LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 18th March 2008 at 10am

Refreshments at 11.30

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 29th January 2008 Part 1 and synopsis of the Part II meeting held on 29th January 2008.		Enclosure 1 & 2
4.	Matters arising		
5.	Chairman's remarks	SR	Oral
6.	Report of the Chief Executive	PB	Enclosure 3
7.	Financial Report, Month 11 2007/08	MD	Enclosure 4
8.	Report of the Medical Director	FM	Enclosure 5
9.	Update re. submission of 2008/09 Budget and Three Year Plan	MD	Oral
10.	Approve Final Assurance Framework for the Annual Healthcheck 07/08	MD	Enclosure 6
11.	Decide on Foundation Trust Application	MD	Enclosure 7
12.	Approve Communications & Engagement Strategy	DJ	Enclosure 8
13.	Estates Plan Update	MD	Presentation
14.	Receive report on delivery of 2007/08 training plan	CH	Enclosure 9
15.	Receive final draft of the Trust's submission to the Healthcare for London consultation	PB	Enclosure 10
16.	Receive CAD 2010 update and migration options	PS	Enclosure 11
17.	SIP 2012 Update	PB	Enclosure 12
18.	Draft Minutes of Clinical Governance Committee, 4th February 2008	BM	Enclosure 13

19. Draft minutes of the Service Development Committee, 26th February 2008	SR	Enclosure 14
20. Draft minutes of the Audit Committee, 3rd March 2008	CS	Enclosure 15
21. Report from Trust Secretary on tenders opened since the last Board meeting	CMc	Enclosure 16
22. Opportunity for members of the public to ask question		Oral
23. Date of next meeting: 10.00am on 20th May 2008, Conference room, LAS HQ, Waterloo Road.		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 29th January 2008

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
	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
Apologies:		
	Caroline Silver	Non Executive Director
In Attendance:		
	Brian Huckett	NED-elect (Term of Office starts 1st February)
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Malcolm Alexander	Chairman of the LAS Patients' Forum (until 12.15)
	Alistair Drummond	Communications Officer
	Christine McMahon	Trust Secretary (Minutes)

01/08 **Declarations of Further Interest**

There were no declarations of further interest.

02/08 **Opportunity for Members of the Public to ask Questions**

There were no questions from members of the public.

03/08 **Minutes of the Meeting held on 27th November 2007**

Agreed: The minutes of the meeting held on 27th September 2007

04/08 **Synopsis of the Trust Board's Part II meeting held on 27th November 2007**

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

05/08 **Matters arising from the minutes of the meeting held on 27th November 2007**

Noted: That the Trust's response to the consultation being undertaken regarding Healthcare in London would be presented to the Service Development Committee in February. ACTION: Director of Service Development.

06/08 **Chairman's remarks**

The Chairman welcomed Brian Huckett to the meeting. Mr Huckett's appointment as a Non Executive Director was confirmed by the Appointments Commission and he officially joins the Trust on 1st February 2008.

The Chairman, on behalf of the Board, congratulated Sarah Waller, Non-Executive Director, who was awarded a CBE in the New Year Honours List. Congratulations were also extended to David Campbell, Ambulance Operations Manager, Bromley Complex, who was awarded an MBE. Members of the Board congratulated the Chairman, who has been awarded an Honorary CBE.

The Chairman reported that he and the Chief Executive had met with their counterparts in the London Fire Brigade and were hopeful that regular meetings of the London Emergency Services would resume.

There had been a disappointing response from the Mayor of London in respect of the funding of Emergency Life Support (ELS) training for Londoners, despite the support the scheme had received from the Greater London Assembly's Health and Public Service Committee. The Chairman said he would write again to the Mayor, pointing out that one of his responsibilities is the reduction of health inequalities and how the ELS training fell into that category.

Dr William Moyes, Executive Chairman of Monitor, recently visited the Trust; after speaking with the Chairman he spent time in the Emergency Operations Centre listening to calls. Dr Moyes said it had been a very informative visit.

The Chairman said he had received an invitation to speak at a meeting of the LAS Patients' Forum on Monday, 4th February.

07/08 **The Chief Executive's report**

The Chief Executive presented his regular report to the Board.

The Chief Executive tabled a revised set of graphs to those circulated in the pack as they more accurately reflected the Trust's performance in December 2007. As requested at the last Board meeting a graph was included (graph 4) to illustrate the volume of Category B[1] demand in the same way that Category A was reported (graph 2). Attention was drawn to the high level of utilisation in December, which reflected the high level of demand experienced during that month. The increased level of demand included a disproportionately high number of Category A[2] calls. Demand rose by 2.5-3% between August and December 2007. Demand in January was around 1% higher than in January 2007 and it was suggested that the rate of increase may be slowing down. Despite the increase the Trust met the majority of its performance targets and improved its response to Category B calls to 87% within 19 minutes. The Chief Executive said the Trust was the second highest

[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.

performing ambulance service in England with respect to the current Category A target; the highest performing service being the West Midlands.

Work was been undertaken to ensure the Trust is in a position to meet the Call Connect[3] performance targets that come into effect 1st April 2008. Call Connect Category A performance was 60% in December 2007 and 64% in January 2008. The Chief Executive circulated a list of 30 actions identified by the Director of Operations that will be taken and should enable the Trust to meet the 75% Category A Call Connect performance target from April 2008.

The Chief Executive said he was pleased to report that for the last three months, with the exception of New Year's Day, EOC Call Takers have answered 95% of calls within five seconds (graph 13).

Discussions were being held with Commissioners to finalise the Trust's 2008/09 funding. The deadline of 28th February 2008 had been set by NHS London for all London Trusts to have Service Level Agreements in place. Work was being undertaken to finalise the Trust's Three Year Plan and 2008/09 budget so as to meet NHS London's deadline of 28th February 2008.

Discussions were also being held with a number of A&E Hospitals in London concerning unacceptable delays in the handover from LAS crews to A&E staff. The Chief Executive had raised the matter with Malcolm Stamp, Chief Executive of the Provider Agency.

The New Ways of Working initiative was launched on the Trust's internal website (the Pulse) on the 29th January. A booklet, explaining the initiative, was circulated to the Non Executive Directors. As previously explained the intention is to choose three ambulance complexes to be the initial exemplars of the New Ways of Working. The Board would be kept informed of progress via the Chief Executive's report to the Board. **ACTION: Chief Executive.**

Communications: the Trust received good coverage following the fire at the Royal Marsden Hospital, the incident at Heathrow airport and in connection with alcohol related issues over the Christmas season. Alex Bass and the rest of the Communications team have done a good job in working with the media.

The Chief Executive identified the following challenges facing the Trust over the next few weeks:

- Implementation of the various initiatives to ensure the 75% Call Connect Category A target is achieved from April onwards.
- Submission of the final Three Year Plan and 2008/09 budget by the deadline of 28th February 2008.
- Spending the 'Invest to Save' funding received from the Department of Health
- Responding to the consultation being undertaken by the NHS London.
- Moving ahead with CAD 2010, a Full Business Case would be presented to the Board in May 2008.
- Procurement of new vehicles once the skill mix of front line crews is agreed.

The Chief Executive thanked the Director of Operations and his team for their efforts over the last nine months which have resulted in significant improvements in call taking, Category A and Category B performance.

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[3] Call Connect: ambulance response times are currently measured from a point when three pieces of key information have 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:

The Disciplinary Policy has been reviewed and updated and would be circulated by the HR Director to the Board for information. Comments made by the Non-Executive Directors and their experience of the Disciplinary process were noted. **ACTION: HR Director**

For the last few years the increase in overall demand has been approximately 3-4% per annum. The increase in demand in late 2007 was due to an increase in the number of cases of chest pain, respiratory illness, and unconsciousness or fainting reported over the Christmas period. It was suggested that the increases in demand year on year also reflected non-clinical factors such as the public's assessment of the other options available to them. The Chief Executive said that, despite the increase in demand in 2007, 12,496 fewer patents were taken to hospital. This was due in part to the introduction of Clinical Telephone Advice.

The Clinical Support Desk, to be introduced in EOC from the Spring, would offer clinical support to both operational and control room staff.

There was some difficulty experienced with the capacity of the Airwave Network service on New Years Eve; this was being investigated and it was hoped that the matter would be quickly resolved.

PTS' bid to Kingston Hospital was 30% higher than the successful tender submitted by OSL. The Director of Finance said that the bid submitted had been realistic and reflected the Board's wish not to sacrifice quality of care. In addition to the contracts it has retained, PTS was picking up ad hoc work from other PCTs and Trusts which enabled it to maintain its profit margins. The PTS Strategy would be presented to the Trust board in March 2008. **ACTION: Director of Finance**

Agreed: To express the Board's appreciation to Richard Webber, Assistant Director of Operations, Control for the significant improvements that have been implemented in EOC performance.

08/08 <u>Presentation: National Emergency Preparedness Audit</u>

The Director of Operations presented the findings of the National Emergency Preparedness Audit undertaken in the Autumn of 2007. He thanked Russell Smith, the Assistant Director of Operations, who reviewed the findings and wrote the presentation.

An Audit of all the ambulance services in England was undertaken at the request of the Department of Health. Its purpose was to establish a baseline and provide assurances that robust, auditable plans and capabilities are in place, meeting the requirements of the Civil Contingencies Act.

The LAS was found to be 73% compliant against the audit tool (the national average was 64% and the LAS was the highest scoring Trust) and also had the highest number of good practices identified. The good practices included the Major Incident Plan ("Concise, well structured plan. Easily navigated and fully compliant"); the Business Continuity plan ("Good plan in place. Clear evidence of Executive led governance and regular review"); Command Training ("the most structured approach to succession planning encountered").

The areas for improvement identified included: improving the capacity to release staff for CBRN training and re-licensing; introducing systems for learning lessons nationally; designing a systematic approach to training and exercising; improving the testing of business continuity plans and re-drafting mass casualty planning to

include "whole health" input. In terms of learning lessons the example given was no comprehensive system in place nationally to learn lessons i.e. the lack of evidence that the lessons learnt from the floods that took place in the summer of 2007 were shared with colleagues in other ambulance services. The Director of Operations made the point that within two weeks of the 7th July Bombings the LAS had held a seminar for all UK services specifically designed to share lessons learnt.

National issues which had emerged from the audit included the need for more clarity around who was responsible for national policy making; the need for improved business continuity planning and the need to ensure that commissioning arrangements include an explicit requirement for all ambulance trusts to provide emergency preparedness plans and to receive mainstream funding for this activity.

An action plan had been drafted to address the areas identified as weak and this would be implemented over the next few months. The national report was expected to be published in 2008.

It was Noted that:

The LAS had been very active in promoting lessons learnt from 7/7 and had been very honest about communication difficulties.

09/08 **Month 9 Finance Report**

The Director of Finance presented the month 9 finance report and said that the Trust was forecasting a year end surplus of £1.1m. He highlighted the following from the report:

- In 2007/08 the Trust received additional funding to help it move toward meeting the 'Call Connect' target, and 'Invest to Save' funding . The Trust received £8.2m non-recurrent funding.
- £.1.2m has been accrued against the risk of incurring a penalty for not meeting the Category B target; discussions were being held with the Commissioners concerning this penalty.
- The trend showed an average expenditure of £18m per month which compared well with last year.
- The spending on overtime was under budget .
- The sale of Buckhurst Hill was expected to raise £3.9m

It was Noted that:

The Director of Finance would circulate information regarding the projects being managed under the Invest to Save programme. **ACTION: Director of Finance.** The Programme included additional operational support e.g. mobile mechanic, additional third party transport and additional equipment.

The Board would like to receive a report on the benefits realised as a result of the increased resources being focussed on frequent callers. **ACTION: Director of Finance.** The Finance Director said that a Benefits Realisation Consultant was being recruited to ensure that the Trust does measure benefits realisation for all the projects being undertaken under the Service Improvement Programme.

10/08 **The Medical Director's report**

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

Serious Untoward Incident (SUI): the Medical Director gave a detailed account of four SUIs currently under investigation, one of which involved a death in police custody. In partnership with the Metropolitan Police Service the LAS was

producing a DVD that would be used to train the Police and LAS crews in the proper procedures to be undertaken when dealing with problematic patients who may be intoxicated with drugs/alcohol or be mentally ill or be in an acute confused state.

The protocols for cooling patients who have a return of spontaneous circulation and a significantly reduced level of consciousness 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 would commence on 4th February 2008.

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

Stroke: Consultant Neurologists with an interest in acute stroke care met 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 were in attendance. Revised guidance would be issued to front line crews concerning the management of stroke.

Clinical Update Newsletter: Copies of the newsletter were circulated for information. The newsletter's focus this month was obstetrics and included an example of an ECG from a 76 year old man who was slightly short of breath and hypertensive with a blood pressure of 168/97.

CARU: A summary of the LAS Annual ST Elevation Myocardial Infarction Report (2006/07) was presented. The following points were highlighted: the increased number of patients receiving primary angioplasty through conveyance direct to a cardiac catheterisation suite (cath labs), the generally high, and increasing, number of patients receiving appropriate therapy, including pain relief and the reduced in-patient stay for this group. Staff have been reminded of 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.

Infection Control: the Medical Director presented the findings of an infection control audit undertaken of ambulance stations and vehicles (ambulances, PTS and FRU vehicles) in late December/early January across the Trust. The findings provide a baseline for the audits that will be undertaken on a quarterly basis in 2008 with regular updates being provided to the Trust Board. An action plan had been drafted and improvement should be discernable as the identified actions were implemented.

Only one of the standards on the audit tool kit used refers to patient interface i.e. vehicles. The findings show that a small number of stations were fully compliant, a number were partially compliant and a few were non-compliant. The Trust is continually seeking to recruit an Infection Control Co-ordinator.

Labels were being purchased to identify cannulae sited by LAS staff outside hospital. This would 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.

The LAS Pandemic Flu plan was being updated in light of the DH 'Pandemic Flu – Guidance for Ambulance Services and their staff,' published in November 2007.

The existing plan largely focused on business continuity and requires more clinical detail. The Assistant Medical Director (Primary Care) was working with the LAS Flu Coordinator to expand this area.

It was Noted that:

The number of patients with left bundle branch block (LBBB) was unknown; the Medical Director undertook to find out if the figure was available. **ACTION: Medical Director**

Access to some Cath labs was very smooth, e.g. London Chest and Harefield, which do not have emergency departments, offer an exceptional service. The system is not as smooth in other hospitals that do have an A&E department as there were sometimes delays in transporting patients to the Cath labs in these hospitals.

The Medical Director said that, following NHS London's consultation on the implications of Lord Darzi's report 'Healthcare for London', it was likely that one of the recommendations, the establishment of 9 stroke centres in London, would be implemented in 2008/09. As there were tight licensing requirements that needed to be met before hospitals were able to deliver thrombolysis, it may be that not all hospitals that aspire to be a stroke centre will be successful. Another issue that has arisen is the question of funding following patients. Stroke patients require rehabilitation following their treatment and need to be repatriated from the stroke centre to their local hospital in order to maintain the stroke centre's capacity. The funding issue was of concern and discussions were on-going.

11/08 **<u>Three Year Service Plan and draft 2008/09 budget</u>**

The Finance Director presented the Three Year Service Plan and the draft 2008/9 budget, which following approval by the Chairman and the Chief Executive, was submitted to NHS London by the deadline of 15th January. Further work would be undertaken prior to the submission of the final 2008/09 budget to NHS London by the deadline of 28th February.

The Finance Director outlined what had been accomplished to date in respect of the 2008/09 budget and identified what further work needed to be completed prior to the final budget being presented to the SDC on 26th February. Confirmation was awaited from the Trust's Commissioners as to the Trust's 2008/09 A&E core funding; from NHS London in respect of the education and development bid that had been submitted; from the Department of Health or NHS London as to who would be funding the preparatory work being undertaken in respect of the 2012 Olympics.

The draft budget included the assumptions of pay inflation of 2.5%; non-pay inflation of 2%; the national CRES[4] of 3% and an internal CRES of 0.5%. The latter is expected to fund 2008/09 developmental work. A surplus of £1.1m was forecast for 2008/09.

Further work being undertaken to finalise the budget included: completion of departmental budgets; approval of strategic projects in line with SIP 2012; income agreement with the Commissioners and other Funders. The Chief Executive and the Finance Director would be meeting with the London Provider Agency, NHS London, on 5th February to review the submitted draft budget.

[4] CRES: Cash Releasing Efficiency Saving

It was Noted that:

A Fleet Plan would be presented to the Trust Board in March. **ACTION: Director of Operations.**

The Three Year Service Plan would highlight that staff engagement was much more difficult for the LAS in comparison to other London NHS Trusts due to the dispersed nature of the workforce. In addition, there would be clarification sought as to the role played by Agency Boards to clear appointments.

Developmental work would take place regarding the management of calls that did not require a vehicular response. The introduction of the Clinical Telephone Advice service had seen a significant number of callers who do not require an ambulance service receiving advice as to alternatives. It was recognised that the key to future development would be better integration of the London healthcare system; this would become clearer once NHS London has concluded its consultation and is able to make its plans accordingly.

The non-core A&E element of the Trust's funding amounted to £20m. This represented a risk for the Trust in terms of long term financial planning, given the uncertainty of funding sources.

Agreed: That the Service Development Committee on 27th February 2008 be delegated authority to approve the final Three Year Plan and 2008/09 budget prior to its submission to NHS London.

12/08 <u>Human Resources Strategy</u>

The HR Director presented the HR Strategy which sets out the key strategic aims for HR; the expected benefits for the organisation and the generalised approach to achieving them. Amongst the objectives were: an overall workforce skill mix which meets the need to respond appropriately to the diverse population of London: the development of 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 and develop leadership capacity and capability for the future development of the LAS. All of which will be supported through excellence in Human Resource Management (HRM) and the Organisation Development and People Programme.

The majority of the above themes were organised and managed through the Organisation Development and People programme; work which was not project based would be managed through the normal route of objective setting for managers and teams.

It was Noted that:

Work was being undertaken under the auspices of the Call Handling Group (sub-group of the National Control Group, Ambulance Leadership Forum) to agree a national skills escalator framework for Call Takers.

The revised workforce plan scheduled to be presented to the Trust Board in March 2008 would incorporate the Call Handling Group's findings. **ACTION: HR Director.**

There was a suggestion that the environment that front line crews have to manage (e.g. rising gun crime, increased drug abuse) may affect staff morale. The HR Director said that the Trust seeks to fully support staff in the carrying out of their roles and responsibilities, details of which were contained in the strategy document.

Until recently it was accepted that the public sector would face problems in the future to an aging population when there would be a smaller pool of potential employees from which to recruit. However, due to immigration London's population has become younger and it was therefore less clear as to the future impact on the labour market profile.

Efforts continue to improve the ethnic composition of the Trust's workforce. The HR Director said that to date in 2007/08 13% of recruits had been from a BME background; this compared favourably with the 2006/07 figures when 10% of recruits were from a BME background.

It was recognised that although 'Command and Control' is necessary under certain circumstances, work was being undertaken to move more towards a transformational culture in the LAS on a day-to-day basis with Managers receiving training to enhance their leadership and people management skills. The New Ways of Working incorporates this approach with its emphasis on leadership in the complexes.

Agreed:

1. **To approve the Human Resources Strategy.**
2. **That the Vision Statement would be discussed again at the Trust Board in March and the comments made by the Non-Executives taken into consideration. ACTION: Chief Executive.**

13/08 Appointment of the chairmen of the Board's committees and proposed future Board development

In accordance with Standing Orders 26.1 the Board confirmed the appointment the following Non-Executive Directors as Chairmen of Board Committees: Caroline Silver (Audit Committee and Charitable Funds Committee) and Dr Beryl Magrath (Clinical Governance Committee). Brian Huckett, the new Non Executive Director, would join the Audit Committee and the Charitable Funds Committee.

14/08 Presentation: Payment by Results

Vicky Clarke, Finance Manager to the Director of Finance, gave a presentation on the Payment by Results project. The project's objectives included: examination and testing of alternative payment mechanisms (currencies and structures); comparing and learning from the outcomes of the other five pilots being undertaken nationally; engaging with Commissioners on local alternatives to the current block contract and volume-related payments, and investigating appropriateness of local versus national tariffs.

A draft summary of the research had been completed and a workshop held to select three currencies and structures to trial. Work was being undertaken on accessing activity data and modelling options. It was possible that the final model could be an amalgamation of all three models (Incidents/Responses Calls; See and Treat/Hear and Treat/See and Convey and Illness Codes/AMPDS codes) outlined in the presentation.

The modelling of the options would be based on Service Level Agreement income having a zero-impact statement (i.e. not increasing the cost of the service to the Commissioners). The options would be tested using sensitivity/scenarios and forecast activity. One model would be chosen for piloting in 2008/09 and work is being undertaken to design the process for capturing and reporting the outcomes.

It was Noted that:

Category A8 were the most expensive calls due to multiple despatches of fast response cars to ensure an 8 minute response and ambulances to transport.

15/08 Update on the Service Improvement Programme 2012

The Chief Executive presented the update on the Service Improvement Programme 2012 and invited members of the Board to ask questions of the Senior Responsibility Officers present. The new style of presentation was commended as being concise and informative.

It was Noted that:

There had been some slippage with the Operational Programme due to the increased demand experienced in December but this was expected to be addressed in the next couple of months.

The 'Invest to Save' Programme included a number of projects that were time critical owing to the additional funding having to be spent this financial year.

New Ways of Working was being managed by the Organisation Development and People and the Operational Programmes; a separate progress report would be presented to the Board.

16/08 Draft minutes of the Clinical Governance Committee, 18th December 2007

Beryl Magrath, Chairman of the Clinical Governance Committee, highlighted the following from the minutes of the meeting held on 18th December 2007:

- Of the 1 in 3 staff who received rest breaks, a quarter was interrupted and a tenth received breaks at the end of their shift. It was requested that the information pack presented to the Board include a graph depicting the allocation of rest breaks. **ACTION: Director of Operations.** The Rest Break Agreement was under discussion with Staff Side as was the whole scale review of rosters and dynamic deployment.
- Following a lengthy process an agreement had been reached with the Metropolitan Police Service on the transportation of people. This had been shared with Staff Side and a LAS procedure note would be presented to the Trust Board for approval.
- Lost property bags are to be provided on a trust wide basis commencing January 2008, funded by the 'Invest to Save' money.

Noted: The draft minutes of the Clinical Governance Committee, 18th December 2007.

17/08 Draft minutes of the Service Development Committee, 18th December 2007

Noted: The draft minutes of the Service Development Committee, 18th December 2007.

18/08 **Report from Trust Secretary on tenders opened since the last Board meeting**

Six tenders have been opened since the last Trust Board:

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

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 had not been used since the last Trust Board meeting.**

19/08 **Any Other Business**

There was no other business.

20/08 **Opportunity for members of the public to ask questions**

There were no questions asked by members of the public.

21/08 **Date of next meeting**

Tuesday, 18th March 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 12.56pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 29th January 2008
held in the Conference Room, LAS HQ, London SE1

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

On the 29th January 2008 in Part II the Trust Board received updates:

Regarding London Airwave Radio Project (LARP) and the difficulties experienced on New Year's Eve. The IM&T Director undertook to keep the Trust Board informed of progress.

On the progress being made in implementing the action plan to achieve 'Call Connect' performance targets with effect from April 2008. Discussions were being held with staff side on such things as dynamic deployment.

On the preparations for the Trust Board's Away Day in April the Chairman said he was collating information about the governance arrangements of Foundation Trusts and would be seeking to identify what were the pitfalls and how other Trusts had resolved them.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 18 MARCH 2008
CHIEF EXECUTIVES REPORT

1 ACCIDENT & EMERGENCY SERVICE

1.1 999 Response Performance

The tables below set out the A&E performance against the key standards for January and February of 2008 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%
January 2008	78.1%	63.9%	86.8%
February 2008	76.1%	62.0%	83.8%
March 2008*	77.5%	65.0%	81.3%
YTD*	78.8%	n/a	84.4%

* Accurate as at 10th March 2008
** Applicable from April 2008

Key highlights

- November and December 2007 were the two busiest months in the history of the Trust with 2661 (921 Cat A) and 2698 (974 Cat A) calls per day respectively. Workload fell slightly in January to 2542 (887 Cat A) but increased again in February to 2580 (891 Cat A) per day
- I am pleased to report that the Trust is continuing to perform well against the current Category A target of 75%, achieving 78.1% in January and 76.1% in February. March is running at 78% and the year to date position is 78.8%.
- Call connect performance recovered to 63.9% in January but fell back to 62% in February predominantly because of poor staffing coupled with increasing workload. Call connect performance has been particularly poor at weekends during the latter part of February and early March in the face of high Cat A volumes and poor staffing on both Ambulances and FRUs.
- It is important however to provide some perspective here in that Call Connect performance last February was 46% with almost exactly the same levels of workload and staffing. At 62% this year we have therefore shown an improvement of 16% over the same period last year.
- The real concern is associated with distance from Trajectory which is now circa 10%. Nationally we have been slipping down the performance table

and need to get back to 68 to 69% to be back with the main leaders. The best call connect performance being delivered nationally is circa 70 to 72% for two services. I am pleased to report that week ending 9th March has seen our call connect performance recover to 68% and the challenge now is to build on this still further through the remainder of March.

- Control Services has continued to perform well and call answering has remained very resilient with the percentage of call taking within 5 secs still consistently in the high 90s for most days even when incoming calls reach circa 4000.
- Category B performance recovered to 86.8% in January our best ever, but has fallen back to 83.8% during February principally due to poor ambulance staffing. When well staffed we can now deliver circa 89 to 90% on most days and I am confident that once full Dynamic Deployment has been introduced we will improve this still further
- Staffing is the biggest challenge currently. Ambulance hours fell by 1245 and 1844hrs in the last two weeks of the February half term when compared to the normal levels we have been producing and FRU hours also fell by circa 200 hrs against the norm, this area is more sensitive with lost FRU hours impacting greatly on performance.
- Overtime working is at very low levels as staff use up annual leave and are mindful that the Christmas bonus of £750 is being paid in February .An overtime incentive scheme has now been introduced to improve the uptake of overtime during both March and April. The scheme is simple and targeted to both Ambulance and FRU hours and is now beginning to show results with staffing improving during the first week of March.
- The Trust moved to REAP level 3 'Severe Pressure' as of week commencing 3rd March given the increasing demand and deteriorating performance and this will now be maintained until the end of April given the call connect challenge.
- Overall Job Cycle times have decreased by some 5-6 minutes since October. This is in part due to greater emphasis from managers on dealing with this issue through Individual Performance Reviews with front line staff and partly due to the introduction of the 'Time at Hospital' visual indicator on the MDTs. We plan to build on this success still further with the removal of the administrative handover across London on the 10th March .

1.2 Activity

- The number of responses made by the Trust in February 2008 rose by 4.9% compared to the same month last year.

- Overall workload, year to date, is up 3.2% on the same period in 2006/7

1.3 Resourcing

- As stated earlier staffing has proved to be the biggest challenge over recent weeks. This has been due to a number of factors including high levels of annual leave, reluctance to work overtime and to a lesser extent operational vacancies and secondments. The two staggered half term weeks in February were particularly difficult and here ambulance hours fell by 1245 and 1844hrs when compared to the normal levels we have been producing . In overall terms we produced slightly less ambulance hours than the same month last year. FRU hours have increased however as we strive to staff more solo responders to improve call connect performance.
- Overtime working has been at very low levels in the last few weeks but following the introduction of the overtime incentive scheme is now picking up and staffing levels are expected to improve during the remainder of March and April.
- Work is ongoing to allow the current resourcing software ProMis to be fully utilised to record and manage all annual leave from April 1st 08. The Resource Centres will also take on additional responsibility for the management and recording of overtime. Finally work is in hand to allow direct communication between PROMIS and the payroll system and in time with the Electronic Staff Record (ESR) system.
- Discussions are currently taking place regarding the utilisation of the same ProMis software to manage the resourcing of PTS. It is envisaged that this will add benefits in terms of efficiencies and uniformity.
- ProMis was used successfully to arrange payments for the Christmas Attendance Bonus and we are also planning to use it again to process payments for the March/April overtime incentive scheme. This is aimed at minimising the additional workload for Station Administrators.
- Work continues to move towards the two Resource Centre configuration as described to the Board at its last meeting. These will be based at Ilford and Croydon and estates work is nearing completion. It is expected that the final moves will now take place in May.

1.4 Emergency Operations Centre

- The Automatic Electronic Dispatching of Ambulances (FREDA) went live on the 7th of December. There has been an improvement noted in the activation times within 2 minutes for Ambulances across both Category A and Category B calls of about 10%. Currently approximately 25% of all Ambulance calls are now being despatched via this much quicker route with an improvement in performance noted of about 10% on those Category A calls. The next step is to ensure that a greater number of ambulance vehicles are dispatched

electronically which will in turn depend on an agreement being reached with staff side colleagues regarding ‘Active Area Cover’.

- The EOC staffing levels for January were good with an overall staffing level achieved of just over 104%. There was a slight dip in February to just above 98%; which was mainly caused by a reduction in uptake of overtime. Work is still underway to ensure that both the numbers and skill levels of staff at work consistently meets the needs of the service across the entire week. Discussions are reaching a conclusion with staff side to amend the core rota to include weekends in the relief week which currently only covers Monday to Friday. Whilst there has been opposition to the intended changes, the case for change and the need to ensure there is an effective service provided to the public consistently across the entire week has been strongly made. There is an intention to amend the existing relief rota as well which has been broadly accepted by staff. The new rota will ensure that whilst providing cover at the times of greatest need, the 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 has continued to improve with most days now consistently exceeding the target of 95% answered in 5 seconds. January as a whole achieved 93.5% with February attaining 94.6 %. In both months 3 of the 5 watches exceeded the 95% target. The change in the order in which questions are asked in call taking has now started to bed down, which has reduced the time taken to obtain certain key parts of information and is resulting in faster activation of resources.

- In terms of the quality of call handling, the level of compliance within AMPDS has remained satisfactory with compliance levels across all watches exceeding the overall Centre of Excellence level standard requirement of 95%. There is a need to further improve Case Entry as this is an area that is failing to achieve the necessary targets; but work is underway on addressing this.

- The second phase of the Control Services reorganisation is now due to go to formal consultation with staff in mid March, with the delay being caused by the need to resolve the rota review negotiations. However, the document has already been shared with the lead staff side reps. The new structure will ensure that the EOC structure in dispatch more closely mirrors the operational structure across the areas. There will be greater accountability of the staff for performance issues and line management of their group of staff on each area desk. There will also be an enhanced managerial overview of call taking as well as providing a career structure for staff who wish to remain in call-taking.

- The Clinical Support desk in EOC is coming close to implementation; with an advertisement already placed in the RIB seeking suitable staff. 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 should be operational at some point in April. 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 Gazetteer is being installed on the 18th of 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 now occurring in EOC. The call taking area was closed at the beginning of March with staff displaced to ICR, UOC and in other areas across EOC for a 2 week period to allow a complete refurbishment. There will be a new configuration and layout, new desks, recabling, installation of new phone turrets, new wall monitoring boards, carpet and a re paint. New chairs and personal lockers arrived during February. The entire lighting system has been fully refurbished with repositioning occurring and individual remote controls issued to adjust lighting levels for each desk in both call taking and despatch areas. We have also entered into an agreement with a local art college to provide works of art on the walls that will be changed on a regular basis to improve the environment.

1.5 Urgent Care

- The target to recruit into training 162 A&E support crews has been achieved, with courses planned for 2008/9. Back filling of EMT1 staff who are due for an up-grade course in May is being planned with the new A&E support crews. The Voluntary Aid Societies and Private Ambulance providers continue to support the Urgent Care Fleet, and there is an agreement to keep them until the end of April.

- As more A&E support crews complete their training, the volume of calls covered will increase. A review of the dispatch functions in the Urgent Operations Centre (UOC) is now underway to ensure there are systems and processes in place to maximise the use of all available resources. Part of the objective is to mirror the Emergence Operations Centre dispatch and deployment areas.

- Recruitment to Clinical Telephone Advice (CTA) has been slower than expected, but we have been able to maintain the current establishment of 50. CTA recruitment open evenings have been held at Headquarters and more are planned in the operational areas during the coming weeks. We are also continuing to examine the possibility of providing remote access for CTA outside of HQ with IM&T colleagues.

- There continues to be a steady improvement in CTA call volumes with circa 1400 calls per week now being managed routinely by CTA. Some 60% of these CTA calls now result in an ambulance not being sent equating to 850

saved patient journeys per week. We will be reviewing the types of calls which are deemed suitable for telephone advice with the medical directorate over next few weeks to ensure that all appropriate calls are being passed to CTA.

- UOC managers are working closely with Patient Transport Services (PTS) managers to ensure PTS suitable journeys taken by call takers in EOC are routinely passed to PTS. Technology improvements have made this a much more streamlined process and PTS now have a target to cover 150 journeys per week for A&E.

1.6 Emergency Preparedness

- The new Major Incident Plan has now been printed and has been distributed to all stations and managers. A read only version is now available on the Pulse.

- New Major Incident Action Cards are now being issued to every member of frontline staff.

- In February the service attended a serious incident when a Boeing 777 crashed at Heathrow airport. The aircraft had 136 persons on board when it suffered engine failure and crashed short of the main runway. All persons were safely evacuated form the aircraft within 90 seconds, with no one sustaining serious injuries. The service although not formally declaring the incident, followed major incident procedures which worked well.

- The service has held two Major/Serious incident debriefs since the last report. These were for the Royal Marsden Hospital fire and the aircraft crash at Heathrow. Both debriefs were successful and useful learning points from both will be built into the management of future incidents.

- In February the service took part in a regional multi-agency flooding exercise. The service was represented at all levels to good effect.

- In March the HART Team plus several LAS managers took part in a national HART (Hazardous Area Response Team)/USaR(Urban Search & Rescue)exercise at the Fire Service College in Gloucestershire. The exercise went well and once debriefed will lead to further improvements in the management of a whole range of incidents.

- The new Gold Command Suite on the first floor is now in commission and provides a dedicated purpose built facility to manage major incidents so removing reliance on taking over the conference room at HQ.

- The Emergency Planning Unit is currently running a poster campaign across the service to try to promote more accurate first on scene reporting to EOC. This is the first of a series of such campaigns targeted to highlight emergency preparedness issues for the Trust.

1.7 Recent E-mail System Failure:

On Tuesday 4 March at approximately 13:00hrs there was a failure of the Trust Wide e-mail and diary system. This did not affect 999 call handling.

Initial analysis of the problem showed that there was a significant hardware error on the main system and there was early optimism that although automatic switch to the back up system had not worked, a manual change over should restore service quickly. However, despite best efforts this did not occur. Various plans were implemented and the IM&T team, supported by Dell and Microsoft, continued work through the evening. As events continued to unfold the team worked through the night, eventually starting to restore service from approximately 07:00hrs on Wednesday 5 March. By 09:00, the night staff had been replaced, approximately 65% of users had service restored and by 11:30 the majority of users had service restored. Via the service desk individual user problems were cleared during the day.

At approximately 07:00 on Thursday 6 March, the system once again failed, due to different hardware errors. Remedial action commenced immediately, initially by remote support with a full team on site by 09:00. It was recognised that part of the problem was capacity problems with the core system. It was therefore decided that 3 separate plans of action were required;

1. Work was immediately commenced to repair the failed system. This continued through Thursday and service was restored to users at 07:00 on Friday 7 March. Although the main service was available, there were various problems, particularly with external e-mail.

2. Recovering hardware from Bow, work commenced on building a new system (in terms of software and hardware). This was a significant task, and by 17:00 on Friday 7 March the main installation was complete and work commenced to transfer some 4000 users accounts (including data) to the new system. Work continued over the weekend and by 14:00hrs on Sunday 9 March the new system was fully operational.

3. By way of contingency, on Thursday 6 March NHS Mail was made available for approximately 100 senior managers and other key users. This allowed secure e-mail facilities, and will be left available as an additional service should any senior manager wish to use it.

Over the coming weeks work will continue to improve the whole e-mail / office automation environment. This will include full testing of DR arrangements. Clearly these problems did cause disruption and difficulty however, operational systems used by the Emergency Operations Centre, and emergency response were not affected.

2. Patient Transport Services

2.1 Commercial

The London Ambulance Service has been announced as the preferred contractor to supply PTS services for the following PCT's:

- Richmond and Twickenham (new business), commences 1 April 2008 and creates 3 new posts.

- Sutton and Merton (new business), commences 1 April 2008 and creates 3 new posts.

- Lambeth PCT and SLAM (new business), commences 1 May 2008. This includes up to 13 staff who will transfer under TUPE to the LAS.

An announcement in respect of Whipps Cross University Hospital (existing) is expected shortly

An expression of interest has been submitted on 28th February to Newham University Hospital Trust, Newham PCT and East London NHS Foundation Trust

2.2 Operations

A new planning system was introduced on 1 March 2008 and replaced the previous "SSL" system which has been in operation since 1980. The implementation has gone smoothly with few problems occurring. Those issues which did arise are being remedied and have not effected the day to day operations.

2.3 Staff

TUPE consultations continue with staff on the UCLH and Kingston contracts which are due to end on 31 March 2008. With the additional posts created from the new contracts above; it is likely that the majority of staff will be given the option to take up new posts within the LAS. PTS managers are working closely with Trade Union representatives to finalise this process and we expect to reach a final position by 20 March 2008.

2.4 Performance

Performance for "Arrival Time" and "Time on Vehicle" improved slightly by 1% to 89% and 94% respectively in February 2008. There was a fall of 1% to 90% for "Departure Time".

3. HUMAN RESOURCES

Staff and Union Engagement

During the week of 3 March 2008 the Area Assistant Directors, together with their Senior Trade Union Representatives, have been holding a number of partnership consultation events. These have been aimed at informing staff of some of the challenges we face as a Trust in improving our service to patients and associated plans in responding to these challenges. The views of staff have been sought and collated. The events have had a mix of attendance levels though have been seen as generally positive.

Workforce Planning

With confirmation of the funding envelope for 2008/09, planning for next year's workforce numbers and skill mix is in the process of being finalised. Headline messages at this stage however are that the Trust will be expanding its frontline workforce in line with the requirements created by the call connect expectations. This growth will be in both qualified and support frontline roles. With this in mind, plans are already well progressed to begin recruitment of a minimum number of 100 Paramedics and Student Paramedics together with 100 A&E support. Up-skilling of existing Technician staff to Paramedic will also continue as planned. Final workforce numbers will be confirmed at the Trust Board in May.

Supporting this expansion and in line with the Trust's desire to create an appropriate career progression framework for A&E support roles, the Trust is introducing a Student Paramedic role with an associated training programme. This will primarily offer the opportunity for A&E support staff to progress through structured assessment and training to become qualified paramedics within a defined time period. The framework will also be modified to allow the framework to support additional recruitment at times of rapid workforce growth. Further details of the scheme can be made available to Trust Board members.

CRB checks

The Trust is currently undertaking retrospective CRB checks for existing staff who meet the criteria set down by the CRB (direct patient contact including over the telephone). Any issues arising from these checks will be managed through existing Trust policy.

Policy Development

The following HP policies/procedures have been published since the previous Trust Board meeting:

- Payment of travelling time – revised travelling time provisions;
- Step-down framework – setting out possible provisions for employees unable to continue to the same extent with their current post.

Sickness absence

Levels of sickness absence have shown a slight increase in January compared to December (6.61% from 6.34%). Close monitoring of application of the attendance management policy through the current audit process is currently being enhanced through increased frequency of the audit process. Human Resources Managers are also assisting local operational managers in following up initial reporting of absence during the period of increased operational pressure.

Rest Breaks

Providing rest breaks for crews is continuing to prove challenging and a new summary sheet detailing the current situation is now included as part of the Trust Board Information Pack. The numbers of breaks given has fallen through November and December to a low of 26% in December. This is principally due to the rises in workload experienced during these two months. The situation improved in January and February to 30%. Clearly these figures are still unacceptable and the meal break agreement is currently under joint review with the trade unions. We will be placing more emphasis on meal break allocation by the control room but it is clear now that some significant changes to the current agreement will need to be negotiated if we are be able to significantly increase the numbers of staff receiving meal breaks.

INTERIM WORKFORCE INFORMATION

Staff Turnover Mar 07/Feb 08	
Staff Group	**Turnover %**
A & C	12.31%
A & E	4.96%
CTA	5.26%
EOC Watch Staff	11.71%
Fleet	12.73%
PTS	9.31%
Resource Staff	2.04%
SMP	5.74%
Grand Total	**6.48%**

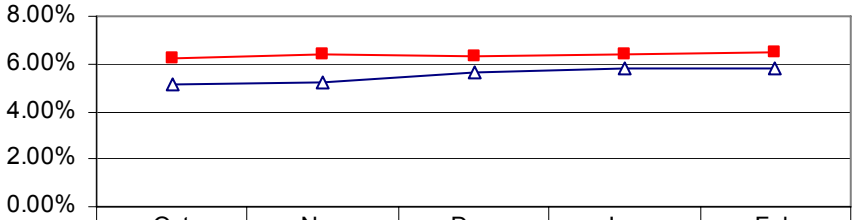
A&E ESTABLISHMENT REPORT – February 2008				
Title	**Funded Establishment**	**Staff in post**	**Variance**	**Leavers**
Team Leader	169.50	161.19	8.31	1.00
ECP	56.00	52.56	3.44	0.00
Paramedic	910.89	812.57	98.32	2.00
EMT4	713.48	856.97	-143.49	7.00
EMT3	730.75	471.74	259.01	2.00
EMT2	0.00	102.11	-102.11	1.00
EMT1	30.00	33.00	-3.00	0.00
Total	**2610.62**	**2490.14**	***120.48**	**12.00**

*Vacancy of 60 held to fund ECPs.

Absence 2007/08	**Nov**	**Dec**	**Jan 08***
A & E Ops East	7.03%	6.92%	6.64%
A&E Ops South	6.58%	7.00%	7.02%
A&E Ops West	6.23%	6.52%	7.78%
Control Services	7.27%	6.83%	6.98%
PTS	8.24%	7.13%	8.27%
Trust Total	**6.47%**	**6.34%**	**6.61%**

* January figures to 27 Jan 2008

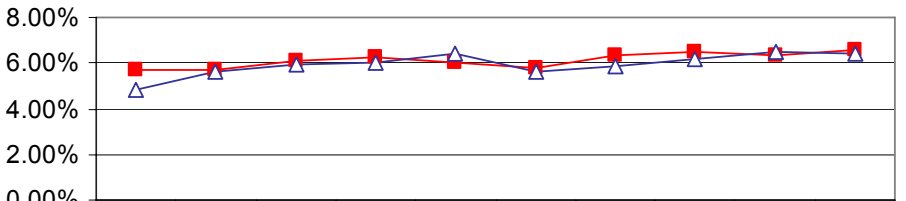
Staff Turnover - Rolling YTD



	Oct	Nov	Dec	Jan	Feb
2007/08	6.27%	6.41%	6.32%	6.44%	6.48%
2006/07	5.15%	5.24%	5.60%	5.81%	5.84%

Trust Sickness Levels

Apr 06/Jan 07 cf Apr 07/Jan 08



	April	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%
2006/07	4.87%	5.59%	5.94%	6.00%	6.38%	5.62%	5.84%	6.20%	6.51%	6.40%

SUSPENSIONS as at 29.02.08		**Date of Suspension**	**Reason**	**Stage in Investigation**	**Investigating Officer**	Hearing Date
East	4	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. Further review letter 04.02.08	Police Investigation.	Seen by Police 12.11.07 and rebailed until January 08. Police confirmed on 04.02.08 that bail extended until 14.02.08. Police update at that time. Court date: 25.02.08, awaiting confirmation of guilty plea?	Trevor Hubbard. Mtg arranged 06.03.08	
		25.02.08	Failure to disclose criminal conviction.		Paul Ward	
		25.02.08	Failure to disclose criminal conviction		Paul Ward	
		21.02.08	Continued to use procedures restricted to a State Registered Paramedic although Paramedic Reg has lapsed.	Investigation has just commenced.	Martin McTigue	
South	1	24.02.08	Allegation of gross misconduct.		Richard Lee	05.03.08
West	1	30.01.08	Allegation of gross misconduct.	Investigation commenced 31.01.08	Natasha Wills	
Control Services	0					
HQ/Fleet/Others	1	10.01.08	Failing to stop at an RTA where a child had been injured.	Police have fined and have given points. LAS investigation to be completed.	Ann Elliott	

4 Communications

Media issues

Hospital turnaround times: The Service was featured in a front page Sunday newspaper article about ambulance turnaround times at hospitals across the country. A statement was issued in response to follow up enquiries from BBC London and the Evening Standard, while the Health Service Journal also covered the Service's position in an article published later that week.

Alcohol-related demand: There has been further coverage about the impact of alcohol-related calls on the Service. A reporter and photographer from The Sun newspaper accompanied a Westminster crew on a night shift as part of a national feature, while the Service's figures concerning an increase in alcohol-related calls were highlighted in a government report reviewing the impact of the new licensing laws.

A paramedic who writes a blog about his work with the Service, and who has recently had a book published about it, has also been interviewed on a number of radio programmes about the impact of alcohol-related calls on frontline staff. The Communications Department has been liaising closely with him and has been kept informed of any planned interviews.

Expansion of motorcycle and cycle response units: News releases and photos were issued to announce the expansion of the motorcycle and cycle response teams in west, south and east London, resulting in a number of articles in papers in the Croydon, Tower Hamlets and Kensington areas.

A feature about the work of the CRU team based at Heathrow Airport was also published in Business Traveller magazine.

Prosecution of frequent caller: A suspended prison sentence given to a woman who has called the Service more than a 1,000 times in three years received significant local media coverage and was also mentioned in the Evening Standard. The woman, from south east London, was also given a prohibited activity order to prevent her from making false and unnecessary emergency calls.

Patient reunions: The reunion of a heart attack patient with the Kenton crew who treated and took him to the specialist centre at the Royal Free Hospital was covered by local newspapers.

Four members of staff from Chase Farm also met up with a man who sustained serious injuries in a car crash last year, and this story was also picked up by the local press.

Incidents: Attendance of staff at a large fire in Camden led to media calls from national and international media.

A gas explosion in a block of flats in Harrow which left one man seriously injured also resulted in a flurry of media interest, while the discovery of eight men inside an empty tanker in south east London attracted similar national attention.

Local news stories: Other local media coverage has included stories about a number of collisions involving ambulances on their way to or from emergency calls, staff delivering a baby outside Queen's Hospital after the mother's waters broke before she could get out of the car, and coverage of the official opening of the new Brixton ambulance station.

On a less positive note, stories also appeared about an alleged lack of paramedics working in the Harrow area, and a mother's criticism of the Service's response because an ambulance wasn't sent after her three-year-old son swallowed a handful of prescription pills.

Internal communications

Partnership events: Communications support has been provided to a series of consultation events run by managers and Staff side representatives.

Patient and Public Involvement

Insight into Management scheme: Four schools in Barking & Dagenham came together to provide work experience placements for their year 12 students in February. This new approach to work experience provided teams of students with the opportunity to work together on a 'real' project within an organisation.

A team of five students came to the LAS and were supported by the Events & Schools Team. Building on last year's Ipsos-MORI research findings, they conducted a project to find out about perceptions of the LAS amongst 14-16 year olds. They completed 186 surveys, designed to find out people's experience of the Service, their views about its plans for the future, and whether they would consider a future career in the ambulance service.

Over half of the students had called the LAS. Their experiences were generally very positive. As with the wider Ipsos-MORI research findings, the young people's priority was that the ambulance service arrived quickly after being called. Some felt that there should be more ambulances available, and others that there should be special 'ambulance lanes' on London's congested roads.

Most respondents liked the idea of single responders and patients being treated at home. At first they were puzzled about the role of the Cycle Response Unit, but their responses improved when they were given more information about this team.

The majority of the young people surveyed did not express an interest in a career in the ambulance service, and the ones who did were more likely to be male than female. However, they felt that the LAS could raise awareness of the different roles available through increased attendance at exhibitions and open days.

The five young people themselves enjoyed the experience of conducting the project, and learned a lot from it. They learned about questionnaire design, how to analyse results, communication and presentation skills. One of the group said that he is now considering the Paramedic Science degree as one of his key career options.

Along with the other year 12 students across the four schools (75 students), the LAS group gave a presentation to their peers and a panel of judges, and won first prize! They have expressed an interest in making their findings available to a wider audience, and it may be possible for them to present at this year's Patient Care Conference on 10th June.

Public Education / New Ways of Working: A sub-group of the Public Education Strategy Steering Group is working with London South Bank University to produce a development programme for staff involved in public education, including the Community Involvement Officers who will be introduced through New Ways of Working.

The development programme will include skills training (e.g. presentation and evaluation) and ongoing learning through the introduction of learning sets and peer feedback. It is hoped that the programme will be accredited, offering public education staff a form of qualification for their work and personal development.

Event on 26th March: On 26th March a PPI event is being held, giving the general public an opportunity to learn about - and comment on - the Service's forthcoming plans in the SIP. The event will also be an opportunity to conduct an Equality Impact Assessment on the SIP.

Patients' Forum: At the February Patients' Forum meeting the Chairman attended to discuss the possibility of the Trust applying for Foundation Trust status. The March meeting focused on commissioning, and Joan Mager (Chief Executive of Richmond & Twickenham PCT) gave a presentation about commissioning ambulance services.

Peter Bradley CBE
Chief Executive Officer
March 18th 2008

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 18th March 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 one further SUI has been declared. This follows concerns expressed over the delay in attending a 36 year old female patient who was bleeding heavily. Communication with the patient and the family was difficult and the significance of the patient's symptoms was not appreciated. A second call via the MPS CAD link indicated that the patient's condition had deteriorated. Sadly, despite the attendance of a Fast Response Unit and two ambulances, the patient died in hospital. The investigation into this case is being led by the Assistant Director of Operations (Control Services).

The inquest into the death of a patient in April 2007, which was investigated under the SUI policy, was held on 26th February. This case involved the death in police custody of a patient requiring restraint. HM Coroner advised that the jury bring in a narrative verdict. No blame was attached to the ambulance staff involved in the case and the Coroner was sympathetic to the suggestion that the LAS pursue an alternative method of chemical sedation in the unusual and infrequent circumstances that it may be required

Procedure on the Transportation of Persons to Hospital

This procedure has been developed with the Metropolitan Police Service (MPS) to ensure a consistent approach to the transportation of patients to hospital in circumstances where ambulance transport is not appropriate. The Procedure was approved by the Clinical Governance Committee on 4th February 2008 and together with a corresponding MPS procedure forms schedules to an Agreement between the LAS and the MPS is presented to the Trust Board for ratification (see Appendix 1).

Latex Policy

The Latex Policy has been revised to bring it into line with best current practice and reflect the use of Nitrile disposable medical examination gloves. It was approved by the Clinical Governance Committee on 4th February 2008 and the Trust Board is requested to ratify this decision.

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.

Eleven alerts were received during the period from 15th January 2007 to 4th March 2008. All alerts were acknowledged, none required any action,

2. Second domain – Clinical and Cost Effectiveness

Update on Cardiac Care

Feasibility study into the provision of therapeutic hypothermia

This study commenced on 4th February 2008. To date two patients have received therapeutic cooling. One has survived to admission to the Intensive Care Unit.

Update on Stroke Care:

An increasing numbers of hospitals are displaying an interest in thrombolysis for acute stroke patients. The trial in South West London, involving St George's, Mayday, Kingston and St Helier Hospitals is going well. In terms of a pan London strategy for centralising care, we await a steer from NHS London.

Patient Specific Protocols (PSP) & Out of Hours (OOH) Palliative Care Handover Forms

The PSP and OOH system continues to be a well utilised resource. We are currently processing on average four PSPs per month and five OOH forms per day. With regard to the PSPs the trend is for "Preferred Place of Care" requests, and "Do Not Resuscitate" information. The OOH form system is being expanded slowly across all London PCTs. The LAS is not insistent upon the use of an exclusively LAS form (the LA255). We will accept the form in use by the PCT / OOH provider concerned. If required we will phone back for any information needed. In actuality this is rare.

Equipment purchased via the Invest to Save (ITS) Programme

The Medical Directorate has, via the ITS programme, been purchasing the following equipment:

- Tourniquets for major haemorrhage control: scale of issue is to be one tourniquet per Primary Response Bag

- EZ-IO Intra Osseous (IO) device for providing both adult and paediatric vascular access – This is the end result of an evaluation of suitable (IO) devices for pre-hospital use. The scale of issue will initially be one device for each FRU, MRU & CRU, with rollout to all A&E vehicles taking place over the next two years.

- Sandell Paediatric Tape for providing information to paramedics dealing with paediatric cardiac arrest / life threatening paediatric illness: scale of issue is to be personal issue to all paramedics

- 8 Faretech CT6 Traction Splint & 8 Kendrick Traction Device: these are being evaluated to see which will be the possible replacement for the Sager Traction Splint currently in use by LAS. Each device on evaluation is a third of the cost of a Sager Splint and is designed to carry out the same function as the Sager. Design improvements to both the Faretech and the Kendrick device now make an evaluation a viable exercise

Other new initiatives

Feasibility study into the use of Continuous Positive Airway Pressure (CPAP).

Training for staff at Whipps Cross starts on 25th March to assess the suitability of using a CPAP system on LAS ambulances. This is primarily for the management of patients suffering acute left ventricular failure.

National Clinical Guidelines Update

The LAS were represented at the JRCALC Guidelines Sub-Committee meeting on 3rd March 2008. The Guidelines are currently being revised and the next edition will be published in 2010.The following topics were discussed: adrenaline for anaphylaxis, the British Thoracic Society Guidelines on Emergency oxygen Therapy, the ABCD2 scoring system (for patients who have suffered a transient ischaemic attack), and a protocol for the drug clopidegrel which is used in addition to aspirin in patients who have symptoms and signs of an acute coronary syndrome.

Introduction of Oromorph

The smallest bottles of oral morphine available for LAS to purchase are 100ml. Fortunately Frimley Park Hospital Pharmacy have agreed to decant the drug into 20ml bottles. It is intended that 2X 20ml bottles will be placed into the paramedic drug pack along with 5ml oral syringes and bungs, over the forthcoming months.

Clinical Update Newsletter

The January edition (issue 5) of the Clinical Update Newsletter covers a number of different areas. It highlights the risks of positional or restraint asphyxia, the importance of obtaining details of patients' past medical history and gives guidance on patients receiving palliative care where resuscitation attempts may be inappropriate or futile.

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 report examining the factors associated with survival from cardiac arrest for patients treated by Waterloo Complex is presented under Appendix 2. Previous reports have highlighted the increased survival to hospital discharge of patients suffering an out of hospital cardiac arrest achieved by this complex. This report includes the role of the motorcycle response unit and points to some areas for potential improvement.

3. Third Domain – Governance

Annual Health Check 07/08

The evidence for demonstrating compliance with the Annual Health Check has been received by the Audit Committee as set out in the Assurance Framework. The Assurance Framework is included elsewhere on the agenda.

24 7 24 7

(24 hours a day 7 days a week we achieve compliance with the 24 standards in the 7 domains of the Annual Health Check)

The Governance Development Unit arranged an interactive event on 13th March for commentators to give feedback on our evidence of compliance with the requirements of the Annual Health Check. The event included presentations by the Chief Executive, Finance Director and the Deputy Director of Operations. More than 50% of London's Overview and Scrutiny Committees were represented at the event which was also attended by Healthcare Commission Managers. This is part of the Unit's programme for developing the Trust's approach to governance.

NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts

The NHSLA convened a workshop held on March 18th to introduce their new Risk Management Standards for Ambulance Trusts and explain details of the related assessment approach for the financial year 2008-9. The event was attended by the Head of Governance and the Education Governance Manager. Details of the new requirements will be disseminated to SMG and accountable managers before the next Trust Board meeting.

The Risk Management Policy

The Trust's Risk Management Policy has been updated and amended in accordance with the Trust's Policy and Procedural requirements for annual review of key governance documents. A summary of the changes is attached to the Assurance Framework included elsewhere on the agenda.

4. Fourth Domain – Patient Focus

The LAS has been chosen to act as an 'Early Adopter' Trust for 'Making Improvements Count.' This is the Department of Health Consultation document which sets out proposals to review and revise the NHS Complaints procedure. It is envisaged that PALS are likely to be brought into the complaints structure. The LAS has been selected along with two local authorities, two PCTs, local acute and mental health Trusts in Westminster and Barking. This will afford us the opportunity to be in the vanguard of the new arrangements and to influence what the model will eventually look like. The inclusion of ambulance services in this process was as a result of lobbying by the Head of Complaints to the Consultation team.

As an additional development preliminary discussions have been help with the National Patient Safety Agency (NPSA) and it is envisaged that they will be working very closely with the Trust in relation to developing a root cause analysis framework.

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

At the meeting of the Infection Control Steering Group held on 27th February, the results of the Baseline Trust wide Infection Control Audit undertaken by every station were reviewed. Arrangements are now being made to repeat the audit in April.

Measles

England and Wales have seen an increase in the number of cases of measles. Following the introduction of the MMR vaccine in 1988 there was a marked reduction in the number of cases recorded annually. With a national decrease in the uptake of MMR vaccination herd immunity has fallen resulting in an increase in the reported cases. The number reported in 2006 was 756, the highest since the current system of monitoring began in 1995. London, which has historically had the greatest number of cases currently has outbreaks in at least two geographical areas.

Two members of LAS staff have contracted measles. The Service is liaising closely with both the Health Protection Agency and our Occupational Health provider to limit any risk to patients and staff who may have been in contact with the disease.

7. Seventh Domain – Public Health

Exercise Orpheus

The LAS Incident Response Unit (IRU), part of the national Hazardous Area Response Unit, took a leading part in Exercise Orpheus, a training exercise designed to explore the tactical and operational response capabilities of the new Ambulance USAR (Urban Search and Rescue) and HART teams in conjunction with other Health Service, Fire & Rescue Service and Police colleagues. Exercise Orpheus is part of the programme of Health Protection Agency (HPA) exercises run on behalf of the Department of Health.

Recommendation

THAT the Board NOTES the report

Fionna Moore,
Medical Director
10th March 2008

Appendix 1.

Procedure on the Transportation of Persons to Hospital

London Ambulance Service NHS Trust

METROPOLITAN POLICE Working together for a safer London

AGREEMENT BETWEEN THE LONDON AMBULANCE SERVICE NHS TRUST AND THE METROPOLITAN POLICE SERVICE ON THE TRANSPORTATION OF PERSONS TO HOSPITAL

The London Ambulance NHS Trust (LAS) and the Metropolitan Police Service (MPS) have been working together to develop their respective procedures on the transportation of persons to hospital to ensure that there is consistent and appropriate practice across London.

In general, persons requiring treatment following assessment by an ambulance crew will be taken to hospital by ambulance. However, there may be exceptional circumstances when assistance from the police is required either to accompany the patient in the LAS vehicle, or when ambulance transport is not appropriate to convey the person to hospital in a police vehicle.

The LAS Procedure (attached) has been approved by the LAS Clinical Governance Committee and will be issued following ratification by the LAS Trust Board. The MPS Procedure is in Draft format and is expected to be finalised during 2008.

The LAS and MPS agree to work together to ensure that their respective procedures on the transportation of persons to hospital are implemented in harmony, that the effectiveness of the procedures are monitored regularly, and formally reviewed at least once every three years.

……..	……..
Signed on behalf of the London Ambulance Service NHS Trust	Signed on behalf of the Metropolitan Police Service
Name……..	Name……..
Position…….	Position……..
Date……	Date……

London Ambulance Service NHS
NHS Trust

Procedure on the Transportation of Persons to Hospital

Introduction

This document is the London Ambulance Service (LAS) Procedure as agreed between the LAS and the Metropolitan Police Service (MPS) to cover the following areas:

- Appropriate transportation of persons to hospital
- Section 136 of the Mental Health Act
- Emergency treatment of persons without capacity who withhold consent

The object of this procedure is to ensure consistency across London in the provision of a safe, secure and supportive service to patients and the general public. This is a statement of intention and best practice that the MPS and LAS will use their best endeavours to observe.

Principles

It is recognised that working relationships between the LAS and MPS at the front line are generally extremely good. This document aims to formalise these working relationships and clarify roles and responsibilities.

Any action taken by the LAS and MPS must be:

- Proportionate
- Legal
- Accountable
- Necessary
- Based on best available information

and in accordance with the Human Rights Act and other legislation, specifically the Health and Safety at Work etc Act 1974, the Mental Capacity Act 2005 and all other relevant statutory provisions and recognised codes of practice.

In accordance with the Mental Health Act Code of Practice, all service users will ‘be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any of these characteristics’.

1.0 Appropriate transportation of patients

1.1 In general the majority of persons requiring treatment following assessment by an ambulance crew will be taken to hospital by ambulance. However, there may be exceptional occasions when ambulance transport is not appropriate, i.e. if there is a risk of the person harming themselves, a member of the ambulance crew or any other person and/or the person is so violent or dangerous that the attendance of a police officer or officers in the ambulance will not adequately address the risk. In reaching this decision, which must be recorded, the ambulance crew should consider the following:

- The person's behaviour at the time
- Any relevant history
- Any risks presented to the person, LAS crew or others

1.2 Where practicable, police officers and other professionals on scene, as well as the person and / or carers should be involved in this risk assessment.

1.3 If police are not already present, and the ambulance crew determine that such a risk exists, consideration will be given to asking for police to attend the scene. In these cases it will be the responsibility of a member of the ambulance crew to provide the police officer(s) with a briefing of the circumstances and the identified risk factors, and precisely what assistance is requested.

1.4 Where the person is under arrest and requires medical treatment at hospital he will normally be conveyed to hospital in an ambulance. At least one police officer will accompany the person in the ambulance at all times whilst he remains under arrest. In these cases the role of the police will be to prevent crime and/or a breach of the peace and to prevent the person's escape from lawful custody and police officers may use such force as is reasonable, necessary and proportionate to those ends.

1.5 Where it is agreed between the ambulance crew and the police officer(s) that, notwithstanding the person's need for medical treatment at hospital, it is necessary and proportionate by reason of the person's behaviour to convey the person to hospital in a police vehicle this course of action will be followed, with the following conditions:

1. In all cases a member of the ambulance crew will accompany the person in the police vehicle in order to maintain constant observation.

2. The ambulance will closely follow the police vehicle to the hospital.

1.6 Where the person is under arrest and objects to being taken to hospital **and** where the ambulance crew advises that the requirement for medical treatment is not urgent the person may be taken directly to a designated police station in a police vehicle.

1.7 Where papers have been completed under sections 2, 3 or 4 of the Mental Health Act 1983 following an assessment on private premises, the patient will normally be conveyed by ambulance to the hospital named in the application. Where the Approved Social Worker/ Approved Mental Health Professional so requests one or more police officers may accompany the patient in the ambulance. In these cases the role of the police will be to ensure the transportation to hospital is effected, prevent crime and/or a breach of the peace and to prevent the patient's escape from lawful custody and police officers may use such force as is reasonable, necessary and proportionate to those ends.

1.8 Where papers have been completed under sections 2, 3 or 4 of the Mental Health Act 1983 following an assessment on private premises **and** the Approved Social Worker/ Approved Mental Health Professional so requests, **and** it is agreed between the ambulance crew and the police officer(s) that the person is so violent or dangerous that it is necessary and proportionate to convey the patient to hospital in a police vehicle this course of action will be followed, with the following conditions:

1. In all cases a member of the ambulance crew will accompany the patient in the police vehicle in order to maintain constant observation.

2. The ambulance will closely follow the police vehicle to the hospital.

1.9 Where the person is not under arrest nor detained under the Mental Health Act as above, a police vehicle **cannot** be used to transport the person. Consideration will be given by the ambulance crew and police as to whether the person is so violent or dangerous that it is proportionate and necessary for police to assist the ambulance crew either by a police officer(s) travelling in the ambulance or by a police vehicle accompanying the ambulance to hospital. In these cases the role of police will be to prevent crime and/or a breach of the peace and police officers may use such force as is reasonable, necessary and proportionate to those ends.

1.10 A police vehicle will **not** be used to carry out inter-hospital transfers.

1.11 Where it is necessary for a police officer to use force during the transportation of a person to hospital he will record all relevant matters in an Evidential Report Book and a member of the ambulance crew will endorse the report.

2.0 Section 136 of the Mental Health Act

2.1 The LAS and MPS are committed to providing a safe, secure and supportive response to people undergoing a mental health crisis in a public place. It is recognised that such people may also have underlying medical conditions that require emergency hospital treatment. For this reason, it is considered appropriate wherever possible to convey by ambulance persons detained by a constable under section 136 of the Mental Health Act. However, it is recognised that there will be occasions when it is not safe to transport in an

ambulance, even with the assistance in the ambulance of a police officer or officers, and the person needs to be conveyed in a police vehicle supported by the crew of an LAS ambulance.

2.2 Section 136 of the Mental Health Act states:

> "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…"

2.3 In every London Borough the police have agreed with mental health trusts a place of safety, which is not a police station. In some boroughs the agreed place of safety is a psychiatric reception unit; in others it is the A&E department.

2.4 Persons detained under section 136 should, as a rule, be conveyed to a place of safety by ambulance, in recognition of:

- their human rights,
- duty of care (both LAS and MPS),
- respect for their dignity,
- public perception.

2.5 The guiding principle is that, if there is a requirement for medical treatment for a physical injury or condition this outweighs the need for assessment under the Mental Health Act.

2.6 If the ambulance crew decide that the person requires medical treatment at hospital (other than a psychiatric hospital), they will determine the destination hospital (usually the nearest A&E department) in accordance with LAS procedures. The police officer(s) will retain custody of the person and accompany the person to hospital in the ambulance. They may use such force as is reasonable, necessary and proportionate to prevent crime and/or breach of the peace and to prevent escape from lawful custody.

2.7 The MPS policy is that, where acute behavioural disturbance is suspected, the person should be treated as in need of emergency medical treatment, because of the known risk of sudden collapse and death in such people, and should be conveyed to the Accident and Emergency Department of a hospital by ambulance. The main features of this extreme state are a period of agitation, excitability, perhaps paranoia, coupled with great strength, aggression and non-pain compliance. Officers are unlikely to know whether the person has a cardiovascular problem or a psychiatric disorder, or indeed whether the person is abusing drugs. All these factors may increase the risk of death.

2.8 Where the ambulance crew decide that medical treatment at hospital for a physical injury or condition is **not** required, the person will be taken by ambulance to the place of safety designated by the local section 136 protocol.

2.9 However, there may be occasions when ambulance transport is not appropriate, i.e if there is a risk of the person harming themselves, a member of the ambulance crew or any other person and the person is so violent or dangerous that the attendance of a police officer or officers in the ambulance will not adequately address the risk. In reaching this decision, the ambulance crew should consider the following:

- the person's behaviour at the time
- any relevant history
- any risks presented to the person, LAS crew or others

Where practicable, police officers and other professionals on scene, as well as the person and/or carers should be involved in this risk assessment.

2.10 If it is agreed between the ambulance crew and the police officer(s) that it is necessary and proportionate by reason of the person's behaviour to convey the person to the designated place of safety in a police vehicle, this course of action will be followed, with the following conditions:
In all cases a member of the ambulance crew will accompany the person in the police vehicle in order to maintain constant observation.
The ambulance will closely follow the police vehicle to the place of safety.

2.11 The police officer(s) are responsible for a 'legal' handover under the Mental Health Act, in accordance with the local protocol. The ambulance crew are responsible for providing a clinical handover to the staff at the hospital or other place of safety. It is not expected that the ambulance crew will remain at the place of safety once they have handed over the person's clinical care.

2.12 Where it is necessary for a police officer to use force during the transportation of a person to hospital he will record all relevant matters in an Evidential Report Book and a member of the ambulance crew will endorse the report.

3.0 Emergency treatment of patients without capacity who withhold consent to treatment.

3.1 If an adult is not capable of making his/her own health care decisions, based on an assessment of his/her capacity (see OP/031 Policy for Consent to Examination or Treatment), LAS staff will have to consider intervention against their wishes under the terms of section 5 of the Mental Capacity Act 2005. These terms apply when a decision is made to act in the best interests of a patient who has been assessed as lacking capacity at that moment.

3.2 Where the Mental Capacity Act is to be invoked LAS staff are aware that the reasons for its use are to be documented on the person's clinical record form (LA4). LAS staff will also have access to form LA5 as an assessment of

capacity tool that will assist in making a decision whether to invoke treatment in the person's best interests. Whilst it would be good practice to involve carers, the urgent circumstances may not allow this to take place. It is also understood that the actions taken by either the LAS or Met Police under the Mental Capacity Act are only to assist in getting a person to a place of safety, be it either an Accident or Emergency Department or another centre of care.

3.3 Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the person of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, the LAS has a duty to intervene safely and provide care in the person's best interests.

3.4 In circumstances where the ambulance crew feel the person will physically resist efforts to take them to hospital, and the person is so violent or dangerous that police assistance is needed, they may request the police to attend to provide assistance or support in removal of the person by force if necessary. The ambulance crew will provide a full briefing to the police officers, including the results of their assessment of the person's capacity, and give a clear request of the nature of the assistance required from the police.

3.5 The role of the police in supporting the LAS in these circumstances will be to prevent crime and/or a breach of the peace and, where requested by a member of the ambulance crew, to assist in restraining the person in order that he may be conveyed to hospital and/or treated as necessary in his best interests and police officers may use such force as is reasonable, necessary and proportionate to those ends.

3.6 The police officer will record the matter in an Evidential Report Book and a member of the ambulance crew will endorse the report to the effect that s/he believes the person lacks the mental capacity to refuse or consent to treatment, that urgent treatment is required to prevent loss of life and/or serious or irreversible deterioration in the person's condition, and that police assistance is requested to prevent crime and/or prevent a breach of the peace and/or to enable the person to be conveyed to hospital and/or treated as necessary in his best interests.

Appendix 2.

Factors associated with survival from cardiac arrest for patients treated by Waterloo Complex – Summary Report.

Author: Dr Rachael Donohoe, Clinical Audit & Research Unit.

Introduction

The aim of this report was to examine the factors underlying Waterloo's higher than average cardiac arrest survival rate. Waterloo Complex was compared to the remainder of the LAS on a range of variables known to be associated with survival from cardiac arrest, including patient demographics, factors associated with the arrest (e.g. location, initial arrest rhythm, bystander intervention, etc.) and response times.

During the period of this report motorcycle responders were almost exclusive to Waterloo Complex and, as such, this report also examined differences in survival between cases where motorcycles were or were not dispatched.

Methods

Data were collected for all patients resuscitated following a cardiac arrest of a presumed cardiac cause during the period April 2006 to March 2007. Data was extracted from Patient Report Forms (PRFs), Mobile Data Terminals (MDTs), FR2 defibrillator data files and Emergency Operations Centre (EOC) records. Data collected included: patient demographics (e.g. age, gender); location of arrest; whether the arrest was witnessed by a bystander; whether bystander CPR had been undertaken; the initial arrest rhythm; operational response details (e.g. type of emergency vehicle dispatched, first responder on scene, and response times), and patient outcomes (i.e. died at scene or survived to hospital discharge).

Statistical analyses

All data were analysed using Statistical Package for Social Sciences (SPSS) version 15.0. Differences between Waterloo Complex and other LAS Complexes were analysed using t-tests and chi-squares as appropriate. A multiple logistical regression

was undertaken to identify, within Waterloo Complex, the independent significant predictors of survival from cardiac arrest.

Key Findings

- Between April 2006 and March 2007 crews from Waterloo Complex attempted to resuscitate a total of 144 patients whose cardiac arrest was of a presumed cardiac cause. This figure represents 4.4% of the 3,280 cardiac arrest patients (with a presumed cardiac aetiology) resuscitated by the LAS during this period.
- Waterloo's survival rate for this particular group of patients was 15.1% (48.4% Utstein^), compared with the LAS's overall survival of 5.2% (15.8% Utstein^).
- Patients attended by crews from Waterloo Complex had a different profile to those treated by the rest of the LAS: they were younger; more likely to collapse in public; their arrests were more likely to be bystander witnessed; they more often presented in VF/VT, and bystanders more regularly provided CPR.
- Waterloo Complex had significantly faster response intervals, arriving with patients an average of 1 minute and 18 seconds faster than the combined average of all other areas.
- Logistical regression analysis identified three significant independent predictors of survival for Waterloo Complex. The strongest independent predictor was a presenting cardiac arrest rhythm of VF/VT. This was followed by patient age (where a younger age was associated with a higher likelihood of survival) and the whether or not the arrest was witnessed (with a bystander witnessed arrest tending to be associated with a better outcome).
- Motorcycle responders were dispatched to only 32% (37/116) of cardiac arrests that occurred during the hours within which they were operational.
- In over eight out of ten times (83%) when motorcycles were dispatched, they were tasked to cardiac arrests that occurred in a public location.
- Motorcycles were first on scene only 15 of the 37 times they were dispatched (40.5%).
- When the motorcycle responders were first to arrive on scene, their response times were over a minute faster than other types of vehicles. When Motorcycles were

not first on scene, the average arrival time of the first attending vehicle was 3.5 minutes.

- When a motorcycle responder was first to arrive on scene the cardiac arrest survival rate was almost two and half times greater than when another type of vehicle arrived first (31% vs. 13%).

Recommendations

- Explore why motorcycles are not being dispatched/prioritised more frequently to cardiac arrests during their hours of operation.
- Consider dispatching motorcycle responders more readily to patients that collapse in the home (particularly as just under half of all cardiac arrests (44%) in Waterloo occurred in a private location).
- Consider expanding the motorcycle response to other areas of London, particularly those where response times are longer.
- Consider adopting a cardiac-specific motorcycle response.

^ *% of survivors to hospital discharge whose arrest was presumed cardiac in origin, was bystander witnessed, and the initial rhythm was VF/VT.*

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 18th March 2008

Final Assurance Framework for the Annual Health Check 07/08

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary The final Assurance Framework demonstrates to the Board that controls and assurances are fully in place to prove compliance with all 24 core standards of the Annual Health Check 2007/08.

4. Recommendation

THAT the Board agrees:

i. The Final Assurance Framework providing evidence of full compliance for the Annual Health Check.

ii. The Final Declaration can be submitted stating that the Trust is fully compliant with the core standards of the Annual Health Check 2007/08.

Trust's Principal Objectives

Top 25 risks on the risk register cross-referenced to the Trust's principal objectives, with the highest scoring risks at the start of the document. These risks and their controls have been mapped against the domains and healthcare standards of the Annual Health Check.

Where there is no principal objective listed there are no risks currently identified among the highest scoring 25 risks that threaten the achievement of these objectives

1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:-
(a) Rest breaks,
(b) Individual Performance Monitoring,
(c) Home responding,
(d) Improved standby and area cover arrangements,
(e) Reduced job cycle times,
(f) Shift Change over (roster changes).

2) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt,
(b) To meet Accident and Emergency targets and prepare for new ones, as follows:-
(1) 75% category A 8 minute (for the year as a whole),
(2) 95% Category A 19 minute (for the year as a whole),
(3) 95% Category B 19 minute by March 2007,
(4) Doctors Urgent (15 minute) by March 2007.

3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard,
(b) Implement Actions from diversity plan,
(c) Disability Equality Scheme,
(d) Review and changes to recruitment practice and policy (including life skills),
(e) Gender Equality Scheme prepared for publication in April 2007,
(f) Work with DH to prepare a single Equality Scheme,
(g) Introduce summary level SMG balanced scorecard,
(h) Complete key supplier review,
(i) Replace EROS purchasing system,
(j) Revise Trust Standing Orders,
(k) Implement ESR.

4) Public Education Strategy and PPI Strategy have local implementation plans that are followed through by Senior Manager's in all areas.

5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services),
(b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.

6) N/A

7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews,
(b) Processes with DH to prepare Single Equality Scheme for publication in 2007,
(c) Improve Trust administrative and five management processes.

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	**Risk ID**	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
What the organisation aims to deliver		***What could prevent this objective being achieved***	***Which area within our organisation this risk primarily relate to***			***Standards that the Government have set and expects all Trusts to aspire to in order to improve the quality of care and treatment provided to patients.***	***What controls/systems we have in place to assist in securing delivery of our objective***	***Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective.***	***We have evidence that shows we are reasonably managing our risks and objective are being delivered.***	***Where are we failing to put controls /systems in place. Where are we failing in making them effective***	
3	**265**	Inability to match resources to demand. Rosters do not match current demand. Weak at weekends.	**OPER**	**20**	**R.S**	3. Governance C7 (f) -Health care organisations meet the existing performance requirements. (standard measured through the use of resources assessment)	1. Moderate uptake with weekend-only rotas for relief staff. 2. Introduction of sector support rotas for weekend cover. 3. Re-profile overtime to times of greatest need. 4. Change core rotas in new model - Agreement being negotiated with unions.	▪ Sector support rotas have been introduced for staff to work solely at night or during weekends ▪ Over time at 'double time' has been made available to staff between 11pm and 3am on Fri., Sat. and Sun. ▪ All new staff join a relief rota where they work 7/10 weekends. ▪ Overtime widely allocated amongst staff - less concern about excessive hours ▪ "New ideal" matches demand to resources (trialled in South, due to roll out to all RCs Mar 08)	- Chief Executive Board Reports - Interim Workforce Information		√
1	**206**	Unavailability or the non-functioning of critical patient care equipment on vehicles.	**LOG**	**20**	**C.V**	1. Safety C4 (b) - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	1. Implement Asset tracking system on Make Ready Sites. 2. Procedure for Vehicle Equipment reviewed.	▪ Make Ready is being utilised to undertake some of the checking e.g. audit defibrillators. ▪ Equipment checked each night on every vehicle made available. ▪ Introduction of hand held asset tracking device is imminent. ▪ - Inclusion of Logistics Support Unit procedure for the handling, isolation, repair, reporting and disposal of faulty obsolete equipment, in OP/25.	- Provision and Maintenance of Defibrillators - Trolley bed, Manger Elk spec - Suction units		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
1	250	Inability to treat Paediatric patients due to equipment out of date (PALS Packs).	LOG	20	C.V	1. Safety C4 (b) - Healthcare organisations keep patients , staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	▪ Vehicle and Equipment Working Group. 1. Ongoing audit of all PALS Packs and update equipment to vehicle working groups.	▪ Logistic team check PALS packs are maintained on vehicles ▪ Systems in place to minimise risks from acquisition and use of medical devices in accordance with guidance issued by MHRA.	- Provision and Maintenance of Defibrillators - Trolley bed, Manger Elk spec - Suction units		√
5	269	At shift changeover times, LAS performance falls as we take longer to reach patients.	CLIN	20	R.S	5. Accessible and Responsive Care C19 - Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services. (standard measured under the existing national targets and new national targets assessment)	1. Existing rest break arrangements to be reinforced following the review. 2. New rotas agreed with staff will not allow a 7am/pm start/finish. 3. Team Leaders have started a new shift, working from 14.00 - 20.00 each day to bridge the evening changeover period. 4. 'New Ways of Working' model will introduce staggered start and finish times at all stations.	▪ Staggered start and finish times for FRUs and 24 hours ambulances.	- Chief Executive Board Reports		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	**Risk ID**	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
3	**267**	Delay in activating vehicles due to unavailability of vehicles.	**OPER**	**20**	**R.S**	3. Governance C7 (f) -Health care organisations meet the existing performance requirements. (standard measured through the use of resources assessment)	▪ AMPDS prioritisation. ▪ OP/023 Procedure for Dispatch of Resources by EOC (which incorporates the section ' Communication of a Delay for Emergency, Urgent and Non urgent Calls'). ▪ DSO and AOMs ensure and encourage crews to be available for calls as quickly as possible after patient hand over ▪ Fleet Status Report Additional funding received and increased mobile workshop provision. 1. Team Leaders and managers to staff extra vehicles, every day, from every complex between 11.00 - 20.00hrs. 2. More use of single responders, by increasing numbers of FRUs, MRUs, and CRUs. 3. Single responders as standard response (part of new model). 4. Shorter job cycle (freeing up ambulances) by having ambulances closer to calls, via dynamic deployment. 5. Increase in Urgent Care (to 202) and CTA (to 70) workforce, reducing calls sent to ambulances. 6. Full staffing. 7. Better allocation of overtime against 'ideal' staffing picture.	▪ Fleet and Transport Management ▪ Operational performance ▪ The Trust is now fully staffed. ▪ Work is underway to reduce the job cycle time, in order to produce more available ambulances. ▪ A reduction in the double-sending of vehicles and more calls receiving a response by FRU will reduce the risk. FRUs will be dispatched to AMBER 1 & 2 calls, but not where there is another ambulance nearer and available. ▪ FRU staff encouraged to advise Sector ASAP when an ambulance is no longer required.	- SMG reports - Chief executive Board Reports		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
3	35	Risk of loss of Patient Report Forms or inappropriate access to patient related information, due to lack of security.	OPER	16	R.S	3. Governance C9 - Healthcare organisations have a systematic and planned approach to the management of records to ensure that from the moment a record is created until its ultimate disposal, the organisation maintains information so it serves the purpose it was collated for and disposes of the information appropriately when no longer required	▪ Information Governance Toolkit return ▪ Information Governance Group ▪ PRF monitoring by CARU and Management Information teams ▪ Records Management Strategy ▪ Records Management Policy ▪ Records & Information Management Team 1. Development of procedure. 2. Audit on PRFs.	▪ Secure post boxes installed on each station ▪ Business Continuity Plans include arrangements for securing patient related information ▪ Minutes of Information Governance Group ▪ PRF Project PID to be written following receipt of Final Audit ▪ PRF user guide and PFR code card	- Records Management Policy - Audit of PRFs - Access to Health Records Policy - Plan for updating TP017 - effective systems in place as advised by Records Management NHS Code of Practice April 2006		√
1	31	Adverse outcome in maternity cases.	CLIN	16	F.M	1. Safety C1 (a) Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	▪ Monitoring by Clinical Governance Committee ▪ Obstetrics Incident Report and Action plan held under review by Clinical Governance Committee ▪ Medical Director has appointed LAS consultant midwife as Trust representative on NPSA Obstetrics Pan London Forum ▪ Prompt sheet issued to crews as part of maternity packs	▪ Working closely with the NPSA and other organisations where there are incidents involving both maternity and ambulance services. ▪ Themed Risk Information Report on Obstetric cases and action plan, presented to CGC.	- SUI action plans - Complaint action plans - RCA criteria and training - Quality Assurance Department newsletters - Infection Control Report - Health, Safety and Risk Training and Provision of H&S Information - Patient Safety - learning and changes		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
									- Incident Reporting Procedure (LA52s)		
3	34	Risk of operational staff not being released to attend regular CPD modules and complex based training activities as defined in the training plan.	OPER	16	M.F	3. Governance C11 (b) -Healthcare organisations ensure that staff concerned with all aspects of healthcare participate in mandatory training programmes.	• Training Services Committee ▪ Processes now in place to ensure that staff who do not attend mandatory training are re-booked and that an audit will take place to ensure that they attend and that their managers are informed. ▪ Successful IHCD inspection of Education and Development completed in February 2006. ▪ TNA reported to Training Service Committee and monitored ▪ Training Plan reported to RCAG 1. New Ways of Working will have protected training time 2. Staff will be able to self book on to modules as and when suits 3. No cancellation of courses over the last year	▪ Discrete packages to update skills are delivered to EMTs on a continuous rolling basis. ▪ Training Records. ▪ Any EMT3 who wishes to progress to EMT 4 is required to have the evidence of having attended all mandatory training ▪ Training Service Committee Minutes ▪ Format for delivering refresher/development courses redesigned to provide training on a one day modular basis. ▪ While E&D tutor vacancies have impacted upon some complex based activities, the current student attendance figures for each CPD module are listed as follows: - Patient Assessment (EMT3/4) = 615 - Adult Advanced Life Support (Para) = 515 - Moving & Handling (EMT+Para) = 306	- Corporate induction - Station local induction records - Mandatory training - HPC standards of proficiency - Policy on the Registration of Professional Clinical Staff		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
1	9	Risk of RTA injury to persons travelling in an LAS A&E vehicle.	HS	16	R.S	1. Safety C1 (a) Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	▪ Process for monitoring incidents reports is regular; received by Corporate Health and Safety Groups ▪ Risk Information report to CGC and RCAG. ▪ Motor Risk Group. 1. Review adequacy of driving course and include training for specific vehicles (i.e. FRUs). 2. Monitor process at Corporate Health and Safety Group. 3. Investigate benefits of a reward scheme. 4. Ensure refresher training is provided following RTA's. 5. Introduce Black Box technology in 20-25 FRU's located in Old West Sector on a phased basis. 6. Develop robust system for tracking individual accident rates, including lease car drivers.	▪ A&E Op's bulletin issued, also H&S bulletin updating on legal requirement. ▪ Incident reporting to NPSA ▪ Risk Reporting and Assessment Procedure. ▪ All new A&E ambulances fitted with recessed child harness in head and attendants seats. ▪ All new PTS ambulances are fitted with all age (above yrs) adjustable harnesses. ▪ All vehicles have a "must be worn" sign. ▪ A&E Op's bulletin issued, also H&S bulletin updating on legal requirement.	- Complaint action plan - RCA criteria and training - Health, Safety and Risk Training and Provision of H&S Information - Patient Safety - learning and changes - Clinical Governance Annual Report - Incident Reporting Procedure (LA52s)		√
7	273	Methods of working at UOC FBC no longer mirror working practices in UOC/EOC post 30.11.05. Staff deployed to Bow will be increasingly unfamiliar with the procedures in place without a replication of the UOC/EOC	BC	16	S.M	7. Public Health C24 - Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.	▪ Fall back test undertaken on 16/17 October ▪ Fall back results being monitored by Business Continuity Steering Group(BCSG)) ▪ DH Audit Report ▪ Major Incident Plan ▪ Emergency Preparedness Strategic Steering Group 1. Develop Plan if required to ensure that UOC will transfer successfully to FBC Bow. 2. Provide adequate training in order that personnel deployed to FBC are familiar with the processes in use.	▪ Action plan under review pending outcome from recent test and to prepare for next test. ▪ BCSG Minutes are reported to Risk Compliance & Assurance Group ▪ Fallback test reviewed at debrief held on 12/11 and Report produced Dec 07 to be discussed at SMG. ▪ Plans in hand to carry out regular tests from May 2008 and first meeting of Project Board took place 21/12. However, Fallback will not provide for operation of UOC or CTA at Bow. ▪ In the light of this it will be	- Major Incident Plan - Audit of Civil Contingencies Act report - Training and fall back tests undertaken		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
		at Bow.						proposed to BCSG that risk is redefined.			
7	274	**No Incident Control Room (ICR) back up site**	BC	16	S.M	7. Public Health C24 - Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.	▪ Requirement being monitored by Business Continuity Steering Group ▪ Major Incident Plan ▪ Emergency Planning Strategy Steering Group	▪ Emergency Planning Manager to determine the requirements for ICR back-up with Director of Operations.	- Major Incident Plan - Audit of Civil Contingencies of English Ambulance Service report		√
5	138	Failing to appreciate the significance and urgency of psychiatric illnesses.	OPER	16	R.S	5. .Accessible and Responsive Care C19 - Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services. (standard measured under the existing national targets and new national targets assessment)	▪ In EOC - AMPDS provides a call prioritisation for all calls including those where the patient has a mental illness. ▪ Addressed on EMT course and intermediate tier course. ▪ ECP training. ▪ Mental Health Strategy. ▪ Training for all operational staff in managing Children and Vulnerable Adults. ▪ Use of guidance for treatment of psychiatric patients in JRCALC Guidelines. ▪ There will be a modular course introduced as part of the new CPD process that will be designed around Mental Health awareness. ▪ Awareness for Uk influenza pandemic contingency plan are discussed at the Emergency Planning Steering Group.	▪ Reporting procedure for patients who are assessed as being “at risk". ▪ Review of TP/018 suspected causes of Child Abuse procedure and TP/019 Suspected Abuse of Vulnerable Adults procedure has been completed, and revised procedures approved by CGC. ▪ Service works with Local Resilience Forum	- Highlighted at Chief Executive Consultation Meetings. - A revised ‘mental health’ module is currently being developed and is dues for completion during April’08.		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
2	20	Failure to fully complete the Patient Report Form causing data not to be captured for analysis and feedback to staff.	CLIN	15	R.S	2. Clinical and Cost Effectiveness C5 (d) - Healthcare organisations ensure that clinicians participate in regular clinical audits and reviews of clinical services.	▪ Electronic KPIs ▪ Feedback to AOMs, Team Leaders of levels of compliance included within the Clinical Update on the PULSE ▪ Clinical Audit Programme ▪ Clinical Audit and Research Advisory Group ▪ Clinical Care Update ▪ The inclusion of data regarding ethnicity is improving. ▪ 74% of PRFs are recording the ethnicity of patients. ▪ The Head of Clinical Audit and Research recommended ethnicity figures be derived only from the CPI database. ▪ Simplified PRF for FRU staff completion. ▪ Team leaders advise staff of importance of PRF completion and feedback on performance individually, and also ongoing team leaders are monitored on inspection of PRFs and feedback to staff.	▪ Boxes provided on station for the storage of PRFs to ensure all forms are collected for recording purposes shortfalls in forums and CPI audit of forms reported to Team Leaders and AOM, as put of Clinical update available on the Trust wide Intranet ▪ TP 017 Procedure for any Patient Identifiable Form Used, Generated or Stored by the LAS ▪ Trainees have 2 hour training sessions on PRF completion ▪ Training Supervisor role course ▪ All training courses discuss the importance of good documentation ▪ Medical Directors Bulletin to emphasise the need of good documentation ▪ CPI checks ▪ Bi-monthly reporting of PRF completion performance by station to AOMs to focus attention.	Forms re-designed to include CAD number and date. - Journal Club evidence for practice seminars - Membership of Clinical Audits - Audit Working Groups Training Plan approved - Feedback as per CPI audit report monthly - presentation on CPIs	PRFs are extensively monitored by CARU but only 94% have recorded ethnicity of patients	√
2	22	Failure to u/take comprehensive clinical assessments which may result in the inappropriate non-conveyance or t/ment of patients.	CLIN	15	F.M	2. Clinical and Cost effectiveness C5 (b) - Health care organisations ensure that clinical care andtreatment are carried out under supervision and leadership.	1. Explore the current use of treat and refer protocols. 2. Use Datix to demonstrate a reduction in incidents. 3. Operational workplace review to take place twice a year. 4. Develop systems whereby staff learn from mistakes. - GB's involvement is in relation to staff learning from complaints, who is encouraging this and developing systems accordingly, for example, the introduction of reflective practice.	▪ EMT4 Modular training provides Standardised lessons on how to undertake comprehensive clinical assessments ▪ Themed report on non conveyance presented to the CGC on 4th Feb and the patient assessment module delivered to staff. ▪ EOC Training officers now conduct such exercises with EOC staff. ▪ Outcome reports completed to	- Information about local management structure / role of Team Leaders / CPIs etc. - KPIs for Rideouts recorded locally by team leaders. Should be available via individual files - Quarterly		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	**Risk ID**	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
								indicate the action taken ▪ The terms of reference of the Complaints Panel are being reviewed to ensure emerging themes, practice and methodology can be widely incorporated. ▪ Reports regularly presented to CGC	Rideout form - Annual Complaints Report		
1	**207**	Risk of staff not being able to download information from Defibrillators and the Service failing to gain the data for analysis.	**CLIN**	**15**	**F.M**	1. Safety C4 (b) - Healthcare Organisations keep patients , staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	▪ CARU check data downloads monitoring of data by Cardiac Care. ▪ Clinical Advisor to analyse cardiac patients treatment. ▪ CARSAG 1. To encourage more routine downloading of information from data cards. 2. Report to AOMs monthly on areas of weak performance to encourage improvement.	▪ Approximately 12% of the downloading information from FR2 and 12 Lead ECG defibrillators is being received by CARU. ▪ The Head of Clinical Audit and Research - some complexes are trailing different approaches and the successful one will be rolled out across the Trust. ▪ New cards will be purchased and card readers mended to facilitate downloads ▪ The system of sending ECG traces direct to CARU has increased the number received. The importance of these downloads has been emphasised in a recent Clinical Update. ▪ There is continual monitoring of FR2 downloading via CARU monthly reports.	- Tender for the Provision and Maintenance of Defibrillators		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
7	279	Pandemic – Total of 25% personnel ill for about 8 days (Duration of pandemic c.12 weeks), with predicted 10% additional absenteeism due to caring for dependants = 35% over total period.	BC	15	S.M	7. Public Health C24 - Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.	▪ Pandemic flu plans developed with LAS staff involved in DH planning groups ▪ V6 of LAS Pandemic Flu Plan issued for comment 24/4/07. ▪ Progress being monitored by Emergency Preparedness Strategic Steering Group and Business Continuity Steering Group. 1. Encourage take-up of appropriate vaccine as available /developed by LAS personnel (critical services and vital support) 2. New version of LAS Pandemic Plan to be produced	▪ LAS Pandemic Plan in place + Pandemic Communications Plan	- Pandemic Influenza Plan currently being rewritten - Major Incident Plan - Audit of Civil Contingencies of English Ambulance Service report		√
1	71	Not learning and changing practice, following receipt of complaints, due to inadequately trained officers or any other cause.	CLIN	12	R.M	1. Safety C1 (b) Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted upon within required timescales.	▪ Risk Management standard ▪ Complaints Policy and Procedures approved by the Board•Internal Audit on Complaints (Feb'07). ▪ Incident Reporting Procedures ▪ Roundtable meetings are used to draw out lessons learnt and actions to prevent re-occurrence. ▪ Complaints used in the Corporate Induction and EMT course for discussion regarding how situations could have been dealt with better and lessons learned ▪ Being Open Policy approved by the Trust Board• Complaints Management is an SMG objective. ▪ Complaints Panel reviews, current complaints and progress with resolution ▪ complaints handling advice pack for managers ▪ Compliance with NHSLA Risk Management Standard Level 2 - learning from experience assessed August '07	▪ Issuing of Bulletins & H&S Minutes ▪ LA52s copied to Estates and Fleet as appropriate. Serious complaints are investigated by Complaints Officers using root cause analysis techniques ▪ SABs management reported to Trust Board, included in the Medical Director's routine reports ▪ Complaints Annual Report ▪ The focus of the new department will be to emphasise the use of all stakeholder feedback as a learning opportunity. The methodology and underpinning ethos of PALS, complaints, etc is being implemented to support this objective. ▪ Proposed review of the existing Outcome Reporting mechanism and create a web component (on	Integrated approach to complaints and concerns led by Patient Service Manager merging complaints and PALS teams - Medical Director bulletins etc. - SABs Reports - Health and Safety Committee - Annual Complaints Report		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
							1. The terms of reference for the complaints panel to be revised 2. Complaints handling staff integrated into joint complaints concerns team 3. Complaints concerns team under one manager	the LAS internet site) which will illustrate learning achieved across the range of stakeholder feedback. ▪ Specific examples are available in the quarterly reports to CGC.			
7	**238**	Inability to dispatch to MDTs from FALL back Centre at Bow.	IMT	12	P.S	7. Public Health C24 - Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.	1. Introduction of new MDT messaging system hardware. 2. Full operational testing of entire system.	▪ ExpressQ infrastructure has been upgraded at FBC in line with the live configuration at HQ. ▪ A full Fall Back test has been completed, however it was not conclusive regarding this problem. ▪ A further test is currently being planned - this risk should therefore remain live until this is completed.	- Major Incident Plan - Audit of Civil Contingencies of English Ambulance Service report		√
1	**231**	Lack of qualified RTA investigators, leads to delayed RTA reporting and exposes the Trust to higher motor risk claims.	**OPER**	**12**	**M.D**	1. Safety C1 (a) Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	▪ RTAs reviewed at Vehicle and Equipment Working Group ▪ Incident Reporting System ▪ Accident Reports ▪ VEWG minutes ▪ LA52 ▪ Risk Information Report 1. Arrange Conference call with Operational managers to discuss reporting performance. 2. Paul Smith and Paul Webster to recommend a system for EOC to alert DSOs when their staff have been involved in a RTA and to record the information in a retrievable format.	▪ The EOC will be asked if the RTA's reported to them could be reported to Stations and Legal Services so that accident reports could be chased, as necessary. ▪ A conference call with Ambulance Operations Managers will also be arranged to discuss how reporting performance could be improved. ▪ Conference call with Operational managers to discuss reporting performance to be arranged.	- SUI action plans - complaint action plans - RCA criteria and training - Health, Safety and Risk Training and Provision of H&S Information - Patient Safety - learning and changes - Clinical Governance Annual Report - Incident Reporting		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
									Procedure (LA52s)		
5	**235**	EOC lack info. at time of disp. and co-ord. between sect. & FRU desks. Sect. desks lack full info., as call is still underway.	**OPER**	**12**	**R.S**	5. .Accessible and Responsive Care C19 - Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services. (standard measured under the existing national targets and new national targets assessment)	▪ EOC Governance Group minutes ▪ Performance monitored by performance improvement manager post 1. FRU desk will be disbanded and vehicles will move to Sector desk.	▪ Further information on calls is passed to crew once call is complete. ▪ All resources now despatched automatically.			√
3	**272**	To achieve Cost Improvement Programme.	**FINAN**	**12**	**M.D**	3. Governance C7 (d) -Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in use of resources. (standard measured through the use of resources assessment)	▪ 136 strand, Project Programme for this financial year identifies areas where saving is required, lead by Dir, of Finance and supported by SMG. ▪ Progress report routinely to SMG and TB. 1. To achieve cost improvement programme by end of financial year	▪ Project programme implementation monitored by Senior Management teams, Finance Directorate and updates prepared for commissioners and SHA	- Use of Resources Assessment 06/07 scored good		√
3	**282**	General failure of personnel to	**BC**	**12**	**S.M**	3. Governance C9 - Healthcare organisations have a	▪ Business Continuity Plan major incident plan ▪ Records management policy and	▪ Client hardware replacement project will include data migration to network drives.	- Audit of PRFs and Project PID to be written		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	Risk ID	Description of Risk	Risk Category	Current Risk Rating	Risk Lead Person				Positive Assurance	Gaps in Control	
		adequately 'back-up' IT.				systematic and planned approach to the management of records to ensure that from the moment a record is created until its ultimate disposal, the organisation maintains information so it serves the purpose it was collated for and disposes of the information appropriately when no longer required	procedure Records ▪ Fall back control systems test 1. The move of business information from hard drives to network drives to be completed.	▪ Emergency Planning strategic Steering Group minutes. ▪ Emergency Planning Audits ▪ Back up systems ▪ Client Hardware Replacement project enabled the movement of some locally stored data to centrally stored and backed up servers by mid 2007. 23/11 - A next stage project is being developed to replace c.600 PCs and migrate this data to network drives.	following receipt of Final Audit - Access to Health Records Policy - Records Management Policy - Plan for updating TP017		
3	**25**	Delay in activating vehicles due to inability to answer calls promptly before the recorded message is played.	**OPER**	**9**	**R.S**	3. Governance C7 (f) -Health care organisations meet the existing performance requirements. (standard measured through the use of resources assessment)	▪ LAS standard to answer all calls within 10 seconds (National Standard 15 Seconds), achieved for over 80% of calls most of the time. ▪ All delays in call answering are measured and monitored by the inbound Call Centre Managers. Base Training Module 2 Call Taking system. ▪ Access to language line, Staff rotation ▪ Redirecting of Dispatchers to answer calls ▪ Procedure for senior staff in EOC for call surges ▪ Standard compliance monitored by new tier of management in EOC 1. Deliver the 32 point plan for EOC improvement. 2. County Services to act as an overspill. 3. Recruit additional staff for EOC. 4. Introduction of LAS standard to answer calls within 5 sec's. 5. Procedure for senior staff in EOC for	▪ Recruitment of extra call takers to handle extra volume of calls. ▪ Recruitment for Control services will continue through 2008 as per the recruitment plan. ▪ Resourcing for call handling has been increased. More consistent call handling is now being noted, at a consistently higher level than achieved previously. ▪ The introduction of GMT Planet software will allow smarter resourcing decisions to be made. ▪ The most recent figures show a narrowing of the differential from 13 per cent in July 2007 to 4 per cent in November 2007. The range has also moved from 74.4 per cent and 87.3 per cent in July 2007 to 89 per cent and 93.8 per cent in November 2007.	Dispatch staff have been given the facility to also answer calls when demand is high. Additional call takers are being recruited. - Monitored at Clinical Governance Committee within the Risk Information Report		√

Principal Objective	Principal Risks					Domains and Standards	Key Controls	Assurances on Controls	Board Assurance		Compliance
Objective No.	**Risk ID**	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
							call surges.				
2	**244**	Lack of protected time for staff professional and career development.	**OPER**	**9**	**R.S**	2. Clinical and Cost effectiveness C5 (c) – Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.	1. Funding per member of staff per year with robust and focused training plan - self-select training introduced. 2. To encompass 'Protected Time' into staff rotas in New Ways of Working process - protected training time being designed into new operating model.	▪ All staff have some development time allocated currently, on CPD courses. This is approx. 3 days per year. ▪ Protected training/development shifts are being incorporated into all FRU rotas. This should be complete by the end of the year. ▪ Next year rotas will be reviewed so that all staff get protected development time within their rotas.	- CPD Module: complex trainers - Area Governance Reports - Team Leader appraisals - probation appraisal pack		√
3	**72**	Inconsistent action relating to the maintenance and repair of trolley beds due to inadequate record keeping.	**LOG**	**9**	**C.V**	3. Governance C9 - Healthcare organisations have a systematic and planned approach to the management of records to ensure that from the moment a record is created until its ultimate disposal, the organisation maintains information so it serves the purpose it was collated for and disposes of the information appropriately when no longer required	1. Set up specific record files for Trolley Beds. 2. DSO's to co-ordinate audit of beds. 3. Considering implementation of asset tracking as part of Integra.	▪ Transferred records to electronic database. ▪ Asset Tracking tool will also assist in locating trolleys. ▪ Fleet Dept. considering replacement of Fleet Plan Computer Record System. ▪ We have had a comprehensive paper based system for recording the servicing of trolley beds in use for the last 11 years and this includes filing the records in the individual vehicle file on which the bed was presented. This will move to an electronic system when the new Fleet Management software system is introduced this year.	- Records Management Policy - Trolley bed spec		√

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 18 March 2008

Foundation Trust Application

1. Sponsoring Executive Director: Director of Finance

2. Purpose: For approval

3. Summary This paper contains a brief overview regarding Foundation Trust status. It asks for approval to progress an FT application.

4. Recommendation

THAT the Trust Board approves the creation of an FT Application project

NHS Foundation Trusts

NHS foundation trusts are a fundamental part of the current NHS reform programme. They reflect the move from a centrally managed service towards one that is managed locally.

NHS foundation trusts are:

- a new type of NHS organisation, established as independent public benefit corporation similar to mutual organisations such as the Co-op or building societies;
- free from central government control and from strategic health authority performance management;
- providers of healthcare according to core NHS principles – free care, based on need and not ability to pay;
- 'membership organisations' accountable to local people and staff , who can become members and governors;
- free to innovate for the benefit of their local community and patients;
- able to decide for themselves what capital investment is needed in order to improve their services;
- free to retain any surpluses they generate and to borrow in order to support this investment;
- required to meet the Department of Health's national standards on service quality and effectiveness;
- subject to inspection by external organisations such as the Healthcare Commission and the NHSLA and:
- authorised and monitored by Monitor – Independent Regulator of NHS Foundation Trusts

Foundation Trusts are still part of the NHS, delivering NHS care to NHS patients.

From April 2009, Ambulance Trusts can apply to become NHS Foundation Trusts. Simon Featherstone, Chief Executive NEAS is leading a national group including all ambulance trusts in England, Department of Health, Monitor, NHS Confederation Foundation Trust Network. Its purpose being to aid the development of 'diagnostic tools' to assist ambulance trusts preparing for the application process, to engender collaboration on common work activities thereby avoid duplication or unnecessary expenditure and to encourage the sharing of best practice / experience. The LAS and NEAS have been selected to become pilot sites by the Department of Health to develop an appropriate diagnostic tool for evaluating ambulance service FT applications.

NHS London have made it clear that they would wish that the LAS apply and succeed in becoming an NHS FT.

Benefits to the LAS of becoming an FT

- improved connection with the public, our patients and our staff by becoming a true ‘membership organisation’
- financial flexibility to facilitate delivery of our strategic plan
- strategic freedom to engage effectively with other NHS partners in delivering better quality healthcare for London
- increased autonomy to work with other partners such as the GLA and local government to improve public services
- Improved reputation as a more modern NHS organisation

Disadvantages of the LAS becoming an FT

- Significant investment in management time in a challenging period for the LAS
- Project costs
- Union support not forthcoming (see attached)
- Perception (even if unfounded) that the LAS is somehow being privatised

Conclusion

NHS foundation trusts are a fundamental part of the current NHS reform programme. The long term benefits of improved engagement with our public, patients and staff plus additional strategic freedoms will allow the LAS to deliver better quality healthcare for London while remaining part of the NHS and maintaining NHS core principles.

Recommendation

The LAS should progress an FT application. A project should be set up as part of the Corporate Processes and Governance Programme. The required resources should be determined as part of the current SPPP process. It is expected that a detailed project plan including a budget will be presented to the May Trust Board.

Appendix

From: Eric Roberts
Sent: 11 March 2008 11:35
To: Michael Dinan
Subject: Foundation Trust Application

Mike,

Please find below an initial response. We will, of course, want to be fully informed and involved in every step taken.

Unison remains opposed to the principles of Foundation Trust Status. We believe that Foundation Trusts are part of a market in which trusts compete against each other, are unaccountable to the Secretary of State and have greater powers than other Trusts, for example to keep surpluses and borrow from the private sector. We believe that Foundation Trusts will lead to increased inequalities of NHS services and the extension of charging.

We would like to see a robust, open debate within the London Ambulance Service so that staff are not only fully engaged in every step, but understand the implications regarding the application process. We believe the case against Foundation Trust Status for our Service is a strong one and we will be campaigning with other interested parties within and outside the Trust to bring our opposition into the public domain, as we have yet to be convinced, nor seen any evidence, about any benefits to patients, staff or the people of London in general.

In our view this is an attempt to move the LAS outside of the NHS and real democratic control by creating a smokescreen of local involvement and 'social ownership'. We have seen in other Foundation Trusts an attempt to break, or ignore, national agreements on pay and Terms and Conditions. We have seen other Foundation Trusts get into severe financial difficulties as they struggle to meet financial needs before health needs.

Unison has played a major part in creating the Service we have now. We are proud of the part we have played in bringing the LAS through difficult times in partnership with the Trust's management. We view the dash to become a Foundation Trust as a threat and a betrayal of that partnership.

Best wishes

Eric

Eric Roberts
Branch Secretary
LAS UNISON
Staff-side Lead
07881810430

Enclosure 7

London Ambulance Service NHS Trust

TRUST BOARD 18 March 2008

Communication and Engagement Strategy 2008 – 2013

1. Sponsoring Executive Director: Chief Executive

2. Purpose: For approval

3. Summary

This strategy sets out the approach of the London Ambulance Service NHS Trust to communicating and engaging, externally and internally, during the life of the Service Improvement Programme.
The strategy contains both long and short term objectives and outlines how the various activities will be measured for effectiveness.

4. Recommendation

THAT the Trust Board approves the Communication and Engagement Strategy for 2008-2013.

London Ambulance Service NHS
NHS Trust

DRAFT

Communication and Engagement Strategy 2008 - 2013

Communication *– the sharing of information in order to increase understanding.*

Engagement *– the development of a two-way relationship in which mutual trust and understanding is created, information is imparted, views are welcomed, taken into account and acted upon wherever possible to the benefit of all parties.*

Contents

1. Context

The London Ambulance Service has a special relationship with the people of our capital city - anyone, at any time, anywhere within our geographical boundaries, may need our care and attention.

While we report to the Government and other bodies on a number of issues, it is to those who live and work in - and visit - London that we are ultimately accountable.

So, while continuing to enhance our relationships and reputation with other organisations within the NHS and beyond, it is the public who should be a major focus of our communication and engagement activities.

Communicating and engaging in a meaningful way will always be a challenge in London with its hundreds of different cultures and languages making up one of the most diverse cities in the world.

We will do our best to ensure we are as inclusive as possible as we reach out to all corners of the capital.

Nurturing and developing our external relationships and reputation is only one side of the coin. The skill levels of our staff have increased dramatically over the past decade and we must maintain this progress towards greater professionalism. We must build a positive culture through encouraging, supporting and developing our people as we continually strive to improve further the quality of care we deliver to patients.

Every time – 2500 times a day – we attend a patient is an opportunity to communicate and engage. The quality of those responses can make or break our reputation. Our staff must possess the right values, skills and information to make their contacts as positive an experience as possible in the circumstances for their patients and the public.

To develop this positive culture we must work with all staff and continue to strengthen our partnership with trade union colleagues.

We have entered a challenging and exciting period in the history of the London Ambulance Service. The face of our organisation is changing as we move away from a one-size-fits-all approach to those who call 999 to providing a more customised response – for example, sometimes instead of despatching a traditional ambulance it may be better for a patient to receive clinical advice over the telephone or be referred to a GP or more appropriate health professional.

As our plans are implemented over the next few years, London will begin to see an organisation of highly skilled health professionals increasingly able to solve or alleviate health problems at first contact without needing to take the majority of patients to hospital.

The way we deliver our service will be very different by 2013 – the year we expect to complete our current Service Improvement Programme.

Changing the way the ambulance service has operated for many years may not be welcomed with open arms by everybody. We must be prepared to explain carefully why we believe the direction we wish to travel will mean an even higher standard of care delivered to our patients. Equally, we must be prepared to listen and change our plans, if necessary.

The London Ambulance Service does not operate in a vacuum. We are part of the NHS which itself is constantly evolving and changing. We will play a central role in implementing the final proposals to emerge from the Healthcare for London consultation and will be involved in the various hospital reconfigurations planned across London. We must be prepared to communicate clearly our position on proposed changes and how we are working with NHS colleagues to improve patient care.

It is also likely that in the near future we will become a Foundation Trust with all the responsibilities of developing and maintaining strong relationships with a large membership.

The London Ambulance Service aspires to become world-class. This ambition must be matched by world-class communications and engagement.

2. Communication and engagement objectives

Our over-arching approach to communication and engagement during this period must be to ensure that the people of London are kept informed of our plans and are invited and encouraged to engage with us in future developments and to express their views about our progress and direction.

General awareness of our future plans amongst our key audiences will not be enough; we need to engage with them in ways that allow for two-way communication, and encourage them to work with us to deliver a better service to our patients in London.

Our communication and engagement activity will also be informed by the results of research undertaken in 2006 on our behalf by Ipsos MORI (http://www.londonambulance.nhs.uk/talkingtous/ppi/ppi.html) which provided a considerable amount of interesting and useful information.

The research found that seven out of 10 Londoners are prepared to speak highly of the London Ambulance Service; a third will do so without being asked. The older a person is, the more likely they are to be an advocate of our service; and (as with many public bodies) white residents are more likely to speak highly of us than black and minority ethnic communities.

The more informed people are, the more likely they are to be advocates of an organisation, and the more likely they are to be satisfied with the service we offer.
Unfortunately, the research showed that Londoners do not appear to be well informed about us. Six out of ten people said in 2006 that they had heard nothing about us in the previous two years (despite the London bombings).

If we want to increase our advocacy and satisfaction levels, we need to focus our communication activity on ensuring Londoners are better informed about what we do. The ability and opportunity to do this will be considerably enhanced by the development and maintenance of a strong and active FT membership.

With such a large and diverse population and a wide variety of interested audiences we must do our best to tailor and target information to ensure the right people are told the right thing at the right time through the right medium.

Our specific objectives over the next six years are:

- to increase public understanding of our role and future plans, so people feel more informed about our service and what to expect if they call us; so they use our service correctly and are more likely to speak highly of the London Ambulance Service

- to improve our reputation among those in black and minority ethnic communities by increasing our contact with them and ensuring we take into account any special needs they have as we seek to improve our service to all our patients

- to develop our public affairs activity, ensuring politicians and other opinion formers understand, and are able to contribute to, our plans for the future

- to involve the public and patients in shaping the way we deliver our service

- to develop and maintain resilient two-way communications with our Foundation Trust membership (should our application for FT status be successful)

- to build relations with those people who are key stakeholders in our improvement programme, so that we can manage and meet their expectations and they can contribute to its delivery

- to develop an environment where members of staff feel informed, listened to, valued, are proud to work for the London Ambulance Service, and actively contribute to improving the care we provide to patients

Service Improvement Programme

Our communication and engagement activity will support our improvement programme which has been designed to deliver our ultimate aim to be:

A world-class ambulance service for London: an organisation of well-trained, enthusiastic, caring, proud people, who are all recognised for their dedication to meeting the needs of the public and all our patients.

The improvement programme is built around a number of strategic aims to create a service which:

- is accessible
- responds appropriately
- engages with the public, patients and partners
- provides greater options for patients
- focuses on service delivery
- has a culture built around its core values

Influenced by the Ambulance Service Review, 'Taking Healthcare to the Patient' (published in June 2005), our Service Improvement Programme was developed in consultation with a number of our many audiences including patients, staff, NHS colleagues, other emergency services, local authorities and suppliers. Our continued communication and engagement with these groups will be important to our success.
Our improvement programme is made up of five different strands:

- Access and connecting the Trust for health
- Improving our operational response
- Organisation development and people
- Planning for the London 2012 Olympic and Paralympic games
- Governance and corporate processes

Within these strands are many different projects. A significant recent addition to the plan is the "New Ways of Working" project which is designed, through improved clinical leadership, to drive up quality of patient care and staff job satisfaction by focussing on a few ambulance stations at a time, making improvements across the board and then rolling out the project to other stations over the next few years.

4. What we will be doing in 2008-2009

This strategy so far has outlined our general approach and commitment to enhancing and progressing our communication and engagement activity.

It is important now to give examples of some of the activities we will undertake in the short term to breathe life into this commitment and make it meaningful for our many audiences.

In 2008-2009 our communication and engagement activity will include:

Supporting the Service Improvement Programme

We will continue to develop communication plans for the many projects within the improvement programme but special attention will need to be given to a number of key areas – e.g. the introduction of the 'Call Connect' regime to meet the Government's new performance target; the New Ways of Working project; the introduction of a new computer aided despatch (CAD 2010) system; the roll-out of a brand new radio system across the Service, known as Airwave; and changes to the make-up of our operational workforce.

Involving and informing patients and the public

We will continue to increase and develop our patient and public involvement (PPI) programme and our public education activity, especially among children attending primary and secondary schools.

Developing our key messages

We will clarify our corporate messages – that is those key messages that reflect what the organisation stands for and where it wants to be in the future.

The way we manage our messages can have a significant impact on public and staff confidence. We should speak with one voice when communicating with our internal and external audiences, and the adoption of key messages can facilitate this.

These messages, and those that are issue specific, need to be made accessible to all staff, so that they can be used consistently when we communicate and engage with our different stakeholders.

Enhancing our communication tools

We will embrace fully the technology required to broaden our contact with people in London. We will develop and launch a brand new internet site and embrace, as appropriate, 'new media' such as blogging, podcasts and social media sites like You Tube.

In doing this we will always bear in mind that there will be people across London who will not have access to technology and will need to be communicated with using more traditional methods.

Demonstrating our learning from patient and public feedback

We will complete the creation of a new Patient Services Department, combining our Patient Advice and Liaison Service (PALS) with our complaints function and put in place clear methods of demonstrating that the organisation is willing and able to learn from feedback.

Instilling confidence in times of crisis

We will continue to ensure that our capability to communicate effectively and speedily during times of crisis – e.g. major incidents, terrorist attacks, natural disasters – is maintained and enhanced.

Implementing strong internal communications

We will facilitate and encourage the development of stronger two-way internal communications across the organisation, using the New Ways of Working project as a launch pad for a new era of meaningful staff communication and engagement.

It is often said that the effective internal communications is key to success. We must use all the communication tools in our armoury – especially face to face contact – to ensure staff feel informed and listened to.

Building on our relationships with the media

We will continue to work proactively with and through the media to enhance the reputation of the Service, providing reassurance to the public and instilling confidence in our capability to care for and serve everyone in London.

Strong relationships with the media will bear fruit in times when we need to react when things go wrong or when we need to rebut unfair publicity.

5. Review annually

This strategy will be reviewed annually to ensure it is still relevant and to adjust the priorities and the actions for the year ahead.

6. Measuring the implementation of this strategy

Wherever possible our communication and engagement activity will be measured for effectiveness and impact. In terms of overall evaluation of this strategy, there are a number of measures that can be used:

- Using the Ipsos MORI research as a benchmark we will (if resources allow) repeat the survey to measure improvement.

- Using the Events and Schools annual report of 2007-2008 as a benchmark, we will demonstrate increasing public education activity, especially in the number of contacts with schoolchildren aged seven to 18.

- We will be able to demonstrate that the lessons the organisation is learning from patient and public feedback are more freely and clearly available on our external and internal websites and in other communication media.

- A new internet website will be launched before the end of 2008 with a tool to measure increasing usage by the public.

- Staff opinion will be sought to measure improvements in internal communication, using the most recent staff survey as a benchmark.

- We will seek to develop measures to demonstrate increasing, positive coverage of the organisation in both national and local media.

7. Resources

This is a challenging communication and engagement agenda. Much can be achieved with existing resources but there will need to be some additional investment if we are to fulfil our ambitions.

8. Further reading

A more detailed version of our communication and engagement plans for the future can be found in the ‘A Communication and Engagement Plan to support the Service Improvement Programme 2008-2013’.

A comprehensive explanation of the ‘New Ways of Working’ project is available as is our Patient and Public Involvement and Public Education action plans as well as plans supporting individual projects in the improvement programme.

David Jervis
Director of Communications
March 2008

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 18 March 2008

Report on Delivery of the Training Plan 2007 – 2008

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

2. Purpose: For noting

3. Summary

The attached report shows activity against the Training Plan for 2007 -08.

The report includes details of core clinical and technical training programmes, modular training, station-based training together with non clinical management and staff development.

Activity data gathering for station-based training is relatively new and currently appears incomplete, with activity for one area seemingly low compared to the other two areas. This will continue to be developed to address the disparity.

Key messages from the report are:

- The introduction of modular training has had a good introduction with over 1800 attendances in year.
- Attendance is very good for those booked onto training (94% – 96% overall).
- Focus will be given to improved booking of staff onto training provision.
- New additional CPD modules will be provided from May 2008.

4. Recommendation

THAT the Trust Board notes the report.

London Ambulance Service NHS
NHS Trust

Training & Development Plan - July 2007 - March 2009

End of Year Report for 2007-2008

1. Introduction

The Training & Development Plan for 2007 to March 2009 recognises the aspirations and strategic direction of the organisation to ultimately deliver more post registration training at complex level whilst maintaining a robust programme of recruitment and pre registration courses at our training centres thereby providing a workforce that is skilled appropriately to satisfy the aspirations of the workforce plan. The first year of the plan has concentrated on developing and delivering the "new style" modular training particularly to frontline clinical staff with an aim of improving access and subsequent attendance.

Work is currently progressing to introduce a centralised data base to capture all training activity with the anticipation that future reports will include comprehensive Trust wide training activity.

This report provides activity data in relation to:

- Modular CPD training
- Standard Core and clinical recruitment training
- Complex based training
- Management and staff development (non clinical)

2. Clinical & Technical

2.1 Modular/CPD Training

The following summarises the planned activity against delivery for all modular clinical/technical training scheduled between April 2007 – March 2008. Attendance levels of staff booked onto each training event is shown in bold and overall demonstrates excellent attendance levels for these staff of 94% representing 1803 attendances. A further breakdown is provided at Appendix 1.

Patient Assessment

111 courses were planned
94 courses were delivered
17 courses were not delivered

- 15 due to no/insufficient uptake of places
- 2 due to centre flooding

65% of available places were booked.
93% of booked students attended

Advanced Life Support

93 courses were planned
82 courses were delivered
11 courses were not delivered

- 10 due to no/insufficient uptake of places
- 1 cancelled in error

77% of available places were booked.
94% of booked student attended

Manual Handling

44 courses were planned and delivered
92% of available places were booked.
95% of booked students attended

Operational Officer Clinical Update

15 courses were planned
14 courses were delivered
1 course was not delivered due to insufficient uptake of places
68% of available places were booked.
86% of booked student attended

Team Leader Clinical Update

24 courses were planned
21 courses were delivered
3 courses were not delivered due to insufficient uptake of places
77% of available places were booked.
94% of booked student attended

Practice Placement Educator Course

8 courses were planned and delivered
96% of available places were booked.
91% of booked student attended

2.2 Core/Recruitment Training

The following reports the planned activity against delivery for all core clinical/technical and recruitment training scheduled between April 2007 and March 2008. Attendance levels of those booked onto each training event is shown in bold and again demonstrates excellent attendance and successful completion overall of 96% (representing 315 successful attendances). Further breakdown is provided at appendix 3.

CTAK

6 courses were planned and delivered.
72% of available places were booked.
89% of students successfully completed the course

Dispatch Courses

5 courses were planned and delivered.
76% of available places were booked.
98% of students successfully completed the course

PTS Courses

4courses were planned
These courses were not required.

PTS Driving

2 courses were planned and delivered.
67% of available places were booked.
100% of students successfully completed the course

A&E Support

14 courses were planned
11 courses were delivered
3 courses were cancelled due to insufficient numbers of students
56% of available places were booked.
100% of students successfully completed the course

Paramedic Course

5 courses were planned and delivered.
86% of available places were booked.
92% of students successfully completed the course

Instructor Qualifying Course

1 course was planned and delivered
100% of available places were booked.
100% of students successfully completed the course

Team Leader Course

1 course was planned and delivered
100% of available places were booked.
100% of students successfully completed the course

Potential Driving Instructor Course

1 course was planned and delivered
100% of available places were booked.
100% of students successfully completed the course

2.3 Complex-based education & Training

There have been a large number of elements of training delivered across complexes during 2007-2008 (appendix 5).

Emphasis has been placed during this year on the delivery of training in the Laryngeal Mask Airway (LMA) and Fast Response Unit (FRU) familiarisation training.

The following numbers of staff have completed these elements during 2007-2008:

LMA = 236

FRU = 182

2.4 University Courses

There is currently a total of 215 students studying at our three partner universities at various stages of their training, a summary of which is shown at appendix 6. Output from these will increase next year as we see the first cohort of Greenwich students qualifying in addition to St Georges and Hertfordshire.

2.5 Lessons Learned

A reasonably high percentage of planned places/courses are still being lost, either through no places being booked at all, or through insufficient (less than 4) places being booked to make running the course viable. This does however

appear to have improved over the period of introducing the modular-based training. The report shows that for those booked onto training places, attendance levels are high. Focus will therefore be placed on improving the booking levels in the coming year.

The introduction of New Ways of Working during 2008 will increase the degree of local ownership of training and education particularly in the “early” complexes.

2.6 Key developments

The following key developments are planned for next year:

- The addition of new CPD modules for:
    - Diversity
    - Obstetrics
    - Mental health
    - 12 Lead ECG (Intermediate and advanced)
    - Major Incidents
    - Advanced Patient Assessment
    - Referral Pathways

- Implementation of the in-house e-learning site

3. Management & Staff development (non-clinical)

Non-clinical management and staff development activity is detailed at appendix 7 and shows a total of 459 attendances in year.

3.1 Key developments

The key development in non-clinical staff development for 2008-2009 will be the introduction of the new Senior Leadership development Course. Designed to compliment our existing ELSA course delivered to junior/middle managers, this new course will be run by an external provider and will be tailored to meet the specific development needs of senior LAS managers, focusing on both the Trust’s values and the NHS Leadership Qualities Framework.

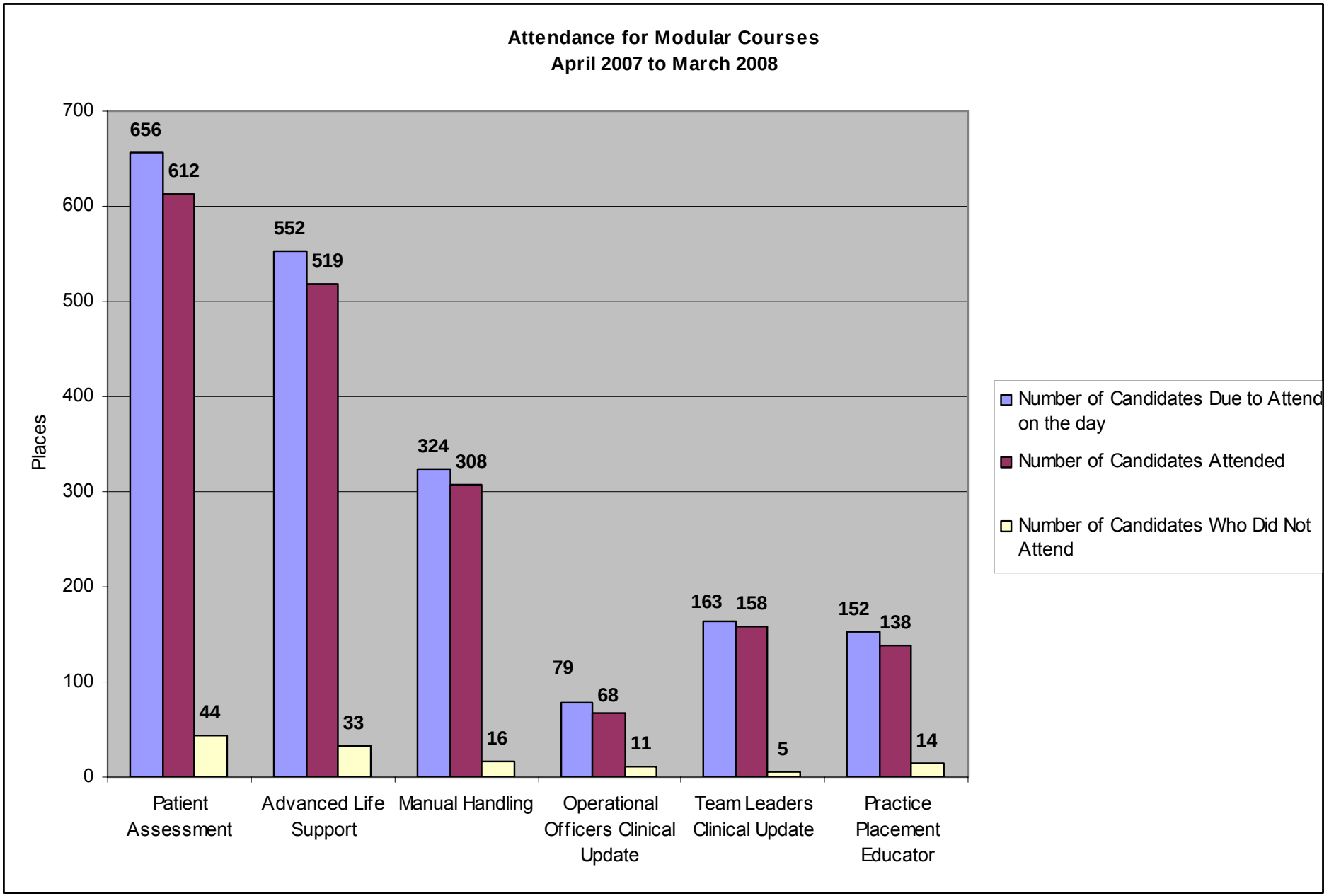
The Trust will also be looking to utilize joint funding from Skills for Health and NHS London to improve training and development available to staff up to and including pay band 4.

Appendix 1

MODULAR TRAINING

Course	Number of Courses Planned	Number of Courses Cancelled	Reason	Number of Courses Not Run	Reason		Number of Places Planned	Number of Places Booked	Number of Places Not Booked	Number of Places Lost Due to Courses Not Run		Number of Candidates Due to Attend on the day	Number of Candidates Attended	Number of Candidates Who Did Not Attend
Patient Assessment	118	7	Converted to another module (7)	17	No Candidates booked on course (9) Other Reasons i.e Centre Flooded (2) Less than 4 candidates booked (6)		1065	688 65%	345 32%	32 3%		656	612 93%	44 7%
Advanced Life Support	93 (incl 7 additional courses converted from Patient Assessment Module)	0		11	No Candidates booked on course (2) Cancelled in error (1) Less than 4 candidates booked (8)		763	585 77%	145 19%	33 4%		552	519 94%	33 6%
Manual Handling	44	0		0			352	324 92%	28 8%	0 0%		324	308 95%	16 5%
Operational Officers Clinical Update	15	0		1	Less than 4 candidates booked (1)		120	81 68%	37 31%	2 1%		79	68 86%	11 14%
Team Leaders Clinical Update	24	0		3	Less than 4 candidates booked (3)		218	167 77%	47 22%	4 1%		163	158 97%	5 3%
Practice Placement Educator	8	0		0			159	152 96%	7 4%	0 0%		152	138 91%	14 9%
Total:							**2677**	**1997 75%**	**609 23%**	**71 2%**		**1926**	**1803 94%**	**123 6%**

Appendix 2

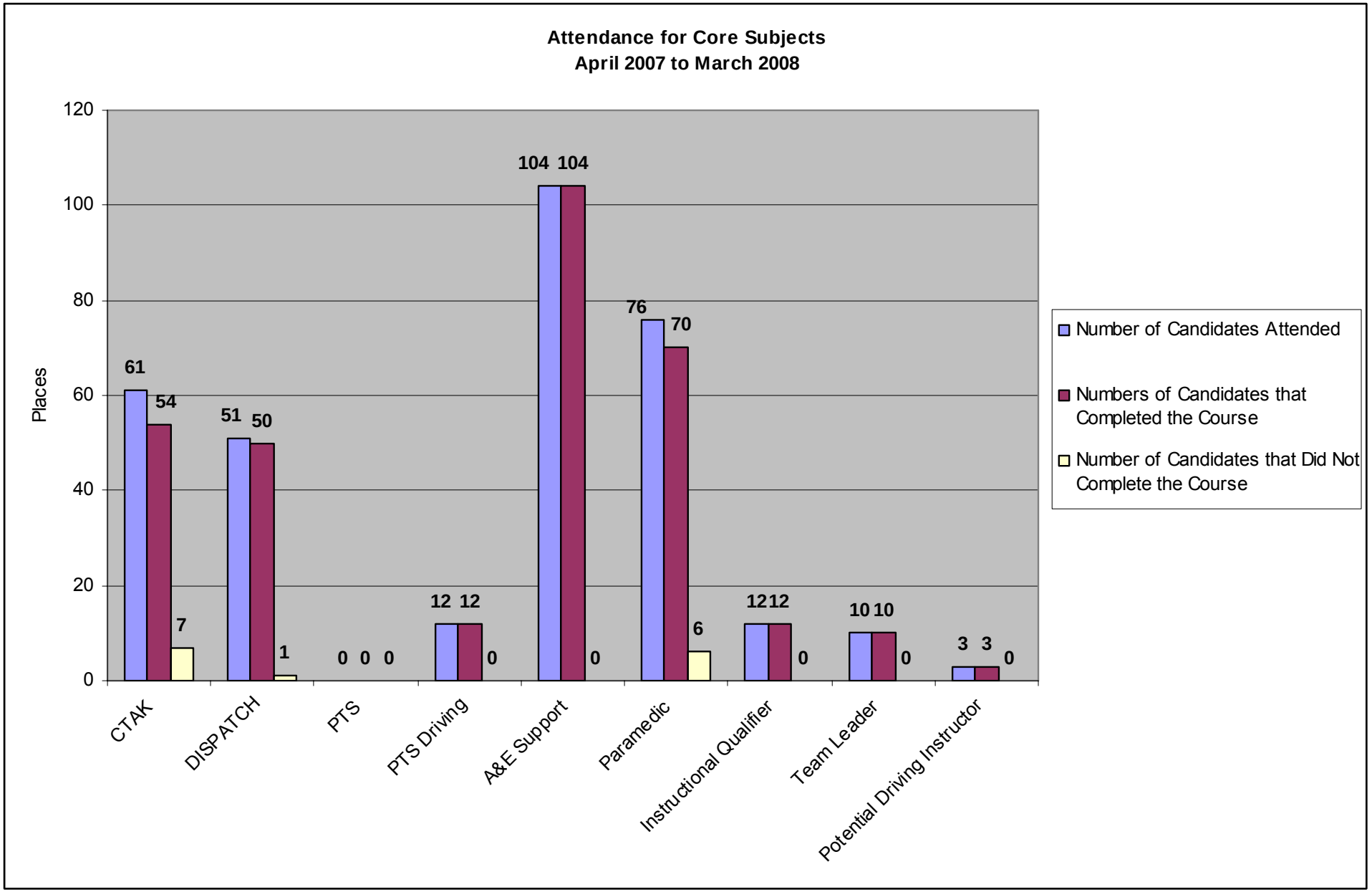

Attendance for Modular Courses
April 2007 to March 2008
Places
700
600
500
400
300
200
100
0
656
612
44
552
519
33
324
308
16
79
68
11
163
158
5
152
138
14
Patient Assessment
Advanced Life Support
Manual Handling
Operational Officers Clinical Update
Team Leaders Clinical Update
Practice Placement Educator
Number of Candidates Due to Attend on the day
Number of Candidates Attended
Number of Candidates Who Did Not Attend

Appendix 3

CORE TRAINING

Course	Number of Courses Planned	Number of Courses Cancelled	Reason		Number of Places Planned	Number of Places Booked	Number of Places Not Booked	Number of Places Lost Due to Courses Cancelled		Number of Candidates Attended	Numbers of Candidates that Completed the Course	Number of Candidates that Did Not Complete the Course
CTAK	6	0			85	61 72%	24 28%	0 0%		61	54 89%	7 11%
DISPATCH	5	0			67	51 76%	16 24%	0 0%		51	50 98%	1 2%
PTS	4	4	Courses not required		48	0 0%	0 0%	48 100%		0	0 0%	0 0%
PTS Driving	2	0			18	12 67%	6 33%	0 0%		12	12 100%	0 0%
A&E Support	14	3	Insufficient Students		186	104 56%	46 25%	36 19%		104	104 100%	0 0%
Paramedic	5	0			88	76 86%	12 14%	0 0%		76	70 92%	6 8%
Instructional Qualifier	1	0			12	12 100%	0 0%	0 0%		12	12 100%	0 0%
Team Leader	1	0			10	10 100%	0 0%	0 0%		10	10 100%	0 0%
Potential Driving Instructor	1	0			3	3 100%	0 0%	0 0%		3	3 100%	0 0%
			Total:		**517**	**329** **64%**	**104** **20%**	**84** **16%**		**329**	**315** **96%**	**14** **4%**

Appendix 4


Attendance for Core Subjects
April 2007 to March 2008
Places
120
100
80
60
40
20
0
61
54
7
51
50
1
0 0 0
12 12
0
104 104
0
76
70
6
12 12
0
10 10
0
3 3
0
CTAK
DISPATCH
PTS
PTS Driving
A&E Support
Paramedic
Instructional Qualifier
Team Leader
Potential Driving Instructor
Number of Candidates Attended
Numbers of Candidates that Completed the Course
Number of Candidates that Did Not Complete the Course

Appendix 5

COMPLEX TRAINING

	NOVEMBER 2007 (Hrs)	DECEMBER 2007 (Hrs)	JANUARY 2007 (Hrs)
EAST COMPLEX – total reported 411.5 hrs			
Chase Farm			
City & Hackney			
Edmonton			
Islington			46
Newham & Tower Hamlets			113
Romford			84
Whipps Cross			168.5
WEST COMPLEX – total reported 1388.5 hrs			
Camden	131.5		
Friern Barnet	21	4	21
Fulham	133	41	98
Hanwell	104	26	48
Hillingdon	95	50	64
Isleworth	201	109	111
Pinner	52	21	58
St John's Wood			
SOUTH COMPLEX – total reported 1318.5 hrs			
Barnehurst	231		
Bromley			
Croydon	197	26	
Deptford	446		
Greenwich			64
New Malden	94.5	101	
Oval			
St Helier			
Waterloo			
Wimbledon			159

Range of Complex Training
12 Lead ECG
ALS
BLS
Capnography
Complaint
Driving
Driving Assessment
DSO Application
End of Year
EPD Training
ETCo2
First Aid & Defib
FRU Training Day
HEMS
Lifting Assessment
LMA
Major Incidents
Maternity & Paeds
Mod G Pre learn
New Mothers & Babies
Paramedic Application
Paramedic Assist
Paramedic Pre Entry
Patient Assessment
PDR
Resus Training
Return to Work
Ride Out
SMART Defib

It should be noted that this data has not been previously captured and reported and should therefore be taken as indicative at this stage with anticipated improvements in data for future reports.

Appendix 6

UNIVERSITY TRAINING

Hertfordshire BSc

NUMBER OF YEAR GROUPS	NUMBER OF COURSES CANCELLED	TOTAL COURSE CAPACITY	BOOKED	ACTUAL ATTENDED
4	0	106	95	95

Hertfordshire FD

NUMBER OF YEAR GROUPS	NUMBER OF COURSES CANCELLED	TOTAL COURSE CAPACITY	BOOKED	ACTUAL ATTENDED
3	0	39	38	38

St Georges

NUMBER OF YEAR GROUPS	NUMBER OF COURSES CANCELLED	TOTAL COURSE CAPACITY	BOOKED	ACTUAL ATTENDED
3	0	48	47	47

Greenwich

NUMBER OF YEAR GROUPS	NUMBER OF COURSES CANCELLED	TOTAL COURSE CAPACITY	BOOKED	ACTUAL ATTENDED
2	0	35	35	35

Appendix 7

LEARNING AND DEVELOPMENT COURSES FROM 1ST APRIL 2007 - 1ST MARCH 2008

COURSE TITLE	TOTAL NUMBER OF ATTENDEES
Station Admin	34
Return to Study	8
Recruitment and Selection	40
Presentation Skills	15
Participating at Meetings	10
Managing Safety and Risk	44
Managing Disciplinaries	38
Managing Attendance	10
Excellence in Patient Communication	31
Essentials of Project Management	24
EOC Management Development	6
ELSA Impact of Impact	25
ELSA Leadership Module	23
ELSA Influencing Skills	24
ELSA Effective Decision-Making	23
ELSA Development Centre	23
Effective Meeting Administration	14
DSE Risk Assessors	13
Assertive Communication	31
Applying for Promotion	23
TOTAL	**459**

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 18th March 2008

Submission to the Healthcare for London Consultation

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

On 26th February the Service Development Committee discussed the Trust's draft response to the Healthcare for London consultation. The Director of Service Development incorporated the comments and feedback received from the members of the Committee when drafting the final response. The final response was submitted to NHS London by the required deadline of 7th March 2008 and is attached for information.

4. Recommendation

THAT the Trust Board note the contents of the submission to the Healthcare for London consultation.

Healthcare for London: A Framework for Action

The contribution of the London Ambulance Service NHS Trust

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March 2008

Introduction

This paper constitutes the London Ambulance Service (LAS) response to *Healthcare for London: A Framework for Action* (HfL).

Healthcare for London recognises how crucial the ambulance service will be in implementing aspects of the changes proposed in the document. Examples of this include the management of stroke and trauma. However, only around 10% of the LAS's million patient contacts a year are for patients with immediately life threatening conditions. What is less widely understood is how the ambulance service, as London's only pan-London trust with a 24 hour mobile operation can and should contribute to the coordination and management of care for patients with long term conditions and the aim of more patients receiving care closer to home.

So, although this paper starts by setting out the LAS response to proposals for seriously ill and injured patients, the most significant parts concern patients with urgent needs and the potential contribution of the ambulance service to keeping people healthy.

The paper suggests the implications for the ambulance service of the HfL proposals and proposes the LAS contribution to making them a reality.

1. Patients with serious and time-critical conditions

The LAS supports the proposal that care for critically ill and injured patients should be concentrated on fewer sites in order that care is of the highest quality. The LAS will work to ensure that patients with stroke and serious trauma are taken as soon as possible to the best place for treatment.

This change will build on the model already adopted for the treatment of ST-elevation myocardial infarction (STEMI) patients. Patients with this condition, confirmed by the use of 12-lead ECG are now taken to one of nine designated heart attack centres in London.

1.1. Stroke

The identification of a potential stroke using the Face Arm Speech Test (FAST) is simple and has been shown to be accurate.

However, as the *diagnosis* of ischaemic stroke can only be made with the aid of a CT scan and even then thrombolysis would only be undertaken for a maximum of 15% of all stroke patients, there is a very real issue around transporting patients longer distances to receive a treatment for which only a few will qualify.

One of the models which has been suggested to deliver improved stroke care is based upon a "Hub and Spoke" concept with several 24 hour acute stroke centres supported by centres operating Monday – Friday during the day. Out of hours, patients would be conveyed to the 24/7 centre and transferred back to their local

hospital after the hyper acute phase of their diagnosis/treatment for ongoing rehabilitation.

Should this type of model be adopted it is important to consider what level of resources would be required to transfer the patient and how this will be provided without hampering 999 ambulance response time performance.

1.2. Major Trauma

The case for centralising major trauma care is equally compelling and the London Ambulance Service supports the view that there is simply not enough major trauma work in London to support 30 equally competent treatment centres.

The small number of such centres proposed in HfL does, however, present a greater challenge to the LAS than the proposals on stroke.

Issues to address include:

- Definition of major trauma (MT)
- Identification of genuine MT calls without swamping trauma centres and without inappropriately reducing the numbers of patients treated more locally
- Dispatch of appropriately trained teams, specifically around the level and mix of their skills
- Status of the team deployed. The Royal London's trauma centre is supported by London's Helicopter Emergency Medical Service (HEMS). Would the development of other MT centres require similar teams at each centre? And given that HEMS is likely to form such a key part of any MT strategy for London, is it prudent to leave it as a charitable organisation dependent on its own fundraising to cover a significant portion of the costs?
- Quick arrival on scene of appropriate skills and equipment. HEMS are restricted to operating in the hours of daylight and when weather permits. At night and in bad weather the HEMS team deploy by car from the Royal London. This has allowed an extension in the hours of operation but does not have the same 'reach' as the helicopter. Should there be car-based teams at each of the MT Centres?
- What treatment is deliverable at the scene of an incident?
- Conveyance to MT centre. Transporting this group of seriously ill patients over longer distances presents specific challenges over and above stroke/STEMI patients.
- Although the additional numbers of patients going to MT centres would in overall terms be small, the financial and resource implications will need to be worked through carefully.

Further work needs to be done on the number and location of these centres. The report acknowledges that opting for three MT centres is at the lower end of recommendations made by the Royal College of Surgeons, but justifies this on the basis of population density. However, the effects of population density on traffic congestion and demand should be considered as should the forecast growth in London's population. These calculations should also allow for the significant

number of commuters and tourists who contribute to London's demand for emergency care.

These plans cannot be made in isolation. With perhaps only three further MT centres in the south east, consideration should also be given to the patients outside London for whom the most appropriate care will be provided at a London MT centre, and the consequences for the local ambulance service and activity figures at these centres.

1.3. Common challenges presented by centralised Stroke & MT

1.3.1. Financial

- Unbundling tariff to follow care of patient thereby encouraging the delivery of each episode of care:
  - at most appropriate location (for stroke) and
  - between regions (for MT).
- Consideration for those trusts that do not continue with MT/emergency surgery and therefore lose income from other work related to these patients whose numbers could fall by up to 40% (see paragraph 1.4).

1.3.2. Operational

Longer ambulance journey times to fewer sites will require that we implement changes to the number and deployment of our resources if we are to continue to meet national response time targets. There will be funding implications in this.

1.3.3. Workforce

Changes will be required in our workforce if/when extended. There are several options:

- Better trained "Critical Care Paramedics" deployed only to MT calls. This option presents specific challenges around dispatching these crews effectively
- Improved training for all paramedics. This option requires we address issues around skills decay. Currently only around 5% of the calls we attend require the skills of a paramedic
- BASICS doctors whose current coverage is patchy and take up is based on good will.

Improved skills could be kept up to date through rotation working in Major Trauma Centres, or critical care retrieval teams could be based at the major trauma sites, with LAS staff a key part of that team.

1.4. Emergency Surgery

The LAS understands the clinical benefits of concentrating emergency surgery on fewer sites. In the past when hospitals have ceased undertaking emergency surgery they have lost as many as 40% of their previous ambulance-borne patients (35% if they continue to undertake minor surgery). This result is counter-

intuitive, since of course surgical emergencies make up a far smaller proportion of the total. It comes about because protocols have been written to exclude any potentially surgical cases, such as acute abdominal pain and urinary tract problems, most of which, of course, turn out to be medical upon diagnosis.

The LAS view is that on-site 24-hour surgical opinion at local hospitals would be a good way of safely reducing the number of patients that need to be taken to a critical care hospital "to be on the safe side" and welcomes the opportunity to be involved in the local hospital feasibility workstream of HfL.

2. Patients with urgent conditions, sometimes serious, and often exacerbations of long term conditions

This section addresses the HfL proposals for patients with urgent but not life-threatening needs.

Over 50% of LAS' 1 million patients a year probably do not need to be treated in an Emergency Department (ED) but around 75% are currently conveyed there (and, once there, many are admitted). There are two reasons for this:

- The traditional focus in ambulance services (and thus in the skills required of front line crews) was on dealing with trauma and immediately life threatening conditions – not on diagnosis and assessment. With the rapid growth in 'urgent' (as opposed to 'emergency') 999 calls it became clear that safe decision making about how to deal with these patients would require a big skill shift. Accordingly, starting in 2004, we introduced Emergency Care Practitioners into our workforce and began shifting the content of paramedic training programmes. But as these changes take time (and money) to work through, many of our front line crews do not (yet) have the skills and confidence to feel safe in routinely deciding to not take many patients to an ED.
- Nearly all the patients that would be better cared for somewhere other than in an ED do, however, require some form of follow up – few can safely be left to their own devices even after our crews have determined that there is no immediate threat to life or limb. Many have had an episode of what will turn out to be a chronic illness, or a relapse – and need to be put on (or back on) the appropriate pathway for their condition. Others need to be followed up as a precaution – by their (or a) GP, a community nurse or by social services. At the moment, access to these alternative pathways is patchy, to put it mildly. We are committed, as a service, to support the development of a wide range of clinically appropriate and cost effective pathways, and aim to take around 200,000 fewer patients to ED per year within five years. But without access to a good range of alternative pathways we will unavoidably continue to take many patients to EDs that do not need to, and would not benefit from, being taken there.

The first point at which we can begin to determine the appropriate disposition for the patient is during their 999 call. Although we will often have an ambulance on the way within a few seconds of the call starting, as we continue with our questioning we can determine that the patient falls into "Category C" – that group of patients for

whom a longer response time is acceptable. Our Medical Director has determined that some of these patients might benefit from telephone advice. If so, we can ring them back and take them through a more detailed telephone assessment, which can lead to advice on self care, or, for example, to visit a pharmacist or GP. More than 100,000 of our patients will receive this service this year and of those, we anticipate that some 55,000 will not receive an ambulance visit.

Healthcare for London recommends the introduction of an extra, possibly London specific, phone number for "urgent" (i.e. not emergency but within 48hrs) calls.

Although a single and easily memorable number may help members of the public choose the right source of care, we believe it is more important to integrate the current providers of services accessed by phone: LAS, NHS Direct and primary care out of hours providers.

The LAS and NHSD are already working together towards developing technical links between our systems. The ultimate ambition is to create virtual "response hubs" as described in appendix 1 to this paper, a system that will ensure:

- All telephone requests for urgent/unscheduled care are answered and dealt with in the same way, regardless of which number the caller dials
- Cases are resolved as soon as possible. This "Hear and Treat" model includes providing advice, securing a home response or a face to face assessment. The latter can include booking an appointment for the patient e.g. with their GP
- All community based resources in the locality, whoever runs them, are available to be tasked and prepared to accept referrals
- Patients only go to A&E when appropriate and necessary
- Cases are managed through to their conclusion. The hub ensures that the promised resource arrives with the patient, or the patient arrives in the planned place, providing transport where medically necessary
- The normal care provider, e.g. the GP or community matron is informed of the contact.

The success of such a system requires an underpinning shared capacity management system, in which real-time, accurate data is commonly available on the services in the community that patients can be assisted to access. The LAS is currently working up a business case to purchase such a system, which would be jointly owned by PCTs and urgent care providers in London.

We believe that the development of a response hub holds the greatest prospect of ensuring appropriate care of any of the proposals in *Healthcare for London.*

When patients do require a face to face assessment, the ambulance service is already able to provide a range of responses:

- A&E Support: crews with basic skills who can be dispatched to low priority calls where transport, rather than treatment at scene, is required
- Single, car-based responders: who can reach calls quickly where an on-scene assessment is required before a double-crewed ambulance is committed

- Double-crewed ambulances: staffed by a combination of Emergency Medical Technicians and Paramedics. These resources are routinely dispatched to our highest priority calls but in the future will otherwise be kept in reserve to be targeted where their skills and equipment are best utilised
- Emergency Care Practitioners (ECP): embedded within PCTs and furnished with extra diagnostic kit and prescribing rights, ECPs are targeted at non emergency calls where their extra training and local knowledge may allow an alternative to a trip to A&E

The Emergency Care Practitioner role was developed precisely with the urgent patient in mind. Although these patients are not life-threatened, it is important to remember that they frequently have complex and often multiple conditions. The diagnostic and decision making skills required to conclude what is right for these complex patients are significantly greater than traditional ambulance skills, which are aimed to save lives. Investment in the ambulance person's skill set in this way will be crucial to the aim of providing appropriate care outside hospital.

Securing care for patients in their own homes is one aim of this way of operating, as is developing strong links back to primary care. The LAS supports the development of referral pathways in order to provide care as close to home as possible. In the near future our complexes will appoint full time community engagement officers part of whose role will be to liaise with stakeholders such as PCTs, service providers (especially GPs, District Nurses etc) and carers/patient groups to exploit opportunities for delivering better models of patient care.

The proposed polyclinics, with their wider array of services and diagnostics are key to this. Our view on polyclinics is:

- We would wish to convey appropriate patients to them (for primary care and minor illness/injury)
- We would wish to have "standby" points at suitably located polyclinics – locations from which we can task our vehicles to calls
- We believe that ambulance staff would be an ideal element of the clinical team in the minor treatment part of the clinic, with their ability to identify and deal with the rare patients who walk in with a more serious condition.

In order for ambulance crews to use such services to the full, they should ideally have the same opening hours and criteria for accepting patients right across London. This is important. Although most minor injuries units and walk-in-centres in London have agreed to accept ambulance-borne patients, ambulance crews under-use this resource. This is partly because they all have different rules and thresholds for accepting patients.

Maximum use of alternative pathways for patients is dependent on have information about:

1. The patient (their complaint/symptoms, location, medical history and preferences),
2. Local options for treatment.

LAS covers 31 PCTs, 11 Mental Health Trusts and countless voluntary organisations and interest groups. The care LAS can deliver is only as good as the availability and accuracy of the information we can access on local services. In order to deliver a consistent level of service it is important that the functions delivered by service providers are available 24-7.

The LAS is not resourced to collect, enter and maintain the integrity of this information, but is currently working with PCTs to find a solution to this issue.

Equally, it is important that we have access to a patient's preferences in order to deliver care according to their wishes. This issue becomes evident when providing end of life care and interactions with patients who lack capacity.

3. Other potential roles for the ambulance service

Although the ambulance service is understandably seen as the emergency arm of the National Health Service, it can also be seen as its "mobile wing". LAS crews see over a million people a year, and could play a part in long term conditions management, diagnosis of unidentified needs, provision of health advice and disease prevention.

We do not intend here to make comprehensive proposals about what else the ambulance service could do, we offer a few examples to illustrate the extent to which the ambulance service is an untapped resource in London's health economy. The LAS could:

- Support early intervention teams in the identification of mental illness
- Provide flu vaccination for target groups
- Undertake home visits on behalf of GPs
- For long term conditions patients:
  - Distribute information to prevent LTCs when we encounter vulnerable patients
  - 1st encounters and referral
  - Provide immediate access to a patient's wider web of care
  - Undertake opportunistic screening to diagnose LTCs such as diabetes
- Help patients access local support groups
- Train health professionals and members of the public in emergency life support skills
- Play a huge part in ensuring that a patient's wishes are respected around their End of Life Care. To this end a register has been set up on which we encourage all relevant patients to log their wishes.

4. Conclusion

This paper has described the view of the London Ambulance Service on *Healthcare for London: A Framework for Action.* The London Ambulance Service is in fact a key to the successful realisation of the vision in the document, particularly in respect of acute and urgent care, but also in respect of keeping people healthy.

Response Hubs – explaining the concept – proposing a pilot

This document prepared by the London Ambulance Service in consultation with NHS Direct, explains the concept of integrated urgent call handling and proposes a pilot to test its operation and effectiveness in London.

Purpose – to ensure that:

- All telephone requests for urgent/unscheduled care are answered and dealt with in the same way, regardless of what number the caller dials
- Cases are resolved as soon as possible. This "Hear and Treat" model includes providing advice, securing a home response or a face to face assessment. The latter can include booking an appointment for the patient e.g. with their GP
- All community based resources in the locality, whoever runs them, are available to be tasked and prepared to accept referrals.
- Patients only go to A&E when appropriate and necessary
- Cases are managed through. The hub ensures that the promised resource arrives with the patient, or the patient arrives in the planned place
- The normal care provider, e.g. the GP or community matron is informed of the contact.

Key features

- Calls can be answered in a number of places – technical links between these places make the system seamless from the patient's point of view
- Call takers undertake rapid triage[5] to identify life-threatening calls quickly and arrange an ambulance immediately
- If there is no life threatening emergency a structured telephone consultation – carried out by experienced and qualified practitioners - is used to identify what the patient needs
- This process is overseen by senior clinicians, most likely GPs, who are able personally to handle cases escalated by nurse or ambulance advisers, to intervene in difficult cases, and to provide overall medical oversight

[5] By triage is meant the initial sorting process designed only to establish the urgency of the case – not the more detailed discussion that establishes what should happen next

- The result of the consultation could be:
  - Advice on self care
  - Advice to make own way to an appropriate treatment or diagnostic centre
  - Tasking or dispatch of a suitable professional (which might result in case closure, or onward transport, depending on need)
  - Arrangement of an appointment e.g. with the patient's own GP
  - Arrangement of a temporary package of support to enable the patient to stay in their own home

- That the patient disposition/pathway will be the same whichever service is dealing with the call

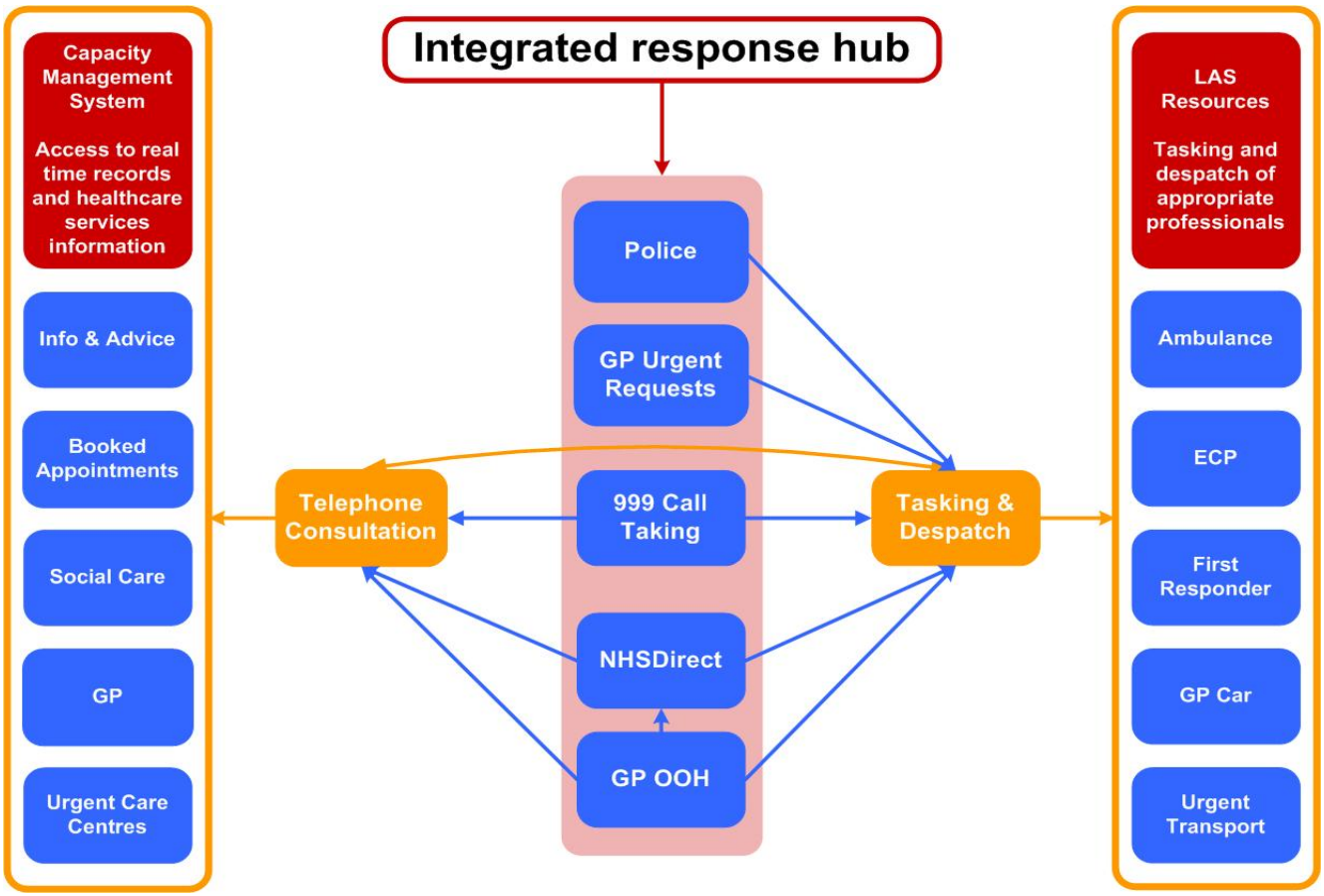
- There is access to a database, updated in real time, of information on the availability of all local acute and community health and social care resources, including the voluntary sector – anything that may be needed by people with unscheduled care needs

- There is also shared access to an up-to-date list of the patients identified as needing regular input to assist them to stay healthy at home (e.g. the community matrons' caseload) and information about who to contact in the case of a sub-acute emergency in these patients

- The system oversees the end of the process, even after handover of clinical responsibility from the hub to the relevant professional, thus minimising risk

- Clinical and other governance is managed and shared

This does not necessarily involve merger of existing organisations such as NHS Direct, LAS and/or GP out of hours services. Nor does it mean the creation of new ones/duplication of existing functions. The idea – illustrated below – is that each organisation uses the same systems and protocols and has access to the same downstream care resources. If a new organisation is not created, the partners involved would need to develop an SLA/common governance arrangements.


Integrated response hub
Capacity Management System
Access to real time records and healthcare services information
Info & Advice
Booked Appointments
Social Care
GP
Urgent Care Centres
Police
GP Urgent Requests
Telephone Consultation
999 Call Taking
Tasking & Despatch
NHSDirect
GP OOH
LAS Resources
Tasking and despatch of appropriate professionals
Ambulance
ECP
First Responder
GP Car
Urgent Transport

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD DATE 18 March 2008

CAD 2010 Update

1. Sponsoring Director: Peter Bradley

2. Purpose: For approval

3. Summary

The purpose of this paper is to update the Trust Board with the progress of the CAD 2010 Project, particularly as it progresses this important Procurement Stage.

The project is currently in Stage 3 – Procurement. The deliverable will be the FBC (Full Business Case) that, as a result of the European Tendering exercise will recommend a defined supplier(s), product(s) and costs. This will be supported by the independent Gate 3 review that will assess this process and comment on its fitness for purpose**.**

This paper sets out current progress of the project, defines the overall timetable for Trust Board approval of a preferred bidder and describes the current plans for the transition (migration) arrangements

4. Recommendations

THAT the Trust Board:

- Notes the progress of the project.
- Supports the preferred approach regarding the transition process
- Notes the outline timetable, particularly the timeline required for the SHA approval
- Considers allowing the project to proceed on a time and materials basis following the presentation of the draft FBC.

Trust Board – 18 March 2008

CAD 2010 Project – Progress Report

Introduction

The objective of the CAD 2010 project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. Full details of the requirement for this project have been previously reported and are not repeated here. The purpose of this paper is to update the Trust Board with the progress of the CAD 2010 Project, particularly as it progresses through its current important procurement stage.

The CAD 2010 Project is following the mandated three-step series of iterative business cases:

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Full Business Case (FBC)

The production and approval of these business cases is, in turn, interlinked with the formal procurement process laid down by the European Union (EU). Ultimately, the current procurement stage will produce the FBC that defines a specific solution and will set out the case for the award of contract(s) with named supplier(s) at defined costs. This will be supported by the independent Gate 3 review that will assess this process and comment on whether it is fit for purpose.

This paper sets out current progress of the project, defines the overall timetable for Trust Board approval of a preferred bidder and describes the current plans for the transition (migration) arrangements.

Procurement PRogress

In December 2007, as a result of the initial evaluation process, two suppliers, Intergraph and Northrop Grumman were invited to participate in the final stages of the competitive dialogue process.

Considerable dialogue has taken place with both bidders regarding the contract documentation and LAS requirements. This has involved extensive negotiations (alternate weeks with each bidder) and included visits both in the UK and USA.

Current focus is on completing the dialogue regarding the technical solutions, implementation, transition and service provision. The terms, conditions and associated schedules can then be finalised, allowing final negotiations to be conducted prior to the issue of the tender documentation.

In parallel with the dialogue, significant progress has been made in developing the required ITSFT (Invitation To Submit Final Tender) evaluation model and award criteria for each bidder.

Due to the intense process of dialogue, the procurement stage has generally remained on schedule for the ITSFT to be issued on 7 April. However, at the time of producing this paper, it has become evident that due to the bidders' understanding of the complexity of the LAS requirements, both parties have needed to extend the time to complete due diligence.

Clear focus is being maintained to ensure the procurement stage remains to plan. However, it is vital that a healthy balance is maintained between the overall timetable and final quality of response. Taking this into account, a twin option timetable (option 1 being current plan, option 2 a revised estimate) has been developed:

Description	Option 1	Option 2
Issue ITSFT	7 April	18 April
Procurement Report to Project Board	7 May	27 May (w/c)
Draft FBC to Trust Board approval and permission to commence work on time and materials	**20 May**	**24 June ***
Gate 3 Review	23 – 27 June	23 – 27 June
Adjust FBC to accommodate Gate 3 recommendations	30 June – 11 July	30 June – 11 July
Trust Board to approve FBC and receive report on Gate 3 review.	29 July	29 July
FBC submitted to SHA**.	30 July	30 July
Trust Board to approve FBC and sign contract with preferred bidder, once SHA process is completed.	Oct – Dec 2008	Oct – Dec 2008

Note: At each stage, there would be agreement with SMG (Senior Management Group) – not shown in order to simplify plan.

* TB will need to consider delegating authority to SDC (Service Development Committee).

** It should be noted that the formal capital approvals process takes around twelve weeks from first submission to the SHA (Strategic Health Authority) to reaching scheduled CIC (Capital Investment Committee) – this suggests CIC approval September / October 2008, prior to it being submitted to the SHA Board.

The main impact of option 2 is commencing time and materials work a month later than planned – a delay that would be subsequently transferred into the overall plan. However given the proposed 9 – 18 month implementation timetable it is a reasonable assumption that this could be recovered. Indeed, if this additional month provides extra clarity in the requirements definition, then it will aid the overall project timetable.

Transition (migration) issues

To reduce potential for confusion with suppliers, this topic is now referred to as "Transition" and the next iteration of the product addressing this subject is the "Initial Transition Plan".

Since the first stage of this project, the Project Team has been investigating and maturing the understanding, options and details of how the LAS can best manage the complex, and sometimes conflicting logistics of preparing for and transitioning to a new CAD system, whilst maintaining a 24 x 7 emergency service. This work was reported in both the SOC and the OBC.

The preferred approach arising out of the research to date, is one of operating both CTAK and the new CAD system in parallel, with an appropriate level of data synchronisation between them. This will allow a progressive period of roll-out into the live control room environment.

Adoption of this approach adds a risk as a result of the inclusion of a further interface (between CTAK and the new CAD). However, this is seen as significantly reducing the risks of a sudden switch-over (often referred to as a Big Bang) which was a part of the difficulties experienced in 1992.

This approach will also accommodate the progressive training of control room staff (rather than trying to train all staff ahead of a single go-live). Through a co-ordinated

training programme, it will enable them to complete training just ahead of starting work on the new system.

Although this parallel transition is the preferred approach, research continues. It is the subject of detailed discussions with the two remaining suppliers, to seek their advice and exploit their experience in order to apply this to best suit the interests of the LAS in order to identify an appropriate balance between risk, cost and timescales. This is vital to ensure continuity of the 24 x 7 emergency service whilst also retaining immediate 'fall back' facilities in the event of sudden failure (as was also a part of the difficulties in 1992).

It is important to recognise that the risks and opportunities of transition to the new CAD System are not confined to technical solutions, but include a number of other very important areas of which patient safety and performance are major considerations. The draft of the Initial Transition Plan currently identifies 11 objectives of the task, these are listed below:

1. Address the relevant lessons from the 1992 project (documented in Product FS1.7).
2. Ensure the uninterrupted continuance of the 24/7 emergency services provided by LAS.
3. Ensure no increased risk to patient or staff safety.
4. Minimise any degradation to service performance.
5. Maintain the capability for any or all of the Control Services operations using the New CAD System to immediately revert to the use of CTAK at any time prior to final acceptance of the New CAD System (or such sooner time as agreed with the Project Executive).
6. Reduce risk of 'Training Fade' by ensuring Control Services staff commence operational use of the New CAD System within a few days of successfully completing their training course.
7. Provide operational users with expert technical and functional support (in the form of 'floor walkers') during the period immediately following their first live operational use of the New CAD System.
8. Progressively increase confidence of users and managers in the New CAD System.
9. Allow management control over the rate of transition up to and including final acceptance of the New CAD System and the consequential decommissioning of CTAK.
10. Minimise the technical complexity of the transition to the new system.
11. Allow transition to the new system within an acceptable timescale.

Attention is drawn to important distinctions between objectives 3 and 4 above. Objective 3 is to - "Ensure no increased risk to patient or staff safety", which rightly allows no flexibility. However, such inflexibility in relation to performance levels would probably be cost prohibitive and set an unrealistic expectation. Therefore, whilst recognising the importance of maintaining performance, objective 4 is to - "Minimise any degradation to service performance".

These objectives are assessed and evaluated in more detail within the current draft of the Initial Transition Plan.

Gateway 3 Review

Gateway Review 3 is titled "Investment Decision". It will investigate the FBC and the governance arrangements for the investment decision to confirm that the project is still required, affordable and achievable. The review also checks that transition plans are robust.

A key part of this review will be to check that all the necessary statutory and procedural requirements were followed throughout the procurement and evaluation process. It will assess whether the investment decision is appropriate before the contract is placed with a supplier and it will provide assurance on the process used to select the supplier (but not the supplier selection decision itself).

The review will also assess whether the procurement process has been well managed; whether the business needs are being met; that both the LAS and the

supplier can implement and manage the proposed solution; and that the necessary processes are in place to achieve a successful outcome.

The Project Team is now in contact with the DH Gateway Review Team to discuss dates for the review. This is likely to be during the week commencing 16 June 2008, prior to the FBC being submitted to the SHA. The Trust Board will be briefed about the outcome of that review at the meeting on 29 July 2008.

This is a strategically crucial review for the LAS and, as with previous reviews; the invited interviewees will include members of the Trust Board, external stakeholders, senior LAS managers, members of the Project Board and the Project Team. Planning the schedule of interviews is already underway and will offer as much flexibility as possible. However; it is a challenging task and may require proactive management of diaries during that period to provide maximum flexibility to the scheduling process and ensure it is as comprehensive as possible.

Full Business Case (FBC)

Drafting of the FBC is progressing well under the leadership of Martyn Salter, supported by Chizoba Okoli and with input from many other members of the Project Team and the Project Board.

This business case focuses upon answering two fundamental questions; is there a case for doing anything; and is the case for procuring the proposed solution from the selected supplier, at the offered cost valid? The answer to the second question is necessarily heavily dependant upon completion of the procurement process. The extent to which the FBC can be drafted prior to that point is therefore limited, but work to prepare all of the supporting areas is progressing at a good pace.

Development of the business case is one of a number of partially inter-dependant milestones, all of which are associated with seeking essential approvals to proceed, but all of which, if not closely scheduled and managed, could contribute to extending the delivery timescale into the period of the London Olympic Games. The timetable options illustrate how it is proposed to manage this scheduling. The plan, with Trust Board approval, to commence work with the preferred supplier on a time and materials basis is key to ensuring that the FBC approval process does not adversely effect the overall project timetable.

Once the procurement report is completed, the financial, transition, planning and other elements of the business case and its appendices can be completed. The most advanced draft available will be submitted to the Trust Board as a basis to approve commencing work with the selected bidder on a time and materials basis. The FBC will then undergo its full formal process through the SHA before returning to the Trust Board. At this time the Trust Board can approve the FBC and the full contract with the preferred supplier can be signed.

Peter Suter
Director of Information Management & Technology

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 18th March 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 2007:

a. Trust Board – every meeting;

b. 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.

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.

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

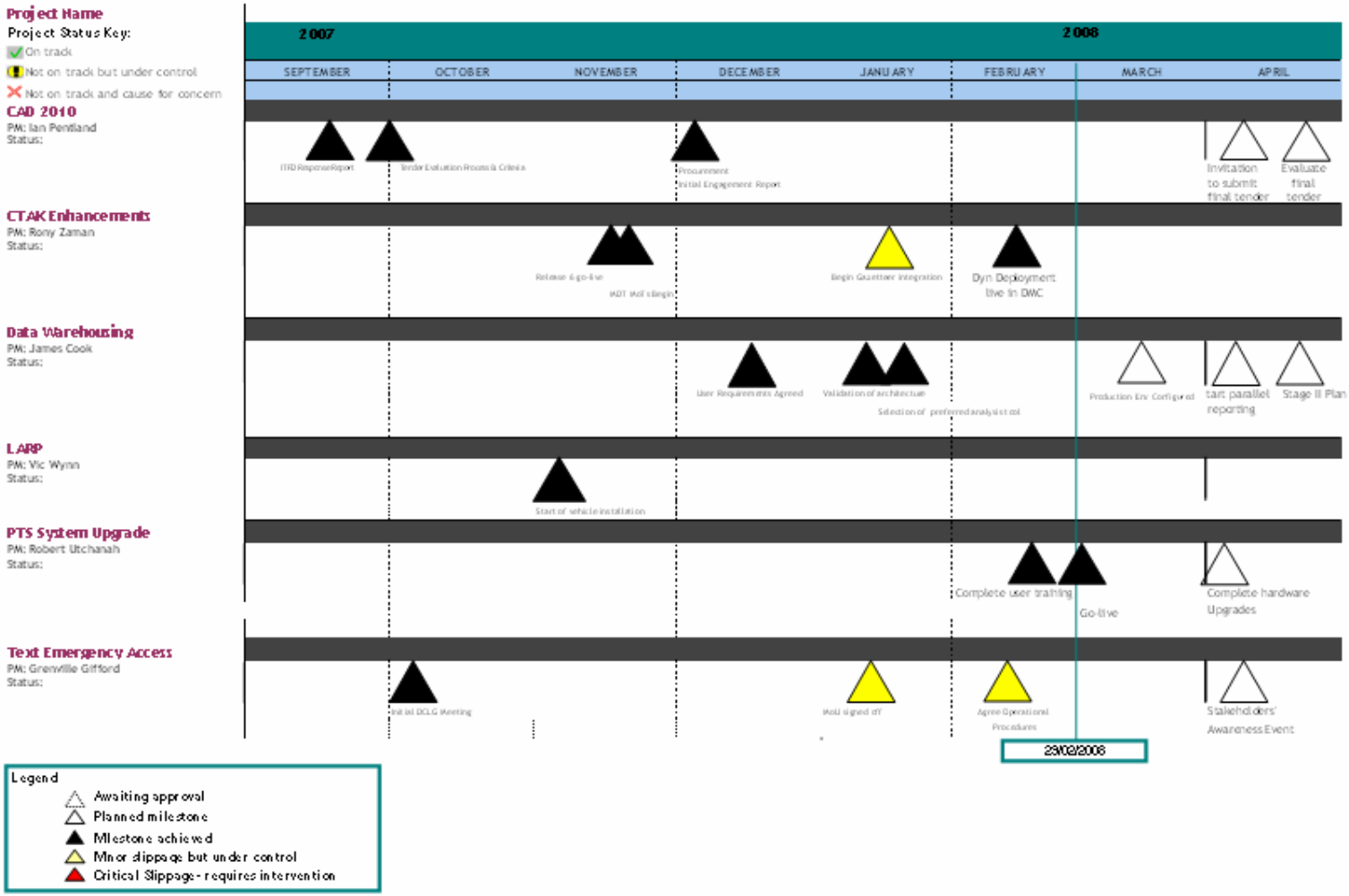
Data Warehousing
Project Manager: James Cook
Within the LAS data is stored in several separate databases with many different means of access to the information. Some require specialist skills to access the data and information, and there are limited reporting tools in place that enable managers to analyse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

LARP (London Ambulance Radio Project)
Project Manager: 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.

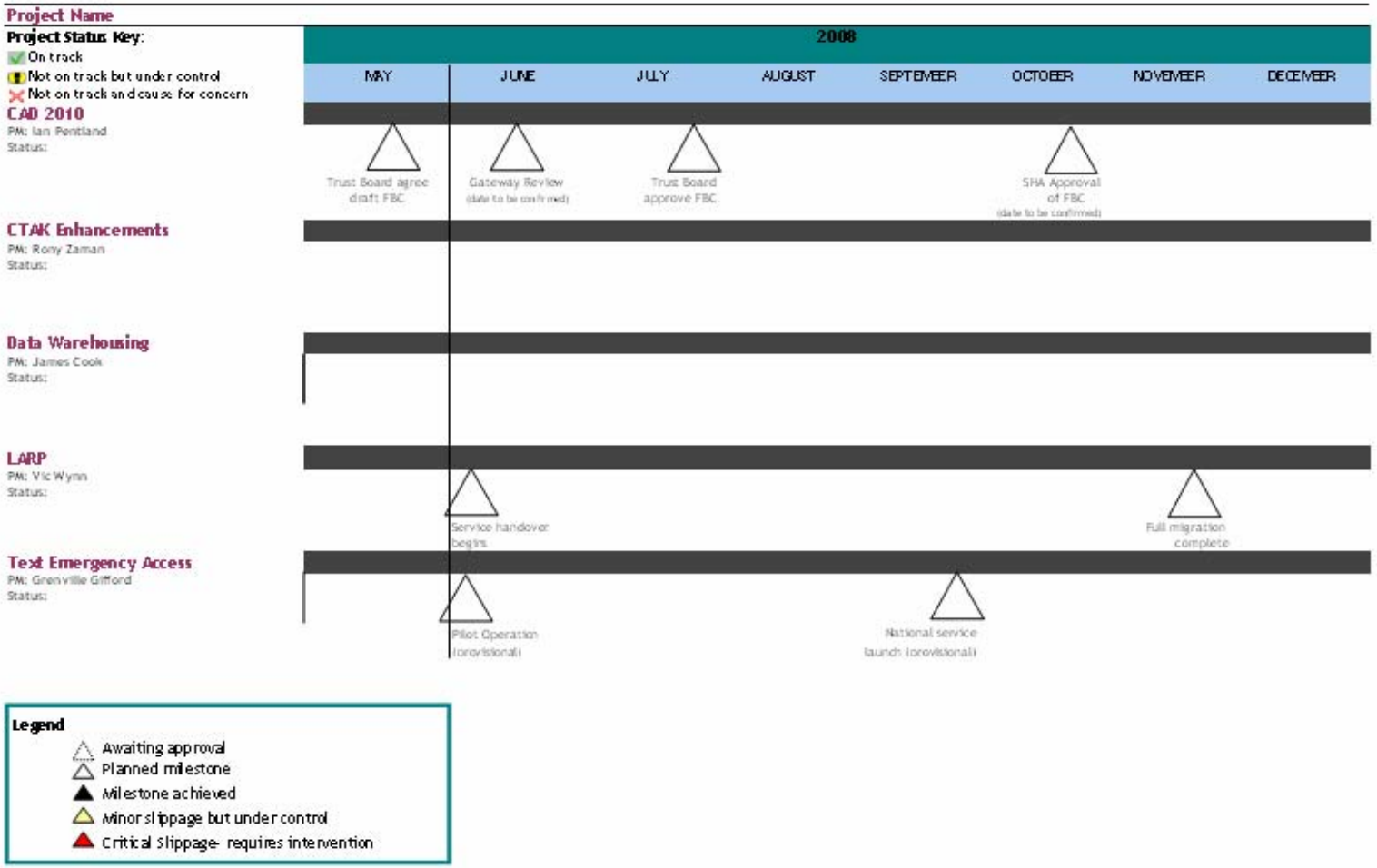
PTS System Upgrade
Project Manger: Robert Utchanah
The intension of this project is to upgrade the existing booking, billing and management reporting system used to support Patient Transport Services operations. The system was previously upgraded in 1999 to ensure Millennium date change compliance but is now obsolescent and unsupported by the software supplier.
Over and above this necessity the objectives of the project include a modern Windows environment, scaleable to meet PTS workload, improved remote access, reduced data keying errors, improved capability to transfer data to / from other corporate MI systems and compatibility with mobile data technology to allow further operational improvements.

TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)
Project Manager: Grenville Gifford
The objective is to provide the capability to respond to patients or their carers who have a speech or hearing impairment that prevents use of the normal '999' facility.
A method piloted by several U.K. police services is to use texting from mobile telephones and at present this would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.
Our intention is to adopt this solution for call taking and this 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



Access CfH Schedule Summary



OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Remove Hospital Administrative Handover
Project Manager: Steve Irving

Whilst accepting that a clinical handover must take placer for every patient that is conveyed, it is not necessarily an ambulance service function to provide a second administrative handover. In recent months it has become evident that their is wide spread support from operational ambulance staff within East London to the removal of the administrative handover at hospital. Coupled with increasing delays at some departments within the region it has become necessary for the ambulance service to withdraw from this process

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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.

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.

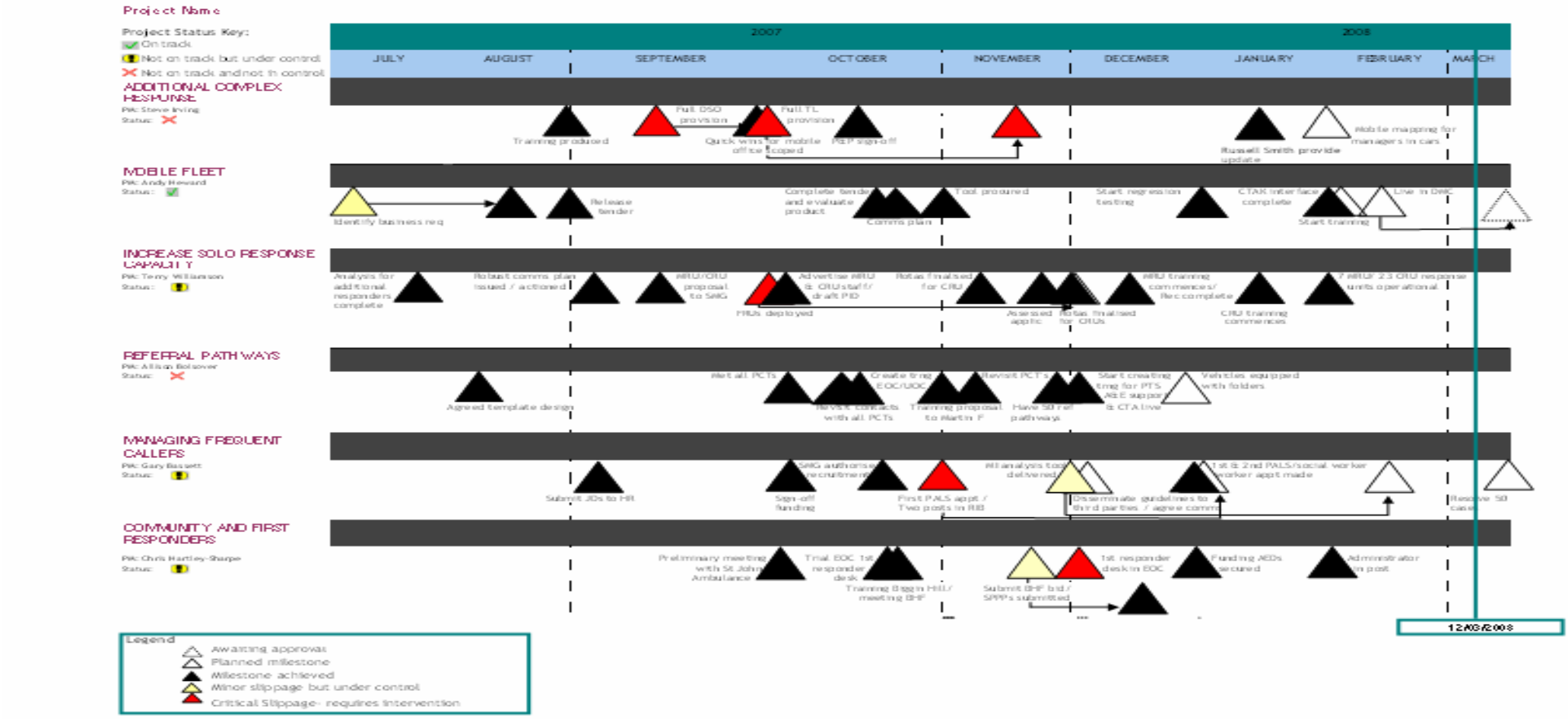
Re-Engineering Call Handling
Project Manager: Vicky Graham

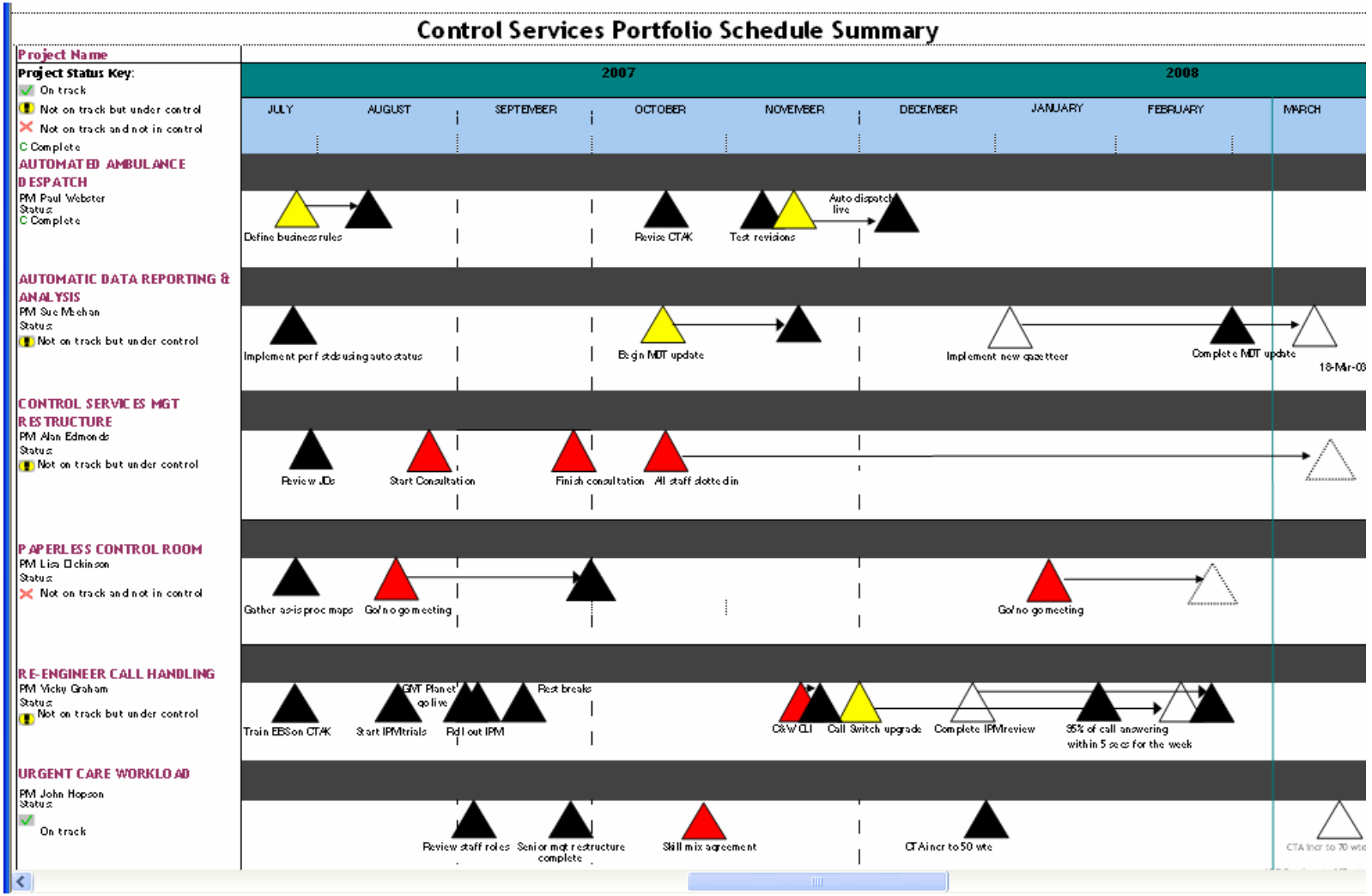
The aim of the project is to reduce call handling times to a predicable and acceptable period of time. This will include changes to consistently answer calls within 5 seconds, to capture Location and Brief Description within 50 seconds and complete the call within 2 minutes.
This will be achieved by adapting rosters and reviewing rest break arrangements to ensure that staff with the optimum skill mix is available to match the demands of call type and volume. Best practice will be established by identifying exemplary staff using IPM then replicating these practices and behaviours with all call takers.

Urgent Care Workload
Project Manager: John Hopson

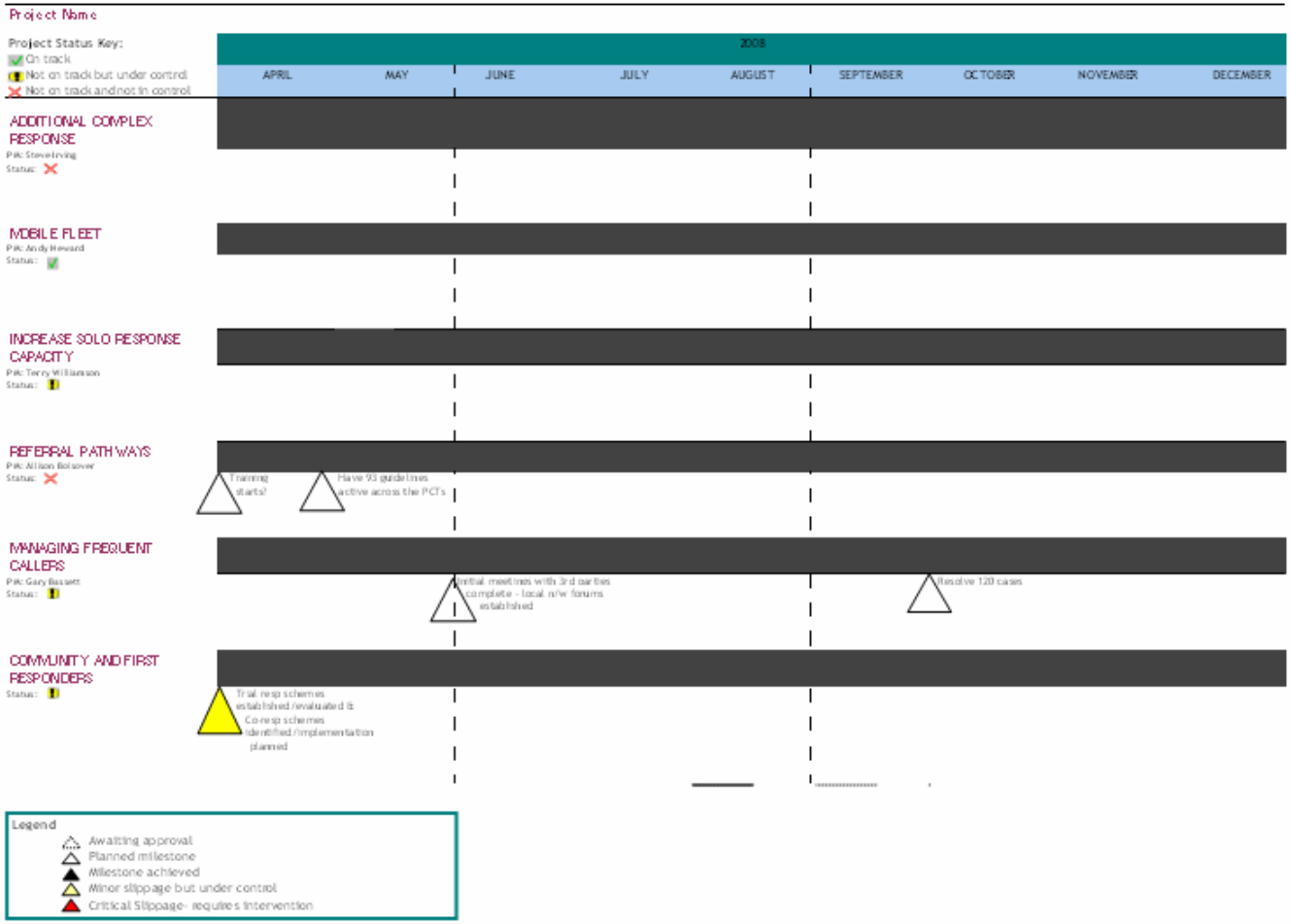
The aim of the project is to increase the role of Urgent Care Services to improved urgent care to patients and reduce the use of emergency care resources to meet these requirements.

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.


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2007
2008
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
ADDITIONAL COMPLEX RESPONSE
PM: Steve Irving
Status:
Training produced
Full DSO provision
Full TL provision
Quick wins for mobile office scoped
REP sign-off
Russell Smith provide update
Mobile mapping for managers in cars
MOBILE FLEET
PM: Andy Heward
Status:
Identify business req
Release tender
Complete tender and evaluate product
Tool procured
Comms plan
Start regression testing
CTAX interface complete
Start training
Live in DMC
INCREASE SOLO RESPONSE CAPABILITY
PM: Terry Williamson
Status:
Analysis for additional responders complete
Robust comms plan issued / actioned
RRU/CRU proposal to SMG
Advertise RRU & CRU staff / draft PID
RRUs deployed
Rotas finalised for CRU
Assessed applic
Rotas finalised for CRUs
RRU training commences / Rec complete
CRU training commences
7 RRU/ 23 CRU response units operational
REFERRAL PATHWAYS
PM: Allison Bolsover
Status:
Agreed template design
Met all PCTs
Revisit contracts with all PCTs
Create ring EOC/UOC
Training proposal to Martin F
Revisit PCTs
Have SD ref pathways
Start creating ring for PTS, REE support & CTA live
Vehicles equipped with folders
MANAGING FREQUENT CALLERS
PM: Gary Bassett
Status:
Submit JDs to HR
SMG authorise recruitment
Sign-off funding
First PALS appt / Two posts in RB
All analysis tools delivered
Disseminate guidelines to third parties / agree comms
1st & 2nd PALS/social worker appt made
Resolve SD case
COMMUNITY AND FIRST RESPONDERS
PM: Chris Hartley-Sharpe
Status:
Preliminary meeting with St John Ambulance
Trial EOC 1st responder desk
Training Biggin Hill / meeting BHF
Submit BHF bid / SPPPs submitted
1st responder desk in EOC
Funding AEDs secured
Administrator in post
12/03/2008
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

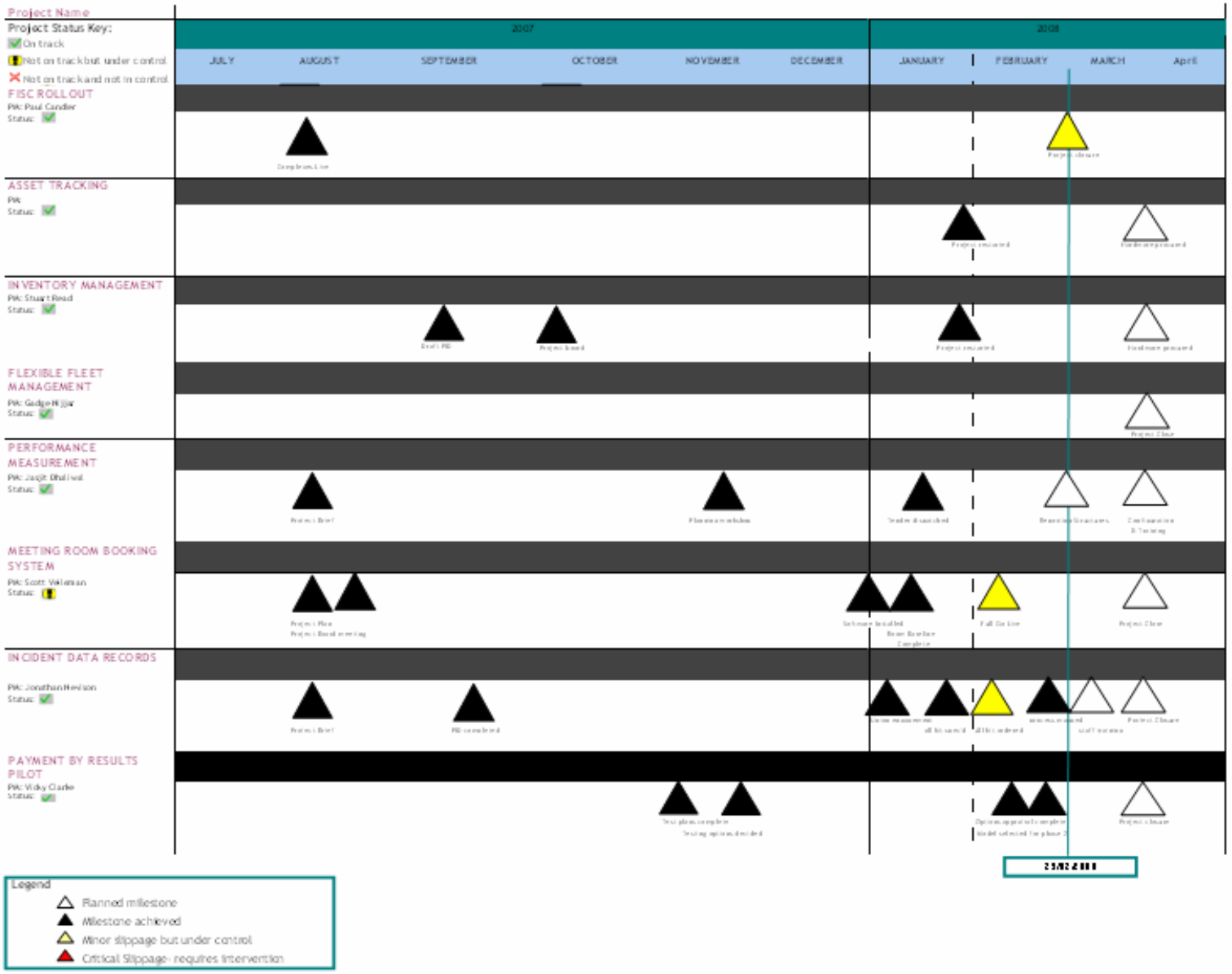

Control Services Portfolio Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
C Complete
2007
2008
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
AUTOMATED AMBULANCE DESPATCH
PM Paul Webster
Status:
C Complete
Define business rules
Revise CTAK
Test revisions
Auto dispatch live
AUTOMATIC DATA REPORTING & ANALYSIS
PM Sue Meehan
Status:
Not on track but under control
Implement perf stds using auto status
Begin MDT update
Implement new questteer
Complete MDT update
18-Mar-08
CONTROL SERVICES MGT RESTRUCTURE
PM Alan Edmonds
Status:
Not on track but under control
Review JDs
Start Consultation
Finish consultation
All staff slotted in
PAPERLESS CONTROL ROOM
PM Lisa Dickinson
Status:
Not on track and not in control
Gather as-is proc maps
Go/no go meeting
Go/no go meeting
RE-ENGINEER CALL HANDLING
PM Vicky Graham
Status:
Not on track but under control
Train EBSon CTAK
GMT Planet go live
Start IPMtrials
Rdl out IPM
Rest breaks
C&W CLI
Call Switch upgrade
Complete IPMtreview
95% of call answering within 5 secs for the week
URGENT CARE WORKLOAD
PM John Hopson
Status:
On track
Review staff roles
Senior mgt restructure complete
Skill mix agreement
CTA incr to 50 wte
CTA incr to 70 wte

Area Project Portfolio - Schedule Summary



Operational Model SSG Report 12/03/08

Corporate Processes Governance Project Portfolio Tranche 1 - 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.

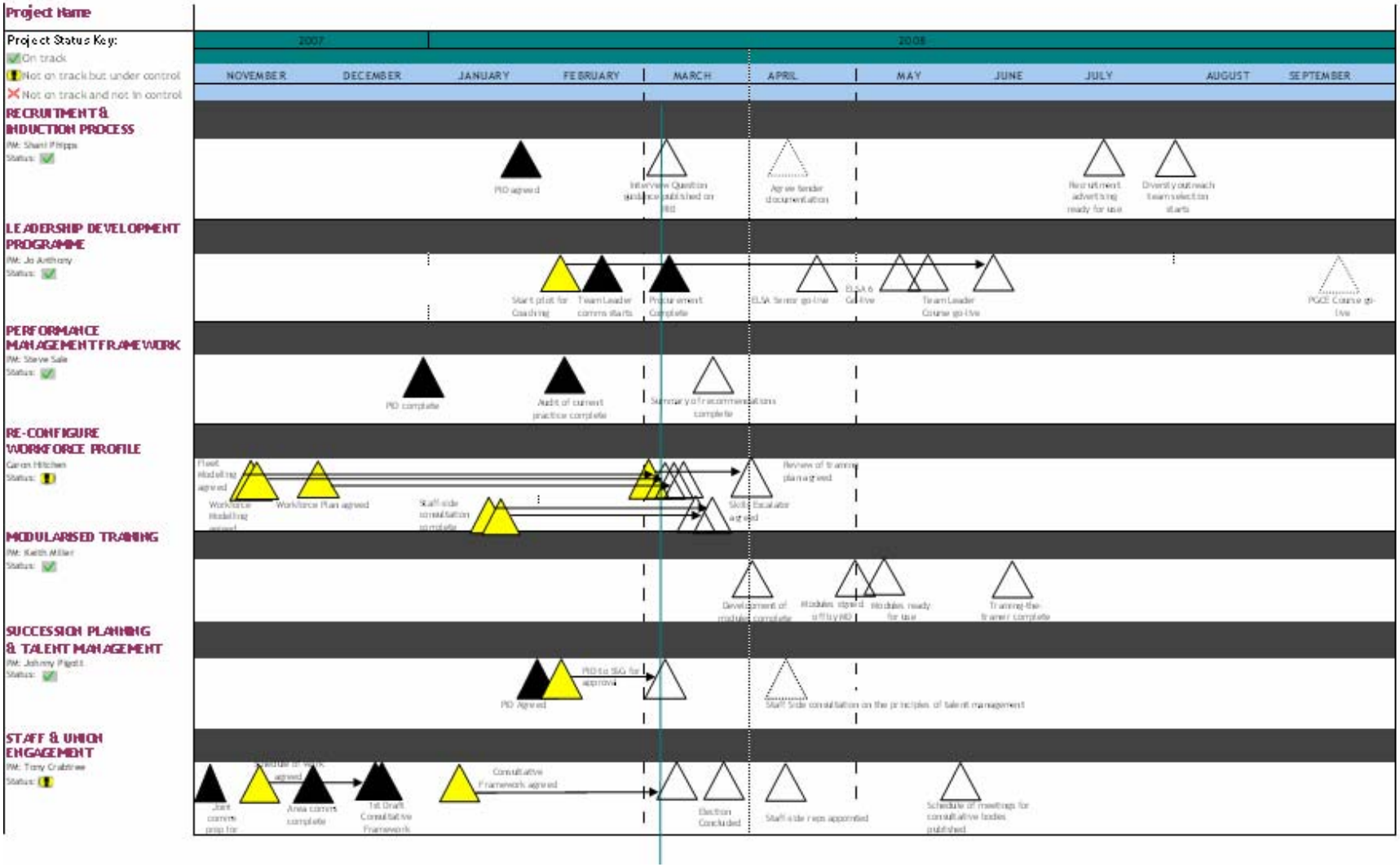
E-Learning
Project Manager: Johnny Pigott

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

Team Briefings
Project Manager: Alex Bass

The aim of this initiative is to explore the use of a team briefing system on complexes that would work around the new roster system. The system would be a face-to-face briefing from the senior manager to staff, to disseminate corporate information, discuss local issues, and feedback any issues centrally. The project will also address the introduction of a team briefing system for support staff.

OD and People Project Portfolio - Schedule Summary



OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE - TRANCH 1 PROGRESS REPORT

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.

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.

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.

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)

OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE - TRANCH 2 PROGRESS REPORT

Map all Processes
Project Manager: Martyn Salter

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

Staff Administration
Project Manager: Jonathan Nevison

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

Real-Time Fleet Management Information
Project Manager: Chris Miles

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.

PRF Handling and Processing
Project Manager: Jonathan Nevison

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

The Intelligent Trust
Project Manager: Stephen Moore

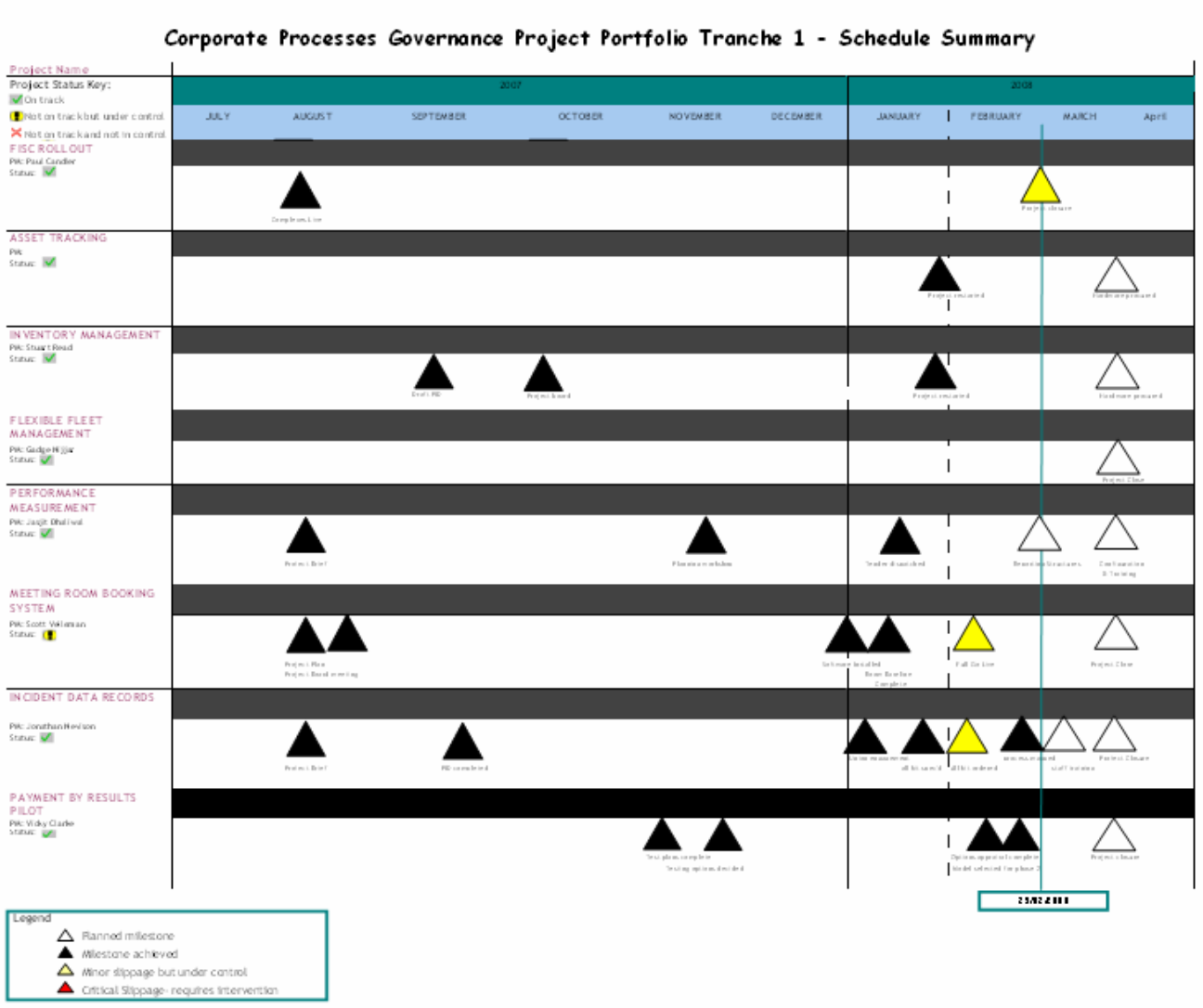
This project is on the programme waiting list. Initial discussions with IM&T indicate that they are planning/initiating a project to implement SharePoint. Olympic Team, under Peter Thorpe, have expressed an interest in acting as the pilot group, wishing to proceed as soon as possible.

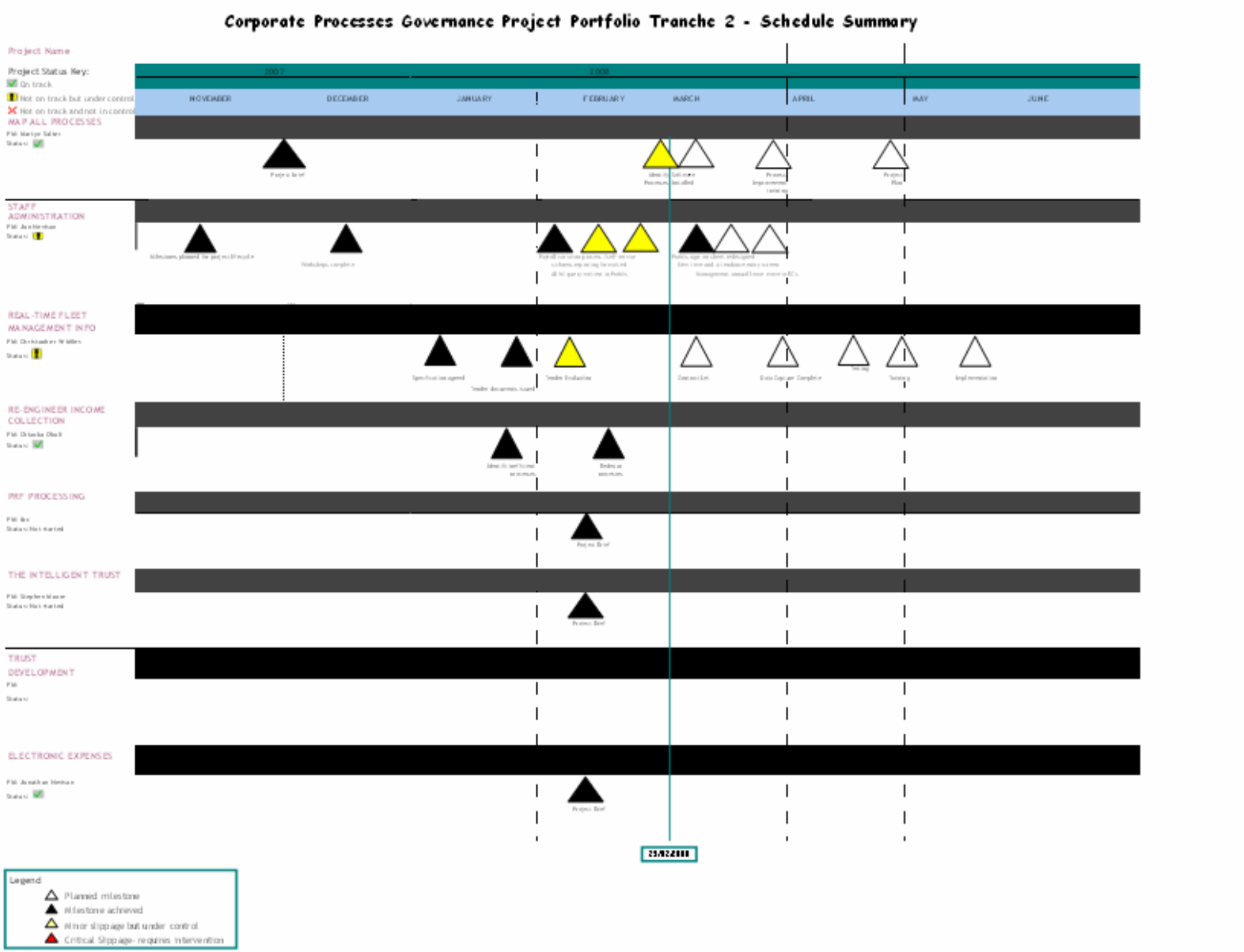
Trust Development
Project Manager:

Update and build on initial research carried out by Margaret Vander in 2007 and consider how to develop Public Involvement outside the FT Membership Process.

Electronic Expenses
Project Manager: Jonathan Nevison

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


Corporate Processes Governance Project Portfolio Tranche 1 - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2007
2008
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
April
FISC ROLLOUT
PM: Paul Candler
Status:
ASSET TRACKING
PM:
Status:
INVENTORY MANAGEMENT
PM: Stuart Read
Status:
FLEXIBLE FLEET MANAGEMENT
PM: Gadge Hijjar
Status:
PERFORMANCE MEASUREMENT
PM: Jasjit Dhaliwal
Status:
MEETING ROOM BOOKING SYSTEM
PM: Scott Velamson
Status:
INCIDENT DATA RECORDS
PM: Jonathan Revison
Status:
PAYMENT BY RESULTS PILOT
PM: Vicky Clarke
Status:
Legend
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention


Corporate Processes Governance Project Portfolio Tranche 2 - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2007
2008
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
MAP ALL PROCESSES
STAFF ADMINISTRATION
REAL-TIME FLEET MANAGEMENT INFO
RE-ENGINEER INCOME COLLECTION
PRF PROCESSING
THE INTELLIGENT TRUST
TRUST DEVELOPMENT
ELECTRONIC EXPENSES
25/02/2008
Legend
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

OVERVIEW OF OLYMPIC PROGRAMME PROJECTS: *to be completed once project initiation documentation signed off*

T1P1: Operations
Project Executive: Jason Killens; Project Manager: Gareth Hughes
The aim of this project is to model the human and non-human requirements for the Games, and identify an approach for command and control. The project is intended to ensure a comprehensive understanding of requirements/assets needed with regards to vehicles/equipment and staff.

T1P2: Communications
Project Executive: Peter Thorpe; Project Manager: Tim Edmonds
This project is intended to finalise the development of the Olympic Programme approach to communications, and knowledge transfer. Its objective is to ensure staff, public, media, and key stakeholders are aware of the role the Service will play during the 2012 Games.

T1P3: Mutual Aid and Volunteers
Project Executive: Peter Thorpe; Project Manager: Steve Irving
This project is intended to identify current partnership agreements and produce a framework for mutual aid/volunteers. One objective of the project is to develop a partnership agreement legacy that will enhance patient care beyond 2012 and contribute to the transfer of knowledge.

T1P4: Clinical Skills Acquisition/Training
Project Manager: Jenny Palmer; Senior Supplier: Keith Miller
This project is intended to identify the training requirements for Games time, and produce and approve a draft timetable, the implementation of which will equip the LAS with the skills to deliver a high level of service throughout the Games. The project is intended to provide a clear awareness of how the requirements for the Olympic Programme will be assimilated into the LAS training programme.

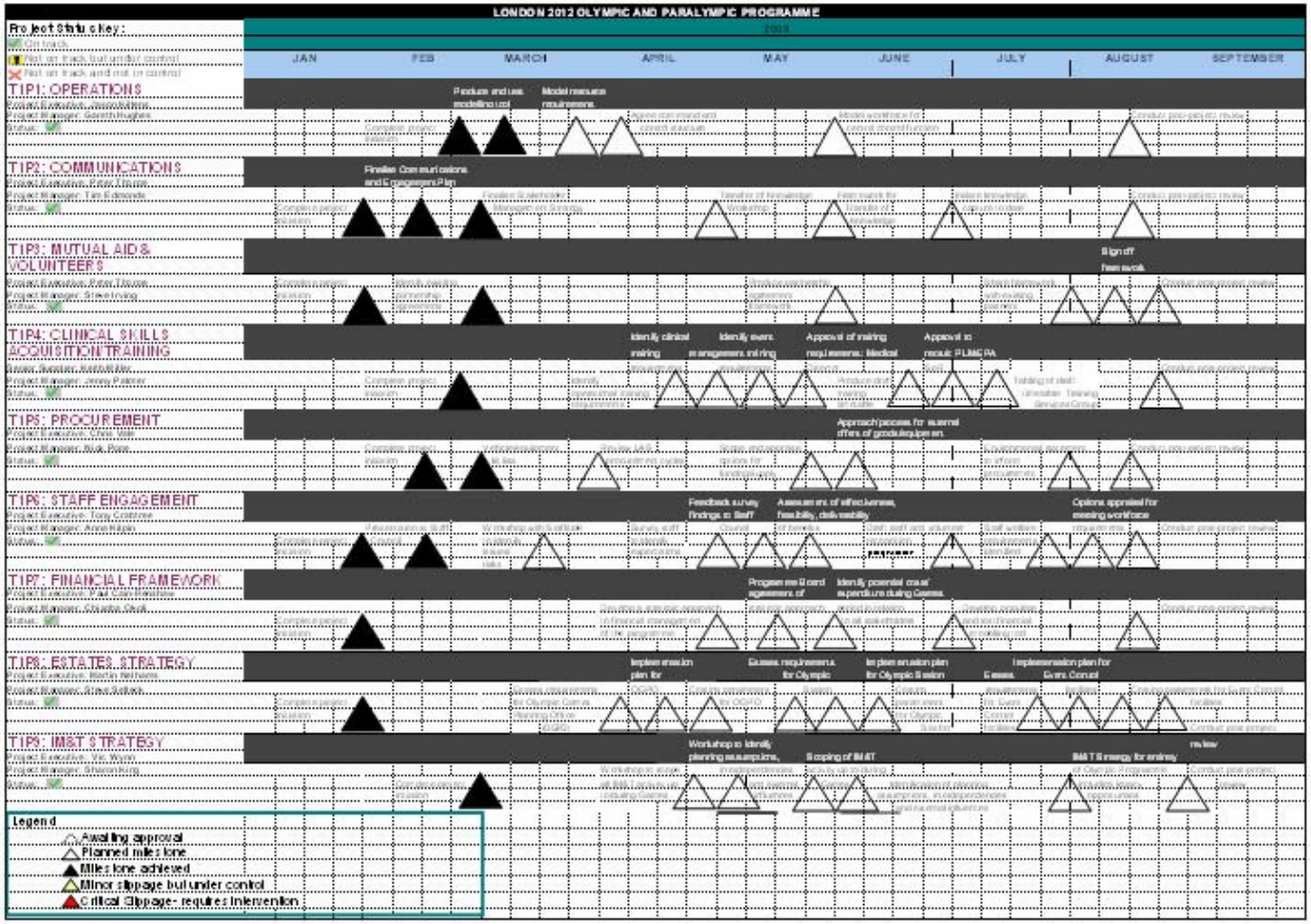
T1P5: Procurement: Vehicles and Equipment
Project Executive: Chris Vale; Project Manager: Nick Pope
This project will consist of the identification of Olympic procurement requirements (and how these fit within LAS procurement cycles) and an approach towards offers of goods/equipment from external organisations. An approach to maintaining awareness of environmental issues/'green' options relating to vehicles and equipment throughout the duration of Olympics Programme will be determined.

T1P6: Staff Engagement
Project Executive: Tony Crabtree; Project Manager: Anna Kilpin
This project will identify an approach to staff engagement which will subsequently underpin the Olympics Programme. The project will consist of the identification of any barriers, an understanding of staff expectations, what incentivisation may be required, and an identified approach to staff benefits.

T1P7: Financial Framework
Project Executive: Paul Cain-Renshaw; Project Manager: Chizoba Okoli
The objective of this project is to ensure that the Olympics Programme has adequate financial controls and management in place to successfully deliver the programme on time and within budget. The project will consist of the development of a strategic and operational approach to financial management at programme-level.

T1P8: Estates Strategy
Project Executive: Martin Nelhams; Project Manager: Steve Sellek
This project will identify estates requirements for the Olympics Programme, the development of implementation plans, and identification of cost parameters. The focus will specifically be on the Olympic Games Planning Office, an 'Olympic Station' and a central control function.

T1P9: IM&T Strategy
Project Executive: Vic Wynn; Project Manager: Sharon King
This project will consist of the identification of a strategic approach to IM&T for the duration of the Olympic Programme. Planning assumptions, interdependencies and external influences will be identified and the potential for realising legacy benefits will be explored.


LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME
Project Status key:
On track
Not on track but under control
Not on track and not in control
2009
JAN
FEB
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
TIP1: OPERATIONS
Produce and use modelling tool
Model resource requirements
TIP2: COMMUNICATIONS
Finalise Communications and Engagement Plan
TIP3: MUTUAL AID & VOLUNTEERS
Sign off framework
TIP4: CLINICAL SKILLS ACQUISITION/TRAINING
Identify clinical training
Identify event arrangements training
Appraisal of training requirements: Medical
Appraisal to recruit: PTLM/CPA
TIP5: PROCUREMENT
Approach process for external offers of goods/equipment
TIP6: STAFF ENGAGEMENT
Feedback survey findings to Staff
Assessment of effectiveness, feasibility, deliverability
Options appraised for meeting workforce
TIP7: FINANCIAL FRAMEWORK
Progress Mutual agreements of
Identify potential cost expenditure during Games
TIP8: ESTATES STRATEGY
Implementation plan for
Assess requirements for Olympic
Implementation plan for Olympic Division
Implementation plan for Games Consult
TIP9: IM&T STRATEGY
Workshop to identify planning assumptions,
Scoping of IM&T
IM&T Synergy for entirety
review
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires Intervention

Enclosure 13

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 4th February 2008

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

3. **Agreed:**

The *Procedure for Transportation of Patients to Hospital;* following some minor amendments and clarification this will be presented to the Trust Board in March for ratification.

The revised *Latex Policy,* which was updated to include current good practice and usage of nitrile disposable medical examination gloves.

Noted:

The Medical Directorate's update, which included the work being undertaken both internally and on a pan London basis in respect of Safeguarding Children and Vulnerable Adults. A training DVD is being jointly produced with the Metropolitan Police Service concerning the management of people who are in custody who may have medical or drug related issues.

That following the introduction of the lost property bags trust wide in February 2008, the Committee will receive the findings of an evaluation to be undertaken in April.

Risk management training: work would be undertaken to ensure the Trust had a pool of managers trained in undertaking root cause analysis

The findings of the Infection Control Audit were considered, these would provide a benchmark for quarterly audits being undertaken in 2008.

Area Governance report: the Acting ADO West and his staff officer presented the governance report for that Area, which included an update on complaints, incidents, training and completion of PDR. NB: there had been a fall in complaints regarding attitude and behaviour and the Area had exceeded the target for staff receiving feedback (target 136 actual 265)

Update re. New Ways of Working, Bill O'Neill said that expressions of interest had been called for from complexes interested in becoming the three exemplar sites for the NWoW, with a decision being made in April 08 and roll-out in September 08.

Exceptions report against the HCC Standards; the Head of Governance reported the progress being made in collating evidence to demonstrate compliance with the HCC standards. The Trust's compliance will be reported as part of the Assurance Framework, and presented to the Trust Board in March 08.

Progress report re. the PRF completion and transportation audit. Although there were concerns regarding the undertaking of the audit, the Internal Auditors' recommendations would be implemented as part of the Corporate Processes & Governance Programme.

The themed risk report regarding non-conveyance which included analysis concerning incident reporting, claims and inquests and PALS and complaints. (for details see RCAG agenda item 11).

Minutes/oral reports received from:

Infection Control Group (13th December 07); Update from the SfBH (22nd January 07); Training Services Group (9th January 2008).

Recommendation: THAT the Trust Board NOTE the minutes of the Clinical Governance Committee, 4th February 2008.

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee (Core)
9.30am, 4th February 2007, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director
David Jervis	Director of Communications
Russell Smith	Deputy Director of Operations
John Wilkins	Head of Governance
Jon Knott	A/Assistant Director of Operations, West
Stephen Moore	Head of Records Management & Business Continuity
Pat Billups	Education Standards Manager (for Keith Miller)
Sajjad Iqbal	Diversity Manager
Gary Bassett	PALS/Complaints Manager
John Selby	Senior Health & Safety Adviser (from 10.30)
Chris Vale	Head of Operational Support
Malcolm Alexander	Chairman, LAS Patients' Forum
Nic Lawrance	Head of Policy, Evaluation and Development.
Christine McMahon	Trust Secretary (minutes)

In attendance:

David Court	Staff Officer, A/ADO, West

Apologies

Sarah Waller	Non-Executive Director
Ingrid Prescod	Non-Executive Director
Kathy Jones	Director of Service Development
Nicola Foad	Head of Legal Services
Paul Tattam	Ambulance Operations Manager - D Watch

01/08 Minutes of the Clinical Governance meeting held on Monday 4th February 2008

Agreed **The minutes of the Clinical Governance Committee meeting held 4th February 2008 with the amendment to minute 85.3 to read that technicians and paramedics were authorised to undertake the placement of LMAs ….**

02/08 Matters Arising

Noted: *Minute 59/07:* lost property bags will be issued after London's Acute Trusts have been informed of their planned introduction. The findings of a three month evaluation would be presented to the Committee in June 2008. ACTION: PALS Manager

Minute 59/07: the Deputy Director of Operations said that the training pack received from NHS Direct has not yet been introduced. Work around the ethnicity question in call taking was being undertaken by a national group and it has been agreed to delay its implementation until that Group finalised its review. There is an expectation that the pack will be introduced 1st March 2008. ACTION: Deputy Director of Operations.

Minute 59/07: following discussion of how the Service could be sure that the monthly Clinical Newsletter was read, it was suggested that Station Administrators be tasked with printing off copies and placing them on station's information boards. It was also suggested that it would be useful for a snapshot audit be undertaken to gauge access to clinical updates; this would be considered when the GDU had additional resources in place to undertake the audit.

Minute 59/07: the Consultant Midwife is attending the Committee's meeting in April to provide an update on developments in the management of obstetrics.

Minute 62/07: the Diversity Manager said that the work in relation to equality impact assessment was on-going. Discussions were being held on the delivery of diversity training to the Trust Board.

Minute 67/07: the level of rest break allocation has been disappointing. The Deputy Director of Operations said that discussions were being held with Staff Side on introducing changes to how rest breaks are allocated. It was recognised that from a clinical governance perspective it was highly

desirable that staff working 12 hour shifts receive a rest break. Efforts were on-going to change the systems in place in EOC to improve allocation.

Minute 67/07: The *Control Services Bulletin* for January was circulated for information with the Committee's papers and was commended by the Committee's Chairman.

Minute 73/07: the Deputy Director of Operations said that the breaking an entry procedure had not yet been issued as legal advice had been received which cast doubt on the Trust's legal position should staff break an entry a property without implied licence from caller or were able to see the injured person. **ACTION: Deputy Director of Operations to present a final version of the procedure to the Committee in April 2008.**

Post meeting note: the cost of claims paid in connection with breaking an entry since March 2007: £5,833.

Minute 78/07: The Head of Records Management will liaise with Safety & Risk Manager to ensure that the next issue of PRFs include a tick box regarding LA52s. **ACTION: Head of Records Management & Business Continuity**

Minute 78/07: The PALS/Complaints Manager would present a briefing paper concerning the re-triaging of ETA calls and ringing back to the Committee in April which will reflect the impact of the recently introduced administrative processes introduced to address the issue. **ACTION: PALS Manager.**

The Medical Director said that though it was unfortunate, it reflected the increase in demand the Service has responded to over the Autumn and Winter period.

Minute 79/07: the Deputy Director of Operations said a meeting was held and a number of actions agreed to address the issue of CARU not receiving data card downloads. One of the actions included using the Invest to Save funding to purchase data cards and additional readers for distribution across the Service.

03/08 Medical Directorate Update

The Medical Director reported that:

Safeguarding Children & Vulnerable Adults (SCVA) Strategy Group recently held its first meeting which was chaired by the PALS/Complaints Manager. The Medical Director is the Trust's lead for safeguarding children.

NHS London has issued a Framework which is being used as an audit tool in relation to SCVA; this is being co-ordinated by the PALS/Complaints Manager. An audit is being undertaken of all London NHS Trusts; PCTs and Local Authorities to ascertain what measures were in place in relation to SCVA. The framework has been primarily designed for use by PCTs and Acute Trusts rather than ambulance services and there has been difficulty in meeting the expected criteria. The LAS has agreed to work closely with the DH/SHA lead and the Safeguarding Children Pan London lead. Resourcing has also been provisionally agreed to enable improved administration of children and vulnerable adult referrals.

The PALS/Complaints Manager said that work was being undertaken to ensure that the ambulance service was represented at local meetings; this was likely to be undertaken by local AOMS rather than the Medical Director.

NICE issued updated guidance regarding Head Injuries in September; this has been reviewed and will be used to strengthen the JRCALC guidelines relating to initial assessment and management of pre-hospital trauma and spine immobilisation. The Medical Director said that front line crews were reminded that head injuries should be taken directly to centres with neurosurgery capability.

NICE is currently undertaking consultation in relation to management of Stroke and the Trust does not need to take any action. A Medical Director's Bulletin will be issued reminding staff as to appropriate treatment.

The Committee discussed the Air Ambulances; work is taking place on drafting a national charter on the usage of air ambulances which is expected to be issued April 2008. The Medical Director is the lead for the clinical governance work stream. Currently there were different arrangements in place across the country. The Helicopter Ambulance Services were not part of the NHS but were funded by charitable funds and there were different arrangements in place nationally as to whether the charities ran the Helicopter service or simply funded it. Air ambulances were despatched by the Ambulance Services' control rooms. Some ambulance services were able to call upon 3-4 air ambulances; London has one air ambulance and a HEMS car which operates at night.

The PALS/Complaints Manager said that there was as yet no formal agreement between HEMS and LAS concerning exchanges of PRFs. The Medical Director did not feel this was a major issue but suggested this be raised when Anne Weaver attends the Committee's meeting in April. The Medical Director said that HEMS uses a running sheet plus a complete database that was singularly more detailed than the information recorded on the PRF.

A training DVD is being produced in partnership with MPS concerning police custody and under influence of drink/drugs or pre existing medical condition which puts custodians at risk.

Noted: **That Anne Weaver will be attending the Clinical Governance Committee's meeting in April for a discussion of joint clinical governance HEMS/LAS.**

04/08 Infection Control Update

The Head of Governance presented the findings of the infection control audit undertaken in late December/early January on a trust wide basis including FRUs and PTS vehicles. The findings provided a baseline against which future quarterly audits would be measured. The Clinical Governance Committee and the Trust Board would receive regular updates as to the assurance systems in place regarding infection control during the course of 2008.

The Deputy Director of Operations said that it had been recognised that there was some overlap with the quarterly premises health and safety audit undertaken and consideration would be given to combining the two audits. Following the infection control audit, a number of quick wins were identified which could be speedily implemented.

In response to a question from the Chairman of the LAS Patients' Forum the Deputy Director of Operations said that there was a very low risk of cross infection taking place in ambulances as crews change the blankets as/when necessary. There was an ongoing issue with having sufficient supply of blankets and pillows; the Head of Operational Support said that the Trust had tried to identify disposable blankets but samples had proved unsuitable.

Noted:

1. **That the Infection Control Audit Tool used would be revised with operational input to ensure it is fully relevant to the LAS station and vehicle environments.**
2. **The varying levels of compliance reported by the ambulance stations;**
3. **That a MRSA audit was being undertaken by CARU.**
4. **That use of intravenous lines has been identified as an area of concern in terms of potential infection control; the LAS will introduce a canuale label to enable hospitals identify patients who have been canulated pre hospital. ACTION: the Head of Operational Support to confirm when the canmulas will be available.**
5. **That the Trust is endeavouring to recruit an Infection Control Manager.**

05/08 **Area Governance Report – West**

Jon Knott, Acting Assistant Director of Operations, West highlighted the following from the presented area governance report:

- Incident statistics for quarter 3 to date show a 25% reduction against the previous quarter. This included a 45% in non physical abuse reporting and 55% in reported cases of physical violence against staff.
- It has been identified that there needs to be collation of incidents at area level as well as on the main datex system to ensure that they are regularly reviewed as part of the Health & Safety meetings. The Head of Governance said that the Trust would be introducing web based systems for capturing data and analysing trends across the organisation.
- Clinical Performance Indicators (CPI) compliance and staff feedback continue to remain the central focus for recognition of clinical practice and patient care. The target of 136 staff receiving feedback was exceeded with 265 members of staff receiving feedback in the quarter 3. The key aspects of care figures for November reflect concern around documentation in initial and final peak flow recording and midwifery details. It was evident that the statistics for non-conveyance, that while the rate of completion of final observations and documented advice is high at 85%, remembering to leave the PRF, or record the leaving of the PRF on scene is low at 67%. Compliance to 95% as a standard requirement for the Paramedic Pre Entry Assessment is seen as a positive driver and a number of complexes have conducted PRF workshops sessions to assist in driving up standards.
- Complaints: current percentage for complaints closure against the 25 day timeline remains 92% for the year. To date the West Area has received 74 complaints, the main causes of these were non-physical abuse (45); treatment (14) and road handling (9).
- Road Traffic Accidents (RTA) for the Service in July-October was 57% with some areas remaining high e.g. Camden and St Johns Wood 71%. It was reported that following two accidents within a short period of time a member of staff was taken off driving duties and informal disciplinary action taken to mitigate any further incidents and the requirement for a driving assessment.
- Personal Development Reviews (PDRs) have been undertaken for the majority of staff except for those who are long term sick.
- Clinical Development: the report detailed the training that had been undertaken in e.g. Hanwell Managers received ALS module; 12 lead refresher; end of year study days; maternity reviews; individual refresher sessions as required. The Medical Director said that work was being undertaken to capture all the training that is undertaken across the Trust.
- Paramedic registration: all Paramedics in the West Area have been successfully registered with HPC; records were kept locally and copies of registration documentation in their PDR portfolio.
- Driving licence checks were undertaken as part of the PDR review; to date 96% of staff have had their licence checked in accordance with service policy.
- Clinical trials: the details of three trials were outlined. These included the trialling of a new disposable airway adjunct; a rapid method of providing infusion in Trauma and Cardiac Arrest patients and the rapid cooling of patients who have been successfully resuscitated.
- Frequent callers were being managed locally with all complexes having a named lead in place that is responsible for reviewing addresses on the High Risk register over 12 months. Local leads are working with PALS to ensure adequate support packages are provided to patients via social services and local mental health teams.
- Defib Data Cards: an audit was recently undertaken across the area and a number of issues were identified and highlighted the need for a radical review corporately. In addition, it was revealed that there was a problem with the submission of ECG strips which are below 10% Pan London average. It was noted that some of the Invest to Save funding would be used to purchase additional data cards and readers. David Court (aide

to A/ADO, West) suggested that the PRF form include a box reminding crews re. ECG strip as an aide memoir. **ACTION: Head of Records Management & Business Continuity**

The Medical Director said that the problem in respect of the ECG strip and data cards not being submitted to CARU is a serious issue. It was recognised that the process needed to be revised so as to make it easier for staff and improve compliance.

The Chairman was assured that A&E support crews were treated as regular members of staff on complexes.

06/08 **Approval of procedure for transportation of patients to hospital**

Stephen Moore, Head of Record Management, presented the procedure for *the transportation of patients to hospital*. Following discussions with the Metropolitan Police Service (MPS), it has been agreed that the overarching agreement between the two organisations for the transportation of patients would be supported by each organisation having its own independent procedure in regard to the matter. This is in recognition that the MPS are expected to take some time to agree a procedure and this is a matter the LAS would like to implement guidance for its staff as soon as possible.

Following discussion of the procedure Nic Lawrance undertook to confirm that 1.7/1.8 reference to the Mental Health Act was correct in regard to the use of an Approved Social Worker/Doctor attending a patient for assessment/treatment and being able to assess a patient in their own home. **ACTION: Nic Lawrance**

It was recognised that in the majority of cases the transportation of patients would be in an ambulance and that only in exceptional circumstances other modes of transport would be necessary.

It was reported that the Head of Legal Services was working closely with the MPS to ensure that their procedure will be in accord with the LAS' procedure.

The Head of Governance said as the procedure was quite lengthy it would be useful to have a summary document outlining the main points of the procedure. Following discussion it was recognised that dissemination of the new procedure would be best served by face:face discussions by front line crews and team leaders rather than solely relying on the Pulse/RIB/LAS News. The establishment of a Clinical Support Desk in EOC will also be a resource for crews to call upon as/when necessary.

Agreed **To approve the procedure for the transportation of patients; this will be presented to the Trust Board in March 2008 for ratification.**

07/08 **Approval of Latex Policy**

The Head of Records Management presented the revised *Latex Policy* which reflected good practice and introduced the use of nitrile gloves which were now universally issued.

In response to a question from the Chairman of the Patients' Forum the PALS Manager said that the Trust has worked closely with special interest groups such as the Latex Sufferers Self Help Group and set up specific patient protocols as/when necessary. The Medical Director said that it is impossible to be able to guarantee a latex free environment but the Trust has endeavoured to meet patients' needs as much as possible.

08/08 **Risk Management Training – update re. root cause analysis training**

The Safety and Risk Adviser said that following the NPSA Clinical Lead's attendance at the Committee's meeting a training session regarding root cause analysis was attended by 14 managers, including three AOMs. The session went quite well, with good feedback being received. Two further courses are planned but no date as yet being confirmed.

The Committee discussed the optimum way of ensuring that sufficient managers were trained in root cause analysis, with one option having an associated cost of £6/7,000.00. Reservations were expressed by members of the Committee, including the Medical Director, as in the past such training had been undertaken only for the managers not to be called upon with the result that the skill atrophied. It was recognised that there was funding available this financial year for such training and a decision needed to be made as quickly as possible if the training was going to be undertaken this financial year. The Head of Governance suggested that he meet with the Health & Safety Adviser and the PALS Manager to discuss the best way forward. **ACTION: Head of Governance**

09/08 **Update re. New Ways of Working (NWoW)**

Bill O'Neill, Assistant Director Organisational Development, (AD OD) who is closely involved with NWoW, said that information had recently been published on the PULSE explaining the initiative and calling for complexes to come forward to be one of the three exemplar sites.

The deadline for expressions of interest is the 29th February; with a decision being made in March with full implementation in September 08. A number of critical success factors that need to be achieved by September have been identified and, if necessary, that deadline will slip. Once the three exemplar sites have been identified work would take place to ensure that they were able to meet the critical success criteria, including requirements for staffing, training etc

The document, copies of which were circulated at the meeting, was essentially an aspirational document and it was recognised that it would be subject to change over the next year. The AD, OD said that he had had a number of discussions with staff at all levels in the organisation and he believed there was commitment to implementing NWoW.

In response to a question from the Chairman of the Patients Forum the AD, OD said that the NWoW had arisen from the stakeholder discussion held in developing the Service Improvement Programme 2012, the aim of which is to improve patient care and staff satisfaction.

The Medical Director said that she expected there to be a discernable improvement in outcome measurement such as complaints, CPI, feedback, problematic inquests and feedback to PALS.

10/08 **Exceptions report against the HCC Standards for which evidence of compliance is still being collated.**

The Head of Governance presented the progress to date in obtaining evidence of compliance against the HCC. This would form part of the Assurance Framework scheduled to be presented to the Trust Board in March. The Standards for Better Health Group meets regularly to review the level of compliance.

Noted:

1. **That the Medical Director should replace the Director of Communications as the lead on child protection issues with the PALS/Complaints Manager having managerial responsibility**
2. **That in regard to standard C13(b) – access to 'language line on scene' responsibility for this should lie with EOC rather than PALS/Complaints Manager.**
3. **That the Trust is holding an event on 13th March at which evidence of compliance with the HCC Standards will be presented to representatives from the 32 London Borough's Oversight and Scrutiny Committees; NHS London and the Patients' Forum**

11/08 **Progress report re. the PRF completion and transportation audit**

The Head of Records Management said that an audit had been undertaken by Bentley Jenison into PRF completion and transportation. Although there were concerns expressed on how the

audit was undertaken, the recommendations from the audit were accepted and would be implemented as part of the Corporate Processes and Governance Programme.

It was recognised that the PRF documentation was a crucial piece of information as it was the only record of patient contact. The issues highlighted by the audit would be addressed, in particular the need to ensure that PRFs undertaken at the weekend were properly managed. It was suggested that as part of the NWoW a review of the administrative processes on the local stations would be undertaken.

12/08 Themed risk report: non-conveyance

Non-conveyance represents a risk for the Trust. A review was undertaken, looking specifically at incident reporting (2007), claims and inquests (2003-07) and PALS and Complaints (16 PALS cases and 36 Complaints).

The Health & Safety Adviser said that there had been 8 incidents identified from submitted LA52s. The underlying causes were faulty vehicles (2); transportation of patients by FRUs (2) and patient own transport (2) and there were two incidents that involved a RTA whilst transporting patients. All the incidents were graded as either 'green' or 'yellow' with 4 of the green graded incidents were investigated locally or using the support staff. There is no evidence that patients' condition deteriorated or affected clinically.

Claims & incidents: the report was considered but not discussed. The issues will be followed up at the next meeting when the Committee will consider its regular Risk Information Report.

PALS/Complaints: the PALS/Complaints Manager reviewed the 54 enquires/complaints received in 2007 that were concerned with non-conveyance. There were a number of incidents that involved triaging by CTA/UOC which highlighted the need for quality assurance of calls in UOC.

The Chairman said that she had recently sat in UOC and listened in on calls. She observed that call takers were expected to follow the laid down defined algorithms (AMPDS/PSIAM).

13/08 Reports from Groups/Committees

1 *Infection Control Group, 13th December 2007*

The Head of Governance said that the Infection Control Group had felt limited by absence of Operational Colleagues at key meetings to discuss the clinical aspects of infection control.

An away day was held to review progress against the Code of Hygiene and the Core standards of the Annual Health Check, in particular C1A. The Trust is endeavouring to recruit an Infection
Control Manager. It has been agreed that responsibility for infection control at local level lies with the AOMs.

2 *Update from SfBH Group,*

The Committee received the notes from the SfBH Group meeting held on 22nd January which included details concerning the evidence of compliance being put forward for each of the Standards at that point.

2 *Complaints Panel*

The Medical Director said the Complaints Panel had discussed Managers' complaints and outcome reports; the restructuring of Complaints and PALS management; the agreement with the MPS regarding primary at scene. The Panel is reviewing its terms of reference with the intention of revitalising the group with a smaller membership.

3 *Training Services Group – 9th January 2007*

The Medical Director said that work was on-going to ensure that informal and formal complex-based training activity was recorded in the monthly statistics; it had noted that progress was being made in the restructure of the education and development department; that further modules were being developed (ECG course; obstetrics; mental health and diversity). Work was taking place to update the ECP educational pack to make it shorter and more structured. The implications of the revised national curriculum were being considered.

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 Race Equality Strategy Group is to be reconstituted**
3. **That the Clinical Steering Group is meeting on the 11th February and will consider whether it wishes to meet as a virtual group in the future. This will enable the Trust to retain the expert clinical guidance without the need to hold bi-annually.**

14/08 Draft 2008 Forward Planner

Noted:

1. **The draft 2008 forward planner.**
2. **That the Committee will receive the findings of the quarterly infection control audit and an evaluation of lost property bags in June 2008.**

15/08 Dates of next meeting:

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

Core: Monday, 2nd June 2008, at 9.30am in the Conference Room, HQ

Meeting concluded at 12.45

Enclosure 14

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 26th February 2008 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 (until 13.10)
	Roy Griffins	Non Executive
	Ingrid Prescod	Non Executive
In attendance:	Caron Hitchen	Director of Human Resources & Organisation Development Director of Finance
	Mike Dinan Martin Flaherty	Director of Operations
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology (until 1pm)
	Kathy Jones	Director of Service Development
	Christine McMahon	Trust Secretary
Apologies:	Fionna Moore	Medical Director

01/08 Minutes of the last meeting of the Service Development Committee, held on 18th December 2007.

The Chairman **signed** the Minutes as a correct record of the meeting held on 18th December 2007.

Matters Arising

Minute 43/07: the IM&T Director said that it is not currently possible to provide (near) real time mapping updates to the LAS Mobile Data Terminal (MDT) System such as were currently available via Tom Tom satellite navigation systems. He was reluctant to introduce additional changes that would need to interface with CAD 2010 since each such additional interface would introduce a further degree of complexity and risk but proposed that the issue be reviewed following successful completion of CAD 2010. The Chairman asked whether the replacement of the CD ROM drives in the vehicles with a different (and updatable) memory device really would require interface with CAD 2010 and, if not, whether it could still be considered before 2011. **Action: IM&T Director.**

Minute 46/07: the Chairman said that there would be a paper presented to the Trust Board in March setting out the advantages and disadvantages of the Trust becoming a Foundation Trust. The presentations being given to the Committee today were intended purely for the purposes of information sharing and discussion.

02/08 Chairman's Update

The Chairman said that Gill Morgan, currently Chief Executive of the NHS Confederation, has been appointed Permanent Secretary to the Welsh Government.

The Ambulance Service Network Board had been formed with John Burnside (North West Ambulance Service NHS Trust) elected as Chairman and Heather Strawbridge (South Western Ambulance Service NHS Trust) elected as Vice-Chairman. Interviews were being held today (26th February) to appoint a Network Director.

The Chief Executive and the Chairman recently met with Patricia Moberly and Ron Kerr, respectively Chairman and Chief Executive of Guys & St Thomas' Foundation Trust, to discuss the opportunities for closer collaboration including, possibly, on polyclinics. The Director of Finance said that the Trust has requested that all proposed polyclinic sites have two dedicated parking spaces for ambulances as well as an office to ensure the ambulance service can utilise the facilities at the new clinics. Beryl Magrath was assured that the Trust would be actively seeking to be involved both clinically as well as operationally i.e. being able to use the sites as stand-by points.

03/08 <u>Performance update</u>

The Director of Operations said that, as previously reported, November and December were two of the busiest months in the history of the LAS with between 921 and 974 Category A Calls being received on average per day; this fell in January to 887 and to 889 in February. The Trust's workload significantly increased in the last four days with the average number of Category A calls rising to 970 per day; the rise in demand was thought to be linked to a further peak in respiratory illnesses.

Category A response time performance in January was 78% within 8 minutes as currently measured, 76% in February and 78.9% year to date.

Category A Call Connect performance has been more challenging. It was 60% in December, 64% in January and 62% in February. An increased workload and problems associated with staffing levels have meant the Trust has struggled to cover Fast Response Units which has affected the Call Connect performance figures. (For comparison, with similar levels of workload and staffing the Call Connect figure in February 2007 was 46%.) It will be a challenge to close the gap of 9-10% between the actual performance and the trajectory toward the 75% target. Nationally, many ambulance services have experienced a plateauing of call connect performance around 65-66%, although South West and West Midlands were achieving 70-71%.

Call answering performance in the Control Room was continuing to improve with 95% of calls being answered in 5 seconds on most days even though the workload has increased with approximately 4,000 calls per day being received.

Category B performance in December was 81% and although it improved in January (87%) it has subsequently slipped in February (84%). There have been some significant improvements in Category B performance and the Director of Operations anticipated the introduction of active area cover[6] would enable faster response times to Category B patients.

Staffing levels have been affected by a staggered two week half-term in London and a very low take up of overtime which meant there were fewer ambulance/car hours available.

The Director of Operations said that due to operational pressures the Trust would be declaring REAP 3 later this week and this was likely to remain in place until the end of April.

[6] Previously known as dynamic deployment

A progress report would be presented to the March Trust Board on the action list, circulated at the January Trust Board, for achieving Call Connect in April 08. **ACTION: Chief Executive**

It was Noted that:

The Trust anticipated achieving 85% Category B performance for the year as a whole which the Commissioners were aware of. The Trust was likely to incur a penalty of £1.2m which had been provided for.

The staffing of FRU vehicles has been challenging in part because staff lose up to £120 per month as they receive rest breaks and go home on time. Currently members of staff volunteer to work on FRUs. A review is being undertaken of the Paramedic contract of employment which will call for new Paramedics to work as directed i.e. in Clinical Telephone Advice, on FRUs etc.

An additional 23 recruits recently joined the bicycle response unit; the recruitment for the Motorbike Response Unit was less successful and it currently has six vacancies.

04/08 **Finance update (month 10)**

The Director of Finance said that the Trust was forecasting a £1.2m surplus at year end. The Invest to Save programme was progressing well and an update, including benefits realised, would be provided to the Trust Board in March. Discussions were on-going with Commissioners as to the Category A and Category B penalties imposed in the 2007/08 commissioning agreement.

PTS had a poor month which was a timing issue as invoices had yet to be submitted to A&E for support given in recent months. PTS was on track to achieve £200,000 surplus at year end.

The capital budget was underspent with the sale price of Buckhurst Hill being higher than anticipated.

It was Noted that:

Although there was high level of turnover of staff in Emergency Operations Control it currently had only one vacancy.

The Trust does not retain any revenue surpluses achieved at year end and has a statutory requirement to break-even. Should the Trust become a Foundation Trust it would be able to retain any cash surpluses it achieves and reinvest it in improved patient care though this would be something that the Commissioners were likely to have a view on when the funding negotiations were taking place. Foundation Trusts were required to make a surplus of 1-1.5%.

05/08 **Approval of final draft 2008/09 budget and three year plan**

The Finance Director presented the latest draft of the 2008/09 budget which had been updated since the Trust Board's meeting in January 2008.

He drew the Committee's attention to the following changes:

- there was now provision for one rather than two HART teams;
- £7m has been received from NHS London for education and development in 2008/09
- £15.7m had been received for Call Connect.

The core A&E contract with Commissioners was close to a conclusion, with agreement reached concerning a 2.3% generic uplift with a mechanism agreed whereby an increase in demand would trigger additional funding. The

Committee recognised that this was a significant achievement in the terms of the funding agreement with Commissioners. The incentive for non-conveyance remained unchanged from 2007/08, £38.00 per incident.

The Finance Director said he expected the Commissioners to require a higher level of reporting which will include more Key Performance Indicators and activity reports.

Risks that have been identified include funding of the preparatory work being undertaken for the Olympics.

Capital Expenditure in 2008/09 will include estates; vehicles; medical equipment (including e.g. 12 lead ECG) and IM&T maintenance projects.

The Senior Management Team was reviewing the high level objectives for 2008/09 and these would be discussed with the Trust Board in March 2008. **ACTION: Chief Executive**

The Committee reviewed the self-certification document required by the London Provider Agency. This would be signed off by the Chief Executive and the Chairman and submitted by the due deadline. **ACTION: Chief Executive and the Chairman**

It was Noted that:

A plan on how the £7m funding for education and development would be spent would be presented to the Trust Board in March. **ACTION: HR Director**

The Chief Executive expressed his thanks to the Finance Director for leading the 2008/09 budgetary negotiations with Commissioners, the London Provider Agency and the NHS London. The Finance Director in turn thanked Paul Cain-Renshaw; Richard Webber and Vicky Clarke for their assistance.

Approved **The final draft of the 2008/09 budget and three year plan to be submitted to NHS London by the deadline of 29th February 20008 (Under delegated authority from the Trust Board).**

06/08 **SIP 2012 update**

The Director of Service Development said the Trust Board receives an overview of the progress of the Service Improvement Programme with in-depth reports on individual programmes being presented to the Committee throughout the year. She said the majority of SIP 2012 projects were on track.

Stakeholder Engagement: the Director of Communications presented a draft communication and stakeholder engagement strategy and invited comments from the Committee. The strategy included how communications would support the work being undertaken by the Trust in regard to the SIP 2102 projects; Call Connect; New Ways of Working; CAD 2010 and the Olympics.

The specific objectives over the next six years were:

- to increase public understanding of our role and future plans, so people feel more informed about our service and what to expect if they call us; so they use our service correctly and are more likely to speak highly of the London Ambulance Service
- to involve the public and patients in shaping the way we deliver our service
- to develop and maintain resilient two-way communications with our Foundation Trust membership (should a successful application for foundation trust status be submitted)

- to build relations with those people who are key stakeholders in our improvement programme, so that we can manage and meet their expectations and they can contribute to its delivery
- to develop an environment where members of staff feel informed, listened to, valued, are proud to work for the London Ambulance Service, and actively contribute to improving the care we provide to patients.

It was Noted that:

It would be useful if definitions of communications and engaging were included at the front of the document and that, where possible, tangible measurements were included in the document in order to evaluate its success. It was also suggested that the reference to improving communications with members of the Black, Minority Ethnic (BME) Communities be put in a clearer context. The Chief Executive suggested that a synopsis of the Mori poll be attached to the Strategy as an annex in order to give a context to the proposed work being undertaken with BME communities in London.

Operational Model: the Director of Operations circulated an updated summary of the Operational Programme and outlined the progress being achieved for each of the associated projects. These included:

Additional Complex Response, an additional 20-25 managers response vehicles being provided between 1100 and 1400, was on track. The additional Team Leader FRUs between 1400 and 2000 was proving more difficult to provide partly because some Team Leader vacancies and partly because there were still some roster changes required to build this function into the Team Leader working on each complex.

Mobile Fleet: following the installation of software this initiative was expected to be deployed mid March.

Increasing Solo Response Capacity: recruitment to all Cycle Response Unit lines has been completed with additional relief capacity being sought through a further advert and training process in March. A further six Motor Cycle Response Unit recruits would attend driver training in March leaving a further four vacancies. The volume of calls handled by the CRU and MRU has increased and was expected to rise even further in March and April.

Referral Pathways: the project has effectively stalled following the now long term absence of the Project Manager. Referral pathways continue to be drafted and agreed with providers but the business of making them consistently available to front line staff has proved very difficult as are the agreement of specific milestones for delivery. The Directors of Service Development and Operations were hoping to restart the project in the next eight weeks.

Managing Frequent Callers: Local Liaison Forums have been established in eight boroughs with four more in development. There is remedial action in hand for the top 20 callers. It was anticipated that action would have been taken on the top 50 cases by end of March 2008 and 120 by September 2008.

First and Co-Responders: this has proved one of the most challenging projects. Biggin Hill scheme was expected to go live on 29th February. It was anticipated that in due course there would be a dedicated 24/7 desk in Control that would manage the deployment of First and Co-Responders.

Control Services
Automated data reporting and analysis: the major exercise to bring all mobile fleet data terminals to the same build state and full functionality, referred to as MDT 'MoT' was currently suspended following resolution of a technical

problem. It was hoped that a remote fix would be possible for the 160 vehicles that remain outstanding and that they will not need to be taken off the road. One of the anticipated improvements is a more accurate location of jobs.

Control Services Management Restructure: this project has been delayed by the decision to proceed with the re-rostering element of 're-engineering call handling'. This project was expected to move ahead in March/April.

Re-engineer Call Handling: this project has made very good progress with performance at or near 95% on most days. Individual monitoring of all call handling staff is moving progressively to business as usual. Rosters were being reviewed to improve weekend cover.

Urgent Care was currently undertaking 40% of Green calls. Clinical Telephone Advisers (CTA) were now dealing with circa 200 calls per day and was on track to reach 230 by the end of March. The Trust was currently not sending a response to 65% of all CTA calls which now represents 54,000 saved ambulance responses per annum. CTA's establishment is currently 46; ideal number of 70.

It was Noted that:

Benefits realised would be undertaken for all the SIP 2012 projects and the findings presented to the Trust Board.

07/08 Further discussion of FT issues

The Chairman said that the Committee's discussion of foundation trust issues was an opportunity for people to make comments and share their views on the possible merits or challenges of the Trust becoming a foundation trust before the decision to be taken by the Trust Board in March.

The Finance Director said that the LAS had been selected to be a pilot site for Foundation Trust diagnostic and would be working closely with Monitor and the Department of Health over the next few months. A draft project plan and budget was being developed in preparation for the Trust Board's discussion in March 2008.

It was recognised that undertaking the application to be a foundation trust would be challenging both in terms of the investment in time and the cost whilst simultaneously undertaking Call Connect, CAD 2010 and the New Operating Model. Staff and union engagement would also be an issue.

In respect of opportunities it was recognised that there may be an advantage in being one of the early implementators and that NHS London would be supportive of the application. Becoming a foundation trust would offer more commercial freedom to engage in Urge Care restructure. There were also some potential benefits in terms of the wider public and patient involvement.

The next steps included further discussion by the Board on 18th March and making a decision as to whether to progress foundation trust application which will include approval of project plan and budget and the creation of a project team as part of Corporate Processes and Governance Programme. Work will continue with Monitor and the London Provider Agency on the ambulance service diagnostic tool. Discussions were ongoing with the PCTs; NHS London and the Department of Health as to possible funding of the project.

The Chairman shared the research he had undertaken in terms of governance arrangements. He had met with Dr William Moyes, Executive Chairman of Monitor to better understand the implications of the Trust becoming a Foundation Trust and the hurdles to be overcome. Dr Moyes had expressed

the view that the Trust's financial position and the make-up of the Board were robust, and that the challenges were likely to be around membership and governance.

As part of his research the Chairman had reviewed the options open to the Trust in terms of the organisation of membership constituencies; partnership organisations, the role of the Governors.

It was Noted that:

Following a conversation with Lord Warner, efforts were being made to deal with the statutory requirement to have a registered nurse or midwife among the executive directors of Foundation Trust. The Health & Social Care Bill was being considered by Parliament and representation would be made to amend it to widen the requirement to include a paramedic.

Northumbria Hospitals Foundation Trust has been innovative in using text messages and text/voice to invite patients to become Members via the web site or by completing a paper form. This has proved to be a very efficient and effective way of communicating with 30/40,000 patients/members and may be a practical solution for the LAS in managing its potential membership base. It might also be a way the Trust can contact service users and obtain fast feedback on their experience of using the Service.

The Chairman would circulate links to the relevant sites on the Department of Health and Monitor web sites. **ACTION: The Chairman**

Following the Trust Board in March there would be further opportunity for discussion at the Board's Away Day on 29th April. The Chairman has invited the chairmen of three Foundation Trusts to talk about their experience and share lessons learnt.

By having information regarding ethnicity, disability and age the Trust would be able to engage in a more meaningful way with different communities in London on how the Service could be improved to meet the needs of all Londoners.

08/08 Update regarding skill mix review

The HR Director referred the Committee to the Workforce Plan, agreed by the Trust Board in March 2007, which set out the creation of a new workforce model for the Trust. This plan involved the ceasing of recruitment to Emergency Medical Technician (EMT); the up-skilling of existing EMTs to become Paramedics and the introduction of a new support role.

Progress in 2007 was reported as 74 new Paramedics trained (with 144 planned in 2008). There were 162 A&E support staff in post (full establishment); 50 Clinical Telephone Advisers were employed and EOC is at full establishment. Emergency Care Practitioners costs have been absorbed into baseline budget through vacancy factor.

The Workforce Planning Group has met to revisit the original assumptions used in drafting the original workforce plan; review the skill mix options, consider the fleet model and refine the modelling tool.

Work is being undertaken to finalise the numbers and roles for 2008/09; the associated training plan and the recruitment plan. The final workforce plan would be presented to the Trust Board in March 2008 for approval.
ACTION: HR Director

It was Noted that:

Although A&E Support Workers would have the opportunity to demonstrate their potential to become Paramedics, not all of them would be become Paramedics and there was no guarantee of progress.

09/08 Draft response to Healthcare for London consultation

The Director of Service Development presented the draft response to the Healthcare for London's consultation which was essentially a briefing document on the Trust's position vis a vis Lord Darzi's strategy for London.

It was Noted that:

A breakdown of calls received by the LAS, which could be compared to the total number of presentations to A&E, would be added to the document.

The role of Urgent Care should be highlighted, particularly in the support it can offer to patients with chronic disease management. This was a significant piece of work that was not generally visible and an area where polyclinics could play a major role in supporting seriously ill people.

The LAS has been working with the various working groups leading the Healthcare for London consultation. The LAS has also underlined the contribution the Service can make in terms of stroke, admissions to hospitals, urgent care and promoting a more integrated approach to healthcare in London.

The response would be submitted to NHS London by the deadline of 7th March 2008.

10/08 Presentation: Counter Fraud

The Director of Finance circulated the presentation he had given concerning Counter Fraud at a recent Senior Manager's Conference. He invited members of the Committee to contact him if they had any queries or comments.

It was Noted that:

The Counter Fraud Investigation Officer investigated 38 allegations of fraud between 2003 and 2007. These involved the fraudulent use of fuel cards, equipment being used on private ambulances, items for sale on E-Bay, timesheet fraud and working elsewhere whilst sick. Following investigation there was one formal caution, seven disciplinary cases and six redresses of monies lost and an individual being struck off by the Health Professionals Council.

12/08 Date of future meetings:

The Trust Board meets on 18th March 2008 at 10.00am in the conference room at the LAS, Waterloo Road, SE1.

The Chairman's Away Day will be held 28th/29th April and will take place at Ravenswood Hotel, West Sussex. Apologies have been received from Brian Huckett and Ingrid Prescod.

The Service Development Committee meets again at 10.00am on 24th June 2008 in the conference room at the LAS, Waterloo Road, SE1.

The meeting concluded at 13.35

Enclosure 15

London Ambulance Service NHS TRUST

Trust Board 18th March 2008

SUMMARY OF THE MINUTES
Audit Committee 3rd March 2008.

1. Chairman of the Committee Caroline Silver

2. Purpose: To provide the Trust Board with a summary of the proceedings of the Audit Committee

3. ❑ **Agreed:**

- The Audit Commission's 2008/09 audit work plan would include CAD 2010 and the electronic procurement system; the scope of such work to be agreed between MD and PS
- That the Annual Audit Committee report be presented to the Trust Board in July 2008;
- That the Assurance Framework be presented to the Trust Board for approval in March 2008
- That, following the circulation of the specification for the provision of an internal audit and counter fraud service, the Chairman would collate members' response and feedback to the Finance Director. It was hoped to undertake a review and appoint an internal auditor in by 1st April 2008 for the 2009/09 audit
- That the Trust would approach the Inland Revenue to seek settlement with regard to the outstanding liability on the Trust's balance sheet in respect of subsistence.

The Committee undertook a self-assessment tool from the Audit Handbook as to its effectiveness and developmental needs; training regarding general risk management was requested.

❑ **Noted:**

- That the Finance Director was undertaking a review of senior managers' expenses and the findings would be presented to the Committee in June.
- That due to the difficulty of recruiting an infection control co-ordinator this post was being filled on an interim basis.
- That work would be undertaken in 2008/09 to ensure that the Trust was compliant with the newly issued International Financial Reporting Standards. The 2008/09 Report and Accounts will be produced under IFRS.
- That the Audit Commission would be formally publishing the ALE scores in May 2008.
- The contents of the Internal Auditors Report, in particular the significant recommendations made in respect of annual leave management and drug control – morphine. Management actions have been taken to address the identified shortcomings and the two areas would be re-audited in 2008/09.
- The contents of the LCFS report.
- The progress to date with the implementation of the auditors recommendations.

❑ **Standing items**:

1. Hospitality declared by the Chairman, and the Directors of IM&T and Service Development..
2. That there were no waivers of standing orders since the last Audit Committee meeting

Minutes Received:

Minutes of the Clinical Governance Committee (4/02/08) and Risk Compliance & Assurance Group (18/02/08)

4. **Recommendation That the Trust Board NOTE the minutes of the Audit Committee**

LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE
2.30pm, Conference Room, LAS HQ

Monday, 3rd March 2008

Present:	Caroline Silver	Non-Executive Director (Chair)
	Roy Griffins	Non-Executive Director
	Sarah Waller	Non-Executive Director
	Brian Huckett	Non-Executive Director
In Attendance:	Peter Bradley	Chief Executive
	Mike Dinan	Director of Finance
	John Wilkins	Head of Governance
	Michael John	Financial Controller
	Chris Rising	Bentley Jennison
	Dominic Bradley	Audit Commission
	John Harling	PriceWaterhouseCooper
	Christine McMahon	Trust Secretary (Minutes)

Circulated at the meeting:

- specification for the provision of an internal audit and counter fraud service
- draft minutes of the Clinical Governance Committee meeting, 4th February 08.

01/08 Minutes of the last Audit Committee meeting held 19th November 2007.

Agreed:
1. **The minutes of the last audit committee meeting held on 19th November 2007.**

Noted:
2. **Minute 48/07: the Finance Director said that he was currently undertaking an audit of senior managers' expenses which he would share with the Audit Committee in June. ACTION: Finance Director**
3. **Minute 49/07: Sarah Waller said that efforts were continuing to recruit an infection control co-ordinator. The Chief Executive said that this post was being covered as an interim measure.**
4. **Minute 50/07: recognised that a feedback loop needs to be put in place to evidence that changes in policy or procedure that are disseminated, are received and implemented. ACTION: Finance Director to report back in June what processes have been put in place to demonstrate the closure of the feedback loop.**

02/08 International Financial Reporting Standards (IFRS)

The Committee received a report, written by the Trust's advisers Baker Tilly, which set out the progress being made to enable the Trust to report under IFRS from 2008/09. The report included the main accounting issues the Trust needs to consider when adopting IFRS and an action plan of the work being carried out over the next few months to assist the Trust, which principally concerns the areas of holiday pay and leased assets.

The finance team would endeavour to ensure that, to the maximum extent possible, work performed at the year end 2007/08 would also take into consideration data required to restate these accounts under IFRS for the purpose of providing prior year figures in 2008/09.

Noted:
1. **The contents of the conversion to International Financial Reporting Standards report.**

2. **That the Trust was working with a number of different agencies to obtain clarification on a number of outstanding areas and NHS London has been helpful in seeking advice from the Treasury**
3. **That a progress report would be presented to the Audit Committee in June, with Trust Board approval of the adoption of the new accounting policies being sought in July 2008**

03/08 Audit Commission

Dominic Bradley presented a progress report of the 2007/08 external audit work and the draft 2008/09 external audit plan.

The 2008/09 external audit plan included a review of CAD 2010 and the electronic procurement system, both of which were considered to be areas of risk for the Trust in 2008/09. The Finance Director supported the planned audits and said that it was good practice for the Trust to have all new systems audited on a routine basis.

Following discussion of the Audit Commission's intention to audit CAD 2010 in 2008/09 it was agreed that such an audit would provide the Trust Board with added assurance on the calibre of the processes and procedures followed in acquiring the new despatch system. The cost of the audit of CAD2010 was identified at approximate [·] days out of a budgeted total of [·] days. Roy Griffins felt it was unnecessary for the Audit Commission to undertake the audit given the safeguards already specifically put in place by the Trust Board. It was recognised that the measures put in place by the Board, which included the appointment of a NED (Roy Griffins) to liaise with an independent consultant to advise the Board on the progress of the procurement of the new despatch system, was a different type of assurance. Efforts would be made to ensure that the Audit Commission did not duplicate the work being undertaken elsewhere in the Trust. It was recognised that CAD 2010 represented a significant reputational risk for the Trust; the memory of the failure of the CAD system in 1992 was at the forefront of peoples' minds. The Finance Director will clarify the scope and terms of the Audit to the Audit committee. ACTION: Finance Director and IM&T Director to liaise and draft a clear proposal of the scope of work for the next Committee meeting.

Agreed: **Noted:**

1. **The Audit Commission's 2008/09 audit work plan would include CAD 2010 and the electronic procurement system but that the scope of the 2010 work needed to be precisely identified;**
2. **That a mechanism would be sought whereby members of the Committee were able to communicate directly with the Audit Commission and express their views as to what audits they wish undertaken.**
3. **The contents of the progress plan which included an update on ALE assessment; Value for Money, Financial Management and Internal Control and the interim audit of systems and controls.**
4. **That the ALE scores would be formally published in May 2008.**
5. **That the Trust does not have a Finance Committee and the work plan would be amended to reflect this. ACTION: Audit Commission**

04/08 Internal Auditor's Report

Chris Rising, Bentley Jennison, presented a progress report on the internal audit plan.

Of the six reports finalised since the last Committee meeting, two provided only limited assurance reports. These were annual leave management and drug controls – morphine.

The audit of annual leave highlighted significant weaknesses with regards to the control framework in respect of the management of annual leave. The audit had been undertaken following concerns raised by the ADO, West. The Chief Executive said that measures have been instituted to address the weaknesses identified by the audit e.g. there is now one

system (PROMIS) in place to record and manage annual leave on complexes rather than the previous two systems. The implementation date for all the recommendations is 1st April 2008.

The audit of drug controls highlights significant weaknesses (and one fundamental recommendation) in respect of compliance with the control framework in place for the management of morphine. The control framework was in place but compliance is unsatisfactory. The Committee expressed concern at the findings of the audit as morphine is a controlled substance. The Finance Director said that as a matter of course morphine would be incorporated within the annual stock check undertaken across the Trust. Work was being undertaken to address the weaknesses identified by the audit and a further audit would be undertaken in early 2008/09.

The Committee's attention was drawn to the audit undertaken of medical devices which provided a solidly achieved 'adequate' assurance, with two significant recommendations being made. These concerned the retention of equipment repair tags by each ambulance station and the maintenance of records re. decontamination. The Internal Auditors felt there had been significant progress since the previous audit was undertaken of this area.

Following audits of key financial systems (creditors, general ledger and budgetary control) there were only two significant recommendations, which is a very positive outcome for the Trust. The Finance Director felt this reflected well on the Financial Controller and the team.

Noted:

1. **That annual leave and drug control – morphine would be re-audited in early 2008/09 to ensure that the lessons learnt from the initial audit had been implemented. The sample to include the original stations as well as additional stations.**
2. **That RCAG would review the Risk Register to ensure that the risk regarding the management of morphine was included. ACTION: Head of Governance**
3. **That the report concerning drug control – morphine would be presented to the Clinical Governance Committee in April 2008. ACTION: Deputy Director of Operations**
4. **The three client briefings included with the Internal Auditor's report: Foundation Trusts (numbers 5 and 6) and Service Line Reporting.**

05/08 Report of the Local Counter Fraud Specialist

Chris Rising presented the Local Counter Fraud Specialist's (LCFS) progress report in Robert Brooker's absence.

The Committee recognised that the reason for the low score in the compound indicator score was that, despite a low level of investigations, the Trust had not demonstrated that it had expended the appropriate time and resource on counter fraud. The LCFS provision had been extended to 40 days which included an educational element (demonstrate greater awareness of counter fraud work in the organisation) that would hopefully improve the Trust's compound indicator score in 2007/08. The Finance Director has had talks with the Lead for London Counter Fraud Services on how the Trust had been scored in 2006/07 and the merit of being benchmarked against other similar organisations e.g. mental health trusts or other ambulance trusts rather than as an organisation based on turnover and staffing levels.

The Committee noted that there appears to be available time left in the 07/08 resource budget and suggested that, given the issues raised regarding drug control in 04/08 above, some of such available resource could be appropriately employed in ensuring compliance with the Trust's drug control systems.

Noted:

1. **The contents of the report including the on-going investigations of fraud.**
2. **That the compute indicator assessment score for 2006/07 of 1 'below adequate performance' was due to it not being evident that the majority of the tasks in the compound indicator assessment document had been completed and the basic requirements for achieving adequate performance had not been met. As a result, the LCFS provision had been increased to 40 days and the Committee's attention was drawn to the work plan.**
3. **That resources would be used to assist in the follow-up to the drug controls report.**
4. **That the risk associated with obtaining a low counter fraud score would be added to the Trust's Risk Register.**
5. **That the Trust's Whistle Blowing policy has been recently publicised. The confidential helpline is managed by Bentley Jennison who provide the Finance Director with a monthly activity report. The Committee would receive an update on this matter as part of the LCFS's annual report to the Committee in June 2008. ACTION: LCFS**
6. **That the LCFS and the Internal Auditors exchange information as/when either identify weaknesses in the course of their work that they feel need to be brought to the others' attention.**

06/08 Draft Annual Audit Committee Report

The Head of Governance presented the draft annual Audit Committee Report to the Committee for comment and approval. The format has been used and tested by other NHS Trusts with success.

Agreed:

1. **That the final annual Audit Committee Report would be presented to the Trust board in July 2008.**

Noted:

2. **That the decision relating to the Company Secretary role would be part of the preparations for Foundation Trust status as/when the Trust Board made the decision on whether to apply for that status. Head of Governance to ascertain whether the legislation required Foundation Trusts to have a company secretary. ACTION: Head of Governance.**
3. **That the reference to the internal auditors being 'independent' was to indicate that Bentley Jennison were third party providers.**
4. **That the reference to the meeting in November 07 should state that the Committee 'reviewed the Trust's financial management, reporting and control systems to enable the NEDS to have a fuller understanding thereof'.**

07/08 Assurance Framework

The Committee reviewed the Assurance Framework prior to its presentation to the Trust Board in March 2008. The Assurance Framework is the process that links clinical governance, controls assurance and risk management systems so that they provide assurance to enable the Board to decide on the extent of compliance with the requirements of the Annual Health Check 2007/08.

In preparation for the next Statement of Internal Control and the Final Declaration of the Annual Health Check 2007/8, this Assurance Framework has been produced from the previous Interim Assurance Framework presented to the Board in November 07. It included the twenty five most serious risks (with the highest risk score) currently held on the Trust's Risk Register. The controls have been updated using the evidence collated by the Standards of Better Health Group to support compliance with the standards for the period covered by the Annual Health Check 07/08. The evidence was presented using two appendices:

Appendix one: Principal Objectives of the Trust and Assurance Framework. The evidence has also been tested against the guidance set out in the Healthcare Commission guidance "Criteria for assessing core standards in 2007/08- Ambulance Trust" published in November 2007.

Appendix two: Core standards that are not included on the Interim Assurance Framework (because none of the top 25 risks currently on the Risk Register relate to these standards), but are currently held under review by the Standards for Better Health Group who monitor the effectiveness of controls and assurance processes to manage and mitigate risks. Controls are routinely evaluated. Evidence from the Framework supports compliance with the Healthcare standards and is presented to external scrutiny bodies as our draft declaration. The Framework will be used to demonstrate the robustness of the Trust's evidence of compliance with the core standards at our 247247 event on 13th March. This event is being held to provide a mechanism for stakeholders (representatives of the London Borough's overview and scrutiny committees, NHS London and the LAS Patients' Forum) to provide commentary for our final declaration.

There is evidence to show that the Trust has responded to identified risks, taken remedial action by either introducing new equipment (manger elks) or new processes, e.g. the measures introduced to manage drug control following the recent audit.

Agreed:
1. **That the evidence presented demonstrates full compliance with all the core standards**
2. **That the Assurance Framework is a tool to monitor the improved level of compliance for the Annual Health Check 2007/08.**
3. **That the Assurance Framework document could be used at the 247247 event.**

Noted:
4. **That the Internal Auditors had reviewed the process and found the process for gathering evidence to demonstrate compliance to be robust and outcome focussed.**
5. **That in 2008/09 the Healthcare Commission would be superseded by the Care Quality Commission.**
6. **That new (web based) software be procured which would support the future management of the assurance framework data.**

08/08 Audit Committee Appraisal

The Committee considered the self-assessment checklist taken from the Audit Committee Handbook which provided a framework by which the Committee could assess its effectiveness, and aid the design and implementation of an action plan to improve its effectiveness for the coming year.

Agreed:
1. **The contents of the self-assessment.**

Noted:
2. **That the following areas of training were requested: general risk management and ethics.**
   Sarah Waller undertook to raise this with the Kings Fund in respect of the future programme for NE/board leadership training.
3. **That the Chairman and Roy Griffins had been impressed by the Audit Committee training delivered by the Kings Fund and recommended it to Brian Huckett.**
4. **That the Committee would review the Trust's accounting polices when it meets in November 2008, at which time the implementation of IFRS would be clearer.**

09/08 Update on the tendering of Internal Audit

The Finance Director tabled the specification for the provision of an internal audit and counter fraud service; he apologised for the delay in circulating the document.

Agreed:

1. **That the Chairman would collate comments received from members of the Committee (deadline Thursday 6th March) and subsequently share them with the Finance Director.**

Noted:

2. **That the Finance Director intended to invite the top five accountancy firms who were on the NHS Framework Agreement to tender for the work, with two being invited to give a presentation to a panel comprising of members of the Executive and/or Audit Committee. The initial contract would be for a year with the option to extend for a further year.**
3. **That key performance indicators would be added to the specification (14.4).**
4. **that an interim extension for a period of no more than three months would be offered to the current Internal Auditors (Bentley Jennison) to cover the procurement period.**

10/08 Report re. subsistence

Michael John, Financial Controller, introduced John Harling from PWC who had undertaken a review of A&E and PTS subsistence claims. The review was performed on a three month sample of claims from three ambulance stations, Camden, Chase Farm and Waterloo.

The Chairman of the Committee said that the Trust needed to ensure that all PAYE and NIC deductions were being made and that the Trust was complying with the dispensation received from HMRC.

In the meantime, the Finance Director confirmed that the £7m provision on the balance sheet would remain until this matter was resolved, now likely to be in 2008/09. No material issues were raised with regard to A&E staff. However, with regard to PTS staff subsistence payments, whilst tax has been deducted, NICs have not since August 2005. This is a straightforward error and PWC recommended that this be disclosed to HMRC with a view to reaching a full and final settlement of any outstanding liabilities.

Agreed:

1. **That the Trust account for both employee's and employer's NIC for PTS staff from 1st April 2008;**
2. **That the Trust discloses to HMRC that NICs have not been deducted from PTS subsistence payments since August 2005 with a view to settling any liability. A voluntary disclosure should serve to mitigate any penalties that HMRC choose to levy.**

Noted:

3. **That subsistence payments made to PTS staff have been liable to deductions of PAYE but not NICs, since August 2005.**
4. **That the Trust's £7m provision for its subsistence liability would remain until clarification had been obtained from HMRC on the potential liability.**
5. **That following the introduction of the rest break agreement, members of staff who do not receive a rest break receive a compensatory payment of £10 which had been subject to PAYE and NICs.**

11/08 Audit Recommendations Database

The report outlined the current status of internal audit recommendations which have been followed up to review progress made since the last Audit Committee meeting held on 19th November 007.

The Committee reviewed the database. It was commented that members of the Committee did not have a sense of whether the level and progress of implementation recommendations and anticipated seeing evidence of further progress by the next Committee meeting. The report was generally considered to be useful.

Agreed: **1. That placing the audit recommendations on the 'x' drive would further enhance reporting and stream line system for more timely and accurate update.**

Noted:

2. That managers have established action plans for implementing accepted recommendations within a reasonable timeframe. Since the last Committee meeting a further 3 significant recommendations have been implemented and progress has begun with another one recommendation which was previously reported as not started.

3. New final reports: of the 13 significant recommendations, 2 recommendations have now been implemented with a further 11 underway.

4. Draft reports: these reports have been circulated to managers and comments forwarded to Bentley–Jenison for finalisation. Since the previous meeting there have been 2 new draft reports which are currently being reviewed and responses prepared by the mangers accountable for planning action.

5. That this item would be placed next to the Internal Auditor's report in future to ensure that that Internal Auditor is given the opportunity to comment.

12/08 Standing Committee Items

Noted:

1. The declarations of hospitality by the Chairman, the Director of IM&T and the Service Director.

2. That there had been no waivers of Standing Orders since the Committee met in November 2008.

13/08 Draft minutes of the Clinical Governance Committee

The Head of Governance presented the draft minutes of the Clinical Governance Committee and highlighted the following:

- Evidence complied to give assurance of compliance with Healthcare Commission's Standards for Better Health.
- Infection Control audit was undertaken in Dec/Jan across the Trust; the results of which provided a benchmark by which subsequent quarterly audit can be used to ascertain improvements.
- Strengthen clinical governance reports from Areas with additional support being provided which will be further enhanced by the introduction of a web based system.

Noted:

1. The draft minutes of the Clinical Governance Committee, 4th February 2008.

2. That the Chairman of the Audit Committee felt it was sub-optimal to have only one NED (Beryl Magrath) at the Clinical Governance Committee. Both Ingrid Prescod and Sarah Waller had given their apologies for the Committee's February meeting.

14/08 Draft minutes of the RCAG, 18th February 2008

The Finance Director, who chaired the RCAG's meeting in February, highlighted the following from the minutes:

- The update received from the Consultant midwife concerning Obstetrics;
- The review of the Trust's Risk Register: a number of risks were deleted, added and regraded. The Group decided that two risks should remain on the Register until further evidence supported regrading/deletion.

- The update from the PALS/Complaints Manager re. the management of Frequent Callers which is on track.

Noted: The draft minutes of the RCAG meeting, 18th February 2008.

15/08 Audit Committee work plan and timetable for meetings in 2008.

Noted:

1. **The contents of the 2008 workplan**
2. **That the accounting policies would be presented to the Committee in September, post IFRS being clarified**
3. **That the Committee would have a fourth meeting in November 2008 as it found the meeting held in November 2007 useful.**
4. **That the Committee would have a private meeting with the external and internal auditors prior to its meeting in June 2008.**

Date of next meeting : 16th June 2008

Meeting finished at 4.50pm

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 18th March 2008

Report of the Trust Secretary
Tenders Received & Use of the Trust Seal

1. Purpose of Report

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

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

2. Tenders Received

There have been 8 tenders received since the last Trust Board meeting.

Leadership Development Programme
Rightrack, Carter Carson; Fletcher Consultancy; Cullen Schofield; Montpellier; The Development Co.; Management Futures; Leadership Trust; MDP; The Work Foundation; University of Leeds; Vector Group; The Morton Partnership; 3L Group Ltd; Quadrant 1 International; Cameron Consulting; University of Lincoln; TSO Consulting; RIGHT Management; Real World Group; First Ascent; University of Herts.; Pera; Now That's Different; Frankham Consultancy; CCC Inspirations; Birbeck University of London; Oakleigh Consulting.

New lifts at HQ
Jackson Lift Group; Otis Limited and Kone

Integrated Governance and Reporting System
Dynamic Change;

Fleet Management Software System
Civica UK Ltd; Jama Fleet Solutions; CFC Solutions; Trace Systems; Chevin Computer Systems Ltd

Units 2 & 3 Falcon Park Industrial Estate
Consiton Limited; Building Associates; TCL Granby/Crispin Borst; Russell Crawberry Ltd; Lakehouse Constructs Ltd

Replacement of the generator, UPS system and associated works at Bow
Gratte Brothers; Norland Managed Services; Haw Systems London Ltd; Lunar Electrical

E-learning
Harbinger Knowledge Products; Trainer 1

Supply & Maintenance of Pneumatic Patient Lifting Device
Manger International

3. Use of Seal

There have been 2 entries, reference 112 and 113 since the last Trust Board meeting. The entries related to:

No. 112	Counterpart lease, car parking spaces, 1-11 Blackfriars Road
No. 113	Reference for Ian Todd, requested by Nursing Midwifery Council

4. Recommendations

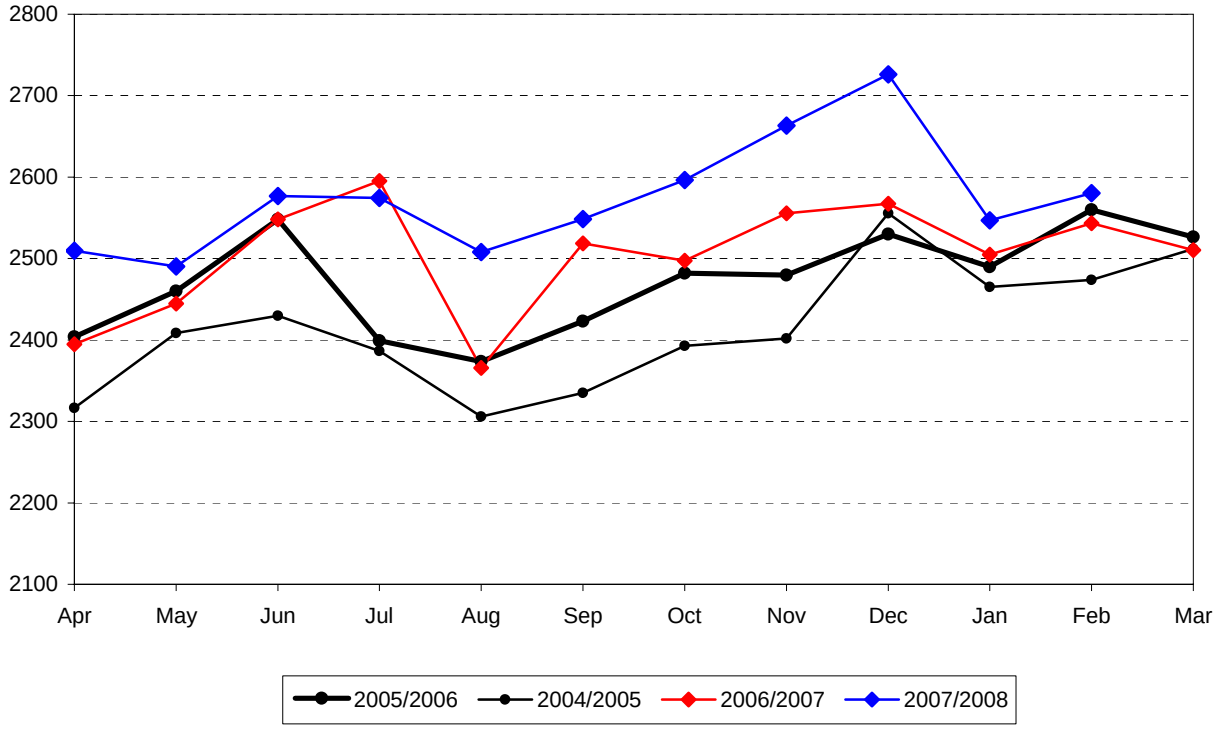
THAT the Board note this report regarding the receipt of tenders and the use of the seal

Christine McMahon
Trust Secretary

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

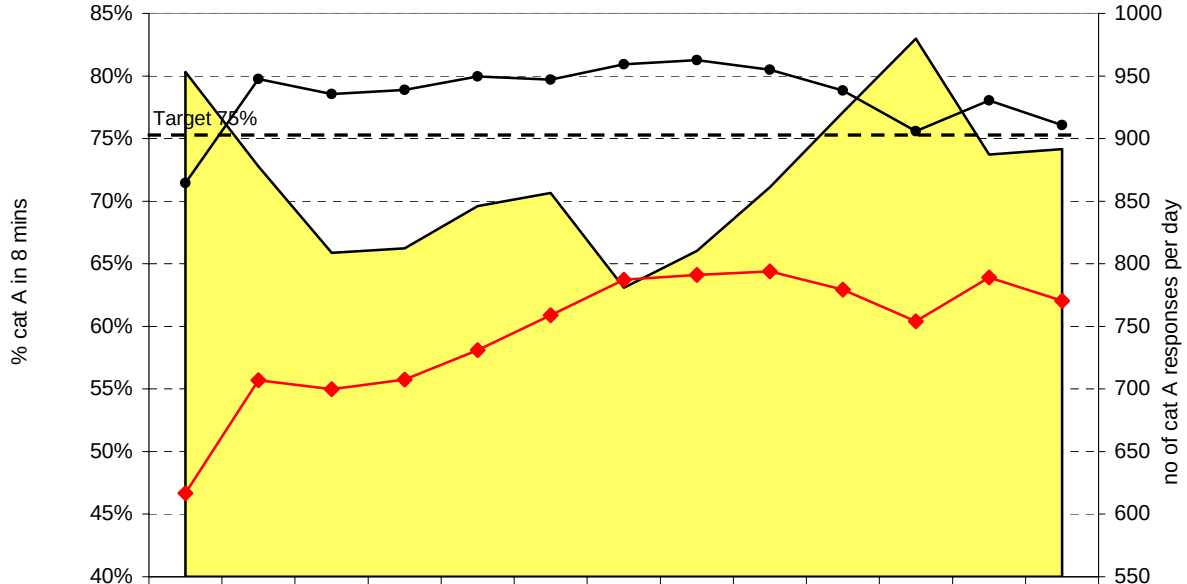


Cat A,B,C and Urgent responses: monthly and year to date comparison

February 07 v February 06	year so far 07 v year so far 06
+5.1%	+3.2%

Graph 2

Category A responses for all responders (8 minutes)

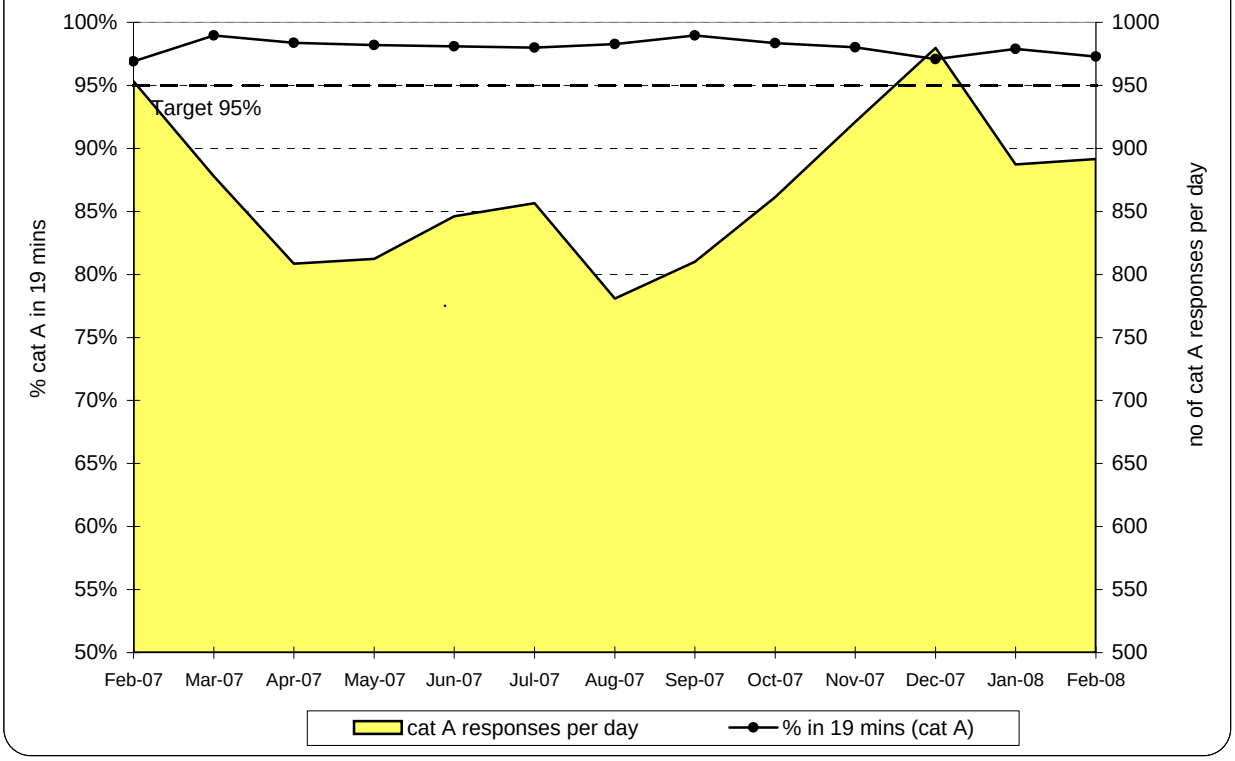


	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08
Cat A resp per day	953	878	809	812	846	857	781	810	861	921	980	887	892
A8 Call Connect % 8 mins	46.7%	55.7%	55.0%	55.7%	58.1%	60.9%	63.7%	64.1%	64.4%	62.9%	60.4%	63.9%	62.0%
A8 Current % 8 mins	71.5%	79.8%	78.6%	78.9%	80.0%	79.7%	80.9%	81.3%	80.5%	78.8%	75.6%	78.0%	76.1%

London Ambulance Service NHS Trust
Accident and Emergency Service
Category A and Category B 19 minute response activity and performance

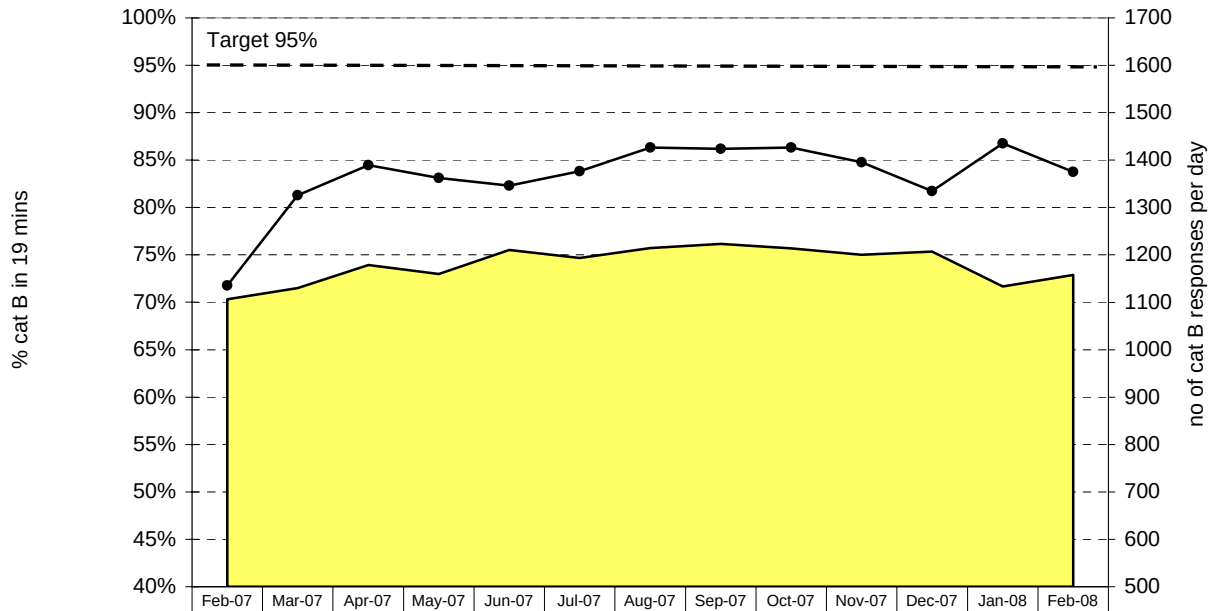
Graph 3

Category A responses (19 minutes)



Graph 4

Category B responses (19 minutes)

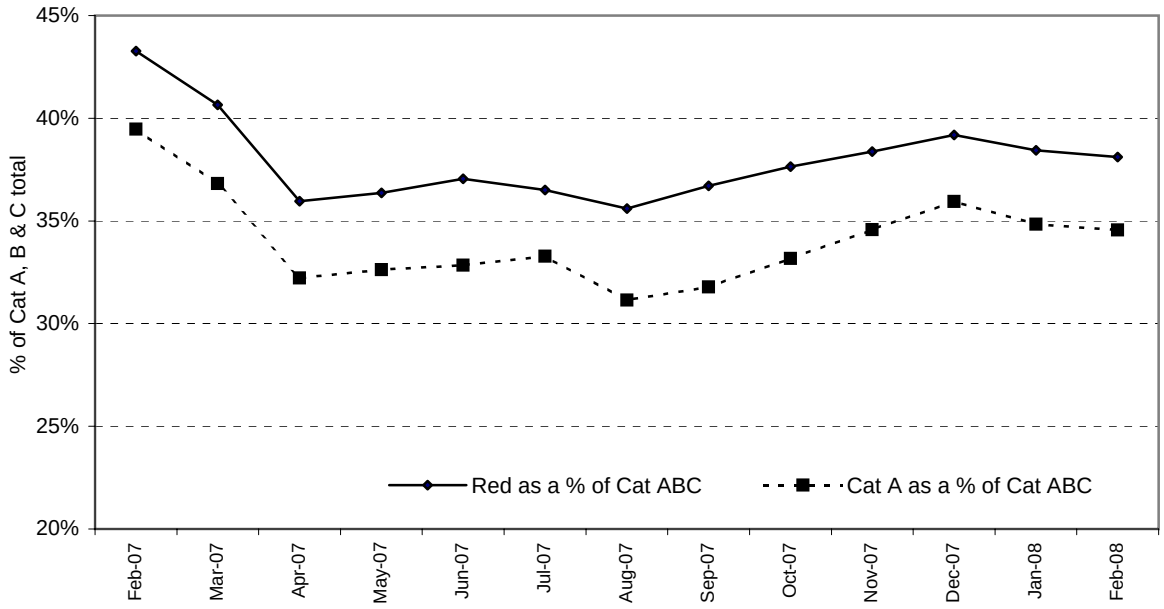


	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08
Cat B responses per day	1107	1130	1179	1160	1210	1194	1215	1223	1214	1200	1207	1133	1158
% Cat B in 19 mins	71.8%	81.3%	84.5%	83.1%	82.3%	83.8%	86.3%	86.2%	86.3%	84.8%	81.7%	86.8%	83.8%

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

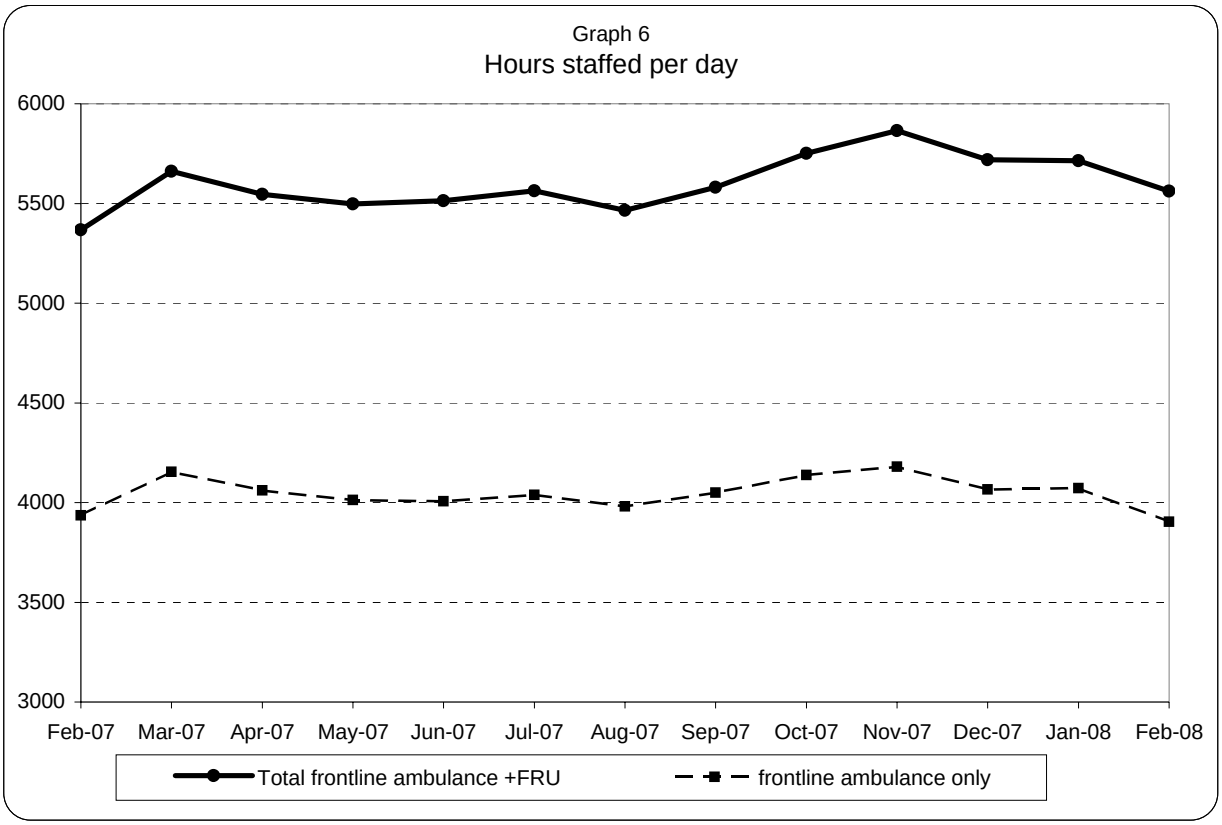
Graph 5

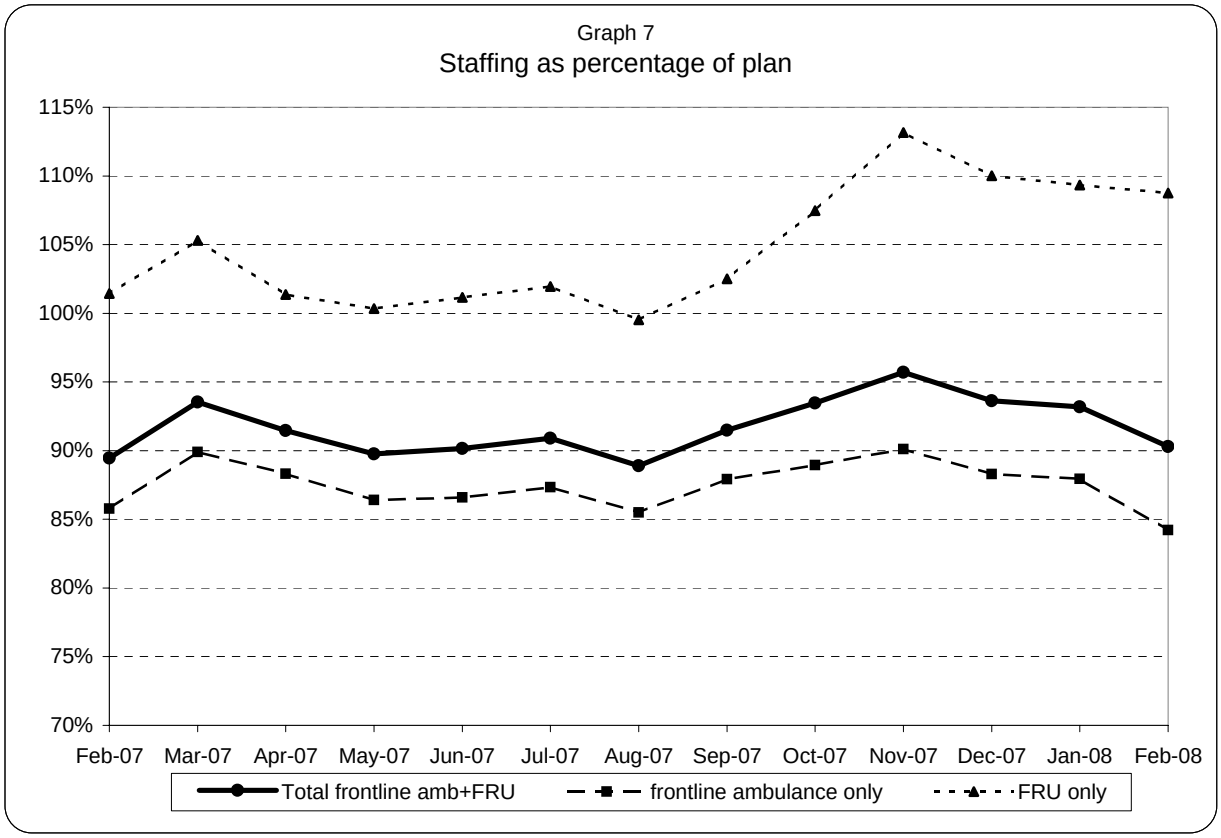
Category A and Red Responses as a percentage of the total Cat A, B & C demand



	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08
Red as a % of Cat ABC	43%	41%	36%	36%	37%	37%	36%	37%	38%	38%	39%	38%	38%
Cat A as a % of Cat ABC	39%	37%	32%	33%	33%	33%	31%	32%	33%	35%	36%	35%	35%

London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance and FRU staffing

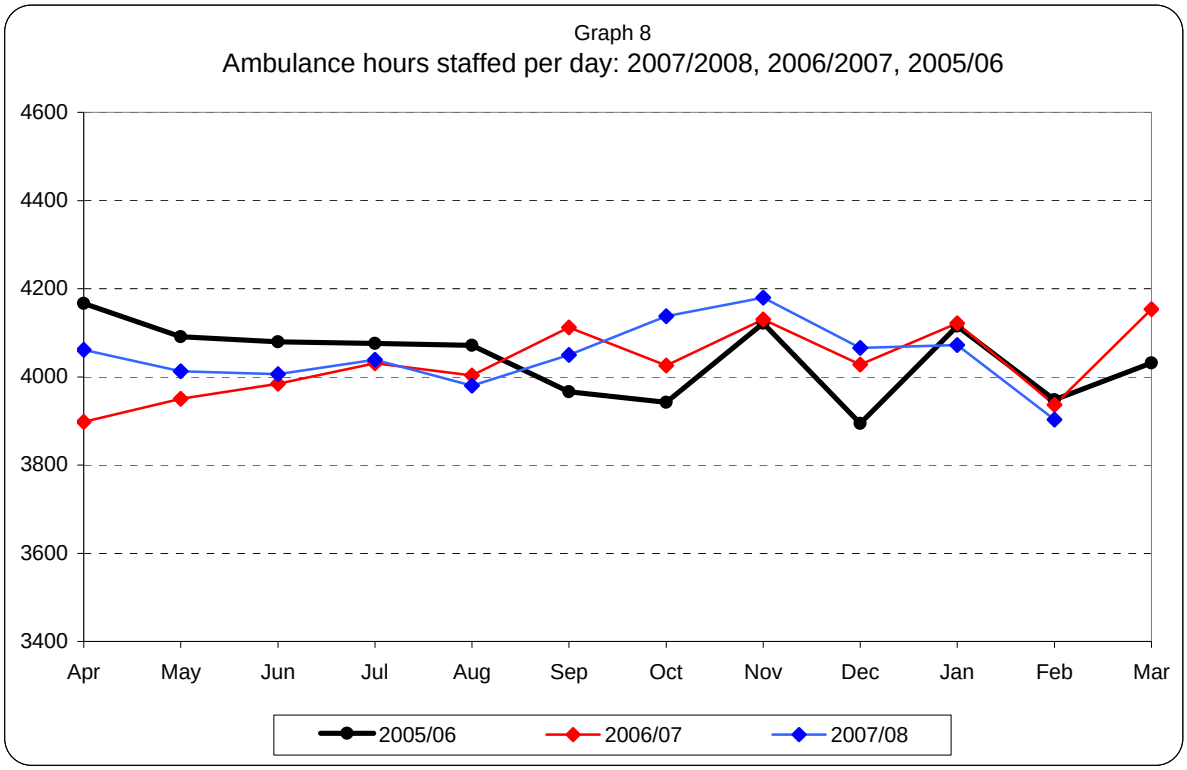




Note: staffed = (plan + additional - unmanned - single)/plan

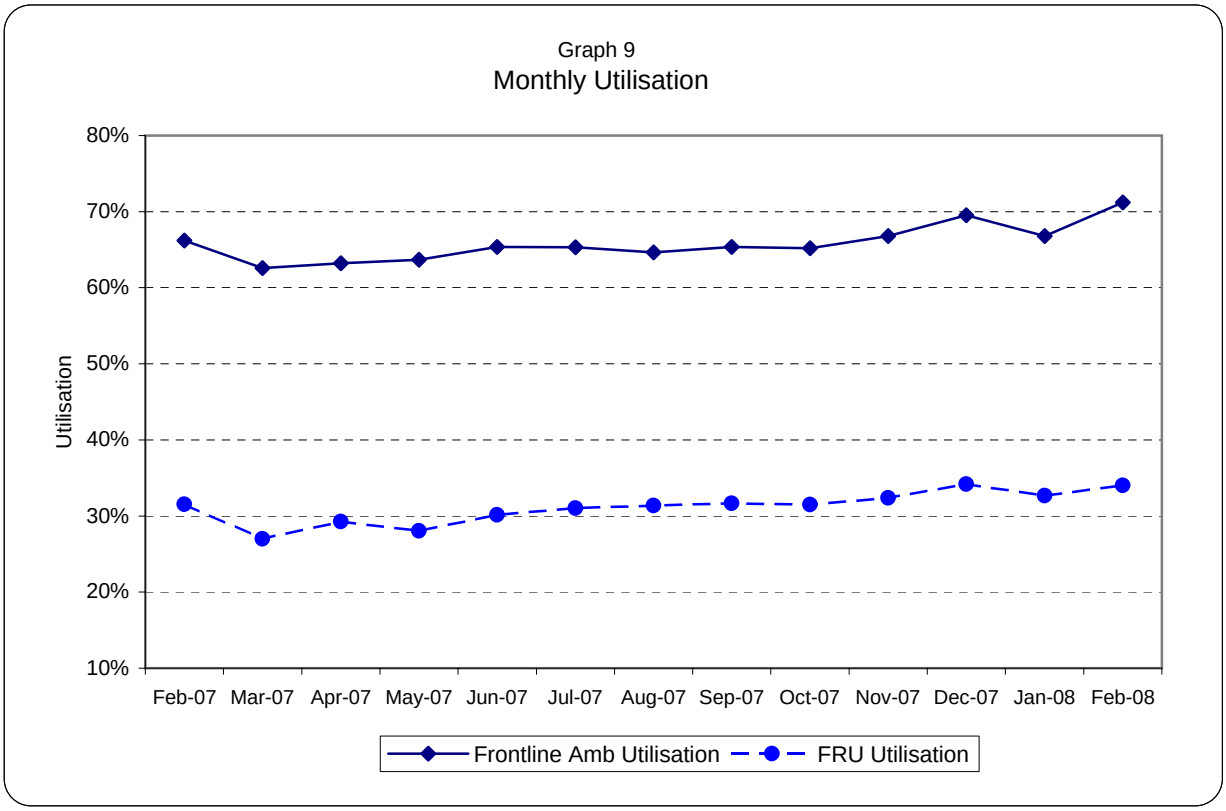
London Ambulance Service NHS Trust
Accident and Emergency Service
Yearly comparison of ambulance staffing and Average Monthly Utilisation

Graph 8



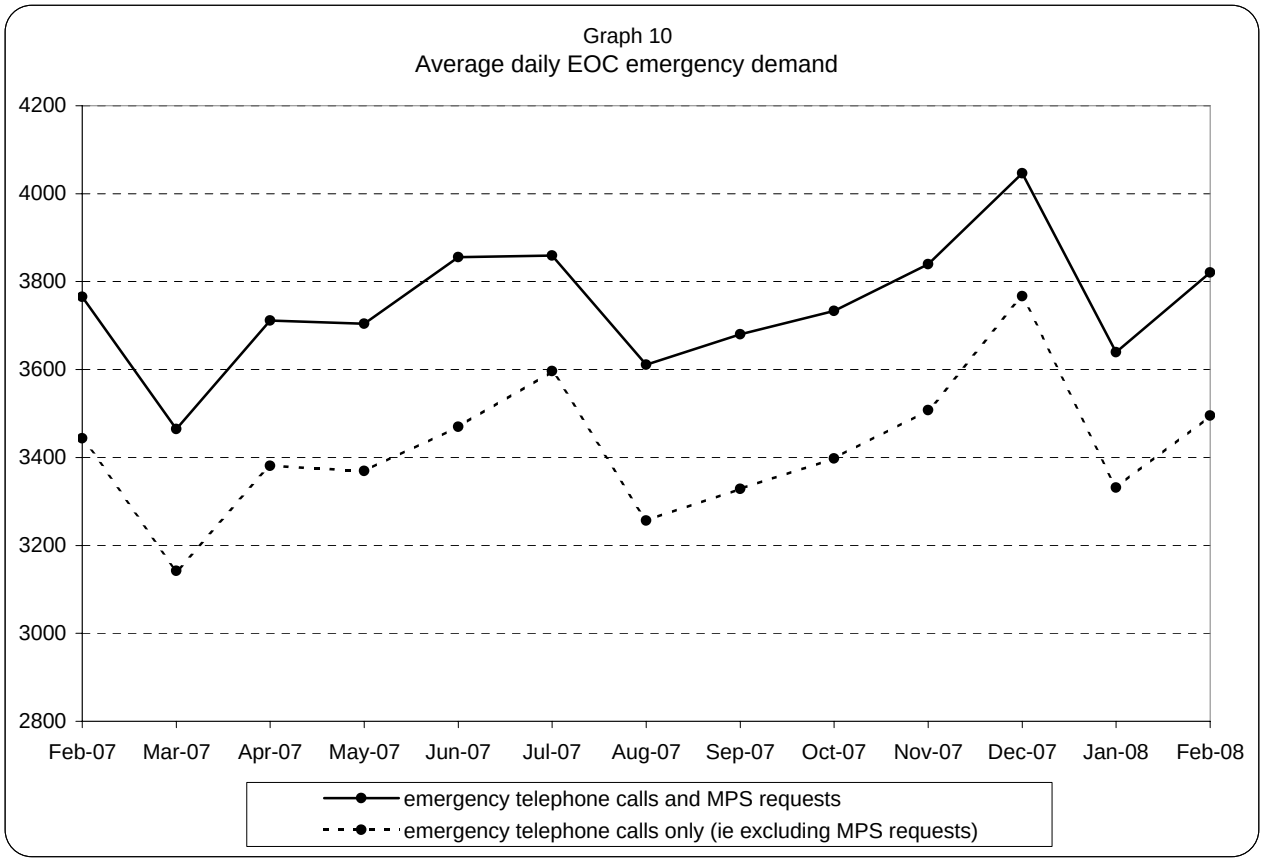
Note: staffed = plan + additional - unmanned - single

Graph 9

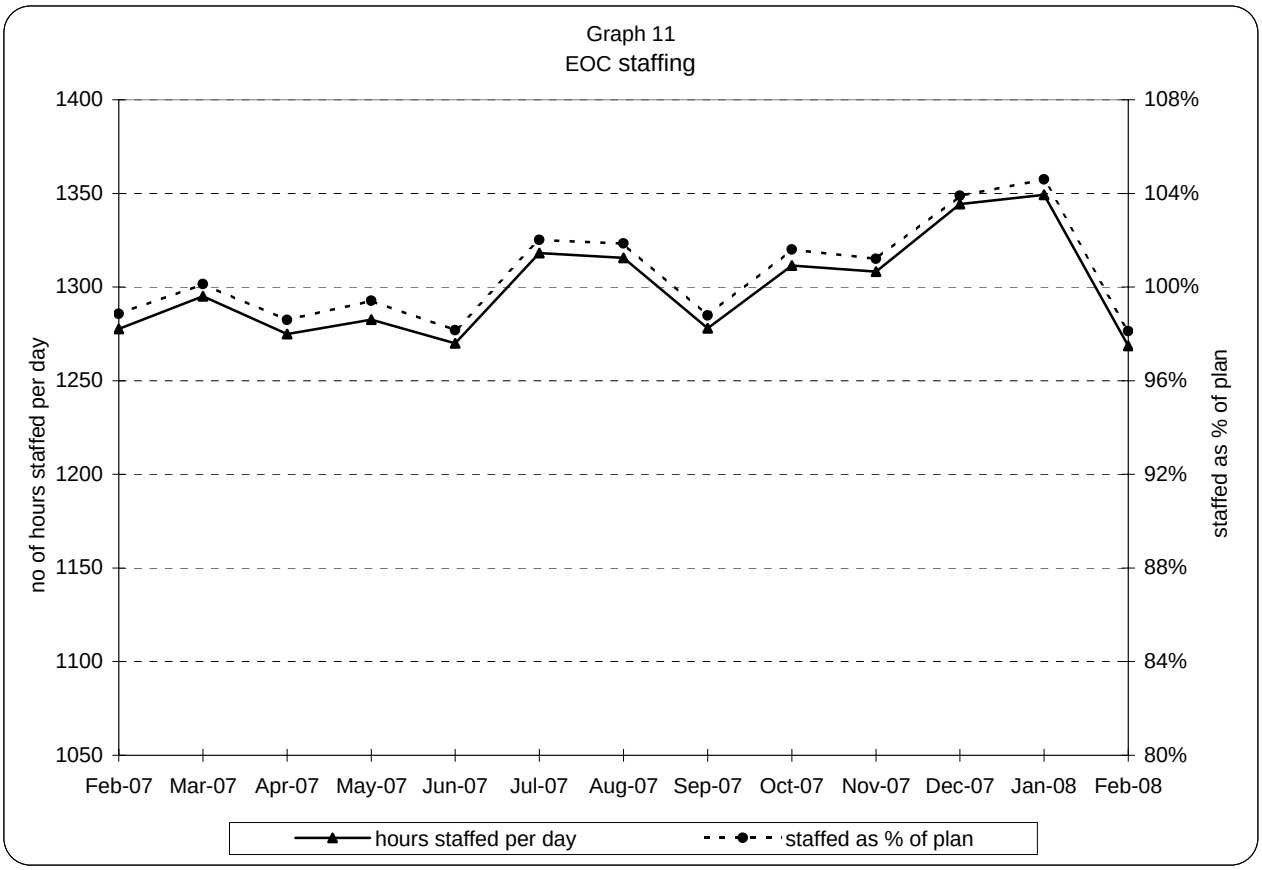


London Ambulance Service NHS Trust
Accident and Emergency Service
EOC activity and staffing

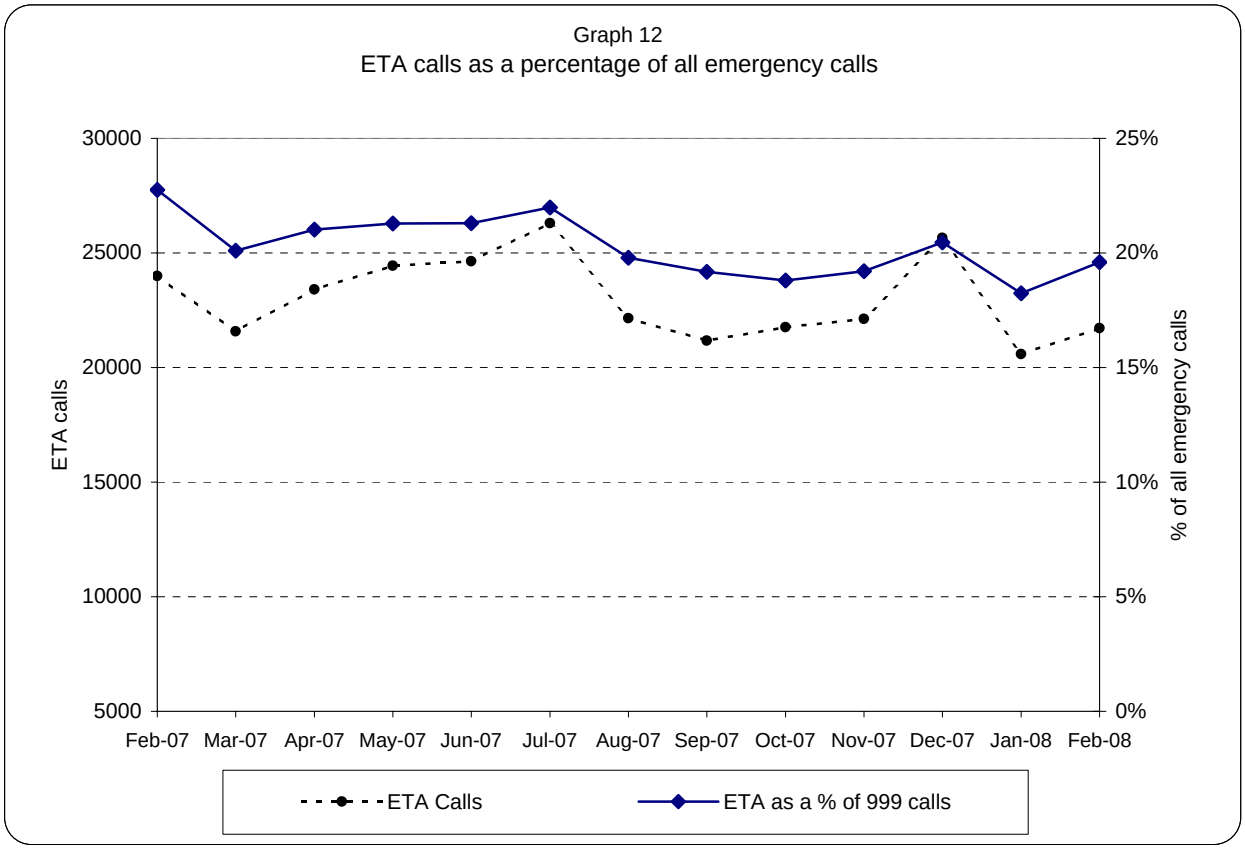
Graph 10
Average daily EOC emergency demand



Graph 11
EOC staffing



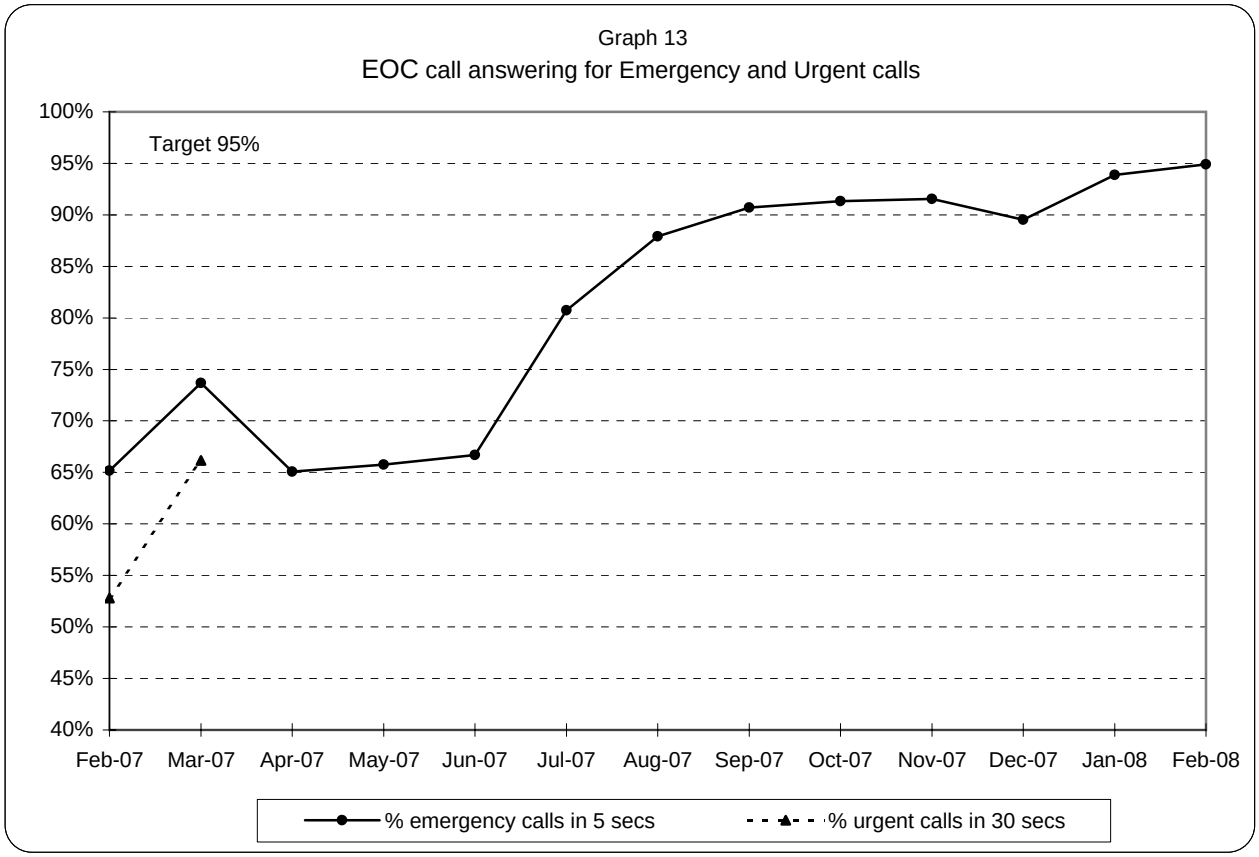
London Ambulance Service NHS Trust
Accident and Emergency Service
ETA calls as a percentage of all emergency calls



London Ambulance Service NHS Trust
Accident and Emergency Service
EOC call answering performance

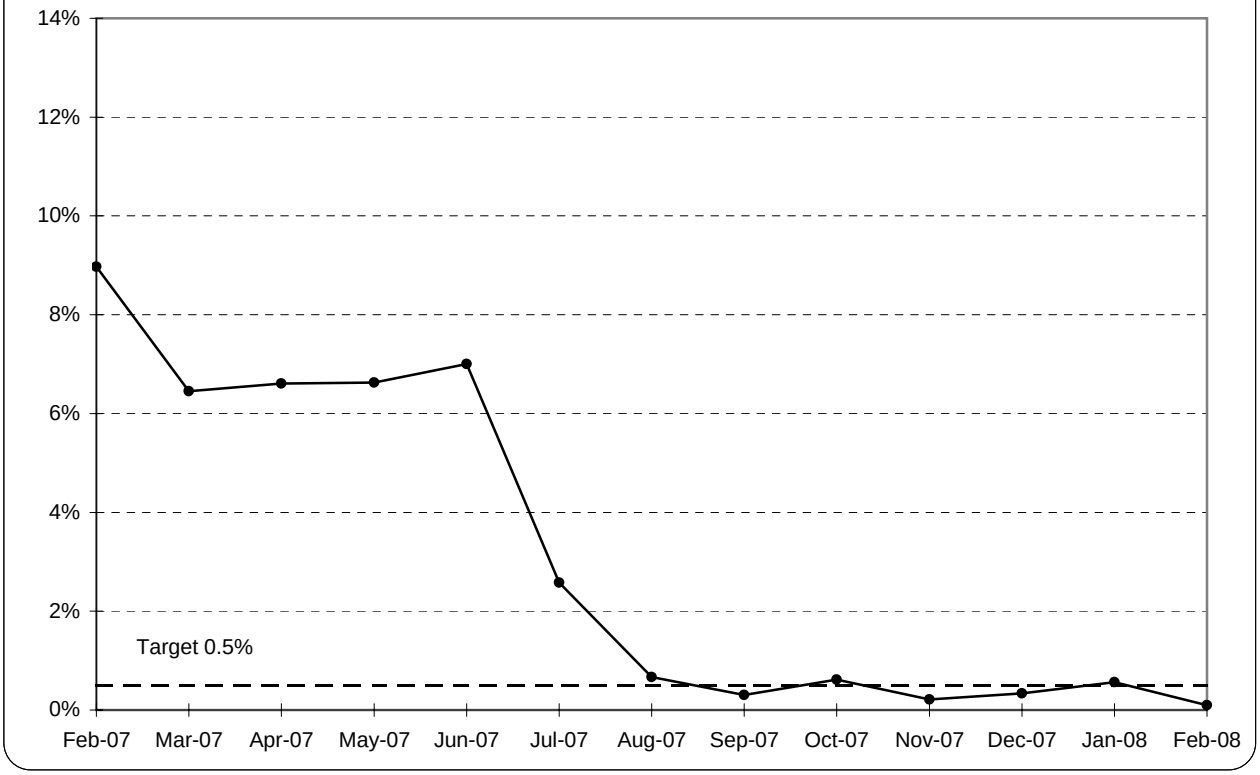
Graph 13

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	**Nov-07**	**Dec-07**	**Jan-08**	**Feb-08**
EMT 1	1972	2297	2076	2088
Whitework	1154	974	1279	1335
PTS	92	170	112	111
ECP	283	332	260	397
VAS	99	180	140	51
PRIVATE	0	6	12	28
CTA	5167	5921	5277	5234
UCS Total (green, urgent, non urgent & CTA)	8767	9880	9156	9244
Non UCS Total (green, urgent, non urgent)	14650	14796	14375	13320
TOTAL	23417	24676	23531	22564
% of total by UCS	37.4%	40.0%	38.9%	41.0%

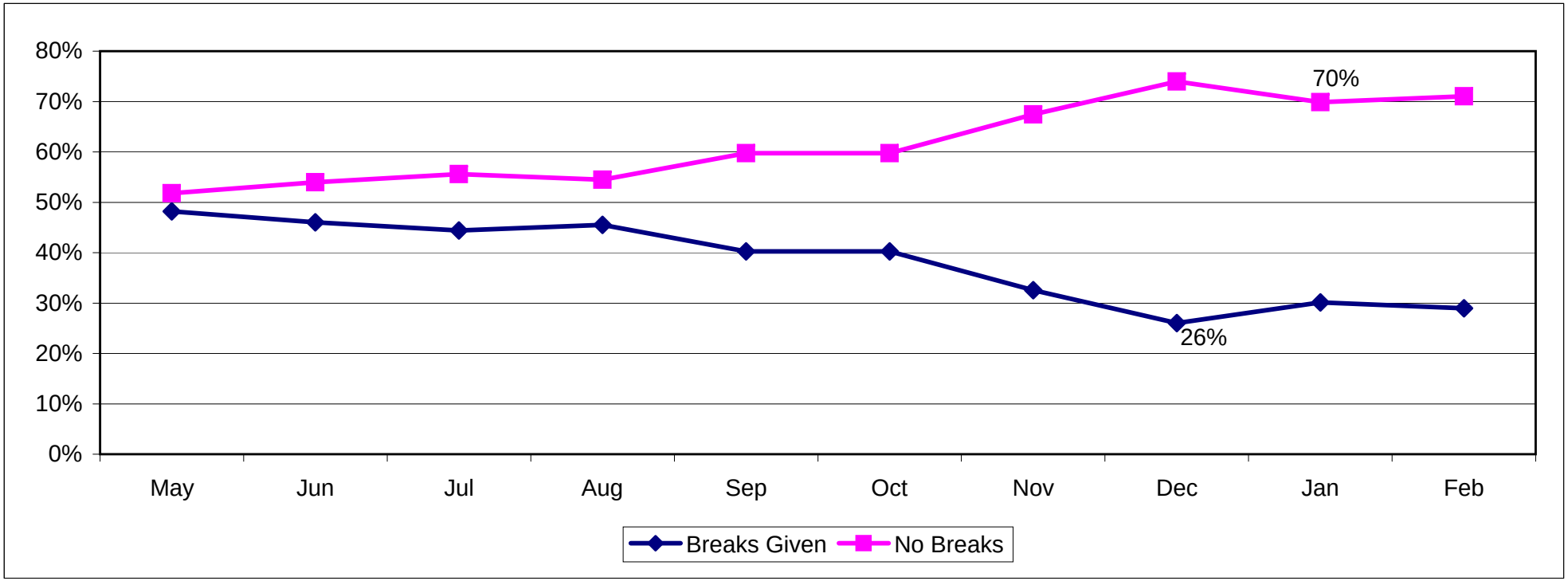
* Workload here refers to all arrivals on scene and will therefore include multiple responses to an incident (except for CTA, which refers to all calls passed to CTA)

London Ambulance Service NHS Trust
Accident and Emergency Service
Category A and B activity and performance by Primary Care Trust

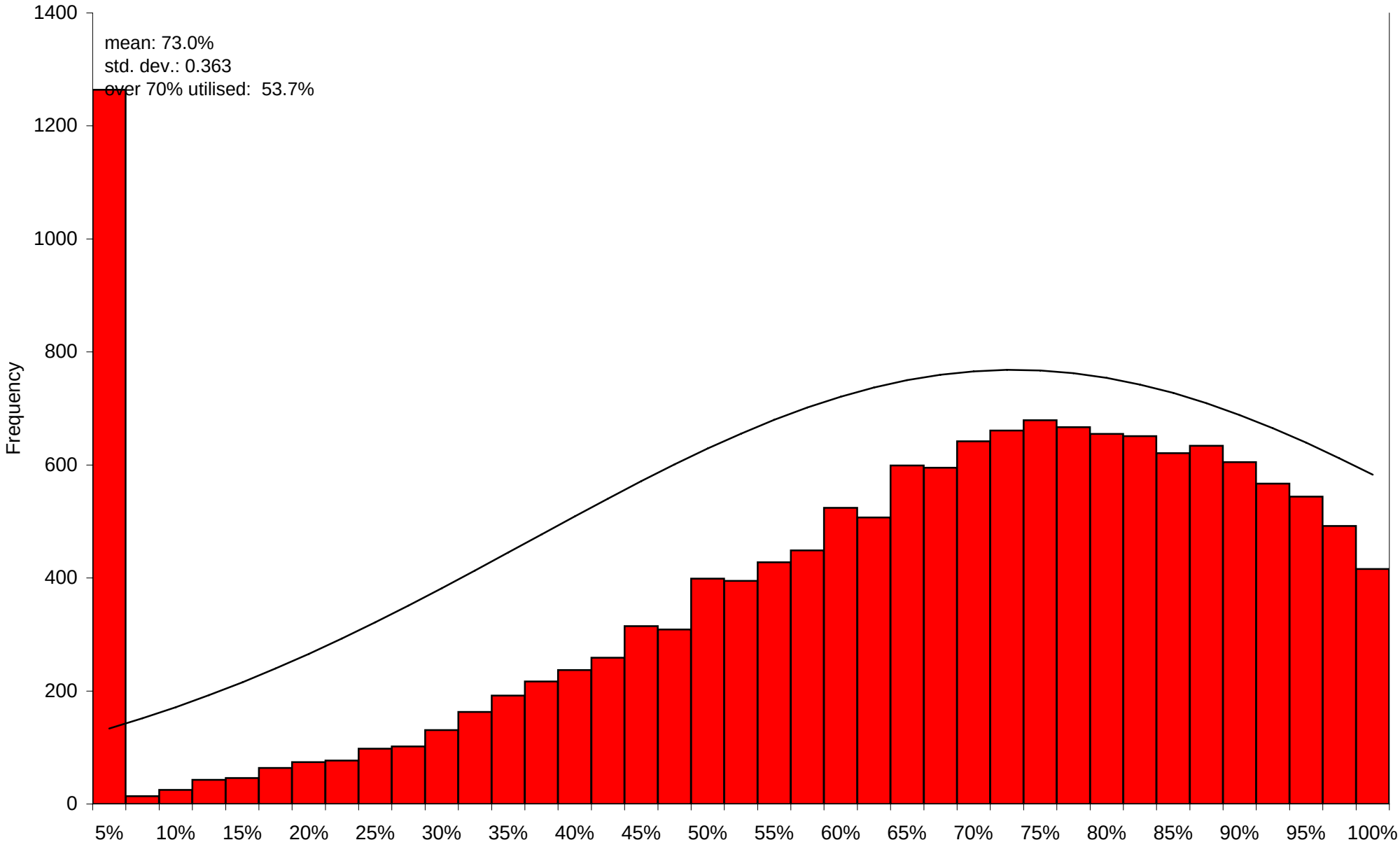
Table 2

	Feb-08				Year to date			
PCT	**Cat A incidents**	**% cat A within 8 mins**	**Cat B incidents**	**% cat B within 19 mins**	**Cat A incidents**	**% cat A within 8 mins**	**Cat B incidents**	**% cat B within 19 mins**
Brent PCT	972	72%	1,226	82%	10,757	79%	14,547	87%
Ealing PCT	1,081	70%	1,281	84%	11,664	76%	15,296	86%
Hammersmith & Fulham PCT	590	80%	840	86%	6,716	83%	9,817	88%
Harrow PCT	592	78%	766	85%	6,773	85%	8,473	88%
Hillingdon PCT	1,042	78%	1,223	83%	10,408	82%	14,479	87%
Hounslow PCT	740	74%	969	81%	8,375	76%	11,309	83%
Kensington & Chelsea PCT	518	76%	665	87%	5,151	80%	7,872	89%
Westminster PCT	1,194	81%	1,694	87%	13,071	83%	20,543	88%
Barnet PCT	933	72%	1,207	86%	10,470	77%	14,322	88%
Camden PCT	859	84%	1,143	87%	9,888	87%	14,344	89%
Enfield PCT	975	77%	1,213	82%	10,554	82%	14,463	85%
Haringey PCT	822	72%	1,192	80%	9,475	76%	14,091	84%
Islington PCT	754	82%	1,009	82%	8,711	82%	11,844	84%
Barking & Dagenham PCT	717	77%	811	78%	7,489	78%	9,720	80%
City & Hackney PCT	919	71%	1,248	79%	10,350	76%	14,995	81%
Havering PCT	716	73%	829	82%	7,781	77%	9,562	81%
Newham PCT	995	72%	1,202	80%	11,316	77%	14,912	79%
Redbridge PCT	751	75%	908	84%	8,383	77%	11,092	83%
Tower Hamlets PCT	892	76%	997	80%	9,850	80%	12,203	82%
Waltham Forest PCT	800	73%	970	81%	8,548	75%	11,524	81%
Bexley PCT	605	71%	802	85%	6,768	76%	9,208	83%
Bromley PCT	752	75%	1,076	88%	8,838	76%	12,390	85%
Greenwich PCT	838	85%	1,131	87%	9,390	82%	13,503	86%
Lambeth PCT	1,022	77%	1,427	83%	11,603	76%	17,588	83%
Lewisham PCT	866	79%	1,254	85%	10,060	79%	14,324	86%
Southwark PCT	1,046	81%	1,460	85%	12,078	81%	16,852	83%
Croydon PCT	1,105	71%	1,409	85%	12,259	76%	16,449	82%
Kingston PCT	402	77%	539	87%	4,533	77%	6,438	86%
Richmond & Twickenham PCT	412	69%	598	81%	4,705	74%	6,746	85%
Sutton & Merton PCT	957	79%	1,332	88%	10,796	78%	15,353	86%
Wandsworth PCT	818	77%	1,010	85%	8,747	75%	12,471	86%
Lowest (excl out of London)		69%				74%		
Highest (excl out of London)		85%				87%		
Range		16%				13%		

Reason	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Total
break given	3,131	8,183	8,213	8,041	7,237	7,742	6,211	4,947	5,780	3,448	**62,933**
break given, but interrupted	54	171	149	180	166	179	176	173	192	122	**1,562**
Breaks Given	**3,185**	**8,354**	**8,362**	**8,221**	**7,403**	**7,921**	**6,387**	**5,120**	**5,972**	**3,570**	**64,495**
no break	2,864	8,314	8,724	5,003	5,471	5,985	6,714	7,538	6,178	3,811	**60,602**
no break, but time given at end of shift	561	1,485	1,673	1,392	1,599	1,667	1,887	1,774	2,879	1,949	**16,866**
no break, but time given at end of shift (interrupted)			78	3,435	3,924	4,112	4,644	5,245	4,791	2,990	**29,219**
No Breaks	**3,425**	**9,799**	**10,475**	**9,830**	**10,994**	**11,764**	**13,245**	**14,557**	**13,848**	**8,750**	**106,687**
Breaks Given	48%	46%	44%	46%	40%	40%	33%	26%	30%	29%	**38%**
No Breaks	52%	54%	56%	54%	60%	60%	67%	74%	70%	71%	**62%**
Grand Total	**6,610**	**18,153**	**18,837**	**18,051**	**18,397**	**19,685**	**19,632**	**19,677**	**19,820**	**12,320**	**171,182**



Distribution of hourly vehicle utilisations by complex - February 2008



LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 29 February 2008 (Month 11)

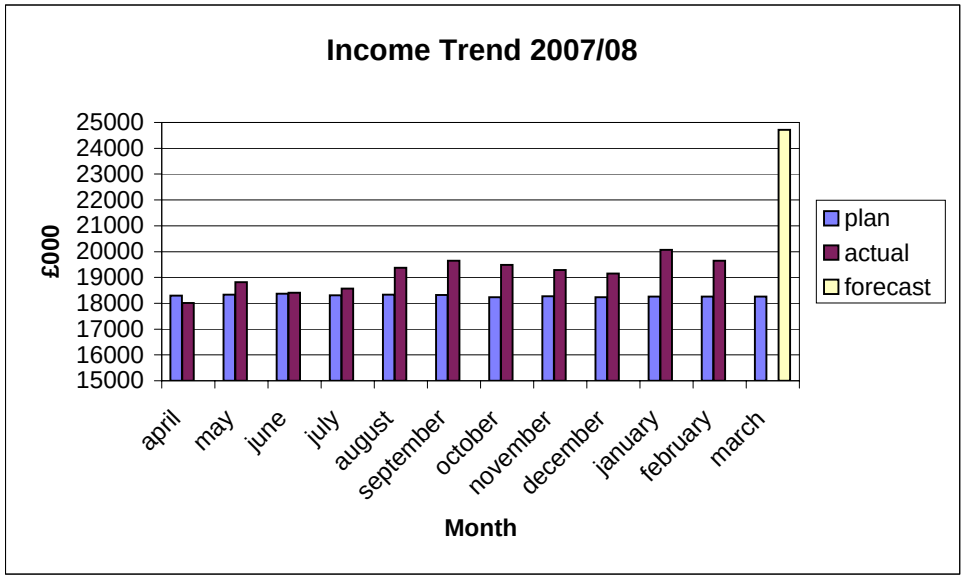
£000s

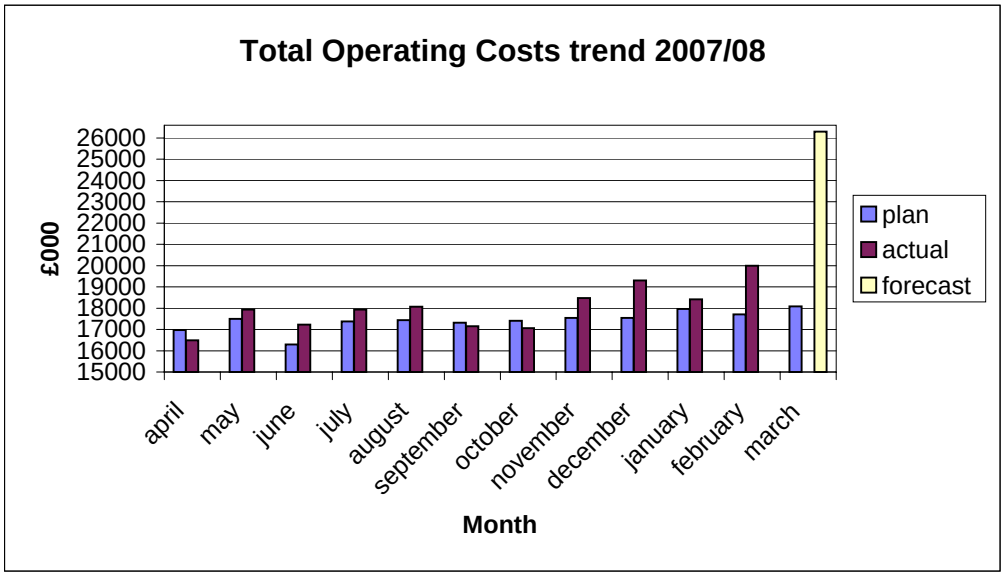
	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	19,641	18,260	1,381F	210,453	201,223	9,231F	4.6%F	235,171	219,481	15,690F
Total Operational Costs	20,000	17,702	(2,298)U	198,064	191,057	(7,007)U	(3.7%)U	224,370	209,141	(15,229)U
EBITDA	**(359)**	**557**	**(917)U**	**12,389**	**10,165**	**2,224F**	**0F**	**10,801**	**10,340**	**461F**
EBITDA Margin	***-2%***	***3%***	**-5%**	***6%***	***5%***	**1%**		***5%***	***5%***	**0%**
Depreciation & Interest	770	818	48F	8,768	8,998	230F	2.6%F	9,534	10,340	805F
Net *Surplus/(Deficit)*	**(1,129)**	**(261)**	**(868)U**	**3,621**	**1,167**	**2,454 F**	**(1.6%)U**	**1,267**	**(0)**	**1,267F**
Net Margin	***-6%***	***1%***	***-7%***	***2%***	***1%***	***1%***		***-1%***	***0%***	***-1%***

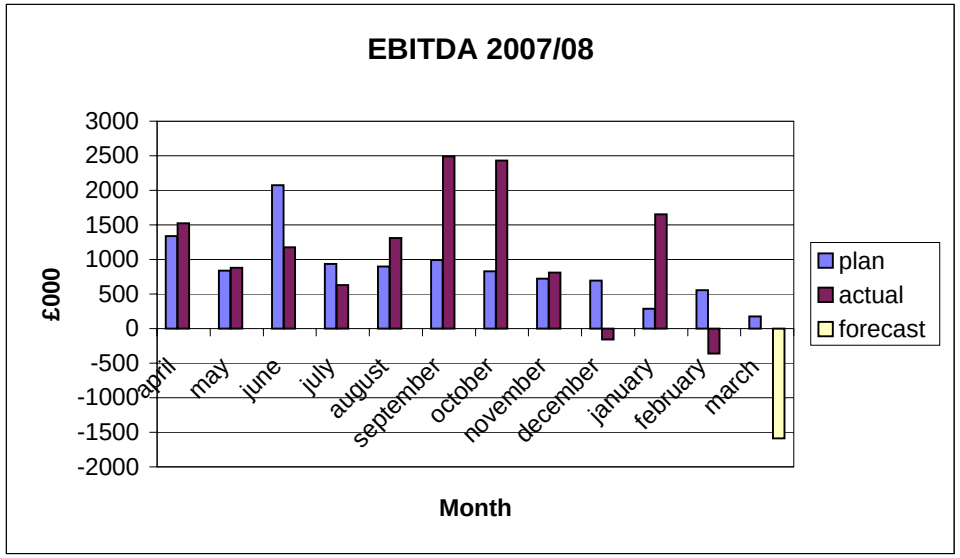
- In month 11 expenditure exceeds income by £1.129m. For the year to date income exceeds expenditure by £3.621m.
- The net financial position to date includes income & expenditure on Invest to Save projects at £1.9m to date.
- The forecast net financial position for month 11 at month 10 was a loss of £1.6m. The actual result in month 11 is a loss of £1.1m. The difference of £0.5m is due to lower than forecast expenditure in Feb on primarily SPPPs, LARP, the MDT update and the AFC provision.
- The annual forecast is £1.267m at month 11, up slightly from £1.204m in month 10. This assumes expenditure and income of £5.17m on ITS projects in March.

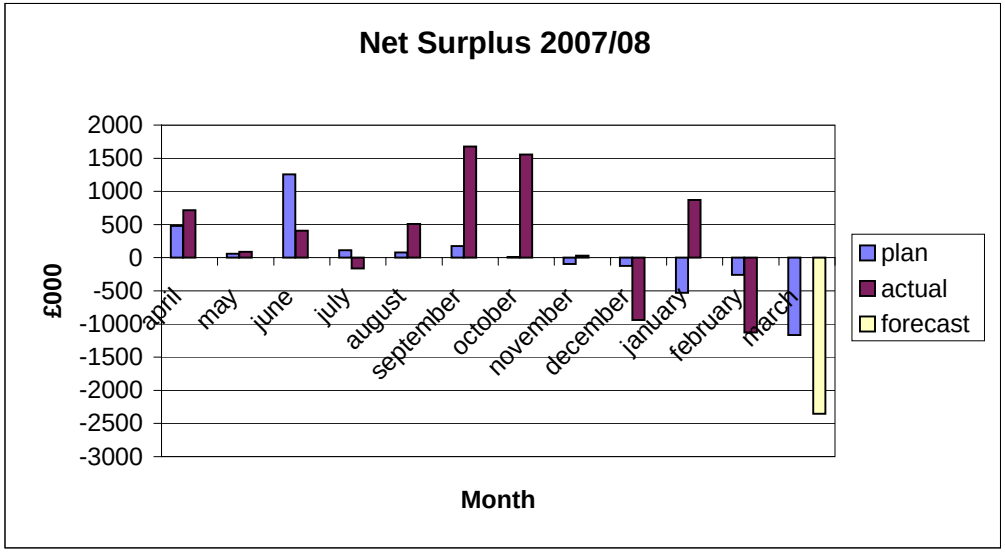
London Ambulance Service NHS Trust

Month 11 Trust Board report - forecast data









LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 29 February 2008 (Month 11)

£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*	*Actual*	*Actual*	*Forecast*	
Income	**18,006**	**18,819**	**18,409**	**18,569**	**19,373**	**19,646**	**19,486**	**19,282**	**19,154**	**20,068**	**19,641**	**24,717**	**235,171**
Pay Expenditure													
A&E Operational Staff	8,087	8,036	8,024	7,995	8,440	8,018	8,088	8,113	9,149	8,227	8,468	8,714	99,360
Overtime	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,168	1,118	1,257	12,849
A&E Management	878	858	873	882	881	912	914	904	940	912	1,027	905	10,886
EOC Staff	859	908	900	921	899	936	920	909	985	954	953	982	11,126
PTS Operational Staff	550	570	529	547	128	457	465	442	487	462	466	432	5,534
PTS Management	81	70	86	80	94	86	80	87	87	85	84	82	1,001
Corporate Support	2,145	2,204	2,120	2,143	2,110	2,119	2,125	2,497	2,239	2,199	3,242	2,957	28,100
Sub Total	**13,456**	**13,379**	**13,467**	**13,700**	**13,723**	**13,569**	**13,637**	**14,101**	**15,132**	**14,007**	**15,357**	**15,328**	**168,856**
Average Daily	*449*	*432*	*449*	*442*	*443*	*452*	*440*	*470*	*488*	*452*	*548*	*494*	*463*
Non-Pay Expenditure													
Staff Related	245	206	191	217	189	205	213	198	189	271	231	250	2,604
Subsistence	53	194	125	159	173	150	175	182	188	244	190	201	2,034
Training	40	184	76	134	158	24	116	173	30	119	123	364	1,492
Medical Consumables & Equipme	226	401	340	291	479	341	312	387	396	510	533	1,020	5,237
Drugs	20	34	25	36	37	19	46	55	36	22	46	37	414
Fuel & Oil	296	317	313	324	319	301	342	373	405	406	391	400	4,188
Third Party Transport	29	51	49	77	113	55	94	92	84	133	161	320	1,259
Vehicle Costs	589	1,044	884	1,021	925	895	977	1,614	1,681	1,091	1,034	2,790	14,545
Accommodation & Estates	707	755	754	623	805	605	757	751	543	922	832	1,186	9,238
Telecommunications	354	426	340	619	407	576	201	489	516	477	677	2,301	7,382
Depreciation	484	494	489	496	510	523	579	534	542	524	524	532	6,230
Other Expenses	470	949	654	740	736	461	184	57	109	214	425	2,109	7,109
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**	**4,932**	**5,167**	**11,509**	**61,744**
Average Daily	*117*	*163*	*142*	*153*	*156*	*137*	*129*	*163*	*152*	*159*	*185*	*371*	*169*
Financial Expenditure	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**260**	**246**	**235**	**3,305**
Average Daily	*11*	*10*	*9*	*9*	*9*	*10*	*10*	*8*	*8*	*8*	*9*	*8*	*9*
Monthly Expenditure	**17,289**	**18,730**	**18,003**	**18,730**	**18,864**	**17,968**	**17,931**	**19,253**	**20,096**	**19,199**	**20,770**	**27,072**	**233,904**
Cumulative	**17,289**	**36,019**	**54,021**	**72,752**	**91,616**	**109,584**	**127,514**	**146,767**	**166,863**	**186,062**	**206,832**	**233,904**	
Monthly Net	**717**	**89**	**406**	**-161**	**509**	**1,678**	**1,555**	**29**	**-942**	**869**	**-1,129**	**-2,355**	**1,267**
Cumulative Net	**717**	**806**	**1,212**	**1,051**	**1,560**	**3,238**	**4,794**	**4,823**	**3,881**	**4,750**	**3,621**	**1,267**	

LONDON AMBULANCE SERVICE NHS TRUST

Comparison of annual forecast
As at 29 February 2008 (Month 11)
£000s

	M10 fcast £000s	M11 fcast £000s	Difference	Comments
Income	**235,018**	**235,171**	**-153**	£50k Increase in Stadia, £31k adj in A&E income, £27k increase in ECP Income
Pay Expenditure				
A&E Operational Staff	**99,145**	**99,360**	**215**	Overtime Incentive of £522k offset by £300k reduction in A&E Staff due to recruitment timing and skill mix differences
Overtime	**12,666**	**12,849**	**183**	To reflect £100k increase in A&E overtime in Feb and a revision to 52000 hours in March
A&E Management	**10,795**	**10,886**	**91**	£127k adjustment for DSO Overtime Payment
EOC Staff	**11,318**	**11,126**	**-193**	Reflects additional leavers and reduced recruitment
PTS Operational Staff	**5,501**	**5,534**	**33**	
PTS Management	**998**	**1,001**	**3**	
Corporate Support	**28,546**	**28,100**	**-447**	To reflect an adjustment to the AFC provision (£306k) and £40k relating to weekly payroll previous month's correction and £80k revision of Fleet Maintenance staff pay
Sub Total	**168,970**	**168,856**	**-114**	
Non-Pay Expenditure				
Staff Related	**2,667**	**2,604**	**-63**	
Subsistence	**2,008**	**2,034**	**26**	
Training	**1,682**	**1,492**	**-189**	Reflects a revision to the ITS forecast
Medical Consumables & Equipment	**5,067**	**5,237**	**170**	Reflects a revision to the ITS forecast
Drugs	**400**	**414**	**14**	
Fuel & Oil	**4,196**	**4,188**	**-8**	
Third Party Transport	**1,050**	**1,259**	**209**	Reflects a revision to the ITS forecast
Vehicle Costs	**13,611**	**14,545**	**934**	To provide for the cost of leased ambulances vehicle conversion
Accommodation & Estates	**9,132**	**9,238**	**106**	Reflects an adjustment to the ITS forecast on estates maintenance (£60k) & an additional £40k Make Ready spend for extra location cleaning and Infection Control
Telecommunications	**7,915**	**7,382**	**-534**	Reflects the capitalisation of dynamic deployment software (£250k), deferral of the MDT update (£162k) and a revision to the ITS forecast (£94k)
Depreciation	**6,225**	**6,230**	**5**	
Other Expenses	**7,578**	**7,109**	**-469**	An adjustment made to reserves to account for lower than forecast expenditure on SPPPs plus a £50k reversal of printing order
Profit/(Loss) on Disposal FA	**12**	**12**	**0**	
Sub Total	**61,542**	**61,744**	**201**	
Financial Expenditure	**3,302**	**3,305**	**3**	
Monthly Expenditure	**233,814**	**233,904**	**-90**	
Forecast Net position	**1,204**	**1,267**	**62**	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
As at 29 February 2008 (Month 11)

Current Year

	MONTHLY SPEND														
	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**17,869**	**17,919**	**17,919**	**19,129**	**18,006**	**18,819**	**18,409**	**18,569**	**19,373**	**19,646**	**19,486**	**19,282**	**19,154**	**20,068**	**19,641**
Pay Expenditure															
A&E Operational Staff	7,907	7,852	8,006	6,770	8,087	8,036	8,024	7,995	8,440	8,018	8,088	8,113	9,149	8,227	8,468
Overtime	1,197	927	542	879	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,168	1,118
A&E Management	856	841	882	839	878	858	873	882	881	912	914	904	940	912	1,027
EOC Staff	872	838	871	703	859	908	900	921	899	936	920	909	985	954	953
PTS Operational Staff	593	573	547	393	550	570	529	547	128	457	465	442	487	462	466
PTS Management	82	83	84	73	81	70	86	80	94	86	80	87	87	85	84
Corporate Support	1,156	2,022	1,948	3,506	2,145	2,204	2,120	2,143	2,110	2,119	2,125	2,497	2,239	2,199	3,242
Sub Total	**12,663**	**13,136**	**12,881**	**13,165**	**13,456**	**13,379**	**13,467**	**13,700**	**13,723**	**13,569**	**13,637**	**14,101**	**15,132**	**14,007**	**15,357**
Average Daily	*408*	*424*	*416*	*425*	*449*	*432*	*449*	*442*	*443*	*452*	*440*	*470*	*488*	*452*	*548*
Non-Pay Expenditure															
Staff Related	444	321	293	169	245	206	191	217	189	205	213	198	189	271	231
Subsistence	0	0	0	0	53	194	125	159	173	150	175	182	188	244	190
Training	140	132	126	191	40	184	76	134	158	24	116	173	30	119	123
Drugs	0	0	0	0	20	34	25	36	37	19	46	55	36	22	533
Medical Consumables & Equipment	367	383	388	248	226	401	340	291	479	341	312	387	396	510	46
Fuel & Oil	317	323	298	318	296	317	313	324	319	301	342	373	405	406	391
Third Party Transport	27	14	37	73	29	51	49	77	113	55	94	92	84	133	161
Vehicle Costs	827	1,109	753	869	589	1,044	884	1,021	925	895	977	1,614	1,681	1,091	1,034
Accommodation & Estates	605	615	692	716	707	755	754	623	805	605	757	751	543	922	832
Telecommunications	374	555	477	606	354	426	340	619	407	576	201	489	516	477	677
Depreciation	478	530	478	484	484	494	489	496	510	523	579	534	542	524	524
Other Expenses	1,026	357	373	336	470	949	654	740	736	461	184	57	109	214	425
Profit/(Loss) on Disposal FA	2	6	0	10	0	2	17	0	1	0	0	2	0	0	0
Sub Total	**4,550**	**4,345**	**3,915**	**4,020**	**3,513**	**5,053**	**4,257**	**4,736**	**4,850**	**4,107**	**3,999**	**4,903**	**4,719**	**4,932**	**5,167**
Average Daily	*147*	*140*	*126*	*130*	*117*	*163*	*142*	*153*	*156*	*137*	*129*	*163*	*152*	*159*	*185*
Financial Expenditure	**319**	**315**	**322**	**273**	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**260**	**246**
Average Daily	*10*	*10*	*10*	*9*	*11*	*10*	*9*	*9*	*9*	*10*	*10*	*8*	*8*	*8*	*9*
Monthly	**17,532**	**17,797**	**17,117**	**17,459**	**17,289**	**18,730**	**18,003**	**18,730**	**18,864**	**17,968**	**17,931**	**19,253**	**20,096**	**19,199**	**20,770**
Monthly net	**337**	**122**	**802**	**1,671**	**717**	**89**	**406**	**(161)**	**509**	**1,678**	**1,555**	**29**	**(942)**	**869**	**(1,129)**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 29 February 2008 (Month 11)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	18,804	17,502	1,302F	201,161	192,512	8,649F	4.5%F	225,102	210,013	15,090F
Sector Services	11,311	11,007	(304)U	122,564	116,278	(6,287)U	(5.4%)U	134,526	127,255	(7,270)U
A&E Operational Support	1,160	961	(199)U	11,468	10,959	(509)U	(4.6%)U	13,888	12,131	(1,757)U
Control Services	1,246	1,129	(117)U	13,138	12,329	(809)U	(6.6%)U	14,475	13,462	(1,013)U
Urgent Care Services	1,031	1,046	15F	10,120	11,481	1,360F	11.8%F	11,241	12,526	1,285F
Total Operations Cost	**14,747**	**14,143**	**(604)U**	**157,291**	**151,047**	**(6,244)U**	**(4.1%)U**	**174,130**	**165,374**	**(8,756)U**
A&E Gross Surplus/(Deficit)	**4,056**	**3,359**	**697F**	**43,871**	**41,466**	**2,405F**	**5.8%F**	**50,972**	**44,639**	**6,334F**
Gross Margin	21.6%	19.2%	3.7%F	21.8%	21.5%	0.3%		22.6%	21.3%	1.4%
Medical Directorate	72	74	1F	714	793	79F	9.9%F	813	869	55F
Service Development	58	63	5F	563	622	59F	9.5%F	629	814	185F
Communications	157	156	(1)U	1,324	1,587	262F	16.5%F	1,455	1,745	290F
Human Resources	888	863	(25)U	9,682	10,143	461F	4.5%F	10,546	11,204	658F
IM&T	1,148	777	(370)U	7,690	7,849	160F	2.0%F	8,502	8,881	379F
Finance	2,762	1,621	(1,141)U	19,289	18,634	(655)U	(3.5%)U	26,720	20,380	(6,340)U
Chief Executive	103	92	(12)U	1,108	1,041	(68)U	(6.5%)U	1,202	1,130	(72)U
Total Corporate	**5,188**	**3,646**	**(1,542)U**	**40,370**	**40,668**	**298F**	**0.7%F**	**49,866**	**45,023**	**(4,844)U**
A&E Net Surplus/(Deficit)	**(1,132)**	**(287)**	**(845)U**	**3,500**	**798**	**2,703F**	**338.7%F**	**1,106**	**(384)**	**1,490F**
A&E Net Margin	(6.0%)	(1.6%)	(4.8%)U	1.7%	0.4%	1.3%	320%	0.5%	(0.2%)	0.7%
Patient Transport Service	**3**	**27**	**(24)U**	**121**	**369**	**(248)U**	**(67.2%)U**	**161**	**384**	**(223)U**
PTS Gross Margin	0.4%	3.5%	(3.1%)U	1.3%	4.2%	(2.9%)U		1.6%	4.1%	(2.4%)U
Trust Result *Surplus/(Deficit)*	**(1,129)**	**(261)**	**(868)U**	**3,621**	**1,167**	**2,454F**	**210.3%F**	**1,267**	**0**	**1,267F**

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 29 February 2008 (Month 11)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	8,468	8,347	(120)U	90,646	90,700	55F	0.1%F	99,360	99,247	(113)U
Overtime	1,118	667	(451)U	11,592	7,327	(4,265)U	(58.2%)U	12,849	7,994	(4,855)U
A&E Management	1,027	902	(124)U	9,981	9,863	(118)U	(1.2%)U	10,886	10,765	(121)U
EOC Staff	953	1,025	72F	10,144	11,162	1,018F	9.1%F	11,126	12,184	1,058F
PTS Operational Staff	466	446	(20)U	5,103	5,131	28F	0.5%F	5,534	5,578	44F
PTS Management	84	80	(4)U	919	893	(26)U	(2.9%)U	1,001	973	(28)U
Corporate Support	3,242	2,189	(1,053)U	25,143	24,388	(755)U	(3.1%)U	28,100	26,580	(1,519)U
	15,357	**13,657**	**(1,700)U**	**153,528**	**149,464**	**(4,064)U**	**(2.7%)U**	**168,856**	**163,322**	**(5,534)U**
Non-Pay Expenditure										
Staff Related	231	204	(27)U	2,355	2,302	(52)U	(2.3%)U	2,604	2,507	(98)U
Subsistence	190	61	(129)U	1,833	754	(1,078)U	(142.9%)U	2,034	816	(1,218)U
Training	123	116	(7)U	1,129	1,378	250F	18.1%F	1,492	1,487	(6)U
Drugs	46	43	(2)U	377	516	139F	26.9%F	414	564	150F
Medical Consumables & Equipment	533	300	(233)U	4,217	3,506	(710)U	(20.3%)U	5,237	4,011	(1,226)U
Fuel & Oil	391	286	(105)U	3,787	3,376	(411)U	(12.2%)U	4,188	3,692	(495)U
Third Party Transport	161	51	(110)U	939	594	(345)U	(58.0%)U	1,259	651	(608)U
Vehicle Costs	1,034	894	(140)U	11,755	9,746	(2,009)U	(20.6%)U	14,545	10,640	(3,905)U
Accommodation & Estates	832	563	(269)U	8,052	7,645	(407)U	(5.3%)U	9,238	8,200	(1,038)U
Telecommunications	677	480	(197)U	5,081	4,840	(241)U	(5.0%)U	7,382	5,320	(2,062)U
Depreciation	524	499	(25)U	5,698	5,484	(215)U	(3.9%)U	6,230	6,506	276F
Other Expenses	425	1,046	621F	5,000	6,935	1,935F	27.9%F	7,109	7,931	822F
Profit/(Loss) on Disposal FA	0	0	0	12	0	(12)U		12	0	(12)U
	5,167	**4,544**	**(623)U**	**50,235**	**47,077**	**(3,158)U**	**(6.7%)U**	**61,744**	**52,325**	**(9,419)U**
Financial Expenditure	**246**	**319**	**73F**	**3,069**	**3,514**	**445F**	**12.7%F**	**3,305**	**3,834**	**529F**
Total Trust Expenditure	**20,770**	**18,520**	**(2,250)U**	**206,832**	**200,056**	**(6,776)U**	**(3.4%)U**	**233,904**	**219,481**	**(14,423)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 29 February 2008 (Month 11)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	16,266	16,304	(38)U	183,675	179,347	4,328F	(2.4%)U	200,949	195,651	5,298F
HEMS Funding	11	3	8F	44	32	12F	(35.9%)U	54	35	19F
Other A&E Income	90	88	2F	977	968	9F	(0.9%)U	1,065	1,056	9F
Foundation Trust Income	9	28	(19)U	171	307	(136)U	44.5%F	183	335	(152)U
CBRN Income	821	717	104F	8,696	7,890	806F	(10.2%)U	9,517	8,607	910F
ECP Income	60	10	49F	282	115	168F	(146.5%)U	316	125	191F
BETS & SCBU Income	57	86	(30)U	803	948	(145)U	15.3%F	878	1,034	(157)U
A & E Long Distance Journey	56	33	23F	422	365	57F	(15.6%)U	460	398	62F
Stadia Attendance	94	56	38F	961	608	353F	(58.0%)U	1,012	663	349F
Heathrow BAA Contract	25	39	(14)U	372	434	(62)U	14.3%F	416	473	(57)U
Resus Training Fees	4	10	(6)U	93	108	(15)U	13.8%F	95	118	(23)U
Education & Training Income	35	23	13F	466	248	219F	(88.4%)U	499	270	229F
	17,528	**17,398**	**130**	**196,961**	**191,368**	**5,593**	**(2.9%)U**	**215,443**	**208,765**	**6,679F**
PTS Income	837	758	115F	9,292	8,711	906F	12.1%F	10,069	9,468	961F
Other Income	1,276	104	1,172F	4,200	1,144	3,056F	267.2%F	9,659	1,248	8,411F
Trust Result	**19,641**	**18,260**	**1,381F**	**210,453**	**201,223**	**9,231F**	**4.6%F**	**235,171**	**219,481**	**15,690F**

LONDON AMBULANCE SERVICE NHS TRUST
Capital Programme 2007/08
Capital forecast as at 28th February 08

		Capital Budget 2007/08	Capital Forecast 2007/08	Variance	Comments
	Projects C/fwd				
T	Major Vehicles	462,000	354,048	107,952	Forecast is based on ytd total costs of 06/07 RRUs
T	Minor Vehicles	189,200	150,648	38,552	Bromley PTS vehicles, CBRN SWEDE and Cycle Transporter Vehicle planned to be purchased in 07/08. Forecast reflects Negotiated discount on CBRN SWEDE base vehicle purchase
P&M	Major Equipment	0	9,173	(9,173)	Ad hoc costs in 07/08 for LP12 Defibs for 06/07 RRUs. We do not anticipate further costs
P&M	Minor Equip	0	8,341	(8,341)	Cost related to old project: Upgrade of Video Production Equipment. We do not expect further costs
B	Major Estates	1,391,875	967,060	424,815	Several projects now deferred to 08/09. Revision of costs for New Brixton AS, Refurbishment of 1st Floor HQ, Becontree Roof & Wall Cladding and Refurbishment of New Addington
B	Minor Estates	782,940	613,987	168,953	Revision of costs for Buckhurst Hill disposal, Deptford replacement windows and Bromley replacement windows & mast removal. This is in addition to settlement of final accounts on completed projects as some amounts retained initially
IT	Major IM&T	2,813,074	2,504,311	308,763	Revision of forecasts in Feb 08. Zero cost forecasted for Increased network bandwidth project
IT	Minor IM&T	80,000	151,527	(71,527)	Expenditure related to old projects now settled together and revision of forecast for Fully integrated supply chain project
		5,719,089	4,759,095	959,994	
	New Projects				
T	Major Vehicles	5,481,513	2,957,243	2,524,270	PTS vehicle procurement deferred. Expecting delivery of 83 RRUs and Base vehicle costs for Zafira Fast Response Unit for Driver training before Mar 08
T	Minor Vehicles	28,200	0	28,200	Modifications to ESV is classified as revenue expenditure
P&M	Major Equipment	277,150	94,225	182,925	Cost of IDRs expensed in 06/07 and Paediatric restraints deferred to 08/09. Expecting costs related to 8 Casualty clearing tents in 07/08
P&M	Minor Equip	73,814	0	73,814	Hand held stock mgt to be funded from ITS. CBRN Transporter deferred to 08/09
B	Major Estates	1,241,750	242,892	998,858	Several projects now deferred to 08/09 and revision of project costs in 07/08
B	Minor Estates	395,500	203,369	192,131	Some projects deferred to 08/09
IT	Major IM&T	865,625	802,722	62,904	More than planned expenditure for VN Ware & SAN and Capitalisation of Dynamic Deployment Software
IT	Minor IM&T	549,023	227,390	321,633	Some project costs funded by ITS. Revision of forecast for IPT and Programme & Project Mgt software
	Other	0	0	0	
		8,912,575	4,527,840	4,384,734	
	Gross Total	14,631,664	9,286,935	5,344,728	
	Disposals	(3,300,000)	(3,900,000)	600,000	Buckhurst Hill
	Net Total	11,331,664	5,386,935	5,944,728	
	CRL	8,978,000	8,978,000		
	(Over)/Under Commitment	(2,353,664)	3,591,065		