity.

- *Service Improvement Programme (SIP)* – is a seven year programme taking the Trust to 2012 and aimed at responding to the changing needs of patients, the changing external environment and developing an organisation which looks, feels and behaves differently. The SIP contains five supporting programmes, including the Organisation Development and People Programme and incorporates a major initiative to introduce new ways of working underpinned by excellent clinical leadership.

- *Employee Relations* – is a significant influencing factor on the progress of any workforce strategy. The Trust will continue its partnership arrangements, building on positive work to date and working within the context of strong union representation.

3. Strategic Aims

Key strategic aims in the area of Human Resources for the LAS are to:

- Provide an overall workforce skill mix which meets the need to respond appropriately to the diverse population of London. In addition to our core front line staff, this will include having the right skills within non operational roles to appropriately support the provision of excellent patient care.

- Develop a flexible workforce and organisation which is responsive to the changing needs of the service and future developments in healthcare.

- Become an employer of choice

- Provide a model career framework

- Develop leadership capacity and capability for the future development of the LAS

- Support the Trust's Service Improvement Programme through excellence in Human Resource Management (HRM) and the Organisation Development and People Programme.

4. Organisation Benefits

The strategic aims identified are intended to deliver an organisation which, in the future has the ability to respond readily to the changing needs of the public, our patients and the wider NHS supported by excellent organisational leadership.

The LAS will attract and employ high quality staff who share the values of the organisation and who have a willingness to adapt as the organisation continues to develop. These staff will be well trained with the knowledge and skills to respond according to patient need.

We will see full benefits of the implementation of Agenda for Change with a flexible, responsive workforce.

The LAS will be recognised and respected as a fully integrated and vital partner in the wider NHS in London.

Most importantly, our patients will experience a high class delivery of healthcare, in particular (and in line with key national objectives) we will:

- Resolve patients' needs without them having to leave home.
- Take fewer patients to A&E Departments
- Achieve better survival rates for patients who are seriously ill or injured
- Achieve better patient satisfaction
- Achieve high levels of staff satisfaction
- Achieve organisational improvement

5. Implementing the strategy

5.1 Workforce skill mix

Workforce Planning

A long term workforce plan has been developed which recognises the change in knowledge and skill requirements to support the provision of wider range of responses to patients and the introduction of a greater number of patient care pathways. The plan demonstrates an incremental move to a higher skilled workforce and introduces a newly developed support worker role. This workforce plan will be reviewed regularly and will be responsive to future changes not currently incorporated within its assumptions.

Recruitment and Retention

Over the life of the previous HR Strategy, the Trust has successfully recruited (in terms of absolute numbers) to a growing workforce. This growth will continue, although as the workforce plan shows, there will be a significant change in the skill mix of staff working to provide direct patient care. This planned change reflects the need for our patients to receive the appropriate response to their clinical and social care needs. It will mean the continued development and embedding of new roles and career pathways.

A career framework will be developed to facilitate the progression of staff within existing and developing roles within the LAS.

In recruiting to all positions we will aim to attract and recruit those people who demonstrate the values, attitudes and behaviours expected of a "world class" service.

The Trust will strive to maintain its current good record on retaining talent by continuing to listen to our staff through information gathered by via exit interviews, Staff Surveys, face to face team briefings and through staff involvement supported by the partnership working arrangements. Review and further development of processes including induction and Personal Development Review (PDR) will also support effective staff satisfaction and retention.

The LAS is committed to strive for a workforce which is more representative of the population it serves. The Trust will therefore continue to develop its "outreach" initiatives, working with community groups and other external partners to improve its ability to attract new staff from the diverse population of London and neighbouring areas.

Learning, Education and Development

The LAS, in common with much of the NHS, is now beginning to move toward a new model of delivery for education and training, working with Higher Education partners and incorporating work-based, practice learning that allows theory and practice to sit as equal partners, using the expertise of experienced practitioners to assist staff in developing their practice. In addition, the provision of on-line learning will further enhance access to development and training for all staff.

Clinical training and education

The LAS' Education & Training Plan recognises the aspirations and strategic direction of the organisation to deliver more post registration continuing professional clinical development and training at workplace level whilst maintaining a programme of recruitment and pre registration courses (including Paramedic and ECP) at our training centres and partner

universities, providing a workforce that is skilled appropriately to satisfy the aspirations of the workforce plan.

Development of Higher Education qualification and internal diploma

Over the next 5 years the LAS will develop an enhanced internal capacity for refreshing and enhancing skill levels, and developing existing Emergency Medical Technicians (EMTs) to Paramedic level together with upskilling existing paramedics to the new standards of proficiency. This will involve not only an enhanced in-house capacity, but greater levels of partnership working with both existing and future Higher Education (HE) partners, and will include the accreditation of all LAS delivered training and education.

National Curriculum

The context within which ambulance services provide education and training for their staff is changing nationally. With greater emphasis on the merging of internally delivered training with HE-based development, the workforce review and the emerging financial/funding pressures for all training outside medicine and nursing, the Trust will design, plan and deliver staff training and development with a greater focus on HE provision. The Trust will work closely with the Strategic Health Authority in developing a robust infrastructure with appropriate funding to deliver future professional training. We will also develop stronger links with the Health Professions Council and professional bodies such as the British Paramedic Association to support the development of appropriate standards against which training is designed and assessed.

5.2 Leadership capacity and capability

Leadership and Management Development

Whilst a traditional ‘managerial’ or transactional approach is sometimes necessary, and is an important part of any leader’s toolkit, it will no longer be the default style for the LAS, where empowering, transformational leadership will become the prevalent style.

The LAS will approach developing the leadership of the organisation in the same way we approach developing patient care, that is, by engaging and communicating with individuals to better understand and meet their existing and emerging needs, and by motivating and inspiring them to develop both themselves and the organisation to enable continual growth, effectiveness and success. In addition, the senior management team will clearly act as role models, providing examples of transformational, values-based leadership in action.

To ensure we develop these “role models” adequately, the Trust will participate in a national audit of leadership capacity within ambulance

services (at national and local level) and will introduce measures necessary to meet the needs identified.

5.3 Model career

Talent Management and Succession Planning

The organisation will put in place a framework of access to dedicated, targeted development for staff from across all departments who has been recognised (or who may recognise themselves) as having the raw talent for leadership. Through a process of initial selection and appraisal, the strengths and potential of these individuals will be explored, and with their managers, a development plan will be designed that enables them to work toward reaching their potential through promotion.

The Trust will also work with the Strategic Health Authority in developing future leaders in the wider NHS.

5.4 Employer of Choice

Staff welfare

The Trust identified a new provider of occupational health and welfare services in 2007, providing an opportunity for a comprehensive overhaul of how staff are supported through issues relating to the effect of work on health and of health on work. There will be specific work-streams devoted to reducing long-term absence and improving access to occupational health services in general, and physiotherapy services to assist in recovery and rehabilitation after musculo-skeletal injuries, in particular.

Further improvements in manual handling training, practice and equipment will be explored. Links with other Ambulance Trusts will be developed to share practice, learning and to combine to influence the market for development of manual handling aids with a view to reducing the incidence and impact of patient moving and carrying, thereby reducing the risk of injury to our staff.

The existing staff support mechanisms introduced as part of the first Service Improvement Programme will be reviewed and developed. The Linc (Listening, Informal, Non-judgemental, Confidential) peer support scheme will be extended to ensure adequate support across the whole of the Trust, and additional staff will be trained in the trauma risk assessment arrangements. The role and scope of counselling services and of the Employee Assistance Programme will be reviewed to ensure adequate access for all staff and quality of service.

Training for managers and staff on signs, symptoms and interventions in cases of stress will be reviewed, and the Trust will continue to support

academic research in these areas with a view to informing future policies and procedures.

Staff Benefits

The range of non-pay benefits available to staff will be reviewed. Currently, child care vouchers are offered, and the Trust has participated in salary sacrifice opportunities such as the former Home Computer Initiative. Similar opportunities will be assessed and considered in the future.

The Trust will actively explore the possibility of engaging with corporate suppliers of a range of benefits, goods and services to its staff, to enhance the pay and reward package available, build the Trust's position as an employer of choice, and enhance recruitment and retention of staff.

5.5 Flexible workforce – "Finding Solutions Together" (in partnership)

The Trust has enjoyed a close working relationship, through arrangements for joint consultative committees, with its recognised Trade Unions for many years. This relationship was enhanced and augmented in 2002 by the introduction of a formal Partnership Agreement.

Working in partnership recognises the role that staff and their representatives have in contributing to service development, service delivery, and improving patient care by constant review of policy, working practices and procedures. It also promotes effective communications between the partners, along with joint ownership and acceptance of issues, concerns and solutions

Supported by the renewed Partnership Agreement the Trust will continue to develop effective partnership working so as to:

- deliver improved services to patients/users
- ensure high standards of modern employment practices
- improve mutual understanding between the Trust, its staff, their representatives, partner organisations and service users
- provide a platform for partners to contribute their experience and ideas to the development and implementation of the workforce implications of policy on health and social care
- ensure more effective implementation of policy
- provide a transparent and streamlined structure for Trade Union, employer and staff engagement.
- recognise the importance of Trade Unions in providing a voice for staff and their shared responsibility for active and effective communication with staff.

The programme of regular joint partnership conferences and events will continue and be devolved to a more local level where staff as well as their representatives will be actively involved.

The formal staff consultative structures and staff involvement arrangements will be reviewed and new arrangements introduced that provide an opportunity for all staff groups to contribute to service development and delivery. The consultative arrangements will be aligned with management structures to ensure a forum for meaningful debate, devolving consideration and decision to the appropriate level.

These arrangements will provide, in turn, a formal forum for staff involvement in regular review of working arrangements (including working patterns for operational and support staff) and practices to better support the requirements of "Taking Healthcare to the Patient: Transforming NHS Ambulance Services". A model of a more flexible approach to work and attendance at work will be developed and implemented.

5.6 Service Improvement Programme

The LAS has introduced its second major Service Improvement Programme with the aim of being responsive to the changing needs of patients in London and becoming a truly "world class" ambulance service.

> *"**Vision:** A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.*
>
> ***Purpose:** The purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement.*
>
> *We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London"*

The Organisation Development and People (OD and People) Programme contains a comprehensive portfolio of projects to support this overarching vision.

The OD and People programme will deliver better patient care through **re-shaping the workforce**, not only to meet the requirements of the New Front End Model (appropriately skilled and confident to use their skills, and a much wider range of care pathways), but also to create a workforce that is more representative of the population of London, and which lives the CRITICAL Values, treating everyone as they would wish to be treated.

It will also bring about a **cultural change** to develop an organisation that looks, feels and behaves differently; a learning organisation that works cross-functionally in a customer-focused, team based way (both internally and with external partners), with a culture of mutual challenge and accountability for personal behaviour and performance.

Within six years **new styles of management,** which support staff and promote staff involvement and development, will be embedded, with leadership (underpinned by clinical, managerial, inter-personal and communications skills) at all levels.

Projects currently active within this Programme include:

OVERVIEW OF OD & PEOPLE PROJECTS
Staff and Union Engagement To develop strong partnership arrangements which enable meaningful engagement and involvement of both trade unions and staff.
Recruitment & Induction To 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 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 product will be comprised of a number of courses and qualifications aimed at specific groups within the organisation to support both the New Ways of Working and OD and People Programmes.
Individual Performance Management 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

To develop the workforce plan that supports the Operational Model by providing the appropriate skill mix and implementing a staff profile that is representative of the population of London.

Modularised Training

To provide all staff with access to appropriate professional development through training and development packages delivered through a variety of media.

Talent Management

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.

Training Restructure

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 and in upskilling existing paramedics to the new standards of proficiency.

These projects will provide significant support to the introduction of New Ways of Working underpinned by enhanced clinical leadership on the "new look" complexes.

5.7 Development of excellence in HRM

Good people management skills are a core requirement for all managers. Well implemented HR policies and best practice, properly aligned with the organisation's strategic aims make significant and measurable improvements

to overall performance and to patient outcomes and experience. The HR function will continue to provide the highest level of support in these key areas through the development and implementation of sound, up to date HR policies and practice.

The HR function has an important role to play in supporting managers to deliver, not only the necessary workforce developments, but also wider service reform.

Building on the restructure of the Senior Human Resource Management team in 2007 providing senior level support across the Trust, the LAS will continue to develop the capability and capacity of the Human Resources team to ensure that the HR function is equipped to contribute effectively to the future challenges of modernised service delivery and its associated workforce implications. Continuous Professional Development (CPD) will therefore be a key focus in performance reviews for all HR staff.

6. Supporting the strategy

Delivery of the strategic aims and the approach to implementing this strategy will be managed and monitored through the MSP (Managing Successful Programmes) framework for the projects contained within the OD and People Programme and through team and individual objective setting.

Appendix 1

Excerpt from “Taking Healthcare to the patient” – recommendations:

Develop the workforce

1. Ambulance clinical training needs to be designed around the case mix they deal with. Course content should therefore be reviewed.

2. The Department should support SHAs in ensuring the NHS has the right staff with the right skills to meet patient needs, as well as helping to identify and remove barriers to robust workforce planning in urgent care.

3. The Department, working with key stakeholders, should develop guidelines on patient pathways to promote consistency between urgent care providers.

4. The training of ambulance clinicians and call handlers should have greater commonality with that of other health professionals and their career pathways should be integrated with the wider NHS, so that people undertaking similar tasks and gaining similar competencies have the opportunity to train and develop together.

5. To aid integration, there should be a move to higher education delivered models of training and education for ambulance clinicians. Initial registration should be at diploma or foundation degree level.

6. There should be improved opportunities for career progression, with scope for ambulance professionals to become clinical leaders. While ambulance trusts will always need clinical direction from a variety of specialties, they should develop the potential of their own staff to influence clinical developments and improve and assure quality of care.

7. The Department, in conjunction with SHAs, should review funding arrangements where necessary to facilitate consistent access to funding.

8. Funding of ambulance clinician education and training should be consistent with the arrangements for other non-medical clinical professions.

9. Ambulance services, PCTs, acute trusts, foundation trusts and SHAs will need to work together to review funding arrangements and priorities for the training of the overall urgent care workforce.

10. The Ambulance Service Association, the British Paramedic Association, NHS Employers, NHS Careers and NHS Jobs work

together to market ambulance clinician roles as a profession with excellent opportunities for development and progression across the NHS.

11. Ambulance services should take increased steps to support the recruitment of black and minority ethnic staff.

12. When recruiting and designing new roles, ambulance services should also focus on the competencies, underpinning education, attitudes and behaviours required to deal with patient need and consider the increased use of and diversification into intermediate grades (between PTS and emergency ambulance grades) as well as more advanced and specialist clinical grades.

13. The recruitment and development of ECPs should continue at pace, encouraging recruitment from a variety of professional backgrounds, including within the NHS.

14. ECPs should be regulated as a profession in their own right with the Health Professions Council and prescribing responsibilities should be actively explored. This should include the development of a national curriculum for ECP training, with education programmes nationally accredited by the HPC and delivered by HPC approved higher education institutions, alongside HPC arrangements for CPD and clinical mentoring.

15. The Department should work with SHAs and ambulance services to develop a five year workforce development plan.

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 29th January 2008

APPOINTMENT OF THE CHAIRMEN OF THE BOARD'S COMMITTEES AND PROPOSED FUTURE BOARD DEVELOPMENT

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For agreement

3. Summary

Board Appointments

Standing Order 26.1 requires the Board to appoint the Chairmen of the Board's Committees at the Trust Board's first meeting of the year and, if desired, Vice Chairmen of the Committees. The membership of the Board's Committees has been reviewed following Brian Huckett's appointment as a Non-Executive Director.

Audit Committee
Caroline Silver (Chairman)
Sarah Waller (Vice Chairman)
Roy Griffins
Brian Huckett

Clinical Governance
Beryl Magrath (Chairman)
Sarah Waller
Ingrid Prescod

Charitable Funds
Caroline Silver (Chairman)
Brian Huckett

Remuneration Committee
Non Executive Members of the Board, chaired by the Chairman.

Service Development Committee
Non Executive Members of the Board and the Chief Executive, chaired by the Chairman.

Board Development

Board development relating to Foundation Trust, as identified by other Trusts who have attained Foundation Trust status, included diversity and financial analysis. It is proposed that as part of the Board's development,

time be allocated for training concerning diversity so as to demonstrate compliance with the various diversity legislation and the core Healthcare Standard C7e; counter-fraud measures and financial matters associated with becoming a Foundation Trust. A one day whole board training programme in finance is being considered. The Board is scheduled to consider the question of whether the Trust should apply for Foundation Trust status in March 2008.

4. Recommendation

THAT the Trust Board:

1. CONFIRM the appointments of the chairman of the Board's committees as set out above;
2. NOTE Brian Huckett appointment to the Audit Committee and to the Charitable Funds Committee.
3. AGREE to the training that is being proposed for the Board in 2008.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 29th January 2008

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting.

3. Summary

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

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

- Trust Board – every meeting;
- SDC – one (or more) of the five sub-programmes which make up the Service Improvement Programme will be presented to each of the five SDC meetings which take place during the year in rotation.

4. Recommendation

THAT the Trust Board NOTE the progress made with the Service Improvement Programme 2012 outlined in the report.

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 29 January 2008

SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE

1. Purpose

To update the Trust Board with progress in implementing the Service Improvement Programme (SIP2012).

2. Approach to Performance Management of SIP 2012

At the September 2007 meeting the Trust Board discussed the approach to performance managing the service improvement programme based on tracking achievement of planned milestones. Various model of reporting progress to the Trust Board were tried during the autumn containing various levels of detail. A revised approach was discussed at the January 2008 meeting of the Strategy Steering Group which is being trialled in this report. Using this approach the report consists of five sections, one for each of the sub-programmes comprising the overall service improvement programme (see below). Each section contains:

- A brief description of the live projects within the sub-programme concerned;
- A graphical representation of progress for each project focusing on planned milestone achievement as at the date indicated on the chart by the vertical line.

Trust Board members are invited to raise any questions for programme lead directors to answer at the meeting.

3. Overview of programme structure

The service improvement programme is made up of five sub-programmes:

- *Access and Connecting (the LAS) for Health* led by the Director of Information Management and Technology);
- *Improving our Response* (known as the "Operational Model") led by the Director of Operations;
- *Organisation Development and People* led by the Director of Human Resources and Organisation Development;
- *Corporate Processes and Governance* led by the Director of Finance;
- *Preparing for the Olympics* led by the Director of Operations;

Please note that the as the Olympics Programme has only just started a highlight report is attached showing activity to date and planned activity for 2008-12.

There is also a supporting *Stakeholder Engagement and Communications Strategy* led by the Director of Communications.

Kathy Jones
Director of Service Development

OVERVIEW OF ACCESS / CONNECTING for HEALTH PROGRAMME

CAD 2010
Project Manager: Ian Pentland

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

Call Taking (CTAK) Enhancements
Project Manager: Rony Zaman

The objective is to enhance CTAK capability as an interim measure pending its ultimate replacement by the system put in place by the CAD 2010 project.
This has been achieved through a series of software releases, incrementally delivering new functionality.

Data Warehousing
Project Manager: James Cook

Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse information. Information is not available from outside the LAS network and therefore it is not accessible to our partners and stakeholders.

To address these issues a data warehouse will be developed that stores LAS data. Eventually this data warehouse will encompass the whole of the LAS, including A&E and PTS data, resources, fleet, finance, estates, staff, recruitment and more. This project is the first step towards that goal and will limit the scope of its data to A&E data and vehicle manning and availability.

London Airwave Radio Project (LARP)
Project Manager: Vic Wynn

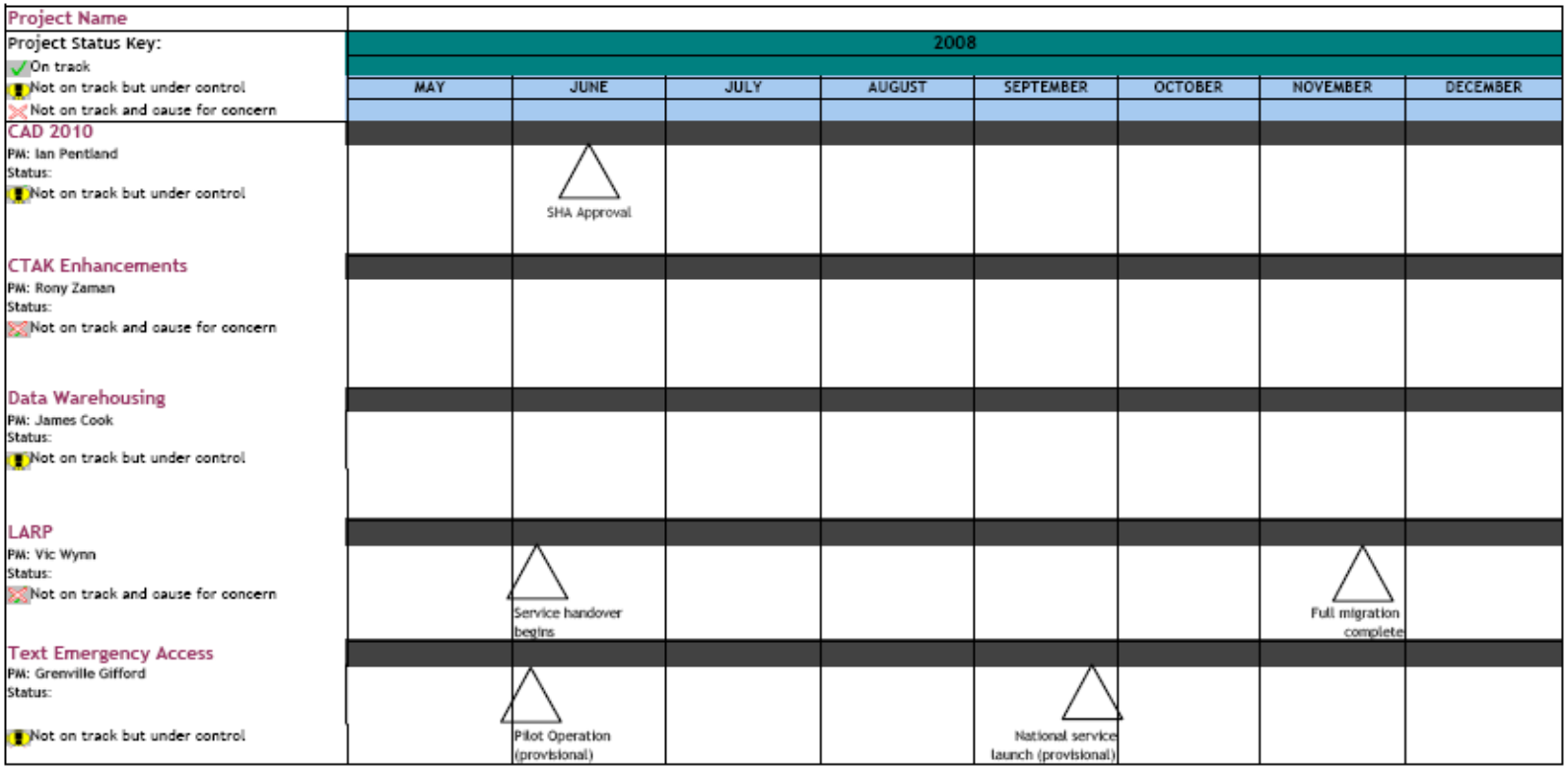
As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable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

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 will be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up next year.

Access CfH Schedule Summary



OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Additional Complex Response
Project Manager: Steve Irving

The aim of this initiative is to provide two sets of resource to staff FRUs to respond to both CAT-A and CAT-B calls. nineteen DSO vehicles need to provide operational cover using managers between 1100 – 1400 daily and the twenty-six team leaders need to be available to staff additional cars between 1400-2000 daily (times stated above may be subject to change).

An additional element to this project requires scoping of mobile office tools that can be utilised by Service personnel whilst on the move.

Increasing Solo Response Capacity
Project Manager: Terry Williamson

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

Mobile Fleet
Project Manager: Andy Heward

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

Referral Pathways
Project Manager: Allison Bolsover

The agreement of pathway protocols with providers, the encouragement of their use by frontline staff and evaluation to ensure that all patients receive consistently appropriate care delivered in a safe manner. This work should result in the LAS taking 200,000 fewer patients a year to A&E by 2012.

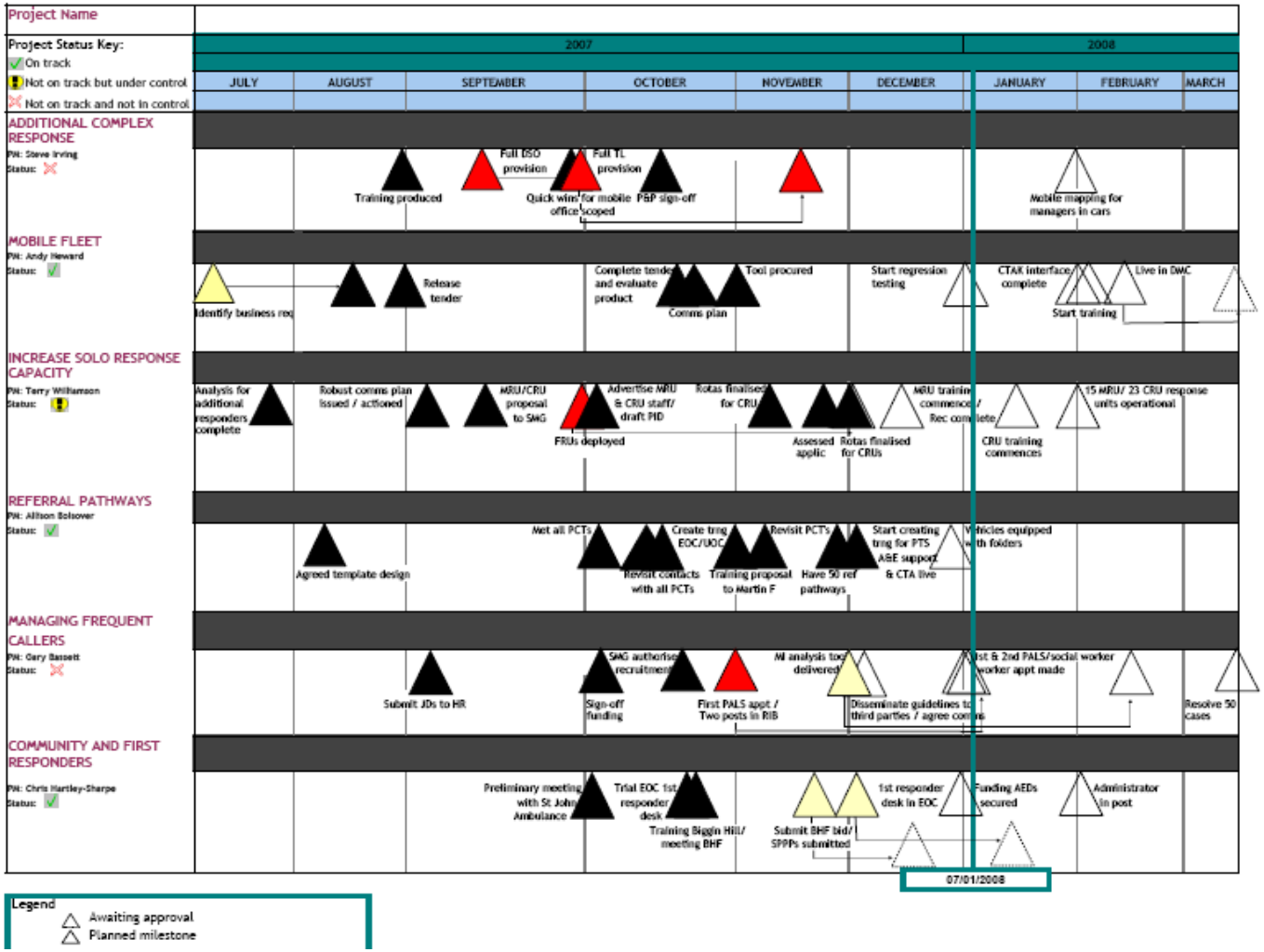
First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe

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

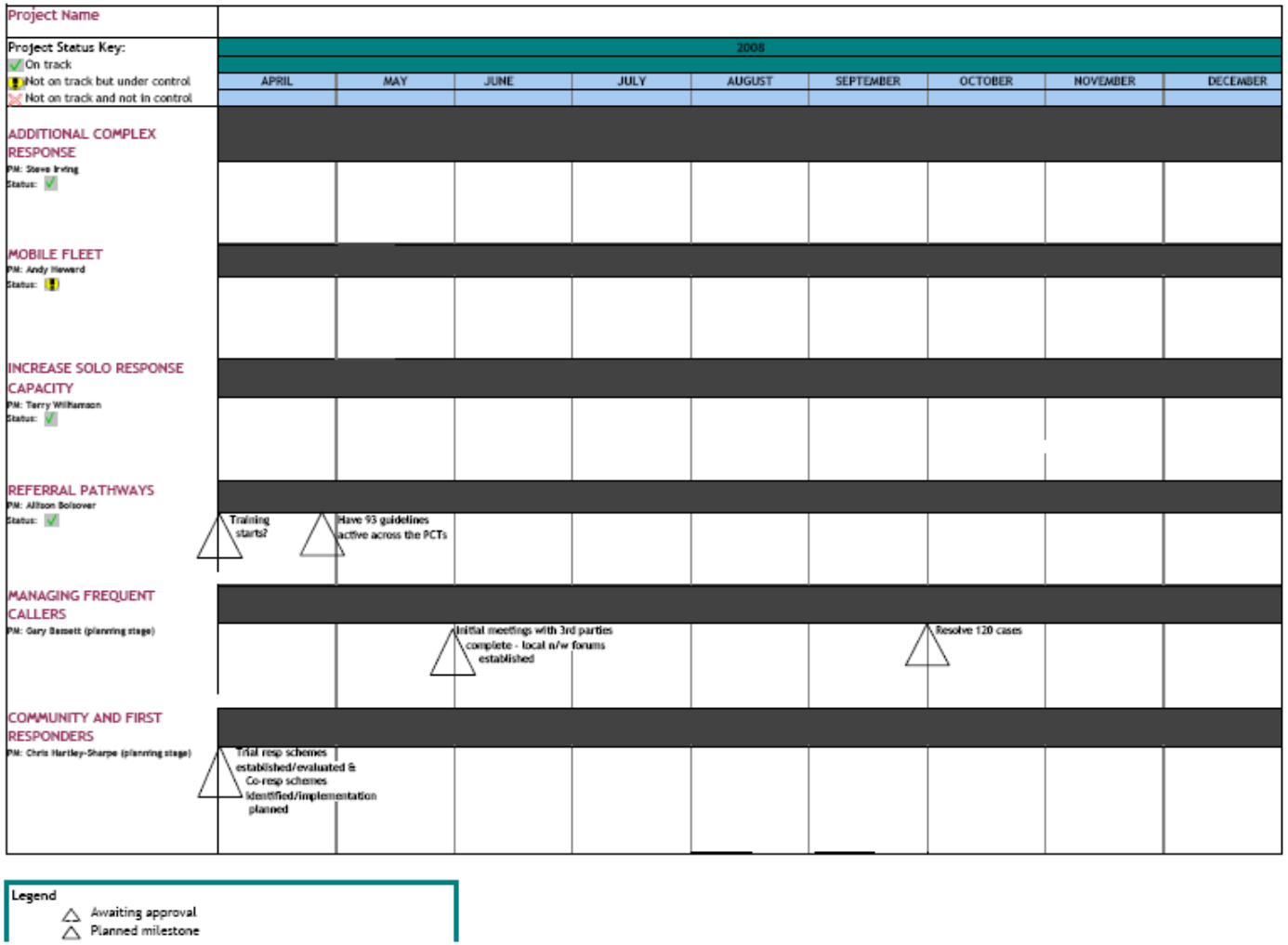
Managing Frequent Callers
Project Manager: Gary Bassett

The aim of this initiative is to achieve an appropriate care pathway for service users where the deployment of an emergency ambulance resource may not be the most appropriate response. Local multi-disciplinary network forums will be created in partnership with local authority and other social and health care agencies with the objective of resolving the issues presented by this patient community. The aim is to achieve a reduction of 10,000 ambulance journeys per annum.

Area Project Portfolio - Schedule Summary



Area Project Portfolio - Schedule Summary



OVERVIEW OF OPERATIONAL MODEL CONTROL SERVICES PROJECTS

Automated Ambulance Dispatch
Project Manager: Paul Webster

The objective is to deliver a technical capability similar to FRED used successful to dispatch FRUs. This should improve response times by anticipating the need to convey the patient and also reduce the allocators' workload in progressing AMBER calls requiring a double-crew response.

Automatic Data Reporting and Analysis
Project Manager: Sue Meehan

The project introduces changes to performance reporting in accordance with KA34 guidance providing the technical capability to capture on scene timings based upon geographical proximity (< 200 metres) of the vehicle to the patient location and subsequently of the vehicle to the hospital.
A second reporting objective is to ensure that the use of static deployed defibrillators, calls to GP surgeries and other KA34 permissible first responses are captured and reflected in performance reporting statistics.

Control Services Management Restructure
Project Manager: Alan Edmonds

The project, which is a continuation of Tranche-1 changes, seeks to restructure management broadly in line with Sector Operating Model to ensure consistency of performance through adequate managerial and supervisory support. Tasking Control Services AOMs to optimise use of resources to ensure compliance with performance targets and to facilitate closer support of CS staff; e.g. improved clinical governance, IPM, better clinical risk management. Finally to ensure appropriate skills are developed and appropriate capability available at all levels of EOC and UOC

Paperless Control Room
Project Manager: Lisa Dickinson

To facilitate the introduction of LARP into EOC and the need to economise on printing costs the project will analyse the use of paper copies, identify essential needs and formulate procedural changes to avoid making unnecessary copies.

Re-Engineering Call Handling
Project Manager: Vicky Graham

The aim of the project is to reduce call handling times to a predicable and acceptable period of time. This will include changes to consistently answer calls within 5 seconds, to capture Location and Brief Description within 50 seconds and complete the call within 2 minutes.

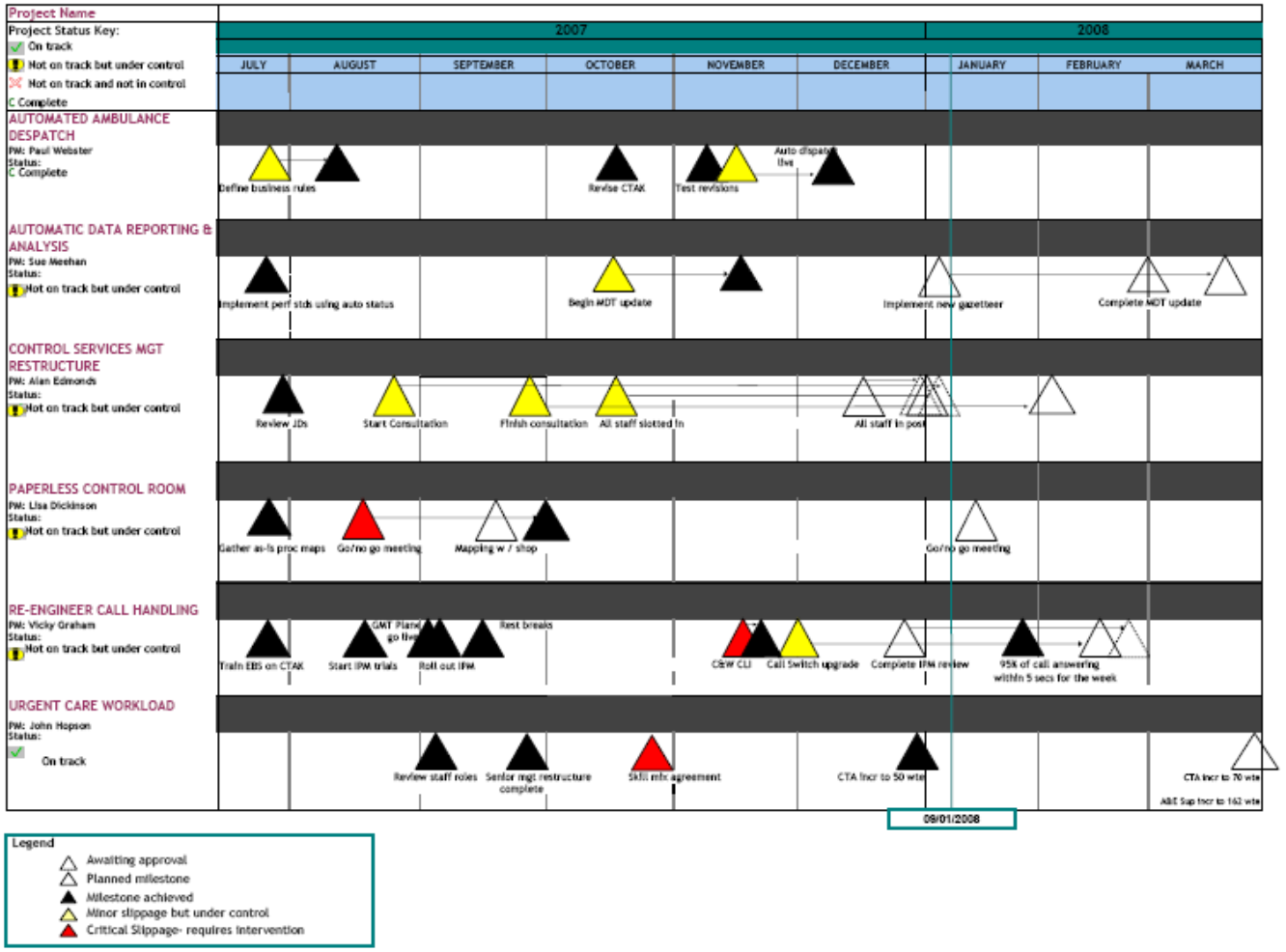
This will be achieved by adapting rosters and reviewing rest break arrangements to ensure that staff with the optimum skill mix are available to match the demands of call type and volume. Best practise will be established by identifying exemplary staff using IPM then replicating these practises and behaviours with all call takers.

Urgent Care Workload
Project Manager: John Hopson

The aim of the project is to increase the role of Urgent Care Services to improved urgent care to patients and reduce the use of emergency care resources to meet these requirements.

This will be achieved via a number of discrete "threads" of activity, partly by increasing the number of staff in both Clinical Telephone Advice and Urgent Care operations and partly by reviewing the skill mix and working arrangements of current staff.

Control Services Portfolio Schedule Summary



OVERVIEW OF OD & PEOPLE PROJECTS

New Ways of Working; Clinical Leadership
Bill O'Neill

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

Recruitment & Induction
Project Manager: Shani Phipps

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

Leadership Development
Project Manager: Jo Anthony

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

Individual Performance Management
Project Manager: Steve Sale

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

Workforce Re-Configuration
Caron Hitchen

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

Modularised Training
Project Manager: Keith Miller

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

Talent Management

Project Manager: Johnny Pigott

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

Staff & Union Engagement
Project Manager: Tony Crabtree

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

Training Restructure
Bill O'Neill

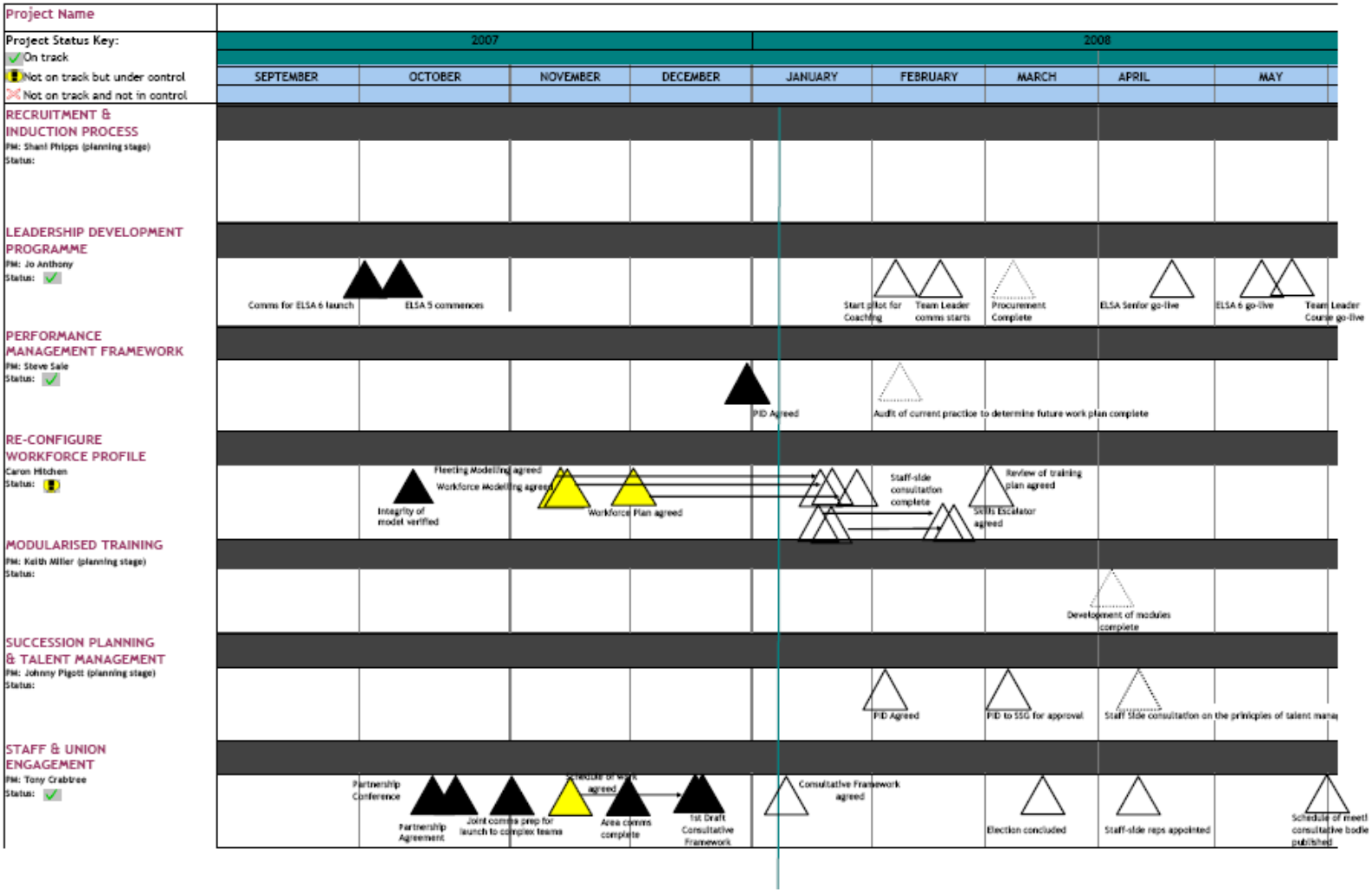
The aim of this initiative is to restructure the clinical education part of the department to meet the following requirements:

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

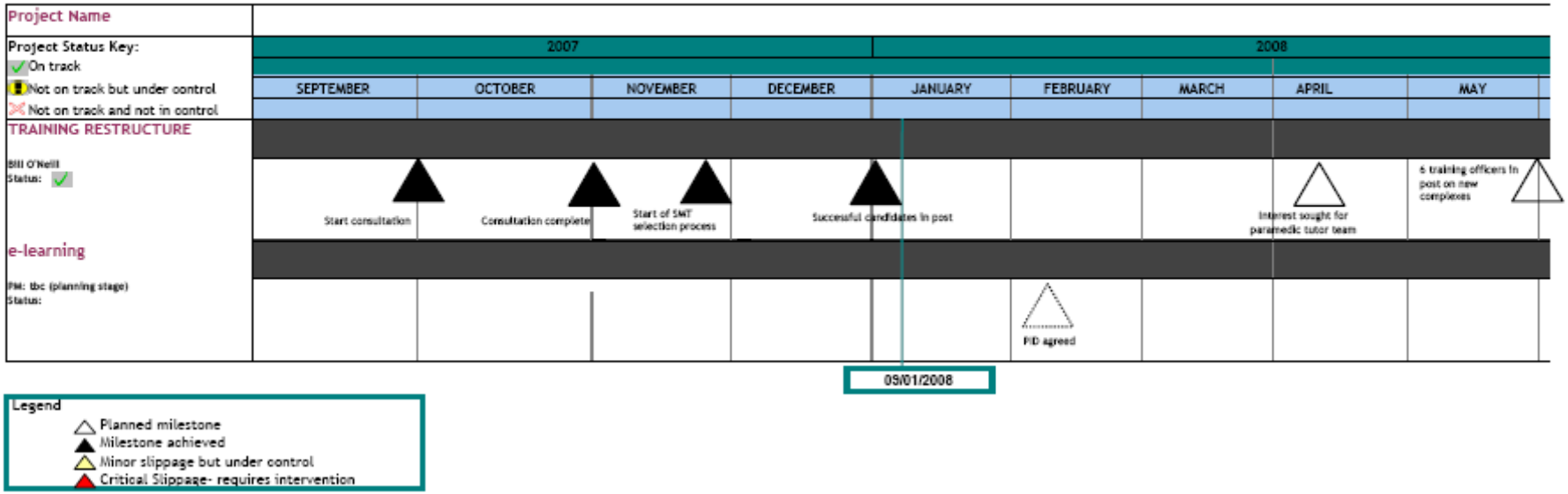
E-Learning
Project Manager: TBC

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.

OD and People Project Portfolio - Schedule Summary



OD and People Project Portfolio - Schedule Summary



OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE - TRANCH 1 PROGRESS REPORT

Map all Processes
Project Manager:

This project involves identifying all corporate processes, producing a Process Mapping Standard for use throughout the Trust and then using the standard to map all key processes. These process maps will then be used by subsequent projects to review processes and improve upon them to deliver the programme vision. A central repository will be identified and developed so that process maps can be stored reliably and are accessible as required.

Staff Administration
Project Manager: Jonathan Nevison

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

FISC (e-Series Web Basket) Roll-Out
Project Manager: Paul Candler

FISC Rollout is the implementation phase of a project continuing from the old SIP, replacing the procurement system with a new module within the Trust's accounting package, 'e-Series Web Basket'. This will streamline the procurement process and includes workflows and facilitates the introduction of automated processes for ordering and managing stock across the Trust.

Asset Tracking
Project Manager: Gadge Nijjar

This project is the roll-out phase of a piloted system for tracking the dozen or so pieces of EBME (Electro Bio-Medical Engineering) on each ambulance, developed in conjunction with the 'make-ready' contractor. This will also offer the facility to track and manage EBME servicing more robustly.

Inventory Management
Project Manager: David Selwood

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

Fleet Strategy and Workshop Review
Project Manager: Colin Gerald

The project objectives are to deliver options appraisals for modernisation of facilities, operating hours and shift patterns, re-configuration of the workshop service, administration and management structures, the function of 'make-ready' and fleet management software.

Flexible Fleet Management
Project Manager: Gadge Nijjar

This project comprises of the implementation phase of a previous pilot for more effective utilisation of vehicles between and across stations and complexes.

Real-Time Fleet Management Information
Project Manager:

This project is on the programme waiting list, until the Fleet Strategy & Workshop Review has been completed.

Re-Engineer Income Collection
Project Manager: Chizoba Okoli

This project has been set up to map and document all income streams and collection processes with a view to streamlining them to improve cashflow.

Performance Measurement
Project Manager: Jas(jit) Dhaliwal

The first phase of the Performance Measurement project will examine the Balanced Scorecard and various weekly reports in the light of the 2007/08 SMG objectives.

Meeting Room Booking System
Project Manager: Scott Velleman

This project involves the identification and implementation of software to allow the management of all room bookings across the Trust, including all training facilities and hot desks.

Incident Data Records
Project Manager: Jonathan Nevison

This project involves the installation and use of incident data recorders in rapid response vehicles to store vehicle telemetry before, during and after road traffic accidents providing hard evidence of the full circumstances of an accident in the event of a claim against the Trust.

PRF Handling and Processing
Project Manager:

This project involves reviewing the process by which the prf is recorded at complexes and transported to Management Information.

The Intelligent Trust
Project Manager:

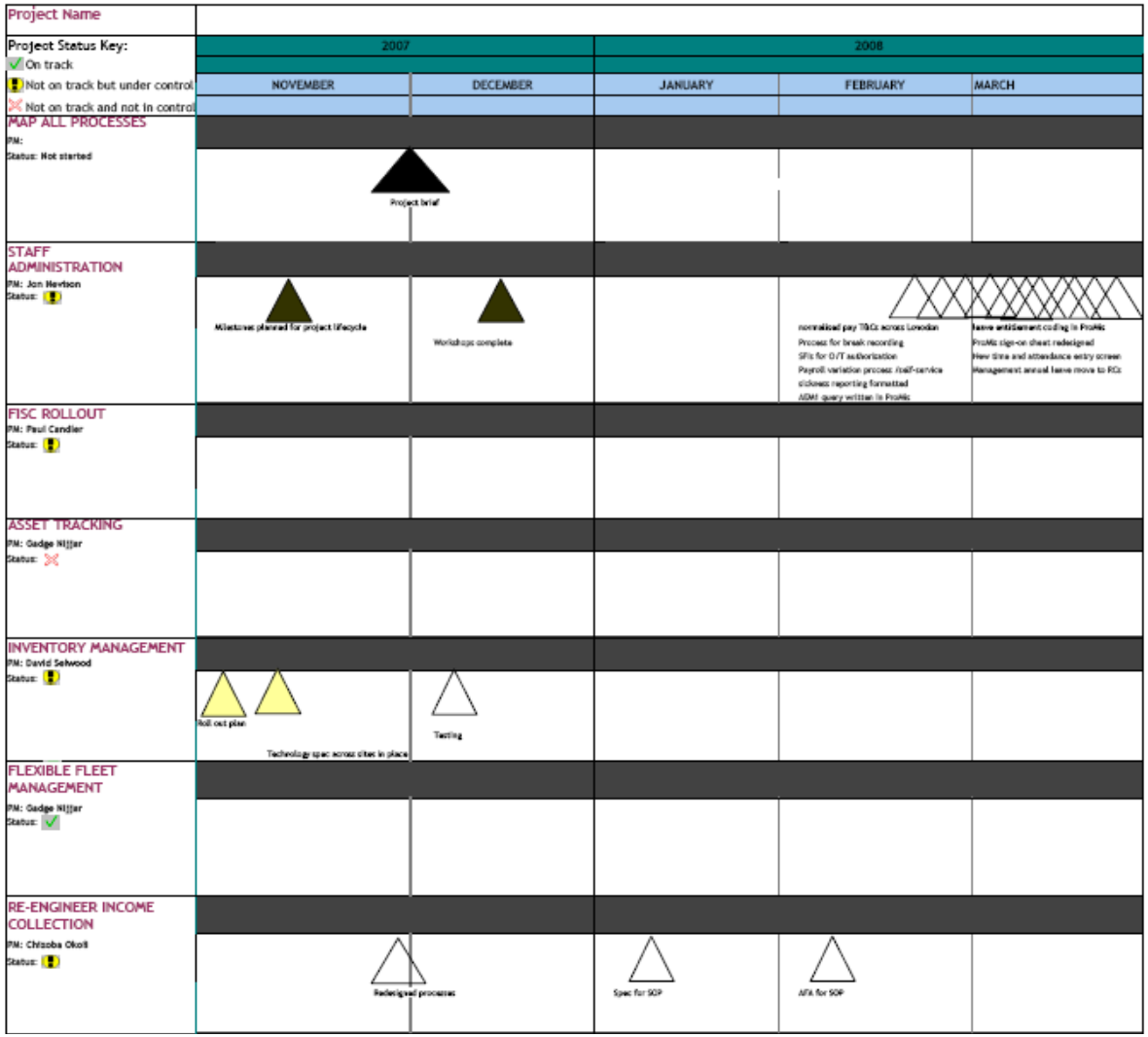
This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement Sharepoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

Trust Development
Project Manager:

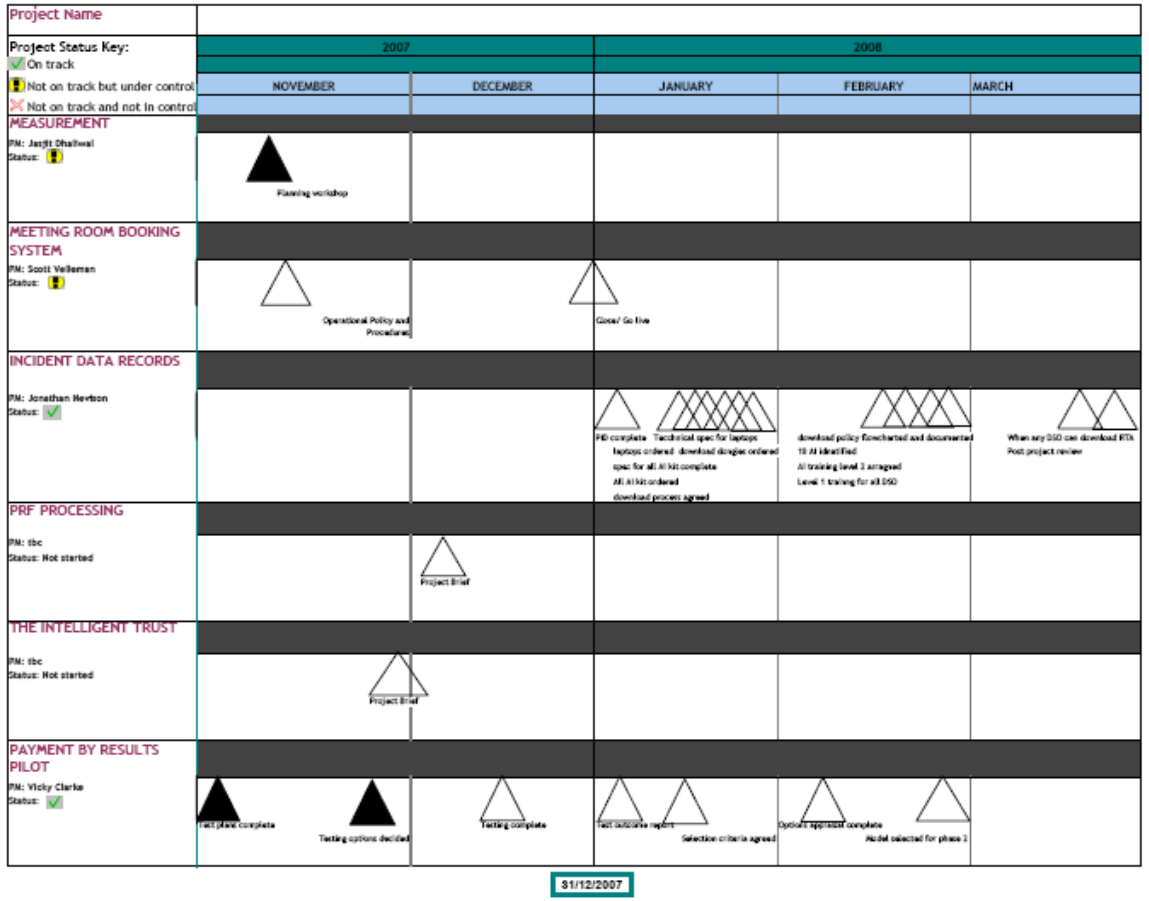
Payment by Tariff Pilot
Project Manager: Vicky Clarke

This project is being started up for LAS to join a national pilot scheme for ambulance service income to be paid by national tariff (or Payment by Results)

Corporate Processes Governance Project Portfolio - Schedule Summary



Corporate Processes Governance Project Portfolio - Schedule Summary



London 2012 Olympic and Paralympic Programme Highlight Report for Strategic Steering Group

Reporting Period	5 December 2007 – 7 January 2008		
Title	Olympic Games Planning Office (OGPO) Update		
Programme Manager	Peter Thorpe	Contact	
Key Issues	Project Manager not yet identified for IM&T Project		

	Products delivered	**Products due for delivery next period**
Capacity & Capability Building	• NHS Management Trainee started working in OGPO 3/1/08	• OGPO Assistant starting w/c 7/1/08 • Start recruitment for Admin Post • Sharepoint Information Framework meeting 09/01/08
Finance	• Finance case incorporated into the Programme Business Case • Met Police to submit to HO summary of CSR costs for all OSD Partners Jan 08.	Awaiting further information on FY 08/09
Programme Management	• First of two project initiation meetings for seven of nine Tranche 1 projects completed: Operations; Communications; Mutual Aid and Volunteers; Procurement; Staff Engagement; Estates; Financial Framework; Clinical Skills Acquisition/Training scheduled for 8 Jan	• Second project initiation for eight of nine projects to be completed and project documents produced

OSD/Security Update	• Response to OSD on concept of Operations and Strategic Governance Documents	Attendance at training delivered by MPS on the "Bowties" risk management methodology by JP/SW/LS and AK.
ODA/LOCOG Update	• Meeting and discussion with Joint Local Authorities Building Control group by LS regarding design and licensing considerations for the Olympic Park and other venues. • Written submission made to ODA/CLM regarding control room requirement for Olympic Park and venues. • Meeting with Duradiamond (Olympic Park Occupational Health Providers0 to develop and share protocols and promote joint working. • Information made available on CTAK locality information and current guidance for attendance at the Olympic Park and Stratford City sites made available to EOC.	• Finalising and agreeing joint procedures with Duradiamond and development of "seamless" handover of patients. • LS to attend Easingwold on courses, including "Temporary Demountable Structures" during January and Feb
Stakeholder Update	• Olympic Programme presentation delivered at Patients' Forum: 7 Jan • Planning commenced for Patient and Public Involvement/Equality Impact Assessment events in March	Meeting with Dir Public Health NHS London on 17th January 2007

Exercise and Scenario Testing	• No planned exercises or events during this period. • OGPO Team attended New Years Eve and New Years Day Events	No planned exercises or events during this period

Abbreviation	Full Name	Abbreviation	Full Name
BCA	British Columbia Ambulance	MAG	Medical Advisory Group
CMO	Chief Medical Officer	ODA	Olympic Development Authority
ICR	Incident Control Room	OSD	Olympic Security Directorate
IOC	International Olympics Committee	OSSRSC	Olympic Safety Security & Resilience Strategic Committee
LDA	London Development Authority	SAGOP	Safety Advisory Group Olympic Park
LOCOG	London Organising Committee for the Olympic Games		

Overarching Programme Plan: 2007-2012				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
2007	MPS Programme Planning & Definition	MPS Programme Planning & Definition	Work Stream Development	**Tranche 1: Foundation commences**
	Work Stream Objectives	Outline Business Case	Benefit Realisation Mapping	Tranche 1 project initiation
	Launch Day	Benefit Identification	Scoping of Tranche 1 projects	
	Programme Documentation	ODA and OSD secondments in place		
		Vision Statement and Blueprint sign off		
2008	Tranche 1 project initiation continued	Tranche 1 project implementation	Tranche 1 project implementation	**Tranche 2: Operational Planning and Readiness commences**
		Scoping of Tranche 2 projects	Scoping of Tranche 2 projects	Review post Beijing
			Tranche 1 Review	Tranche 2 project initiation

	Review post Beijing continued	Tranche 2 project implementation	Tranche 2 project implementation	Tranche 2 project implementation
2009	Training Venue Bid process			
	Tranche 2 project initiation continued			
2010	Tranche 2 project implementation	Tranche 2 project implementation	Tranche 2 project implementation	Tranche 2 project implementation
	Vancouver Winter Olympics			Tranche 2 Review
			Scoping of Tranche 3 projects	Scoping of Tranche 3 projects
2011	**Tranche 3: Testing, Exercises and Operational Implementation commences**	Tranche 3 project implementation	Tranche 3 project implementation	Tranche 3 project implementation
	Tranche 3 project implementation	Testing and exercise	Testing and exercise sites commissioned	Testing and exercise sites commissioned
	Testing and exercise			
2012	Tranche 3 project implementation	Tranche 3 project implementation	**Tranche 4: Games Time and Knowledge Transfer commences**	Tranche 4 project implementation
	Testing and exercise sites commissioned	Testing and exercises sites commissioned	Security Lockdown	Review – debrief and knowledge transfer into 2013 as required
	Scoping of Tranche 4 projects	IOC Visit	London 2012: Games Time	
		Torch Relay		
		Scoping of Tranche 4 projects		
		Tranche 3 Review		

Enclosure 10

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 18th December 2007

1.	**Chairman of the Committee**	**Dr Beryl Magrath**
2.	**Purpose:**	**To provide the Trust Board with a summary of the proceedings of the Clinical Governance Committee (CGC).**

3. **Agreed:**

The revised wording of the 'breaking an entry to a patient's home' procedure with an addendum added explicitly stating the actions Control should take when such an event takes place.

That two of the clinical risks on the Risk Register would be recommended to the RCAG for deletion.

Noted:

The contents of Operation's Pan London Governance report

That a formalised process for learning from incidents that were subsequently found not to be SUIs would be undertaken with the drafting of an 'Adverse Incident' process.

That an agreement with the Metropolitan Police Service regarding the transportation of patients had been received and was currently with staff side for comment.

The improvements in the process for obtaining data regarding Clinical Performance Indicators which has led to a significant improvement in number of Patient Report Form (PRFs) audited and the quality of information on the PRFs. The introduction of feedback to crews has led to a demonstrable improvement in clinical practice.

The progress achieved by mid December in evidencing compliance with the core health standards. The Head of Governance would be presenting evidence of the Trust's compliance with the healthcare standards to the LAS Patient's Forum in January 2008 prior to the Forum providing a commentary as part of the Annual Health Check for 2007/08.

A self assessment infection control audit would be undertaken on a Trust-wide basis in late December/early January, the findings would provide the Trust with a baseline for future work on infection control.

The contents of the Risk Information Report (July-September 2007).

That lost property bags would be introduced on a Trust wide basis

That steps would be taken to ensure that the monthly Clinical Update was widely publicised and brought to the attention of crews

That a series of workshops were planned at which a number of the Trust's policies and procedures would be reviewed whilst simultaneously training managers in the process of equality impact assessment

Minutes/oral reports received from:

PPI Committee (4th October 07); RCAG (30th October 2007); Training Services Group (31st October 2007).

Recommendation: THAT the Trust Board note the minutes of the Clinical Governance Committee, 18th December 2007.

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee
2.00pm 18th December 2007, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Sarah Waller	Non-Executive Director (until 15.00)
Fionna Moore (Vice chair)	Medical Director
David Jervis	Director of Communications
Russell Smith	Deputy Director of Operations
John Wilkins	Head of Governance
Paul Woodrow	Assistant Director of Operations, South
Nicola Foad	Head of Legal Services
Stephen Moore	Head of Records Management
Paul Tattam	Ambulance Operations Manager - D Watch
Pat Billups	Education Governance Manager (for Keith Miller)
Sajjad Iqbal	Diversity Manager
Rachael Donohue	Head of Clinical Audit & Research
Margaret Vander	PPI Manager
Gary Bassett	PALS Manager
Tony Crabtree	Assistant Director, Employee Services
John Selby	Senior Health & Safety Adviser
Kathy Jones	Director of Service Development
Christine McMahon	Trust Secretary (minutes)

In attendance:

Benjamin Jones	EMT
Steve Silverson	EMD
Brendan Bradley	Clinical Audit Facilitator
Annie Shillingford	Equality & Diversity Officer
Heather Ransom	Staff Officer to the Deputy Directors of Operations
Nic Lawrence	Head of Policy, Evaluation and Development

Apologies

Ingrid Prescod	Non-Executive Director
Chris Vale	Head of Operational Support
Malcolm Alexander	Chairman, LAS Patients' Forum

71/07 **Minutes of the Clinical Governance meeting held on Monday 15th October 2007**

Agreed **The minutes of the Clinical Governance Committee meeting held 15th October 2007.**

72/07 **Matters Arising**

Noted: *Minute 59/07:* the Head of Complaints said that from January lost property bags would be introduced on a Trust wide basis. The Chairman welcomed this news.

Minute 59/07: following Paul Dargan's presentation to the Senior Management Group it was agreed that the LAS would work with the National Poisons Information Service (NPIS) with the establishment of a clinical support desk in EOC. The Medical Director said that a funding bid would be submitted to facilitate access to a clinical services scheme that would ensure front line staff have access to medical and clinical advice. This service would also be available to UOC.

Minute 59/07: the Deputy Director of Operations said that the training pack used by NHS Direct to enable call takers to ask patients/callers their ethnicity had been received and would be implemented from 1st January. An update would be provided at a future clinical governance meeting. ACTION: Deputy Director of Operations.

Minute 59/07: the PPI Manager said that a bid for lottery funding would be submitted in due course. A funding bid would be drawn up following workshops being held to identity what materials and resources would be required.

Minute 59/07: the Medical Director said that child protection issues would be highlighted in a future edition of the monthly Clinical Update; the recent edition had focussed on obstetrics. Following discussion as to how the Clinical Update could be brought to the attention of front line staff the Deputy Director of Operations undertook to alert station administrators and to ask them to publicise it on their stations. ACTION: Deputy Director of Operations. The Director of Communications said that all active users should be alerted to the issuing of the monthly Clinical Update.

Sarah Waller said that the Audit Committee had recently considered the question of how the Trust could ensure that frontline staff were aware of changes in practice.

Minute 59/07: the Consultant Midwife would be invited to attend the Committee's meeting in April to provide an update on developments in the management of obstetrics. ACTION: Medical Director.

Minute 62/07: the Diversity Manager said that as yet an equality impact assessment had not been undertaken. A series of training workshops were planned for the end of January at which a number of policies and procedures would be reviewed whilst simultaneously training managers to undertake the assessment.

Minute 63/07: the Head of Governance said that, following the Trust Board's approval of the Annual Clinical Governance Report, the document had been submitted to the Governance Lead at NHS London.

Minute 67/07: the Deputy Director of Operations said it had not been possible to provide a breakdown of rest break allocation to the Trust Board in November; currently such analysis was undertaken manually which was time consuming. The Deputy Director of Operations said that staff on FRUs received a break most days, Urgent Care staff rarely received a rest break and ambulance staff received paid breaks on the whole. This reflected November being one of the busiest months the Trust has experienced. The number of front line staff receiving rest breaks has fallen in recent months.

Minute 67/07: a quality assessor has been recruited to work with Clinical Telephone Advisers (CTA). The Trust Secretary had circulated the Control Services Bulletin and would circulate the December issue. ACTION: Trust Secretary.

Minute 69/07(1): that approximately three copies of the infection control manual had been despatched to all complexes.

Minute 69/07(4): the Head of Clinical Audit & Research said that she had joined a number of research network which should widen the Trust's opportunities for collaborative working with NHS colleagues. In April 2008 Anne Weaver, HEMs, would attend the Clinical Governance Committee to discuss joint clinical governance arrangements between HEMs and the LAS.

73/07 **Revised 'Breaking an entry to a patient's home' procedure**

The Deputy Director of Operations presented the revised wording of the procedure for breaking an entry to a patient's home which is an extract from Operational Policy OP/017, 'procedure on actions on scene indirectly related to the patient'. The Committee considered the revised wording. The following suggestions were made: that Control be substituted for the current wording 'EOC' and that an addendum be added explicitly setting out the actions that Control should take in the event of crews needing to effect breaking an entry to a patient's home. ACTION: Deputy Director of Operations

Agreed: **The revised wording to be used in regard to 'breaking an entry to a patient's home incorporating the above suggestions.**

74/07 **Agreement with the Metropolitan Police Service Update**

The Committee was informed that the agreement regarding the transportation of patients had been received back from the Metropolitan Police Service's (MPS) solicitors. It was currently with Staff Side for comment. In recognition of the importance of this matter the Agreement would be presented to the Trust Board on 29th January and a report presented to the Committee on 4th February thereafter.

Agreed:

1. **That the Agreement between the LAS and the MPS on the Procedure for the Transportation of Persons to Hospital would be presented to the Trust Board for approval on 29th January 08.**

Noted:

2. **That as the MPS would take 6-7 months to draft a procedure to accompany the Agreement, a way forward had been agreed whereby the LAS would issue a front sheet to accompany the Trust's policy for the transportation of persons to hospital in close liaison with the MPS. The accompanying front sheet would be accepted by the MPS as an interim measure.**
3. **That in August 2003 a procedure, OP/020 Conveyance of Patients in Police Vehicles, had been issued but then immediately withdrawn following concerns raised by the MPS**.

75/07 **Presentation: CPI Development**

Brendan Bradley, CARU, presented an update on the developments that have taken place with the Clinical Performance Indicators (CPI) process during the last year and outlined those due to take place in the near future. The Patient Report Form (PRF) is the only source of data as to the contact that takes place between the patient and LAS personnel. Seven CPIs were audited including a 1:20 random documentation PRF audit by Team Leaders.

The developments included: the launch of an improved CPI database in July 2007; statistics for the number of audits undertaken; the feedback given and the quality of care documented on the PRF. Front line staff have been given access to their own CPI data, whereby they can access all audit data relating to them, and a history of all feedback session received. The feedback forms include details on audited PRFs for that individual, with five areas for improvement and five areas of recognised good practice highlighted. The feedback sessions can be included as part of the PDR meetings and be used to identify training need or areas where clarification is needed. The target for feedback sessions is two per individual per year. In 2006/07 2,500 feedback sessions were undertaken. In 2007/08, to date, 3,800 sessions have been undertaken.

A Complex refresher training programme was underway and quality assurance was being undertaken of CPI audits by Complex Training Officers to ensure accuracy and consistency of auditing practices.

Four specific CPIs for Emergency Care Practitioners (additional three CPIs – confusion, paediatrics and abdominal pain) have recently been implemented.

A representative from CARU attends monthly Area business meetings and a monthly CPI report is published highlighting Complexes' progress via the use of traffic lights (an example was circulated at the meeting).

The Head of Clinical Audit & Research proposed that the 7 CPI topics be reviewed as they were agreed eight years ago on the basis of evidence available at that time and the risk presented to the organisation. The Head of Clinical Audit & Research proposed substituting Obstetrics with a Stroke CPI, and monitoring obstetrics cases via regular clinical audit. In addition, it was proposed that instead of Team Leaders reviewing 1:20 PRFs they review 1:10. The Medical Director said that as the increased number of patients being left at home presented a high level of risk for the Trust the current system of 1:20 audits should remain unchanged for a further few months. The Medical Director agreed that the Obstetric CPIs could be replaced with a Stroke CPI on the condition that regular snapshot audits are undertaken of Obstetric PRFs.

The Head of Clinical Audit & Research reported that CARU are developing a system whereby CARU select PRFs and send them to Team Leaders as an electronic image for auditing. The Head of Clinical Audit & Research said that a bid had been submitted for non-recurrent LAS funding to provide Team Leaders with a second monitor to enable them to access electronic PRF images whilst simultaneously viewing the CPI database. This should make the process much more efficient and user friendly.

The Deputy Director of Operations said that the number of PRFs audited on most stations had significantly increased during recent years and it was pleasing to see the improvements in practice brought about by the feedback session as evidenced by the presentation from CARU.

The Director of Service Development said she welcomed the availability of this data as it would allow conversations about turnaround times at hospital to include discussions on clinical matters such as the CPI audits. Long turnaround times at hospital did have a clinical impact as it meant patients were waiting for ambulances.

The Assistant Director of Operations, South, said that from January 2008 the process for paramedic application would incorporate aspects of care as evidenced by CPI audits. An application to be a paramedic would require the support of Team Leader and Training Officer, who would base their assessment on the aspects of care as evidenced by CPI.

The Head of PALS welcomed the developments and suggested that the Head of Clinical Audit & Research liaise with Paul Cain Renshaw with regard to submitting it for consideration by the NHS Innovations[12].

76/07 **Review of Progress with evidencing the Core Standards for the Annual Health**

The Healthcare Commission has finalised the criteria for assessing core standards in ambulance trusts for 2007/08. The Head of Governance said that the evidence for the Annual Health Check 2007/08 was being collated. A snapshot of progress as of Tuesday 12th December was presented to the Committee. There was substantial evidence of compliance with 39% of the core standards; some evidence of compliance with 40% of the core standards but no evidence of compliance with 21% of the core standards. It is intended that evidence of compliance with the healthcare standards be presented to the LAS Patients' Forum in January 2008, prior to the Forum providing a commentary as part of the Annual Health Check for 2007/08.

Following discussion, it was suggested that the Head of Governance liaise with the Head of Programme and Project Management as to possibility of stakeholder engagement being undertaken in regard to compliance with the healthcare standards. An event was being planned by the Service Development team to check next year's services plan which might meet the requirement of stakeholder engagement. If necessary, a separate event would be held in early March to which representatives of local Overview and Scrutiny Committees, stakeholders, including the Patients' Forum, would be invited.

77/07 **Infection Control Update**

The Medical Director said that the Infection Control Policy had been revised and presented to the Trust Board in November 2007.

The Head of Governance undertook an analysis of the findings of the recent Healthcare Commission investigation undertaken into the outbreak of Clostridium difficile (CDiff) at Maidstone & Tunbridge Wells NHS Trust and subsequently drew up an action plan for implementing the lessons applicable for the ambulance service. The progress of the action plan would be reported to the Trust Board via the Medical Director's report. Amongst the actions included the appointment of an Infection Control Co-ordinator.

[12] NHS Innovations: established to provide services to the NHS to help Trusts identify, protect and develop their intellectual property (IP).

The Head of Governance recently met with the Deputy Director of Operations and the ADOs and received their support for complexes to undertake a self-assessment infection control audit, with a deadline of 7th January. The findings of the audit would provide the Trust with a baseline for future work on infection control. The audit tool had been trialled at other ambulance services. Following discussion it was agreed that PTS managers would be asked to separately audit PTS vehicles and that FRUs would be separately audited. ACTION: Deputy Director of Operations.

78/07 **Risk Information Report**

The Head of Governance presented the Risk Information report which covered the period 1st July to 30th September 07 and analysed themes and trends that have been identified in each section.

Incident Reporting: the report outlined the total number of clinical incidents reported to the Safety and Risk Department based on LA52 completion. 161 clinical incidents were reported, 10 of which were recorded as having an impact on patients. Overall, there appeared to be a steady decline in the reporting of clinical incidents. There were 151 near misses reported.

The Senior Health & Safety Adviser said that following discussions with the National Patient Safety Agency (NPSA) a tick box would be added to the PRF form reminding staff of the need to raise a LA52 in the event of an incident. The NPSA has offered to provide training to operational staff in root cause analysis in December and January.

Following discussion it was AGREED that the Head of Operational Support would replace packs of 50 chest electrodes on vehicles with packs of 10 to counteract the problem of the gel drying out and becoming useless. ACTION: Head of Operational Support

Clinical Negligence Claims, Potential Claims and Problematic Inquests: the report identified the caseload opened; emerging themes in Quarter 2 and the output from the round table review of cases closed in this quarter. There were no significant changes to draw to the Committee's attention. The information in this section of the report has been passed to the Area Governance Groups in the West and South, and would go to the East for their next meeting in February 2008.

The following actions have been taken following claims and contentious inquests:

- in regard to delayed ambulances, systems were now in place to show the nearest FRU and would be introduced to identify the nearest available Ambulance for EOC/UOC.
- a bulletin has been issued in the 'LAS News' not to accept information from a third party in regard to refusal and the actions expected. When necessary Crews were able to access a Capacity Tool.

The Head of Legal Services said that round table discussions were making good progress following the participation of operational colleagues. The Chairman asked the Deputy Director of Operations to encourage operational staff to implement the actions agreed at round table discussions.

PALS and Complaints: this outlined the activity undertaken by PALS and the Complaints received during the period, identifying the emerging themes and providing useful case examples. Incidents not declared as SUIs have been outlined and proposals made.

The PALS Manager said that there were examples of long delays in relation to lower priority calls; that due to a consistently high demand in EOC, callers were frequently not rung back within the designated 30 minutes timeframe and ETA calls were frequently not re-triaged. The Deputy Director of Operations, Control Services has taken pro-active steps by issuing a reminder via team briefings about the need for callers to be rang back within 30 minutes if an ambulance has not been despatched and the necessity for ETA calls to be re-triaged. Steve Silverson (EMD) said that stickers have been put on screens reminding call takers of the need to undertake retriage.

NOTED: 265 letters of appreciation had been received between July and September 2007.

Diversity: as the Diversity Manager joined the Trust on 17th September the report outlined work undertaken during September to December. Future reports on diversity would cover the same time period as the other sections of the report.

As part of demonstrating the Trust's ongoing commitment to equality and diversity and human rights the Diversity Manager has been in discussion with Stonewall regarding the LAS joining the Diversity Champions Programme.

The Diversity Manager said that he would be suggesting training on diversity for Senior Management and the Trust Board as it has been some time since the last training session was held. ACTION: Diversity Manager.

79/07 Clinical risks on the Risk Register

Agreed:

1. **That the following risks would be proposed to the RCAG for regrading/deletions:**

   Risk 188 to be proposed for deletion. ACTION: Deputy Director of Operations.
   Risk 133 to be proposed for deletion and a new risk submitted for the Register in respect of the resources required to co-ordinate the reporting of suspected abuse of children/vulnerable adults. ACTION: Head of PALS/Complaints.

2. **That the following risks remained unchanged as there was no evidence to support regrading/deletion: 269, 31, 16, 138, 20, 22, 71, 211, 188, 179**

Noted:

3. **That the following actions would be undertaken in relation to the individual risks on the register:**
   Risk 22: operational work place review to take place twice a year, ACTION: Education Governance Manager
   Risk 207: RD to be responsible Officer; ACTION: Deputy Director of Operations to co-ordinate a meeting of ADO South, Head of Clinical Audit & Research and Benjamin Jones to review the process for capturing the FR2 data as CARU were receiving only 24% of data cards for patients who have suffered a heart attack.
   Risk 211: Medical Director, Director of Communications, Senior Clinical Adviser to Medical Director and ADO, South to discuss how members of staff could be encouraged to improve the reporting of near misses in respect of drug errors and adverse events.

80/07 Findings of the PRF completion and transportation audit.

The Head of Records Management said that a draft audit report undertaken by the Internal Auditors concerning completion, management and distribution of Patient Report Forms was considered on 16th November but there were concerns about its coverage and conclusions. The Auditors had been requested to make a number of changes and a final report is awaited. This report will be presented to the Committee in February. ACTION: Head of Records Management.

81/07 Update from PALS

The Head of PALS highlighted the following from his report:

A formalised process for learning from incidents that were subsequently found not to be SUIs would be undertaken with the drafting of an 'Adverse Incident' procedure. This would be managed by the new Patient Feedback Department and would emphasis learning and improvement of practice. ACTION: DJ/GB/PB/RM/JW to discuss the new Adverse Incident Procedure and Policy.

It was suggested that Paul Tattam assume Lyn Sugg's role as NHS Direct liaison officer.

The Director of Service Development said the case histories included in the report made for interesting reading.

82/07 **Operation's Pan London Governance Report**

The Deputy Director of Operations highlighted the following from his report:

- Incidents: for the fourth quarter there has been a decrease in the number of incidents
- CPI: the average performance to date was 63% with 11 complexes achieving the 70% target. The target for front line staff to receive feedback on their CPI is twice a year, and as was previously reported (Minute 75/07), this was being exceeded in some areas.
- Alternative response vehicles were being staffed by team leaders between 11 and 2pm
- Call answering: 1st week in December 95% of calls were answered within 5 seconds which was a notable achievement.
- Clinical development: The first modules included resuscitation, patient assessment and manual handling/core skills revision.
- The Committee's attention was drawn to the training taking place at local ambulance stations, including a ten week Bengali language class that was being run at Newham AS.
- Rest break allocation performance had fallen from 72% to 67%.[13] There had been difficulties delivering rest breaks due to the Trust experiencing very high levels of demand in November.
- Driving licence checks were being undertaken on a six monthly basis as part of the PDR process.
- During the period 24th September to 21st November 2007 there were 177 requests for paramedics to attend the scene of an incident as an extra resource to provide more appropriate assistance. Of these requests 92.3% were able to be complied with.
- Handover summits were being held in each Area to completely rebuild, with hospital managers, the handover process that takes place between crews and A&E medical personnel. These have been well attended so far with positive feedback and should result in an end to the administrative handover in all London hospitals, which will save potentially 5 minutes per call which would give an extra 10% resource to the Service.

Control Services: the Ambulance Operations Manager, D Watch, highlighted the test of the fall back control room that had taken place in October; a follow up test was planned for February/March 2008.

The ADO South highlighted the following: there had been a marked improvement in feedback sessions, rising from 69 in April to 107 in October. He praised CARU for listening to user's feedback and their endeavours to make the process user-friendly. A research project was being undertaken in regard to diabetics and an update would be given to the Committee in February. The Medical Director suggested that this might be of interest to the Emergency Medical Journal.

83/07 **Update re. NICE**

The Medical Director said that NICE had not recently issued guidance relevant to accident and emergency services; guidance was awaited regarding cardiac chest pain.

[13] Rest Breaks: 32.8% received no break. Of the 67%, 33.8% received a break; 9.4% received no break but had time at the end of their shift; 0.9% had an interrupted break and 23.1% were given a break at the end of their shift but were interrupted.

84/07 **Reports from Groups/Committees**

1 *PPI Committee, 4th October 2007*

The Director of Communications highlighted the following from the PPI minutes:

- the non-attendance by members of the Patients' Forum at the Committee's meeting had been disappointing;
- the progress of the projects taking place in Tower Hamlets which included a DVD produced by Richard Walker that contained different scenarios with different illnesses and how they could each be treated. The DVD had an interactive facility that would allow it to be used by different audiences.

He reported that:

- The PPI Manager had recently attended a NCI national conference to talk about the Tower Hamlets project and had joined a new PPI leadership group for the ambulance service.
- The Public Education Strategy had been published
- The Diversity Manager would be joining the membership of the Committee.

2 *Risk Compliance & Assurance Group, 30th October 2007*

The Medical Director highlighted that the RCAG had noted:

- the analysis of the Healthcare Commission's Enquiry into the failings in infection control at Maidstone & Tunbridge Wells NHS Trust and what lessons could be learnt by Ambulance Services;
- the test undertaken of the fall back control room;
- the findings of the Trust wide risk assessment,
- the training plan
- the quarterly report regarding claims, incidents and problematic inquests
- the minutes of a number of reporting groups/committees.

3 *Training Services Group – 31st October 2007*

The Medical Director reported that at the recent meeting on 31st October discussions were held to clarify the position regarding Laryngeal Mask Airway (LMA) and it was agreed that technician and paramedics were authorised to undertake LMAs even if they had not completed the theatre placement part of their training.

The pre-course support instituted to support members of staff applying to become paramedics had been successful with the pass rate rising from 25% to 75%. The support had been provided mainly by Training Officers.

Work was being undertaken to agree the course contents of the next wave of modular courses. There would be no training courses delivered until the end of April so as to support Operational colleagues deliver patient care.

A bid was submitted to NHS London for the provision of education and training that would be delivered in 2008/09.

The Group recently met in November (minutes not yet available) and considered the systems in place to record all training pan-LAS.

A training package has been put together for members of staff who were undertaking FRU duties on a regular basis; this would include driving assessment and remedial package for any shortcomings identified and would also address the challenges of lone working.

Noted:

1. **That the following groups have not met since the last CGC meeting: the Clinical Steering Group, CARSG and the Race Equality and the Diversity Strategy Group.**
2. **That the Race Equality Strategy Group is to be reconstituted**

3. **The minutes of the Complaints Panel (27th November) and the Training Services Group (30th November) were unavailable for the meeting.**
4. **The Infection Control Group met on 13th December 07**

85/07 **Draft 2008 Forward Planner**

Agreed:
1. The draft 2008 forward planner
2. That Pan London report would go to the full meetings of the Governance Committee with Area reports being presented to the core meeting group.
3. That the focus for the themed risk information report in February meeting would be non-conveyance. ACTION: Head of Governance to co-ordinate themed report.

86/07 **Dates of next meeting:**

Core: Monday, 4th February 2008, at 9.30am in the Conference Room, HQ
Full: Monday, 28th April 2007 at 9.30am in the Conference Room, HQ

Meeting concluded at 17.35

Enclosure 11

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 18th December 2007 at 10:00 a.m.
Held in the Conference Room, LAS HQ

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Sarah Waller	Non Executive
	Beryl Magrath	Non Executive
	Caroline Silver	Non Executive
	Roy Griffins	Non Executive (until 13.05)
In attendance:	Caron Hitchen	Director of Human Resources & Organisation Development
	Fionna Moore	Medical Director
	Mike Dinan	Director of Finance
	Russell Smith	Deputy Director of Operations
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development
	Christine McMahon	Trust Secretary
Apologies:	Ingrid Prescod	Non Executive
	Martin Flaherty	Director of Operations

41/07 Minutes of the last meeting of the Service Development Committee, held on 30th October 2007.

The Chairman **signed** the Minutes as a correct record of the meeting held on 30th October 2007.

Matters Arising

Minute 28/07: the Chairman said that to date no funding had been received from the Mayor of London in respect of Emergency Life Support Training

Minute 31/07: the Finance Director said that Incident Data Recorders had been installed on the Trust's new Fast Response Units. Discussions were being held with Staff Side as to how the information provided by the Incident Data Recorders would be used. A group of Duty Station Officers was being trained to interpret the data produced by the Recorders. The Incident Data Recorder Project was being managed as part of the Corporate Processes and Governance Programme.

42/07 Chairman's Update

The Chairman said that, following interviews held on the 11th December, Brian Huckett would be recommended to the Appointments Commission to fill the vacancy created by retirement of Barry MacDonald. The Chairman said that Mr Huckett would bring a wealth of experience to the Board, particularly in regard to Audit Committees. It was anticipated the Appointments Commission would confirm Mr Huckett's appointment when it meets on 7th January and that he would attend the Trust Board meeting on 29th January 2008.

The Chairman drew the Committee's attention to the recently published Operating Framework. **ACTION: Trust Secretary** to forward electronic links to the document and to provide hard copies as requested. The Chief Executive said that the Operating Framework signalled the services the Department of Health expected

Commissioners to commission from their local Providers. The 2008/09 Operating Framework referred to CBRN for the first time, thereby raising the profile of emergency preparedness nationally.

The Chairman said that the Department of Health intended to retain the Category B 19 target for 2008/09. This would have an impact on the negotiations taking place with the Trust's Commissioners as the Trust would be required to achieve 95% Category B 19 performance in 2008/09.

The Chairman said that in 2008 he would be seeking the resumption of the meetings of the Chairs and Chief Officers of the London Emergency services (Metropolitan Police Service, London Fire Brigade and the LAS). These had been held regularly for a while but with key people moving on at both the MPS and the LFB, had become irregular and then stopped.

43/07 <u>Performance update</u>

The Deputy Director of Operations said that November had been the Trust's busiest month with 70,831 calls being received. Compared to November 2006 there was a 2.73% increase in overall demand and a 7% increase in Category A - due mainly to a rise in respiratory illnesses. Category A 8 performance in November was 78% on the current measure; it was anticipated that the Trust would meet the 75% target for the year as a whole.

Achieving the new 'Call Connect' performance target remained a significant challenge for the Trust; in November the Trust achieved 62.92% against the trajectory of 68%. Category B 19 performance in November was 84.83% against the target of 90%.

In December to date, there was a 4% increase in overall demand with Category A demand increasing by 2.56%. 'Call Connect' performance was 56% and it was suggested that staying on the trajectory of 72% for 'Call Connect' in January-March and 75% in April 2008 would be a significant challenge for the Trust.

The Deputy Director of Operations outlined a number of initiatives that were being implemented to improve performance:

- Caller Line Identification had been introduced for calls received via Cable and Wireless; this enabled vehicles to be despatched once the Call Taker had verified the address that appears on the screen;
- FREDA, the automatic despatch of ambulances, was introduced in early December;
- Dynamic Deployment of Fast Response Units was introduced in December. Cars were being deployed to locations where historic data indicated periods of high demand at specific locations.
- The Motor Cycle and Cycle response units have been expanded (15 and 25 additional members of staff respectively).
- To improve turnaround times at hospitals a clock had been installed on the Mobile Data Terminals (MDTs), alerting crews as to how long they had been at hospital and reminding them to contact EOC if the turnaround time exceeded 25 minutes. In December and January MDTs would be upgraded; this would include better mapping, antiviral software and access to television.

It was Noted that:

The MDT mapping software is manually updated every six months and does not receive the real time updates that were available from commercial satellite navigation aids, such as Tom-Tom. The Director of IM&T said an investigation would be undertaken to ascertain the feasibility of the Trust accessing data on a real time basis. **ACTION: the Director of IM&T.**

44/07 Draft 2008/09 budget

The Director of Finance presented a draft of the 2008/09 budget and a three year plan. He outlined the NHS London planning process: this included the publication of the NHS London Planning Guidance (11th December) and the NHS Operating Framework (14th December). All London NHS Trusts were expected to submit a draft 2008/09 Plan and Commentary to NHS London by 15th January 2008. All NHS London Service Level Agreements were expected to be agreed by 29th February, with Trusts submitting their final 2008/09 budget by 29th February 2008.

The draft budget presented to the Committee was based on a top down assessment of the expenditure necessary to achieve the Trust's performance targets in 2008/09: 75% of Category A calls reached in 8 minutes counted from when the call comes in ('Call Connect') and 95% of Category B calls reached in 19 minutes. The same information was presented to the Commissioners as part of the initial discussions regarding 2008/09 funding.

In terms of income, the Trust anticipated receiving £7.4m CBRN funding; £5m in respect of providing two HART teams and funding of the preparatory work being undertaken in respect of the 2012 Olympics. A decision was still awaited as to whether the Department of Health or NHS London would be funding the Trust's preparation for the Olympics. A bid for £18m in respect of education and training had been submitted to NHS London. PTS' 2008/09 budget reflected the contracts lost in 2007/08 and it was expected to be smaller but maintain its existing profit margins.

The budget reflected the recent guidance from the Department of Health which required 'cash releasing savings' of 3% (CRES); an additional 0.5% saving is planned internally.

The Finance Director said that the impact of the new NHS capital regime had yet to be determined. The new regime essentially provides a capital allocation equivalent to the current year's depreciation cost. Any additional capital required would either have to be generated internally or borrowed from the NHS formally. This is in line with how Foundation Trusts operate. Currently, the LAS had a Prudential Borrowing Limit (PBL) of £24m with the NHS.

The Three Year Assumptions included an increase in Accident & Emergency income of 2% and an increase of 3% for other income net of inflation and CRES. PTS was expected to remain stable with a turnover of £8m and 4% net margin. The EBITDA[14] margin would improve from 5.3% to 6.0% with finance and depreciation costs decreasing from 4.8% of income to 4.5%. The Trust was forecasting a net surplus of 1.5% by 2010/11.

Further work would be undertaken with different departments to produce a 'bottom up' budget that the Senior Management Group would review on the 9th January 2008. The Trust Board would further review the budget at both the January 2008 meeting and the Service Development Committee meeting in February 2008. **ACTION: The Finance Director.**

[14] EBITDA (earnings before interest, taxation, depreciation and amortisation) is a measure of an organisation's operating cashflow

It was Noted that:

NHS London was aware that the LAS' Board, and indeed those of many of the London Trusts, would not have formally approved the draft 2008/09 budgets required to be submitted by the 15th January, as the majority of Boards hold their meetings at the end of the month. In his discussions with NHS London, the Director of Finance had said that the submitted draft budget would be subject to material change prior to the submission of the final budget at the end of February.

The recently published Operating Framework included a reference to 'volume increase' which recognised that increases in demand should be matched by additional funding; this issue had been raised with the Trust's Commissioners.

There was a concern that the Commissioners might not fully appreciate the significance of the high levels of utilisation of the LAS' front line resources. The introduction of the 'Call Connect' Category A 8 minute performance target will require an almost instantaneous dispatch of a resource within a short distance. Given the high levels of utilisation (around 70% overall and 100% at certain times in some areas) there is a high probability that there would be no available resource to despatch until the next one becomes free. There was a discussion as to how the significance of utilisation could be demonstrated to the Commissioners.

Despite a 2.73% increase in demand experienced in November, the Trust transported 2,000 fewer patients to hospital. This would have translated into savings for London's health service of around £1.5m.

Current national benchmarking analysis showed the LAS receiving £26.54 per annum per head of population compared to a UK average of £24.40. This analysis would be further developed to take account of location inflation levels and transient population.

The CAD 2010 project would require a mixture of capital and revenue expenditure. The Director of Finance said that NHS London and the Commissioners were aware of the potential costs involved with the project.

It was AGREED that the Chairman would review the draft budget prior to submission to NHS London on 15th January. **ACTION: The Chairman**

45/07 **Presentation re. exemplar complexes (including clinical leadership)**

The Chief Executive presented an update regarding 'New Ways of Working' (NWoW) which was described in a series of documents that included: New Ways of Working – An Overview; Future Operational Response; Workforce Plan; Education & Development Restructure; Training & Development Plan 2007-2009; Education & Training Delivery Model; Working Practice Modernisation and Clinical Leadership & Support.

The Chief Executive outlined the process for identifying the three exemplar complexes, how they would be supported and the implementation of the 'New Ways of Working' with effect from September 2008.

A number of desirable and essential criteria have been identified. The essential criteria included: the complex wanting to do it; commitment from management & the complex team to see the development through; demonstrable understanding of the specific profile of the local population and support from the local Primary Care Trust.

In addition, a number of factors have been identified as being crucial for the success of the project: a fully staffed and committed management team employing new styles of leadership; a leadership development and team development programme

for the whole team and high quality Trainers with recent clinical development and strong links to the Trust's Clinical Audit and Research Unit.

The benefits expected from undertaking this project were: significant improvements in patient care and increased job satisfaction for staff. The Chief Executive said that the Assistant Director of Organisation Development (Bill O Neill) had reported receiving both positive and negative feedback concerning the initiative.

It was Noted that:

The applications from complexes interested in being amongst the early implementers would require support from a majority of staff on the complex as the initiative would entail significant changes in the ways complexes work, including the up-skilling of front line crews.

The motivating factor for the complexes would be the opportunity, and the support being offered, to deliver a world class service to the local population.

46/07 **Discussion of Foundation Trust Application**

The Director of Finance outlined the work that had been taking place in preparation for the Trust Board's discussion concerning application for Foundation Trust status.

The Trust will be using some of the £8.2m received from NHS London under the 'Invest to Save' scheme to fund two projects were that were specifically concerned with foundation trust status; one involved an analysis of the Trust's potential membership and another concerned financial modelling. The Trust would be working with NHS London and Monitor[15] in respect of a diagnostic tool for ambulance services applying for foundation trust status. The Trust would be considering the pros and cons of joining the Foundation Trust Network. Funds would be set aside in the 2008/09 budget to support the application process should the Board decide to proceed with the application.

Although the Finance Director raised the question of the possible impact of the Private Patient Cap it was agreed that it was unlikely to be much of an issue for the Trust.

It was Noted that:

A paper outlining what the benefits of Foundation Trust status would be for the Trust would be presented to the Committee in February with the Trust Board making a formal decision in March 2008. **ACTION: Director of Finance**

If the Board should decide to apply for Foundation Trust status, the application would be submitted August/September 2009.

The Chairman would consider inviting NHS colleagues whose Trusts had become Foundation Trusts to the Board's Away Day in April 2008 to speak about their experiences. **ACTION: the Chairman**

The membership required as a Foundation Trust would present a number of challenges in terms of recruitment and on-going maintenance. Consideration would be given as to how the Trust would utilise future members to be a benefit rather than simply a cost to the Trust, for example by being a pool from which members of focus group could be recruited to advise the Trust on service developments. It was accepted that there were significant costs associated with maintaining and engaging with such a membership.

[15] Monitor authorises and regulates NHS Foundation Trusts to ensure that they are well managed and financially strong

The work being undertaken in regard to Foundation Trust should not jeopardise the Service Improvement Programme in general nor the NWoW initiative in particular. It was proposed that whatever decision is made by the Trust Board, it should complement the Trust's developmental work and support the objective of 'responding appropriately to all our patients'.

47/07 NHS London Provider Agency Assessment

The Finance Director gave a brief description of the London Provider Agency (LPA), most of whose operating personnel were previously employed by Monitor. The LPA is an arms length organisation of NHS London, responsible for performance managing NHS Trusts in London, excluding Foundation Trusts.

Although initially rated as 'red' for both finance and governance the Trust was recently re-evaluated as 'green' for each of these areas as it had satisfied the LPA that it had proper systems and processes in place. The Trust's rating in regard to services provided had been changed from 'amber' to 'green' to reflect the Healthcare Commission's ratings of 'good' for clinical care in 2006/07.

It was Noted that:

As part of the Board's development the Chairman would consider the provision of additional financial training in preparation for applying for Foundation Trust status. **ACTION: the Chairman.**

48/07 Digital Radio Implementation

The national ambulance radio programme was established to replace analogue voice and data services with a new digital system for NHS Ambulance Trust in England and Wales. Since July 2005, the three emergency services, Police, Fire and Ambulance, have been signed up to switch to a digital radio system. Following the bombings in London on 7th July 2005, the LAS requested that its participation in the roll out of the new digital radio system be brought forward by 12 months to September 2008.

Amongst the benefits of the new system would be: the Trust would no longer be bound by geographical constraint; there would be improvements in coverage; improvements in audio quality, capacity, reliability and functionality. It would also provide inter-operability with other emergency services and Trusts; greater flexibility and options for new ways of working.

In 2007 200 new digital radios were received and distributed to key users throughout the Trust.

In October 2007 the National Project 'paused' due to issues concerning the supply/interface with the systems in control rooms around the country; this had led to a five month delay to the implementation of the programme. The Director of IM&T said he was confident that the Trust would be able to manage the expected five month delay down to two months as a number of parallel activities were being undertaken in mitigation (e.g. new software was being tested in Bow). The roll out of the new radio system was currently planned to complete by September, although the Director of IM&T expected that October/November 2008 would probably be more realistic.

It was Noted that:

Although the Trust received funding from the Department of Health for the core equipment; the Trust was required to fund the costs for additional equipment and for staffing.

In response to the Committee's wish for assurance as to the contingency arrangements should a national emergency arise the Director of IM&T said that once the new system was fully operational, it would be much more resilient than the current system and there would be robust arrangements in place to ensure the system would function in the event of an emergency situation.

49/07 Report by technology monitoring team on CAD 2010

Roy Griffins said that as the Trust Board's nominated representative he had recently met with the Consultant engaged to provide the Board with assurance regarding CAD 2010. Ms Armitage's report had been circulated via email prior to the Committee's meeting. Ms Armitage stated that the process to date has been undertaken in an exemplary manner and that "the recommendation to the Project Board to take two suppliers forward in the Competitive Dialogue process is in line with current OGC good practice guidance".

The Consultant identified four issues. There were two that were considered to be matters of internal management, and two that were matters to be brought to the Committee's attention. The internal issues concerned the desirability of incorporating procurement as part of the project, and the reliance on consultants for project management. The Director of IM&T said that both of these matters were in hand; the procurement process going forward would be embedded in the overall project planning and management process and there were plans in place for the project management to be taken in-house.

In discussion, Roy Griffins and the Director of IM&T emphasised the need for caution should members of the Board be approached by the short-listed suppliers. They suggested that any conversation be carefully recorded as discussions were at a delicate stage.

There was discussion of the migration strategy from current systems to the new ones and in particular of the need for the Board to be fully aware of the nature of the risks associated with any migration strategy and plan. It was AGREED that the Director of IM&T would present a report to the Trust Board prior to May 2008 outlining the options and risks involved in the migration strategy. **ACTION: Director of IM&T**

It was Noted that:

If matters developed as the Director of IM&T anticipated, a report would be presented to the Trust Board in May 2008, recommending a preferred supplier of the new system and authority to commence work on a time and material basis (remaining within the delegated authority of the Trust). This would enable the project to progress while completing the Gate 3 review[16] (investment decision) and seeking approval of NHS London, prior to obtaining the Trust Board's full approval in September 2008.

50/07 SIP 2012 update: organisation development and people

The HR Director presented an update on the Organisation Development and People Programme.

The HR Director reminded the Committee of the programme structure for SIP 2012, referred to the inter-dependencies that existed between the five programmes and the underpinning role of the Stakeholder engagement programme. 'New Ways

[16] The Office of Government Commerce (OGC) developed the Gateway Project Review Process to review all high risk investment projects and programmes. The Gateway Project Review Process looks at the readiness of a project or programme to progress to the next phase at six key stages, or Gates, in the life of the project.

of Working' was not a separate programme in its own right but would be delivered by four of the five programmes (the fifth being the Olympics programme).

The Programme's objectives included establishing:

- a workforce profile that supports the Operational Model with the profile representative of London, appropriately skilled & confident in use of skills;
- a learning organisation that works cross-functionally in a customer focussed and team-based way;
- a culture of diversity, with mutual challenge and accountability for personal behaviour and performance, where behaviour is value driven;
- new styles of management that would be supportive of staff and promote staff involvement and development, with leadership at all levels underpinned by the necessary skills

Within the Organisation Development and People Programme, 11 projects have been identified to date. The 11 projects included: Workforce Reconfiguration; Staff and Union Engagement; Recruitment and Induction; Training Restructure; Modularised Training and Learning Management Systems

Workforce Reconfiguration: the initial workforce plan has been agreed and further modelling was taking place to identify the desired overall skill mix into the next financial year and beyond.

Recruitment and Induction: project planning was in progress and products to support 'values based recruitment' were being assessed as to their suitability. The HR Director said that in 2007/08 to date, 13% of recruits were from a Black and Minority Ethnic (BME) background compared to 10% in 2006/07.

Staff and Union Engagement: there had been approval of the Partnership Agreement with an associated work schedule yet to be agreed. A Partnership Forum had been established and was working well. The consultative arrangements were being reviewed and would be finalised in January 2008.

Modularised Training: three training modules were introduced (resuscitation, patient assessment and manual handling) and, since May 2007, 1,500 members of staff have attended training sessions. An implementation plan for the introduction of new modules in 2008 had been drawn up and developmental work was being undertaken in respect of an e-learning site.

Training Restructure: a new senior management structure would be in place from 1st January 2008; this would be followed up by the appointment of high calibre training officers to local complexes.

Leadership Development: there was a coaching programme for new AOMs in place. In 2008/09 an enhanced leadership development programme would be rolled out with the sixth ELSA[17] course commencing October 2008. The HR Director undertook to circulate the overview of the ELSA programme to the NEDs. **ACTION: HR Director.**

The Performance Management Framework was in the final planning stages. The project had been scoped; the project brief and milestone plans agreed and a project manager identified to lead on the project

The outstanding projects included: Learning Management System, which would capture information on <u>all</u> the training undertaken within the Trust, and Team Briefings, which would support staff involvement and communication.

[17] ELSA (Exploring Leadership & Self Awareness)

It was Noted that:

The draft revised Vision Statement shared with the Committee would be formally presented to the Trust Board in January for approval. **ACTION: Chief Executive**

51/07 Any Other Business

The Finance Director said that the Trust was currently forecasting a surplus of £900,000 at year end.

52/07 Date of future meetings:

The Service Development Committee meets again at 10.00am on 26th February 2007 in the conference room at the LAS, Waterloo Road, SE1.

The meeting concluded at 13.15

Enclosure 12

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 29th January 2008

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 6 tenders received since the last Trust Board meeting.

Provision of a Gazetteer	Dotted Eyes ESRI Northgate
Provision of Casualty Management Shelter	PPS
Provision of Medical Gases in Cylinders	BOC MGS Air Liquide
Buckhurst Hill (Stage II)	Jordan James Aspen Healthcare
Automated External Defibrillators	Zoll Laerdal Physio Control
St Hellier AS Reconfiguration & Heating Systems replacement works	Expert Property Solutions Neilcott Construction Ltd Fairhurst Ward Abbott Ltd Lakehouse Contracts Ltd Russell Crawberry WT Cuffe

3. Recommendations

THAT the Board note this report regarding the receipt of tenders.

Christine McMahon
Trust Secretary

London Ambulance Service
NHS Trust

Information Pack for Trust Board

December 2007

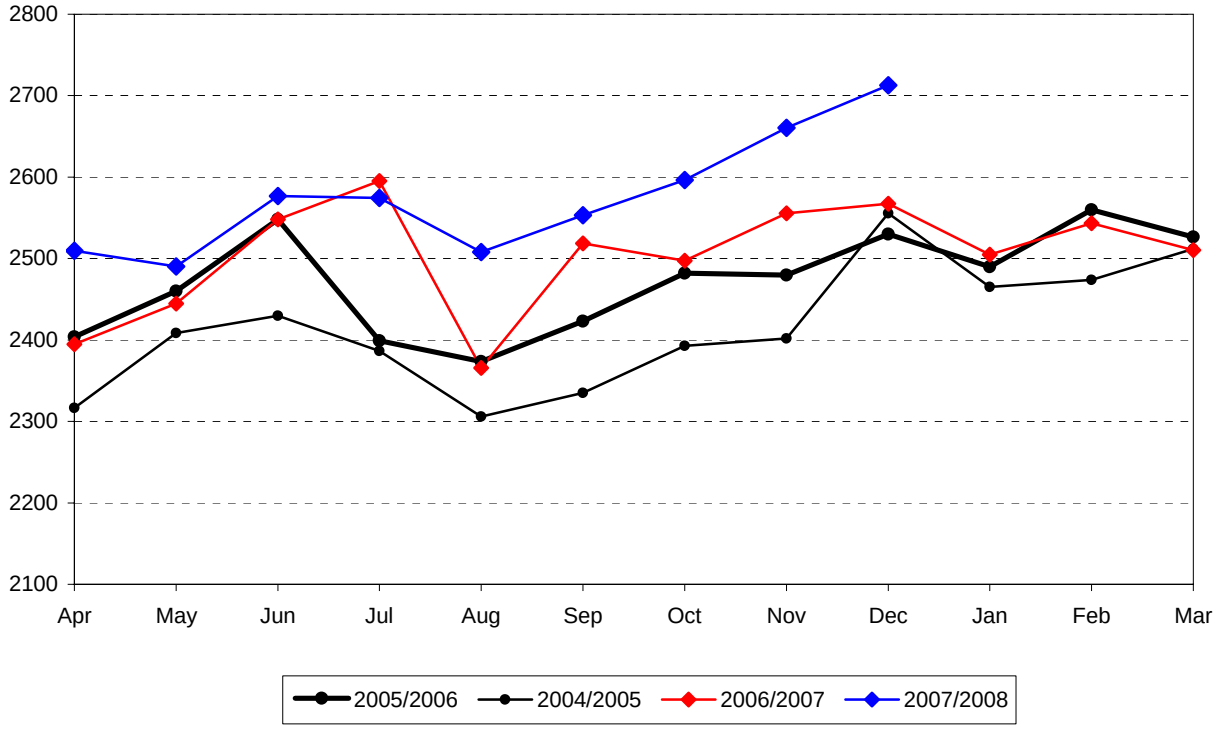
Please note:

PRF data entry is up to 23/12/07

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity and Category A and performance

Graph 1

Average number of Cat A,B,C and Urgent responses per day: 2004/05, 2005/06, 2006/07, 2007/08

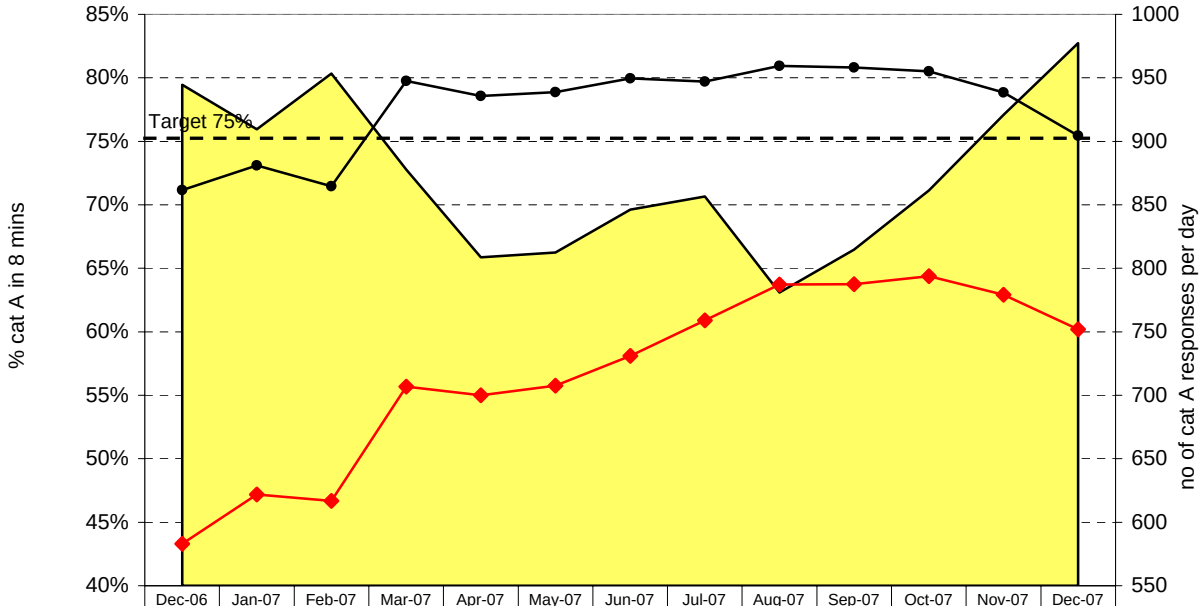


Cat A,B,C and Urgent responses: monthly and year to date comparison

December 07 v December 06	year so far 07 v year so far 06
+5.7%	+3.1%

Graph 2

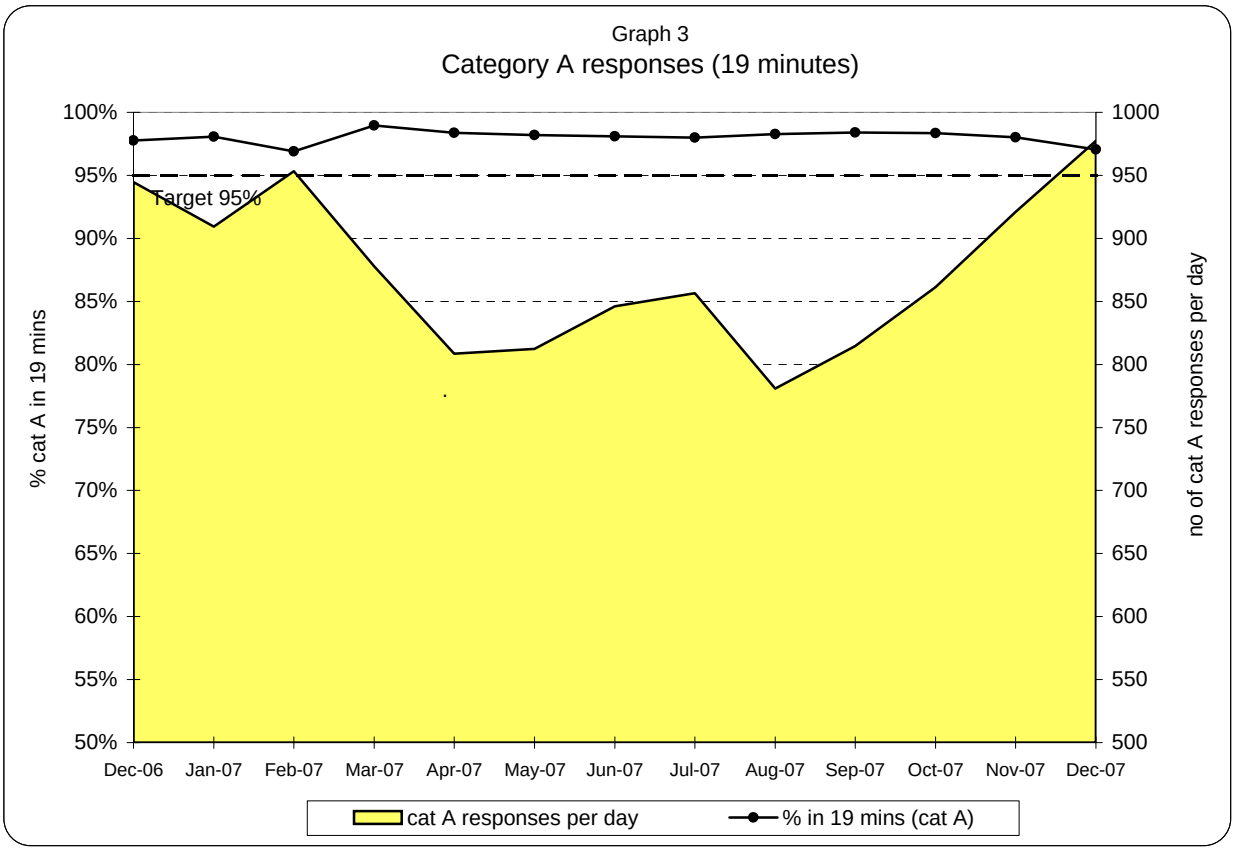
Category A responses for all responders (8 minutes)



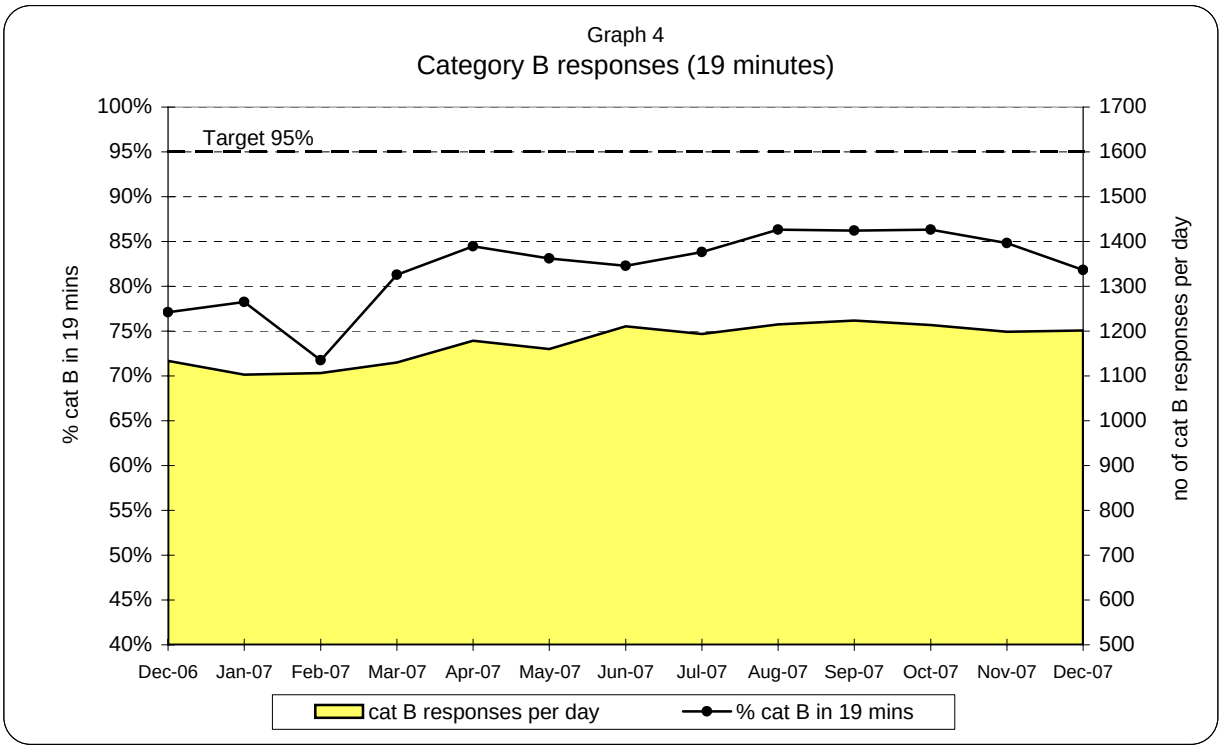
	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07
Cat A resp per day	945	909	953	878	809	812	846	857	781	815	861	921	977
A8 Call Connect % 8 mins	43.3%	47.2%	46.7%	55.7%	55.0%	55.7%	58.1%	60.9%	63.7%	63.8%	64.4%	62.9%	60.2%
A8 Current % 8 mins	71.2%	73.1%	71.5%	79.8%	78.6%	78.9%	80.0%	79.7%	80.9%	80.8%	80.5%	78.8%	75.4%

London Ambulance Service NHS Trust
Accident and Emergency Service
Category A and Category B 19 minute response activity and performance

Graph 3



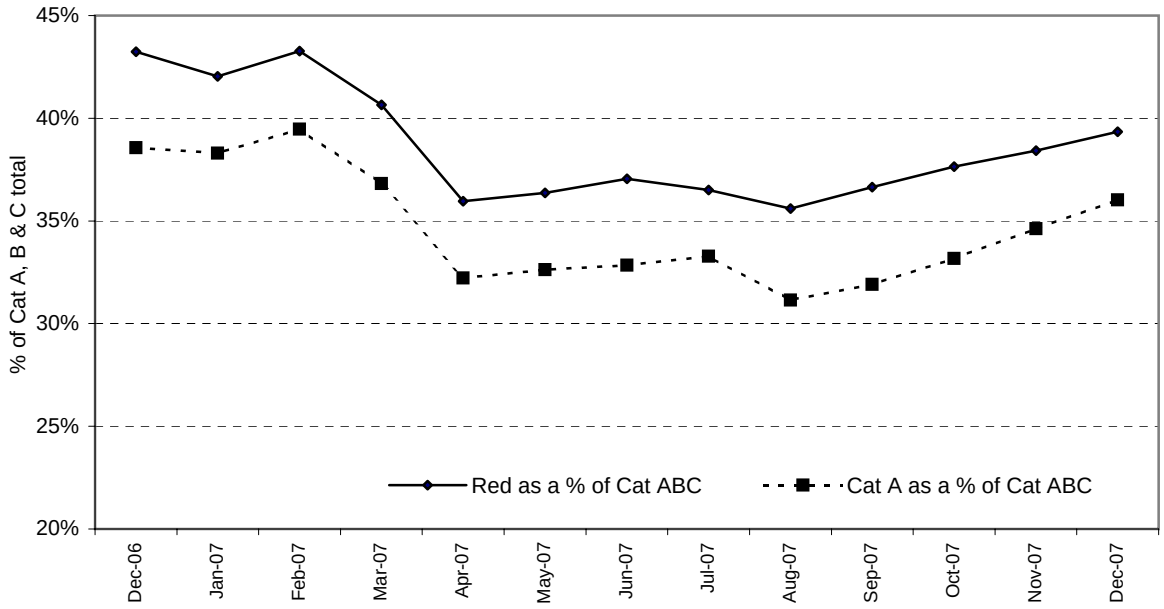
Graph 4



London Ambulance Service NHS Trust
Accident and Emergency Service
Category A and Red Responses as a percentage of the total Cat A, B C demand

Graph 5

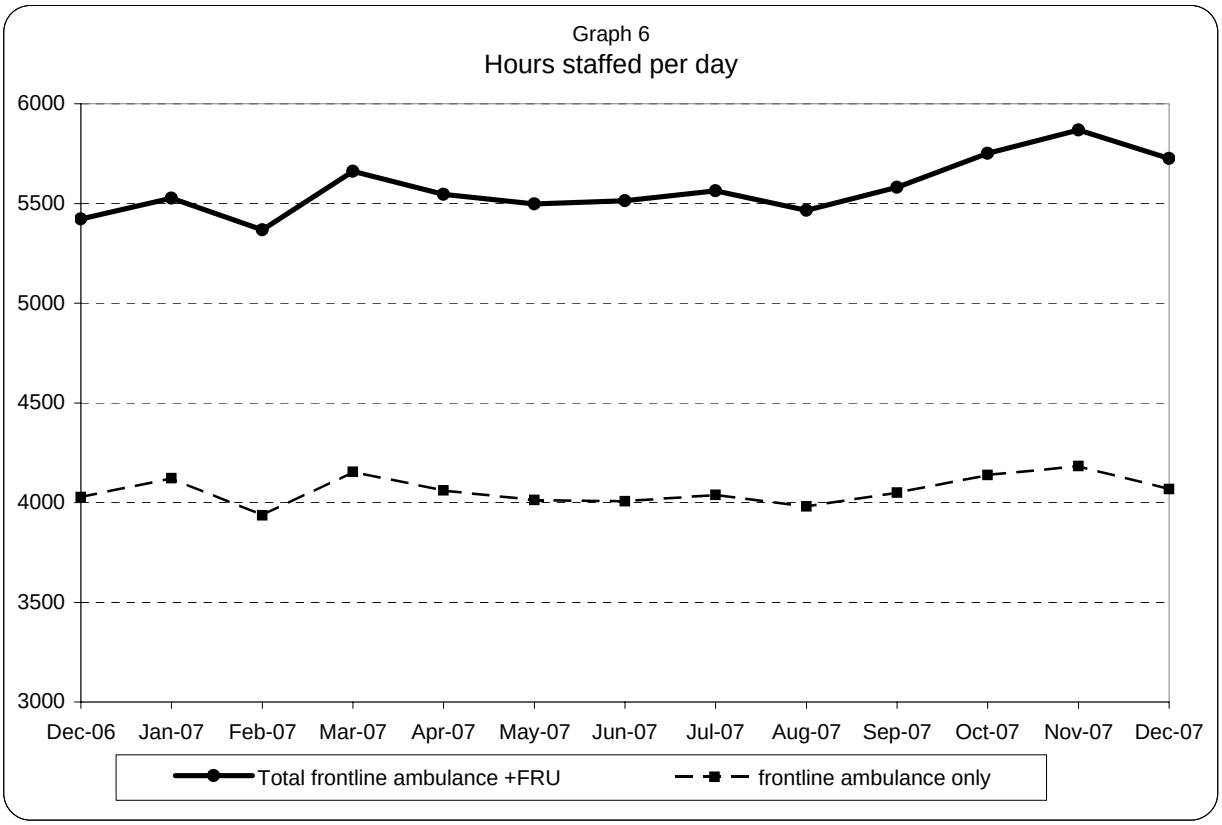
Category A and Red Responses as a percentage of the total Cat A, B & C demand



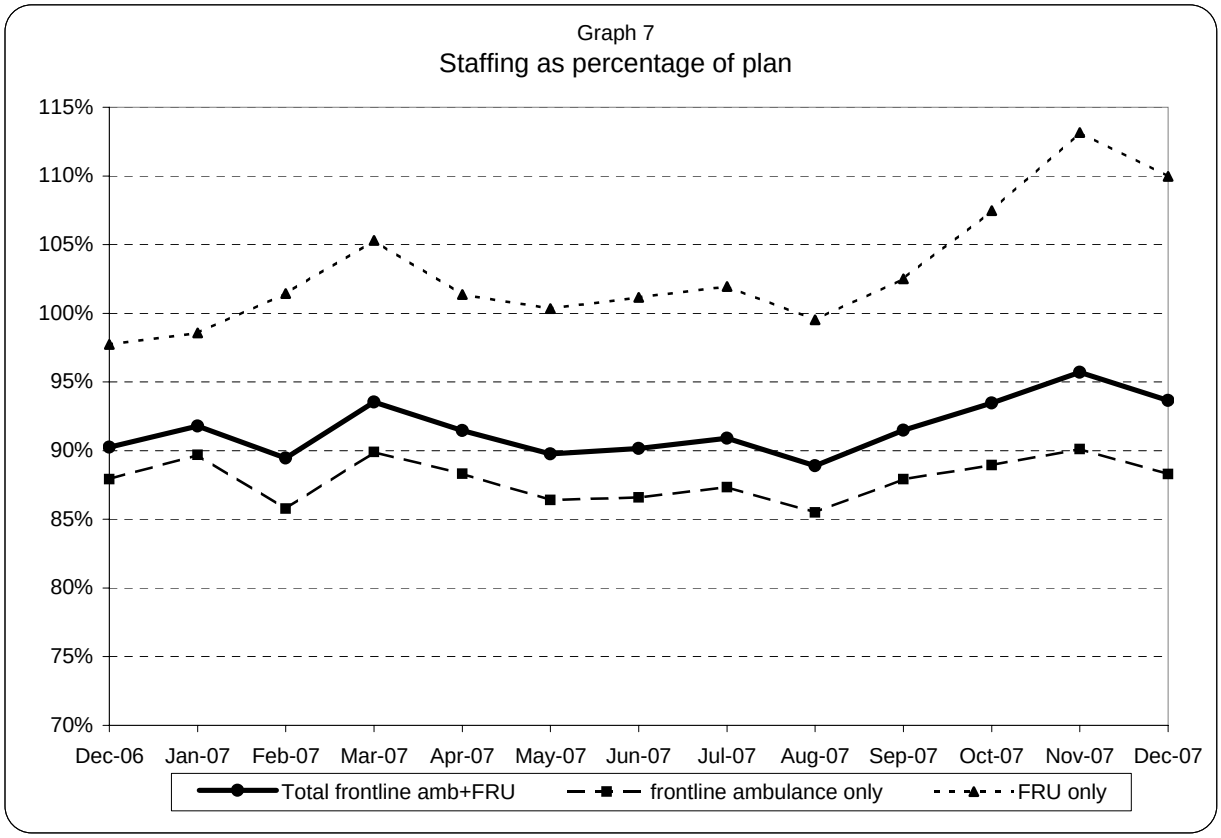
	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07
Red as a % of Cat ABC	43%	42%	43%	41%	36%	36%	37%	37%	36%	37%	38%	38%	39%
Cat A as a % of Cat ABC	39%	38%	39%	37%	32%	33%	33%	33%	31%	32%	33%	35%	36%

London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance and FRU staffing

Graph 6



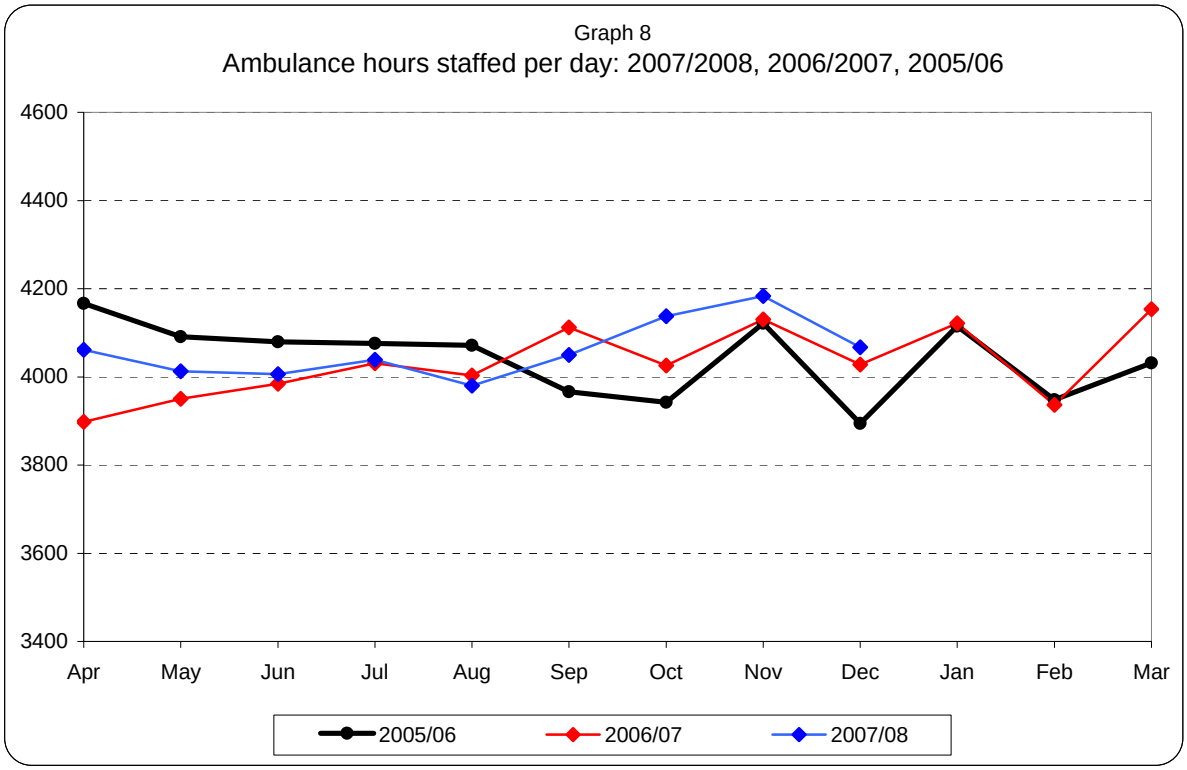
Graph 7



Note: staffed = (plan + additional - unmanned - single)/plan

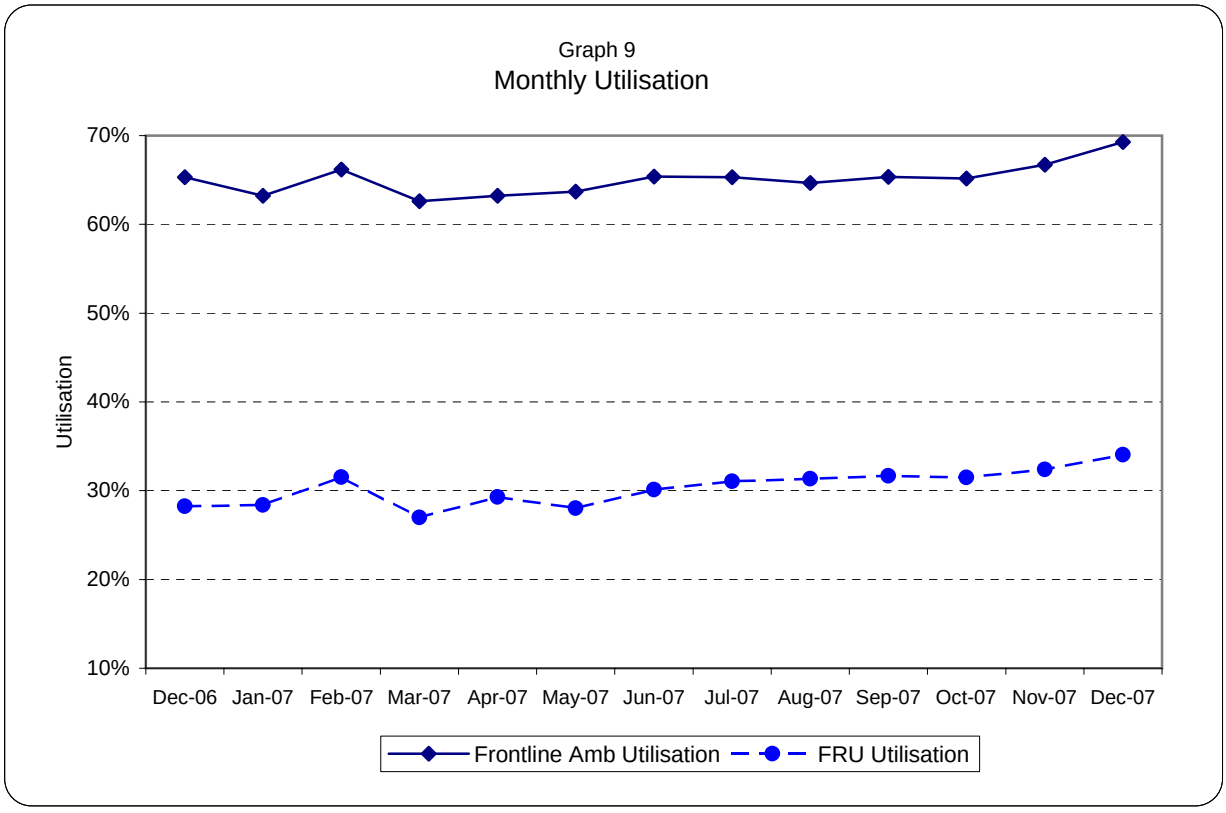
London Ambulance Service NHS Trust
Accident and Emergency Service
Yearly comparison of ambulance staffing and Average Monthly Utilisation

Graph 8



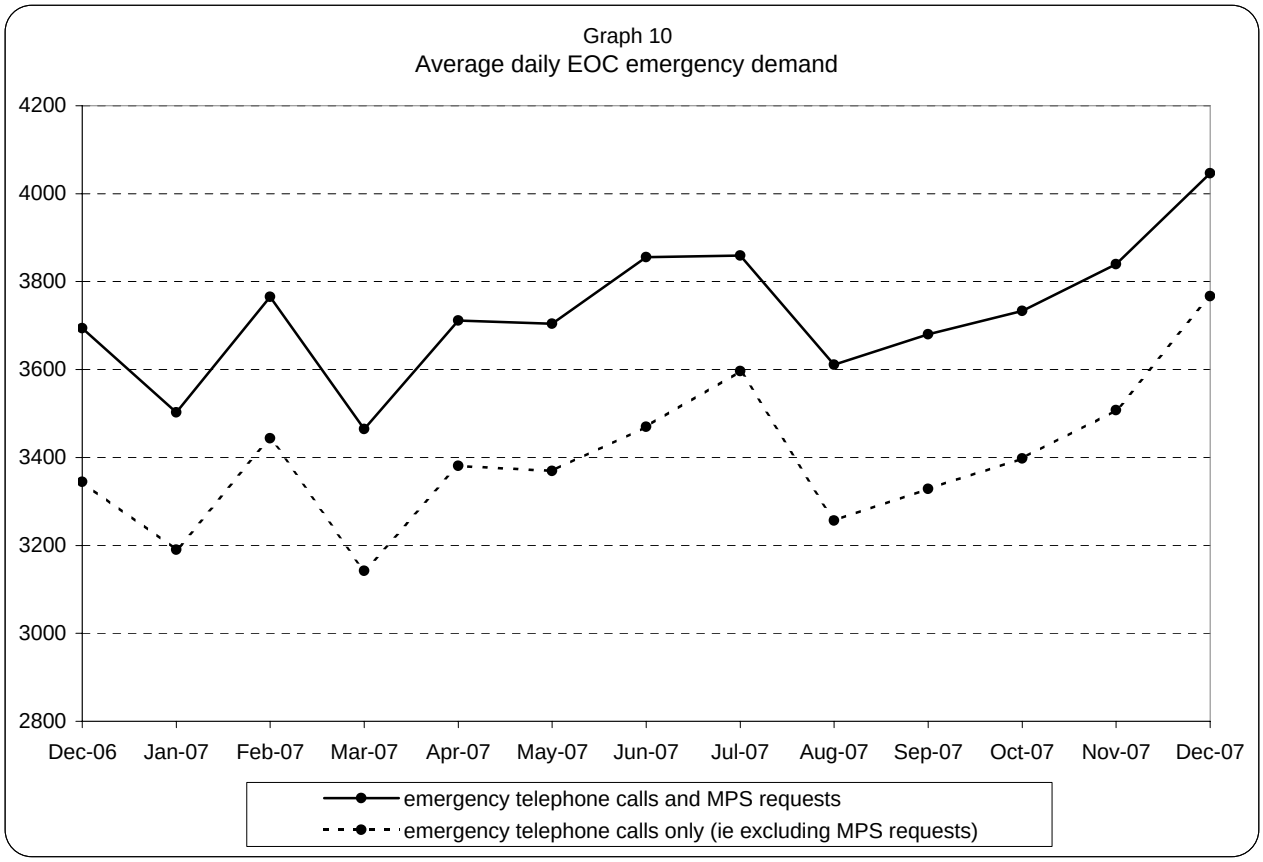
Note: staffed = plan + additional - unmanned - single

Graph 9

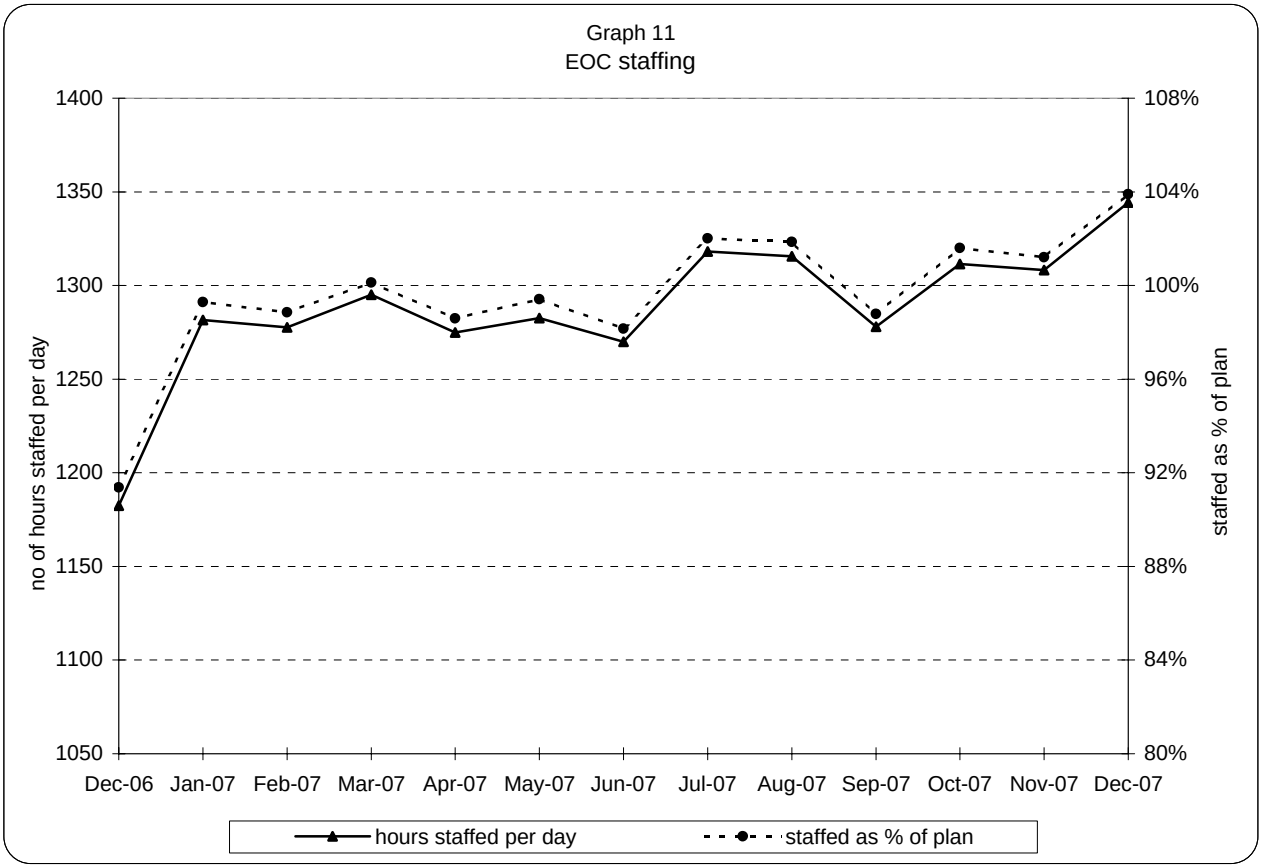


London Ambulance Service NHS Trust
Accident and Emergency Service
EOC activity and staffing

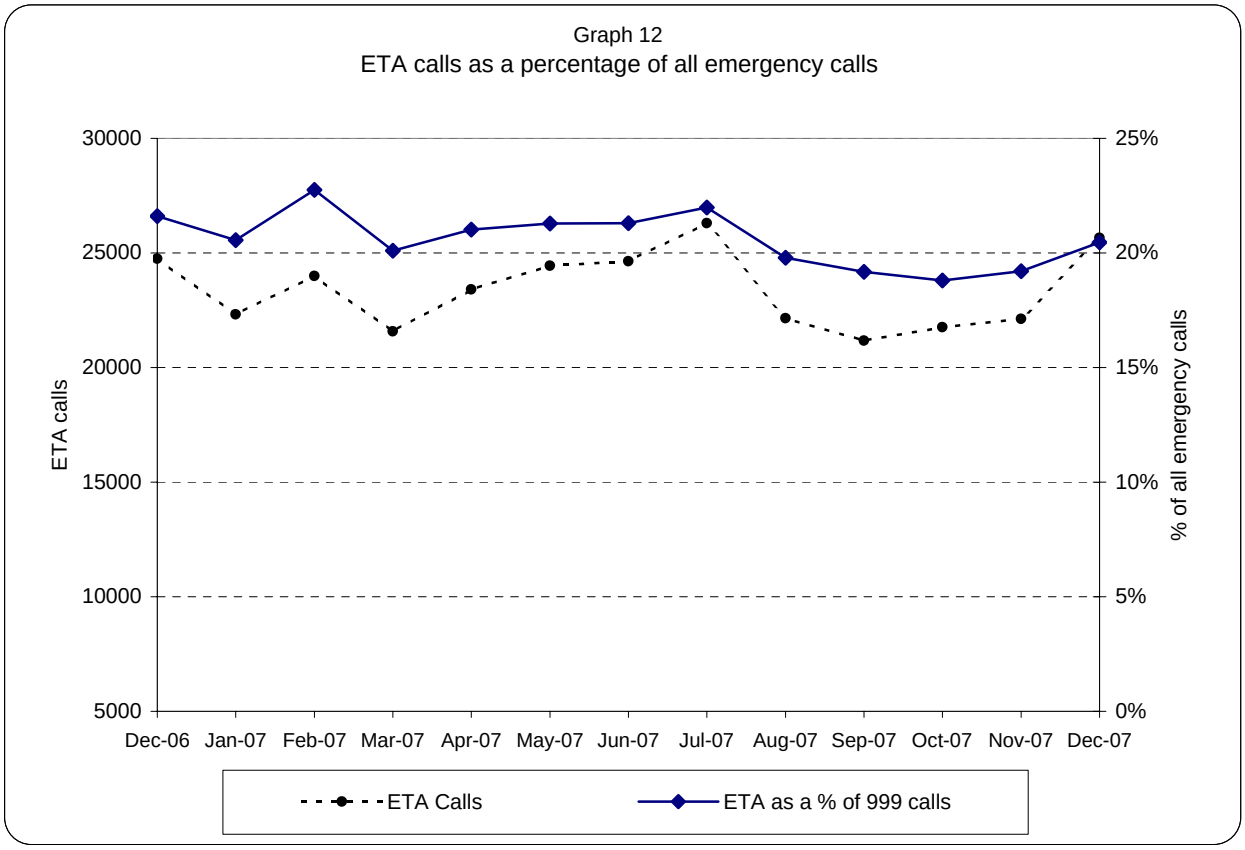
Graph 10
Average daily EOC emergency demand



Graph 11
EOC staffing



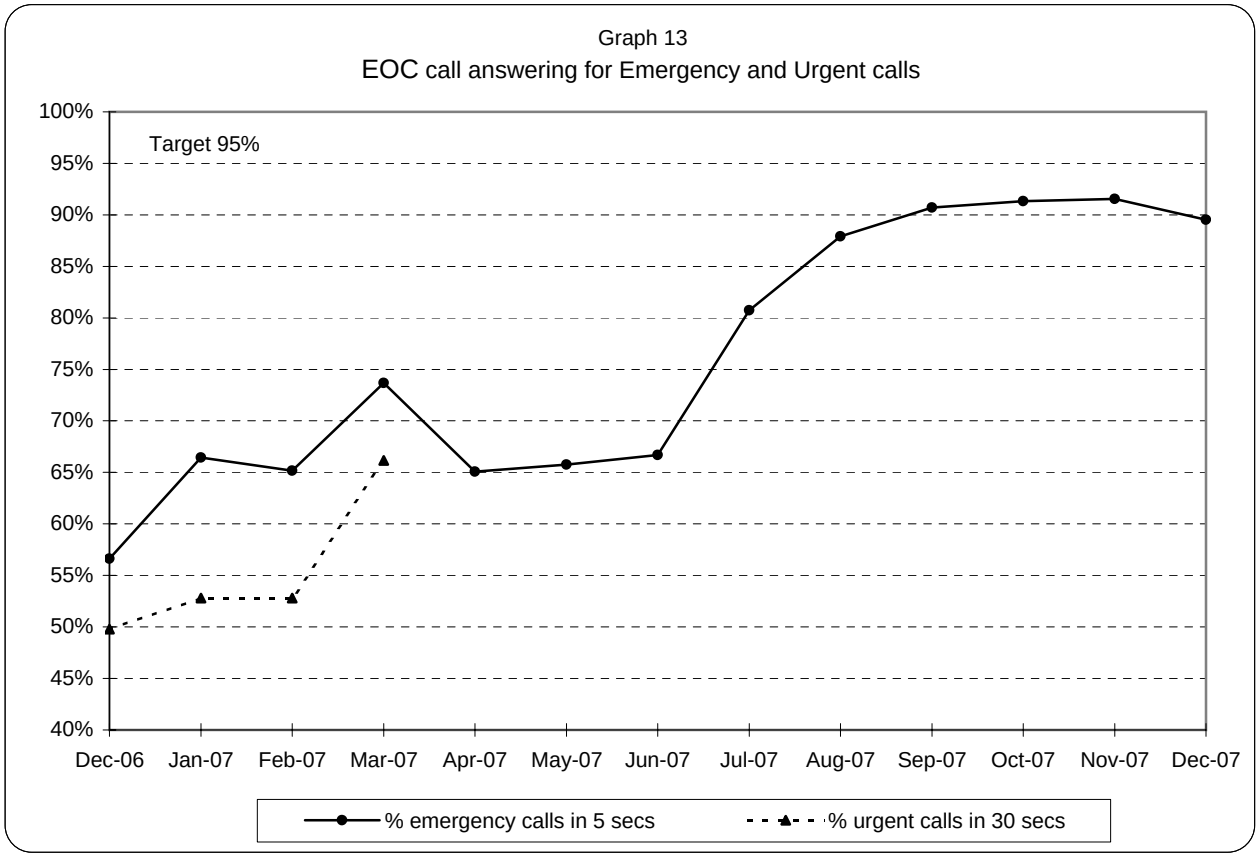
London Ambulance Service NHS Trust
Accident and Emergency Service
ETA calls as a percentage of all emergency calls



London Ambulance Service NHS Trust
Accident and Emergency Service
EOC call answering performance

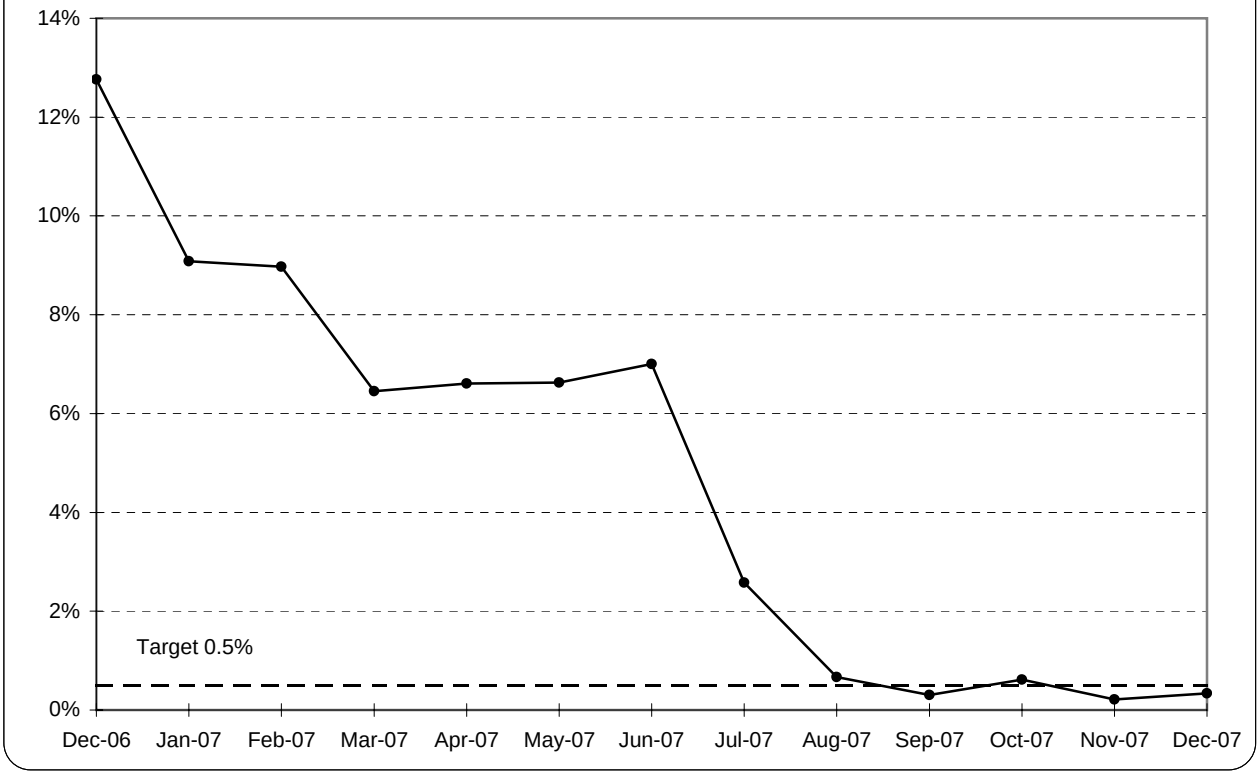
Graph 13

EOC call answering for Emergency and Urgent calls



Graph 14

Percentage of emergency calls answered after 120 seconds



Note: 95% target applies to both Emergency and Urgent call answering

London Ambulance Service NHS Trust
Accident and Emergency Service
Urgent Care Service workload

Table 1: Workload by UCS crews, for Green, Urgent, Non Urgent and CTA

Crew type	Sep-07	Oct-07	Nov-07	Dec-07
EMT 1	1682	1918	1972	2277
Whitework	874	1152	1154	952
PTS	62	84	92	170
ECP	302	255	283	329
VAS	63	78	51	17
CTA	4674	5340	5167	5921
UCS Total (green, urgent, non urgent & CTA)	7657	8827	8719	9666
Non UCS Total (green, urgent, non urgent)	14248	14618	14653	14701
TOTAL	21905	23445	23372	24367
% of total by UCS	35.0%	37.6%	37.3%	39.7%

* Workload here refers to all arrivals on scene and will therefore include multiple responses to an incident (except for CTA, which refers to all calls passed to CTA)

London Ambulance Service NHS Trust
Accident and Emergency Service
Category A activity and performance by Primary Care Trust

Table 2

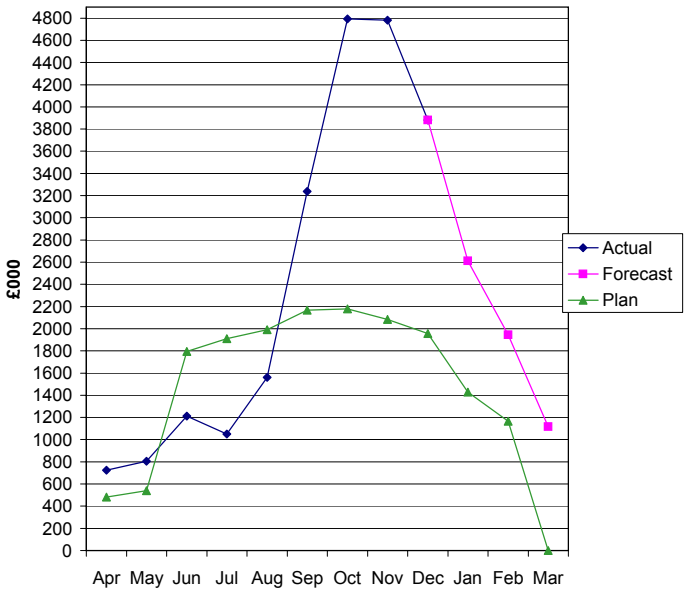
		Oct-07			Nov-07			Dec-07			Year to date		
		Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins
5K5	Brent PCT	979	818	84%	1,078	832	77%	1,125	835	74%	8,733	7,007	80%
5HX	Ealing PCT	1,076	848	79%	1,077	800	74%	1,261	901	71%	9,439	7,299	77%
5H1	Hammersmith & Fulham PCT	625	507	81%	683	555	81%	664	546	82%	5,521	4,602	83%
5K6	Harrow PCT	654	564	86%	667	561	84%	717	595	83%	5,564	4,765	86%
5AT	Hillingdon PCT	944	788	83%	977	815	83%	1,083	887	82%	8,296	6,833	82%
5HY	Hounslow PCT	786	610	78%	831	629	76%	922	687	75%	6,831	5,226	77%
5LA	Kensington & Chelsea PCT	433	343	79%	521	399	77%	495	382	77%	4,135	3,307	80%
5LC	Westminster PCT	1,242	1,036	83%	1,294	1,066	82%	1,325	1,043	79%	10,690	8,848	83%
5A9	Barnet PCT	962	777	81%	979	763	78%	1,107	839	76%	8,448	6,585	78%
5K7	Camden PCT	920	814	88%	919	804	87%	1,053	873	83%	8,118	7,074	87%
5C1	Enfield PCT	971	840	87%	1,026	832	81%	1,151	945	82%	8,588	7,117	83%
5C9	Haringey PCT	858	668	78%	880	693	79%	1,046	744	71%	7,742	5,965	77%
5K8	Islington PCT	833	696	84%	871	708	81%	858	683	80%	7,141	5,885	82%
5C2	Barking & Dagenham PCT	685	555	81%	759	590	78%	769	558	73%	6,033	4,681	78%
5C3	City & Hackney PCT	964	722	75%	936	702	75%	1,010	737	73%	8,497	6,465	76%
5A4	Havering PCT	715	584	82%	733	584	80%	853	618	72%	6,314	4,892	77%
5C5	Newham PCT	1,000	777	78%	1,100	867	79%	1,179	862	73%	9,148	7,081	77%
5NA	Redbridge PCT	754	606	80%	771	606	79%	872	640	73%	6,785	5,202	77%
5C4	Tower Hamlets PCT	931	759	82%	950	758	80%	986	758	77%	8,022	6,430	80%
5NC	Waltham Forest PCT	755	587	78%	793	614	77%	909	666	73%	6,933	5,256	76%
5AX	Bexley PCT	601	444	74%	672	522	78%	804	558	69%	5,498	4,242	77%
5A7	Bromley PCT	830	642	77%	845	628	74%	1,038	735	71%	7,248	5,488	76%
5A8	Greenwich PCT	898	726	81%	881	736	84%	973	778	80%	7,659	6,252	82%
5LD	Lambeth PCT	1,029	811	79%	1,076	799	74%	1,158	831	72%	9,471	7,209	76%
5LF	Lewisham PCT	947	741	78%	1,046	827	79%	1,079	798	74%	8,249	6,517	79%
5LE	Southwark PCT	1,163	966	83%	1,159	948	82%	1,232	966	78%	9,914	7,996	81%
5K9	Croydon PCT	1,193	938	79%	1,121	857	76%	1,304	949	73%	10,019	7,696	77%
5A5	Kingston PCT	394	321	81%	400	308	77%	491	360	73%	3,649	2,826	77%
5M6	Richmond & Twickenham PCT	459	352	77%	484	360	74%	514	359	70%	3,854	2,869	74%
5M7	Sutton & Merton PCT	1,063	851	80%	1,047	814	78%	1,183	888	75%	8,800	6,858	78%
5LG	Wandsworth PCT	861	641	74%	886	657	74%	884	616	70%	7,153	5,361	75%
	Lowest (excl out of London)			74%			74%			69%			74%
	Highest (excl out of London)			88%			87%			83%			87%
	Range			15%			13%			14%			13%

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 31st Dec (Month 9)

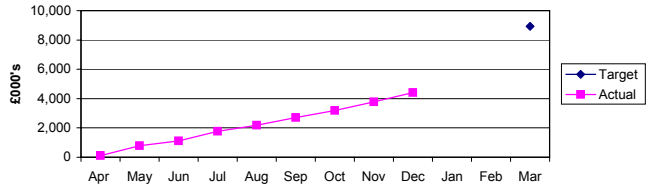
Income and Expenditure

Cumulative Net Financial Position

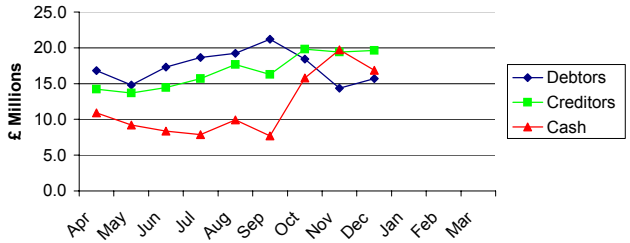


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	Oct	Nov	Nov	Risk rating
Asset turnover ratio	1.87	1.89	1.89	●
Debtors % > 90 days	26%	288%	27%	●
A&E Debtor days	3	0.36	-0.097	●
PTS Debtor days	48	44	48.63	●
PSPP NHS	100%	100%	100%	●
PSPP Non NHS	86%	88%	88%	●

Key Financial Indicators

	Oct	Nov	Dec
A&E Overtime (£000) / Day (Month)	£34	£38	£40
A&E Overtime (% of paybill)	8%	8%	8%
Subsistence (£000) / Day (Month)	£5.65	£6.07	£6.06
Subsistence per head £	£44.27	£46.18	£47.57
Third Party Transport expenditure / Day (Month)	£3,041	£3,071	£2,721
A&E Cost per incident	£177	£188	£193
A&E Gross Surplus (YTD) (% of Income)	23.2%	22.6%	21.3%
A&E Net Margin (YTD) (% of Income)	3.6%	3.2%	2.2%
PTS Gross Margin (YTD) (% of Income)	3.7%	3.7%	3.6%
Cat B performance (cumulative)	85%	85%	84%

Financial Risks

	Overall risk rating	MED	●
1	Failure to meet Cat B activity targets	HIGH	●
2	Failure to manage A&E overtime within plan	MED	●
3	Failure to meet Trust CIP	MED	●
4	Failure to manage and control 3rd party exp	MED	●
5	PTS profitability less than forecast	LOW	●

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31 December 2007 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	19,154	18,236	919F	170,744	164,704	6,041F	3.7%F	236,006	219,481	16,525F
Total Operational Costs	19,309	17,542	(1,767)U	159,649	155,384	(4,265)U	(2.7%)U	225,285	209,141	(16,144)U
EBITDA	**-155**	**693**	**(849)U**	**11,095**	**9,320**	**1,776F**	**0F**	**10,720**	**10,340**	**381F**
EBITDA Margin	***1%***	***4%***	***-5%***	***6%***	***6%***	**1%**		***5%***	***5%***	**0%**
Depreciation & Interest	786	818	32F	7,214	7,362	148F	2.0%F	9,603	10,340	737F
Net *Surplus/(Deficit)*	**-942**	**-125**	**(817)U**	**3,881**	**1,958**	**1,924 F**	**(1.1%)U**	**1,117**	**0**	**1,117F**
Net Margin	***-5%***	***1%***	***-6%***	***2%***	***1%***	***1%***		***0%***	***0%***	***0%***

- In month 9 expenditure is higher than income by £942k. For the year to date income exceeds expenditure by £3,881K.

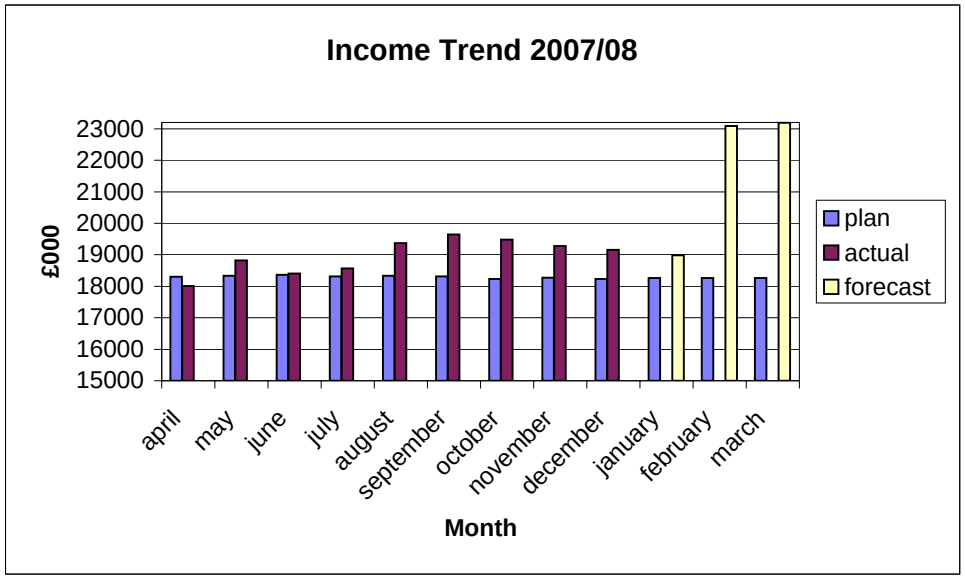
- Income of £19,194k is in line with previous months and includes call connect income. Invest to Save (ITS) income of £8.3m has not been accrued to date but is in the annual forecast.

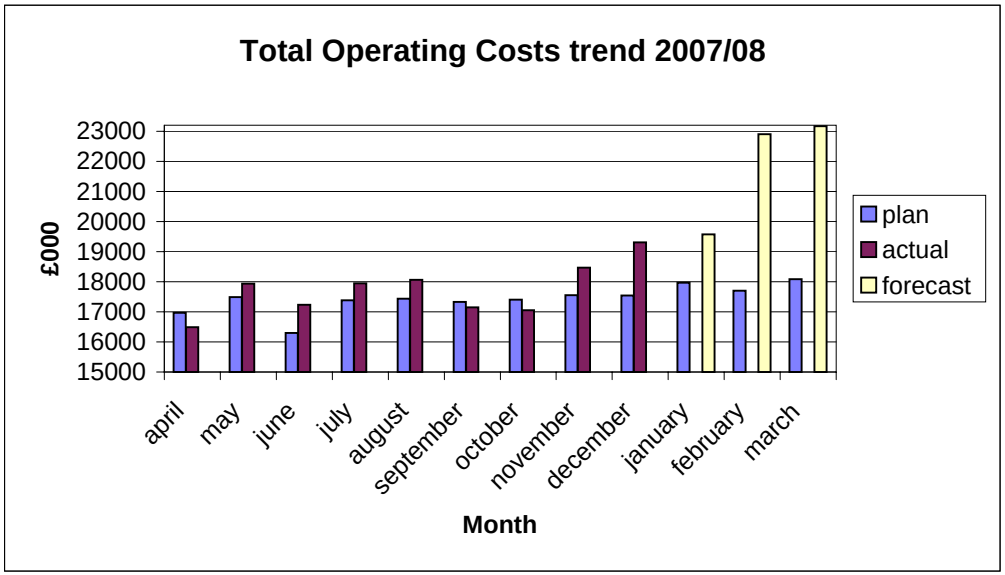
- Expenditure of £20,095k is higher than the previous month by £843k .This is due to an accrual made to account for Xmas cover arrangements and the payment of £125 annual bonus to all staff.

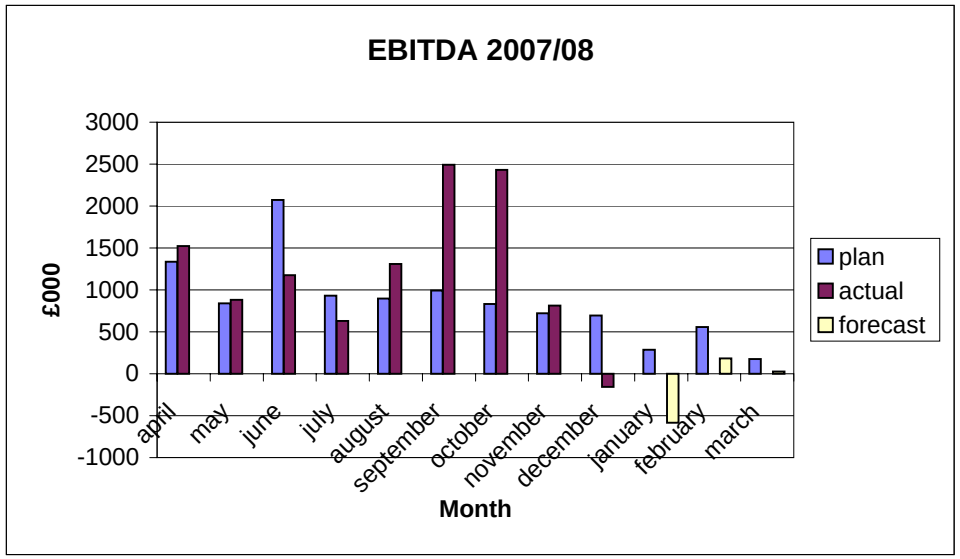
- The net financial position is £942k unfavourable in month 9. The net financial position forecast for month 9 at month 8 was £2512k. The difference of £1,571k is largely due to estimated expenditure on ITS items and SPPPs in December that did not occur in December and has been pushed back into Jan - Mar.

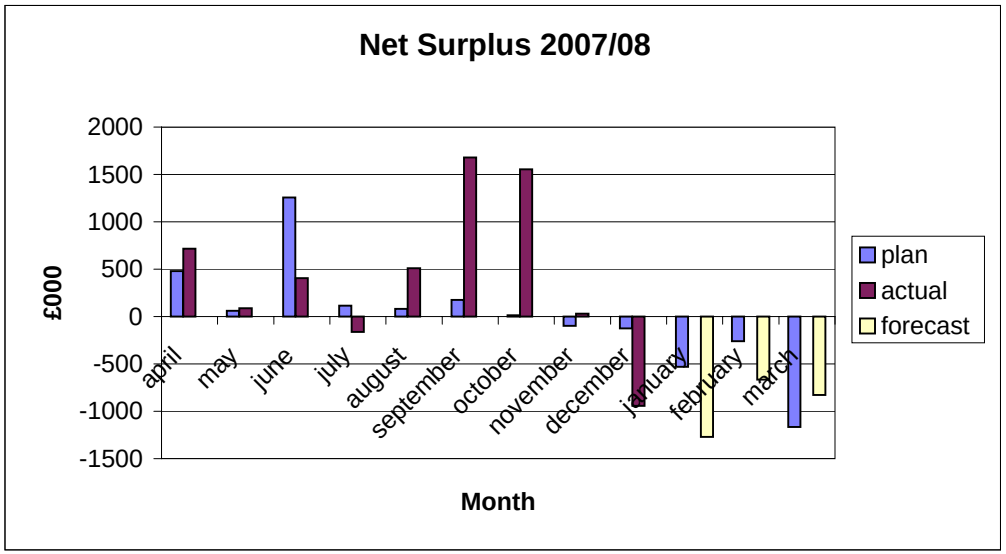
- The annual forecast is £1,117k at month 9, up from £901k favourable in month 8. This assumes call connect expenditure of £6.8m and Invest to Save expenditure of £7.5m.

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









LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 December 2007 (Month 9)

£000s

	MONTHLY SPEND												
	April	May	June	July	August	September	October	November	December	January	February	March	Total
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
Income	**18,006**	**18,819**	**18,409**	**18,569**	**19,373**	**19,646**	**19,486**	**19,282**	**19,154**	**18,985**	**23,086**	**23,191**	**236,006**
Pay Expenditure													
A&E Operational Staff	8,087	8,036	8,024	7,995	8,440	8,018	8,088	8,113	9,149	8,401	8,468	8,456	99,276
Overtime	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,170	1,148	1,154	12,778
A&E Management	878	858	873	882	881	912	914	904	940	933	929	929	10,834
EOC Staff	859	908	900	921	899	936	920	909	985	1,026	1,094	1,145	11,502
PTS Operational Staff	550	570	529	547	128	457	465	442	487	442	439	435	5,490
PTS Management	81	70	86	80	94	86	80	87	87	82	82	82	996
Corporate Support	2,145	2,204	2,120	2,143	2,110	2,119	2,125	2,497	2,239	2,777	2,761	2,722	27,963
Sub Total	**13,456**	**13,379**	**13,467**	**13,700**	**13,723**	**13,569**	**13,637**	**14,101**	**15,132**	**14,832**	**14,920**	**14,923**	**168,838**
Average Daily	*449*	*432*	*449*	*442*	*443*	*452*	*440*	*470*	*488*	*478*	*533*	*481*	*463*
Non-Pay Expenditure													
Staff Related	245	206	191	217	189	205	213	198	189	319	264	218	2,653
Subsistence	53	194	125	159	173	150	175	182	188	173	175	180	1,928
Training	40	184	76	134	158	24	116	173	30	187	125	126	1,324
Medical Consumables & Equipment	226	401	340	291	479	341	312	387	396	474	577	549	4,773
Drugs	20	34	25	36	37	19	46	55	36	44	38	38	430
Fuel & Oil	296	317	313	324	319	301	342	373	405	398	399	400	4,187
Third Party Transport	29	51	49	77	113	55	94	92	84	102	100	102	949
Vehicle Costs	589	1,044	884	1,021	925	895	977	1,614	1,681	1,089	1,011	1,011	12,742
Accommodation & Estates	707	755	754	623	805	605	757	751	543	778	641	723	8,441
Telecommunications	354	426	340	619	407	576	201	489	516	602	629	882	6,040
Depreciation	484	494	489	496	510	523	579	534	542	420	579	579	6,229
Other Expenses	470	949	654	740	736	461	184	57	109	571	4,025	4,011	12,968
Profit/(Loss) on Disposal FA	0	2	17	0	1	0	0	2	0	0	0	0	12
Sub Total	**3,513**	**5,053**	**4,257**	**4,736**	**4,850**	**4,107**	**3,999**	**4,903**	**4,719**	**5,156**	**8,564**	**8,820**	**62,676**
Average Daily	*117*	*163*	*142*	*153*	*156*	*137*	*129*	*163*	*152*	*166*	*306*	*285*	*172*
Financial Expenditure	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**267**	**267**	**277**	**3,374**
Average Daily	*11*	*10*	*9*	*9*	*9*	*10*	*10*	*8*	*8*	*9*	*10*	*9*	*9*
Monthly Expenditure	**17,289**	**18,730**	**18,003**	**18,730**	**18,864**	**17,968**	**17,931**	**19,253**	**20,096**	**20,255**	**23,751**	**24,019**	**234,888**
Cumulative	**17,289**	**36,019**	**54,021**	**72,752**	**91,616**	**109,584**	**127,514**	**146,767**	**166,863**	**187,118**	**210,869**	**234,888**	
Monthly Net	**717**	**89**	**406**	**-161**	**509**	**1,678**	**1,555**	**29**	**-942**	**-1,271**	**-665**	**-829**	**1,117**
Cumulative Net	**717**	**806**	**1,212**	**1,051**	**1,560**	**3,238**	**4,794**	**4,823**	**3,881**	**2,611**	**1,946**	**1,117**	

LONDON AMBULANCE SERVICE NHS TRUST

Financial year end forecast
As at 31 December 2007 (Month 9)

	£000s	£000s		
	Month 8	Month 9	Variance	Notes
Income	**236,611**	**236,006**	**-605**	There has been an increase in provision against Cat B income of 2% points equating to £600k decrease in Income forecast
Pay Expenditure				
A&E Operational Staff	99,383	99,276	-106	There was a higher number of leavers than forecast in December (11WTE instead of 6WTE). Therefore leavers forecast for last 3 months has been increased by 4 WTE. Also 2 additional Paramedics will transfer to CTA in March.
Overtime	13,809	12,778	-1,031	The A&E overtime forecast has been revised to 44000 hrs per month based on lower than expected uptake on overtime in December (£225k lower than forecast).
A&E Management	10,855	10,834	-21	
EOC Staff	11,412	11,502	90	There are 2 additional CTA staff forecast in month 9. Also . Also includes staffing recharge for Community Responder Desk (2.24 WTE) and an adjustment made to correct a previous months pay award accrual
PTS Operational Staff	5,426	5,490	64	The increase is due to the annual bonus payout which was forecast under Corporate Support Staff in month 8 and an increase on the Barts Renal contract costs
PTS Management	991	996	4	
Corporate Support	29,253	27,963	-1,291	The annual bonus payment of £125 to all staff was accounted for here in M8 and has been paid out in all pay categories in m9. In addition expenditure associated with forthcoming SPPPs was forecast here in M8 and this has been moved to the "Other Expenses" line in M9.
Sub Total	**171,130**	**168,838**	**2,292**	
Non-Pay Expenditure				
Staff Related	2,625	2,653	28	
Subsistence	1,905	1,928	23	
Training	1,446	1,324	-122	The forecast has been revised downwards in light of lower than expected expenditure in December.
Medical Consumables & Equipment	4,692	4,773	82	There has been an increase in spend due to winter pressures (up 33%). Also Medical Gases expenditure has increased month on month , this trend has now been reflected in the forecast
Drugs	438	430	-7	
Fuel & Oil	3,988	4,187	199	The forecast increased from Jan to Mar from £300K to £360k per month in line with increased Dec 07 spend. The increase is based on higher than expected price increases (approx 3p per litre) and expected high consumption due to demand.
Third Party Transport	1,610	949	-661	The month 8 forecast included a £500k provision for Alternative Response vehicles and this has now been transferred to ITS recorded under "Other Expenses". The forecast has also been reduced in Operations in line with actual spend whilst factoring in additional ERS costs (at approx £1k per day).
Vehicle Costs	12,665	12,742	77	Increased demand has caused an increase in vehicle maintenance. Also vehicle recovery costs in December were higher than forecast.
Accommodation & Estates	8,814	8,441	-373	The estates maintenance expenditure has been revised in line with expected spend from Jan - March. Business Rates expenditure has been revised to account for zero expenditure in Feb & March in line with the payment policy.
Telecommunications	5,928	6,040	112	The forecast now includes a provision of £142k for Ordnance Survey Maps & Geographical data agreement with the NHS Information Centre.
Depreciation	6,390	6,229	-161	The reduction takes account of funding for depreciation of HART vehicle received from DH (£159k)
Other Expenses	10,691	12,968	2,277	A provision has been made to account for ITS expenditure expected. In addition expenditure associated with forthcoming SPPPs was forecast under "Corporate Support" in M8 and has now been moved here in M9.
Profit/(Loss) on Disposal FA	12	12	0	
Sub Total	**61,202**	**62,676**	**1,473**	
Average Daily				
Financial Expenditure	**3,378**	**3,374**	**-3**	
Average Daily	*9*	*9*		
Total Expenditure	**235,710**	**234,888**	**-822**	
Net	**901**	**1,117**	**-217**	

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 December 2007 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	18,307	17,478	829F	163,104	157,509	5,596F	3.6%F	226,036	210,013	16,023F
Sector Services	12,908	10,669	(2,239)U	100,476	94,187	(6,289)U	(6.7%)U	134,990	127,255	(7,734)U
A&E Operational Support	1,081	985	(96)U	9,151	8,927	(224)U	(2.5%)U	13,341	12,111	(1,230)U
Control Services	1,230	1,128	(103)U	10,645	10,071	(574)U	(5.7%)U	14,558	13,462	(1,096)U
Urgent Care Services	1,031	1,040	8F	8,032	9,377	1,345F	14.3%F	11,390	12,526	1,136F
Total Operations Cost	**16,251**	**13,821**	**(2,430)U**	**128,304**	**122,562**	**(5,742)U**	**(4.7%)U**	**174,278**	**165,354**	**(8,924)U**
A&E Gross Surplus/(Deficit)	**2,056**	**3,657**	**(1,601)U**	**34,800**	**34,946**	**(146)U**	**(0.4%)U**	**51,758**	**44,659**	**7,100F**
Gross Margin	11.2%	20.9%	(8.7%)U	21.3%	22.2%	-0.9%		22.9%	21.3%	1.6%
Medical Directorate	49	72	22F	571	645	73F	11.4%F	792	869	77F
Service Development	40	63	23F	452	495	42F	8.6%F	644	814	170F
Communications	122	156	34F	1,046	1,274	228F	17.9%F	1,470	1,745	276F
Human Resources	899	856	(44)U	7,859	8,412	553F	6.6%F	11,165	11,204	39F
IM&T	725	787	62F	5,881	6,294	412F	6.6%F	8,508	8,881	373F
Finance	1,079	1,783	703F	14,492	15,326	834F	5.4%F	27,248	20,403	(6,845)U
Chief Executive	105	92	(13)U	892	857	(35)U	(4.1%)U	1,210	1,130	(80)U
Total Corporate	**3,020**	**3,808**	**789F**	**31,195**	**33,302**	**2,108F**	**(6.3%)U**	**51,037**	**45,045**	**(5,991)U**
A&E Net Surplus/(Deficit)	**(963)**	**(151)**	**(812)U**	**3,605**	**1,644**	**1,961F**	**(119.3%)U**	**722**	**(387)**	**1,108F**
A&E Net Margin	(5.3%)	(0.9%)	(4.6%)U	2.2%	1.0%	1.2%	112%	0.3%	(0.2%)	0.5%
Patient Transport Service	**22**	**27**	**(5)U**	**276**	**314**	**(37)U**	**(11.9%)U**	**395**	**387**	**8F**
PTS Gross Margin	2.6%	3.5%	(0.6%)U	3.6%	4.4%	(0.5%)U		4.0%	4.1%	0.1%F
Trust Result *Surplus/(Deficit)*	**(942)**	**(125)**	**(817)U**	**3,881**	**1,958**	**1,924F**	**(98.3%)U**	**1,116**	**0**	**1,116F**

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 December 2007 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	9,149	8,362	(787)U	73,951	73,999	47F	0.1%F	99,276	99,247	(29)U
Overtime	1,245	667	(578)U	9,306	5,989	(3,318)U	(55.4%)U	12,778	7,994	(4,784)U
A&E Management	940	902	(38)U	8,043	8,059	15F	0.2%F	10,834	10,765	(69)U
EOC Staff	985	1,018	33F	8,236	9,116	879F	9.6%F	11,502	12,184	682F
PTS Operational Staff	487	448	(40)U	4,175	4,228	53F	1.3%F	5,490	5,578	88F
PTS Management	87	80	(6)U	750	732	(18)U	(2.4%)U	996	973	(23)U
Corporate Support	2,239	2,214	(25)U	19,702	19,955	253F	1.3%F	27,963	26,580	(1,383)U
	15,132	**13,691**	**(1,441)U**	**124,164**	**122,078**	**(2,086)U**	**(1.7%)U**	**168,838**	**163,322**	**5,516**
Non-Pay Expenditure										
Staff Related	189	204	15F	1,852	1,880	28F	1.5%F	2,653	2,507	(146)U
Subsistence	188	61	(127)U	1,399	612	(787)U	(128.7%)U	1,928	816	(1,112)U
Training	30	108	78F	886	1,146	259F	22.6%F	1,324	1,487	163F
Drugs	36	53	17F	310	424	114F	27.0%F	430	564	134F
Medical Consumables & Equipn	396	339	(57)U	3,173	2,833	(340)U	(12.0%)U	4,773	3,991	(782)U
Fuel & Oil	405	342	(63)U	2,990	2,779	(211)U	(7.6%)U	4,187	3,692	(495)U
Third Party Transport	84	53	(32)U	644	496	(149)U	(30.0%)U	949	651	(298)U
Vehicle Costs	1,681	894	(787)U	9,630	7,958	(1,672)U	(21.0%)U	12,742	10,640	(2,102)U
Accommodation & Estates	543	711	168F	6,299	6,369	70F	1.1%F	8,441	8,200	(240)U
Telecommunications	516	480	(36)U	3,927	3,881	(47)U	(1.2%)U	6,040	5,320	(720)U
Depreciation	542	499	(44)U	4,651	4,487	(164)U	(3.7%)U	6,229	6,506	277F
Other Expenses	109	605	497F	4,361	4,929	568F	11.5%F	12,968	7,951	(5,017)U
Profit/(Loss) on Disposal FA	0	0	0	12	0	(12)U	#DIV/0!	12	0	(12)U
	4,719	**4,350**	**(370)U**	**40,136**	**37,793**	**(2,343)U**	**(6.2%)U**	**62,676**	**52,325**	**(10,351)U**
Financial Expenditure	**244**	**320**	**75F**	**2,563**	**2,876**	**313F**	**10.9%F**	**3,374**	**3,834**	**460F**
Total Trust Expenditure	**20,096**	**18,360**	**(1,736)U**	**166,863**	**162,746**	**(4,117)U**	**(2.5%)U**	**234,888**	**219,481**	**(15,407)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 December 2007 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	16,855	16,304	551F	150,654	146,738	3,915F	2.7%F	200,918	195,651	5,267F
HEMS Funding	2	3	(0)U	22	26	(4)U	(14.8%)U	54	35	19F
Other A&E Income	89	88	1F	798	792	6F	0.8%F	1,064	1,056	8F
Foundation Trust Income	3	28	(25)U	149	252	(103)U	(40.9%)U	187	335	(148)U
CBRN Income	821	717	104F	7,054	6,455	599F	9.3%F	9,517	8,607	910F
ECP Income	36	10	26F	245	94	151F	161.4%F	296	125	171F
BETS & SCBU Income	62	86	(25)U	668	776	(107)U	(13.8%)U	889	1,034	(145)U
A & E Long Distance Journey	45	33	12F	310	298	11F	3.8%F	416	398	18F
Stadia Attendance	70	32	38F	791	496	294F	59.3%F	936	663	273F
Heathrow BAA Contract	35	39	(5)U	312	355	(43)U	(12.1%)U	416	473	(57)U
Resus Training Fees	4	10	(6)U	82	89	(6)U	(6.8%)U	102	118	(16)U
Education & Training Income	34	23	11F	398	203	196F	96.8%F	489	270	219F
	18,055	**17,374**	**681**	**161,247**	**156,590**	**4,911**	**3.1%F**	**215,276**	**208,765**	**6,519F**
PTS Income	847	758	89F	7,640	7,195	445F	6.2%F	9,970	9,468	502F
Other Income	253	104	149F	1,620	936	684F	73.1%F	10,752	1,248	9,504F
Trust Result	**19,155**	**18,236**	**919F**	**170,744**	**164,704**	**6,040F**	**3.7%F**	**236,006**	**219,481**	**16,525F**

LONDON AMBULANCE SERVICE NHS TRUST
Capital Programme 2007/08
Capital forecast as at December 31st 07

		Capital Budget 2007/08	Capital Forecast 2007/08	Variance	Comment
	Projects C/fwd				
T	Major Vehicles	462,000	462,000	0	
T	Minor Vehicles	189,200	209,085	(19,885)	Bromley PTS vehicles, CBRN SWEDE and Cycle Transporter Vehicle planned to be purchased in 07/08
P&M	Major Equipment	0	0	0	
P&M	Minor Equip	0	8,341	(8,341)	
B	Major Estates	1,391,875	1,037,343	354,532	Several projects now deferred to 08/09
B	Minor Estates	782,940	1,238,765	(455,825)	Additional cost of Bromley refurb, Whipps Cross FSP (Crooked Billet), Buckhurst Hill disposal and Wembley rebuild. Revision of costs for Deptford & Kenton Refurbishment
IT	Major IM&T	2,813,074	3,058,376	(245,302)	Additional EOC telephony & LARP approved expenditure.
IT	Minor IM&T	80,000	134,998	(54,998)	
		5,719,089	6,148,908	(429,819)	
	New Projects				
T	Major Vehicles	5,481,513	2,460,000	3,021,513	60 RRUs in 2007/08. 23 deferred to 08/09. PTS Stretcher Vehicles and single wheelchair patient carriers deferred to 08/09
T	Minor Vehicles	28,200	0	28,200	Modifications to ESV is revenue
P&M	Major Equipment	277,150	116,000	161,150	IDRs are revenue. Paediatric restraints deferred to 08/09.
P&M	Minor Equip	73,814	20,939	52,875	CBRN Transporter deferred to 08/09.
B	Major Estates	1,241,750	1,194,925	46,825	Some projects deferred to 08/09
B	Minor Estates	395,500	302,400	93,100	Some projects deferred to 08/09
IT	Major IM&T	865,625	574,050	291,575	VM Ware and SAN & Data Warehousing not to complete in 0708.
IT	Minor IM&T	549,023	498,883	50,140	Business Enabling Software & Fleet Mgt Software u/s
	Other	0	577,500	(577,500)	FRUs for driver training, PC replacement programme.
		8,912,575	5,744,697	3,167,878	
	Gross Total	14,631,664	11,893,605	2,738,059	
	Disposals	(3,300,000)	(3,900,000)	600,000	Buckhurst Hill
	Net Total	11,331,664	7,993,605	3,338,059	
	CRL	8,978,000	8,978,000		
	(Over)/Under Commitment	(2,353,664)	984,396		

LONDON AMBULANCE SERVICE NHS Trust

Forecast Balance Sheet

For the Month Ending 31 December 2007 (Month 9)

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
Intangible assets	1,593	1,585	1,571	1,556	1,542	1,547	1,535	2,463	2,487	2,487	2,487	2,487	2,487	
Tangible assets	113,013	119,725	119,943	119,785	119,943	119,831	119,850	118,823	117,792	117,880	119,660	123,969	119,978	
	114,606	121,310	121,514	121,341	121,485	121,378	121,385	121,286	120,279	120,367	122,147	126,456	122,465	
Current Assets														
Stocks & WIP	1,965	1,955	1,814	1,813	1,813	1,711	1,716	1,715	1,713	1,711	1,711	1,711	1,711	Trade Debtors
NHS Trade Debtors	1,654	672	14	2,353	2,337	2,854	3,271	4,183	157	2,047	3,808	3,705	3,505	A&E £468k > 60 days (20.38%), Nov - £1,011k > 60 days (226.48%)
Non NHS Trade Debtors	0	511	275	62	65	76	73	71	72	82	150	135	208	PTS £584k > 60 days (25.47%), Nov - £393k > 60 days (88.14%)
Other Debtors	663	272	238	208	247	152	318	575	454	383	456	4,505	3,576	
Accrued Income	993	1,079	2,101	1,944	3,598	4,306	5,517	1,081	1,189	727	727	727	0	
Prepayments	2,811	2,755	2,414	2,922	2,611	2,021	2,372	2,602	2,622	2,569	2,630	2,691	2,752	
Investments	0	7,500	9,500	8,000	7,500	9,400	6,900	15,700	17,500	15,900	10,000	5,000	0	
Cash at Bank and in Hand	644	1,014	(231)	349	387	527	783	87	2,236	976	84	227	1,530	
Total Current Assets	8,730	15,758	16,125	17,651	18,558	21,047	20,950	26,014	25,943	24,395	19,566	18,700	13,281	
Creditors: Amounts falling due within one year														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Trade Creditors	3,929	4,888	4,924	5,192	4,452	5,723	6,756	6,044	5,479	6,464	10,657	11,877	8,007	NHS PSPP - This month (xx%), Nov (100%), Ytd (xx%)
Other Creditors	2,035	6,195	6,401	6,214	6,256	6,509	6,395	6,492	7,109	6,773	2,065	2,100	2,101	Non NHS PSPP - This month (xx%), Nov (88%), Ytd (xx%)
PDC Dividend Creditor	0	340	680	1,020	1,360	1,700	0	339	679	1,019	1,359	1,699	0	
Capital Creditors	388	30	30	190	114	26	30	67	58	59	2,200	5,011	511	
Accruals	513	1,038	776	774	1,758	1,484	1,082	957	956	1,448	1,348	1,198	948	
Deferred Income	58	439	691	1,042	1,690	2,206	2,002	5,865	5,130	3,832	2,555	1,278	0	
Total Current Liabilities	6,923	12,930	13,502	14,432	15,630	17,648	16,265	19,764	19,411	19,595	20,184	23,163	11,567	
Net Current Assets	1,807	2,828	2,623	3,219	2,928	3,399	4,685	6,250	6,532	4,800	(618)	(4,463)	1,714	
Long Term Debtors	9,766	9,785	9,803	9,804	9,796	9,815	9,730	9,934	9,877	9,894	9,894	9,894	9,894	
Total Assets less current liabilities	126,179	133,923	133,940	134,364	134,209	134,592	135,800	137,470	136,688	135,061	131,423	131,887	134,073	
Creditors: Amounts falling due after more than one year														
Provisions for Liabilities & Charges	15,464	15,423	15,370	15,407	15,415	15,326	15,443	15,576	15,861	15,995	15,926	15,906	15,442	
Total Assets Employed	110,715	118,500	118,570	118,957	118,794	119,266	120,357	121,894	120,827	119,066	115,497	115,981	118,631	
Taxpayers' Equity														
Public Dividend Capital	55,526	55,526	55,526	55,526	55,526	55,526	54,959	54,959	54,959	54,159	54,159	54,159	56,488	
Revaluation Reserve	46,776	53,855	53,855	53,845	53,888	53,888	53,876	53,874	52,797	52,784	52,784	52,784	52,784	
Donated Asset Reserve	294	282	264	244	215	205	79	166	146	127	108	89	70	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Income & Expenditure Reserve	8,538	9,256	9,344	9,761	9,584	10,066	11,862	13,314	13,344	12,415	8,865	9,368	9,708	
Total Taxpayers' Equity	110,715	118,500	118,570	118,957	118,794	119,266	120,357	121,894	120,827	119,066	115,497	115,981	118,631	

LONDON AMBULANCE SERVICE NHS Trust

Forecast Cashflow Statement
For the Month Ending 31 December 2007 (Month 9)

	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
EBITDA after exceptionals	1,521	881	1,201	630	1,309	2,483	2,430	810	(156)	(2,882)	1,330	1,177	10,734
Excluding Non cash I&E items	(19)	(19)	0	(19)	(19)	(19)	(19)	0	0	(19)	(19)	(19)	(171)
Movement in working capital													
Stocks & Work in Progress	10	141	(1)	0	(102)	(5)	1	2	2	0	0	0	48
NHS Trade Debtors	837	658	(2,339)	46	(517)	(417)	(912)	4,026	(1,890)	(1,761)	103	200	(1,966)
Long Term Debtors	(19)	(18)	(1)	8	(19)	85	(204)	57	(17)	0	0	0	(128)
Non NHS Trade Debtors	(162)	236	213	(3)	(11)	3	2	(1)	(10)	(68)	15	(73)	141
Other Debtors	186	34	30	(69)	95	(166)	(257)	121	71	(73)	(4,049)	929	(3,148)
Accrued Income	(86)	(1,022)	157	(1,654)	(708)	(1,211)	4,436	(108)	462	0	0	727	993
Prepayments	56	341	(508)	311	590	(351)	(230)	(20)	53	(61)	(61)	(61)	59
Trade Creditors	983	36	268	(817)	1,183	1,033	(712)	(565)	985	4,193	1,220	(3,870)	3,937
Other Creditors	3,802	206	(159)	(313)	505	(211)	226	623	(320)	(4,701)	42	8	(292)
Payments on Account	340	340	0	0	0	0	0	0	0	0	0	0	680
Accruals	525	(262)	(2)	984	(274)	(402)	(125)	(1)	492	(100)	(150)	(250)	435
Deferred Income	381	252	351	648	517	(204)	3,863	(735)	(1,298)	(1,277)	(1,277)	(1,278)	(57)
Provisions & Liabilities	(41)	(53)	37	8	(89)	117	133	285	134	(69)	(20)	(464)	(22)
Net Cashflow from operating activities	6,812	889	(1,954)	(851)	1,170	(1,729)	6,221	3,684	(1,336)	(3,917)	(4,177)	(4,132)	681
Returns on Investments & Servicing of Finance													
Interest received	32	54	73	58	61	60	57	104	108	85	85	75	852
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from returns on investments & servicing of finance	32	54	73	58	61	60	57	104	108	85	85	75	852
Capital Expenditure													
Tangible fixed assets acquired	(476)	(1,050)	(300)	(220)	(481)	(443)	(576)	(647)	(676)	(59)	(2,077)	(4,888)	(11,893)
Tangible fixed assets disposed	0	0	0	0	0	0	0	0	0	0	0	3,800	3,800
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from capital expenditure	(476)	(1,050)	(300)	(220)	(481)	(443)	(576)	(647)	(676)	(59)	(2,077)	(1,088)	(8,093)
PDC Dividends paid	0	0	0	0	0	(2,040)	0	0	0	0	0	(2,039)	(4,079)
Net Cashflow before financing	7,870	755	(980)	(402)	2,040	(1,688)	8,113	3,951	(2,060)	(6,792)	(4,858)	(6,026)	(76)
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	2,329	2,329
Public Dividend Capital Repaid	0	0	0	0	0	(567)	0	0	(800)	0	0	0	(1,367)
Net Cashflow inflow/(outflow) from financing	0	0	0	0	0	(567)	0	0	(800)	0	0	2,329	962
Increase/(decrease) in cash	7,870	755	(980)	(402)	2,040	(2,255)	8,113	3,951	(2,860)	(6,792)	(4,858)	(3,697)	886
Closing cash balance	8,514	9,269	8,289	7,887	9,927	7,672	15,785	19,736	16,876	10,084	5,227	1,530	1,530