LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 20th May 2008 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1. Apologies & Declarations of Further Interest.		
2. Opportunity for Members of the Public to ask Questions.		
3. Minutes of the meeting held on 18th March 2008 Part 1 and synopsis of the Part II meeting held on 18th March 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 12 2007/08	MD	Enclosure 4
8. Financial Report, Month 1 2008/09	MD	Enclosure 5
9. Report of the Medical Director	FM	Enclosure 6
10. Receive Annual Complaints and PALS Report	PB	Enclosure 7
Refreshments		
11. Approve Workforce Plan	CH	Enclosure 8
12. Approve FT Project Plan	MD	Enclosure 9
13. Receive report regarding Call Connect Diagnostic Visit to LAS	RW	Enclosure 10
14. Approve Fleet Plan	RW	Enclosure 11
15. Rules on the capture, recording and calculation of LAS performance (KA34)	PS	Enclosure 12
16. Estates Plan Update including ratification of Chairman's Urgent Action in respect of the sale of Buckhurst Hill.	MD	Presentation Enclosure 13
17. Discuss LAS approach to Corporate Social Responsibility	MD	Presentation
18. Note results of Board Effectiveness Review	SR	Presentation
19. Service Improvement Programme 2012 Update	PB	Enclosure 14

20	Draft Minutes of Clinical Governance Committee, 28th April 2008	BM	Enclosure 15
21	Draft minutes of the Remuneration Committee, 18th March 2008	SR	Enclosure 16
22.	Draft notes of the Board's Away Day 29th April 2008	SR	Enclosure 17
23.	Report from Trust Secretary on tenders opened since the last Board meeting	CMc	Enclosure 18
24.	Opportunity for members of the public to ask question		Oral
25.	Date of next meeting: 10.00am on 29th July 2008, Conference room, LAS HQ, Waterloo Road.		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 18th March 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
	Brian Huckett	Non Executive Director
	Caroline Silver	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Martin Flaherty	Director of Operations
	Caron Hitchen	Director of Human Resources & Organisation Development
In Attendance:		
	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	George Shaw	LAS Patients' Forum
	Angie Patton	Head of Communications
	Christine McMahon	Trust Secretary (Minutes)

22/08 Declarations of Further Interest

There were no declarations of further interest.

23/08 Opportunity for Members of the Public to ask Questions

There were no questions from members of the public.

24/08 Minutes of the Meeting held on 29th January 2008

Agreed: The minutes of the meeting held on 29th January 2008 with the correction to minute 14/08, 'Category A were the most expensive calls due to the despatch of multiple responses, which included fast response cars and ambulances, to ensure the achievement of the Category A8 minute response time.

25/08 Synopsis of the Trust Board's Part II meeting held on 29th January 2008

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

26/08 Matters arising from the minutes of the meeting held on 29th January 2008

Noted:

1. **Minute 06/08: That the Chairman will write to the Mayor of London, pointing out that one of Mayor's responsibilities was the reduction in health inequalities and highlight how Emergency Life Support training fell into that category. ACTION: The Chairman**
2. **Minute 09/08: That the Trust Board in May will receive a report on the benefits realised from the Invest to Save Programme. The report will include the benefits realised from the Frequent Callers Project. ACTION: Finance Director**
3. **Minute 10/08: That in regard to Left Bundle Branch Block (LBBB), the Medical Director said that the exact number of patients conveyed to 'Heart Attack Centres' since the change in the procedure was very small, and the number of patients in the community with asymptomatic LBBB was approximately 0.45% (men) and 0.2% (women).**

27/08 Chairman's remarks

The Chairman said that the arrangements for the Board's Away Day in April were progressing well. Three NHS Foundation Trust Chairmen were attending the morning session to talk about their respective Trust's experience of becoming a foundation trust. In the afternoon David Sissling, Programme Director of Healthcare for London, will be attending to discuss the future implementation of the Healthcare for London programme.

28/08 The Chief Executive's report

The Chief Executive presented his regular report to the Board. The Trust had achieved its best performance to date in terms of call answering and its response to Category A[1] and Category B[2] calls. Preparations were in place to ensure that the Trust is in a good position to respond to the new Call Connect[3] target commencing April 2008.

Achieving the required 75% 'Call Connect' Category A performance target in April would be a significant challenge given that the Trust had achieved 65% Call Connect Category A performance in March. Amongst the number of initiatives being considered to ensure that this performance target is achieved was Active Area Cover[4]. Negotiations were taking place with Staff Side regarding Active Area Cover and it was anticipated that once agreement had been reached front line staff would be activated from a mobile start rather than, as is the current practice, from their ambulance stations.

Despite the recent disruption caused by refurbishment of the call taking area in the main Control Room, call taking had remained consistently high. The refurbishment has improved the working environment and will ultimately provide 36 call taking positions which is an increase of 10 over and above that provided by the old layout.

The Chief Executive said that the take-up of overtime was disappointing and the Trust currently has a number of vacancies among front line crews. The Workforce Plan was being re-worked in light of the additional investment secured from Commissioners to achieve the new Call Connect standards. The Trust would be recruiting 100 paramedics and student

[1] Category A: presenting conditions which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.
[2] Category B: presenting conditions which though serious are not immediately life threatening and must receive a response within 19 minutes.
[3] Call Connect: Call Connect: ambulance response times are currently measured from a point when 3 pieces of key information has been obtained (location, telephone number and chief complaint). From 1 April 2008, the clock will start earlier - when the call is connected to the ambulance control room.
[4] Active Area Cover – previously known as dynamic deployment.

paramedics and 100 A&E support workers in early 2008/09. A more detailed report will be presented to the Trust Board in May 2008. **ACTION: HR Director.**

The Director of Information Management and Technology spoke about the recent problems experienced with the Trust's email system; the cause and the remedial action taken. The Board was assured that 999 call handling was not affected.

The Patient Transport Service (PTS) had a good year financially, was meeting its performance targets and had won a number of additional contracts e.g. Whipps Cross.

Efforts were continuing to ensure that sickness absence was actively managed as this had risen in recent months. The Chief Executive expressed particular concern at the increased level of sickness absence reported by PTS.

The allocation of rest breaks was also a concern; the Director of Operations said there would be a renewed focus in the Control Room, despite the current performance pressures, to ensure that the number of crews receiving breaks was improved. Management and staff side representatives were currently undertaking a joint review of the Rest Break Agreement.

The Chief Executive said that the Director of Communications was preparing a public education campaign that would be launched at the end of the March, asking the public to use the ambulance service thoughtfully.

The ending of administrative handover at hospitals took place as planned on 10th March and has been generally well received by members of staff. Management presence has been increased at hospitals throughout the two weeks following 10th March and local teething problems were being addressed, both with our own members of staff and the hospitals themselves. The next Chief Executive's report will provide some further detail on the changes and the impact on overall job cycle times. **ACTION: Director of Operations.**

The LAS has recently assisted other ambulance trusts. Ten ambulances were lent to the Great Western Ambulance Service, who had a particularly acute vehicle problem, and more recently six control room members of staff were provided to assist South Central Ambulance Service.

It was Noted that:

A&E Departments in North East London in particular had experienced significant capacity issues in recent weeks leading to an unacceptable level of diverts and closures. The Service was working closely with the trusts concerned to try and broker sensible diverts across the area and so help alleviate potentially capacity problems.

The Trust had reached 75% of Category A calls in every Primary Care Trust (PCT) area but two (Richmond and Twickenham) and had met the target of not falling below 70% in any PCT area.

The recent national review of Agenda for Change had not altered the framework for ambulance trusts in respect of unsocial hours payment.

The LAS' Patients' Forum will officially cease to exist as a statutory body with effect from 31st March and will be replaced by LINks[5]. The LAS' Patients' Forum has set itself up as an independent charity. A proposal to enter into a formal Memorandum of Understanding has been received from the Forum and is under consideration.

The deployment of additional resources, such as motorcycle and bicycles, has improved performance times by 1-2% in Tower Hamlets and Newham.

A strategic review was being undertaken of Emergency Bed Service (EBS) and will be presented to the Trust Board in July. **ACTION: Director of Operations.**

[5] LINks: Local Involvement Networks, whose role will be to find out what people want, monitor local health and social care services and se their powers to hold local authorities and other service providers to account.

Although EOC has a higher staff turnover than A&E operations, this was normal for this area of work. The HR Director confirmed that the EOC staff receive the same incentives as front line operational staff as they are considered to be operational staff. She also pointed out that a proportion of those who leave EOC do not leave the Trust but do so to train as front line staff. A detailed breakdown of EOC leavers will be presented to the Trust Board in May 2008. **ACTION: HR Director.** The HR Director said that the Trust had been successful in recruiting to EOC.

The 'Insight into Management' Scheme, which was undertaken in East London, had been a very worthwhile project. Although the five young participants in the Scheme had not expressed interest in joining the LAS as operational members of staff, there was interest expressed in the work of the IT department.

Agreed:

1. **To express its appreciation of the contribution that the LAS Patients' Forum had made to the work of the Trust.**
2. **To congratulate the staff of EOC in maintaining the service under challenging circumstances and also to the support provided by the Estates and the IM&T departments which enable the refurbishment to proceed smoothly.**
3. **To congratulate the A&E service, both staff and management teams, in achieving the best ever annual operational performance against a background of rising demand and the challenges of preparing for Call Connect.**

29/08 Financial Report, Month 11

The Director of Finance apologised that the normal financial report had not been presented; this was due to the Board meeting taking place earlier than normal in the month because of Easter falling in March. A full financial report would be circulated to Board members. **ACTION: Director of Finance.**

The forecast year end position is £1.2m surplus. There has been a lot of activity in procurement and other departments to ensure that the Invest to Save programme was delivered this financial year. The Invest to Save Programme comprised 110 projects and a review of the benefits realised would be undertaken to ensure that value for money had been obtained. The findings will be presented to the Trust Board in May 2008. **ACTION: Director of Finance.**

The Director of Finance was undertaking a review of the balance sheet, which will include a review of the vehicle leasing arrangements. The outcome of the review will be reported to the Audit Committee in April and to the Trust Board in May 2008.

The Trust has reached a settlement of £1m with the Commissioners in respect of the various penalties inherent in the 2007/08 A&E contract.

The Trust was currently forecasting £13m cash at the end of the financial year. Guidance was awaited from the Department of Health as to the amount of cash the Trust would be permitted to retain. The cash would be used to fund the 2008/09 capital programme.

Caroline Silver, Chairman of the Audit Committee, requested that the Internal Auditors, Bentley Jennison, audit the benefits realisation review. **ACTION: Director of Finance**

30/08 Report of the Medical Director

The Medical Director reported that a Serious Untoward Incident (SUI) had been declared since the last Trust Board meeting. It had been declared following a delay in attending a 36 year old female patient who was bleeding heavily. There had been difficulties in communicating with the patient and the family, and the significance of the patient's symptoms were not appreciated.

Sadly, despite the attendance of a Fast Response Car and two ambulances, the patient later died in hospital.

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 a death in police custody of a patient requiring restraint. 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 restraint (perhaps chemical) in the unusual and infrequent circumstances of this kind.

Procedure on the Transportation of Persons to Hospital: an Agreement has been reached with the Metropolitan Police Service (MPS) regarding the transport of persons to hospital. The LAS has written a procedure with the 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 together with a corresponding MPS procedure that was currently in draft. The Agreement between the LAS and the MPS was presented to the Trust Board for ratification.

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

Patient Specific Protocols (PSP) & Out of Hours (OOH) Palliative Care Handover Forms 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 Attempt Resuscitate" information. The OOH form system is being rolled out slowly across all London PCTs.

Equipment purchased via the Invest to Save (ITS) Programme has included 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.

- Sandell Paediatric Tape for providing information on drug dosage and equipment sizing 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 as a 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

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.

Introduction of Oromorph - the smallest bottles of oral morphine available for LAS to purchase were 100ml, following a change in presentation by the manufacturer. Fortunately Frimley Park Hospital Pharmacy has agreed to decant the drug into 20ml bottles. It is intended that two 20ml bottles will be placed into the paramedic drug pack along with 5ml oral syringes and bungs, over the forthcoming months.

The Clinical Audit & Research Unit provided a summary of the report examining the factors associated with survival from cardiac arrest for patients treated by staff from the Waterloo Complex. 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 included the role of the motorcycle response unit and points to some areas for potential improvement.

The Risk Management Policy has been updated and amended in accordance with the Trust's Policy and Procedural requirements for an annual review of key governance documents. Guidance is awaited from the NHS Litigation Authority before the document is finalised.

'Making Improvements Count'. The LAS has been chosen to act as an 'Early Adopter' Trust for 'Making Improvements Count.' This is the Department of Health Consultation document that sets out proposals to review and revise the NHS Complaints procedure. It is envisaged that Patients Advice Liaison Service (PALS) is 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 give the Trust the opportunity 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

Measles: there have been outbreaks of measles in several London boroughs. The percentage of patients that were routinely inoculated against measles has fallen in the last ten years due to concerns relating to the MMR vaccine. There has been an increase in the number of reported cases with approximately 900 reports of incidents measles in the UK in 2007. Recently two members of staff were suspected of contracting measles and the Trust liaised with the Health Protection Agency (HPA) and the Occupational Health Service.

HART (Hazardous Area Response Team, which is now part of the Incident Response Unit, IRU) participated in the recent Exercise Orpheus[6]. There were significant number of lessons learnt and the team presented itself very positively.

It was Noted that:

The Trust was considering its position in respect of introducing screening for measles for both recruits and existing front line staff. The Director of Operations said that the suspicion of exposure to measles has a potentially serious impact on staffing resources as staff that had come into contact with someone who had been diagnosed as having measles had to be tested and in the interim were unavailable for work. In answer to a question the Medical Director said that she did not think the use of immunoglobulin would be a viable alternative to screening due to its limited availability.

The Trust has not yet appointed an Infection Control Manager but efforts to recruit to this post were continuing.

The Chairman suggested the team undertaking the Hypothermia Pilot should liaise with South East Coast Ambulance Service (SECAmb) which was also undertaking a pilot, as it would enlarge the number of patients. The Medical Director said she would share the suggestion with the team. **ACTION: Medical Director**

POST MEETING NOTE: SECAmb has not yet implemented therapeutic hypothermia, although it is considering so doing.

Agreed: To ratify the agreement with the Metropolitan Police Service, and the procedure, concerning the transportation of patients to hospital

31/08 <u>Update re. submission of 2008/09 Budget and three year plan</u>

The Finance Director said that the final 2008/09 budget and three year plan had been submitted to the London Provider Agency (LPA) following approval at the recent Service Development

[6] Exercise Orpheus: a training exercise that was part of the programme of Health Protection Agency exercises run on behalf of the Department of Health.

Committee in February[7]. Although queries were received asking for clarification no negative feedback has been received.

It was Noted that:

There has been an internal restructure at the LPA with the number of performance managers cut from three to one.

The 2008/09 agreement with Commissioners included a penalty if the Trust failed to achieve 90% Category B performance target; there was no penalty attached to failing to achieve 75% Category A performance target.

32/08 Final Assurance Framework for the Annual Healthcheck 07/08

The Director of Finance presented the Final Assurance Framework for the Annual Healthcheck 2007/08. An event was held on the 13th March, "247247" at which the Trust demonstrated its compliance with the Healthcheck standards. The event was attended by representatives from 13 of the Overview and Scrutiny Committees of the 32 London Boroughs; the LAS' Patients' Forum and the Healthcare

Commission. Questions were asked by attendees concerning the potential impact of hospital closures and the implications of the Trust becoming a foundation trust.

As part of the Assurance Framework the Board received a report that set out the Trust's 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 were mapped against the domains and healthcare standards of the Annual Health Check.

It was Noted that:

In the column reporting the control systems in place there appeared to be the inclusion of future action points rather than current controls in place. The Finance
Director said he would review this, perhaps by amending the column's title. **ACTION: Finance Director**

Risk 273 and 274 highlighted there was currently no fall back control for Urgent Operations Centre or the Incident Control Room although there is one for Emergency Operations Centre. These two risks were being managed through the Business Continuity Steering Group.

Agreed:
1. **That the Final Assurance Framework provided evidence of full compliance for the Annual Health Check**
2. **That the Final Declaration be submitted stating that the Trust is fully compliant with the core standards of the Annual Health Check 2007/08.**

33/08 Foundation Trust Application

The Director of Finance presented a brief overview regarding foundation trust status which described NHS Foundation Trusts:

- a new type of NHS organisation, established as independent public benefit corporation similar to mutual organisations such as the Co-op or building
  societies; providers of healthcare according to core NHS principles – free care, based on need and not ability to pay;
- required to meet the Department of Health's national standards on service quality and effectiveness;
- authorised and monitored by Monitor, the independent Regulator of NHS Foundation Trusts.

[7] In January 2008, the Trust Board delegated authority to the Service Development Committee to approve the 2008/09 budget and three year plan in order to meet the LPA's deadline of 28th February 2008 (Minute 11/08).

The paper set out the benefits and disadvantages of the LAS becoming a foundation trust. The benefits included: an opportunity for a more meaningful connection with the public, our patients and our staff by becoming a true 'membership organisation'; financial flexibility to facilitate delivery of our strategic plan and greater strategic freedom to engage effectively with other NHS partners in delivering better quality healthcare for London. The disadvantages included the cost of preparing an application and of a significant investment in management time at a challenging time for the LAS and the lack of support from the local Unison representative.

In discussion it was Noted that:

In making the argument for foundation trust status, specific examples should be given of what would be the benefits for patients and staff.

The benefits to the Ambulance Service were less obvious than for Acute Trusts, as ambulance services have historically suffered less interference than that experienced by other parts of the NHS.

The Unison Branch Secretary had reservations concerning the LAS becoming a foundation trust. These were outlined in an email to the Director of Finance and a copy of this was circulated with the agenda. Discussions would take place with Staffside representatives, reassuring them that becoming a foundation trust would not affect the current Partnership Agreement.

A report detailing the proposed project plan, budget and governance arrangements to progress the foundation trust application would be presented to the Trust Board in May 2008. **ACTION: Finance Director.**

Agreed: That the LAS should progress a foundation trust application.

34/08 <u>Communication and Engagement Strategy</u>

The Director of Communications presented the Communications and Engagement Strategy that had been amended to reflect the comments made when the document was considered by the Service Development Committee in February 2008.

The objectives of the strategy included:

- increasing Londoners' understanding of our role and future plans;
- involving the public and patients in shaping the way the Trust delivers its service and building relations with those people who are key stakeholders in our Service Improvement Programme;
- improving our reputation among black and minority ethnic (BME) communities;
- developing our public affairs activity and develop an environment where members of staff feel valued, are proud to work for the Service and actively contribute to improving patient care.

The research undertaken by MORI in 2006 informed the strategy, particularly the need to provide the public with more information about the role of the ambulance service and to investigate why those in black and minority ethnic communities tended to speak less highly of the Service than others. The Director of Communications said that the findings of the MORI research could be found on the Trust's web site.

The strategy comprised both long term objectives (as set out above) and specific pieces of work which would be undertaken in 2008/09, such as supporting the Service Improvement Programme (Call Connect, New Ways of Working, CAD 2010 and the Olympics). Other work would include involving and informing patients and the public, developing key messages, adding to communication tools (for example by introducing a new web site) and demonstrating learning from feedback received, for example from PALS' enquiries or complaints. Work would also continue to implement strong internal communications and to ensure that there was an infrastructure in place to ensure the Trust can instil confidence in times of crisis. The Board

will receive an annual report on the implementation of the Communications and Engagement Strategy. **ACTION: Director of Communications**

It was Noted that:

The strategy, which was felt to be well written, would be placed on the Trust's web site for a wider audience than the Trust Board to read. **ACTION: Director of Communications**

It is planned that the Trust would have the facility to recruit via its web site in the next 12 months although this function was not yet in place. The HR Director said she expected to have the necessary interface with NHS Jobs on the Trust's web site within the next 12 months.
In the section that refers to BME communities being less satisfied with the service than the population at large it was proposed that the phrase 'as with many public bodies' be removed from the document as it might convey the impression that the lower satisfaction was, therefore, OK.

The Director of Service Development reminded the board that, following the Patients' Surveys undertaken by Commission for Health Improvement (CHI) in 2003 and 2004, the Trust had requested that the data be analysed to identify differences in the responses on the basis of ethnicity. This showed that although the level of satisfaction was very high it was less so amongst patients from BME communities. Focus groups were then organised to better understand why this occurred and although the Trust was not able to resolve all the concerns that were raised it has endeavoured to respond to them. For example, front line crews on vehicles can now access LanguageLine to help communication with patients and their carers when there is a language barrier. The Director of Communications said that the Patient Public Involvement (PPI) work currently being undertaken in Tower Hamlets was as a direct result of the findings from the focus groups. The Director of Service Development undertook to share the findings of the focus group with Ingrid Prescod. **ACTION: The Director of Service Development**

In a discussion around raising the profile of the organisation as a employer with various sixth form and higher education establishments it was recognised that trends indicated that the average age that staff join the Service was thought to be in their mid '20s rather than 16 or 18 when they leave school. The HR Director said whilst there was no lower age limit for recruiting staff, the necessity of having a driving licence with C1 category generally meant recruits were over 21 years.

Although the Trust would like to reach out to younger members of the population (and particularly in the BME communities) to encourage them to consider a career in the ambulance service, it was not in a position to offer work experience on the front line due to the nature of the work undertaken. There was, however, a work experience programme in place in support services. The HR Director reminded the Board that the Trust had no difficulty recruiting and that it continued to strive to improve the diversity of its workforce.

Approved: The Communications and Engagement Strategy, 2008-13 which will be reviewed annually by the Trust Board.

35/08 Presentation: Estates Plan Update

The Director of Finance gave a presentation updating the Board on the work being undertaken in respect of the Estates Strategy that will be presented to the Trust Board in July 2008. The Director of Finance proposed that the strategy be a 'live' document, reviewed annually by the Board. **ACTION: Director of Finance**

Work undertaken in 2007/08 included: updating the strategic plan for estates in line with SIP 2102; implementing a workshop project; the sale of Buckhurst Hill and evaluating the fixed satellite options. Links were made with the London Fire Brigade, the Metropolitan Police Service, Transport for London, the Greater London Assembly and NHS London. Work was also undertaken in respect of the Olympics and what additional estates provision would be

necessary, if any. An options analysis in respect of the HQ building was also being undertaken.

The review of the Estates Strategy included exploration of current and future service delivery; evaluation of the existing estate against potential requirements and consideration of options for change and their implications. The strategic considerations included: the requirements of the new Operating Model and Healthcare for London; Emergency Planning; Business Continuity; CAD2010 and the 2012 Olympics.

36/08 **Delivery of 2007/08 Training Plan**

The HR Director presented a report showing activity against the 2007/08 training plan. The report included details of the core clinical and technical training programmes, modular training, station-based training together with non-clinical management and staff development. The activity data gathered from station-based training was being developed to ensure that all activity data was reported.

The introduction of modular training has gone well with over 1,800 attendances in 2007/08; 94-96% of those booked on to training there had attended which was considered to be excellent. The HR Director said that efforts would continue to improve the booking of staff onto training programmes. From May 2008 the following additional Continuing Professional Development (CPD) modules would be introduced: diversity; obstetrics; mental health; 12 Lead ECG (intermediate and advanced); major incidents; advanced patient assessment and referral pathways.

It was Noted that:

44 staff had failed to attend the Patient Assessment module. This module was crucial given the changes in practice that were being introduced across the Trust. The HR Director said that the 7% non-attendance (of those booked on a course) was in line with the Trust's sickness levels and was not therefore thought to be a cause for concern.

Although only 95 of the 106 places on the University of Hertfordshire's BSc course were filled this was not considered by the Executive Directors to reflect negatively on the popularity of the course. The Medical Director said that there was a different cohort of students studying for the BSc four year sandwich degree than on the other further education courses. The Director of Operations said that the course was generally well subscribed and that the Trust was satisfied with the calibre of graduates joining the Trusts on completion of their degree.

37/08 **Final draft of the Trust's submission to the Healthcare for London consultation**

Following the comments and feedback received when the Service Development Committee considered the draft submission to the Healthcare for London, the final response was submitted to NHS London by the required deadline of 7th March 2008.

The Director of Service Development said that the submission would be used, both internally and externally, as a briefing document on the Trust's position regarding Healthcare for London. A key element of the Trust's response has been advocating the introduction of integrated response hubs.

The Trust was working with the Senior Responsible Owners and/or Project Managers of the six workstreams of Healthcare for London: Unscheduled Care; Polyclinics; Stroke; Local Hospital Feasibility; Trauma; Chronic Disease Management. The Medical Director was a member of the Clinical Advisory Group to the 'Healthcare for London' project.

It was Noted that:

Sarah Waller requested a copy of the template concerning polyclinics and a copy of the submission to the Healthcare for London. **ACTION: Medical Director and Director of Service Development.**

The Chronic Diseases Management workstream was initially focussing on diabetes rather then end of life. It was recognised that patients with chronic diseases, which included COPD[8] as well as cancer, often found it very difficult to co-ordinate their care with different NHS providers. The Director of Service Development said the Trust's submission to Healthcare for London included the suggestion that the LAS introduce a register containing information that terminally ill patients wished the Trust to have. This would facilitate a co-ordinated response between the patient's healthcare providers and ensure that the patient's wishes regarding their end of life care was respected.

Two potential bidders to manage polyclinics have expressed interest in working closely with the LAS in preparing their bids.

Lord Darzi had been invited to speak at the LAS' Patients Care Conference in June 2008.

In addition to being submitted to the Healthcare for London consultation the document had been sent to the Senior Responsible Owners, Project Managers and senior figures at NHS London. The document will be shared with Lord Darzi and the Chief Executives and Chairmen of the London PCTs. **ACTION: Chief Executive and the Chairman.**

Noted:
1. **The contents of the submission to the Healthcare for London consultation.**
2. **That the Trust Board will receive updates on a quarterly basis concerning Healthcare for London. ACTION: Director of Service Development**

38/08 CAD 2010 update and migration options

Procurement: The Director of IM&T presented the report outlining the progress of the CAD 2010 Project. The Project was currently in Stage 3 – Procurement. Following the completion of the European Tendering exercise a defined supplier(s), product(s) and costs will be set out in the Full Business Case (FBC). Extensive negotiations were taking place with two suppliers concerning all aspects of the CAD 2010 contract. The paper set out two options for approving the FBC. The Director of IM&T stated that the preferred option was to submit a draft FBC to the Board for approval on 24th June 2008, with approval of the final FBC and contract being signed in October-December 2008.

Transition (migration) issues: The Director of IM&T said that a number of options were being explored but the current preference was for 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. This will be a very complex process and there was an element of risk involved - as there would be regardless of which migration option was chosen.

Gateway Review: the Gateway 3 Review was scheduled to take place on 23rd June 2008.

Work on the FBC was making good progress and the Director of IM&T was confident that once the procurement had been concluded the FBC could be compiled in a timely manner. Roy Griffins, who was tasked by the Board with keeping an eye on CAD 2010, referred the Board to the recent report from the Consultant engaged to independently advise the Board in regard to CAD 2010. Mr Griffins said he supported the Director of IM&T's recommendations in respect of a gradual transition as it can be closely monitored. He drew the Board's attention to the procurement and project challenges within the report.

The Director of IM&T said the Consultant's report had been helpful but disagreed with her statement that there had been a delay to the project caused by the management approach adopted. In regard to the leadership of the project, he had discussed the report with the Director of Finance and though both would continue to be closely involved, the Director of IM&T had responsibility as Senior Responsible Owner of the project. He said that there was a misunderstanding by the Consultant in respect of the FBC as there was a definite plan in place.

[8] COPD: Chronic Obstructive Pulmonary Disease

The draft FBC will be presented to the Board in June 2008. **ACTION: Director of IM&T**

It was Noted that:

The Director of Finance said he would like the Consultant to focus on providing more detailed technical advice regarding the various options on CAD 2010. The Director of Finance said that when the Trust negotiated with Commissioners regarding 2008/09 funding it had been made clear that CAD 2010 was not included in that arrangement and that once the cost of the project was confirmed, further separate discussions would be held with the Commissioners.

The request for time and material will be specific to the work being undertaken by the preferred supplier during the time between approval of the draft FBC and the final FBC. The contract that will be signed will include the time and material provision. The Chairman suggested that given Brian Huckett's experience with similar large projects at Visa he might work with Roy Griffins in advising his Board colleagues in respect of the CAD 2010 project.

A number of ambulance services in England were procuring CAD systems of a similar size and complexity to that being procured by the LAS. The Director of IM&T was liaising closely with his colleagues in the other ambulance services.

The approval of the draft FBC in June 2008 will be a crucial decision by the Trust Board as it will set out the case for choosing the preferred supplier of the CAD 2010.

Noted:

1. **The progress of the project;**
2. **The preferred approach regarding the transition process;**
3. **The outline timetable, particularly the timeline required for Strategic Health Authority approval;**
4. **That the Trust Board will be asked to consider allowing the project to proceed on a time and material basis following the presentation of the draft FBC; which will be within strict parameters set by the Trust Board.**

39/08 SIP 2012 Update

The Director of Service Development presented the SIP 2012 update which included a description of each project currently included in the five programmes and a milestone chart for each programme showing progress as of early February.

It was Noted that:

The Board was satisfied with the reporting format but would like to receive, on an exceptions basis, a report concerning projects that were not on track.

Although a few projects were reported as not being on track or not under control this did not always reflect the reality.; There was a timing issue as the milestone chart had been prepared early March. The Director of Operations pointed out that one of the projects, 'Re-Engineer Call Handling', had slipped due to a wish to bed down the new management arrangements before introducing new rostering. The Director of Service Development said that the term 'control' in the context of Project Management was a specific technical term that meant a slippage in delivering the project had not been resolved rather than the project was 'out of control'.

The Project 'Paperless Control Room' was on hold at the moment as the Director of IM&T wished to ensure there was an adequate back up in place should the new 'paperless' system fail. He said the system currently in place had demonstrated it was needed when, recently, there had been a need to resort to a paper based system because of technical difficulties.

Progress with the Referral Pathway Project had slipped due a member of staff being on long term sick leave. The Director of Service Development said that 200 referral pathways had been established but work was needed to ensure they were fully utilised locally.

During 2008/09 the report format will be modified to concentrate on the delivery of benefits as well as the progress of projects. **ACTION: Director of Service Development.**

40/08 Draft minutes of the Clinical Governance Committee, 4th February 2008

The Chairman of the Clinical Governance Committee highlighted the following from the draft minutes of the recent meeting:

Lost property bags (one of which was circulated at the meeting) will be introduced on all ambulances with effect from April 2008. The Head of Complaints estimated that 50% of the enquiries or complaints received by the PALS office were concerned with lost property. A benefits realisation report will be presented to the Clinical Governance Committee in due course.

Work was continuing to ascertain the ethnicity of 999 callers. The Service was working closely with NHS Direct and the Ambulance Leadership Forum to introduce an ethnic monitoring for this group of users.

There had been discussion as to how the Service could be sure that communications, such as the monthly Clinical Update were received; read by individual front line members of staff and the required changes in practice implemented. It was proposed that Station Administrators be asked to post copies of the Clinical Update on the Stations' information boards. In due course an audit will be undertaken to determine the level of awareness amongst staff of the Clinical update. Although all members of staff have individual email accounts, a more mobile fleet meant front line crews were less likely to have access to email on a regular basis.

Noted: The draft minutes of the Clinical Governance Committee, 4th February 2008.

41/08 Draft minutes of the Service Development Committee, 26th February 2008

Noted: The draft minutes of the Service Development Committee, 28th February 2008, with the amendment that Brian Huckett be added to the list of atendees.

42/08 Draft minutes of the Audit Committee, 3rd March 2008

Caroline Silver, Chairman of the Audit Committee, presented the draft minutes to the Trust Board. She said there had been a lively debate concerning the proposal that the Audit Commission review CAD 2010. It had been agreed that the Audit Commission's remit would be precisely defined so as not to duplicate work being undertaken by the Consultant to the Board or the Gateway Review process. This audit would comprise 5% of the total audit work being undertaken by the Audit Commission in 2008/09.

The Committee reviewed the Assurance Framework, which had been presented to the Board today for approval. The Committee approved approaching the Inland Revenue to make final settlement with regard to the outstanding liability on the Trust's balance sheet in respect of subsistence.

The Committee received a report regarding the introduction of IFRS[9] and the preparatory work being undertaken by the Trust in respect of the 2007/08 and 2008/09 financial accounts. The Director of Finance said that the requirement to produce the accounts in the IFRS format may be deferred until 2009.

[9] International Financial Reporting Standards

The Chairman drew the Board's attention to two audits undertaken by Bentley Jennison, the Internal Auditors, concerning annual leave management and drug control. Significant recommendations were made by the Internal Auditors in respect of the two audits and assurances were received that these were being implemented. The Committee requested that both of these areas be re-audited in 2008/09.

The report concerning drug control would be presented to the Clinical Governance Committee in April 2008. The Medical Director said she was disappointed that the Internal Auditors had not spoken to her when they undertook the drug control audit.

Noted: The draft minutes of the Audit Committee, 3rd March 2008.

43/08 <u>Report from Trust Secretary on tenders opened since the last Board meeting</u>

Eight tenders have been opened since the last Trust Board:

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; Birkbeck 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

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

In respect of the use of the Trust Seal, there have been 2 entries relating to the use of the seal:

No. 112	Counterpart lease, car parking spaces, 1-11 Blackfriars Road
No. 113	Reference for Ian Todd, requested by Nursing Midwifery Council

Noted:
1. **The report of the Trust Secretary on tenders received**
2. **That only tenders subject to European Union tender regulations were reported to the Trust Board; these were tenders whose value exceeded £90,000 over the duration of the contract.**
3. **That the Trust's seal had been used twice since the last Trust Board meeting.**

44/08 Any Other Business

There was no other business.

45/08 Opportunity for members of the public to ask questions

George Shaw, LAS Patient's Forum, had a number of questions for the Trust Board:

1. *The timeline for responding to the Memorandum of Understanding between the LAS and the Patients' Forum.* The Chairman said he did not think it was necessary to have a Memorandum of Understanding between the two organisations; he was happy for representatives of the Forum to continue attending the Board meeting and working with the Trust. The Chairman said there would be a meeting with the Chairman of the Patients' Forum to discuss this matter further. In the event that the LAS becomes a foundation trust members of the forum could become members of the foundation trust and stand for election to the Board of Governors.
2. *The Forum was concerned at the decline in Category B19 performance in recent months and asked what remedial action was being taken.* The Director of Operations said that Category B19 performance had been 86.8% in January 2008; it had fallen in the succeeding months due to an increase in workload and the availability of staffing but had recovered in March and was now 84.4%. He said that performance was generally good mid week but fell at the weekends; this was being addressed by a review of the rosters to increase the number of staff available at weekends. He added that the Trust would have a performance target of 90% Category B19 in 2008/09 and a number of initiatives were being considered to ensure that this was achieved.
3. *What advice and support was available to front line staff when they were transporting mentally ill patients.* The Medical Director said that although she shared the concern expressed by the Patients' Forum there were a number of mechanisms in place to support and advise staff when they were transporting mentally ill patients. Support was available from local management teams; the Control Room; the Clinical Support Desk (which will be in operation from the end of April) and the On Call Clinical Advisers. In addition, training on mental health will be one of the modules being introduced from May 2008.
4. *What has been the impact of the recent increase in fuel costs?* The Finance Director said that the Trust was managing that risk by switching from petrol to diesel as it was cheaper, being a more efficient fuel. In addition, the Trust, in partnership with the NHS and the Ministry of Defence, will be participating in a re-tendering exercise for fuel that should mitigate increase in fuel costs.

46/08 **Date of next meeting**

Tuesday, 20th May 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 13.37

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 20 MAY 2008
CHIEF EXECUTIVE'S REPORT

1. SERVICE DEVELOPMENT

Healthcare For London

The consultation on healthcare for London finished on March 7th. The responses have been collated and are available on the HfL website at http://www.healthcareforlondon.nhs.uk/ConsultationDocs/FinalH4LCtCreport.pdf. After consideration by a number of committees, including the Clinical Advisory Group on which Fionna Moore sits, there will be a meeting of the Joint Committee of PCTs on June 12th which will agree the next steps.

The consultation demonstrated broad support for the concepts within Healthcare for London. Each PCT will need to decide how to take the proposals forward in their areas and will need to consult separately on any changes. In many cases the involvement of the LAS will be important, locally as well as, up until now, centrally.

The central involvement has included the submission of an LAS response as agreed by the Board in February and subsequent meetings with David Sissling, the Healthcare for London Programme Director, who also attended the Board awayday in April. The LAS is represented on the Clinical Advisory Group, as mentioned above and also in panels and working groups for the HfL workstreams on stroke and trauma. Further information on LAS involvement in HfL activities can be found in the Medical Director's report.

Annual Health check 07/08

The Trust has completed the submission of the final declaration for the annual health check 07/08. The declaration is now available on the Trust's website in compliance with the Healthcare Commission's requirements for providing access to the public. Positive commentaries on our self assessment of full compliance with the core standards for the second year in succession were received from NHS London and the Patients Forum. 8 overview and scrutiny committees commented.

All executive directors were involved in providing assurance to the Board of our compliance with the standards and this work was detailed in the Assurance Framework received by the Board on March 18th. The outcome will be announced by the Healthcare Commission in October. For the Annual Health check 08/09 attention will need to be given to the challenge of building relationships with the new borough-based LINK acquisitions. The standards for better health group led by the Finance Director will continue to provide assurance and review controls and risks to ensure compliance in 2008/2009.

Foundation Trust preparations

As the Board will be aware, the LAS is one of the two Ambulance Trusts piloting the assessment process prior to Ambulance Trusts being able to apply to become a Foundation Trust. John Wilkins has been appointed to Project Manager to take us through the assessment phase

New Ways of Working

I am pleased to announce that Barnehurst complex and Chase Farm complex have been selected as the first two example complexes. The implementation support team is now being recruited to assist both the station management teams through the initial diagnostic phase. A further more detailed update on progress will be provided at the next Board meeting.

2. SERVICE DELIVERY

2.1 Accident & Emergency service performance and activity (graphs 1-8)

The tables below set out the A&E performance against the key standards for March and April of 2008 and for the 2007/08 year. Please note that call connect was not a cumulative target for last year and has therefore been omitted in terms of ytd values. Category B figures below for April and May are against the new clock start time.

	CAT A8 (current)	CAT A8 (call connect)**	CAT B19	CAT B19 (call connect)**
Standard	75.0%	75.0%	90.0%	90.0%
March 2008	78.1%	63.9%	86.8%	-
2007-08	78.94%	n/a	84.4%	-
April 2008	n/a	76.9%	-	88.4%
May 2008*	n/a	76.2%	-	85.6%

* Accurate as at 11th May 2008
** Applicable from April 2008

- I am pleased to report that the Trust exceeded the 2007/08 Category A target of 75% and attained 78.94% across the year. This is the best performance the Trust has ever attained and is a considerable achievement.
- Call Connect performance for 2008/09 has started well with the Trust achieving 76.9% in April. The first few days of May have seen an increase in workload due to the hot weather, however the Trust has continued to deliver performance in excess of 76%. This is a very positive start to this year, particularly when considering the progress made towards the new target in the last quarter, and compares well to other Trusts across the UK.
- It is important to provide some perspective here in that Call Connect performance last April was 56% with broadly similar levels of workload

and staffing. At 76% this year we have therefore shown an improvement of 20% over the same period last year.

- Control Services has continued to perform well and call answering has remained very resilient with the percentage of call taking within 5 seconds at 96.2% for April with some weeks achieving 98%.
- Category B performance for the year was 84.4%. Whilst this is some way off the target, it is an improvement of about 4% over the previous year. The target is now measured against the new Call Connect standard and there is still some work to be done to ensure that this target is achieved this year.
- Workload in April fell slightly compared to the previous 3 months. In April we responded to 2538 (842 Cat A) calls per day as compared to March when we responded to 2590 (891 Cat A), February to 2580 (891 Cat A) per day and in January we responded to 2542 (887 Cat A) calls. Compared to last year March and April activity was up by about 1%.
- In April CTA handled 7,494 calls with 3,653 calls resulting in care being delivered other than by sending an Ambulance. This was a good achievement and resulted in 121 Ambulance journeys a day being saved.

2.2 Patient Transport Service performance and activity (graph 9-12)

A more comprehensive update on activity and performance will be provided at the next Board meeting.

Performance on the quality statistics have improved in April to:

- Arrival time: 90%
- Departure time: 91%
- Time on Vehicle: 95%

The new contracts for Lambeth PCT, South London and the Maudsley NHS Trust and Whipps Cross University Hospital all commenced operation on 1 May 2008. Initial feedback from the customers has been good and there have been few issues on start-up.

The NHS Purchasing and Supply Agency have issued a tender notice to establish a framework agreement for PTS services across London. They have estimated that the potential value of this business could be up to £55 million. The deadline for expressions of interest is 12:00 noon on 14th May 2008 and the LAS is currently putting its submission together in response.

2.3 Operational Developments

- The amalgamation of Bow Resource Centre and Ilford Resource Centre has been deferred until the end of May. This was a planned deferral due to the operational pressures put upon the Resource Centres to improve staffing levels during April. It seemed prudent not to disrupt them during this busy time.

- The Trust was at REAP level 3 'Severe Pressure' until late April, but was reduced to REAP level 2 'Concern' following the performance improvement noted.

- The administrative handover across London ceased on the 10th March. This has settled down quite well with issues only reported at a small number of Trusts, where further work is now underway. This has resulted in further reductions in crew time at hospital; although not quite to the levels desired but we are confident that this will be rectified in the forthcoming months as the changes become embedded.

- The second phase of the Control Services reorganisation was formally agreed with staffside in mid April. Work is now underway to implement the new structure and the posts are currently being filled.

- The Clinical Support desk in EOC commenced its Trial on the 21st April following the appointment and training of 6 experienced Paramedics. The desk is used to provide clinical support to both operational crews on the road as well as Control room staff and there have already been several cases where the Clinical Care delivered to patients has been enhanced by the input received.

- On March 30th the service attended a serious incident when a Cessna light aircraft crashed near Biggin Hill airport. The aircraft had 5 persons on board when it crashed into a house, short of the airfield. All persons on board were unfortunately killed. The Service although not 'declaring' the incident, followed major incident procedures with our multi-agency partners, which worked well.

- In March, HART (Hazardous Area Response Team) plus several LAS managers took part in a national HART / USaR (Urban Search & Rescue) exercise at the Fire Service College. This exercise was on a national scale and was attended by several ministers. Initial feedback to the LAS is positive towards our input.

- On 6th April the Emergency Planning Unit put plans in place to cover the Olympic Torch relay through London. This plan proved its worth. The event was tightly managed by the police and relatively quiet from our

point of view with only 8 persons being treated and 1 taken to hospital. This was however an event which was under the international spotlight and had great potential to be more difficult.

- On 13th April once again the Emergency Planning Unit put in place its well exercised plans for the covering of the Flora London Marathon. This event was managed successfully with our partners St. John Ambulance, with 4293 persons treated and 64 persons taken to hospital.

- Several exercises have been attended during this reporting period. Three of note are: Live tunnel exercise in Rotherhithe Tunnel; Live military exercise with the Tactical Response Force: and CBRN victim recovery exercise at Winterbourne Gunner training centre.

- Plans are well underway for delivering a national Emergency Preparedness 'Lessons Identified' conference in July, hosted by the Trust. This event is focussed on Emergency Planners and Directors of Operations from around the country and is aimed at sharing lessons from recent major incidents, as suggested by the Civil Contingency audit last year.

3. HUMAN RESOURCES

Employee Relations

The following provides an update on progress and activity related to developing new partnership and consultative arrangements within the LAS.

In 2007 a new Partnership Agreement was signed between the Trust and the recognised Trade Unions (Unison, GMB, Amicus, TGWU). It should be noted that the merger of the latter two unions to form "Unite" has been agreed formally at national level and is expected to be completed by November 2008.

A Trust-wide Partnership Conference was held in the autumn of 2007, followed in November by the establishment of the Operational Consultation Forum, comprising senior staff representatives and senior managers from the Trust. As a sub-group of the long-established Staff Council, this has become the key consultative group for operational staff within the Trust.

In view of this, the current review of the overall consultative arrangements will confirm the Operational Consultation Forum as a standing sub-committee of the new Staff Council, which will have an enhanced corporate and strategic role with membership extended to include the Directors of Finance and IM&T. It is also intended to establish a specific and separate joint terms and conditions/policy group primarily to consider corporate matters affecting all staff groups. The proposals for the new constitution are currently with Staff side and agreement is expected at the next meeting of the existing Staff Council in July.

The Operational Consultation Forum has met regularly (every three weeks) to discuss the many issues facing the Trust at a time of unprecedented change. The management and staff side representatives are jointly committed to work in partnership, through the forum, to achieve the changes required to attain the new performance standards and other quality improvements.. A number of agreements have already been reached and frameworks agreed through the Consultative Forum, including:

- Area and local updates and presentations have been delivered jointly by Assistant Directors of Operations and senior staff side representatives.
- The administrative handover at hospital has been ended.
- A framework has been agreed for the future arrangements for any review of working patterns, linking any change to evidence that it is needed.
- The framework has already been used successfully to facilitate joint agreement on revisions to working patterns in EOC, achieving a better spread of cover, more equitable workload and hence improved patient care.
- A framework for "step-down" arrangements has been agreed, allowing consideration of requests for permanent redeployment to alternative duties based upon personal need.
- Consultation on career progression including the introduction of the student paramedic programme, providing the opportunity for staff to progress their professional career.
- A joint review of mileage rates and travel expenses arrangements has begun.
- A framework for active area cover has been agreed, and the formal arrangements have been the subject of further extensive consultation.
- Regular discussion on New Ways of Working.

Transfer of PTS staff

Apart from one of the Site Managers, all staff who requested to remain with the LAS following the loss of the UCLH and Kingston Hospital NHS Trusts, have been redeployed onto other contracts. The Site Manager concerned transferred under TUPE across to Door to Door who were successful in wining part of the UCLH contract.

With the commencement of the Lambeth PCT contract on 1 May 2008; 13 Ambulance Persons transferred into the LAS under TUPE. These staff previously worked for the PCT and consequently transferred across on their existing NHS terms and conditions of service. They have been receiving both familiarisation and clinical training during their first 2 weeks with the LAS

Retrospective CRB checks

The Trust is currently undertaking CRB checks for all existing staff who have patient contact and thus meet the criteria of the Criminal Records Bureau. This exercise commenced in mid February. Almost 2000 staff were required to undergo the process and to date almost 75% have complied. A final reminder for returns has been sent to all those staff whose check is still outstanding. This reminder will warn of the potentially serious consequences of continued non-compliance.

From the returns received to date, 61 checks have been 'positive'. This will include offences which have already been disclosed to the Service by the individual. Each 'positive' check has been considered by a single panel to decide what further action might be necessary. As a result 11 investigations under the disciplinary procedure have been or will be undertaken. Any disciplinary hearing which is convened will also be heard by a single (different) panel. The process is being managed extremely tightly both in order to comply with the Trust's and CRB requirements for confidentiality and to ensure that Trust wide consistency is maintained.

Introduction of the Student Paramedic role

The Trust Board are receiving the report on the Workforce Plan for 2008/09 at this meeting. The recruitment and training activity associated with this plan is extensive and recruitment to the new Student Paramedic role has begun with the first cohort of recruits having commenced training on 12 May 2008. The Workforce plan provides more detail on the Trust's plans to meet its challenging objective of filling all existing vacancies and recruiting to an increased A&E establishment.

NHS London

The Director of Human Resources continues to work closely with the SHA in developing a joint understanding of workforce issues related to the plans contained within "Healthcare for London".

The LAS recently participated in a London wide event, *Staffscope,* organised by the SHA and will work with the facilitators of that event and the SHA at a further LAS specific event on 23 May 2008.

Funding for Education and Development, recently agreed with the SHA is linked to this joint strategic aim of developing a more highly skilled workforce with the ability to deliver services which reflect the aspirations of both the LAS and Healthcare for London.

Sickness Absence (graph 13)

Absence levels for February and March have shown a downward trend. Levels of absence in March are the lowest for the year. Whilst this is encouraging, it should be noted that an overtime incentive scheme was introduced in March to support the Trust in achieving its "call connect" standard and it is likely this has made an impact on staff attendance.

The Trust has set a target of absence levels below 6% for the year as a whole in 2008/09. HR Managers will be closely monitoring local levels and ensuring robust application by managers of the Trust's Managing Attendance Policy. The existing HR audit of policy application will be strengthened and conducted routinely on monthly basis. Current practice allows for quarterly auditing for good performing areas but it is recognised this has the potential to allow a loss of focus during intermittent months.

In addition we will work with Atos, our Occupational Health providers at developing a specific project plan for reducing long term absence. Supporting information is currently being gathered to inform the focus of this work.

Rest Breaks (graph 14)

There has been an increased focus on rest breaks during April. The net effect has seen over 60% of crews getting rest breaks and a reduction in the number of crews ending their shift early. This has contributed to more stable performance and a reduction in performance fall at shift change-over time thus ensuring a more consistent level of care delivery across the day.

Resourcing (graphs 15-19)

Resourcing has significantly improved during March and April, assisted by an incentive scheme. Ambulance hours produced were similar for the same period last year (1st March – 22nd April) at circa 220,000 hrs however we have seen an increase of FRU hours by circa 1,000 hours to 79,000hrs for the period. There is still a good appetite for overtime as we go into May and we have seen some excellent resourcing.

EOC resourcing

EOC staffing continues to run at over plan since the beginning of March. This has supported the consistent and sustained levels of call taking performance. Changes to the existing core and relief rotas from 14 April have resulted in more consistent call answering performance at the weekends.

Suspensions

As of 29 April 2008 there were 12 suspensions, the oldest shown below:-

East: (21 February 2008)

South: (14 March 2008)

West: (30 January 2008)

HQ/Fleet/Others: (10 January 2008)

WORKFORCE INFORMATION

Table 1

A&E ESTABLISHMENT REPORT - March 2008				
Position Title	**Funded Establishment**	**Staff in post**	**Variance**	**Leavers**
Team Leader	169.50	161.19	8.31	0.00
ECP	56.00	52.56	3.44	0.00
Paramedic	910.89	818.18	92.71	4.00
EMT4	713.48	851.69	-138.21	6.00
EMT3	682.75	460.35	222.40	1.00
EMT2	0.00	99.11	-99.11	0.00
Total	**2532.62**	**2443.08**	**89.54**	**11.00**

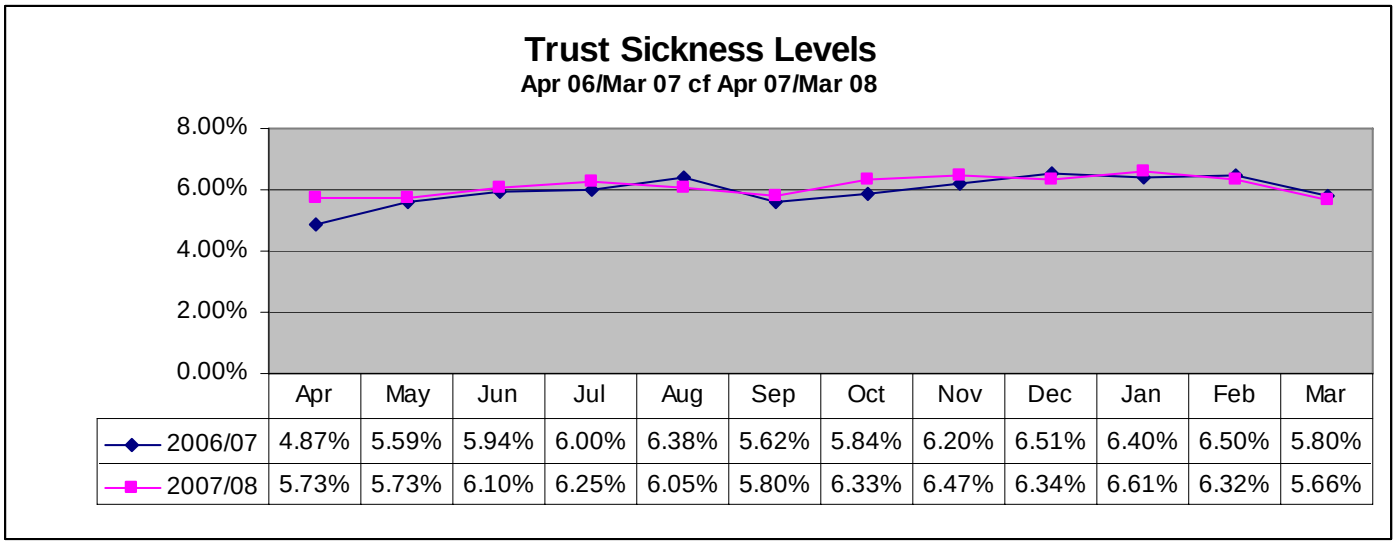
Table 2

Staff Turnover		
Staff Group	**Apr 06/ Mar 07**	**Apr 07/ Mar 08**
A & C	11.04	13.13
A & E	4.64	5.13
CTA	0.00	5.13
EOC Watch Staff	11.04	11.70
Fleet	5.08	10.91
PTS	6.16	11.02
Resource Staff	1.96	2.04
SMP	6.72	6.74
Grand Total	**5.87**	**6.83**

Table 3

Absence 2007/08	**Nov 07**	**Dec 07**	**Jan 08**	**Feb 08**	**Mar 08**
A & E Ops East	7.03%	6.92%	6.64%	6.23%	5.63%
A&E Ops South	6.58%	7.00%	7.02%	6.36%	5.91%
A&E Ops West	6.23%	6.52%	7.78%	6.77%	6.61%
Control Services	7.27%	6.83%	6.98%	6.79%	5.40%
PTS	8.24%	7.13%	8.27%	9.86%	8.36%
Trust Total	**6.47%**	**6.34%**	**6.61%**	**6.32%**	**5.66%**

Graph 13



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2006/07	4.87%	5.59%	5.94%	6.00%	6.38%	5.62%	5.84%	6.20%	6.51%	6.40%	6.50%	5.80%
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%

4. COMMUNICATIONS

Campaigns

Use your ambulance service wisely: The completion of the Service's best ever year, including the achievement of the Government's Category A performance standards, was recognised by coverage in a number of local newspapers, as well as in a short news report on ITV London.

At the same time at the beginning of April – and to coincide with the introduction of the new Call Connect target - an advertising campaign was launched to encourage the public only to call 999 in the event of a genuine emergency.

Adverts featuring the image of an ambulance in a fire alarm box were placed in the Metro, London Lite and the London Paper, and also for two consecutive weeks in more than 50 weekly papers across London. As well as encouraging the public to 'use your ambulance service wisely', the adverts also outlined the range of other healthcare options available to those with less serious illnesses or injuries. Adapted version of the adverts will be running across the London Underground during the first two weeks of June, while poster versions are being distributed to stations for display in ambulances and local public buildings.

British Heart Foundation: The BHF launched a four-week London version of 'Doubt Kills' in May to raise awareness about the symptoms of heart attacks and what to do when they occur. The Service is supporting the BHF in communicating the campaign and will also be measuring the impact it has on the number of 999 calls received relating to chest pain.

The BHF has also launched a year-long campaign to raise £100,000 to fund more defibrillators for the Service's community defibrillation project and the ambulance community responder scheme. Community Defibrillation Officer Jo Smith and CRU Matt Chute assisted in launching the campaign at a charity jog at the Tower of London.

Media

Harrow building collapse: Multiple calls were received from national, regional and local media following the collapse of a building in Harrow after a reported explosion. One man who was trapped in the building died, and two other patients were treated and taken to hospital by crews in the incident.

Chelsea firearms incident: The department dealt with a number of calls from national media about a firearms incident at a residential address in Chelsea in which a man died after shots were fired after armed police arrived on the scene.

Filming – London Ambulance: Filming has begun for a second six-part series of London Ambulance which will be broadcast on ITV London later in the summer. Last year's series which followed crews at work in the capital attracted up to 360,000 viewers on a Friday evening.

Patient and public involvement

Strategic plan: A successful public event, 'It's your call', was held on 26 March to obtain views from Londoners about our future plans and about the equality impact assessments that have been carried out. Over 80 people attended, including a number of people with learning disabilities, who are traditionally very hard to engage. The results are currently being written up and will be used to inform future developments.

Meetings were held with two groups for deaf people run by the Enfield Deaf Project to discuss the Access Programme and specifically the project to improve access to the Service for deaf people. The feedback will be used in the project's development.

Public Education: A development programme is being designed for staff involved in public education, in collaboration with South Bank University. Due to start in September, this will include some skills training (e.g. presentation skills, instructional methods) and will use a learning set/reflective practice approach. It is hoped the course will be accredited by the university.

A public education co-ordinator is to be appointed to co-ordinate the staff involved in public education activity and the materials and resources they need to carry out this role effectively.

Risk Assessments for public events: Concern has been expressed that the current LA168 risk assessment forms, for the Service's attendance at public events, are not always being completed. As a result, the form is being revised; the new form will also include information about how staff will be paid for working at the event (ie overtime, time in lieu, swapping shifts etc), which should encourage them to complete it.

New Ways of Working: Two community involvement officers are to be appointed to work closely with community groups, partner organisations, patients and the public on the two complexes that have been identified to adopt the New Ways of Working model. The post holders will also have a role in the management of frequent callers and the high risk register.

Tower Hamlets Project: As one of a number of initiatives led by Tower Hamlets PCT, a health education pack and training programme, 'Get the Right Treatment', has been selected for the national finals of the Health & Social Care Awards. The training programme, which is currently being delivered to NHS staff and members of the public in Tower Hamlets, highlights the range of local NHS services that people should access in a variety of circumstances. The supporting DVD was produced by the Service's Media Resources Unit.

5. INFORMATION MANAGEMENT & TECHNOLOGY

CAD 2010 Update

At the March Trust Board a full report was given on the progress of CAD 2010. I am pleased to report that in line with the timetable provided, negotiations were completed with the two suppliers for formal invitations to submit final tenders on 17 April. This marked a significant milestone in a long and complex procurement process. Responses were received back on 9 May, and we are currently on track for the evaluation report to be ready for consideration by the CAD 2010 Project Board w/c 27 May. Provided the evaluation report is able to make a clear recommendation, then data from this will be used to complete a draft FBC (Full Business Case) for consideration by the Trust Board before it is submitted to the SHA before returning to the Trust Board for final approval.

As previously discussed, in order to ensure there is minimal delay in commencing work with the preferred supplier, the Trust Board is invited to delegate authority to the Service Development Committee to:

1: Approve the recommendation of the preferred supplier

2. Approve that work should commence with the preferred supplier on the basis of a letter of intent while full approval via the SHA is finalised. The Trust would be liable for limited costs on a time and materials basis only if a full contract was not signed, and the LAS did not proceed with the full procurement. Given the strategic importance of this project and the detailed procurement process, the risk of this happening should be considered as low.

Peter Bradley CBE
Chief Executive Officer
May 13th 2008

Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 20 May 2008

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

No new SUIs have been declared since my last report to the Trust Board in March. The investigation of an existing SUI, into the care provided to a 36 year old woman who was bleeding heavily, has been completed, an action plan drawn up and approved by the Senior Management Group.

Safety Alert Broadcasting System:

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

Twenty six alerts were received from 4th March to 30th April 2008. All alerts were acknowledged; only one required any action; this involved alerting staff to pen torches where the bulb is incorrectly sited. This issue has been circulated throughout the Service with a photograph illustrating the faulty pen torch and instructions on returning any identified to the Logistics Department.

Safety Cannulae

Following concerns expressed by staff about the performance of the current safety cannulae a potentially more suitable model is now on trial with the Health and Safety reps in each of the old sectors. 6 Sectors have reported back indicating a preference for the new design. The Purchasing Department are liaising with the supplier to establish what training materials are available to support its introduction. This new cannulae could be available from June and the training implications are under discussion.

2. Second domain – Clinical and Cost Effectiveness

Medical Support to Control Services

The post of Assistant Medical Director, with responsibility for Control Services has been advertised. Short listed candidates will be interviewed on 12th May. It is anticipated that this appointment will strengthen the Medical Directorate and provide clinical support to both Control Rooms.

Mental Health update

The Secretary of State for Health has laid a revised Mental Health Act 1983 Code of Practice before Parliament. Subject to Parliamentary review, this will come into force on Monday 3 November 2008, at the same time as the majority of the main changes made in the Mental Health Act 2007 to the previous Mental Health Act (1983).

The Head of Policy, Evaluation and Development will develop the LAS Mental Health Strategy and relevant policies over the summer to meet the requirements of the new Code of Practice. One change came into effect on 30th April 2007: Section 44 of the 2007 Act amends sections 135 and 136 of the 1983 Act to allow a person to be taken from one place of safety to one or more other places of safety, during the 72 hour maximum overall period during which they may be detained under either of these two sections. The next edition of Patient Care News section in the LAS News and the next clinical update will carry advice for crews on this.

Work has commenced around updating the Mental Health CPD module and investigating the LAS's role in transporting patients back to secure units if they break the terms of their Supervised Community Treatment Order.

The recent change in the procedure for booking Assessments under Section 135 of the Act from EOC to UOC will be evaluated at the end of May.

The Joint Agreement between LAS and MPS for conveying members of the public will be signed off shortly.

Healthcare for London Update

Unscheduled Care

Healthcare for London have engaged PA Consulting to project manage this work stream, initially focusing on collecting in-depth data from six PCTs. The Head of Policy, Evaluation and Development attends workshops on behalf of LAS.

This data suggested 8 key areas of improvement:

1. Supporting patients in improving self care and management.
2. More effective chronic disease management in the community.
3. Single telephone number – urgent care by phone
4. Better use of pharmacies
5. Improved access to GPs
6. Better provision of generalist urgent care centres aligned to A&E departments
7. Better provision of specialist unscheduled care centres e.g. for the elderly and paediatrics
8. Improving the current models of unscheduled care provision

The LAS focus has been on two main areas:

- To encourage better links between LAS, NHSD and Out Of Hours providers so that patients can be easily transferred to the most appropriate team, without having to resubmit their details. It has been pointed out that NHSD does already provide a second number and the fact that this is not used as an urgent care telephone service (as originally envisaged) should be addressed before another service is introduced, potentially at great expense.
- As well as providing LAS with additional options for resource deployment, the possibility of positioning vehicles at Urgent Care Centres (polyclinics?) might reassure the public that in the event of an emergency speedy transfer, by experienced staff, to an A&E environment is available.

Major Trauma

Healthcare for London held a workshop, chaired by Professor Matt Thompson, Clinical Director of the project, on 22nd April. Many of the Acute Trusts were represented. The Medical Director presented on the pre hospital phase of the major trauma pathway. Acute trusts were encouraged to consider setting up networks where several trauma units would support a Major Trauma unit, and the US model for accrediting Major Trauma centres was covered in some detail.

A Clinical Expert Panel has been formed and held its first meeting.

Implications for LAS (identifying suitable cases, initial management and triage and managing the implications for job cycle times) are being investigated by a short life working group, chaired by the Director of Service Development.

Stroke

This project (again, project managed by PA Consulting) is the most developed of the work streams, both at Healthcare for London and local level. The Head of Policy, Evaluation and Development and the Clinical Practice Manager represent LAS on the Stroke Clinical Expert Panel.

An acute pathway model for FAST positive patients is being scoped to care for those patients eligible and not eligible for thrombolysis. A drive to provide gold standard care has led to the development of performance standards for the pathway, with full and interim targets developed for each. Those standards of particular relevance for the LAS include the time from call to the emergency services to admission to the Emergency Department, percentage of patients admitted to the Emergency Department within 2 hours of the onset of symptoms and the percentage of patients receiving thrombolysis within 3 hours of symptoms onset.

The precise model to be advocated by Healthcare for London (eg. all 24/7 centres, a hub and spoke model, local networks supporting telemedicine) is yet to be decided. The position preferred by the LAS is that only those centres offering 24/7 care can deliver similar benefits to those delivered by the primary angioplasty model.

However, given the potential difficulty of implementing this, the next best option is for one 24/7 centre (a hub) to be supported by several centres accepting patients 12 hours per day. LAS will support this approach, not simply to coincide with shift changes, but to ensure patients (and resources) are not forced to travel long distances to central hubs during the rush hour (eg 0700-0900 and 1700-1900).

South West London
The hub and spoke model trial is into its third month and is due to be evaluated mid June. Volumes have been low but several successes have been recorded. (24/7 care provided by St George's, supported by 0830-1630, 5 days per week centres at Kingston, St Helier and Mayday Hospitals).

North Central London
The LAS has worked closely with commissioners to inform the type of service they should develop.

North West London
LAS have just begun working with their Clinical Reference Group to assist in the design of a pathway.

Enthusiasm to implement improved acute care is such that 19 units have committed to deliver either 24/7 or 12 hour thrombolysis. Therefore, the LAS are proposing to divert all patients except those on the western and eastern fringes of London to their nearest acute stroke centre from1st September and have requested support from NHS London to implement this.

Clinical Update Newsletter

The April edition (issue 7) of the Clinical Update Newsletter covers the management of so called 'suspension trauma.' The 'Lesson of the Month' reminds crews to take the defibrillator with patients who have suffered a STEMI and are being conveyed from the ambulance to the cardiac catheter laboratory.

The May edition (issue 8) covers issues arising around the use of the Recognition of Life Extinct (ROLE) procedure. This has now been in use for over a year and the article addresses some concerns expressed by both crews and HM Coroners.

Both editions contain the 'ECG of the Month'.

Copies of this bulletin will be available at the meeting.

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

Appendix 1 provides a summary of the Clinical Performance Indicator (CPI) figures for 2007/2008. It demonstrates a very significant increase in the CPI completion rate and highlights the importance of the feedback given to crews. The Service is still however having difficulty in reaching the target of 80 % CPI completion.

3. Third Domain – Governance

Risk Information Report

The Clinical Governance Committee regularly receives information on risks identified through reporting of incidents, complaints, problematic inquests, potential claims and enquiries to the PALS Department. This information is collated and presented as a risk information report to identify emerging themes and trends. Twice a year a themed report is produced where a particular area of potential risk to the Trust is identified and clinical incidents relating to this risk are gathered to identify lessons. To date two themed reports have been considered, covering obstetrics and non conveyed patients. The lessons identified from these reports are then communicated through the Area Governance network, through the Department of Education and Development and through the Medical Directorate.

An example of a themed report, featuring obstetrics, is included under Appendix 2.

4. Fourth Domain – Patient Focus

Nothing further to report.

5. Fifth Domain – Accessible and Responsive Care

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

6. Sixth Domain – Care Environment and Amenities

Infection Control

The next Trust wide Infection Control Audit will be undertaken in May.

Measles

No further cases of measles have been identified within the Service and no hospitals have reported further outbreaks in their areas.

Identification of cannulae sited outside hospital

Discussions are ongoing with the Department of Health on the introduction of a 'cannula kit' comprising a sterile pack which provides the following: Sterile towel, cannula sticker (Date/Time), Chlorhexidine applicator, cannula securing plaster which is transparent to identify the early stages of infection, and gauze. We are investigating how quickly these could be introduced.

7. Seventh Domain – Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director
12th May 2008

Appendix 1.

Clinical Audit & Research Summary Reports for the Trust Board

Summary of Clinical Performance Indicator (CPI) Figures 2007/08

Author: Brendan Bradley

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

The Clinical Audit Facilitator produces a monthly report which monitors the completion of CPI audits, compliance to clinical care standards by staff and the number of feedback sessions being undertaken. This document summarises the findings from the Clinical Performance Indicator process between April 2007 and March 2008.

CPI Completion

CPI completion is a percentage figure used to monitor how many PRFs were audited by Team Leaders compared to the expected number of PRFs that were eligible for audit. The LAS has set incremental targets to encourage the completion of CPI audits; in 2007/08 the target was 80% and this increased to 95% in March 2008.

The LAS achieved an overall completion rate of 66%, indicating that a third of the expected number of PRFs were not audited. Average completion rates across the different CPI indicators ranged from 82% for the Difficulty in Breathing CPI to 30% for the Obstetric Emergencies CPI.

Team Leaders reported that they were unable to undertake CPI audits for almost a third of the time available to them. The main reason given for this was that they were unable to undertake CPI duties as they were staffing vehicles.

CPI Compliance

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

The table below displays the compliance rates achieved by the LAS in 2007/08. Overall, LAS staff complied with 91% of clinical care standards; thus indicating that a high standard of care is being provided to patients.

Clinical Performance Indicator (CPI)	Average LAS Compliance
1 in 20 (Basic documentation audit)	92%
Acute Coronary Syndrome	93%
Cardiac Arrest	92%
Difficulty in Breathing	91%
Glycaemic Emergencies	94%
Obstetric Emergencies	90%
Not-Conveyed Patients	88%
Overall	**91%**

CPI Feedback

Team Leaders use information generated from the CPI audits to provide feedback sessions to staff on areas of good practice and concern. To ensure that each member of staff receives feedback twice a year, a target number of 5160 feedback sessions was set for 2007/08. Team Leaders exceeded this target and provided a total of 5207 feedback sessions to staff, which demonstrates that the Service has made excellent progress in ensuring crew staff are regularly updated on their individual clinical performance.

In addition to the feedback given by Team Leaders, a new facility was added to the CPI database in December 2007 to allow frontline staff to view data to monitor their own clinical performance.

Summary

The LAS has demonstrated a vast improvement in the number of CPI audits being undertaken. The overall completion rate of 66% in 2007/08 was almost double that of 2006/07, which was 37%. The increase in the number of audits being undertaken has resulted in Team Leaders being able to provide more reliable and meaningful feedback to staff on the quality of care provided to patients.

The overall compliance rate of 91% demonstrates that a high standard of clinical care is being delivered to patients. It is expected that the increased levels of feedback given to staff, coupled with an increase in the number of audits being undertaken in each CPI area, will help the LAS move closer towards the 100% compliance target.

Appendix 2 (annexed to Trust Board papers).

Themed Risk Information report on Obstetrics

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Annual Complaints & PALS Report

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

The enclosed report sets out:

- The restructuring of the process for capturing service user feedback through a variety of routes, i.e. PALS, complaints, incident reporting etc.
- That the Trust has been selected as a pilot site for the 'Making Experiences Count' programme, unifying the complaints process across health and social care.
- The activity and workload of PALS and Complaints
- The reduction of calls achieved through the Frequent Callers Project
- Summary of case histories illustrating both individual and organisational learning

4. Recommendation

THAT the Trust Board NOTE the contents of the report

Introduction

In October 2007, the Head of Patient Services was charged with creating a new department, unifying the differing ways the LAS receives service user and stakeholder feedback. This includes the following work streams:

- Adult Protection referrals
- Complaints
- Freedom of Information
- 'Frequent Callers' project
- High Risk Register referrals
- Incident Reporting (internally and externally)
- PALS
- Safeguarding Children Referrals

Complaints Management

The review described was prompted by recent reports from the Department of Health and other agencies, with particular emphasis on the problems faced by patients in achieving a satisfactory response to complaints and the failure of the NHS to use lessons from complaints to improve services.

The Health Service Ombudsman's report *Making things better? A report on reform of the NHS complaints procedure in England* describes some of the problems caused by the fragmentation of complaints systems which are mirrored by the historic structure and methodology utilised by the Trust. The Ombudsman concluded that this consideration, combined with a failure to focus on patient needs and a lack of capacity and competence in complaint handling, has led to a system which fails to achieve meaningful outcomes aimed at change and improvement and in many cases, to address the deep rooted culture of defensiveness and apprehension of staff who are subject to a complaint.

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Similarly, *Developing the Patient Advice & Liaison Service: Key Messages for NHS organisations from the National Evaluation of PALS* highlighted the core messages from the national evaluation of PALS, emphasising the success of PALS but drawing attention to a two tiered system with PALS as the poor relative in relation to resourcing and profile.

Drawing on these reports and *The NHS Plan, 'Making Experiences Count'* (MEC) announced the government's intention to reform complaints management and advocated *"a comprehensive single complaints system across health and social care"*, focusing on a less adversarial and a more patient-centred and unified approach. This will be achieved by 2009, with the implicit intention to combine the PALS complaints functions.

The Trust has been chosen as a pilot sight for the MEC programme. This will operate between April and October 2008 and a DH support team will be made available to provide guidance and assistance. This will also enable the Trust to have an

influencing role in shaping the eventual model to be rolled out across the NHS and social care.

We are also to work closely with the NPSA to achieve a core application of Root Cause Analysis (RCA).

Revised structure and methodology

We are working to unify the role of PALS and Complaints Officers. A gradual approach will also be taken to unpick the existing area-based structure of complaints management, to enable optimum resourcing and skill acquisition.

Complaints Officers are responsible for deciding what information is required and for accessing that information. Local managers may be asked to approach staff as required but they are no longer required to produce reports. Information is collated by the Complaints Officer and where learning points are identified the Complaints Officer will liaise with the AOM/DSO regarding the action to be taken. Complaints Officers facilitate draft complaint responses which we aim to share with all those involved prior to release to enable comment and collective ownership.

Complaints data is regularly made available which can be accessed at the Trust xdrive; this includes details for each area, 'open' complaints and the 'closed' complaints awaiting further action. Information is similarly available as to performance of each area in relation to the 25 working days target. It is also proposed to extend this to include PALS data.

Activity 2007/08

Complaints (Figures in parenthesis are 2006/2007)

• Total number of complaints received – 539 (557)
• Written number of complaints received – 231 (290)
• 267 complaints were categorised as involving 'Non-Physical Abuse' 94 of the 231 being written complaints, this is the main subject heading in relation to 'attitude & behaviour' issues. These do however include a number of sub-subject variants. (138 for the previous year))
• 134 complaints involved a delay in an ambulance response and 37 related to conveyance issues. (192 and 16)
• 123 complaints involved the clinical care provided. (98)
• 43 complaints involved driving related issues. (23)

The Trust provided final responses to 81% of complainants within 25 days against its target of 80%.

PALS

• Total number of enquiries received - 4712
• 87 cases were categorised under 'communication - attitude & behaviour'
19 cases were referred as formal complaints with the complainant advised of ICAS

NB: 13 cases involved poor attitude towards LAS staff by external health and social care agencies.

• 72 cases involved delay in an ambulance response and 69 related to conveyance issues.

• 130 cases involved the clinical care provided, 720 cases involved the provision of medical records and 209 cases some explanation of the chronology of events.

• 125 incident report referrals were received from LAS staff

NB: It is proposed to unify the subject categorisations and take the opportunity to review sub-categorisations.

PALS by Subjects and Received by quarter from 01 April 2007 to 31 March 2008

	2007 Q2	2007 Q3	2007 Q4	2008 Q1	Total
Access	7	9	10	9	35
Aggravating Factors	0	1	0	0	1
Appreciation	214	271	205	163	853
Physical Violence	1	0	1	0	2
Clinical Equipment	7	5	5	1	18
Clinical	50	40	32	19	141
Communication	46	26	28	26	126
Conveyance	21	17	13	20	71
Delay	38	18	15	7	78
Non-physical abuse	3	0	1	0	4
Dignity and Privacy	1	2	2	0	5
Non - Clinical Equipment	5	4	1	1	11
Frequent Callers	35	31	22	39	127
Information/Enquiries	504	563	662	642	2371
Lost Property	124	125	130	146	525
Non-conveyance	4	3	3	1	11
Other	6	4	6	2	18
Policy/ Procedure	48	44	18	25	135
Road Traffic Accident	4	2	2	0	8
Social Services	14	38	43	31	126
Totals:	1132	1203	1199	1132	4666

PALS by Subjects and Received by quarter between 01 April 2006 to 31 March 2007

	2006 Q2	2006 Q3	2006 Q4	2007 Q1	Total
Access	17	16	23	8	64
Aggravating Factors	1	0	3	1	5
Appreciation	161	182	173	199	715
Physical Violence	3	1	1	0	5
Clinical Equipment	10	9	11	3	33
Clinical	29	46	52	38	165
Communication	45	50	55	31	181
Conveyance	23	34	18	25	100
Delay	39	32	30	27	128
Non-physical abuse	1	1	1	0	3
Dignity and Privacy	1	1	7	0	9

Non - Clinical Equipment	5	9	5	1	20
Frequent Callers	27	37	18	20	102
Information/Enquiries	472	475	521	497	1965
Lost Property	109	94	120	127	450
Non-conveyance	8	1	0	2	11
Other	12	8	5	7	32
Policy/ Procedure	57	56	62	56	231
Road Traffic Accident	1	5	1	8	15
Social Services	30	25	35	22	112
Totals:	1051	1082	1141	1072	4346

Attitude & Behaviour

This issue continues to be the subject of poor patient and stakeholder experience and the concept of 'reflective practice' has been introduced as the principal method to enable learning. For example, in relation to EOC/UOC, these exercises are facilitated by EOC Training Managers. We also record the identity of the staff involved so that we can realise any repeat incidents involving the same staff and/or emerging local or departmental trends. Unless appropriate, disciplinary action is no longer initiated as a routine action measure, in keeping with accepted clinical governance practice.

We are also preparing case examples and data for an agency the LAS have engaged to facilitate *'Excellence in Patient Communications'* training; on some occasions, we recommend that the member of staff involved is allocated a place on this course.

Delay

This issue continues to be the subject of poor patient and stakeholder experience. In particular, a sub-category involving calls categorised as a low priority, or non-urgent/GP referrals/intra-hospital transfers continued to feature throughout the year. Individual cases included an excessive delay to an 84YOF with a fracture, a patient awaiting surgery to re-adhere an ear torn off in an attack and a patient scheduled for urgent angioplasty.

Using a Root Cause Analysis framework, the following re-occurring factors have been identified:
• The non- triage of ETA calls. A Team Brief has been issued reminding EOC staff of the protocol in this respect.
• Less than optimum resourcing. Each individual case has been brought to the attention of the relevant ADO.
• Performance problems at shift change-over, being considered by SMG.
• Inappropriate deployment of voluntary aid society (VAS) resources. My understanding is that LAS have no means of verifying the training afforded to voluntary agency staff. Difficulties in accessing PRFs completed by VAS remains a related issue.

Other measures that have been implemented to address this issue:
• EOC reorganisation
• Increased resourcing
• FRED/FREDA automatic dispatch

• Changes to the manner in which GP urgent referrals etc are triaged and resources allocated
• The introduction of the Vehicle Resource Centre to source spare vehicles across the Trust
• Pilot scheme to accommodate ASW MHA 'Section' referrals.

We will of course continue to report back on developments in relation to this particular issue, especially in the light of the 'Call Connect' programme.

Lost Property

PALS received 518 enquiries of which only 98 (19%) were resolved. One case in now the subject of an investigation by the Health Service Ombudsman.

Funding has been given to enable the implementation of a new system, utilising *The Smart Evidence & Baggage System* (SEBS) – see www.smartmci.com - which was been introduced on 9th April.

A communications strategy was devised which has enabled information and guidance to be made available across the Trust and to all London hospital A&E departments. Trust policy (OP/17) has also been revised to reflect staff responsibilities accordingly. An evaluation and monitoring scheme is being devised.

Frequent Callers Project

Staffing
It had been agreed that the project would require dedicated resourcing including two full time Officers and a part time Community Social Work Liaison post. Both Officers are now in post and an advertisement for the social work post will be placed in *Community Care* in the next few weeks.

Structure
One of the core objectives of the project is to embed a mechanism whereby local liaison forums are established, involving local health and social care agencies, according to geographic PCT/local authority area. Each ambulance complex has an existing responsibility for a specific PCT/local authority and thus it has been a relatively simple task to align each complex accordingly. This mechanism dovetails with the review of policy and practice in relation to the High Risk Register and is in keeping with cross agency working envisaged in the *Clinical Leadership model.*

The existing liaison arrangements are however variable across each complex and significant input will be almost universally required to progress the aims and objectives of the project. Similarly, the number and extent of engagement of local complex representatives is sporadic. In order to achieve a systemic approach, AOMs will be required to assume lead responsibility for local action and it is proposed that this consideration be included in AOM/ADO performance assessment criteria.

As an interim measure, PALS have been working with various complexes and the following liaison forums have been established, although it should be noted that

further input will be required to enable all of these forums to become embedded and fully operational in terms of the project objectives:

Bromley
Enfield
Greenwich
Haringey
Havering
Lewisham
Newham
Tower Hamlets

The following PCTs/local authorities have also expressed interest

Barking & Dagenham
Barnet
Bexley
Redbridge
Waltham Forest
Westminster

Caseload Methodology

Case load is determined by reference to cases referred by each complex, using Datix case management system, although work has had to be undertaken to produce a patient list in keeping with aligning each complex with a specific PCT/local authority, given that multiple complexes often serve an individual patient.

Case Data

- Estimated calls reduction: 10,838
- Following a review, 178 cases have been closed where the issue has been resolved, or identified as no longer for inclusion within the project.
- 297 'open' cases remain on file.

The 20 most frequent users have been identified and some form of action has been undertaken. Each patient is being monitored to establish if a reduction in calls is being achieved and whether interventions have therefore been effective.

Our involvement has most usually been in prompting case conferences involving all relevant agencies across the health ands social care economy. Typical solutions include re-location to supported accommodation or residential or nursing care and enhanced community care packages, with lead care responsibilities being coordinated by a named GP, Community Matron or Social Worker.

Following a precedent case in Greenwich (see below) we are now actively pursuing 3 further cases in terms of legal action towards achieving Prohibitive Activity Orders or Acceptable Behaviour Contracts. We have met with NHS CFSMS and MPS accordingly towards establishing a pan-London approach.

Case examples

LC1275: Suspended sentence and 'Prohibitive Activity Order' imposed. Condition of Order requires patient to arrange third party contact with the 999 service. Significant media coverage.

JC8192: evidence of call volume used to influence placement to nursing home.

RC19053: evidence of call volume used to influence revised care package.

CG16138: evidence of call volume used to influence family intervention.

MM15272: evidence of call volume used to influence placement to residential care.

AE16654: Patient travels across London to achieve conveyance to multiple A&E sites to achieve pain relief. Evidence of call volume used to influence Sickle Cell Centre intervention.

Pending outcome:

BP12681: CPS considering court action; evidence of call volume submitted as supporting evidence.

MT15463: evidence of call volume used to influence revised intensive care package now put into place. Patient now readmitted to hospital.

WM16169: 'No send' policy put in place. Frequency of attendances reduced. Situation under review pending possible ABC application.

AM12988: evidence of call volume used to influence revised care package. Patient currently admitted to hospital and awaiting discharge planning meeting.

RC9053: evidence of call volume used to influence application for sheltered housing. Awaiting outcome.

Case examples from Complaints and PALS

1. Following a complaint where an EMT was dispatched to a patient who had experienced an epileptic seizure and was unable to administer the appropriate medication, a mechanism was introduced enabling EOC skill level indication for all operational vehicles.

2. Following a separate incident to the above, the highlighting mechanism indicating that *'Status Epilepticus'* calls required an automatic paramedic attendance was extended to all calls involving seizures, for example febrile convulsion.

3. The patient was under the impression that if she self-harmed she would be seen more quickly at hospital. The patient produced a Stanley knife while the ambulance staff were on scene; they interpreted this as a threat which resulted in the police being requested to attend. The matter was passed to Training Directorate to consider using this incident as a case example within the metal health training module.

4. The patient was given the impression that she had only two options, to stay at home or go to hospital. The incident is to be made available to the *'Excellence in Patient Communication'* training as an example of how some staff are interpreting corporate messages about reducing demand. Numerous other examples are to be similarly made available.

5. The attending staff did not recognise that a patient was in the final stages of renal failure. The Medical Director is to highlight the clinical symptoms to improve recognition and awareness in an article in *LAS News.*

6. The attending ambulance staff left an elderly patient having re-filled the hot water bottle she was using as relief for back pain. The patient later incurred burns. Service Development are working on proposals to produce a 'good practice checklist' as part of the Strategy for Older People.

7. Following identification of an emerging trend from complaints and PALS enquiries, an EOC Team Brief was issued reminding EOC staff of the importance of re-triaging 'ETA' calls that had originally been afforded a low priority categorisation, to enable possible priority upgrade.

8. Following identification of an emerging trend from complaints and PALS enquiries, an EOC Team Brief was issued reminding EOC staff of the 20 minutes call back protocol.

9. Liaison was affected with a mental health Trust to enable an agreed care pathway following a complaint where the attending staff had been unable to convey a patient with mental health difficulties to the hospital responsible for his care.

10. Feedback from complaints and PALS enquiries contributed to UOC introducing a procedure to accommodate mental health patients awaiting inter-unit transfer or MHA assessment; historically, such requests fell outwith MPDS and long delays often resulted in an ambulance being dispatched.

11. A Canadian family were visiting the UK to attend the funeral of a relative. The family were seeking clarification of the circumstances leading to the patient's death and wished to lay flowers at the scene. PALS made contact with origin 999 caller and in view of the limited period in which the family were in the UK, met the family at their hotel to provide copies of the records held by LAS. The PALS officer also accompanied the family to the location where the patient had died.

12. PALS provided a comprehensive report following an apparent significant delay in LAS accommodating a hospital transfer. It transpired that LAS had dispatched but that the patient was not sufficiently stable to be transferred. The importance of

ensuring a patient is clinically stable at the time of the transfer request was emphasised to the hospital.

13. PALS facilitated a report at the behest of a hospital midwifery unit about the care provided to a patient and her unborn baby. PALS identified that the call should have been afforded a higher priority. It was recommended that the EMD involved undertake a reflective practice exercise with an EOC manager. It was further recommended that midwives be made aware of the importance of stressing the potential life-threatening situation to the unborn child in these circumstances.

14. A sickle cell patient had placed 168 emergency calls over two years. It transpired that the patient had also independently attended a very high proportion of the A&E units throughout London. It appeared that the patient may have developed a dependence on pain relief. The local Social Services department to the patient's home address were made aware of the situation and after assessment, a referral was made to the mental health provider.

15. Arrangements were put in place to pre-plan conveyance in relation to a patient who requires an urgent lung transplant and is awaiting a donor.

16. A totality of care review was undertaken following concerns being raised by a hospital at the apparent delay in transferring a patient and the equipment carried by LAS. The evidence supported a view that the attending crew took the most expedient route to the hospital and that the ambulance staff acted appropriately in terms of monitoring of the patient, given the facilities available. The hospital agreed to action a requirement for the provision of an accompanying clinician and advanced monitoring equipment in future cases nature.

17. A GP contacted PALS as he had been unable to ascertain the outcome of arrangements of a patient who had died at his home. Following enquiries, PALS were able to identify that the attending crew had not complied with the relevant protocol. With the support of the GP, PALS liaised with a local manager to ensure the crew concerned were able to use the incident as a learning opportunity and to ensure awareness of the relevant procedures.

18. PALS received an approach from a Social Services department who were planning the relocation of a patient liable to emergency care requirements to supported accommodation. PALS arranged for a local DSO to visit the facility to ensure ease of access and egress.

19. A Resuscitation Training Officer at NHS London sought PALS assistance in reviewing an incident at a mental health facility. The Training Officer agreed to use the evidence produced to support the training of staff at the facility.

20. Following lengthy liaison with health and social care professionals, PALS were able to enlist the support of the Medical Directorate to arrange a PSP in relation to a frequent caller with multiple complex medical problems. Matters had become exacerbated as following an incident where the patient had exhibited challenging behaviour, the patient had been placed on the High Risk Register. However, the patient had subsequently developed a terminal illness and delays were ensuing prior to

conveyance whilst the attending ambulance staff awaited the arrival of the police. PALS were able to confirm that the patient posed very little risk. The HRR entry was removed and replaced with an agreed care plan.

21. PALS were contacted by the wife of deceased pt that LAS attended 2 years previously. The lady was still unsure of exactly what happened to her husband immediately before his death in a hostel as the Coroner had recorded an open verdict. PALS provided the PRF etc and made contact with the Coroners Office who were able to clarify the circumstances surrounding the patient's death.

22. PALS contacted the RSPCA after a report from an ambulance crew who had attended a patient who had collapsed behind locked doors. The patient had no relatives or neighbours who were available to care for a numbers of pets. The RSPCA subsequently agreed care arrangements of the animals with the patient.

23. PALS received an Incident Report completed by the attending crew and a telephone call from the GP involved; both parties were concerned at the management of an incident by the other. With the support of the Medical Directorate, PALS were able to arrange a reflective practice meeting so that all those involved could improve their respective understanding of the role played by each other and work towards improved collaboration in the future.

24. Following a Quality Assurance report regarding the poor attitude and compliance with protocols by an EMD, PALS were able to identify that the same EMD had previously been the subject of seven complaints about the same matters. PALS alerted EOC senior managers accordingly.

25. PALS received three incident reports involving the same hospital within the same month. With the support of the Medical Director, a meeting was subsequently arranged with hospital senior managers to improve the LAS – A&E interface and thus promote improved patient care.

Gary Bassett
PALS / Complaints Manager
10 May 2008

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Workforce Plan

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

2. Purpose: For approval

3. Summary

The A&E Workforce Plan sets out the ambitions for the Trust within 2008/09 to recruit and train additional staff aimed at meeting the long term aspirations contained within the LAS Strategic Plan and the current requirements of the national response standards.

The growth in workforce numbers is identified and the challenges in achieving a full workforce by the end of March 2009.

The plan shows the introduction of the Student Paramedic role and success of achieving the plan is particularly reliant on the Trust's ability to recruit and train sufficient numbers of these staff in year.

Key risks are identified within the document.

This plan forms part of a wider package of work relating to workforce development within the LAS. Other aspects to be finalised and to follow are:

- Skills escalator and associated student paramedic programme description
- Finalised training plan
- Plan to move to a Higher Education training model

Progress against the workforce plan will be monitored through the A&E Resources group and reported to SMG monthly from June 2008. The Trust Board will receive regular updates on progress.

4. Recommendation

THAT the Trust Board APPROVE the A&E Workforce Plan for 2008/09

LONDON AMBULANCE SERVICE

Trust Board Meeting, 20 May 2008

A&E WORKFORCE PLAN 2008 / 09

Introduction

The long term Workforce Plan for the London Ambulance Service states the desired move from 2007 to 2013 to a more highly skilled frontline workforce providing a wider range of responses to the population of London which are more appropriate to their needs. The continuing development of this workforce plan also takes account of the changing face of healthcare provision generally in London such as the proposals contained within "Healthcare for London" together with the national expectation on improved response times for Ambulance Trusts.

Further work has therefore been undertaken through a multidisciplinary workforce planning group and the SMG to ensure the workforce plan for 2008/09 reflects the current requirements and prepares adequately for the longer term aspirations of the Trust within the wider London context.

This paper forms part of a wider package of work relating to workforce development within the LAS. Other aspects to be finalised are:

- Skills escalator and associated student paramedic programme description
- Finalised training plan
- Plan to move to a Higher Education training model

Revision to A&E workforce establishment

The following sets out the proposed skill mix and workforce numbers for 2008/09. These numbers incorporate one HART (Hazardous Area Response Team) team of 42 staff within the funded establishment. The revised establishment accounts for assumptions on staff movements, such as:

- Move of paramedics to Team Leader, ECP or exit from the LAS
- Move of EMT to Paramedic or exit the LAS
- Move of A&E Support staff to Student Paramedic or exit the LAS

These movements are based on historic trends and current expectations. However, we will monitor these closely in year, and will make adjustments if trends change.

The A&E workforce establishment for 2008/09 is set out below:

	In Post March 08	2007/08 establishment	**2008/09 plan**
Team Leader	161	170	**175**
ECP	53	56	**86**
Paramedic	818	911	**830**
Student Paramedic			**300**
EMTs	1411	1396	**1220**
A&E Support	196	202	**232**
CTA	49	70	**70**
	2688	2805	**2913**

The A&E staff establishment will increase to 2913 and constitutes a workforce growth of 108 staff on the previous year.

Staff in post at the beginning of the year against this increased establishment shows a vacancy factor of 225. This, together with the anticipated leavers throughout the year of around 180 identifies an overall recruitment requirement of 405 staff by the end of March 2009.

Student Paramedic

The introduction of the Student Paramedic role will significantly support this annual workforce plan by providing the opportunity through which the Trust can develop the careers of existing staff to become qualified Registered Paramedics. In addition, it will allow the Trust to enhance its direct recruitment of staff who will, under the Student Paramedic programme, train to become Registered Paramedics.

In addition, the Trust will continue to train existing Technician staff to qualified Paramedic. This training is discreet from the Student Paramedic Programme and these staff will continue to transfer direct from EMT to Paramedic once qualified.

The Trust will continue to support and further develop links with Universities both to receive qualified Paramedics as recruits to the LAS and to develop an LAS diploma level Paramedic programme for both the above routes of progression.

Recruitment Training Plan

The training plan to support the recruitment of additional staff to the revised skill mix is currently being finalised and involves the creation of additional training resources. This is with the aim to have recruited to full establishment by the end of March 2009.

Student Paramedic Programmes are being delivered from May 2008 aimed at both internal and external candidates. These planned programmes will deliver a total of 132 places. Work is ongoing to secure an additional dedicated training location at Hannibal House in Elephant and Castle together with additional Trainers. This resource is expected to be able to provide three Paramedic training programmes concurrently with 54 participants in total. Dependant on time of completion of this work, this facility will deliver between 108 and 162 places by March 2009. The Training Department are also considering the potential for increasing existing provision should this facility not be completed in time to deliver the maximum capacity anticipated.

This training activity will also be complimented by 144 places planned for 2008/09 for the training of Technician staff to Paramedic.

Existing plans for A&E Support training are felt to be sufficient to meet requirements and may offer the opportunity for conversion to Student Paramedic places should the movement of A&E Support staff remain consistent with initial indications.

Recruitment of additional ECPs will be in line with the introduction of the “New Ways of Working” early implementer sites.

Once these plans (particularly in relation to the additional resource) have been finalised, a workforce recruitment profile for the year will be presented and used to monitor progress against the plan. This is expected to be in place by the end of May 2008.

Recruitment

Recruitment to the Student Paramedic programme is underway and entails a robust assessment process which includes numerical and verbal reasoning. This is to ensure the Trust recruits candidates with the ability to successfully complete the required training and qualify as a Registered Paramedic.

The recruitment plan aims to have adequate numbers of successful candidates ready to place within training programmes in sufficient numbers to achieve this workforce plan.

Recruitment to A&E Support roles is ongoing and continues to meet the requirements of the plan.

The Trust struggles to exceed 50 CTA staff and will continue to raise the profile of this role both internally and externally. Opportunities through NHS Professionals are currently being explored though to date progress has been slow.

Risks

The following key risks to achieving the workforce plan fully by the end of March 2009 have been identified:

- Inability to recruit to the numbers required: –
  - The Student Paramedic role is previously untested and whilst we anticipate it will prove to be popular, this has yet to be evidenced.
  - To mitigate the barrier associated with the requirement to hold a C1 driving licence, the Trust will offer financial support to successful candidates to obtain this prior to commencing employment with a "payback" agreement once employed.

- Inability to train the numbers required: –
  - It is hoped that the additional training resources can be secured in time to meet the full requirements of the plan for Student Paramedics.
  - If this is not the case and sufficient increases to existing in-house training cannot be achieved, this will result in slippage of one month into the month of April 2009.

- Increase in number of leavers to those anticipated, either through movement within or exit out: –
  - The workforce plan is premised on assumptions of movement of staff based on historic trends. If the actual numbers of staff moving or leaving are significantly greater than these assumptions, this will place more pressure both on the recruitment and training demands.
  - Plans for A&E Support staff can accommodate higher numbers. If, however, we experience greater movement of existing Paramedics and EMT staff, the plan may not be fully achieved by March 2009.
  - We will continue to have access to the additional facilities at Hannibal House to continue to provide additional training in to the year 2009/10 should the need arise.

Monitoring

Progress against this workforce plan will be monitored through the A&E Resources Group with monthly reporting to SMG and through the balanced scorecard.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 20th May 2008

FT Project Plan

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

The attached paper seeks to inform the Board of the first stage of the pilot FT Project Programme and a timetable for implementation is enclosed.

The Trust has been chosen as one of two ambulance service trust to pilot the ambulance service sector specific diagnostic. This involves us working with NHS London on an accelerated programme containing rehearsals of key aspects of the application process to become a FT. The output from this pilot will be a diagnostic report. This will enable us to anticipate the challenges presented by the formal process and identify what is to be done in order to comply with Monitor's detailed reviewing for aspirant foundation trusts.

This work is being co-ordinated through the mechanism of our internal team led by the Head of Governance.

The following abbreviations are used in the timetable:

a. IBP Integrated Business Plan
b. LTFM Long Term Financial Model
c. SDS Service Development Strategy

4. Recommendation

THAT the Trust Board APPROVE the schedule set out in the report.

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Call Connect Diagnostic Visit to LAS by Department of Health Team

1. Sponsoring Executive Director: Martin Flaherty
(Paper presented by Richard Webber- Acting Deputy Director of Operations)

2. Purpose: For noting

3. Summary

The Department of Health undertook diagnostic visits to each of the UK Ambulance Services earlier this year. The LAS visit took place in early April 2008.

The purpose of the visit was to ascertain the robustness of the Trust's Performance Improvement Plan and the anticipated ability of the LAS to deliver Call Connect. The subsequent report identified several Areas of Best Practice within the LAS and also made Recommendations for the Executive Team to further consider.

4. Recommendation

THAT hat the Trust Board NOTE notes the positive nature of the report and that an Action Plan will be produced and promulgated in due course.

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Fleet procurement and policy plan 2008/13

1. Sponsoring Executive Director: Martin Flaherty
(Richard Webber presenting paper as Acting Director of Operations).

2. Purpose: For approval.

3. Summary

In 2004 the Trust approved a three year vehicle acquisition policy which has now expired.

The new Fleet Procurement Plan document sets out the revised vehicle acquisition programme for all front line ambulances, Urgent Care Vehicles, Rapid Response Cars, Duty Station Officer Vehicle, Motor Bike Response Units, Education and Development vehicles, PTS Vehicles, support and other specialist vehicles. It covers the period 2008/2013.

The Plan takes account of replacement cycles for existing vehicles. It also anticipates the number and type of vehicles required under the New Front End Model to maintain Call Connect Targets. The Plan takes account of the expansion of the Urgent Care Service and the requirement for vehicles to be provided for the Olympic Games in 2012.

A recommendation of this plan is that a Vehicle Procurement Unit team be established.

4. Recommendation

THAT the Trust Board APPROVE the five year plan for front line A&E, PTS, emergency preparedness and support vehicles. This programme would:

1. Be the basis for future vehicle acquisition
2. Enable the Fleet to be better managed through a scheduled replacement of all vehicles to avoid the premature replacement and disposal of vehicles or retaining vehicles beyond their effective life.
3. Allow flexibility of replacement arrangements which also take account of any reductions or increases in the size of the fleet.
4. Enable the Trust to plan future financial commitments in respect of vehicle acquisition
5. Enable the Trust to achieve better value for money in planning future acquisitions and maintenance arrangements etc.

London Ambulance Service NHS Trust

Fleet Procurement Policy and Plan

2008/13

Christopher Vale

Head of Operational Support

May 2008

1. PURPOSE OF THE PLAN

1.1 The Trust in 2004 approved a three year vehicle acquisition policy which has now expired.

1.2 This Fleet Procurement Plan document sets out the revised vehicle acquisition programme for all front line A&E vehicles, Urgent Care Vehicles, Rapid Response Cars, Duty Station Officer Vehicle, Motor Bike Response Units, Education and Development Vehicles, PTS Vehicles, support and other specialist vehicles. It covers the period 2008/2013.

1.3 The Plan takes account of replacement cycles for existing vehicles. It also anticipates the number and type of vehicles required under the New Front End Model to meet Call Connect Targets from April 2008. The Plan takes account of the expansion of the Urgent Care Service and the requirement for vehicles to be provided for the Olympic Games in 2012.

2. BACKGROUND

2.1 The Trust must ensure that sufficient road worthy vehicles of the correct specification are available to meet operational requirements and targets, and provide robust and consistent patient care. The fleet must be of sufficient size to maintain A&E Peak Vehicle Requirement and PTS contractual obligations. Through the work of the Vehicle Resource Centre, Flexible Fleet Scheme, and improved maintenance and service regimes, the Trust will seek to reduce the size of the fleet by means of improved utilisation and availability. The Trust will work towards a reduction in the vehicle relief factor to 10% by 2010.

2.2 The Trust is aware that vehicle reliability / availability is a major factor in providing the level of patient care required and this deteriorates as the vehicle age profile increases. In this respect the Trust will aim to ensure that it has no vehicles more than six years old in the fleet and that replacements will be purchased or leased on a regular basis.

2.3 The Plan will cover specialist vehicles such as those used for bariatric patients, BETS, control services and CBRN/HAZMAT.

2.4 Vehicles required for station management support and other support functions will also be covered by the Plan. This includes Training, Complex based Corsa's, Equipment Support Vehicles and Fleet Support Services.

2.5 The Trust will seek to achieve the best possible value for money when acquiring and replacing vehicles. This will include considerations on buying and leasing vehicles to produce the most economic whole life cost.

2.6 The requirement to procure environmentally friendly vehicles to reduce carbon emission will form part of all specifications. All future vehicles will need to comply with the requirements of the London Emission Zone where necessary.

2.7 A summary of vehicle fleet sizes and how these will be replaced during the life of the plan is attached at annex 1. A comprehensive plan will be held on the Operational Support Department areas of the London Ambulance Service NHS Trust (LAS) X drive. This will be updated at regular intervals.

3. VEHICLE EQUIPMENT WORKING GROUP

3.1 All vehicle types purchased or leased by the LAS have individual specifications which are used for tendering and vehicle build acceptance. These specifications are compiled by a User Group under the guidance of the Operational Support Department and the Vehicle and Equipment Working Group (VEWG).

3.2 The function of the VEWG forum is to bring together management and staff side representatives to define the operational needs for base vehicle purchase and conversion. The Group contains representatives from Fleet, Purchasing, Health and Safety, the Medical Directorate and Operations.

3.3 The group defines, researches and trials new vehicles and major equipment to ensure they are both safe and viable for the LAS to use with patients. The trials sometimes generate changes to the original vehicle and or equipment specification to make it acceptable to the LAS. When these are agreed they are converted into a practicable specification for base vehicle procurement and conversion.

4. FINANCIAL AFFORDABILITY

4.1 Depending upon the full value of the vehicle(s) either an Application for Financial Approval (AFA) or Business Case be raised. If the value is under £250k an AFA is raised and for values over £250k a Business Case is required.

4.2 Both the AFA and Business Case will ensure that:

- Vehicle option selection is robust
- Financial funding paths and selection is robust
- The preferred option for Value for Money (VFM) has been fully tested
- The preferred option is affordable to the LAS
- Reliability of the replacement vehicle is higher that the current vehicle (if appropriate).

4.3 The AFA or Business Case will ensure that all other costs for items affected by the acquisition of vehicles are also covered including: estates; additional workshop staff and equipment; technology staff and equipment; clinical equipment; fuel etc.

5. COMMITTEE FOR EUROPEAN NORMALISATION (CEN)

5.1 It is now incumbent upon the Trust to ensure where practicable, all newly purchased patient carrying vehicles comply with the latest Committee for European Normalisation (CEN) guidance. The Trust has agreed that alternatives to CEN can be considered if the standards and quality proposed are of an equivalent nature.

5.2 The LAS ambulance body conversion specifications are centred on this guidance as the standard for meeting good practice and thereby reducing the LAS exposure to litigation.

6. ENVIRONMENTAL STANDARDS

6.1 The LAS supports environment controls for the atmosphere and uses diesel engine vehicles specified to the latest emission standards as far as possible. Currently

London has a Low Emissions Zone and all but five of our vehicles comply. As new technologies for vehicles become available the Trust will carry out research and assess their impacts on vehicle operations. This will enable the Trust to make a positive contribution to environmental improvements.

7. PROCUREMENT POLICY

7.1 The LAS uses the NHS National procurement policies produced by The NHS Procurement and Supplies Agency (PASA); LAS Standing Financial Instructions (SFI's) and Trust Standing Orders (SO's) for the procurement of vehicles,

7.2 Where the accrued cost is under the Official Journal of European Union (OJEU) limit then procurement is conducted via the LAS SFI's and SO's using a minimum of three tenders.

7.3 Where the accrued cost of vehicle purchase over the three year period is estimated to be in excess of the OJEU limit then the procurement must be in line with the OJEU ruling. PASA have selected companies and vehicle types through the OJEU route and these are registered in their Vehicle and Vehicle Conversion Framework Agreements for use by any NHS organisation. LAS where possible will procure and convert vehicles using the PASA Frame Work Agreements and contractual documents.

7.4 The LAS also has the right to separately tender through OJEU. In this case the formal OJEU tender submission action and the full process have to be adhered to.

7.5 The Trust will seek to purchase or lease vehicles consistently from the same manufacturer whenever financial and engineering considerations allow. This encourages the development of long term supplier relationships which will result in collaborative working and potential for future financial savings. It also provides for potential savings to be made on generic vehicle spare parts. This policy also assists the training and development of maintenance staff and the provision of diagnostic tools.

7.6 Vehicle specifications will be reviewed for multi-role functionality where possible thereby minimising the number of vehicles whilst retaining efficiency and effectiveness

7.7 The Trust is working with other Ambulance Services to develop a national specification for front line A&E vehicles. This has involved consideration and development of a generic ambulance specification. This has significant potential to standardise ambulance design with the resulting cost savings this could bring.

7.8 The work of the National Specification Group has produced a number of potential specifications which are still under consideration.

8. MAINTENANCE

8.1 All vehicles procured or leased by the LAS will wherever possible be maintained by the Fleet Workshops. This ensures priority to vehicle repairs, maintenance and preparation for MOT's etc which is not offered by commercial organisations

8.2 Given the fleet size and diversity of vehicles it is essential the LAS workshops employ adequate sized work forces who are:

- qualified
- multi-skilled
- trained in appropriate new technologies

8.3 The Trust is currently in the process of reviewing the delivery of Fleet Support Services. As a result of this exercise, changes will be made to the vehicle maintenance regime aimed at improving throughput and reducing downtime.

9. VEHICLE ACQUISITION/REPLACEMENT PROGRAMME

9.1 Each vehicle type in use by the LAS has a specification covering the user and support services defined requirements. This is agreed before the procurement of the base vehicle and body conversion.

9.2 Vehicle manufacturers change design and specification of vehicle without consultation, therefore it may not be possible to continue to procure or lease the same style or manufacturer of vehicles for replacements purposes.

9.3 At the outset of each replacement cycle the specification is reviewed against:

- The current user requirement.
- Vehicle types available for procurement through the current PASA Framework
- Agreements for A&E and PTS vehicles
- Approved PASA A&E and PTS vehicle converters. Where there is not a PASA Framework agreement for vehicle conversion i.e. non-ambulance vehicles, the work may be tendered through OJEU.

9.4 The Trust authorises the acquisition of all vehicles through approval of the AFA or Business Case as briefly described in section 4.

10. AMBULANCE VEHICLES

10.1 The LAS A&E fleet is currently made up of 260 Mercedes and 123 LDV ambulances which are between 3 and 11 years old.

10.2 The LDV Fleet now requires replacement. The purchase of 123 Mercedes Sprinter Ambulances during 2008 has been agreed to facilitate this objective. These vehicles are now unlikely to be delivered until early 2009.

10.3 The future size of the combined A&E and Urgent Care Fleet has been considered in light of the establishment of the Vehicle Resource Centre (VRC). The VRC has improved the utilisation of the fleet and the management of spare capacity on a daily basis. In addition, the implementation of the review of Fleet Support Services will provide improved efficiency in the maintenance and repair process. This will allow the fleet relief factor to be reduced to 10% by 2010. These initiatives will allow additional demand to be absorbed without the need to purchase additional vehicles.

10.4 Should there be a requirement to increase the fleet size there is sufficient flexibility within the life of the plan to acquire additional vehicles.

10.5 The remainder of the A&E Fleet are Mercedes Sprinters which require replacement at the following intervals :-

2009/10 – 130

2010/11 – 65

2011/12 – 65

10.6 Replacement of these vehicles is tied to leasing agreements. The agreements allow for new chassis's to be acquired at the intervals mentioned above, and for the existing bodies/saloon to be refurbished and remounted on the new chassis. Alternatively, new chassis and bodies can be acquired.

10.7 The financial aspects of these options are being fully considered, but this will not affect the timescale of the replacement programme.

10.8 The Trust will have a responsibility to provide ambulance vehicles to support the 2012 Olympic Games. The replacement programme in 2012 may therefore be varied to allow for vehicles to be made available for this purpose.

11. URGENT CARE

11.1 For the purpose of vehicle acquisition, Urgent Care requirements have been included in the A&E acquisition section above. A generic A&E vehicle specification can be utilised by Urgent Care staff with appropriate equipment removed during their utilisation of the vehicle. This enables the maintenance of maximum vehicle flexibility with the A&E area of work.

11.2 The current 11 Movano van conversion used by Urgent Care will be removed from service or redeployed when the LDV fleet has been replaced.

12. A&E RAPID RESPONSE AND ECP VEHICLES

12.1 Following delivery of 83 FRU cars during 2008, the Fleet is now of the required size (197). Over the next five years a regular replacement programme will be implemented to ensure the car fleet remains of the correct age.

12.2 An increase in ECP vehicles (Zafiras) is anticipated in 2009 and 2010 which will bring the Fleet up to 40 vehicles.

13. MOTOR BIKES

New motor bikes have been procured this year bringing the Fleet size to 23. To meet Call Connect performance targets, 12 further motor bikes may be procured over the course of the plan.

14. DUTY STATION OFICER VEHICLES

The Duty Station Officer Zafira's are due for replacement in 2009. The Galaxy vehicles are now past their due date for replacement. A User Group is considering the specification of a new vehicle.

15. PTS VEHICLES

15.1 The PTS Fleet will be enlarged or renewed in accordance with contract obligations over the period of the plan. If new contracts are awarded, additional vehicles may be required. A clear focus will be given on improving the age profile of the Fleet which will support bids for new contracts. Strategies to reduce the time scales for acquisition of new vehicles will be considered and developed.

15.2 During the early years of the plan, replacement stretcher and sitting vehicles will be acquired. Vehicles with a bariatric carrying capability will also be acquired as will replacement vehicles that can transport patients in wheelchairs.

16. EMERGENCY SUPPORT VEHICLES

16.1 There are a number of vehicles under this umbrella including Emergency Support Vehicles (ESV), Emergency Control Vehicles (ECV), and those used for HAZMAT and CBRN.

16.2 A number of replacements for these vehicles are planned for the early years of the plan including ESV's and ECV's. Of particular concern is the replacement programme for Emergency Pod Vehicles which are funded by the Department of Health. Early confirmation will be sought to assess the timescales for this work.

16.3 These vehicles will be regularly reviewed during their operational life. Ultimately replacements will be based on mileage and changing operational need. Opportunities will be taken wherever possible to provide dual purpose vehicles to maximise potential use.

17. TRAINING AND SUPPORT VEHICLES

17.1 A number of Training and Support Vehicles will be maintained as part of this plan. This will include Driving Training Vehicles, Equipment Support Vehicles, Fleet Support Vehicles and Station Corsa Cars.

17.2 It is considered a vital element of this plan that "Support Service" vehicles are not neglected in terms of age and suitability for purpose.

18. VEHICLE PROCUREMENT PLAN

18.1 A recommendation of this plan is that a Vehicle Procurement Plan be established. This would enable a clearer focus on the acquisition of vehicles to be achieved in a timely fashion and promote further expertise

18.2 The OSD has absorbed vehicle project work formally carried out by the Project Support Office and also elements of the procurement function. It is suggested that the Fleet engineers working in this area are supported directly by a Procurement Officer and Project Manager/Administrator.

18.3 The Unit would manage all aspects of vehicle procurement, and maintain a detailed plan.

Chris Vale
Head of Operational Support
May 2008

ANNEX 1 - VEHICLE FLEET ACQUISITION/REPLACEMENT PROGRAMME 2008/13

VEHICLE	FLEET SIZE	2008/09	2009/10	2010/11
A&E AMBULANCE AND URGENT CARE	394 (current) 361(planned)	123 (replacement)	108(replacement)	65 (replacemen
RAPID RESPONSE CARS (INC. ESP and DSO)	230 (present) 258 (planned)	25(replacement)	89(replacement) 14 (new)	83 (replacemen 14 (new)
MOTORBIKES	23 (current) 35 (planned)		11 (replacement) 12 (new)	
EMERGENCY/SPECIAL VEHICLES	25(current) 30 (planned)	10 (replacement) 1 (new)	15 (replacement) 4 (new)	
PTS STRETCHER VEHICLES	40	20 (replacement)	20 (replacement)	
PTS MINI-BUS	86	43 (replacement)	43 (replacement)	
PTS – WHEEL CHAIR CARRIER	14	14 (replacement)		
PTS VANS/CARS	28	15 (replacement)		13 (replacemen
PTS BARIATRIC	3	3 (new)		
TRAINING VEHICLES	48 (current) 52 (planned)	14 (replacement) 4 (new)	32 (replacement)	

VEHICLE	FLEET SIZE	2008/09	2009/10	2010/11	2011/12	2012/13
CORSA CARS	40		32 (replacement)			8 (replacement)
EQUIPMENT SUPPORT/FLEET VEHICLES	28		22 (replacement)	6 (replacement)		
RESUS. UNIT VANS	7			7 (replacement)		

TOTAL FLEET SIZE – 966 (current)
982 (planned)

AVERAGE AGE (YEARS) OF FLEET IN EACH FINANCIAL YEAR (FOLLOWING ACQUISITION OF VEHICLES)

VEHICLE TYPE	2008/09	2009/10	2010/11	2011/12	2012/13
A&E/URGENT CARE AMBULANCES	3.4	2.3	2	1.8	2.8
A&E CARS	1	1.7	2.7	2.2	3.2
EMERGENCY/SPECIAL VEHICLES	3.6	0.4	1.4	2.4	3.4
PTS VEHICLES	2.7	1.4	1.5	2.5	3.5
TRAINING VEHICLES	3.9	1.7	1.5	2.5	3.2

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 2008

Compliance with DH Response Time Data Reporting Requirements (KA34 2008/9)

1. Sponsoring Director: Peter Bradley

2. Purpose: For approval

3. Summary

This paper describes the rules on how the LAS capture, record and calculate performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with the guidance issued by the DH Information Centre for the KA34 yearly return (version 08-09 final guidance).

It is presented to the Trust Board as a record of compliance.

4. Recommendations

THAT the Trust Board NOTE the contents of the report.

Compliance with DH Response Time Data Reporting Requirements (KA34 2008/9)

1. Background

This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. This paper incorporates LAS compliance with the guidance issued by the DoH Information Centre for the KA34 yearly return (version 08-09 final guidance).

2. Clock synchronisation

The Computer Aided Despatch System (CTAK) uses NTP* (Network Time Protocol) to synchronise its internal clock to public time servers on the Internet. The precision is between 15 and 3 microseconds. This is a constant procedure (i.e. not a scheduled process) as the servers have permanent access to the Internet for this protocol.

The current Satellite Navigation software allows the MDT clock to be set accurately down to milliseconds. The MDT synchronises the clock every time it starts up, this is every time it has been switched off manually or when it switches off automatically because it hasn't been used for more than 30 minutes. It also synchronises every hour on the hour.

3. Call Connect Time

The Call Connect Time is taken from when the call is presented at the telephone switch. CTAK detects the call arrival and timestamps it instantly. This process is an accepted industry standard. The timestamp is stored by the CLI (Calling Line Identity Process) process.

Approximately 2% of calls do not go through the main incoming 999 lines (hence the CLI process) or are not public calls. These calls do not have a call connect time so the start time (call answer time) is used where necessary. Further investigations are taking place to identify whether the call connect time could be collected for some of these calls, however, there will always be a small percentage of calls where the call connect time is not recordable.

Compliance in capturing call connect times was recently audited by DH representatives in 2007 and the service was deemed compliant.

4. Clock Start Times (Call Connect)

- **Calls generated by a 999 call**

  The clock start time (Call Connect) is when the call is presented to the control room telephone switch. This is time stamped in CTAK.

  This is the start time used for Category A, B and C calls.

- **Running calls**

  The clock start time for running calls is when the call is answered either from telephone or radio. The time is taken from the clocks on the EOC wall synchronised to the national time standard currently broadcast from Anthorn in Cumbria (formerly Rugby). There are no seconds displayed.

- **Calls taken during CTAK downtime**

  As running calls above.

5. Arrival times

Arrival times for all categories of calls are generated from automatic status reporting at scene, based on a vehicle being within 200m of the original incident location. This complies with a best practice set of guidelines agreed by the National Directors of Operations Group.

If the automatic status reporting time is not available, the MDT "red at scene" button press time is used. If neither of these times is available the PRF time is used.

PRF times are used for those calls which are not generated from a 999 call. This also applies to calls that are generated within an operational "footprint" (e.g. New Years Eve). These calls will be added into the database manually within Management Information, based entirely on data from the PRF.

At the time of this report KA34 guidance states the following:

"Category A : …….Presenting conditions, which require a fully equipped ambulance vehicle to attend the incident, must have an ambulance vehicle arrive within 19 minutes of the request for transport being made in 95% of cases, unless the control room decides that an ambulance is not required."

Currently the LAS does not operate the front end model where they wait for confirmation from the initial responder that an ambulance is required. An ambulance routinely forms part of the initial response and is not requested as described in the guidance.

6. Technical Details

Time stamp	Definition	CTAK database field	Clock used	How synchronised	Confirmed by	KA34 Compliant
Call connected	When the call hits the telephone switch	cti_eisec.time_arrived	CTAK server	CTAK servers are using NTP protocol to synchronise their internal clock to public time servers on the internet. The precision is between 15 and 3 microseconds.	George Dervis	Yes
Call answered	When the call is answered by the call taker	Incidents.recv_start_time	CTAK server	Same as above	George Dervis	Not applicable
Arrived at scene (Auto status)	When the vehicle arrives within 200m of the incident using AVLS	Log record	CTAK server	Same as below	Vic Wynn	Yes
Arrived at scene (MDT)	This is when the crew press the MDT button to indicate the resource has arrived at the patient's location	log_entry.param1 where record_type=6 and param=3	MDT	MDTs synchronise with the SatNav clock when they start up and then every hour on the hour. The accuracy is within milliseconds. The SatNav uses GPS time.	Vic Wynn	Yes

Sources of data

UTC

Universal Time Co-ordinated - the internationally agreed time standard set by synchronised atomic clocks run by several countries.

MSF ("Rugby time")

UK national time standard transmitted by the atomic clock run by the National Physical Laboratory in Teddington, but transmitted from a site near Anthorn, Cumbria. This clock is one of the synchronised official UTC clocks. The wall clocks in EOC are synchronised using this signal.

***NTP**

Network Time Protocol - this is the system by which internet servers synchronise each other to UTC. Every computer connected to the internet can synchronise its clock with this signal, using a number of public time servers run by the American military. All LAS servers are using this method to maintain synchronisation with each other.

7. Categorisation of calls during CTAK downtime or where AMPDS is not used.

Calls taken during CTAK downtime are manually allocated an AMPDS code. However, this code is not entered into the performance database and all manual calls are categorised as Category B and Amber 1.

Running calls do not go through AMPDS; all running calls are categorised as Category A.

8. MPS calls

Incidents received through the MPS link are time stamped when the call hits the LAS server. The call is categorised with a red, amber or green category by the system used by MP but there is no AMPDS code, so the calls are categorised as Category B in the performance database.

9. Changing incident attributes such as AMPDS code, category or system generated time stamps

There are no facilities in the CTAK software to make any changes to the record once the call taker completes the call. This has been confirmed by the System Manager, George Dervis. A call can be upgraded or downgraded if further information is supplied regarding a call. This up/down grading is recorded and doesn't overwrite the original categorisation. If a call is up/down graded in EOC/UOC, the categorisation used for performance calculations remains at the original category awarded.

The opportunity exists within Management Information to amend anything in the database, however, AMPDS codes, categories and time stamps are never changed.

10. Cross border calls

The KA34 return states the following:

"Each NHS Ambulance Service is responsible for reporting on the performance of all emergency calls for which it receives the initial call. This includes calls received by a Service that relate to incidents occurring outside its recognised boundary and calls relating to incidents within or outside its boundary that are subsequently transferred to another Service for response.

An Ambulance Service should not report or report on the performance relating to any incident where another Ambulance Service received the initial call, even if the call was transferred to and dealt with by that Ambulance Service. Trusts responsible for dealing with any cross-border calls should advise the trusts who received the initial call of all appropriate clock start times for performance reporting purposes."

Calls transferred to the LAS from other ambulance services are excluded from the performance calculations. Work is currently underway to share information with other ambulance services for calls received by the LAS but transferred to other ambulance services for a response.

11. Calls to a hospital or GP surgery or location where a defibrillator is available

Calls to a Hospital or GP surgery or location where a defibrillator is available (e.g. Heathrow airport, some railway stations etc.) are treated as a zero response in line with KA34 guidance.

Peter Suter
Director of IM&T
13 May 2008

Enclosure 13

London Ambulance Service NHS TRUST

Trust Board – 20 May 2008

Chairman's Urgent Action authorising sale of Buckhurst Hill

1. Director — Mike Dinan

2. Purpose: — Ratification of Chairman's Urgent Action

3. Summary

A copy of the Chairman's Urgent Action and the executive summary of the Full Business Case relating to the sale of Buckhurst Hill is attached for information, and explains the reason for the Urgent Action.

4. Recommendation

THAT the Trust Board RATIFY the Chairman's Urgent Action in relation to the sale of Buckhurst Hill.

Urgent Action Sheet

Date: 27th March 2008 No. 01/08

Standing Orders state that:

41.1.1 Where an urgent decision is required on a matter which would normally be reserved to the Trust Board in advance of a meeting of the Trust Board, the matter will normally be raised by the Chief Executive, or a Board Director with the Chairman, or in his absence the Vice Chairman, with a recommended course of action. The Chairman, or in his absence the Vice Chairman, shall be authorised to act on behalf of the Board where time is of the essence.

41.1.2 Where the Chief Executive, or in his absence, one of the Board Directors other than the Board Director directly involved in the issue, authorises urgent action after consulting with the Chairman of the Board, or in his absence, the Vice-Chairman, in respect of a matter on behalf of the Trust which would normally have been considered by the Board itself, such action shall be reported to the next appropriate meeting of the Board.

It is requested that the Chairman, on behalf of Trust Board, agree to the disposal of Buckhurst Hill Ambulance Station for the sum of £3.9m.

The Outline Business Case relating to the disposal of Buckhurst Hill Ambulance Station was agreed by the Trust Board in March 2006. Due to other commitments i.e. the Invest to Save Programme it was not possible to finalise the Full Business Case until this week. The Finance Director has kept the Trust Board informed of the progress of the sale of Buckhurst Hill Ambulance Station, e.g. in March 2008 when the Board received an update regarding Estates.

The planned exchange of documents to complete the sale is due to take place on 28th March 2008 which is the reason for the Chairman's Urgent Action being requested. The Full Business Case will be presented to the Trust Board in May 2008.

The Executive Summary of the Final Business Case relating to the disposal of Buckhurst Hill Ambulance Station is attached for information.

The Chairman is requested to sign, with the Chief Executive, the Land Registry transfer forms relating to the sale of Buckhurst Hill Ambulance Station in order that the sale can proceed.

The proposed Urgent Action is: agreed ☐ not agreed ☐

Signature of Chairman/Vice Chairman ……..
Date:

Signature of Executive Director …….
Date:

The Urgent Action will be reported to the Trust Board on 20th May 2008

EXECUTIVE SUMMARY

1.1 Strategic Case

1.1.1 The current Buckhurst Hill station is part of the Whipps Cross complex within the East area of the London Ambulance Service NHS Trust (LAS). Geographically, it is located outside the Trust's operational boundary in the borough of Epping Forest, Essex and serves the areas of Buckhurst Hill, Woodford Green, South Woodford and Chingford.

1.1.2 The station's location means that it has difficulty in meeting the required performance targets for Category A calls of 75% within 8 minutes. It has been calculated that a 6.3% improvement in response times could be achieved across the sector by relocating the station closer to its area of greatest demand in the Woodford Green and South Woodford areas.

1.1.3 The station is also under-utilised, with only 2 emergency vehicles now based there. The site covers an area of 2885m² and provides internal garage and accommodation of 950m². There are also 11 Patient Transport Vehicles located at Buckhurst Hill.

1.1.4 The station is located in a mainly residential area. Planning permission to build 16 flats on the site of the existing station was recently granted.

1.1.5 The site has been valued at £3.9m with the benefit of the planning permission for residential development. The realisation of the sale proceeds will be an important component of the Trust's Capital Programme for reinvestment in other assets.

1.2 Economic Case

1.2.1 The requirement for the new ambulance station site is approximately 400m². The space requirement for separate Patient Transport Service accommodation is 700m². If a combined accommodation is provided then a site of approximately 1100m² would be required.

1.2.2 The shortlisted options considered at OBC were:

1. Do nothing: Remain at Buckhurst Hill
2. Combined Station: Acquire land and build
3. Combined Station: Acquire building and refurbish
4 Two separate stations for A&E and PTS vehicles: Acquire land and build
5. Two separate stations for A&E and PTS vehicles: Acquire buildings and refurbish

1.2.3 The preferred option at OBC was Option 4. However, since publication, 2 existing sites have been identified that are available on a leased basis. The first, for A&E vehicles, is a site owned by Transport for London upon which a suitable ambulance station can be constructed. The second, for PTS vehicles, is a commercial unit on a local industrial estate.

1.2.4 This effectively creates a hybrid of OBC Options 4 and 5, but on the basis of leased rather than purchased sites. This new option has been labelled Option 6 and can be tested

against the Do Nothing option and the other options shortlisted at OBC.

1.2.5 The table below summarises the results of the latest economic appraisal, updated for this FBC, using a 3.5% discount rate:

	Option 1 Do nothing	**Option 2** Acquire 1 site	**Option 3** Purchase 1 building & refurb	**Option 4** Acquire 2 sites	**Option 5** Purchase 2 buildings & refurb	**Option 6** Lease 2 sites
EAC	61.7	18.4	21.9	5.9	12.8	-14.1
Weighted benefit score (WBS)	100	870	850	948	918	933
EAC per WBS	**0.62**	**0.02**	**0.03**	**0.01**	**0.01**	**-0.02**
Risk adjusted EAC	62.6	23.0	26.4	10.2	17.1	-10.1
Risk adjusted EAC per WBS	**0.63**	**0.03**	**0.03**	**0.01**	**0.02**	**-0.01**
Ranking	**6**	**4**	**5**	**2**	**3**	**1**

1.2.6 The updated analysis shows that the preferred option is the new Option 6.

1.3 Financial Case

1.3.1 The capital cost of the preferred option is relatively minor as the sites will be leased under operating leases and therefore remain off balance sheet. £350k capital (£404k including VAT) will be required for construction and refurbishment works. This will be funded by the sale proceeds of the current Buckhurst Hill site, estimated at £3.9 million.

1.3.2 The annual revenue costs of the preferred option are £146k, an increase of £81k compared with the existing costs.

1.4 Commercial Case

1.4.1 The land housing the current Buckhurst Hill station was sold on the open market. The sale process is nearing completion and the capital receipt of £3.9m is almost certain.

1.4.2 Leases for the 2 new facilities are also nearing agreement, pending final legal opinions, and no significant further issues are anticipated in agreeing these within the economic and financial parameters set out in this FBC.

1.5 Management Case

1.5.1 The project will be managed by the LAS Estates Department supported by specialist advisors as required.

1.5.2 The project is generally low risk and the arrangements for benefits realisation and post-project evaluation have been agreed.

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 20 May 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:

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

4. Recommendation

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

LONDON AMBULANCE SERVICE

TRUST BOARD MEETING, 20 May 2008

Service Improvement Programme 2012 update

1. Purpose

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

2. Approach to Performance Management of SIP 2012

The approach to performance managing the service improvement programme is based on tracking achievement of planned milestones. Using this approach the report consists of five sections, one for each of the sub-programmes comprising the overall service improvement programme (see below). Each section contains:

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

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

3. Overview of programme structure

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

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

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

4. Exceptions

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

Improving our Response

Referral pathways

The project has effectively stalled following the now long term absence of the project manager. Referral pathways continue to be developed and agreed with providers but making them consistently available to front line staff is proving very difficult as is the agreement of specific milestones for delivery. The deliverable of a comprehensive set of referral pathways in each PCT area which are routinely used by staff has moved into 2008/09. It should be noted however that the Trust met its target to take 21000 fewer patients to A&E in 2007/08 although this was predominantly achieved by increasing CTA volumes. Next steps are to:

- Recruit a new project manager to ensue this initiative doesn't fall further behind schedule;
- Complete all training packages and redefine timescales for training of team leaders prior to cascading to front line staff;
- Continue to explore an electronic solution to displaying available pathways via MDTs.

5. Recommendation

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

Kathy Jones
Director of Service Development

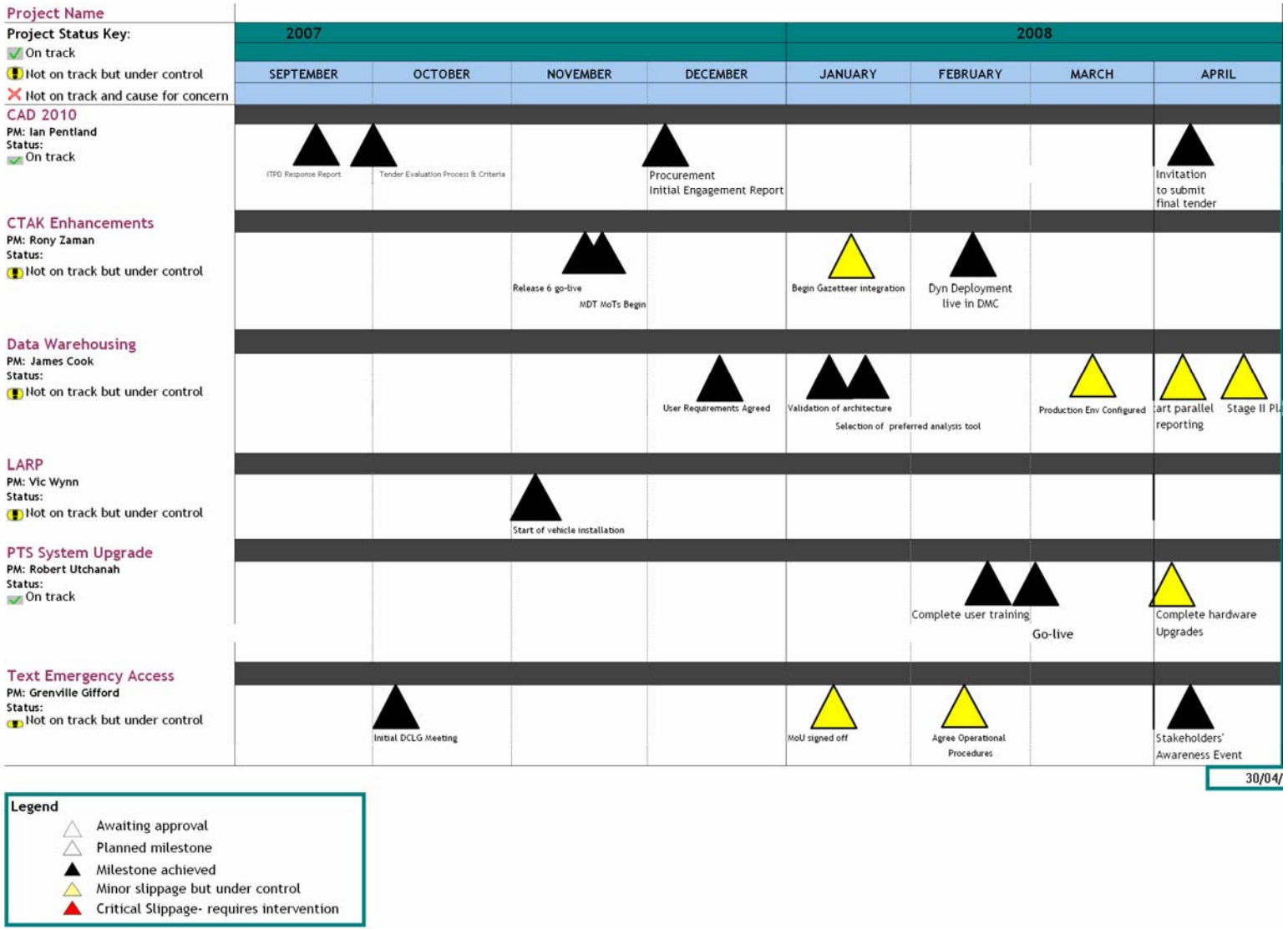
OVERVIEW OF ACCESS / CONNECTING for HEALTH PROGRAMME

CAD 2010
Project Manager: 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


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and cause for concern
2007
2008
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
CAD 2010
PM: Ian Pentland
Status:
On track
ITPD Response Report
Tender Evaluation Process & Criteria
Procurement
Initial Engagement Report
Invitation
to submit
final tender
CTAK Enhancements
PM: Rony Zaman
Status:
Not on track but under control
Release 6 go-live
MDT MoTs Begin
Begin Gazetteer integration
Dyn Deployment
live in DMC
Data Warehousing
PM: James Cook
Status:
Not on track but under control
User Requirements Agreed
Validation of architecture
Selection of preferred analysis tool
Production Env Configured
art parallel
reporting
Stage II Pl
LARP
PM: Vic Wynn
Status:
Not on track but under control
Start of vehicle installation
PTS System Upgrade
PM: Robert Utchanah
Status:
On track
Complete user training
Go-live
Complete hardware
Upgrades
Text Emergency Access
PM: Grenville Gifford
Status:
Not on track but under control
Initial DCLG Meeting
MoU signed off
Agree Operational
Procedures
Stakeholders'
Awareness Event
30/04/
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

Project Name	2008							
Project Status Key: On track Not on track but under control Not on track and cause for concern	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
CAD 2010 **PM: Ian Pentland** **Status:** On track	Receive and review Tenders	Trust Board approve draft FBC Gateway Review 26Jun / 1July	Trust Board approve FBC			SHA Approval of FBC (date to be confirmed)		
CTAK Enhancements **PM: Rony Zaman** **Status:** Not on track but under control								
Data Warehousing **PM: James Cook** **Status:** Not on track but under control								
LARP **PM: Vic Wynn** **Status:** Not on track but under control				Service handover begins			Full migration complete	
Text Emergency Access **PM: Grenville Gifford** **Status:** Not on track but under control					National service launch (provisional)		Pilot Operation (provisional)	

30/04/2008

Legend

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

OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Additional Complex Response
Project Manager: Steve Irving

The aim of this initiative is to provide two sets of resource to staff FRUs to respond to both CAT-A and CAT-B calls. nineteen DSO vehicles need to provide operational cover using managers between 1100 – 1400 daily and the twenty-six team leaders need to be available to staff additional cars between 1400-2000 daily (times stated above may be subject to change).
An additional element to this project requires scoping of mobile office tools that can be utilised by Service personnel whilst on the move.

Increasing Solo Response Capacity
Project Manager: Terry Williamson

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

Mobile Fleet
Project Manager: Andy Heward

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

Referral Pathways
Project Manager: Allison Bolsover

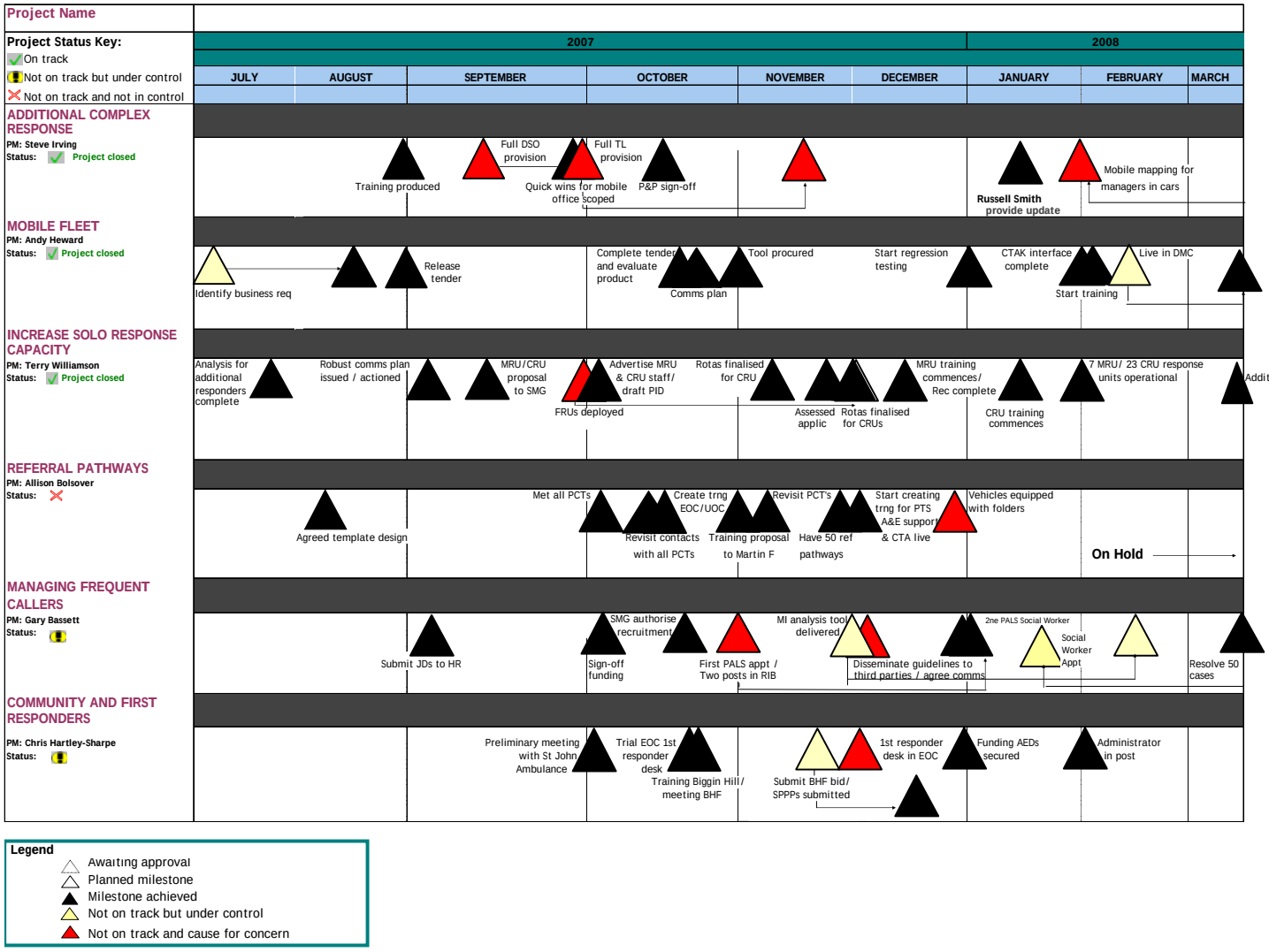
The agreement of pathway protocols with providers, the encouragement of their use by frontline staff and evaluation to ensure that all patients receive consistently appropriate care delivered in a safe manner. This work should result in the LAS taking 200,000 fewer patients a year to A&E by 2012.

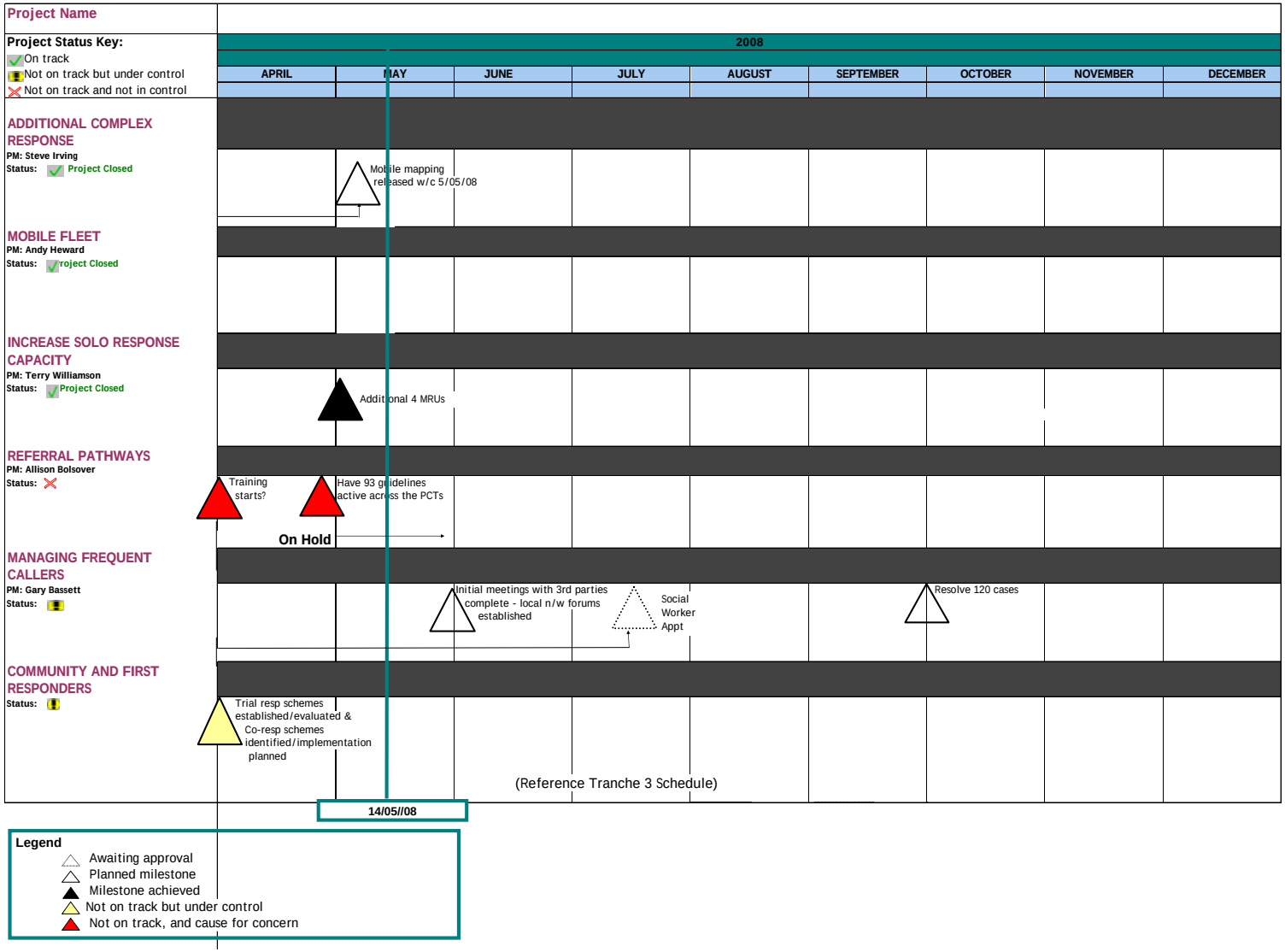
First and Co-responding schemes
Project Manager: Chris Hartley-Sharpe

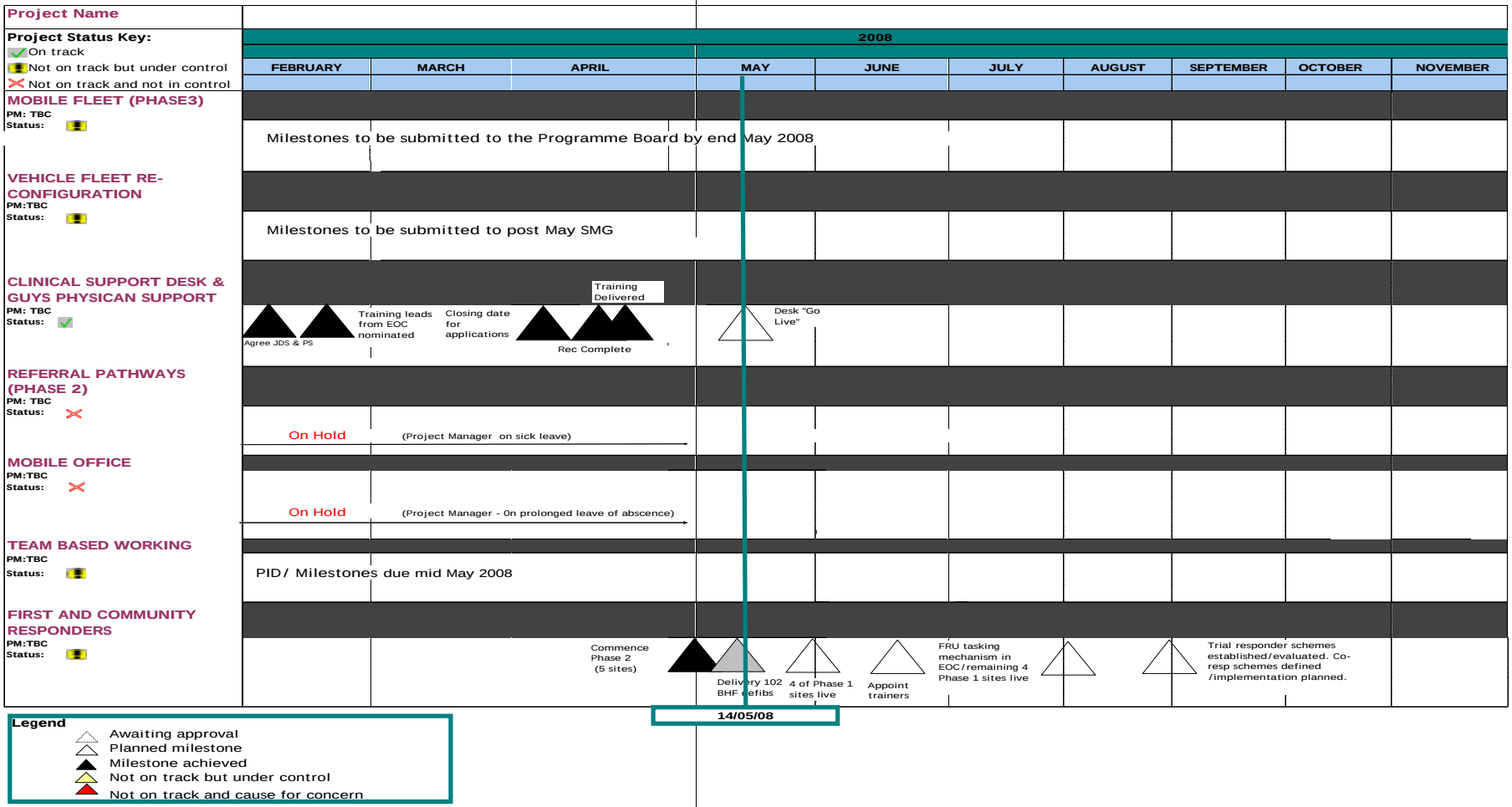
The LAS is looking to revise and expand existing responder schemes which broadly fall into one of three categories: Static defibrillator sites where staff who work in the vicinity are trained to provide Emergency Life support, Co-responders that work for established organisations and who respond to selected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

Managing Frequent Callers
Project Manager: Gary Bassett

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


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: Project closed
Training produced
Full DSO provision
Quick wins for mobile office scoped
Full TL provision
P&P sign-off
Russell Smith provide update
Mobile mapping for managers in cars
MOBILE FLEET
PM: Andy Heward
Status: Project closed
Identify business req
Release tender
Complete tender and evaluate product
Comms plan
Tool procured
Start regression testing
CTAK interface complete
Start training
Live in DMC
INCREASE SOLO RESPONSE CAPACITY
PM: Terry Williamson
Status: Project closed
Analysis for additional responders complete
Robust comms plan issued / actioned
MRU/CRU proposal to SMG
FRUs deployed
Advertise MRU & CRU staff/ draft PID
Rotas finalised for CRU
Assessed applic
Rotas finalised for CRUs
MRU training commences/ Rec complete
CRU training commences
7 MRU/ 23 CRU response units operational
Additio
REFERRAL PATHWAYS
PM: Allison Bolsover
Status:
Agreed template design
Met all PCTs
Revisit contacts with all PCTs
Create trng EOC/UOC
Training proposal to Martin F
Revisit PCT's
Have 50 ref pathways
Start creating trng for PTS A&E support & CTA live
Vehicles equipped with folders
On Hold
MANAGING FREQUENT CALLERS
PM: Gary Bassett
Status:
Submit JDs to HR
SMG authorise recruitment
Sign-off funding
First PALS appt / Two posts in RIB
MI analysis tool delivered
Disseminate guidelines to third parties / agree comms
2ne PALS Social Worker
Social Worker Appt
Resolve 50 cases
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
Legend
Awaiting approval
Planned milestone
Milestone achieved
Not on track but under control
Not on track and cause for concern


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2008
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
ADDITIONAL COMPLEX RESPONSE
PM: Steve Irving
Status: Project Closed
Mobile mapping released w/c 5/05/08
MOBILE FLEET
PM: Andy Heward
Status: Project Closed
INCREASE SOLO RESPONSE CAPACITY
PM: Terry Williamson
Status: Project Closed
Additional 4 MRUs
REFERRAL PATHWAYS
PM: Allison Bolsover
Status:
Training starts?
Have 93 guidelines active across the PCTs
On Hold
MANAGING FREQUENT CALLERS
PM: Gary Bassett
Status:
Initial meetings with 3rd parties complete - local n/w forums established
Social Worker Appt
Resolve 120 cases
COMMUNITY AND FIRST RESPONDERS
Status:
Trial resp schemes established/evaluated & Co-resp schemes identified/implementation planned
(Reference Tranche 3 Schedule)
14/05//08
Legend
Awaiting approval
Planned milestone
Milestone achieved
Not on track but under control
Not on track, and cause for concern


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2008
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
MOBILE FLEET (PHASE3)
PM: TBC
Status:
Milestones to be submitted to the Programme Board by end May 2008
VEHICLE FLEET RE-CONFIGURATION
PM:TBC
Status:
Milestones to be submitted to post May SMG
CLINICAL SUPPORT DESK & GUYS PHYSICAN SUPPORT
PM: TBC
Status:
Training Delivered
Agree JDS & PS
Training leads from EOC nominated
Closing date for applications
Rec Complete
Desk "Go Live"
REFERRAL PATHWAYS (PHASE 2)
PM: TBC
Status:
On Hold
(Project Manager on sick leave)
MOBILE OFFICE
PM:TBC
Status:
On Hold
(Project Manager - 0n prolonged leave of abscence)
TEAM BASED WORKING
PM:TBC
Status:
PID/ Milestones due mid May 2008
FIRST AND COMMUNITY RESPONDERS
PM:TBC
Status:
Commence Phase 2 (5 sites)
Delivery 102 BHF defibs
4 of Phase 1 sites live
Appoint trainers
FRU tasking mechanism in EOC/remaining 4 Phase 1 sites live
Trial responder schemes established/evaluated. Co-resp schemes defined /implementation planned.
14/05/08
Legend
Awaiting approval
Planned milestone
Milestone achieved
Not on track but under control
Not on track and cause for concern

OVERVIEW OF OPERATIONAL MODEL CONTROL SERVICES PROJECTS

Automated Ambulance Dispatch
Project Manager: Paul Webster

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

Automatic Data Reporting and Analysis
Project Manager: Sue Meehan

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

Control Services Management Restructure
Project Manager: Alan Edmonds

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

Paperless Control Room
Project Manager: Lisa Dickinson

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

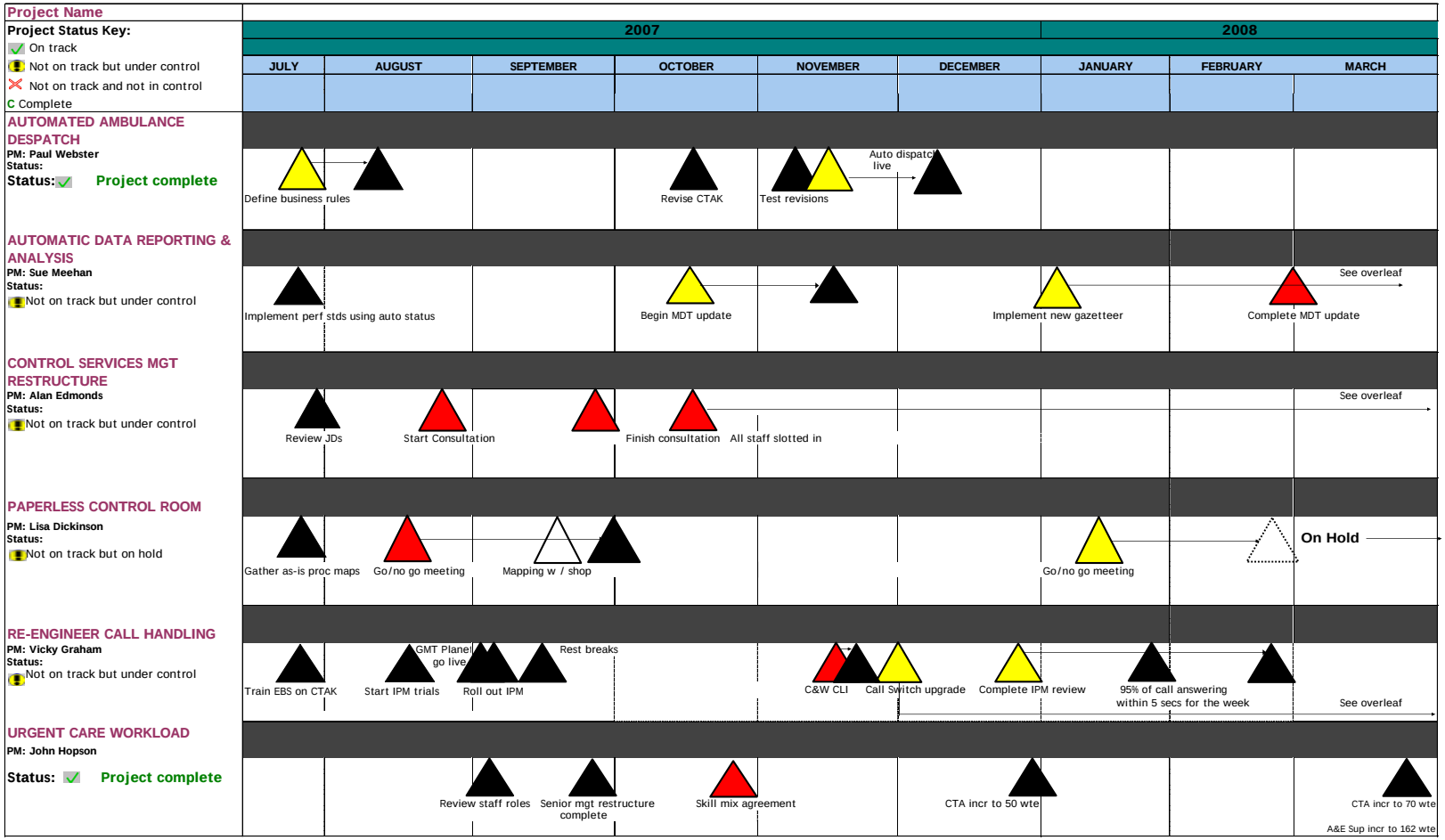
Re-Engineering Call Handling
Project Manager: Vicky Graham

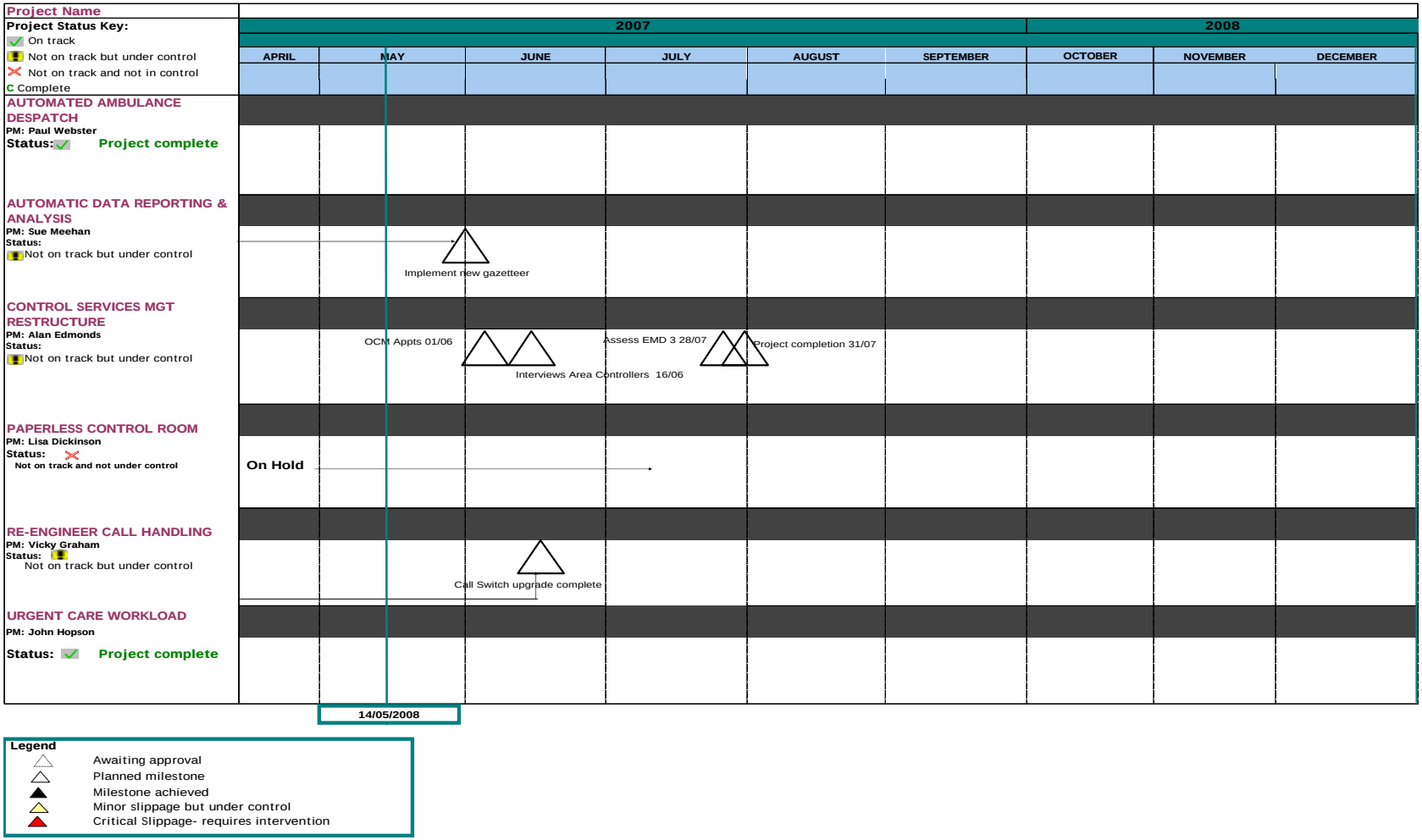
The aim of the project is to reduce call handling times to a predicable and acceptable period of time. This will include changes to consistently answer calls within 5 seconds, to capture Location and Brief Description within 50 seconds and complete the call within 2 minutes.
This will be achieved by adapting rosters and reviewing rest break arrangements to ensure that staff with the optimum skill mix are available to match the demands of call type and volume. Best practise will be established by identifying exemplary staff using IPM then replicating these practises and behaviors 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
C Complete
2007
2008
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
AUTOMATED AMBULANCE DESPATCH
PM: Paul Webster
Status:
Status: Project 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 gazetteer
Complete MDT update
See overleaf
CONTROL SERVICES MGT RESTRUCTURE
PM: Alan Edmonds
Status:
Not on track but under control
Review JDs
Start Consultation
Finish consultation
All staff slotted in
See overleaf
PAPERLESS CONTROL ROOM
PM: Lisa Dickinson
Status:
Not on track but on hold
Gather as-is proc maps
Go/no go meeting
Mapping w / shop
Go/no go meeting
On Hold
RE-ENGINEER CALL HANDLING
PM: Vicky Graham
Status:
Not on track but under control
Train EBS on CTAK
Start IPM trials
GMT Planel go live
Roll out IPM
Rest breaks
C&W CLI
Call Switch upgrade
Complete IPM review
95% of call answering within 5 secs for the week
See overleaf
URGENT CARE WORKLOAD
PM: John Hopson
Status: Project complete
Review staff roles
Senior mgt restructure complete
Skill mix agreement
CTA incr to 50 wte
CTA incr to 70 wte
A&E Sup incr to 162 wte
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention


Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
C Complete
2007
2008
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
AUTOMATED AMBULANCE DESPATCH
PM: Paul Webster
Status: Project complete
AUTOMATIC DATA REPORTING & ANALYSIS
PM: Sue Meehan
Status:
Not on track but under control
Implement new gazetteer
CONTROL SERVICES MGT RESTRUCTURE
PM: Alan Edmonds
Status:
Not on track but under control
OCM Appts 01/06
Interviews Area Controllers 16/06
Assess EMD 3 28/07
Project completion 31/07
PAPERLESS CONTROL ROOM
PM: Lisa Dickinson
Status:
Not on track and not under control
On Hold
RE-ENGINEER CALL HANDLING
PM: Vicky Graham
Status:
Not on track but under control
Call Switch upgrade complete
URGENT CARE WORKLOAD
PM: John Hopson
Status: Project complete
14/05/2008
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

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. Modules include;

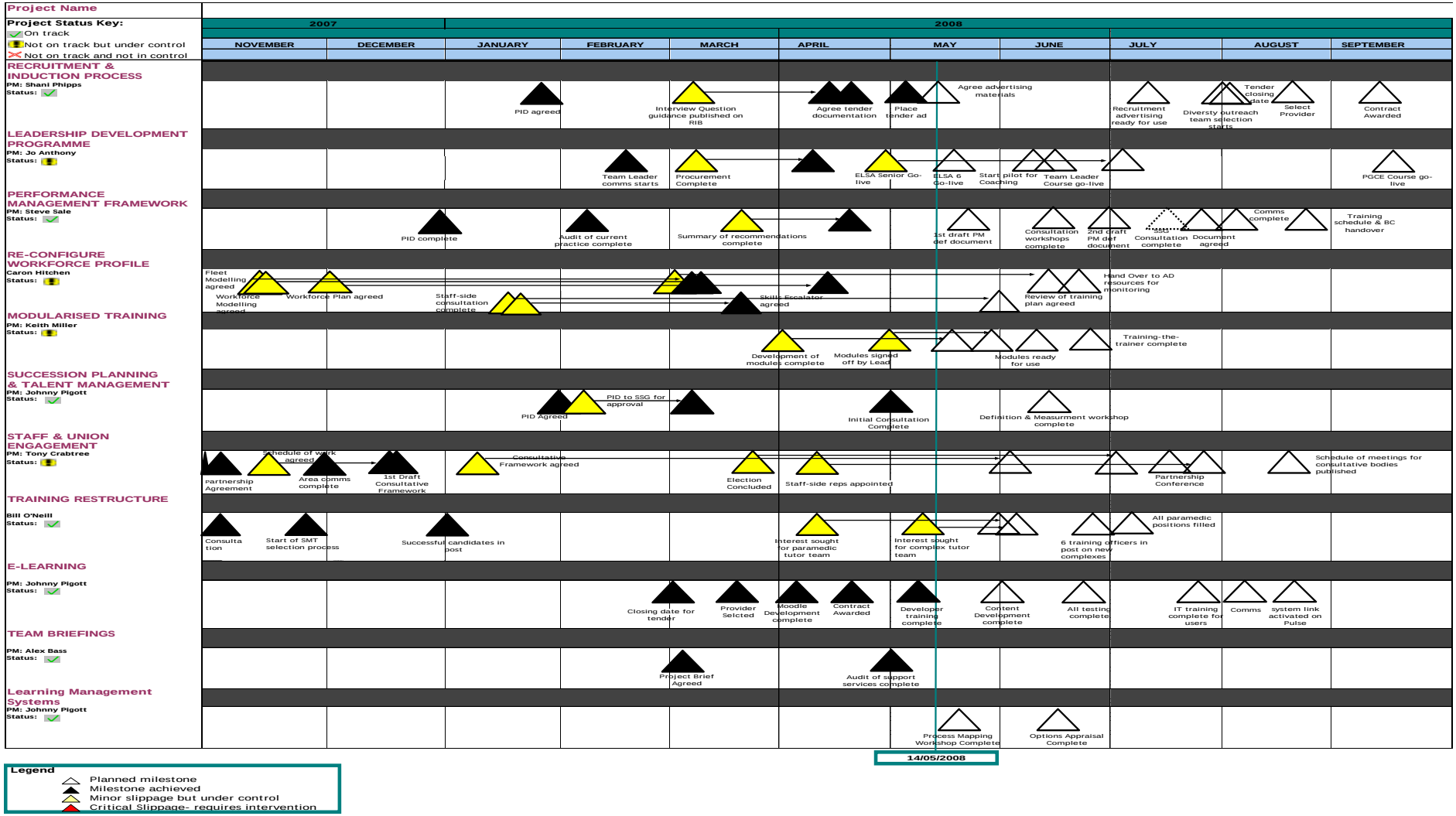
- 12 – Lead ECG
- Obstetrics
- Mental Heath
- Diversity
- Major Incidents

Team Briefings
Project Manager: Alex Bass

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

Learning Management Systems
Project Manager: Johnny Pigott

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


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
JULY
AUGUST
SEPTEMBER
RECRUITMENT & INDUCTION PROCESS
PM: Shani Phipps
Status:
PID agreed
Interview Question guidance published on RIB
Agree tender documentation
Place tender ad
Agree advertising materials
Recruitment advertising ready for use
Diversity outreach team selection starts
Tender closing date
Select Provider
Contract Awarded
LEADERSHIP DEVELOPMENT PROGRAMME
PM: Jo Anthony
Status:
Team Leader comms starts
Procurement Complete
ELSA Senior Go-live
ELSA 6 Go-live
Start pilot for Coaching
Team Leader Course go-live
PGCE Course go-live
PERFORMANCE MANAGEMENT FRAMEWORK
PM: Steve Sale
Status:
PID complete
Audit of current practice complete
Summary of recommendations complete
1st draft PM def document
Consultation workshops complete
2nd draft PM def document
SSG
Consultation complete
Document agreed
Comms complete
Training schedule & BC handover
RE-CONFIGURE WORKFORCE PROFILE
Caron Hitchen
Status:
Fleet Modelling agreed
Workforce Modelling agreed
Workforce Plan agreed
Staff-side consultation complete
Skills Escalator agreed
Review of training plan agreed
Hand Over to AD resources for monitoring
MODULARISED TRAINING
PM: Keith Miller
Status:
Development of modules complete
Modules signed off by Lead
Modules ready for use
Training-the-trainer complete
SUCCESSION PLANNING & TALENT MANAGEMENT
PM: Johnny Pigott
Status:
PID Agreed
PID to SSG for approval
Initial Consultation Complete
Definition & Measurment workshop complete
STAFF & UNION ENGAGEMENT
PM: Tony Crabtree
Status:
Partnership Agreement
Schedule of work agreed
Area comms complete
1st Draft Consultative Framework
Consultative Framework agreed
Election Concluded
Staff-side reps appointed
Partnership Conference
Schedule of meetings for consultative bodies published
TRAINING RESTRUCTURE
Bill O'Neill
Status:
Consultation
Start of SMT selection process
Successful candidates in post
Interest sought for paramedic tutor team
Interest sought for complex tutor team
6 training officers in post on new complexes
All paramedic positions filled
E-LEARNING
PM: Johnny Pigott
Status:
Closing date for tender
Provider Selcted
Moodle Development complete
Contract Awarded
Developer training complete
Content Development complete
All testing complete
IT training complete for users
Comms
system link activated on Pulse
TEAM BRIEFINGS
PM: Alex Bass
Status:
Project Brief Agreed
Audit of support services complete
Learning Management Systems
PM: Johnny Pigott
Status:
Process Mapping Workshop Complete
Options Appraisal Complete
14/05/2008
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.

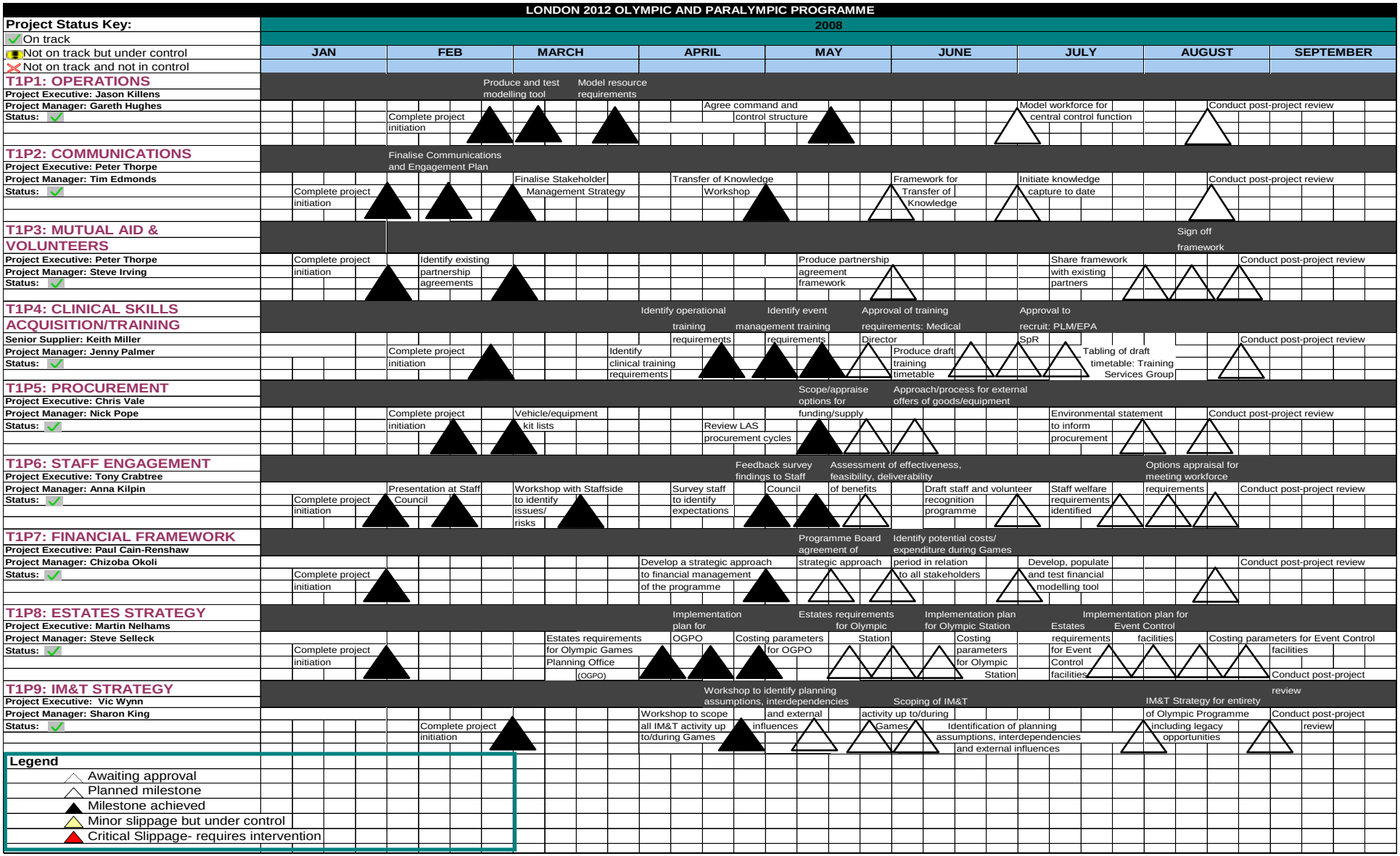
T1P5: Procurement: Vehicles and Equipment
Project Executive: Chris Vale; Project Manager: Nick Pope
This project will consist of the identification of Olympic procurement requirements (and how these fit within LAS procurement cycles) and an approach towards offers of goods/equipment from external organisations. 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
2008
JAN
FEB
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
T1P1: OPERATIONS
Project Executive: Jason Killens
Project Manager: Gareth Hughes
Status:
Produce and test modelling tool
Model resource requirements
Complete project initiation
Agree command and control structure
Model workforce for central control function
Conduct post-project review
T1P2: COMMUNICATIONS
Project Executive: Peter Thorpe
Project Manager: Tim Edmonds
Status:
Finalise Communications and Engagement Plan
Complete project initiation
Finalise Stakeholder Management Strategy
Transfer of Knowledge Workshop
Framework for Transfer of Knowledge
Initiate knowledge capture to date
Conduct post-project review
T1P3: MUTUAL AID & VOLUNTEERS
Project Executive: Peter Thorpe
Project Manager: Steve Irving
Status:
Sign off framework
Complete project initiation
Identify existing partnership agreements
Produce partnership agreement framework
Share framework with existing partners
Conduct post-project review
T1P4: CLINICAL SKILLS ACQUISITION/TRAINING
Senior Supplier: Keith Miller
Project Manager: Jenny Palmer
Status:
Identify operational training requirements
Identify event management training requirements
Approval of training requirements: Medical Director
Approval to recruit: PLM/EPA SpR
Conduct post-project review
Complete project initiation
Identify clinical training requirements
Produce draft training timetable
Tabling of draft timetable: Training Services Group
T1P5: PROCUREMENT
Project Executive: Chris Vale
Project Manager: Nick Pope
Status:
Scope/appraise options for funding/supply
Approach/process for external offers of goods/equipment
Complete project initiation
Vehicle/equipment kit lists
Review LAS procurement cycles
Environmental statement to inform procurement
Conduct post-project review
T1P6: STAFF ENGAGEMENT
Project Executive: Tony Crabtree
Project Manager: Anna Kilpin
Status:
Feedback survey findings to Staff Council
Assessment of effectiveness, feasibility, deliverability of benefits
Options appraisal for meeting workforce requirements
Complete project initiation
Presentation at Staff Council
Workshop with Staffside to identify issues/ risks
Survey staff to identify expectations
Draft staff and volunteer recognition programme
Staff welfare requirements identified
Conduct post-project review
T1P7: FINANCIAL FRAMEWORK
Project Executive: Paul Cain-Renshaw
Project Manager: Chizoba Okoli
Status:
Programme Board agreement of strategic approach
Identify potential costs/ expenditure during Games period in relation to all stakeholders
Develop, populate and test financial modelling tool
Conduct post-project review
Complete project initiation
Develop a strategic approach to financial management of the programme
T1P8: ESTATES STRATEGY
Project Executive: Martin Nelhams
Project Manager: Steve Selleck
Status:
Implementation plan for OGPO
Estates requirements for Olympic Station
Implementation plan for Olympic Station
Implementation plan for Estates Event Control
Complete project initiation
Estates requirements for Olympic Games Planning Office (OGPO)
Costing parameters for OGPO
Costing parameters for Olympic Station
Costing parameters for Event Control facilities
Conduct post-project
T1P9: IM&T STRATEGY
Project Executive: Vic Wynn
Project Manager: Sharon King
Status:
Workshop to identify planning assumptions, interdependencies and external influences
Scoping of IM&T activity up to/during Games
IM&T Strategy for entirety including legacy opportunities
review
Complete project initiation
Workshop to scope all IM&T activity up to/during Games
Identification of planning assumptions, interdependencies and external influences
Conduct post-project review
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

Enclosure 15

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 28th April 2008

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

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

3. **Agreed:**

- The procedure on 'Action on scene indirectly related to the patient'.
- That the interim position put forward in the brief (HIV Infected Healthcare Workers) and considered by the Committee be adopted until such time as the Trust Board makes a decision to change the Trust's current policy. The interim position is that a local definition of exposure prone practice would effect HEMS paramedics only and the DH policy would be adopted in regard to these staff. Further advice was being sought from a Consultant in HIV and Sexual Health.
- The proposed rewording of Risk 133 concerning the reporting of suspected abuse of children, this will be considered by RCAG on 21st May 208.

Noted:

- That the procedure for the 'clinical handover of patients would be re-presented to the Committee in June 2008.
- That Lost Property Bags have been introduced with a reported drop of 70-80% fall in enquiries received by the PALS team.
- That the post of the Infection Control Manager has been re-banded and will be re-advertised.
- An infection control audit was scheduled to take place in May 2008; its findings will be presented to the Committee in June 2008.
- That a draft copy of the Metropolitan Police/LAS DVD 'Preventing death in custody' has been received and was being circulated amongst operational members of staff for comment.
- The contents of the General Governance Area report, the format of which was under discussion so as to ensure the Committee received qualitative information on outcomes.
- The response to the recommendations of the Internal Auditors in regard to the drug management control – morphine. A further audit of this area will be undertaken in 2008/09.
- That the Trust had declared itself to be fully compliant in its annual submission to the Healthcare Commission.
- That work would be undertaken by AOMs as part of their local liaising as/when the borough based LINk organisations, replacing the Patients' Forum, are set up.
- The contents of the draft Annual Complaints & PALS Report 2007/08.
- In April-October the Trust will be piloting 'Making Experience Count' as part of a Department of Health initiative to reform complaints management for the health and social care.
- That the Trust will be assessed in October 2008 at Level 1 under the new NHSLA risk management criteria.
- The contents of the PPI report and the work being undertaken by the PPI Manager.

- The findings and recommendations of two audits undertaken by CARU: an analysis of the factors associated with survival from cardiac arrest for patients treated by Waterloo complex and the documentation of patient ethnicity in the LAS.
- The contents of the Risk Information Report.

Minutes/oral reports received from:

Infection Control Group (27th February 08); Update from the SfBH (22nd January 07); Training Services Group (17th March 08); RCAG (18th February 08); CARSG (14th March 08).

Minutes of the Clinical Steering Group (11th February 08) to be circulated between meetings.

Recommendation: THAT the Trust Board NOTE the minutes of the Clinical Governance Committee, 28th April 2008.

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee (full)
9.00am, 28th April 2008, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director (until 10.30)
Sarah Waller	Non Executive Director (until 11.50)
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
Nicola Foad	Head of Legal Services
Ian Todd	Assistant Director of Operations, Urgent Care & Clinical Development
John Wilkins	Head of Governance
Stephen Moore	Head of Records Management & Business Continuity
Pat Billups	Education Standards Manager (for Keith Miller)
Annie Shillingford	Diversity Manager (until 11.50)
Gary Bassett	Complaints/ PALS Manager
John Selby	Senior Health & Safety Adviser (from 10.40)
Chris Vale	Head of Operational Support
Malcolm Alexander	Chairman, LAS Patients' Forum
Margaret Vander	PPI Manager
Rachael Donohoe	Head of Clinical Audit & Research
Tony Crabtree	Assistant Director, Employee Support Services
Christine McMahon	Trust Secretary (minutes)

In attendance:

Anne Weaver	Consultant in Emergency Medicine and Pre-hospital care & Clinical Lead, HEMS

Apologies

Russell Smith	Deputy Director of Operations
Ingrid Prescod	Non-Executive Director
Paul Tattam	Ambulance Operations Manager - D Watch
Benjamin Jones	EMT
Stephen Silverson	EMD
Dr Julian Redhead	Consultant, St Mary's

16/08 Minutes of the Clinical Governance meeting held on Monday 4th February 2008

Agreed The minutes of the previous meeting

17/08 Matters Arising

Noted: **Minute 59/07** The Consultant Midwife gave a presentation to RCAG in February 2008 and will attend Clinical Governance Committee in August 2008.

Minute 02/08 Lost property bags have been introduced and within a week there was a fall in enquiries received by PALS of 70-80%. The Committee will receive a report in October 2008 concerning the introduction of the lost property bags. **ACTION: Complaints/PALS Manager**

Minute 02/08 The Head of Information Management & Business Continuity said that work was in hand regarding revisions to the PRF; the project group was scheduled to meet in May 2008.

Minute 03/08 Safeguarding Children & Vulnerable Adults (SCVP), the PALS/Complaints Manager said that to support this area of work additional administrative resource had been provisionally agreed as well as an ECP working with the PALS team 12 hours a week. PALS will take on full responsible for the management of SCVP by the end of June.

Minute 04/08 The post of Infection Control Manager has been re-banded and will be re-advertised. Arrangements were in place for the quarterly infection control audit in May 2008.

Minute 04/08 The Medical Director said that there was a lack of interest from London hospitals in regard to a proposal to audit MRSA even thought the average patient was not swabbed until 48 hours after admission to hospital.

Minute 06/08 That the Procedure for the Transportation of Patients to hospital was ratified at the Trust Board in March 208.
Minute 08/08 It was confirmed that training in Root Cause Analysis was undertaken and that efforts were on-going to work with the National Patient Safety Agency (NPSA).
Minute 10/08 An event was held on 13th March 08, '247-247' to promote understanding of the LAS' compliance with the Healthcare Standards for representatives from the 31 Scrutiny & Overview Committees in London. The event was attended by representatives from other stakeholders including the Patients' Forum.
Minute 13/08 The reconstitution of the Race Equality Strategy Group was under consideration.

18/08 Report from Helicopter Emergency Medical Service (HEMS)

Anne Weaver, Consultant in Emergency Medicine and Pre-hospital care & Clinical Lead for HEMS, gave a presentation that explained the role of HEMS, its governance arrangements and its relationship with the LAS and the Department of Health. The Service was funded by charitable donation (£1.7m) and by public funding from the Department of Health. It was tasked by the LAS and operated from the Royal London NHS Trust.

During the day the helicopter was despatched by the LAS to serious emergency accidents where time was of the essence; in the evening five HEMS cars were despatched to calls situated within a three mile radius. HEMS was a protocol led organisation that emphases keeping equipment and procedures simple. The HEMS team undertake risky procedures and the survival rate of 12% was amongst the best in the world. There was a strong emphasis on training, good team work and constant monitoring of the treatment given to patients.

The Head of CARU said that the long audit undertaken of a sample of jobs by HEMS was something the LAS could consider at the bi-monthly seminar when attending paramedics and technicians could be asked to nominate a job for the group to review on a quarterly basis.

The Complaints/PALS Manager said he was impressed by the innovative approach adopted to training and learning lessons. He said that in the past there had been an occasion when the LAS had difficulty accessing HEMS records; it was agreed that a way forward would be sought whereby HEMS could share details of calls they respond to as/when necessary.

Post meeting note: a Memorandum of Understanding will be drawn up between the two organisations concerning the sharing of information. **ACTION: Head of Records Information and Business Continuity/Senior Clinical Adviser.**

Noted:
1. **The impressive governance arrangements HEMS has in place including the regular pan London meetings and the detailed long audit that reviewed every aspect of a job, from the time the call was received to when the patient was admitted to hospital.**
2. **That work was being undertaken with regards to a Service Level Agreement between HEMS and LAS.**

19/08 Clinical procedures for approval

The Committee reviewed the procedures relating to 'The clinical handover of patients' and 'Action on scene indirectly related to the patient'.

Agreed
1. **The procedure on 'Action on scene indirectly related to the patient'.**

Noted:
2. **That the procedure for 'The clinical handover of patients would be amended to reflect comments made at the meeting and re-presented to the Committee in June. ACTION: Head of Records Management & Business Continuity.**
3. **That an Equality Impact Assessment had yet to be undertaken of the above procedures.**

20/08 Medical Directorate Update

The Medical Director said that a draft of the DVD produced by the Metropolitan Police and the LAS, 'Preventing death in custody', had been received. The Senior Clinical Adviser was co-ordinating the feedback on the DVD from SMG and other members of staff. The Head of Legal Services said she

had seen the DVD and regarded it as 'essential viewing' for front line staff. Copies of the DVD will be shared with the Trust Board in due course. **ACTION: Medical Director**

Noted:
1. **That a draft copy of the Metropolitan Police/LAS DVD, 'Preventing death in custody', has been received and was being circulated for comment.**
2. **That there has been no recent guidance issued by NICE relevant to the LAS.**
3. **That the Healthcare Commission's investigation into Staffordshire AS Trust had been recently published; a summary of the recommendations will be presented to the Committee in June. ACTION: Medical Director.**

21/08 Infection Control Update

The quarterly infection control audit will be undertaken in May 2008; the results will be presented to the Committee in June. **ACTION: Head of Operational Support**

The new provider of Occupational Health medicine to the Trust was anxious that the LAS adopt the Department of Health (DH) guidance (HIV Infected Care Workers: Guidance on Management and Patient Notification, 2005) regarding the employment of HIV+ individuals and AIDs sufferers.

The Medical Director set out the Trust's position in regards to the DH guidance, referring the Committee to a briefing paper drafted by the Assistant Director, Employee Support Services, which was tabled at the meeting. The paper set out the Trust's current HIV Policy; applicants are not required to take a HIV test nor will they be refused an offer of work just because they are HIV positive. Existing staff are not required to take an HIV antibody test and only those workers with AIDS will be considered for reasonable adjustments including suitable alternative employment and/or retraining. The key difference with DH guidance was that all new applicants are not tested for HIV and existing staff that would be precluded from performing exposure prone practice (EPPs) because of the HIV status should also not perform pre-hospital trauma care.

The adoption of the DH guidance would present a number of potential issues for the Trust including the risk of rejected applicants bringing claims of direct and indirect discrimination against LAS and the possibility that existing staff would effectively be no longer be able to practice at all, given that 'pre hospital trauma care' is an extremely broad term.

The Medical Director said the risk of infection was very unlikely to occur for ambulance staff except in the rare occurrence of 'bleedback'. It was recognised that in a hospital setting there was a higher number of exposure prone procedures undertaken. The Trust had sought legal advice which indicated that the Trust would be exposing itself to the risk of discriminating either directly/indirectly members of staff who were HIV+.

The different options were considered and the interim options of agreeing a local definition of which staff undertake EPP. It was likely that this would extend, on current practice and arrangements, to HEMS paramedics only and the DH policy would be adopted in regard to these staff.

Agreed
1. **That the interim position put forward in the brief be adopted until such time as the Trust Board makes a decision. ACTION: Medical Director.**

Noted:
2. **That a submission regarding this risk would be presented to the RCAG when it met on 21st May. ACTION: Assistant Director, Employee Support Services.**
3. **That advice would be sought from the Consultant in HIV & Sexual Health UKAP. ACTION: Assistant Director, Employee Support Services.**
4. **That there was no report or evidence of patients treated by LAS staff having occurrences of 'bleedback' in the wound.**

22/08 General Area Governance Report

The Assistant Director, UOC and Development, presented the general Area Governance Report. Following discussion it was suggested that the format of the report be changed so as to emphasis quality rather than quantity of information and include trend analysis rather than raw data concerning

PDR etc. Outcomes were absent from the reports. The content and structure of this report needed to be revised for the next committee meeting. Future area governance reports need to be up to the standard of the reports presented at previous meetings of the Committee.

Discussions will take place between the Medical Director, the Chairman and the Deputy Director of Operations concerning the content of the Area Governance Reports. A new net based reporting system is being introduced and there is an opportunity for area officers to be given licences and training to use the system as it is rolled out.

Noted

1. **That the Trust had achieved Call Connect performance 75% Category A8 Minute target in April 2008 and Category B19 performance had also improved. Call answering remained high with 95% of calls being answered within five seconds.**
2. **That a clinical audit was being undertaken of CTA calls. ACTION: Head of Clinical Audit & Research**
3. **That rest break allocation had improved in recent months and there was continued focus in the Control Room to allocate rest breaks.**
4. **That the level of CPI completion had remained consistent despite the operational pressures in March and April.**
5. **That disappointingly attitude and behaviour continued to be the main cause of complaints received by the Trust.**
6. **That a proposal regarding the format of the Area Governance report will be presented to the Clinical Governance Committee in June. ACTION: Deputy Director of Operations/Head of Governance**

23/08 **Internal Auditor's report: drug management control**

The Committee received the summary report written by the Internal Auditors, Bentley Jennison, following the audit of three ambulance stations' management of the drug morphine. The seven significant recommendations made by the Internal Auditors in connection with the management of morphine have been accepted by the Trust. It was recognised that although the Corporate Logistics Manager was the nominated responsible lead the implementation of the recommendations rested with Operational staff to ensure adherence of the Trust's policies and procedures.

Noted:

1. **That the Trust's existing policies and procedures were not criticised by the Internal Auditors; adherence to the laid down policies and procedures would have addressed the majority of the shortcomings identified by the Internal Auditors. This area will be further audited in 2008/09 to ensure that the lessons have been learnt. ACTION: Head of Governance to liaise with the Internal Auditors.**
2. **That the monthly Clinical Update will include a reminder to staff about the necessity of following the Trust's policy and procedures particularly in reference to the management and control of morphine. ACTION: Medical Director**
3. **That a progress report on the implementation of the recommendations will be presented to RCAG on 21st May. ACTION: Deputy Director of Operations/Head of Operational Support.**
4. **The comments made by the Senior Clinical Adviser in response to the audit, specifically that neither the Senior Clinical Adviser or the Medical Director were contacted by the internal auditors when the drug management control audit was undertaken.**
5. **That periodically stations were 'locked down' if ampoules of morphine were found to be missing due to the stations following the laid down protocols which also included the Police being informed and a full investigation being undertaken.**

24/08 **HCC – 2007/08 Final Declaration**

The Head of Governance said that the Trust had declared itself to be fully compliant in its annual submission to the Healthcare Commission. An event was held on 13th March, '247-247' to actively engage with the 31 overview and scrutiny committees in London; eight felt sufficiently informed to

make a contribution to the submission that they were satisfied the Trust was fully compliant. Representatives from other stakeholders including Healthcare Commission and the Patients' Forum also attended the event.

Relationships will be built with the borough based LINk organisations that will be established to replace the Patients' Forums. It was recognised that the Trust as part of its preparations for foundation trust status and recruiting a membership will need to forge links with these new organisations. The Chairman of the Patients' Forum said that many of the LINk organisations would not be established until September. The Complaints/PALS Manager said AOMs, as part of their local liaison work, will be encouraged to engage with the 31 London Borough Leads who will be setting up the LINk organisations.

25/08 **PALS and Complaints – Draft Annual Report 2007/08**

Gary Bassett, PALS/Complaints Manager, presented the draft annual report for 2007/08; he highlighted that the number of enquiries received by PALS had increased by 12% while the number of complaints remained the same.

The Trust has been chosen as a pilot site for 'Make Experience Count'; as part of the Government's plan to reform complaints management, advocating a comprehensive single complaints system across health and social care. The pilot will operate between April and October 2008 and a Department of Health support team will be made available to provide guidance and assistance.

Noted:

1. **The contents of the draft annual report prior to its submission to the Trust Board in May 2008.**
2. **That attitude and behaviour and delays in sending a response were the main topics of complaints received by the Trust.**
3. **The examples given of the outcomes of enquires and complaints received by PALS.**
4. **That the work undertaken in relation to benefits realised for the Frequent Callers Project will be reported to the Trust Board as part of the benefits realised of the Invest to Save report. ACTION: Director of Finance**

26/08 **Update regarding new NHSLA standards**

The Head of Governance said that the Trust will be assessed against five standards. The Trust will be assessed at Level 1, demonstrating that it has policies and procedures in place to manage risk.

Noted:

1. **That the NHSLA assessment will take place in October 2008.**
2. **That monthly meetings were taking place to consolidate the quality or evidence required to achieve compliance with the requirements of Level 1.**

27/08 **Patient and Public Involvement Update**

The PPI Manager highlight the following from her report:

The Trust held an event on 26th March 2008 that was attended by 80 members of the public who represented various stakeholders (PCTs, people with learning disabilities, patients and carers) who were asked for their views on the Service Improvement Programme. The Project Manager for the Access Programme has met with representatives of the deaf community to determine how the Trust can improve access for people who are deaf.

The Public Education Group was developing a public education programme, which will be accredited by South Bank University and will be rolled out to events and school teams as/when required.

The Risk Assessment form used by all staff who arrange and attend events was being updated to make it more user-friendly and it will be a web based document.

The PPI Manager was drafting a reimbursement and payment policy which will enable the Trust to pay members of the pubic when they are invited to attend LAS events. This was a NHS wide practice.

It was recognised that the recruiting members for the LAS Foundation Trust will be quite challenging given that the composition of the membership is expected to reflect London's demographics in terms of age, gender, social grade etc.

The report included details of the local PPI activity undertaken at complex level.

28/08 **Clinical Audit & Research Unit (CARU) Update**

The Head of CARU highlighted two audits undertaken by CARU.

1. *An analysis of the factors associated with survival from cardiac arrest for patients treated by Waterloo complex was undertake*n and the following recommendations made:

   - 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 (in light of the fact that 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.

2 *Documentation of patient ethnicity in the London Ambulance Service.*

The purpose of the audit was to assess the documentation of ethnicity codes on a sample of 400 Patient Report Forms selected from a six week period in August and September 2007. The audit found that 77% of PRFs recorded ethnicity;

- 73% described the patient's ethnicity
- 27% reported a 'z' code identifying that the patient's ethnicity was unobtainable.

The following recommendations were made:

- that the LAS continue to employ monitoring and feedback methods (such at the CPI audits) to encourage the documentation of ethnicity codes
- that crew staff reminded to use 'z' codes for children where it is not possible to obtain ethnicity.

29/08 **Clinical Risk**

The Committee reviewed each of the Clinical Risks on the Trust's Risk Register

Agreed:

1. **That the title and controls in place to mitigate risk 133 (risk of potential legal action/negative publicity due to staff being unaware of how to report suspected abuse of children) be amended. This will be presented to RCAG approval in May 2008.**

Noted:

Post meeting note: Medical Director agreed with the recommendation.

2. **That the following risks would be considered for re-grading when the Clinical Governance Committee meets in June: 20 (PRF completion), 22 (failure to undertake clinical assessments) and 207 (risk of staff not being able to download information from defibrillators and the service failing to gain the data for analysis).**
3. **That the Head of Clinical Audit's name should be listed as the leading manager for risk 207**

4. **That a report regarding the Older Persons' strategy (risk 165) will be presented to the Committee in June. ACTION: Director of Service Development**
5. **That the notes for risk 179 (failure to meet responsibility under the Race Relations Act) will be updated. ACTION: Diversity Officer**

30/08 **Full Risk Information Report**

The requirements for the Risk Information Report previously agreed at the Committee's meeting on 11th June 2007 were circulated at the meeting by the Head of Governance. This was to confirm requirements for the future production of the report with contributors.

Incident reporting: The report outlined the total number of clinical incidents reported to the Safety and Risk Department based on LA52 completion. In total 576 clinical incidents were reported, with 14 of these recorded as having an impact on the patient. Overall, despite the increase in quarter 4, the report shows a decline in the reporting of clinical incidents for the first quarter of 2008.

A query was raised as to how many of the LA52s concerned vehicles managed by Make Ready. The Head of Operational Support said that any issues with Make Ready should be reported to the DSO and the appropriate action taken. **ACTION: Senior Health & Safety Adviser to review the LA52s and provide a post meeting update.**

Clinical Negligence Claims, Potential Claims and Contentious Inquests: identified the caseload opened and the emerging themes in quarters 3 and 4 2007/08. The review of clinical negligence claims, incidents, and contentious inquests was conducted on 15 April 2008. Owing to the performance pressures on Operations it was not possible to conduct the usual round table reviews with Operational Staff, and these therefore took place by telephone. The output from the discussions will be included in the reports to the Area Governance Groups when they next meet. The procedure that is directly relevant to staff making or requesting the police to force entry to premises was revised by the Deputy Director of Operations March 2008 in response to the learning from earlier claims.

Equality and Diversity: the Diversity Manager said that following the baseline enquiry, carried out by the previous Diversity Manager, into the work on Equality, Diversity and Human Rights at the LAS a number of recommendations and actions were planned for the 3rd quarter. A progress report on these recommendations and actions was presented as part of the Risk Information Report.

Sarah Waller asked who authorised the LAS joining Stonewall, a campaigning organisation, as it may have unintended consequences for the Trust. **ACTION: Diversity Manager to report back at the next meeting.**

Post meeting note: the Committee was informed that the Trust was in discussion regarding the LAS joining Stonewall's Diversity Champions Programme.

The Committee will receive an update on progress concerning CTA undertaking ethnicity monitoring at its meeting in June 2008. **ACTION: Deputy Director of Operations.**

Noted **That the Head of Complaints/PALS did not have anything to add to his submitted report and the draft Annual Complaints Report discussed earlier in the meeting.**

31/08 **Reports from Groups/Committees**

1 *Update from the SfBH Group 22nd January 2008*

Noted: **That the Group met to confirm the quality of compliance with the requirement of the Annual Healthcheck for 2007/08 and will be re-convened in October 2008 when**

the Healthcare Commission publishes its findings including performance ratings of all NHS Trust.

2 *Clinical Steering Group, 11th February 2008 (?)*

Noted: The minutes of the Clinical Steering Group were not available for the meeting and will be circulated by the Trust Secretary. ACTION: Trust Secretary

2 *Risk Compliance & Assurance Group – 18th February 2008*

Noted:
1. **The minutes of the RCAG meeting that took place in February 2008.**
2. **That there was concern expressed about the quality of service received from LanguageLine which was used by the Trust to communicate with callers/patients who do not speak English.**

3 *Infection Control Group – 27th February 2008*

Noted:
1. **That an infection control audit was being undertaken in May 2008**
2. **That a deep clean had been undertaken of PTS and Fast Response Vehicles :**

4 *CARSG – 14th March 2008*

Noted: The minutes of the meeting held in March 2008.

5 *Training Services Group – 17th March 2008*

Noted: The summary of the discussions held at the Training Services Group's meeting on the 17th March 08.

32/08 Draft 2008 Forward Planner

Noted: The forward planner.

33//08 Dates of next meeting:

Core: Monday, 2nd June 2008, at 9.00am in the Conference Room, HQ
Full: Monday, 4th August 2008 at 9.00am in the Conference Room, HQ

Meeting concluded at 12.10

Enclosure 16

London Ambulance Service NHS Trust

Remuneration Committee Meeting

LAS HQ, Conference Room
18 March 2008 at 0900 hours

Present:	Sigurd Reinton	Chairman
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Roy Griffins	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Brian Huckett	Non Executive Director
	Caroline Silver	Non Executive Director

In attendance: Peter Bradley, Chief Executive

1. Apologies

There were no apologies

2. Previous minutes

Ingrid Prescod asked for an insertion on page 4 of the minutes of the previous meeting, to read "IP said, to secure her retention, it was important that she receive support from the Service". The minutes were then approved and signed by the Chairman.

3. Matters arising

There were no matters arising.

4. Car leasing

Peter Bradley presented a paper on car leasing and said that progress had not been as fast as he had hoped and the leasing policy had not yet been finalised, but would be presented to the Trust Board in May. Guidance from the Inland Revenue had not yet been issued. PB had also spoken to other ambulance services but there was obviously no scheme standardisation.

Beryl Magrath said there was too much detail in the paper for the committee to make a decision on what category of staff needed leased cars and that the environment should also be considered. She felt strongly that people who had accidents should pay for the repair themselves. Sarah Waller said the conclusions were sensible. There might also be a resultant cost saving; however, tax issues might complicate matters.

The Chairman said that there were potentially three categories:

1. Those needing a blue light car
2. Those needing a car in order to do their job – definition required.
3. Those people to whom we may wish to offer a pay and benefits package which included a car, provided it was tax efficient. The paper provided to the Remuneration Committee did not help much on this.

Brian Huckett said that his former company abolished company cars entirely. They moved to a cash alternative which then became a problem about whether it was pensionable or not. The company paid business mileage rates for personal cars. This alternative did not seem to have been covered in the paper presented by the Chief Executive.

Roy Griffins said that he thought categories 1 and 2 were fine. Running a perk system, even tax efficiently, was complicated and he thought it best to simply increase salaries.

The Chairman summarised the definition of categories: Category 1, blue light cars was not a problem. Category 2 should be more clearly defined about who would be included and what the criteria for inclusion were.

Peter Bradley reminded the committee that it dealt with the Board's pay and benefits, rather than the wider LAS. It was agreed that the committee would reconvene once a proper analysis had been completed to determine whether a car benefit for people not falling into Categories 1 or 2 was still a tax efficient way to deliver benefits to the relevant groups, taking account of the cost to the LAS of administering the scheme and of any changes resulting from recent budget announcements. Consideration would also need to be given to transition arrangements for staff not falling into categories 1 and 2, as it would be a difficult change. Peter Bradley said a paper would be prepared and brought to the Trust Board.

Beryl Magrath said she was uncomfortable with the present arrangement of paying extra for the car of choice rather than having a standard make and model of blue light cars throughout the Service. Peter Bradley said this had previously been suggested and there had been vociferous discussion and dissention on the subject. Caroline Silver asked why hybrid cars were not used.

The Chairman said that most of the cars concerned were used as family cars most of the time; the blue light facility was there to enable the user to respond when needed. He said that depending on what the new policy is, transition arrangements will be needed in many cases.

4. **Director performance and remuneration**

The Chief Executive said he had held preliminary end of year meetings with all the SMG members and that the submitted paper reflected their conversations. He would hold formal appraisal meetings with all SMG members during April but did not expect the substance of what he said to the Committee to change as a result of these meetings.

It had been the LAS' most successful year, with the best ever response time performance and best Healthcare Commission rating.

He had been able to get some pay benchmarking information but it was less useful than in the past because of the introduction of the VSM pay framework. The information obtained would indicate that there was still quite a variation in pay across the country, especially as Acute Trusts and Foundation Trusts were not covered by the VSM framework.

The Chief Executive had taken the unusual step of asking members of SMG what they thought of their own pay levels and said he would feed this back to the Remuneration Committee.

He presented the individual performance assessments and, following discussion, these were agreed

Bonus Payments

The VSM allows for one off bonus payments for staff whose performance for that year has been either outstanding or has exceeded expectations. Last year the remuneration committee awarded one off bonus payments to the Medical Director, Chief Executive and Director of IM&T on that basis. There were three options for the remuneration committee to consider - recognising that option three does not strictly fall within the VSM guidelines.

1. Do nothing
2. Pay a one-off percentage bonus of between 5% and 10% to those SMG members whose performance has been either above standard or outstanding
3. Pay a team one-off bonus payment of, say, £5,000 to all SMG members.

Pay and bonus recommendations

The Chief Executive recommended:

- That the general inflationary uplift, once known, is applied to the salaries of David Jervis, Caron Hitchen and Kathy Jones (from 1 April 2008)

- That Mike Dinan's salary is increased to the VSM guideline salary of £108,705 with effect from 1 April 2008 and that any inflationary uplift is retrospectively applied from that date.

- That Martin Flaherty's salary is increased to the same as Mike Dinan's - £108,705, with effect from 1 April 2008 and that any inflationary uplift is retrospectively applied to that date

- That Peter Suter's salary is increased to £95,000 from 1 April 2008 and that any inflationary uplift is retrospectively applied to that date.

- That a team one-off bonus payment is made to all SMG members in recognition of the very successful year the Service has enjoyed.

The committee agreed with these recommendations but suggested after discussion that the team bonus should be set at approximately this level but as a percentage of salary.

The Chairman presented his appraisal of Peter Bradley, which reflected comments and suggestions from non executive directors and from the London SHA Provider Agency

The Chairman recommended that Peter should receive the same team bonus (as a percentage of salary) as the rest of the team, and a salary of £170,000 from 1st April 2008 and the committee agreed this. In addition, he receives a 10% responsibility allowance for his work for the DH as National Ambulance Advisor. (Note: the LAS receives £90,000 a year from the DH for Peter's work.)

The resulting pay structure is set out in Appendix 1 below.

Appendix 1

SENIOR MANAGEMENT TEAM
REMUNERATION FOR THE YEAR ENDING 31 MARCH 2009
(As agreed by the Remuneration Committee on 18 March 2008)

VSM Scale	**Executive Directors**	**Salary from 1 April 2008**	**Recruitment & Retention Premium**	**Extra responsibility payment**	**Leasing car allowance**	**Bonus payment**
144,940	Peter Bradley	170,000	25,060[10]	17,000	5,550	9,421
86,964	Caron Hitchen	TBC[11]	-	-	5,034[12]	5,456
108,705	Mike Dinan	[108,705][13]	-	-	5,034[14]	6,281
N/A	Fionna Moore	N/A[15]	-	-	5,290	6,200
101,458	Martin Flaherty	[108,705][16]	7,247[17]	-	5,550	6,281

VSM Scale	**Directors**	**Salary from 1 April 2008**	**RRP payment**	**Extra responsibility payment**	**Leasing car allowance**	**Bonus payment**
N/A	Kathy Jones	TBC[18]	-	-	5,034	5,053
N/A	David Jervis	TBC[19]	-	-	5,386	5,056
N/A	Peter Suter	95,000	-	-	5,034*	5,401

[10] Included in salary
[11] VSM salary uplift not yet published. When it is, CH KJ, DJ, PS, MF and MD will receive the uplift as agreed at the remuneration committee. This schedule will then be updated and attached to the minutes.
[12] Leasing car allowance for MD, PS and CH is paid as part of the salary (salary shown plus the car allowance equals total salary paid)
[13] See 2 above
[14] See 3 above
[15] Fionna Moore is paid by the Hammersmith Hospitals NHS Trust
[16] See 2 above
[17] Included in salary
[18] See 2 above
[19] See 2 above

Enclosure 17

Chairman's Away Day

9.00am, 30th April 2008, the Ravenswood, West Sussex

Present:

Sigurd Reinton (Chairman)	Peter Bradley	Sarah Waller
Beryl Magrath	Roy Griffins	Fionna Moore
Caroline Silver	Caron Hitchen	Mike Dinan
Martin Flaherty	Kathy Jones	Peter Suter
David Jervis	Christine McMahon (minutes)	

Apologies:

Ingrid Prescod	Brian Huckett

Guest Speakers:

Stephen Hay	Chief Operating Officer Monitor
David Mellish	Chairman, Oxleas NHS Foundation Trust
Michael Parker	Chairman, Kings College Hospital NHS Foundation Trust
Patricia Moberly	Chairman, Guy's and St Thomas' NHS Foundation Trust
David Sissling	Programme Director for Healthcare for London

1. Reflections on Foundation Trust Status

Stephen Hay (Chief Operating Officer, Monitor) spoke briefly about the benefits of NHS foundation trust (FT) status. These included:

- freedom to provide more responsive innovative patient care,
- ability to reinvest surpluses in improved patient services,
- ability to borrow commercially to finance capital investment,
- strengthening contractual arrangements with commissioners (legally binding contracts),
- be independent and autonomous organisations operations operating in a regulatory environment.

He outlined the reasons why NHS Trusts have failed to achieve authorisation:

- the inexperience of the Board,
- the quality of the NEDs,
- the lack of transparency in regards to financial information,
- the lack of robust business planning and financial projects,
- the lack of sound financial management and investment decision;
- local health economy deficits,
- historic debt,
- failure to meet key national standards.

To support ambulance services obtaining authorisation to become FTs the following action has been identified:

- review skill set and composition of the Board, to ensure the appropriate financial and commercial challenge of the executive team;
- consider progress on financial reporting procedures
- address concerns regarding key national target performance
- secure a representative membership which will be particularly challenging as ambulance trusts cover large catchments areas.
- mitigate against any potential competitive risks on income streams (i.e. Patient Transport Service)
- mitigate the impact of activity fluctuations without tariff based systems.

The following points were made during the ensuing discussion:

- Although FTs have legally binding contracts with their Commissioners, this was as yet untested in a Court of Law.
- New model contracts for Mental Health Trusts and the Acute Trusts were being drafted and would be published later this year.
- Applicants will not be required to have three year contracts signed by the time of authorisation though they should be in the process of being finalised. Monitor will require the contracts to be signed off by one of the four major accountancy firms.
- To date there is no provision in place should a FT become insolvent. The NHS was currently in surplus, with £1.9billion on the collective balance sheet; a large amount of uncommitted working capital and the majority of the FTs have a risk rating of less than 3.
- Although there was no empirical evidence demonstrating improved clinical performance by FTs there was greater transparency in regard to financial performance. Monitor was seeking to devise a number of clinical Key Performance Indicators that would be reflected in the regulatory framework. With the exception of MRSA, FTs have performed better as measured against the current Key Performance Indicators.
- The Trust's retention of surpluses for reinvestment in services and building increase the Trust's asset base. It will be necessary to negotiation with Commissioners to avoid future funding top sliced by Commissioners. As part of the Trust's application for FT status, funding for a three year period will need to be negotiated with Commissioners.
- Although Monitor did not set a minimum number in regards to a FT's membership it did require membership to reflect the Trust's catchment area. This will be a major challenge for the LAS as it is a pan-London organisation. Members will need to be recruited during the preparation for FT authorisation and will be measured at the point of Authorisation. FT membership was, on average, 9,000-12,000, with established FTs' membership growing on average by 9% per annum. Monitor did not have a formal position on the proposal that the membership of acute FTs be co-opted as members of ambulance trusts.
- Monitor was considering whether to continue with self certification by FTs in regards to Governance or to request a third party certify the FT's governance submissions.
- Monitor's review of the applications for FT included: assurance that the business plan was grounded in reality; that it reflected negotiations with local Commissioners and testing key assumptions such as forecasted income and activity.
- Monitor did not actively involve itself in the routine business of a FT unless there was a breach of the Trust's Authorisation. In such circumstances it was empowered to step in and remove the Board of Directors and/or Governors if need be. In the event that a dispute arose between a FT and its Commissioners Monitor would encourage dialogue and negotiation but would not seek to active involvement.
- Monitor has written to the Department of Health on 15th April raising the following concerns about ambulance trusts becoming FTs: the requirement to have a nurse/doctor on the Board of Directors; the implications of the Civil Contingency Act 2004 and the challenge of recruiting membership from a much greater catchment area. A response to the letter was awaited.
- Monitor anticipated receiving the first wave of applications from ambulance trusts in the autumn of 2009.

2. The experience of three Foundation Trusts: Oxleas; Guy's & St Thomas' and Kings College

The Chairmen of the following FTs, Oxleas Mental Health Foundation Trust; Guy's & St Thomas' NHS Foundation Trust and Kings College NSH Foundation Trust shared their Trust's experiences of recruiting Members and establishing a Board of Governors, or in the case of Guy's & St Thomas', Members' Council.

Oxleas: it had improved involvement in the Trust by users/carers and it was a genuine exercise of accountability.

Guy's & St Thomas': it had entailed additional work for the Chairman, which would need to be shared with the NEDs and Executive Directors. In recruiting members, consideration should be given as to why a member of the public would wish to be Member and what value does it add to the organisation. The Members' Council comprised Members from a variety of backgrounds; stakeholder representatives and staff representatives.

Kings: emphasis was placed on the opportunity to retain surpluses that can be reinvested in the services provided. The process of becoming a FT meant a greater degree of openness and transparency across the Trust, with an emphasis on performance management leading to improved services. The recruitment of Members and the activity of the Board of Governors had led to real engagement with the public which was reflected in an improvement in the services and the patient's experience. Members played an invaluable role in King's campaign regarding Denmark Hill BR Station.

It was Noted that:

- The size of three FT's Membership (excluding staff) was: Oxleas 1,334; Guys & St Thomas'7,000; King's 7,500. The size of the Board of Governors/Members' Council was: Oxleas 45; Guy's & St Thomas' 38; King's 38.
- Members received newsletters keeping them informed about the Trust, planned open days, health seminars, elections and meeting dates.
- The cost of maintaining the membership, which included holding elections and supporting the quarterly meetings of the Board of Governors/Members Council, was approximately £10,000 per annum.

3. Discussion Groups

Members of the Committee, attendants and the three Chairmen broke away to form three discussion groups and considered the following questions:

1. How can we create a membership?
2. What should be the role, size and makeup of the Members' Council/Board of Governors?
3. What should our business model look like?

4. Healthcare for London

David Sissling, Programme Director, Healthcare for London, joined the meeting to brief the Committee as to the progress of the implementation of Lord Ara Darzi's 'Framework for Action'. PCTs had undertaken consultation on the proposals contained in the Healthcare for London and a report containing recommendations will be formally presented to the Joint Committees of PCTs on June 12th 2008. The report, which is expected to be broadly in line with Lord Darzi's vision for an improved healthcare service in London, will be owned by the 31 London PCTs and will direct the local commissioning process, reflecting the different healthcare

needs of the PCTs' catchment areas. It was anticipated that commissioning work will take place both on an individual PCT basis or in clusters, with PCTs commissioning as a group or on a pan London basis as is appropriate.

In the interim, HfL was undertaking the following six programmes of work: Stroke, Trauma, Local Hospital Feasibility, Diabetes, Unscheduled Care and Polyclinics.

- HfL anticipated tangible results being achieved by March 2009 and improvements in service delivery in the following areas: stroke, trauma, polyclinics, new ways of delivering care and a review of unscheduled care.
- An evaluation framework was being drawn up which would support the commissioning process and will include the following five domains: access, clinical outcome, health and well being, use of resources and patient experience.

The following risks have been identified in achieving the desired integrated clinical healthcare in London:

- adequate information technology to support access to patient care records,
- a workforce with the appropriate skills and supportive of change,
- having the continued support of the mainstream political bodies,
- improving the capabilities of the commissioning service, to take forward the process and implement new model commissioning arrangements.

David Sissling said that Lord Darzi's appointment as Minister for Health is a strong indicator that there is the political will to the implementing of the Framework for Action.

During the ensuing discussion the following points were made:

- Although commissioning would remain with the individual 31 PCTs, NHS London will play an active role in overseeing the process. The Chief Executives of the PCTs have been actively involved in driving forward the consultation process and the various Programmes.
- The financial assumptions underlying Lord Darzi's 'Framework for Action' were being revised as specific proposals were being developed. Detailed financial analysis was being undertaken to identify any areas of concern in respect of the affordability of the various Programmes.
- Lord Darzi recognised the pivotal role the ambulance service has to play in implementing an integrated care delivery model and be an agent of change.
- The PCTs' commissioning function would undoubtedly need to change over the next few years and it was possible that it would divest itself of the provision of other services and focus solely on commissioning. It was recognised that Service Providers would need to have confidence in the Commissioning process to ensure they are willing to invest in developing new services to implement an integrated care model in London.
- There were a number of areas where technological development would be invaluable in delivering a more integrated service, e.g. electronic patient records to allow access to patient's records. Another developmental area will support patients remaining at home and not having to visit polyclinics or hospitals.
- There was an acceptance that further work was needed in respect of tariffs to ensure that there was no mismatch in the financial regime; that funding followed the patient and there were incentives in respect of good clinical outcomes that reflected the quality of care and the patient experience.
- As part of the LAS' application for FT status in 2009 a three year business plan will be submitted to Monitor. In preparing the business plan the Trust

will actively engage with its Commissioners concerning the developmental work and the transitional investment required to implement the wider HfL agenda.

- In terms of political support for HfL, the appointment of Lord Darzi as Minster for Health was a clear indication of the Government's commitment to the process. It was recognised that there may be opposition from individual Members of Parliament should proposed changes affect their local hospitals. It was suggested that one way of addressing this opposition would be to have alternative provision in place helping people to have confidence in the proposed new system; it was recognised this would have cost implications.

5. Implications of Healthcare for London for the LAS

Kathy Jones, the Director of Service Development, presented an update to the briefing regarding the implications of HfL previously given to the Trust Board in March 2008.

The following work was being undertaken in respect of the six HfL Programmes:

Unscheduled Care, early discussions were being held with NHS Direct on having technical links between the two organisations. A project to introduce a capacity managed system had been initiated.

Polyclinics: HfL has received applications from 29 PCTs to establish 50 polyclinics. The Medical Director said that the specification for polyclinics was quite exciting. It was anticipated that there would eventually be 150 polyclinics established. A pilot, involving 5-10 polyclinics, will enable facilitate variation in terms of location and organisational structure, and for the cost/benefit of the proposal to be fully evaluated. Following the conclusion of the pilots a tender exercise will be undertaken to appoint providers to manage the polyclinics. The Chairman said that the LAS had been approached by two/three large acute hospitals with a view to submitting joint bids to HfL to run polyclinics. `

Estates. HfL was undertaking a major exercise reviewing NHS estate in London, including consideration of the commercial options available.

Stroke. In January 2008 a pilot commenced in South West London in respect of stroke; an evaluation will be concluded in June 2008. The Director of Service Development said there was evidence from other countries to support the proposed changes to the treatment of patients who have suffered a stroke. The LAS' Stroke Care co-ordinator had been approached by North London and North Central London PCTs to set up pilots in their areas. HfL was undertaking work in respect of the tariff for the treatment of stroke.

Local Hospital Feasibility. Work was being undertaken to fully understand the ramifications for District General Hospitals if patients who may need surgery are taken to specialist hospitals.

Diabetes. The Director of Service Development said that a sizeable number of members of the public have undiagnosed diabetes and the Trust could, via a very simple test, routinely screen patients to identify diabetics and refer them to their GPs. There was also recognition that the Trust was often used by long term diabetics to manage their condition i.e. in cases of hypoglycaemia.

Trauma. The Medical Director said that the consensus following the recent Trauma Conference organised by HfL was that there would need to be more than the three trauma centres. It was proposed that there should be a major trauma centre within each network with a number of trauma centres, situated in general hospitals, to treat less serous trauma cases.

Workforce. The HR Director said the Trust had been represented on the NHS London's Strategic Steering Group for Workforce & Education; the Group was undertaking work in relation to the future educational requirement and the commissioning implications of the HfL proposal. NHS London will be launching its workforce strategy on 16th September 2008. The LAS' has shared the New Ways of Working: Clinical Leadership Model and the Service Improvement Programme with NHS London, which together with the HfL details, will inform a joint strategy with NHS London. Further events to develop the LAS/NHS London strategy were scheduled.

The funding received following the successful Education and Development bid will be used to:

- recruit and train additional Paramedics; Student Paramedics and Emergency Care Practitioners,
- provide additional clinical support,
- improve leadership development
- further enhance patient assessment and other training for Paramedics.

The Chief Executive said that in addition to the development work being undertaken by the LAS there was continued focus on getting the basics right. Within the next 24 months a new radio system will be introduced; 700 staff recruited and 100 new ambulances purchased. There would also be challenges concerning the introduction of Student Paramedics as well as the proposed new AfC banding of Paramedics.

The Chief Executive said that unscheduled care was very complicated and fragmented and it was possible that there was some duplication of effort in the system. The Chief Executive said a clinical leadership model for London was crucial and in that respect the LAS was undertaking a review of its clinical leadership structure.

In recognition of the above challenges, additional support was being recruited and developed so as to strengthen the capacity of the senior management team to deliver the Service Improvement Programme and to progress the Foundation Trust application.

6. The Chairman concluded the meeting by thanking the guest speakers for attending the meeting and sharing their experiences.

The Chairman congratulated the Executive team on achieving 75% Call Connect Category A8 minute response target in April, which he said was a considerable achievement.

The Chairman said he was pleased that LAS' potentially central role in implementing Lord Darzi's Framework for Action had been recognised.

Meeting finished at 4.00pm

Enclosure 18

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 20th May 2008

Report of the Trust Secretary
Tenders Received & the Use of the 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 5 tenders received since the last Trust Board meeting.

Provision and Maintenance of Stretch Trolleys
- VW Limited
- Stryker
- Ferno

Security Services at LAS Headquarters
- Chargecrest Security Ltd
- Charter Security Services
- City Security
- Empire Services Plc
- Legion Group Plc
- Mitie Security (London) Ltd
- OCS
- Octavian Security
- S2 Securities Ltd
- Sectorguard
- Vigil Security Management

Consultancy re. Benefits Realisation
- PriceWaterhouseCooper
- Sigma

Provision and Maintenace of defibillators
- Zoll
- Schiller (Amazon Medical)
- Physio Control
- Laerdal

CAD 2010 Procurement
- Integraph
- Northrop Grumman

3. Use of Seal

There have been three entries, reference 114, 115 and 116 since the last Trust Board meeting. The entries related to:

No.114	Sale of Buckhurst Hill to Aspen Healthcare Ltd. (authorised via Chairman's Urgent Action)
No. 115	Members Agreement, health and Social Care Information Centre.
No. 116	Planning deed re. 392 Shooters Hill Road, Blackheath SE18.

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

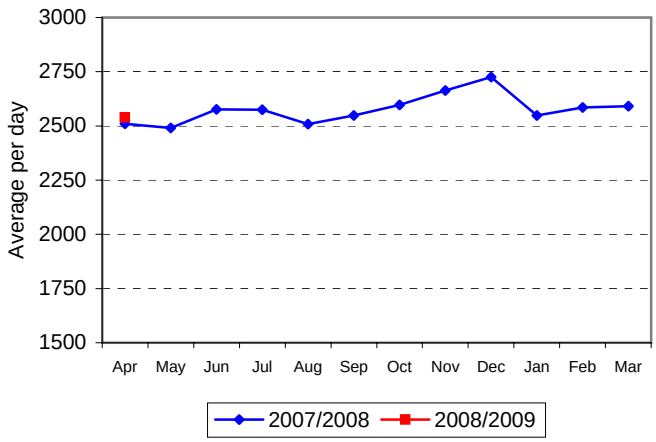
Information Pack for Trust Board

April 08

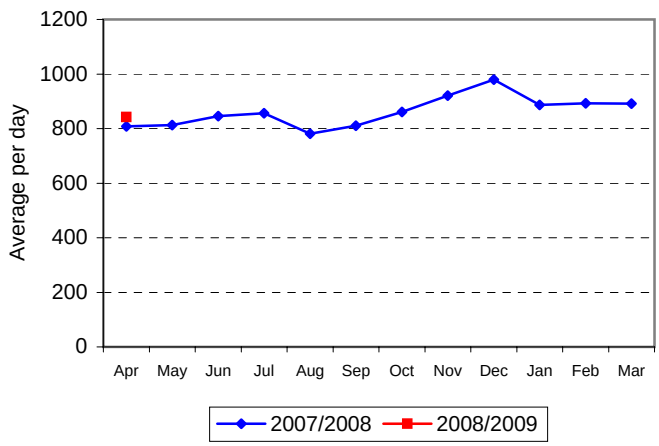
PRF data entry is not yet complete for April

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity - April 2008

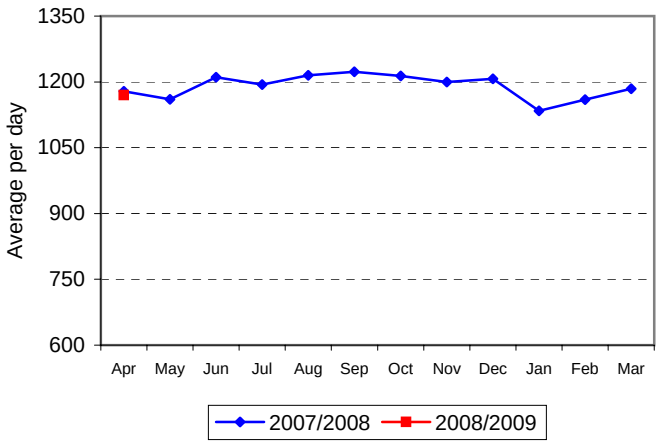
Graph 1
Average number of Cat A, B & C incidents per day



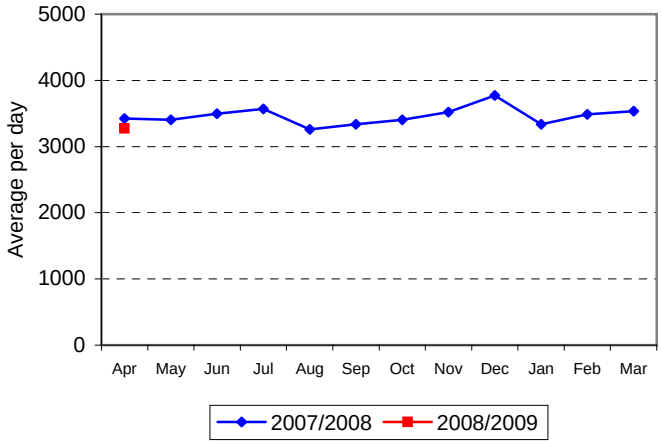
Graph 2
Average number of Cat A incidents per day



Graph 3
Average number of Cat B incidents per day

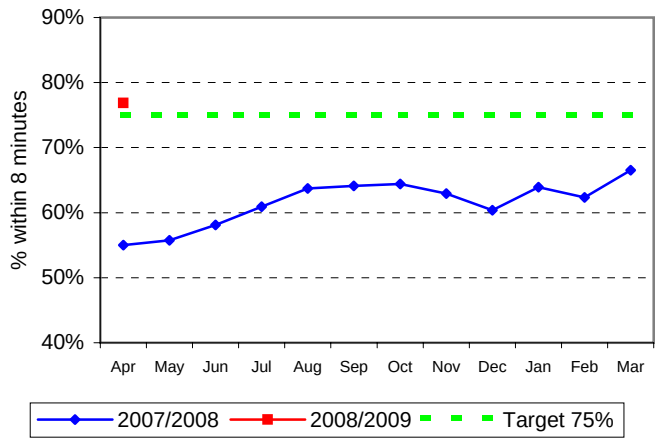


Graph 4
Average number of 999 calls received per day

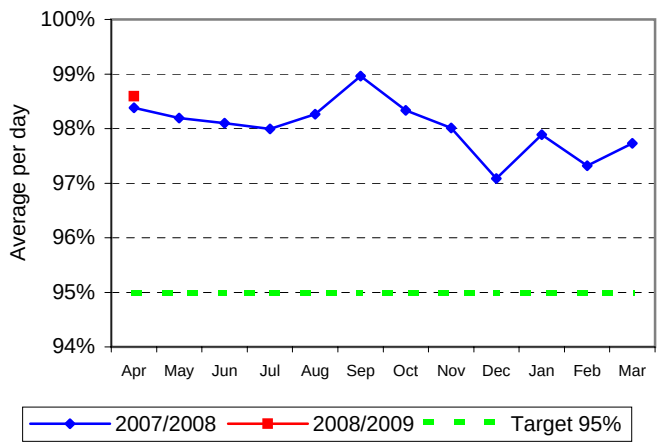


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2008

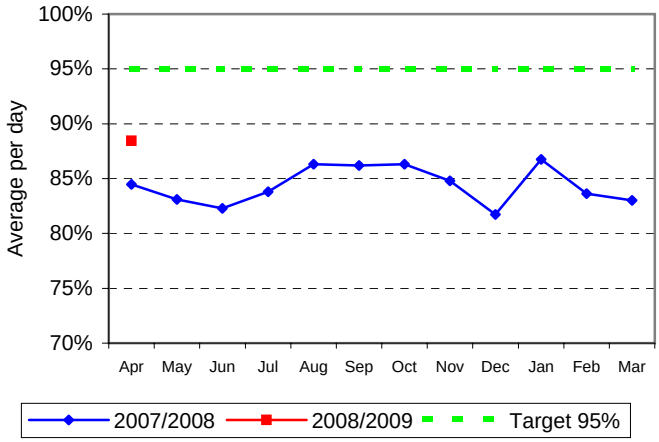
Graph 5
Category A 8 minute performance



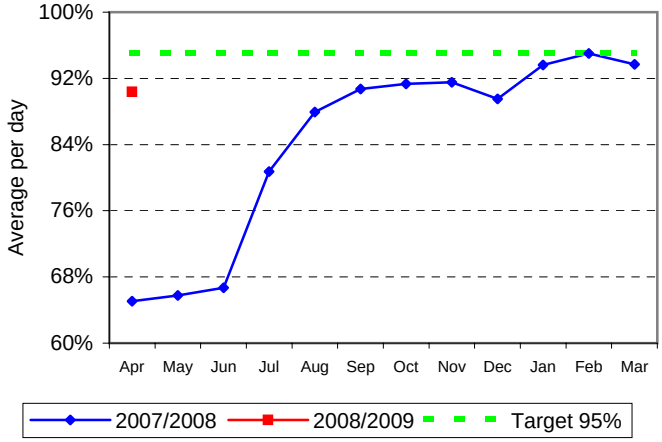
Graph 6
Category A 19 minute performance



Graph 7
Category B 19 minute performance

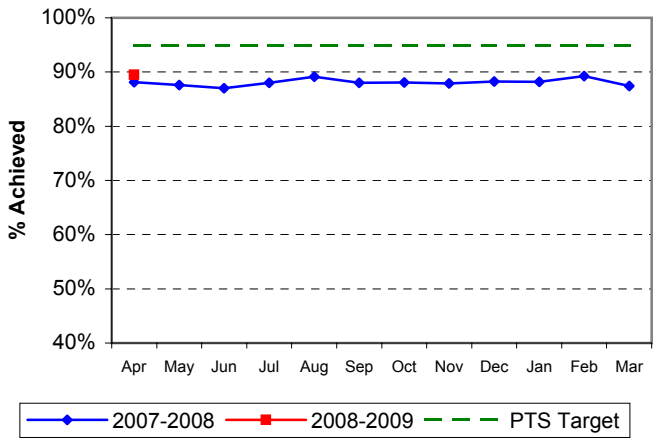


Graph 8
Percentage of calls answered within 5 seconds

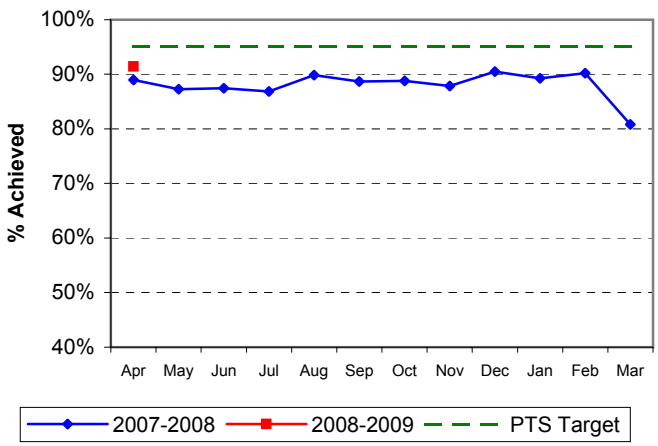


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - April 2008

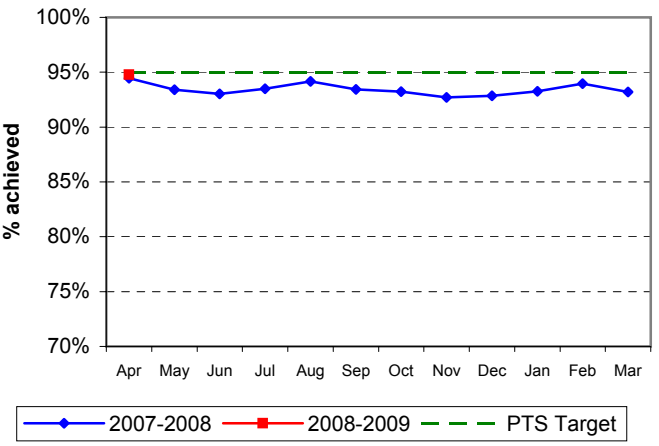
Graph 9
Arrival at Hospital Against Appointment Time



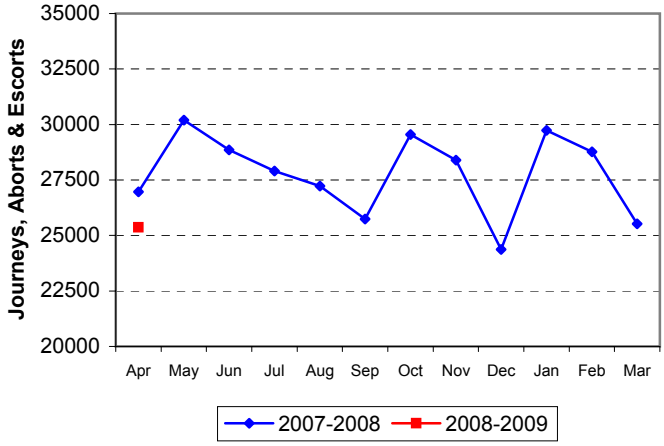
Graph 10
Departure Against Ready Time



Graph 11
Time spent on Vehicle

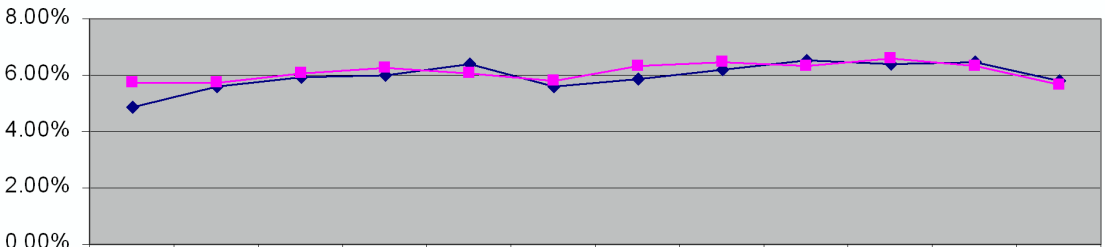


Graph 12
PTS Total Activity



Trust Sickness Levels

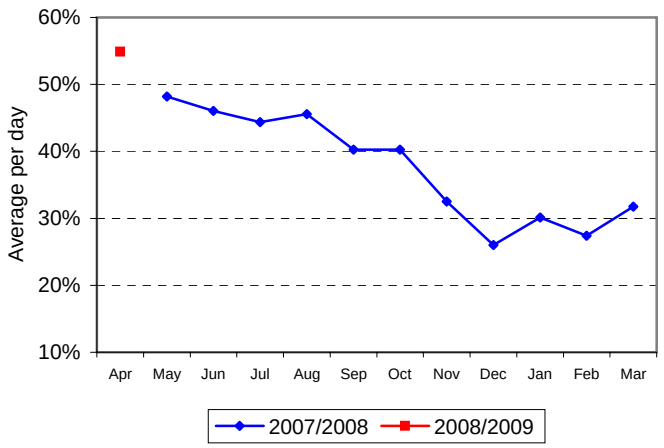
Apr 06/Mar 07 cf Apr 07/Mar 08



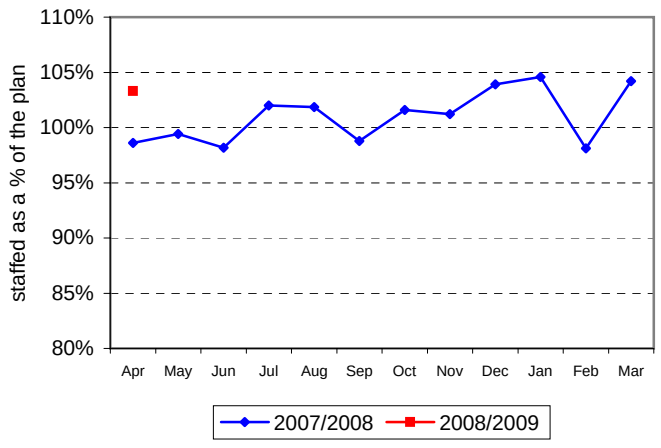
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2006/07	4.87%	5.59%	5.94%	6.00%	6.38%	5.62%	5.84%	6.20%	6.51%	6.40%	6.50%	5.80%
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%

London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - April 2008

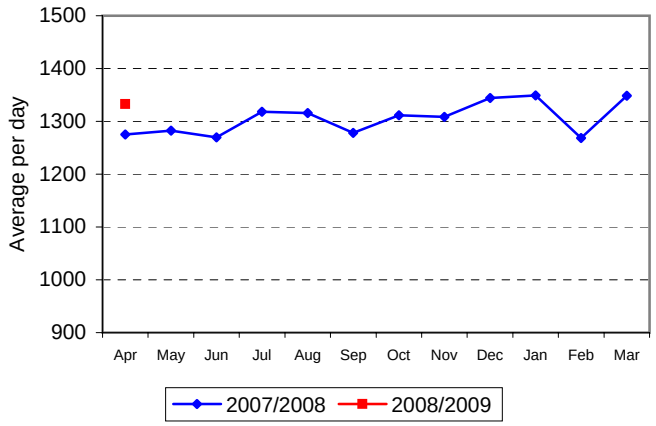
Graph 14
% of vehicles given a rest breaks



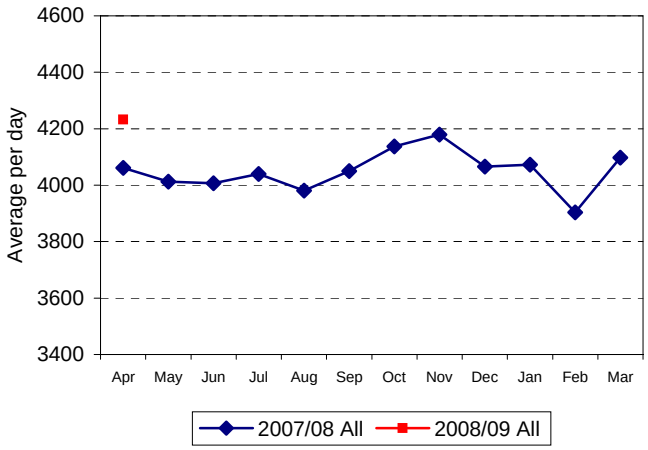
Graph 15
EOC Staffing as a % of the plan



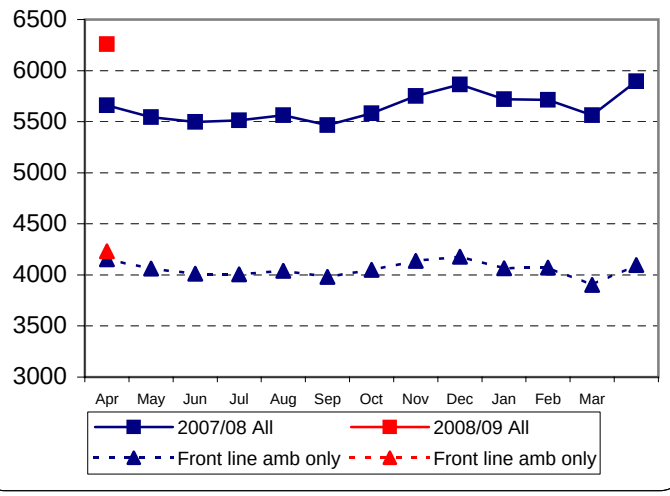
Graph 16
EOC hours staffed per day



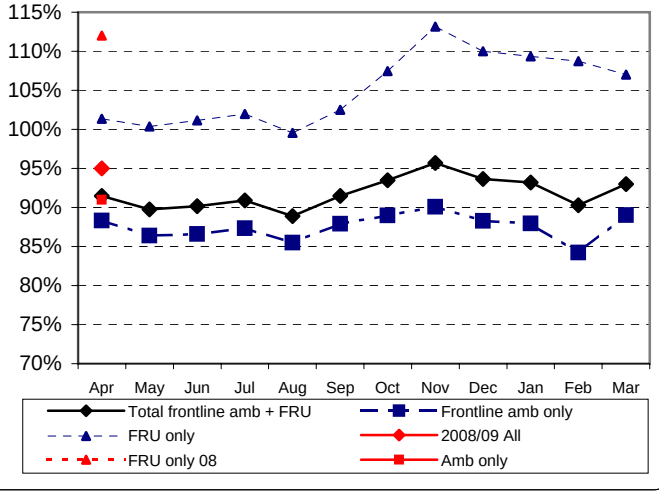
Graph 17
Ambulance hours per day



Graph 18
Total hours staffed AEU + FRU per day



Graph 19
Staffing as percentage of plan

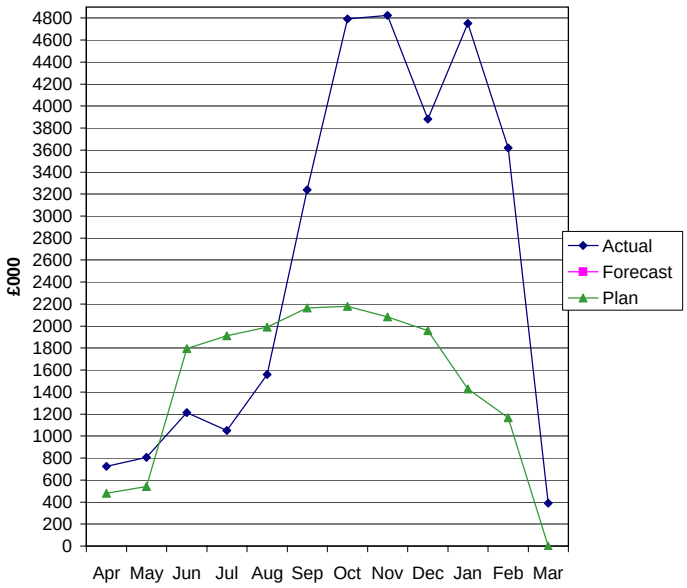


London Ambulance Service NHS Trust

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

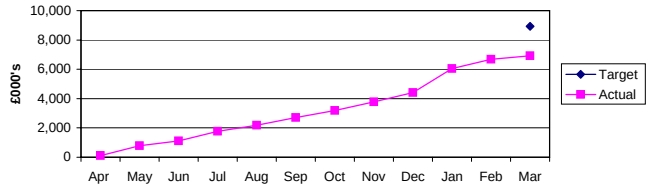
Income and Expenditure

Cumulative Net Financial Position

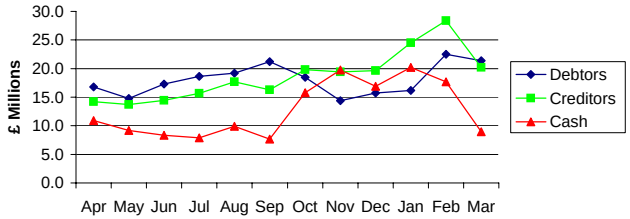


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	Jan	Feb	Mar
Asset turnover ratio	1.88	1.53	1.91
Debtors % > 90 days	33.57	5%	23.54
A&E Debtor days	1.27	7.47	5.14
PTS Debtor days	51.76	43.33	36.09
PSPP NHS	92%	77%	78
PSPP Non NHS	82%	85%	85%

Key Financial Indicators

	Jan	Feb	Mar
A&E Overtime (£000) / Day (Month)	£38	£39	£57
A&E Overtime (% of paybill)	8%	7%	11%
Subsistence (£000) / Day (Month)	£7.87	£6.54	£6.73
Subsistence per head £	£61.43	£47.37	£52.68
Third Party Transport expenditure / Day (Month)	£4,294	£5,556	£5,583
A&E Cost per incident	£181	£197	£234
A&E Gross Surplus (YTD) (% of Income)	21.8%	21.8%	22.4%
A&E Net Margin (YTD) (% of Income)	2.5%	1.7%	0.1%
PTS Gross Margin (YTD) (% of Income)	1.4%	1.3%	1.1%
Cat B performance (cumulative)	85%	85%	88%

Financial Risks - Results

1	Failure to meet Cat B activity targets	YES
2	Failure to manage A&E overtime within plan	NO
3	Failure to meet Trust CIP	YES
4	Failure to manage and control 3rd party exp	NO
5	PTS profitability less than forecast	NO

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31 March 2008 (Month 12)

	IN THE MONTH			*ANNUAL*			
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance
Total Income	25,730	18,258	7,472F	236,184	219,481	16,703F	7.6%F
Total Operational Costs	28,085	18,084	(10,001)U	226,149	209,141	(17,008)U	(8.1%)U
EBITDA	**(2,354)**	**175**	**(2,529)U**	**10,035**	**10,340**	**(305)U**	**(0)U**
EBITDA Margin	***-9%***	***1%***	**-10%**	***4%***	***5%***	**0%**	
Depreciation & Interest	877	1,342	465F	9,644	10,340	695F	6.7%F
Net *Surplus/(Deficit)*	**(3,231)**	**(1,167)**	**(2,064)U**	**391**	**0**	**391 F**	**(7.2%)U**
Net Margin	***-13%***	***-6%***	***-6%***	***0%***	***0%***	***0%***	

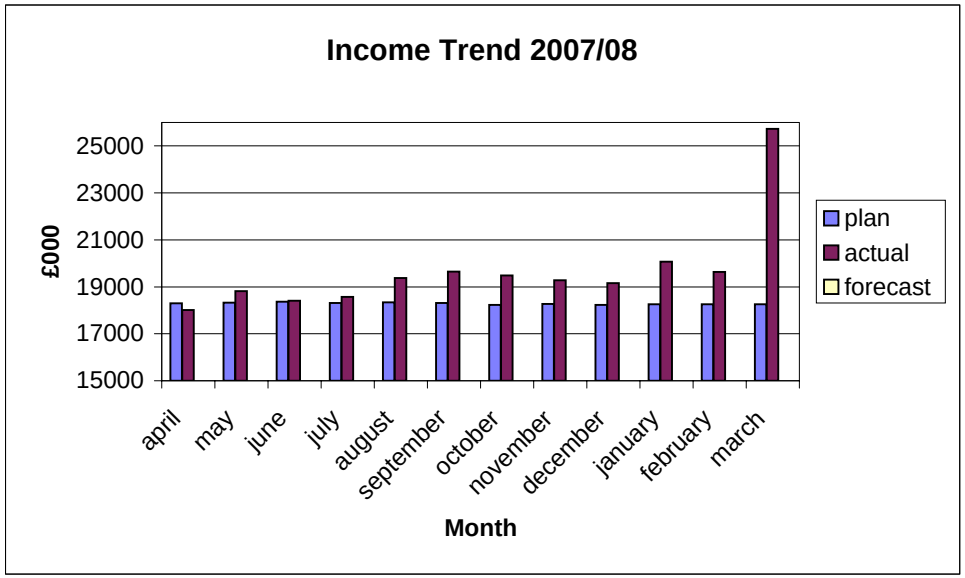
● In month 12 expenditure exceeds income by £3.2m, this was anticipated as the majority of expenditure on Invest to Save (ITS) projects occurred in the last month of the year.

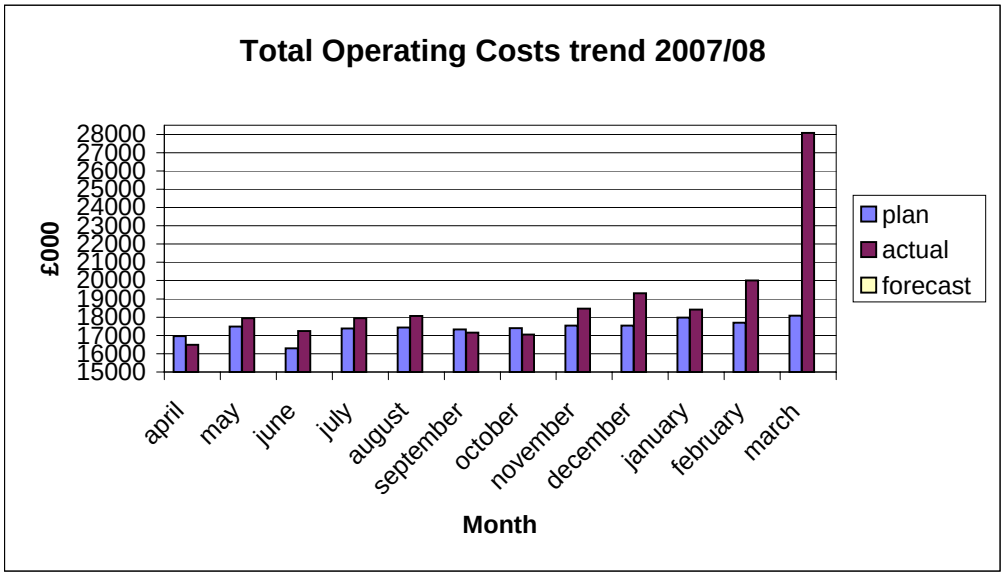
● The net financial position at the end of 2007/08 is a surplus of £391k. The year end surplus differs from the month 11 forecast of £1267k surplus by £876k. The main reason in the decrease is a lower than forecast spend on ITS projects compensated by higher than expected costs associated with provisions and the year end stock movement. A detailed breakdown of the forecast movement is shown on page 4.

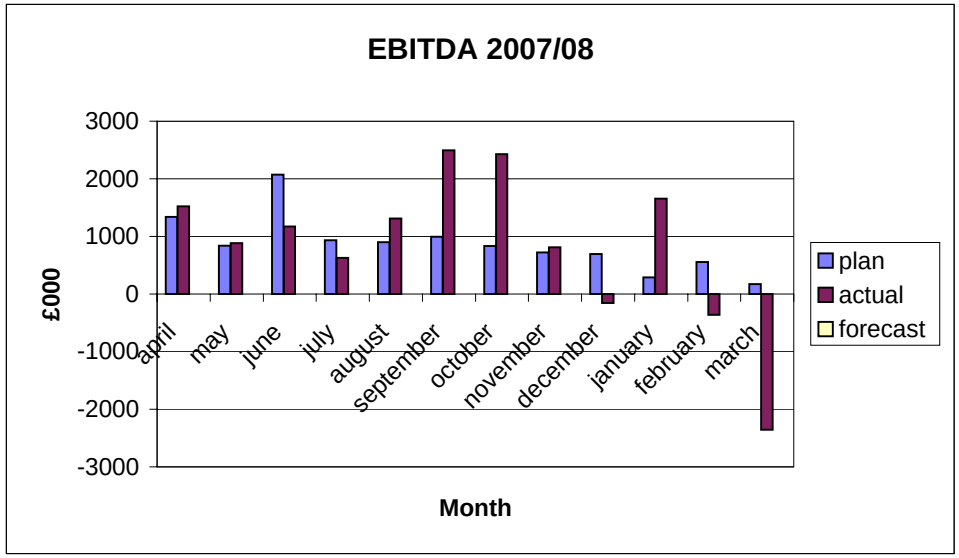
● The annual expenditure includes £6.8m expenditure on call connect iniatives which has helped the Trust meet its performance targets in 2007/08 and it ends the year in a good position to meet the targets for 2008/09. The Trust spent £6.6 million on Invest to Save projects which has enabled to Trust to bring forward some developments, the benefits of which will be seen in 08/09 and beyond.

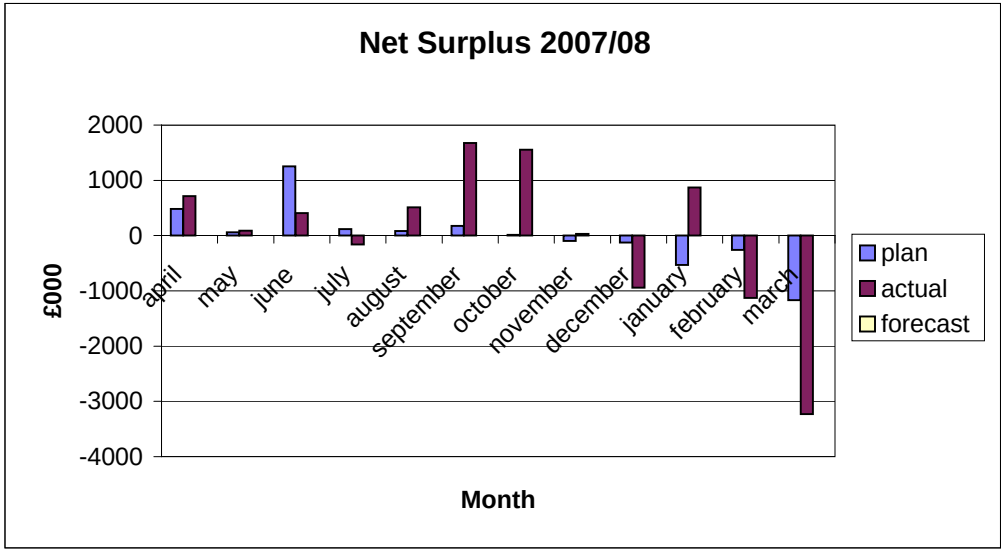
London Ambulance Service NHS Trust

Month 12 Trust Board report - I&E data









LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 March 2008 (Month 12)

£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*	*Actual*	
Income	**18,006**	**18,819**	**18,409**	**18,569**	**19,373**	**19,646**	**19,486**	**19,282**	**19,154**	**20,068**	**19,641**	**25,730**	**236,184**
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	8,677	99,322
Overtime	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,168	1,118	1,764	13,357
A&E Management	878	858	873	882	881	912	914	904	940	912	1,027	911	10,893
EOC Staff	859	908	900	921	899	936	920	909	985	954	953	946	11,090
PTS Operational Staff	550	570	529	547	128	457	465	442	487	462	466	459	5,561
PTS Management	81	70	86	80	94	86	80	87	87	85	84	88	1,007
Corporate Support	2,145	2,204	2,120	2,143	2,110	2,119	2,125	2,497	2,239	2,199	3,242	3,155	28,297
Sub Total	**13,456**	**13,379**	**13,467**	**13,700**	**13,723**	**13,569**	**13,637**	**14,101**	**15,132**	**14,007**	**15,357**	**15,999**	**169,527**
Average Daily	*449*	*432*	*449*	*442*	*443*	*452*	*440*	*470*	*488*	*452*	*548*	*516*	*464*
Non-Pay Expenditure													
Staff Related	245	206	191	217	189	205	213	198	189	271	231	386	2,741
Subsistence	53	194	125	159	173	150	175	182	188	244	190	209	2,042
Training	40	184	76	134	158	24	116	173	30	119	123	258	1,386
Medical Consumables & Equipment	226	401	340	291	479	341	312	387	396	510	533	1,814	6,030
Drugs	20	34	25	36	37	19	46	55	36	22	46	28	406
Fuel & Oil	296	317	313	324	319	301	342	373	405	406	391	417	4,205
Third Party Transport	29	51	49	77	113	55	94	92	84	133	161	173	1,112
Vehicle Costs	589	1,044	884	1,021	925	895	977	1,614	1,681	1,091	1,034	2,895	14,650
Accommodation & Estates	707	755	754	623	805	605	757	751	543	922	832	1,702	9,755
Telecommunications	354	426	340	619	407	576	201	489	516	477	677	2,134	7,215
Depreciation	484	494	489	496	510	523	579	534	542	524	524	706	6,405
Other Expenses	470	949	654	740	736	461	184	57	109	214	425	2,039	7,040
Profit/(Loss) on Disposal FA	0	2	17	0	1	0	0	2	0	0	0	29	41
Sub Total	**3,513**	**5,053**	**4,257**	**4,736**	**4,850**	**4,107**	**3,999**	**4,903**	**4,719**	**4,932**	**5,167**	**12,792**	**63,027**
Average Daily	*117*	*163*	*142*	*153*	*156*	*137*	*129*	*163*	*152*	*159*	*185*	*413*	*173*
Financial Expenditure	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**260**	**246**	**170**	**3,240**
Average Daily	*11*	*10*	*9*	*9*	*9*	*10*	*10*	*8*	*8*	*8*	*9*	*5*	*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**	**28,961**	**235,793**
Cumulative	**17,289**	**36,019**	**54,021**	**72,752**	**91,616**	**109,584**	**127,514**	**146,767**	**166,863**	**186,062**	**206,832**	**235,793**	
Monthly Net	**717**	**89**	**406**	**(161)**	**509**	**1,678**	**1,555**	**29**	**(942)**	**869**	**(1,129)**	**(3,231)**	**391**
Cumulative Net	**717**	**806**	**1,212**	**1,051**	**1,560**	**3,238**	**4,794**	**4,823**	**3,881**	**4,750**	**3,621**	**391**	

LONDON AMBULANCE SERVICE NHS TRUST

Comparison of annual forecasts at Month 12 and Month 11
As at 31 March 2008 (Month 12)

		YEAR TO DATE				
		Month 12	Month 11	Variance		Comments
Income		**236,184**	**235,171**	**1,013**		Income is higher than forecast due to the revision of the assumption around the carry forward of ITS income.
Pay Expenditure						
A&E Operational Staff		99,322	99,360	**38**		
Overtime		13,357	12,849	**(508)**		Overtime exp is higher than forecast to account for high levels of overtime in March
A&E Management		10,893	10,886	**(7)**		
EOC Staff		11,090	11,126	**36**		
PTS Operational Staff		5,561	5,534	**(27)**		
PTS Management		1,007	1,001	**(6)**		
Corporate Support		28,297	28,100	**(198)**		The increase accounts for a higher than expected provision for restructure.
Sub Total		**169,527**	**168,856**	**(671)**		
Non-Pay Expenditure						
Staff Related		2,741	2,604	**(137)**		This is to account for expenditure on high vis jackets and vests funded as part of ITS.
Subsistence		2,042	2,034	**(8)**		
Training		1,386	1,492	**106**		Lower expenditure than forecast on ITS projects due to revision to delivery times on some projects
Drugs		406	414	**8**		
Medical Consumables & Equipment		6,030	5,237	**(793)**		The increase over forecast is due to the year end stock movements and a higher level of expenditure on ITS projects than forecast.
Fuel & Oil		4,205	4,188	**(17)**		
Third Party Transport		1,112	1,259	**147**		The use of the alternative response vehicle was less than forecast in March.
Vehicle Costs		14,650	14,545	**(105)**		An adjustment was made to account for additional third party accident damage due to updated information received from our insurance company.
Accommodation & Estates		9,755	9,238	**(517)**		The increase stems from additional estates maintenance expenditure funded by ITS
Telecommunications		7,215	7,382	**167**		To account for lower than forecast expenditure on ITS projects
Depreciation		6,405	6,230	**(175)**		The increase stems from a review of our capital projects.
Other Expenses		7,040	7,109	**69**		This accounts for a slight increase across the board on office & station equipment.
Profit/(Loss) on Disposal FA		41	12	**(29)**		
		63,027	**61,744**	**(1,283)**		
Financial Expenditure		**3,240**	**3,305**	**65**		
Total Expenditure		**235,793**	**233,904**	**(1,889)**		
Net		**391**	**1,267**	**(876)**		

Movement from the month 11 forecast to the year end position

	£k
month 11 forecast	**1,267**
ITS	
Movement in delivery of projects	1,706
	1,706
Changes in provisions	
Third party accident damage	(224)
Ambulance lease conversion	(773)
Bad debt	60
Restructure	(61)
	(998)
Other	
Movement in delivery of IPT project	(427)
Estates expenditure	(277)
A&E income adjustment	(265)
Overtime,bonus and unsocial hours prem	(271)
Stock movement	(327)
Capital project review	(46)
Other	29
	(1,584)
Total movement	(876)
Month 12 y/e position	**391**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
As at 31 March 2008 (Month 12)

	MONTHLY SPEND													
	February	March	April	May	June	July	August	September	October	November	ecember	January	February	March
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**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**	**25,730**
Pay Expenditure														
A&E Operational Staff	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	8,677
Overtime	542	879	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,168	1,118	1,764
A&E Management	882	839	878	858	873	882	881	912	914	904	940	912	1,027	911
EOC Staff	871	703	859	908	900	921	899	936	920	909	985	954	953	946
PTS Operational Staff	547	393	550	570	529	547	128	457	465	442	487	462	466	459
PTS Management	84	73	81	70	86	80	94	86	80	87	87	85	84	88
Corporate Support	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	3,154
Sub Total	**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**	**15,999**
Average Daily	*416*	*425*	*434*	*432*	*449*	*442*	*457*	*438*	*440*	*470*	*488*	*467*	*495*	*516*
Non-Pay Expenditure														
Staff Related	293	169	245	206	191	217	189	205	213	198	189	271	231	386
Subsistence	0	0	53	194	125	159	173	150	175	182	188	244	190	209
Training	126	191	40	184	76	134	158	24	116	173	30	119	123	258
Drugs	0	0	20	34	25	36	37	19	46	55	36	22	46	1,814
Medical Consumables & Equipment	388	248	226	401	340	291	479	341	312	387	396	510	533	28
Fuel & Oil	298	318	296	317	313	324	319	301	342	373	405	406	391	417
Third Party Transport	37	73	29	51	49	77	113	55	94	92	84	133	161	173
Vehicle Costs	753	869	589	1,044	884	1,021	925	895	977	1,614	1,681	1,091	1,034	2,895
Accommodation & Estates	692	716	707	755	754	623	805	605	757	751	543	922	832	1,702
Telecommunications	477	606	354	426	340	619	407	576	201	489	516	477	677	2,134
Depreciation	478	484	484	494	489	496	510	523	579	534	542	524	524	706
Other Expenses	373	336	470	949	654	740	736	461	184	57	109	214	425	2,039
Profit/(Loss) on Disposal FA	0	10	0	2	17	0	1	0	0	2	0	0	0	29
Sub Total	**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**	**12,792**
Average Daily	*126*	*130*	*113*	*163*	*142*	*153*	*162*	*132*	*129*	*163*	*152*	*164*	*167*	*413*
Financial Expenditure	**322**	**273**	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**260**	**246**	**170**
Average Daily	*10*	*9*	*10*	*10*	*9*	*9*	*10*	*9*	*10*	*8*	*8*	*9*	*8*	*5*
Monthly	**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**	**28,961**
Monthly Net	**802**	**1,671**	**717**	**89**	**406**	**-161**	**509**	**1,678**	**1,555**	**29**	**-942**	**869**	**-1,129**	**-3,230**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 March 2008 (Month 12)

	IN THE MONTH			*Annual*			
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance
Income	24,919	17,501	7,419F	226,081	210,013	16,068F	7.7%F
Sector Services	14,360	10,978	(3,382)U	136,924	127,255	(9,669)U	(7.6%)U
A&E Operational Support	1,370	1,172	(198)U	12,838	12,131	(707)U	(5.8%)U
Control Services	1,338	1,132	(206)U	14,476	13,462	(1,014)U	(7.5%)U
Urgent Care Services	1,119	1,046	(74)U	11,240	12,526	1,287F	10.3%F
Total Operations Cost	**18,187**	**14,328**	**(3,859)U**	**175,478**	**165,374**	**(10,103)U**	**(6.1%)U**
A&E Gross Surplus/(Deficit)	**6,733**	**3,173**	**3,560F**	**50,603**	**44,639**	**5,965F**	**13.4%F**
Gross Margin	27.0%	18.1%	8.9%F	22.4%	21.3%	1.1%	
Medical Directorate	94	63	(31)U	676	711	35F	4.9%F
Service Development	73	192	119F	636	814	178F	21.9%F
Communications	166	159	(7)U	1,490	1,745	255F	14.6%F
Human Resources	1,365	1,075	(290)U	11,179	11,362	183F	1.6%F
IM&T	2,220	1,031	(1,188)U	9,909	8,881	(1,028)U	(11.6%)U
Finance	6,001	1,746	(4,255)U	25,290	20,380	(4,910)U	(24.1%)U
Chief Executive	32	89	57F	1,140	1,130	(10)U	(0.9%)U
Total Corporate	**9,950**	**4,355**	**(5,595)U**	**50,320**	**45,023**	**(5,298)U**	**11.8%F**
A&E Net Surplus/(Deficit)	**(3,218)**	**(1,182)**	**(2,036)U**	**283**	**(384)**	**667F**	**173.6%F**
A&E Net Margin	(12.9%)	(6.8%)	(11.6%)U	0.1%	(0.2%)	0.3%	
Patient Transport Service	**(13)**	**15**	**(28)U**	**108**	**384**	**(276)U**	**(72.0%)U**
PTS Gross Margin	(1.6%)	2.0%	(3.7%)U	1.1%	4.1%	(2.9%)U	
Trust Result *Surplus/(Deficit)*	**(3,231)**	**(1,167)**	**(2,064)U**	**391**	**(0)**	**391F**	

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 March 2008 (Month 12)

£000s

	IN THE MONTH			*ANNUAL*			
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance
Pay Expenditure							
A&E Operational Staff	8,677	8,547	(130)U	99,322	99,247	(75)U	(0.1%)U
Overtime	1,764	667	(1,097)U	13,357	7,994	(5,363)U	(67.1%)U
A&E Management	911	902	(9)U	10,893	10,765	(128)U	(1.2%)U
EOC Staff	946	1,022	76F	11,090	12,184	1,094F	9.0%F
PTS Operational Staff	459	448	(11)U	5,561	5,578	17F	0.3%F
PTS Management	88	80	(8)U	1,007	973	(34)U	(3.5%)U
Corporate Support	3,155	2,192	(963)U	28,297	26,580	(1,717)U	(6.5%)U
	15,999	**13,858**	**(2,141)U**	**169,527**	**163,322**	**(6,205)U**	**(3.8%)U**
Non-Pay Expenditure							
Staff Related	386	204	(182)U	2,741	2,507	(234)U	(9.4%)U
Subsistence	209	61	(147)U	2,042	816	(1,226)U	(150.3%)U
Training	258	108	(149)U	1,386	1,487	100F	6.7%F
Drugs	28	48	20F	406	564	159F	28.1%F
Medical Consumables & Equipment	1,814	505	(1,309)U	6,030	4,011	(2,019)U	(50.3%)U
Fuel & Oil	417	317	(101)U	4,205	3,692	(512)U	(13.9%)U
Third Party Transport	173	57	(116)U	1,112	651	(461)U	(70.7%)U
Vehicle Costs	2,895	894	(2,001)U	14,650	10,640	(4,010)U	(37.7%)U
Accommodation & Estates	1,702	555	(1,147)U	9,755	8,200	(1,554)U	(19.0%)U
Telecommunications	2,134	480	(1,655)U	7,215	5,320	(1,896)U	(35.6%)U
Depreciation	706	1,022	316F	6,405	6,506	101F	1.6%F
Other Expenses	2,039	996	(1,043)U	7,040	7,931	891F	11.2%F
Profit/(Loss) on Disposal FA	29	0	(29)U	41	0	(41)U	
	12,792	**5,248**	**(7,544)U**	**63,027**	**52,325**	**(10,702)U**	**(20.5%)U**
Financial Expenditure	**170**	**320**	**149F**	**3,240**	**3,834**	**594F**	**15.5%F**
Total Trust Expenditure	**28,961**	**19,425**	**(9,536)U**	**235,793**	**219,481**	**(16,312)U**	**(7.4%)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 March 2008 (Month 12)

£000s

	IN THE MONTH			*ANNUAL*			
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance
A&E Income							
A&E Services Contract	25,836	16,304	9,532F	209,511	195,651	13,860F	7.1%F
HEMS Funding	11	3	8F	54	35	19F	54.9%F
Other A&E Income	89	88	1F	1,065	1,056	9F	0.9%F
Foundation Trust Income	92	28	64F	263	335	(72)U	(21.5%)U
CBRN Income	827	717	110F	9,523	8,607	916F	10.6%F
ECP Income	58	10	47F	340	125	215F	172.0%F
BETS & SCBU Income	28	86	(114)U	775	1,034	(259)U	(25.1%)U
A & E Long Distance Journey	42	33	(75)U	380	398	(18)U	(4.5%)U
Stadia Attendance	62	55	8F	1,023	663	360F	54.3%F
Heathrow BAA Contract	44	39	5F	416	473	(57)U	(12.0%)U
Resus Training Fees	35	10	25F	128	118	10F	8.7%F
Education & Training Income	41	23	18F	507	270	237F	87.8%F
	27,024	**17,397**	**9,628**	**223,986**	**208,765**	**15,221**	**7.3%F**
PTS Income	811	758	88F	10,103	9,468	635F	6.7%F
Other Income	2,105	104	(2,209)U	2,095	1,248	848F	67.9%F
Trust Result	**25,730**	**18,258**	**7,472F**	**236,184**	**219,481**	**16,703F**	**7.6%F**

LONDON AMBULANCE SERVICE NHS Trust

Balance Sheet
For the Month Ending 31 March 2008 (Month 12)

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	
Intangible assets	1,593	1,585	1,571	1,556	1,542	1,547	1,535	2,463	2,487	2,487	3,034	3,042	3,765	
Tangible assets	113,013	119,725	119,943	119,785	119,943	119,831	119,850	118,823	117,792	117,880	118,440	117,090	119,652	
	114,606	121,310	121,514	121,341	121,485	121,378	121,385	121,286	120,279	120,367	121,474	120,132	123,417	
Current Assets														
Stocks & WIP	1,965	1,955	1,814	1,813	1,813	1,711	1,716	1,715	1,713	1,711	1,715	1,846	1,930	Trade Debtors
NHS Trade Debtors	1,654	672	14	2,353	2,337	2,854	3,271	4,183	157	2,047	2,334	9,897	1,607	A&E £230k > 60 days (12.56%), Feb - £141k > 60 days (1.39%)
Non NHS Trade Debtors	0	511	275	62	65	76	73	71	72	82	92	3,986	72	PTS £240k > 60 days (13.09%), Feb - £547k > 60 days (5.39%)
Other Debtors	663	272	238	208	247	152	318	575	454	383	243	283	4,337	
Accrued Income	993	1,079	2,101	1,944	3,598	4,306	5,517	1,081	1,189	727	1,278	424	247	
Prepayments	2,811	2,755	2,414	2,922	2,611	2,021	2,372	2,602	2,622	2,569	2,332	1,871	5,237	
Investments	0	7,500	9,500	8,000	7,500	9,400	6,900	15,700	17,500	15,900	21,100	17,400	0	
Cash at Bank and in Hand	644	1,014	(231)	349	387	527	783	87	2,236	976	(901)	273	8,965	
Total Current Assets	8,730	15,758	16,125	17,651	18,558	21,047	20,950	26,014	25,943	24,395	28,193	35,980	22,395	
Creditors: Amounts falling due within one year														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Trade Creditors	3,929	4,888	4,924	5,192	4,452	5,723	6,756	6,044	5,479	6,464	10,927	8,956	13,403	NHS PSPP - This month (78%), Feb (77%), Ytd (84%)
Other Creditors	2,035	6,195	6,401	6,214	6,256	6,509	6,395	6,492	7,109	6,773	6,774	7,055	1,751	Non NHS PSPP - This month (85%), Feb (85%), Ytd (85%)
PDC Dividend Creditor	0	340	680	1,020	1,360	1,700	0	339	679	1,019	1,359	1,699	0	
Capital Creditors	388	30	30	190	114	26	30	67	58	59	46	18	2,756	
Accruals	513	1,038	776	774	1,758	1,484	1,082	957	956	1,448	1,743	1,691	618	
Deferred Income	58	439	691	1,042	1,690	2,206	2,002	5,865	5,130	3,832	2,737	8,908	152	
Total Current Liabilities	6,923	12,930	13,502	14,432	15,630	17,648	16,265	19,764	19,411	19,595	23,586	28,327	18,680	
Net Current Assets	1,807	2,828	2,623	3,219	2,928	3,399	4,685	6,250	6,532	4,800	4,607	7,653	3,715	
Long Term Debtors	9,766	9,785	9,803	9,804	9,796	9,815	9,730	9,934	9,877	9,894	9,905	9,928	9,875	
Total Assets less current liabilities	126,179	133,923	133,940	134,364	134,209	134,592	135,800	137,470	136,688	135,061	135,986	137,713	137,007	
Creditors: Amounts falling due after more than one year														
Provisions for Liabilities & Charges	15,464	15,423	15,370	15,407	15,415	15,326	15,443	15,576	15,861	15,995	16,071	16,496	16,825	
Total Assets Employed	110,715	118,500	118,570	118,957	118,794	119,266	120,357	121,894	120,827	119,066	119,915	121,217	120,182	
Taxpayers' Equity														
Public Dividend Capital	55,526	55,526	55,526	55,526	55,526	55,526	54,959	54,959	54,959	54,159	54,159	54,159	56,488	
Revaluation Reserve	46,776	53,855	53,855	53,845	53,888	53,888	53,876	53,874	52,797	52,784	52,784	51,908	50,605	
Donated Asset Reserve	294	282	264	244	215	205	79	166	146	127	107	88	68	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Income & Expenditure Reserve	8,538	9,256	9,344	9,761	9,584	10,066	11,862	13,314	13,344	12,415	13,284	15,481	13,440	
Total Taxpayers' Equity	110,715	118,500	118,570	118,957	118,794	119,266	120,357	121,894	120,827	119,066	119,915	121,217	120,182	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 March 2008 (Month 12)

	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	
EBITDA after exceptionals	1,521	881	1,201	630	1,309	2,483	2,430	810	(156)	1,654	(361)	(2,319)	10,083
Excluding Non cash I&E items	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(25)	(234)
Movement in working capital													
Stocks & Work in Progress	10	141	1	0	102	(5)	1	2	2	(4)	(131)	(84)	35
NHS Trade Debtors	837	658	(2,339)	46	(517)	(417)	(912)	4,026	(1,890)	(287)	(7,563)	8,290	(68)
Long Term Debtors	(19)	(18)	(1)	8	(19)	85	(204)	57	(17)	(11)	(23)	53	(109)
Non NHS Trade Debtors	(162)	236	213	(3)	(11)	3	2	(1)	(10)	(10)	(34)	3,913	4,136
Other Debtors	186	34	30	(69)	95	(166)	(257)	121	71	140	(40)	(4,054)	(3,909)
Accrued Income	(86)	(1,022)	157	(1,654)	(708)	(1,211)	4,436	(108)	462	(551)	854	177	746
Prepayments	56	341	(508)	311	590	(351)	(230)	(20)	53	237	461	(3,366)	(2,426)
Trade Creditors	983	36	268	(817)	1,183	1,033	(712)	(565)	985	4,463	(1,971)	4,447	9,333
Other Creditors	3,802	206	(43)	(360)	313	(188)	229	652	(289)	(1,247)	(262)	(2,157)	656
Payments on Account	340	340	0	0	0	0	0	0	0	0	0	0	680
Accruals	525	(262)	(2)	984	(274)	(402)	(125)	(1)	492	295	(52)	(1,073)	105
Deferred Income	381	252	351	648	517	(204)	3,863	(735)	(1,298)	(1,095)	6,171	(8,756)	95
Provisions & Liabilities	(54)	(66)	24	(5)	(101)	105	121	273	122	64	413	318	1,214
Net Cashflow from operating activities	6,799	876	(1,849)	(911)	1,170	(1,718)	6,212	3,701	(1,317)	1,994	(2,177)	(2,292)	10,488
Returns on Investments & Servicing of Finance													
Interest received	32	54	73	58	61	60	57	104	108	91	108	107	913
Interest paid	0	0	0	0	0	0	0	0	0	0	0	(3)	(3)
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from returns on investments & servicing of finance	32	54	73	58	61	60	57	104	108	91	108	104	910
Capital Expenditure													
Tangible fixed assets acquired	(476)	(1,050)	(300)	(220)	(481)	(443)	(576)	(647)	(676)	(397)	(77)	(4,466)	(9,809)
Tangible fixed assets disposed	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from capital expenditure	(476)	(1,050)	(300)	(220)	(481)	(443)	(576)	(647)	(676)	(397)	(77)	(4,466)	(9,809)
PDC Dividends paid	0	0	0	0	0	(2,040)	0	0	0	0	0	(2,039)	(4,079)
Net Cashflow before financing	7,857	742	(894)	(462)	2,040	(1,677)	8,104	3,949	(2,060)	3,323	(2,526)	(11,037)	7,359
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	2,329	2,329
Public Dividend Capital Repaid	0	0	0	0	0	(567)	0	0	(800)	0	0	0	(1,367)
Net Cashflow inflow/(outflow) from financing	0	0	0	0	0	(567)	0	0	(800)	0	0	2,329	962
Increase/(decrease) in cash	7,857	742	(894)	(462)	2,040	(2,244)	8,104	3,949	(2,860)	3,323	(2,526)	(8,708)	8,321
Closing cash balance	8,501	9,243	8,349	7,887	9,927	7,683	15,787	19,736	16,876	20,199	17,673	8,965	8,965

LONDON AMBULANCE SERVICE NHS TRUST
Capital Programme 2007/08
Capital expenditure as at 31st March 08

		Capital Budget 2007/08	Capital Expenditure 2007/08	Variance	Comments
	Projects C/fwd				
T	Major Vehicles	462,000	350,818	111,182	YTD total costs of 06/07 RRUs
T	Minor Vehicles	189,200	145,082	44,118	Less than budgeted cost of Cycle Transporter Vehicle. Actuals also 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.
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	1,026,811	365,064	Several projects now deferred to 08/09. This is against higher than budgeted costs for Refurbishment of 1st Floor LAS HQ and settlement invoices for some 06/07 projects
B	Minor Estates	782,940	1,054,177	(271,237)	Increased costs for Whipps Cross Fixed Satellite Point, Kenton Roof Repair and Wembley Rebuild projects and settlement of final accounts on some 06/07 projects.
IT	Major IM&T	2,813,074	2,360,136	452,938	Mainly attributed to reclassification of project costs as revenue
IT	Minor IM&T	80,000	151,283	(71,283)	Expenditure related to old projects now settled together with increased costs on Fully Integrated Supply Chain and Siemens Voicemail System projects
		5,719,089	5,105,821	613,268	
	New Projects				
T	Major Vehicles	5,481,513	2,583,998	2,897,515	PTS vehicle and Single Wheel Chair Patient Carrier vehicles procurement deferred. Costs for 07/08 RRUs and Base vehicle costs for Zafira Fast Response Unit for Driver training incurred
T	Minor Vehicles	28,200	99,875	(71,675)	Modifications to ESV is classified as revenue expenditure. This is against costs for MRU & CRU Expansion project that was not in the original plan
P&M	Major Equipment	277,150	0	277,150	Cost of IDRs expensed in 06/07 and Paediatric restraints deferred to 08/09. Costs of casualty clearing tents reclassified to revenue
P&M	Minor Equip	73,814	64,704	9,110	Hand held stock mgt to be funded from ITS. CBRN Transporter deferred to 08/09
B	Major Estates	1,241,750	368,317	873,433	Several projects now deferred to 08/09 and less than planned expenditure on Shutter Doors and Upgrade of BOW UPS projects. This is against costs for Greenwich Refurbishment project
B	Minor Estates	395,500	301,289	94,211	Some projects deferred to 08/09. This is against capitalisation of certain project costs from Revenue
IT	Major IM&T	865,625	1,696,628	(831,003)	More than planned expenditure for VN Ware & SAN and capitalisation of Dynamic Deployment Software together with capitalisation of some ITS project costs
IT	Minor IM&T	549,023	588,711	(39,688)	Higher than planned expenditure for Voice Data and Video Convergence project and some ITS expenditure now capitalised
	Other	0	0	0	
		8,912,575	5,703,521	3,209,053	
	Gross Total	14,631,664	10,809,342	3,822,321	
	Disposals	(3,300,000)	(3,887,694)	587,694	Buckhurst Hill
	Net Total	11,331,664	6,921,648	4,410,015	
	CRL	8,978,000	8,978,000		
	(Over)/Under Commitment	(2,353,664)	2,056,352		

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 30 April 2008 (Month 1)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	21,086	21,053	33F	21,086	21,053	33F	0.2%F	252,669	252,638	31F
Total Operational Costs	20,467	20,781	314F	20,467	20,781	314F	1.5%F	239,838	239,785	(52)U
EBITDA	**619**	**272**	**347F**	**619**	**272**	**347F**	**0F**	**12,831**	**12,852**	**(21)U**
EBITDA Margin	***3%***	***1%***	***2%***	***3%***	***1%***	***2%***		***5%***	***5%***	***-24%***
Depreciation & Interest	925	976	51F	925	976	51F	5.3%F	11,661	11,712	51F
Net *Surplus/(Deficit)*	**-306**	**-704**	**398F**	**-306**	**-704**	**398 F**	**(3.6%)U**	**1,171**	**1,140**	**30F**
Net Margin	***-1%***	***-3%***	***2%***	***-1%***	***-3%***	***2%***		***0%***	***0%***	***25%***

LONDON AMBULANCE SERVICE NHS TRUST

Monthly Forecast
As at 30 April 2008 (Month 1)

£000s

	MONTHLY SPEND												
	April	May	June	July	August	September	October	November	December	January	February	March	Total
	Actual	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Income	**21,086**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**21,053**	**252,669**
Pay Expenditure													
A&E Operational Staff	9,087	9,122	9,036	8,462	8,526	8,810	8,956	9,188	9,269	9,306	9,354	9,429	108,544
Overtime	1,910	1,900	1,773	936	878	807	704	649	697	628	532	607	12,021
A&E Management	948	978	978	978	978	978	978	978	978	978	978	978	11,708
EOC Staff	977	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,090	12,970
PTS Operational Staff	450	434	434	434	434	434	434	434	434	434	434	434	5,228
PTS Management	81	95	95	95	95	95	95	95	95	95	95	95	1,127
Corporate Support	2,339	2,503	2,520	2,527	2,527	2,527	2,530	2,530	2,530	2,530	2,530	2,530	30,123
Sub Total	**15,791**	**16,122**	**15,926**	**14,523**	**14,529**	**14,742**	**14,788**	**14,965**	**15,094**	**15,062**	**15,014**	**15,165**	**181,721**
Average Daily	*526*	*520*	*531*	*468*	*469*	*491*	*477*	*499*	*487*	*486*	*536*	*489*	*498*
Non-Pay Expenditure													
Staff Related	223	276	279	284	276	282	284	276	279	279	276	276	3,292
Subsistence	343	200	115	115	115	115	115	115	115	115	115	115	1,693
Training	64	177	177	177	177	177	177	177	177	177	177	177	2,010
Medical Consumables & Equipment	450	349	349	349	349	349	349	349	349	349	349	349	4,286
Drugs	37	43	43	43	43	43	43	43	43	43	43	43	515
Fuel & Oil	415	429	429	441	431	425	445	441	461	442	410	442	5,212
Third Party Transport	213	63	66	72	63	69	72	63	66	66	63	63	938
Vehicle Costs	1,114	972	972	972	972	972	972	972	972	972	972	972	11,802
Accommodation & Estates	783	789	789	789	789	789	789	789	789	789	789	789	9,466
Telecommunications	558	549	549	531	531	531	493	493	493	493	493	493	6,207
Depreciation	597	652	652	652	652	652	652	652	652	652	652	652	7,764
Other Expenses	476	1,152	1,152	1,102	1,102	1,102	1,102	1,102	1,102	1,102	1,102	1,102	12,697
Profit/(Loss) on Disposal FA	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub Total	**5,273**	**5,650**	**5,572**	**5,527**	**5,500**	**5,505**	**5,493**	**5,472**	**5,498**	**5,478**	**5,440**	**5,473**	**65,881**
Average Daily	*176*	*182*	*186*	*178*	*177*	*184*	*177*	*182*	*177*	*177*	*194*	*177*	*180*
Financial Expenditure	**328**	**324**	**324**	**324**	**324**	**324**	**324**	**324**	**324**	**324**	**324**	**324**	**3,897**
Average Daily	*11*	*10*	*11*	*10*	*10*	*11*	*10*	*11*	*10*	*10*	*12*	*10*	*11*
Monthly Expenditure	**21,392**	**22,097**	**21,822**	**20,374**	**20,353**	**20,572**	**20,605**	**20,761**	**20,917**	**20,865**	**20,778**	**20,962**	**251,498**
Cumulative	**21,392**	**43,489**	**65,311**	**85,685**	**106,038**	**126,610**	**147,215**	**167,977**	**188,893**	**209,758**	**230,536**	**251,498**	
Monthly Net	**-306**	**-1,044**	**-769**	**679**	**700**	**481**	**448**	**292**	**136**	**188**	**275**	**91**	**1,171**
Cumulative Net	**-306**	**-1,350**	**-2,119**	**-1,440**	**-740**	**-259**	**189**	**480**	**617**	**805**	**1,080**	**1,171**	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
As at 30th April March 2008 (Month 1)

	MONTHLY SPEND														
	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**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**	**25,730**	**21,086**
Pay Expenditure															
A&E Operational Staff	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	8,677	9,087
Overtime	542	879	855	733	935	1,133	1,171	1,041	1,045	1,149	1,245	1,168	1,118	1,764	1,910
A&E Management	882	839	878	858	873	882	881	912	914	904	940	912	1,027	911	948
EOC Staff	871	703	859	908	900	921	899	936	920	909	985	954	953	946	977
PTS Operational Staff	547	393	550	570	529	547	128	457	465	442	487	462	466	459	450
PTS Management	84	73	81	70	86	80	94	86	80	87	87	85	84	88	81
Corporate Support	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	3,154	2,339
Sub Total	**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**	**15,999**	**15,791**
Average Daily	*416*	*425*	*434*	*432*	*449*	*442*	*457*	*438*	*440*	*470*	*488*	*467*	*495*	*516*	526
Non-Pay Expenditure															
Staff Related	293	169	245	206	191	217	189	205	213	198	189	271	231	386	223
Subsistence	0	0	53	194	125	159	173	150	175	182	188	244	190	209	343
Training	126	191	40	184	76	134	158	24	116	173	30	119	123	258	64
Drugs	0	0	20	34	25	36	37	19	46	55	36	22	46	1,814	450
Medical Consumables & Equipment	388	248	226	401	340	291	479	341	312	387	396	510	533	28	37
Fuel & Oil	298	318	296	317	313	324	319	301	342	373	405	406	391	417	415
Third Party Transport	37	73	29	51	49	77	113	55	94	92	84	133	161	173	213
Vehicle Costs	753	869	589	1,044	884	1,021	925	895	977	1,614	1,681	1,091	1,034	2,895	1,114
Accommodation & Estates	692	716	707	755	754	623	805	605	757	751	543	922	832	1,702	783
Telecommunications	477	606	354	426	340	619	407	576	201	489	516	477	677	2,134	558
Depreciation	478	484	484	494	489	496	510	523	579	534	542	524	524	706	597
Other Expenses	373	336	470	949	654	740	736	461	184	57	109	214	425	2,039	476
Profit/(Loss) on Disposal FA	0	10	0	2	17	0	1	0	0	2	0	0	0	29	0
Sub Total	**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**	**12,792**	**5,273**
Average Daily	*126*	*130*	*113*	*163*	*142*	*153*	*162*	*132*	*129*	*163*	*152*	*164*	*167*	*413*	176
Financial Expenditure	**322**	**273**	**320**	**298**	**279**	**294**	**292**	**292**	**295**	**249**	**244**	**260**	**246**	**170**	**328**
Average Daily	*10*	*9*	*10*	*10*	*9*	*9*	*10*	*9*	*10*	*8*	*8*	*9*	*8*	*5*	11
Monthly	**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**	**28,961**	**21,392**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 30 April 2008 (Month 1)

	Year to Date				Annual
	Actual	Budget	Variance	%	Budget
Income	20,367	20,343	24F	0.12%	244,116
Sector Services	13,819	13,065	(754)U	-5.77%	145,407
A&E Operational Support	1,114	1,017	(97)U	-9.52%	12,209
Control Services	1,501	1,578	77F	4.87%	17,988
Planning and Specialised Ops	185	368	183F	49.73%	4,391
Total Operations Cost	**16,620**	**16,028**	**(591)U**	**-3.69%**	**179,994**
A&E Gross Surplus/(Deficit)	**3,747**	**4,314**	**(567)U**	**-13.15%**	**64,122**
Gross Margin	20.0%	22.7%	(2.7%)U		27.8%
Medical Directorate	48	76	28F	36.99%	912
Service Development	63	62	(1)U	-1.21%	777
Communications	130	161	31F	19.39%	2,041
Human Resources	792	1,329	537F	40.42%	18,887
IM&T	875	996	120F	12.08%	11,614
Finance	1,923	2,302	379F	16.47%	27,678
Chief Executive	102	97	(5)U	-5.17%	1,161
Total Corporate	**3,933**	**5,024**	**1,090F**	**21.71%**	**63,071**
A&E Net Surplus/(Deficit)	**(186)**	**(709)**	**532F**	**74.97%**	**1,051**
A&E Net Margin	0.6%	(2.0%)	2.6%F		2.0%
Patient Transport Service	**(120)**	**6**	**(126)U**	**-2146.60%**	**89**
PTS Gross Margin	(16.7%)	0.8%	(17.7%)U		1.0%
Trust Result *Surplus/(Deficit)*	**(306)**	**(704)**	**406F**	**57.72%**	**1,140**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 30 April 2008 (Month 1)

	YEAR TO DATE				
	Actual	Budget	Variance	% Variance	Budget
A&E Income					
A&E Services Contract	18,089	18,139	(50)U	-0.3%	217,669
HEMS Funding	11	11	(0)U	-0.5%	128
Other A&E Income	88	91	(3)U	-3.1%	1,090
Foundation Trust Income	31	16	14F	89.3%	242
CBRN Income	899	897	1F	0.1%	10,769
ECP Income	31	13	18F	141.2%	153
BETS & SCBU Income	78	76	2F	2.6%	911
A & E Long Distance Journey	47	37	11F	29.7%	439
Stadia Attendance	46	89	(44)U	-48.7%	1,074
Heathrow BAA Contract	44	44	0F	0.0%	532
Education & Training Income	684	686	(2)U	-0.2%	8,231
	20,048	**20,099**	**(51)U**	**-0.3%**	**241,237**
PTS Income	718	710	8F	1.1%	8,471
Other Income	320	241	79F	32.7%	2,928
Trust Result	**21,086**	**21,050**	**35F**	**0.2%**	**252,637**

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 30 April 2008 (Month 1)

	YEAR TO DATE				*Annual*
	Actual	Budget	Variance	% Variance	Budget
Pay Expenditure					
A&E Operational Staff	9,087	9,085	(2)U	(0.0%)U	109,836
Overtime	1,910	1,686	(225)U	(13.3%)U	9,772
A&E Management	948	978	30F	3.1%F	11,738
EOC Staff	977	1,090	114F	10.4%F	13,084
PTS Operational Staff	450	434	(16)U	(3.6%)U	5,212
PTS Management	81	95	14F	14.7%F	1,140
Corporate Support	2,339	2,497	158F	6.3%F	30,281
	15,791	**15,865**	**74F**	**0.5%F**	**181,064**
Non-Pay Expenditure					
Staff Related	223	282	59F	21.0%F	3,351
Subsistence	343	115	(228)U	(198.0%)U	1,380
Training	64	177	112F	63.5%F	2,122
Drugs	37	43	6F	14.1%F	521
Medical Consumables & Equipment	450	349	(102)U	(29.2%)U	4,184
Fuel & Oil	415	419	4F	1.1%F	5,216
Third Party Transport	213	69	(144)U	(209.4%)U	793
Vehicle Costs	1,114	972	(142)U	(14.6%)U	11,660
Accommodation & Estates	783	789	7F	0.8%F	9,472
Telecommunications	558	549	(9)U	(1.6%)U	6,199
Depreciation	597	652	55F	8.4%F	7,819
Other Expenses	476	1,152	676F	58.7%F	13,823
Profit/(Loss) on Disposal FA	0	0	0F		0
	5,273	**5,568**	**295F**	**5.3%F**	**66,540**
Financial Expenditure	**328**	**324**	**(4)U**	**(1.1%)U**	**3,893**
Total Trust Expenditure	**21,392**	**21,757**	**365F**	**1.7%F**	**251,497**

LONDON AMBULANCE SERVICE NHS TRUST
Capital Programme 2008/09
Capital expenditure as at 30 April 2008

	Capital Budget 2008/09	Capital Forecast 2008/09	Variance	Comments
Estates - Maintenance	720	1,252	(532)	Re-allocation
Estates - Non Maintenance	2,208	1,676	532	Re-allocation
Disposals	(1,500)	(1,500)	0	Plans under review as part of Estates review
Vehicles	4,923	4,923	0	PTS Vehicle tendered. Mercedes chassis booked
Medical Equipment	2,733	2,733	0	Tender closed and currently under evaluation
Other	4,246	4,246	0	CAD 2010 tender closed and under review
Total	13,330	13,330	0	

LONDON AMBULANCE SERVICE NHS TRUST

Invest to Save 2007/08 Programme

1. Background

1.1. In October 2007, the London SHA indicated there may be non-recurrent funds available to NHS Trusts in London which could be used on an 'Invest to Save' basis. LAS developed the scope of the Invest to Save 2007/08 Programme, which was agreed on 28 November 2007. The LAS' Senior Management Group, acting as the 'sponsoring group' endorsed the scope of the programme at their 26 November 2007 meeting.

1.2. The SHA confirmed the funding of £8.3m on 2 December 2007. This revenue funding was to be spent during the financial year 2007/08. The agreed funding was made against a portfolio of projects to be delivered over the 16 week period of the programme. The SHA additionally agreed other projects may be added, if agreed; following a review of potential spend the initial list of projects. APPENDIX 1 reproduces the schedule of projects agreed by the SHA.

2. Programme Business Case

2.1. No specific business case was produced. However, the schedule agreed with the SHA, reproduced as APPENDIX 1, was used instead of a formal business case. The vision for the programme was stated as:

"This sixteen week programme will deliver better patient care by ensuring that invest to save initiatives contribute to patient experience and outcomes by supporting the front line, reducing operational and clinical risk and providing better integration with the whole system (LAS, NHS and London-wide services). This will be done by improving efficiency, quality/effectiveness and cycle time."

2.2. As each project was initiated the project brief identified the expected benefits. These were cross checked against APPENDIX 1. Therefore, the £8.3m allocated by the SHA was to produce a set of benefits, although these were not in a 'SMART' format.

3. Expenditure

3.1. 2007/08

3.1.1. At the end of 2007/08 financial year the amount spent on the programme was £7,455. This sum was broken down to £6,592k was charged against the revenue account and £863k was defined as capital expenditure. Therefore, against the

original revenue allocation (£8,290), there was a surplus of £1,698, which contributed to the Trust's overall surplus. The Trust separately identified other non-recurrent cost items to offset this underspend. Due to the timing of the ItS Programme, these expenses were managed within the existing financial analysis and reporting process. The capital sum reduced the potential underspend against the overall capital budget. The detailed expenditure analysis, by project can be found at APPENDIX 2.

3.2. **2008/09**

3.2.1. Projects started under the programme with an impact in 2008/09 amount to £801k. As part of the 2008/09 planning process, £500k was planned as a contingency. The balance will be covered from existing budgets.

4. Benefits Realisation

4.1. Benefits Realisation is currently underway on all projects. A full report will be presented to the Audit Committee in June. This report is planned to be audited by our Internal Auditors. The report will also be presented to the SDC in June.

M. Dinan
Director of Finance
15 May, 2008

Appendix 1

Programme Summary

Programme Summary

#	PM	Programme	Description	Benefits	Base Cost £k	Prob	Adj Cost £k	Inv Req
OS		**Operational Support**						
OS1	?	Hospital Turnaround	Project team to proactively manage Acute handover	Reduced job cycle time, improved ambulance avialability	634	86.1%	546	Jan-08
OS2	JH	Urgent Care Support	Alternative Response Vehicles, St John Ambulance, Red Cross	Reduce CatC workload for CatA/CatB staff	1,200	90.3%	1,083	Jan-08
OS3	CV	Logistics/Fleet	Mobile Mechanics, longer opening hours	Increased Vehicle availability	918	94.4%	866	Jan-08
OS4	AO	IM&T Resilience	Additional Ctak Resource, Improved Local Mgt Info	Increased CAD resilience	760	89.2%	677	Jan-08
OS5	GH	Winter Pressures	Additional cover over Wmas period	Limitseasonal operating risk	900	100.0%	900	Jan-08
		Subtotal			4,412	92.3%	4,072	
IO		**Improved Outcomes**						
IO1	AB	Pathway Management	Procure & implement eCMS (Pathway Mgt software)	Reduce A&E attendances	300	81.5%	245	Jan-08
IO2	CHS	Community Defbrillation	Procure and rollout additional community defibrillators	Improve cardiac survival rate	596	55.2%	329	Jan-08
IO3	BON	Training	Rollout more local, complex based training	Better trained staff	860	77.3%	665	Jan-08
IO4	MS	Other	Patient Property bags, additional paedeatric & clinical equip	Reduce PALs queries. Reduce clinical risk	450	87.5%	394	Jan-08
		Subtotal			2,206	74.0%	1,632	
AS		**Accelerated Spend**						
AS1	CV	Vehicle Procurement	MRU/CRU/FRU additional vehicles & equip	Improved CatA response	914	67.6%	618	Feb-08
AS2	MN	Estates	Maintenance backlog	Improved working condtions, reduced reactive maintenance	422	88.7%	374	Jan-08
AS3	JD	IM&T	Implement wireless Lan, additional IT security	Improved IT resilience	274	90.0%	247	Jan-08
AS4	MS	Supply Chain & Procurement	Accelerate top 100 supplier analysis, rollout asset tracking & inventory managemer	Increased Non Pay cost reduction & improved quality, reduced clinical risk	244	83.2%	203	Jan-08
AS5	MS	Staff Admin	Rollout Staff admin project	Improved CIP 0809	219	86.5%	189	Dec-08
AS6	JW/VC	Finance & Governance	PbR & Strategic Planning Model, Governance web based software	FT preparation	331	90.0%	298	Dec-08
		Subtotal			2,404	80.3%	1,929	
O		**Other**						
O1	AB	Communications	FT Membership analysis, revamp website	FT preparation	315	85.2%	269	Jan-08
O2	MJ	Accounting	Balance Sheet review - Ctak Investment	Reduce LT Capital Employed	200	90.0%	180	Jan-08
O3	MS	Programme Mgt	Manage ItS programme	Deliver Non Recurrent projects	258	81.3%	210	Dec-08
		Subtotal			773	85.1%	658	
		Total			9,795	84.7%	8,292	

Appendix 2

Project Expenditure Summary

Project Group	Cost Centre	Original Budget (£000s)	2007/08 Revenue Spend	2007/08 Capital Spend	Total 2007/08 Spend	Forecast 2008/09 Revenue	Forecast 2008/09 Capital	Total Forecast Spend
Operational Support								
CTAK Support Specialist	60198	0	17	0	17	(0)	0	**17**
Service Desk Support	60199	0	75	0	75	0	0	**75**
SharePoint + IM&T (Intelligent Trust)	60191	790	798	64	862	14	50	**926**
ITIL Configuration Manager	60170	43	195	0	195	2	0	**197**
Customer Services Manager	60200	0	19	0	19	0	0	**19**
IM&T Equipment	60201	0	265	139	404	22	18	**444**
Internet Development	60203	0	8	0	8	0	0	**8**
Systems Implementation Specialists	60205	0	20	0	20	0	0	**20**
Web developer (High Risk Register)	60166	43	18	0	18	12	0	**30**
Data Security, Encryption & laptop replacement	60169	43	33	0	33	0	0	**33**
ITIL Manager Training	60206	0	17	0	17	0	0	**17**
Alternative Response Vehicles	60194	360	66	0	66	0	0	**66**
Logistics/Fleet	60148	866	621	0	621	3	0	**624**
Business Case Production	60176	40	76	0	76	11	0	**87**
ORH (EOC) Call-Taking Review	60168	27	12	0	12	0	0	**12**
Total Operational Support		**2,212**	**2,239**	**203**	**2,442**	**64**	**68**	**2,574**
Improved Outcomes								
Public Information Campaign	60173	45	75	0	75	0		**75**
Community Defibrillation (First Responders)	60152	329	50	0	50	50		**100**
Clinical Training	60153	271	72	0	72	135		**208**
Blended Learning (formerly e-Training)	60193	394	51	0	51	0	0	**51**
Patient Property bags	60154	56	8	0	8	0		**8**
Paediatric Equipment	60156	90	106	0	106	0		**106**
Additional CRB checks	60158	68	0	0	0	33		**33**
Enhancing Audit Processes	60195	0	26	0	26	0		**26**
Total Improved Outcomes		**1,253**	**389**	**0**	**389**	**218**	**0**	**608**
Accelerated Spend								
Vehicle Procurement	60159	309	547	0	547	180		**727**
Incident Data Recorder	60160	125	24	0	24	0		**24**
Real Time Fleet Information	60162	145	0	0	0	0	145	**145**
Maintenance backlog (Estates)	60163	315	685	0	685	0		**685**
Strategic Plan support (Estates Strategy)	60164	32	0	0	0	0		**0**
Heat Integration	60165	27	0	54	54	0	5	**59**
N/W Monitoring	60208	0	6	0	6	0		**6**

Project Group	Cost Centre	Original Budget (£000s)	2007/08 Revenue Spend	2007/08 Capital Spend	Total 2007/08 Spend	Forecast 2008/09 Revenue	Forecast 2008/09 Capital	Total Forecast Spend
Wireless Access LAN	60167	90	321	541	862	139	0	**1,000**
Procurement Software	60171	23	97	0	97	0		**97**
Inventory Management	60175	83	96	11	107	37	5	**149**
Staff Administration	60177	189	154	0	154	0		**154**
PbR model	60178	32	101	0	101	0		**101**
Strategic Planning Model	60179	72	84	0	84	0		**84**
Governance Support	60180	24	9	0	9	2		**11**
Performance Measurement	60181	72	105	0	105	0		**105**
Counter Fraud Support	60182	32	16	0	16	0		**16**
Business Continuity Support	60183	32	0	0	0	0		**0**
Asset Tracking	80345	0	0	19	19	0		**19**
Total Accelerated Spend		**1,602**	**2,245**	**625**	**2,870**	**357**	**155**	**3,381**
Other								
Communications Support	60185	45	37	10	47	0		**47**
Recruitment Advertising	60186	59	3	0	3	0		**3**
New Internet	60188	75	18	0	18	92		**109**
Migration to IFRS	60189	180	16	0	16	36		**52**
Programme Management	60190	97	125	0	125	0		**125**
Museum Audit/Evaluation	60209	0	13	0	13	0		**13**
Capitalisation Review (Rev to Cap)	60196	0	9	0	9	0		**9**
Benefits Realisation Consultancy	60211	0	12	0	12	0		**12**
Cards for ACM EOC Switch	60213	0	187	0	187	0		**187**
Process Central	60197	0	4	25	29	0		**29**
Laptops for Training	60214	0	0	0	0	0		**0**
EIA & PPI Stakeholder Events	60216	0	45	0	45	0		**45**
Total Other Projects		**456**	**470**	**35**	**505**	**128**	**0**	**633**
Further Projects								
Plasma Screens	60233	0	18	0	18	0	0	**18**
Process Improvement Training	60231	0	14	0	14	0	0	**14**
Rules of the Road	60219	0	0	0	0	15	0	**15**
Finance Processes Review - Consultant Business analyst	60220	0	26	0	26	0	0	**26**
Cashflow Forecaster	60228	0	45	0	45	5	0	**50**
PTS Strategic Overview	60236	0	95	0	95	0	0	**95**
Asset Register systems review	60240	0	8	0	8	8	0	**15**
Total Further Projects		**0**	**206**	**0**	**206**	**27**	**0**	**233**
Closed projects								
Pathway Management	60151	200	0	0	0	0	0	**0**
Capacity Management System	60184	32	0	0	0	0	0	**0**

Project Group	Cost Centre	Original Budget (£000s)	2007/08 Revenue Spend	2007/08 Capital Spend	Total 2007/08 Spend	Forecast 2008/09 Revenue	Forecast 2008/09 Capital	Total Forecast Spend
Winter pressures	60150	900	964	0	964	0	0	**964**
Hospital Turnaround	60146	546	0	0	0	0	0	**0**
Urgent Care Support	60147	723	0	0	0	0	0	**0**
Procurement Support	60172	64	0	0	0	0	0	**0**
Supplier Info Database - Phase 2	60174	32	0	0	0	0	0	**0**
Buckhurst Hill (Business Case)	60234	0	34	0	34	0	0	**34**
Driver Licence Checks	60155	90	0	0	0	0	0	**0**
Psychometric Testing	60157	90	46	0	46	7	0	**52**
FT membership preparation	60187	90	0	0	0	0	0	**0**
Total Closed Projects		**2,767**	**1,043**	**0**	**1,043**	**7**	**0**	**1,050**
Totals		**8,290**	**6,592**	**863**	**7,455**	**801**	**223**	**8,479**

London Ambulance Service
NHS Trust

Obstetric Emergencies

Themed Section of the Risk Information Report

Clinical Governance [13.08.07]

OBSTETRIC EMERGENCIES
RISK INFORMATION REPORT

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1. COMPLAINTS

Obstetric Complaints 2001 to 2007

The number of complaints received by the Service relating to Obstetric issues is recorded as:

2001 - 8
2002 - 8
2003 - 8
2004 - 7
2005 - 8
2006 - 13
2007 - 14 (to current date)

The number of complaints relating to Obstetric cases should be considered against the number of such cases that are handled by the LAS each year as follows:

2001 - 20560
2002 - 20649
2003 - 21506
2004 - 22042
2005 - 20670
2006 - 20145
2007 - 10664 (up to the end of June07)

2001
Of the eight complaints recorded, 3 babies died, 1 baby suffered from brain damage, 1 baby was premature, 1 case involved Placenta Abrupta, 2 babies were born before arrival and there were 2 instances of a delayed response. In 2 cases, the mother was not taken to the hospital of choice, 2 complaints were related to walking the patient and there were 2 cases where the attitude or comments of the crew were the subject of complaint.

2002
Of the eight complaints recorded, 2 babies died, one case related to Placenta Abrupta, 2 complaints were made relating to treatment or the lack or treatment and 3 complaints related to walking the patient. ! mother was not taken to the hospital of choice, 1 patient was not conveyed and 4 complaints related to the attitude or comments of the ambulance crew.

2003
Of the eight complaints recorded, 2 babies died, 2 babies were born before arrival and 3 complaints were made relating to treatment or the lack of treatment. 1 cases related to the walking of the patient, 2 related to a delayed response, 2 complaints related to the attitude or comments of the crew and in 1 case the patient was taken to A&E instead of Maternity.

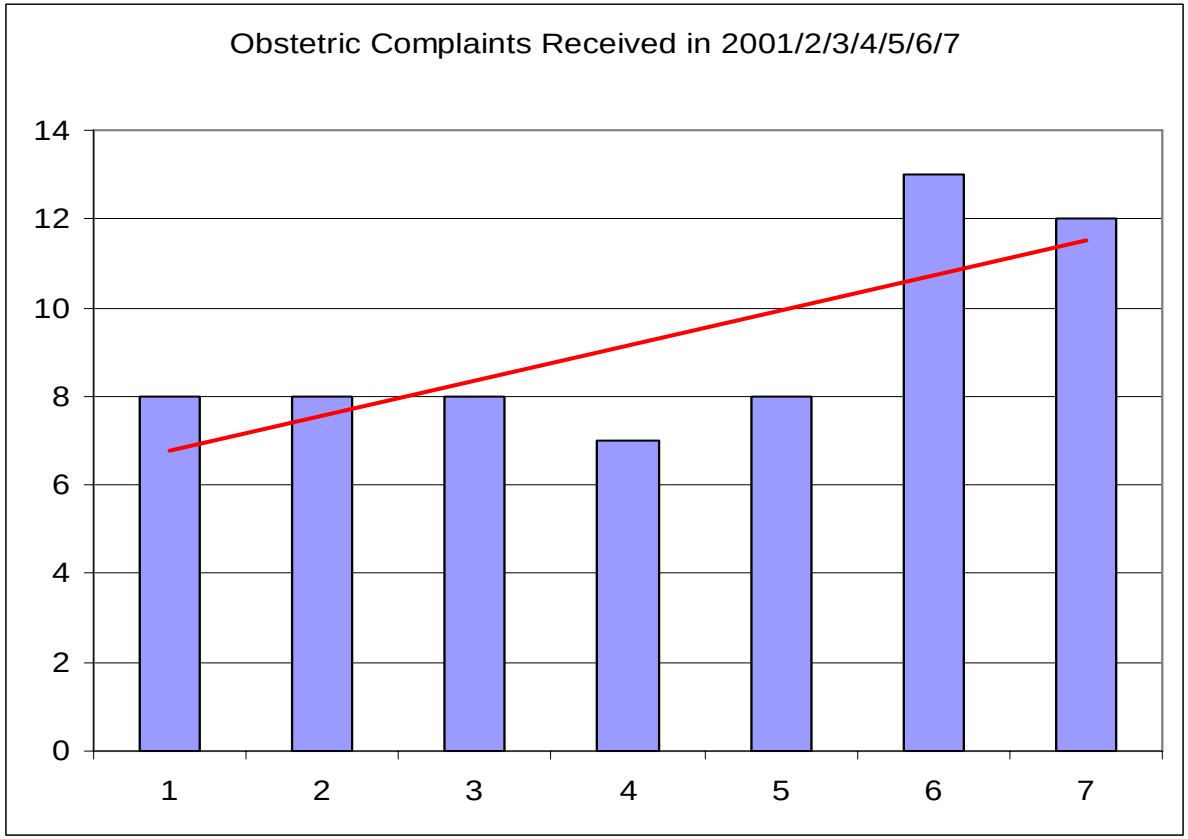
2004
Seven complaints are recorded for this year. 1 baby died and one was premature. 3 complaints were made relating to treatment or the lack of treatment and 4 complaints were made relating to the attitude or comments of the crew.

2005
Eight complaints are recorded for this year. 3 babies died. 2 patients were not conveyed, there was 1 delayed response and 6 complaints relating to the attitude or comments of the crew.

2006
13 complaints were recorded in 2006. Of these, the baby died in 3 cases and there was 1 case of Placenta Abrupta. 6 complaints related to treatment or the lack of treatment, 1 case related to walking the patient. 2 caes related to delayed responses and 1 related to non conveyance. A total of 8 complaints related to the attitude or comments of the crew. 1 complaint related to the baby not being secured in the ambulance.

2007
12 complaints had been recorded up to the time of this report. Of these the baby died in 4 cases and in 2 cases the baby was born before arrival. 4 complaints related to treatment or the lack of treatment, 1 case related to walking the patient, there were 7 delayed responses and 2 cases of non conveyance. 5 complaints related to the attitude or comments of the crew.

Analysis of Obstetric Complaints Received from 2001 to 2007



Ref	First received	Closed	Details
0012/01/smc	05-Jan-2001	19-Feb-2001	Family unhappy with the way her baby was managed by the crew, believe that the baby suffering brain damage and this was related to the way the crew handled her child.
0077/01/jn	12-Feb-2001	14-Mar-2001	Patient was made to walk down 3 flights of stairs, wasn't helped and fell. Crew did not report this to the hospital staff - patient also pregnant
0229/01	25-Apr-2001	25-May-2001	Patient 38 weeks pregnant, called for an ambulance. Was asked if she could make her own way. Ambulance sent - crew assumed pains were normal labour pains but were in fact due to placenta separating. Baby died.
0342/01/jn	12-Jul-01	24-Oct-01	Complainant gave birth to premature baby, an ambulance was delayed in responding to her '999' call and baby later died.
0424/01/jn	24-Aug-01	25-Sep-01	Patient delivered baby whilst waiting for ambulance and then three arrived in one go, could have been complications in the birth.
0511/01/jn	17-Oct-2001	15-Nov-2001	Complainant unhappy with the attitude of the crew that was called to her pregnant friend. They apparently told her that it was a waste of her time.
0562/01/smc	13-Nov-2001	18-Dec-2001	Crew refused to take a pregnant woman to the hospital she requested then discussed the patient with one of her neighbours.
0591/01/jn	28-Nov-2001	21-Mar-2002	Delayed response of an emergency ambulance, then crew took her to the wrong hospital, delivered a stillborn baby by c section

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2001	**1**	1	1												
	2			1	1										
	3					1	1								
	4						1	1	1	1					
	5								1	1					
	6										1				
	7										1	1			
	8						1		1			1			
Total		**1**	**1**	**1**	**1**	**1**	**3**	**1**	**3**	**2**	**2**	**2**	**0**	**0**	**0**

Ref	First received	Closed	Details
0014/02/jn	09-Jan-2002	12-Jun-2002	Pt states baby's head must have been showing at her home, ambulance crew made her walk - no examination was carried out by the ambulance crew that attended to her.
0022/02/smc	14-Jan-2002	26-Feb-2002	Pt pregnant and was worried that she was going to lose her baby. Female member of the crew was rude and told her if her husband was following in the car he should have driven her to the hospital and not called an ambulance.
0040/02/smc	23-Jan-2002	11-Mar-2002	Pt pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
0078/02/smc	07-Feb-2002	03-Apr-2002	Patient fell, (pregnant) crew did not convey
0129/02/jn	11-Mar-2002	28-Oct-2002	Patient believes that the crew did not treat her situation as an emergency. Lady was pregnant and was experiencing continuous abdominal pain. Subsequently had a stillbirth.
0126/02/smc	11-Mar-2002	16-Apr-2002	Pregnant patient booked into St Thomas taken to Kings and left in the A&E.
0268/02/smc	02-Jul-2002	02-Oct-2002	Pt 35 wks pregnant with severe stomach pains. Crew failed to recognise obstetric emergency. Walked pt to ambulance and drove with no urgency. Pt suffered a placental abruption. Delivered stillborn baby girl few hours later

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2002	**1**										1				
	2	1		1											
	3										1				
	4										1				
	5				1								1		
	6	1					1				1				
	7											1			
	8			1		1	1								
Total		**2**	**0**	**2**	**1**	**1**	**2**	**0**	**0**	**0**	**4**	**1**	**1**	**0**	**0**

Ref	First received	Closed	Details
0343/03/jn	05-Aug-2003	17-Oct-2003	Crew took pregnant woman with PV bleed to A&E instead of delivery suite.
0377/03/smc	27-Aug-2003	22-Sep-2003	Crew called to BBA breech birth, cut cord, baby died. Complainant unhappy with treatment provided
0412/03/smc	19-Sep-2003	23-Sep-2003	Patient needed to be transferred from the Birth Centre urgently due to the baby's condition. EMD's did not seem to understand this until the patient started bleeding and the foetal heart was lost.
0456/03/jn	17-Oct-2003	05-Nov-2003	Delayed ambulance response to pregnant woman who had collapsed.
0467/03/jn	23-Oct-2003	19-Feb-2004	Called an ambulance for patient who is 16 weeks pregnant and had fallen, waited an hour and twenty five minutes before an ambulance arrived.
0472/03/smc	24-Oct-2003	30-Oct-2003	concerns raised by the hospital about a BBA,
0537/03/smc	19-Dec-2003	29-Jan-2004	Crew were rude and pushed a 6 month pregnant lady out of the way

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2003	**1**				1						1				
	2													1	
	3	1					1			1					
	4	1					1								
	5								1						
	6								1						
	7	1								1					
	8										1				
Total		**3**	**0**	**0**	**1**	**0**	**2**	**0**	**2**	**2**	**2**	**0**	**0**	**1**	**0**

Ref	First received	Closed	Details
0087/04/smc	04-Mar-2004	12-Mar-2004	Complainant unhappy with the crews attitude toward them being called out to his pregnant wife who had high blood pressure. Wife had a premature birth.
0120/04/ab/pt	24-Mar-2004	24-Mar-2004	Parents concerns about the treatment offered to new born baby. Baby subsequently passed away.
0241/04/jn	23-Jun-2004	09-Aug-2004	Maternity emergency: crew clamped and cut cord, moved patient with placenta in situ, didn't wait for midwife. Baby cold on arrival but now ok.
0342/04/jn	24-Sep-2004	12-Nov-2004	Patient unhappy with crews attitude following her calling them out to her when she was vomiting, had severe back ache and was pregnant and concerned for her unborn child. Patient kept in hospital for 3 days and given morphine to control the pain she was in
0395/04/jn	02-Nov-2004	29-Nov-2004	RTA involving complainants daughter and son in law, daughter is pregnant - crew were very uncaring in their attitude and caused friction on scene and tried to blame the complainant for the patients high blood pressure.
0435/04/smc	07-Dec-2004	14-Dec-2004	QEH not happy that patient was brought to their hospital, when she was in fact booked into Lewisham and QMS was nearer if the patient had complications. Maternity unit was stretched to cope.

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2004	**1**										1				
	2							1			1				
	3	1					1								
	4	1													
	5	1									1				
	6										1				
	7											1			
Total		**3**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**4**	**1**	**0**	**0**	**0**

Ref	First received	Closed	Details
0048/05/smc	10-Feb-2005	25-Feb-2005	Patient is 38 weeks pregnant, told by hospital to call for an ambulance as she had belly pains. Female crew arrived and were very rude with their comments and made her feel like she was wasting their time and abusing the service.
0078/05/jn	04-Mar-2005	15-Mar-2005	Patient is 10 weeks pregnant and had PV bleed, person at train station called for an ambulance and was told by the crew that she should have called a taxi and were very off with the patient.
0092/05/jn	10-Mar-2005	26-Jul-2005	Patient was in extensive labour pains, crew arrived and took her to one hospital and kept her waiting in the ambulance for 10 minutes, then came out and said the hospital didn't have a bed. Crew then had to convey her to another hospital and she was bleeding severely, at hospital found that the baby had no heartbeat. Family unhappy that crew didn't do more
0319/05/jn	26-Aug-2005	26-Aug-2005	Delivery Suite at Hospital state that the baby was stillborn and crew rushed the baby to hospital leaving the mother at home with the placenta in situ. Hospital unsure if mother was left on her own or if there was another crew present.
0359/05/jn	25-Sep-05	20-Jan-06	Pt in labour, crew arrived and state that partner was assaulting patient. Police took partner away, patient not conveyed ? refused. Mother in law attended and called ambulance, this crew conveyed the baby and then another ambulance came to take the patient.
0465/05/jn	01-Dec-2005	12-Dec-2005	Wife pregnant, crew arrived but were delayed as couldn't find the address. Complainant feels this is because they used there SAT NAV system. En-route to the hospital crew went a long way to the hospital and complainant states that they again used the SAT NAV.
0478/05/smc	08-Dec-2005	12-Dec-2005	Partner unhappy with the behaviour of the ambulance man that attended to his wife. Wife is 16 weeks pregnant and woke up in pain in the abdominal area. Ambulance man launched into a series of questions and gave no assistance to his wife in getting down the stairs.

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2005	**1**						1						1		
	2										1				
	3										1				
	4						1				1				
	5						1								
	6										1		1		
	7								1		1				
	8			1							1				
Total		**0**	**0**	**1**	**0**	**0**	**3**	**0**	**1**	**0**	**6**	**0**	**2**	**0**	**0**

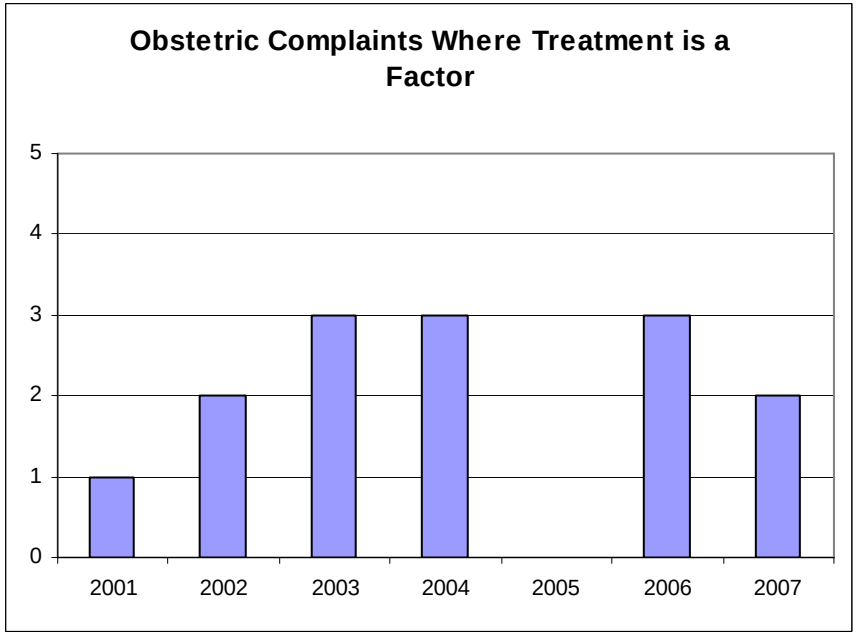
Ref	First received	Closed	Details
0010/06/jn	09-Jan-2006	30-Jan-2006	Patient pregnant, had pains and an ambulance was called on the advice of the GP. Crew arrived and stated that they should not have called for an ambulance and said that there were people more serious. When told called on advice of GP crew replied that the GP was wrong in his advice.
0037/06/SMC	23-Jan-2006	17-Feb-2006	Complaint against treatment and attitude of crew, patient was 3 months pregnant, and following events lost her baby.
0076/06/jn	13-Feb-2006	12-Jul-2006	Patient delivered baby at birth centre but on monitoring her blood pressure dropped significantly and her pulse became raised. Ambulance crew were called but staff are concerned regarding the treatment the crew offered, Paramedic would not cannulate and crew complained about having to carry patient down the stairs. Patient fitted several times and staff state she was not strapped in.
0102/06/smc	03-Mar-2006	23-Mar-2006	Newborn baby needed to be conveyed from Harold Wood Hospital to The Royal London Hospital, baby conveyed in arms throughout journey - no appropriate means of securing baby in vehicle.
0181/06/smc	27-Apr-2006	23-May-2006	Patient had a miscarriage. Crew who arrived said they could not touch or deal properly with the umbilical cord and that she would have to wait for one of their female colleagues to be present. Also stated is that the baby was put into a rubbish bag and placed near a heater inside the ambulance. In the journey to hospital the patient and partner smelt burning.
0185/06/smc	03-May-2006	06-Jun-2006	Patient is pregnant, was experiencing abdominal pain. Ambulance was called and chased up by patient who was at home on her own. Husband was working in Bristol and travelled home to her. He got home before an ambulance and conveyed his wife to the hospital.
0249/06/ch	21-Jun-2006	27-Jun-2006	Pt pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
0357/06/JN	24-Aug-2006	09-May-2007	Complainant's wife 8 months pregnant and started bleeding very heavily. Ambulance arrived but first thing crew asked was 'Is it domestic violence?' then called the police and refused to treat patient. Husband had to take wife the stairs himself - crew did not examine or treat patient until police arrived. Complainant arrested by police due to allegations of domestic violence made by the crew - allegations false! Complainant released by police. Complainant very distressed due to the whole situation.
0428/06/SMC	16-Oct-2006	16-Nov-2006	Ambulance crew who dropped off pt at a Brent Birth Centre did not give a hand over of her condition. They also seemed in a hurry to leave. The crew left before the pt was checked over to see if it was safe for her to have her baby delivered there. Due to complications another ambulance had to be called to take the pt to Northwick Park Hospital.
0476/06/jn	20-Nov-06	Open	Patient went into hospital, was given medication and sent home, hospital then contacted and said she needed to return urgently. LAS crew arrived and were stand offish with patient and questioned her about her having no money for a cab but that she is having a baby. Crew also would not convey to the hospital where she was being treated and in the ambulance patient only had a seat belt put on her when the ambulance went over a bump and the patient lifted out of her chair. Patient not sure if this was all because she is a young, black lady.
0492/06/ch	28-Nov-2006	09-Mar-2007	Woman pregnant with twins, in labour. Delay (30-45 mins) for ambulance, crew members offered no first aid assistance, crew members did not examine patient. On arrival at the hospital discovered that babies were dead.
0538/06/jn	21-Dec-2006	04-Apr-2007	Patient in early stages of pregnancy crew offered no assistance to the patient just put the steps down and told her to sit down. At hospital they just opened the door and directed patient to get out at A&E. There were Police at the hospital who ended up helping the patient.

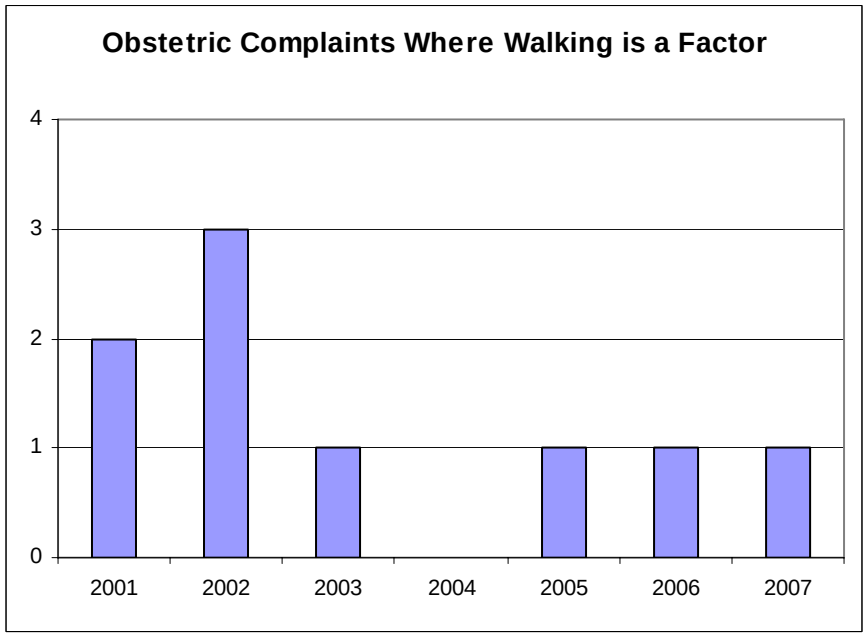
Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2006	**1**	1		1		1	1								
	2										1				
	3	1					1				1				
	4	1									1				
	5														1
	6						1				1				
	7								1				1		
	8										1				
	9	1									1				
	10										1				
	11										1	1			
	12	1					1		1						
	13	1		1										1	
Total		**3**	**0**	**1**	**0**	**1**	**3**	**0**	**1**	**0**	**8**	**0**	**1**	**0**	**1**

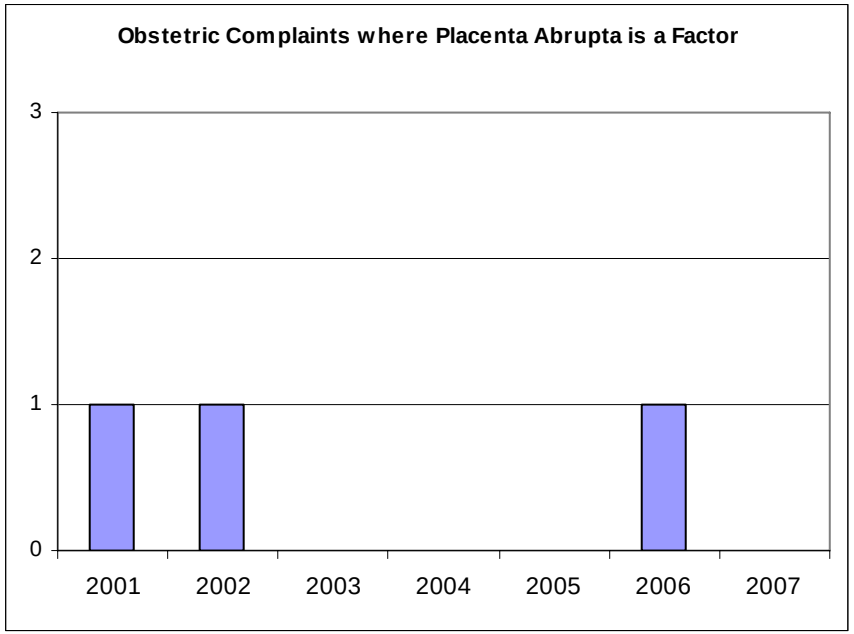
Ref	First received	Closed	Details
0053/07/CH	05-Feb-2007	15-Mar-2007	Pt fell off stool, 3 1/2 months pregnant. Was told ambulance was on the way. 12:30 ambulance service called back informing of delay with ambulance. 12:45 complainant rang ambulance service for update, still no ambulances available. 13:00 Pt's sister arrived and decided to convey Pt personally, so rang ambulance and cancelled. Pt has since lost baby.
0066/07/ch	12-Feb-2007	15-Mar-2007	Patient involved in an RTC, is 7 months pregnant and had to wait 55 minutes for an ambulance to arrive. Ambulances kept passing them, so they flagged one down in the end, told that the ambulance was told to take it's rest break when it could have been dispatched to attend them.
0106/07/dm	05-Mar-2007	02-Apr-2007	Patient complained to hospital, also mentions in letter that the crew when they arrived were very distant and cold in their behaviour toward her. She asked them for a chair but they told her she could walk. Patient pregnant and waters had broken.
0112/07/ch	06-Mar-2007	03-Apr-2007	Husband complaining that an ambulance was not available to send to him when his wife had back pain when she was 4 months pregnant.
0125/07/jn	15-Mar-2007		Patient 24 weeks pregnant, waters broke and she was bleeding. Crew told her they were not a taxi service and that she should have paid for a cab. Patient lost her baby.
0163/07/JH	30-Mar-2007	03-May-2007	Delay in ambulance arriving. Patient in labour and delivered baby at home whilst waiting for ambulance. Crew did not seem to know much about what to do. Complainant unhappy with delay and that treatment wasn't very good.
0170/07/dm	05-Apr-2007	30-May-2007	Patient about 4 weeks pregnant, was at work and then got stomach pains and collapsed. Crew arrived and were rude and unsympathetic. Crew gave no assistance to the patient and when she was sick said 'oh another van to clean'. Patient feels the crew showed no interest and felt that she was exaggerating. Patient lost the baby.
0182/07/jh	16-Apr-2007	18-May-2007	Patient complained to hospital and also mentions LAS delay. Patient taken in twice, first time was fine but second time patient states there was a delay. Patient was having a miscarriage and had to undergo an emergency operation.
0205/07/smc	01-May-2007	29-May-2007	Patient in third trimester of pregnancy, she became unwell on train and collapsed to the floor and was unconscious for 10 minutes. Crew did ob's and she was given a sugary drink. Patient not given choice to go to hospital and husband who is a Dr is concerned with what the crew have recorded on the PRF and still they did not convey her.
0244/07/jh	24-May-2007		Hospital looking into clinical incident re patient being brought in, the Consultant Gynaecologist is concerned that the patient who was known to be pregnant but with an empty uterus (therefore an ectopic until proved otherwise) Waited an hour for an ambulance when she developed abdominal pain.

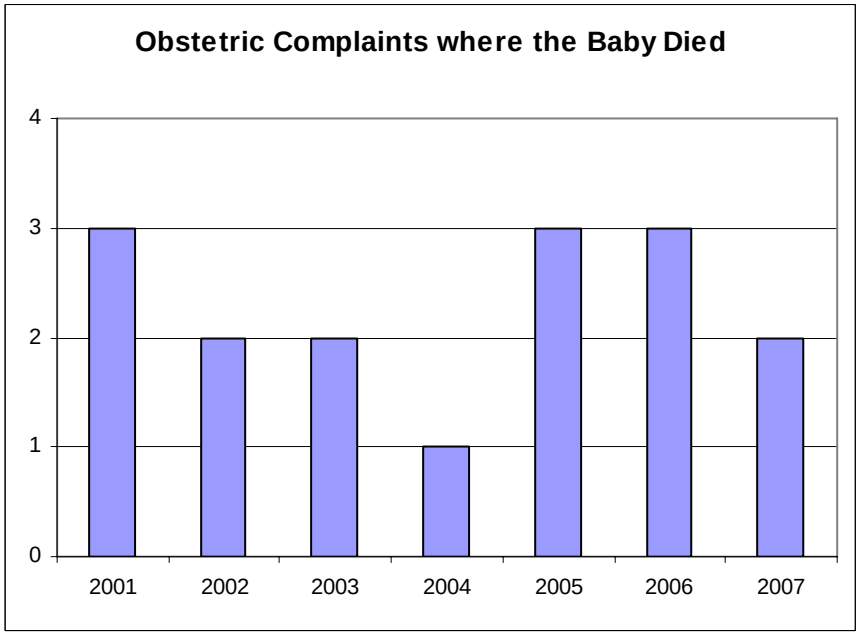
Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2007	**1**	1							1	1					
	2								1						
	3						1		1						
	4								1		1				
	5			1							1				
	6										1		1		
	7						1				1				
	8	1							1	1					
	9	1					1				1				
	10						1		1						
	11	1											1		
	12								1						
Total		**2**	**0**	**1**	**0**	**0**	**2**	**0**	**5**	**2**	**5**	**0**	**1**	**0**	**0**

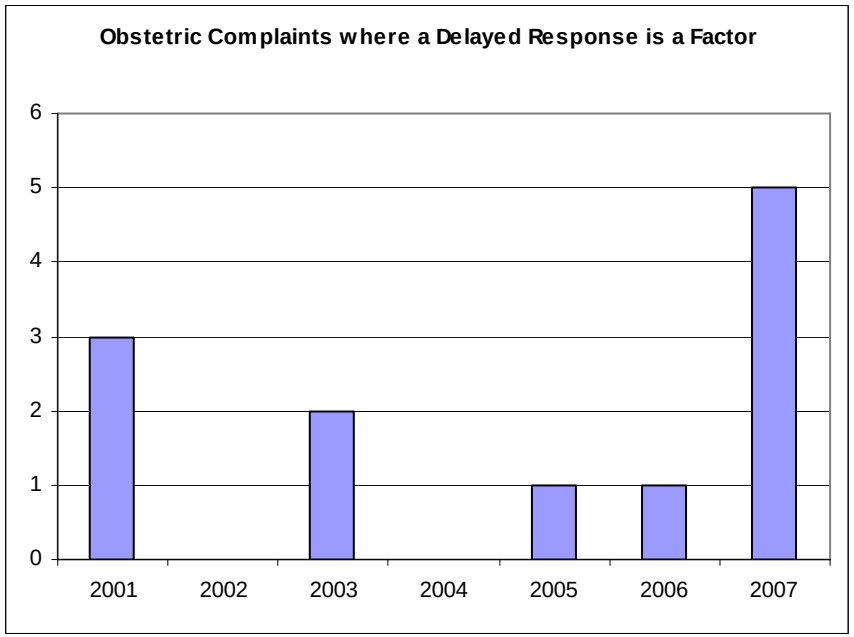
	Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2001	1	1	2	1	1	3	1	3	2	2	2	0	0	0
2002	2	0	3	1	1	2	0	0	0	4	1	1	0	0
2003	3	0	1	1	0	2	0	2	2	2	0	0	1	0
2004	3	0	0	0	0	1	1	0	0	4	1	0	0	0
2005	0	0	1	0	0	3	0	1	0	6	0	2	0	0
2006	3	0	1	0	1	3	0	1	0	8	0	1	0	1
2007	2	0	1	0	0	2	0	5	2	5	0	1	0	0
Totals	**14**	**1**	**9**	**3**	**3**	**16**	**2**	**12**	**6**	**31**	**4**	**5**	**1**	**1**

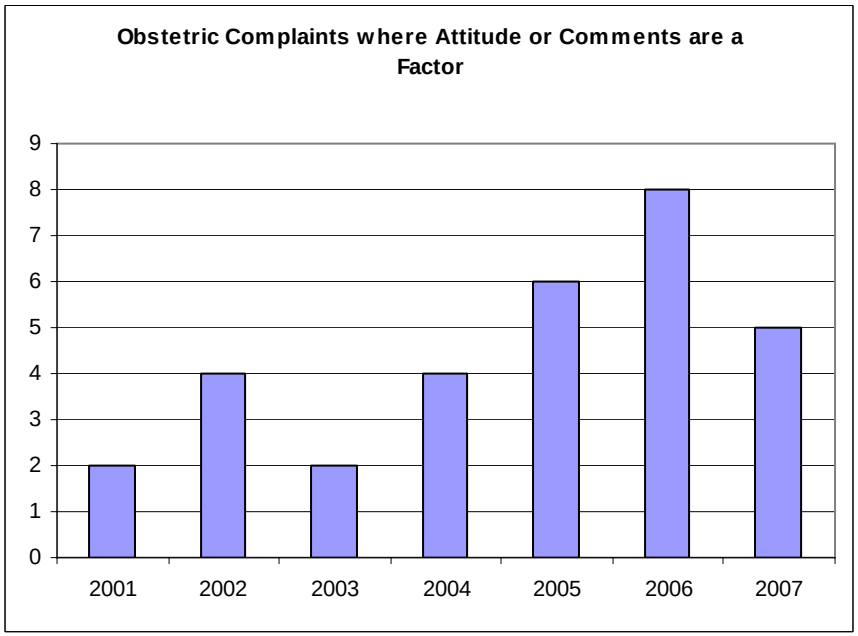

Obstetric Complaints Where Treatment is a Factor
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

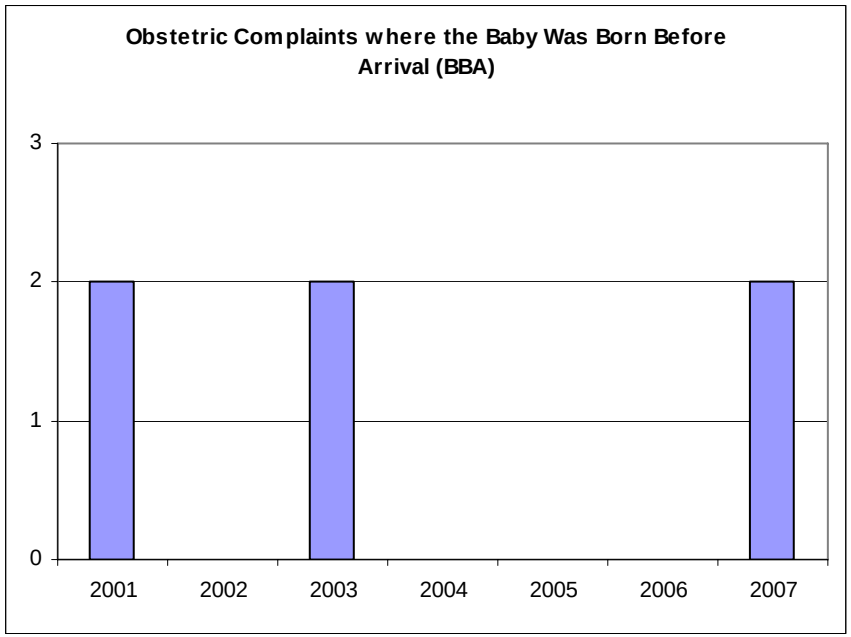

Obstetric Complaints Where Walking is a Factor
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

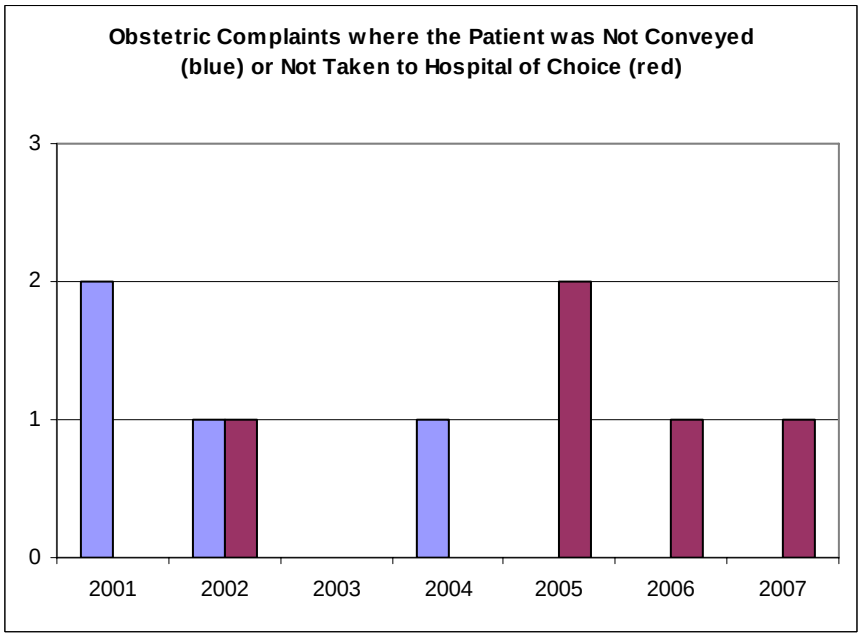

Obstetric Complaints where Placenta Abrupta is a Factor
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Baby Died
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where a Delayed Response is a Factor
6
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where Attitude or Comments are a Factor
9
8
7
6
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Baby Was Born Before Arrival (BBA)
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Patient was Not Conveyed (blue) or Not Taken to Hospital of Choice (red)
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

2. OBSTETRIC INCIDENTS AND CLAIMS

2.1 Introduction

This section provides an analysis of the obstetric incidents and claims notified to the LAS and recorded on Datix.

All of the cases have been reported to the Clinical Risk Group and Risk Management Group, or Clinical Governance Committee.

Many of the files have been destroyed because limitation has been reached and / or the claim has been closed. The date of incident on four cases predated the LAS becoming a Trust (on 1 April 1996). Where the files have been destroyed the information in this report is taken from Datix alone.

2.2 Themes

Appendix 1 provides details of all of the obstetric incidents and claims recorded. Datix has been upgraded over time and some of the data recorded now was not entered and documents were not attached electronically to provide a case history.

2.3 Investigations

The investigations of claims and potential claims are governed by the Claims Policy and Procedure. It has been a requirement of the NHS Litigation Authority that Trusts follow the rules of the indemnity schemes and compliance has been tested in the Risk Management Standards assessments. The current Claims Policy and Procedure states that The Medical Director has a key role in determining the extent to which LAS employees may have caused or contributed to a particular injury or loss to enable the claim to be managed in accordance with the civil litigation rules and NHS Litigation Authority's CNST Reporting Guidelines. In addition the Head of Education and Development provides an assessment of the care and assistance provided by staff and whether this was in accordance with the Trust's protocols, procedures, training, or with National Clinical Guidelines and whether or not the care provided fell below an acceptable standard leading to the allegations made.

In the cases that proceeded to litigation or an indication was given that was given that litigation may occur and satisfied the claim reporting criteria of the NHS Litigation Authority the opinions of the Medical Director and Head of Education and Development were sought.

I have reviewed the files held in store that have been closed and ascertained that :

LC734

The first notification about the call came as a solicitor enquiry in July 1999. There was no prior record of a complaint or LA52 report. A microfilm copy of the call records were obtained and preserved. Witness statements were obtained from the crew. The Medical Director reviewed the papers and advised that the double technician crew conveyed the patient to hospital as quickly as they could, that they were not able to site an intravenous infusion or give fluids, that their treatment with oxygen and the institution of CPR when the patient suffered a cardio-respiratory arrest was entirely correct and according to protocol. The case was reported to the NHSLA as a potential claim in June 2000 but in the absence of communication from the claimant's solicitor the file was closed in July 2004.

PC 885

Notification about the case came as a solicitor application for records in January 2002. There was no prior record of a complaint or LA52 report. The case was reported to the NHSLA as a potential claim and in view of the potential criticisms being investigated panel solicitors were instructed. Detailed witness statements were obtained from the crew and the opinion of the Medical Director was obtained. The crew witness statements confirmed that they followed the LAS protocols and that it was appropriate to ask for the midwife to attend. When the midwife attended it was her decision that the mother should be taken to hospital for the birth. The conclusion reached by the panel solicitor which reflected independent expert advice was that there was no reason to believe that the actions of the ambulance technicians or the midwife could be criticised. Independent evidence on causation was also favourable to the other NHS bodies. The crew were advised that the claim is not being pursued against the LAS.

PC878

Notification came in May 2002 from solicitors acting for the claimant advising that they were investigating a potential claim arising from the treatment and conveyance to hospital by an ambulance crew on 17 March 2002. There is no prior record of a complaint or LA52 report on file. Witness statements were obtained from the crew and these were passed to the Medical Director and Head of Training to review.

The Medical Director noted that the RRU arrived on scene four minutes after the ORCON start time. There was little detail on the RRU patient report form. The transcript of the calls indicated that the RRU was concerned that if the ambulance failed to arrive he might be faced with an imminent delivery. The ambulance had difficulty in finding the exact location of the patient's location and there was a problem with opening the rear doors of the ambulance but this was soon rectified. The Medical Director advised that it was current practice to encourage women in labour to stay mobile and the allegation that the crew were wrong to encourage the patient to walk was incorrect. The Medical Director concluded that the crew had acted in accordance with their protocols and that their assessment of the patient was as detailed as LAS protocols allowed.

The Head of Training drew attention to some shortcomings in the detail recorded on the patient report forms and that information included in the witness statements was not on the patient report form. The Head of Training concurred with the opinion of the Medical Director about walking a woman in labour.

Based on the opinions of the Medical Director and Head of Training a detailed reply to the areas on concern about not taking the patients symptoms seriously, failing to undertake an examination of the patient, encouraging the patient to walk, and problems with the opening of the rear doors of the ambulance was sent to the Claimant's solicitor in September 2002 and after confirming that they would take their client's instructions nothing further was heard.

PC1052

Notification of a potential claim was received in March 2005 by solicitors requesting the Trust's records, including a transcript of the calls, and protocols for obstetric cases. The solicitor advised that it was not possible to state the nature of the infant's longer term condition and that there were other potential NHS claimants. The infant suffered severe hypoxic ischaemic encephalopathy at birth. The case was reported to the NHSLA. Witness statements were obtained and the views of the Medical Director and the Head of Education and Development were sought. The Medical Director reviewed the call handling and the actions of the ambulance crews on scene. With regard to the call handling the Medical Director advised that she was not satisfied that the first call was prioritized correctly as vital pieces of information were missing. The circumstances of the call were difficult in part through having to use a third party through language line. The call handling on the second call 17 minutes after the start of the first call was of a high standard with an attempt to deliver the emergency child birth instructions in accordance with protocol.

The actions and documentation of the ambulance crews on scene appeared to be appropriate and professional who were faced with an unexpected breech delivery and neonatal cardiac arrest.

In June 2005 the solicitors acting for the family advised that the infant had died and the parents did not wish to pursue the matter further.

PC1074

Notification of the case was received in an application for records in June 2005. There was no prior LA 52 report or PALS enquiry or complaint. The opinions of the Medical Director and Educational Standards Manager were sought and in view of the potential quantum of a claim the case was reported to the NHSLA.

The Medical Director noted that it was likely the patient suffered an ante partum haemorrhage at 36 weeks and around the time the first call was made. The Medical Director considered that the call handling was prompt. In 1998 the LAS had not introduced AMPDS and so the call taking was less structured nevertheless the problem was established and the response time of 16 minutes was reasonable. No structured pre-arrival instructions were given as AMPDS was not in place, but the call handler offered appropriate advice to the caller.

The Medical Director noted that oxygen was not administered contrary to the protocols in place at the time. Removal to the vehicle was rapid but blue lights and sirens were not used. The maternity unit were not pre-warned of the patient's arrival however, in 1998 there was not a dedicated telephone line and so the maternity unit might not have had time to prepare for an obstetric emergency arriving in less than ten minutes.

It appeared that the crew recognised that the amount of pain was not due to normal contractions but failed to recognise the symptoms were indicative of a placental abruption.

In March 2006 the solicitors acting for the claimant advised they were no longer proceeding with the case.

LC375
The first notification about the case came in July 1994 as an enquiry to the Patient Services Bureau from a senior midwife at the Whittington Hospital requesting the LAS records to be held in case the hospital received a formal complaint from the parents. A copy of the patient report form was filed with that request. A tape of the telephone calls was not taken.

Grace Barry v NHS Litigation Authority was litigated and heard in the High Court between 20 and 28 February 2002. It was the Claimant's case that the severe damage to parts of the brain was due to a delay in transferring Grace's mother by ambulance from her home to hospital following a prolapse of the umbilical cord and that without the delay the damage would not have occurred.

The judgment by Mr Justice Roderick Evans
Within moments of arrival the crew recognized that it was not a BBA call but a prolapsed cord. No member of the crew (there were 3) had experience of dealing with a prolapsed cord, but they had had training and knew it was an emergency and that the patient had to be removed to hospital as quickly as possible. Advice was passed to the crew from the Registrar in Obstetrics and Gynaecology about the position the patient was to be conveyed to hospital. The crew's evidence was that they gave careful thought to the removal to the ambulance and made sure that each knew what the other was doing.

The contemporaneous records Form LA4 Emergency and Urgent Assignment record and form LAS 26 testified that the attendant had carried out the advice of the Registrar to keep the baby's head off the cord. The advice given was also recorded in the hospital notes.

The evidence of the LAS driver about the route taken to hospital was accepted and the evidence put on behalf of the claimant was rejected.

It was not possible to be precise about the time the ambulance arrived at hospital but it was concluded that this 3 – 4 minutes later than the time recorded on the Form LA4.

The judge concluded "I am satisfied that this was a crew of competent ambulance men. There was no evidence that they engaged in activities that were not immediately connected with the patient's welfare. While it is possible that another crew might have performed the tasks in a shorter time I am not persuaded that the crew was in any way negligent." The claimant had not established that the ambulance crew were in breach of their duty of care and the claim failed. The outcome was reported to the Trust Board and the crew were thanked by the Medical Director.

2.4 Outcomes
Most of the cases did not proceed to litigation. One case was heard in the High Court and judgment was given in favour of the Trust. Leave to appeal to the Court of Appeal was refused.

Damages were paid in two cases and an ex-gratia payment was made on one case following a meeting with the claimant and solicitor, the Medical Director, Head of Training, and Head of Legal Services.

Treatment protocols governing obstetric emergencies were revised and have been supplemented by National Clinical Guidelines.

2.5 Conclusions and Recommendations
Civil claims involving obstetric emergencies, where there may be substantial claims for future care, potentially are the most expensive claims a Trust can face. The LAS has reviewed the procedures and training for staff following the claims and potential claims notified. The crew who attended Mrs B had received training in obstetric emergencies.

However, if the closed files reviewed are a representative sample it is clear that untoward incident reporting has not been good. Opportunities to collect evidence before memories faded in some instances were lost together with the opportunity to conduct a wider investigation than required for an actual or potential civil claim.

There have been significant changes in Control Services and in communication between Control and crews following the introduction of AMPDS and mobile data terminals.

The Clinical Governance Committee is asked to Note the findings from the report and to consider whether the governance arrangements in place enable the Trust to learn from and act upon untoward incidents involving obstetric cases.

Obstetric claims, potential claims and incidents

Ref	Incident date	Opened date	Description	Outcome	Closed date
PC1074	13/12/1998	30/06/2005	Mother alleges the LAS were called three times as she was suffering heavy bleeding. Took 30 mins to arrive. No lights or sirens during conveyance. Call not treated as urgent. Alleged delay in reaching the patient, and conveying to hospital. Alleged ambulance report mislaid.	WITHD	17/03/2006
LC577	07/11/1997	22/07/1998	Patient who was in labour complained that a crew that were requested to attend did not carry her to the ambulance and that she had to walk down a staircase. The baby was in part delivered before arrival at hospital. The baby died 7 days later and the complainant believes this was due to the treatment received. 3/8/98 LBA received from solicitors acting for plaintiff. Claim form issued 3/11/2000 forwarded to Capsticks. Consent Order requires the claimants to serve a schedule of special damages by 1/2/2001 and amended particulars of claim by 1/4/2001. Notice of discontinuance served 10/7/2001.	WITHD	03/05/2001
UI424	12/03/1997	08/12/1999	Patient in labour. Baby very brain damaged. Also see SOL/ENQ/1913.		15/02/2006
LC375	10/06/1994	17/06/1996	This case concerns the allegation that the LAS failed to treat Mrs. B as an emergency, she was pregnant with the plaintiff and had suffered a prolapsed cord. It is alleged that there was no further advice was given, once the CAC operative had asked Mr. B to feel the cord for a pulse. 16/11/96 a Consultant Obstetrician at Lewisham Hospital prepared a report on the results of the investigation which concluded that the LAS did all that was possible and the poor outcome for the baby was a consequence of the medical problem and not the way that the incident was managed.	DISM	23/06/2004
LC429	25/05/1996	04/04/1997	Plaintiff claims that due to not being carried to an ambulance in a carrying chair she suffered a miscarriage. A letter has been sent to the plaintiff denying liability. Advice obtained from the Medical Director that the actions of the crew had no bearing on the outcome of the pregnancy.	DORM	05/07/1999
LC870		11/04/2002	Particulars of claim not notified but concerned the medical treatment which resulted in heart failure, admission to hospital and the still birth of the baby. Dates not given.	LIMIT	27/09/2002
PC950	26/08/2000	19/11/2003	Patient 25 weeks pregnant in labour. Being transferred by LAS to another hospital for delivery. On arrival baby was dead. Alleged delay of 75 minutes between hospitals.	WITHD	30/04/2004
PC1052	20/02/2004	24/03/2005	Delay in arrival of ambulance to lady in labour at 10 months gestation. Baby delivered by crew at home in breech position. Baby suspended and resuscitated by crew before conveying to hospital.		16/08/2005
LC626	01/12/1996	13/01/1999	Alleged failure by CAC to refer to the patient having a prolapsed cord, and the delay in the crew ascertaining this condition, alleged failure of the crew to comply with the relevant treatment protocol and training, alleged delay in conveying the patient to hospital and to place the patient in the correct position, and incorrectly identifying that one of the crew was a paramedic.	POC	28/11/2000

Ref	Incident date	Opened date	Description	Outcome	Close
LC395	12/07/1996	15/08/1996	The plaintiff claims damages for negligent treatment given by the ambulance crew who attended the call. The allegations are that there was a delay in taking the patient from home to ambulance, a further delay on the journey to hospital. Failure to put patient on a drip whilst in the ambulance, failure to alert Ashford Hospital of the arrival of an emergency, which resulted in further delay to assemble medical team at the hospital. Protocols were not followed in treating the patient. The result of which plaintiff has suffered great distress and baby suffered neo-natal death. Investigation to be undertaken. Letter from Graham Bash and Co stating that they are without instructions. 19/1/98 advised Capsticks that the HSC was considering whether to investigate a complaint against the LAS about the handling of a complaint and the former should close their file. Claimant instructed Stone Rowe Brewer Solicitors. Allegation that the LAS's actions led to claimants further psychological distress.	PBP	21/09/1999
LC585	13/09/1991	18/08/1998	Letter before action received from solicitors stating that the LAS attended the plaintiff when she was in labour. There was a delay in an ambulance attending and that the crew did not treat the incident as a medical emergency. The baby was delivered by caesarian section, and suffered from cerebral palsy and subsequently died in 1997. At this stage we have written back to the plaintiffs solicitors asking for more details to allow us to trace the incident.	DORM	04/09/2002
PC885	03/03/1998	12/08/2002	Alleged unnecessary and negligent delay in providing an ambulance for patient in labour, 40 minute delay from origin to arrival of ambulance as initial ambulance broke down en route to the call. Further delay on scene of an hour waiting for midwife. Emergency caesarean section resulting in baby being born with brain damage.	WITHD	15/03/2004
LC861	05/11/2001	06/03/2002	Alleged that the ambulance response was delayed by 45 minutes, significant blood loss, and was not conveyed to the nearest obstetric department. Independent medical report indicated that causation would not be established therefore the claim will not proceed under the RESOLVE pilot scheme .	EXGRAT	26/09/2003
PC1094		07/09/2005	No specific allegations of negligence at this point. However allegations of delay in ambulance arriving and delays in conveying the patient to hospital once the crew had arrived on scene.		
LC384	11/04/1994	23/07/1996	Solicitors acting for the family claim that over a period of two hours several calls were made requesting an ambulance for the mother who was in labour. An ambulance did not arrive and the mother was taken to Hospital by a neighbour. No request for an ambulance could be found for the date and time given 20/8/96. A different location was provided and the records were obtained and sent to plaintiffs solicitors. Following an investigation by the CAC complaints department it has been found that available ambulance crews were over looked prior to an ambulance eventually being allocated.	DORM	04/09/2002
LC734	14/09/1996	20/04/2000	Claim by minors (in respect of the death of the mother G D) against Marie Stopes & Camden & Islington HA. Ectopic pregnancy. Claiming LAS did not set up IV drip on route to hospital following cardiac arrest by patient.	DORM	26/07/2004
PC878	17/03/2002	28/06/2002	Patient was in labour. Alleged that crew made patient walk to ambulance, ambulance doors would not open, failed to examine the patient, no blue lights to hospital, patient was made to get off the stretcher unaided and crew were rude. Baby was delivered within 10 minutes of arrival at A&E	WITHD	16/07/2004

Ref	Incident date	Opened date	Description	Outcome	Close
			and required resuscitation.		
UI82	18/09/1997	08/10/1997	Patient 31 weeks pregnant and was diagnosed by locum GP as having a separating placenta. Obstetric consultant recommended immediate transfer to hospital at 19:50. Patient arrived at St Georges at 20:32 via casualty. Crew had difficulty finding the labour ward. By this time the baby was dead. Enquiry originally to PSB by the mother who wished to know what instruction was given to the crew and whether they knew the urgency of the call	DIED	27/07/2004

Total number of records 18

3. INCIDENT REPORTING

Obstetric Related Incident Summary 2002 to Date

The following is a summary of all the incidents reported and entered on Datix in regard to obstetric incidents entered since 2002. The summary is based on the data entered at the time of the incident.
As can be seen from table 2, of the 35 incidents 20% were related to delay in treatment. The blanks in the table relate to items where crews have either not provided any information or these incidents occurred at a time when the free text was not entered onto Datix.
Of interest is also the fact that 6 of the 35 incidents related to issues that occurred at hospitals e.g. crews reporting poor communication or support when on scene at the Hospital.
One incident related to availability of Drugs and the Others category includes issues such as family or relatives affecting care delivery.

Table 1 - Incident Grading

Number of incidents	Grading based on New Matrix Grading	Grading As Entered on Datix using Old matrix Grading
14	Low	Insignificant
14	No grading	No grading
7	Moderate	Low

Table 1 shows that 14 of the incidents were graded as low (insignificant) and 7 as moderate (low). The remaining 14 had no grading entered as these were entered when the Datix system was introduced and when grading was not entered on the system.

Table 2 - Breakdown Table of Maternity Incidents

	Broad Category	No
1	Mat Delay	7
2	Blanks	13
3	Mat Equipment	4
4	Mat Hosp	6
5	Mat Other	4
6	Mat Drug	1

4. EDUCATION AND TRAINING

The Department of Education & Development currently facilitates training in Obstetric and Gynaecological emergencies to the following groups of staff.

4.1 Emergency Medical Technician (EMT) 2

All new staff attending an EMT2 training course receive a formal one day training session on the topic of Obstetric and Gynaecological emergencies. The training session is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. Further reinforcement and support is then provided by the course tutors throughout the remainder of the programme.

The subject of Obstetrics is a mandatory element of the course. As a consequence, all training objectives and assessments are developed on a national basis by the Institute of Health Care & Development (IHCD). (See references)

4.2 Paramedic

Similar to EMT2's, trainee Paramedic staff undertake IHCD training relevant to their role which once again is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. However, the duration of this training is two days.

The traditional three yearly Paramedic Recertification courses (which in the past included an obstetrics update session) has recently been withdrawn. It is being replaced by a series of new 'Modular' Continuous Professional Development (CPD) days, which will include a specific Obstetrics module in due course.

4.3 A&E Support & PTS

Although we do not offer specific training to either of these staff groups, all students are provided with guidance on the actions required in the event of becoming involved in an obstetrics case.

Staff from A&E Support and PTS are not ordinarily deployed to such cases, so any intervention would normally arise from being summoned in a public place etc.

References

Ambulance Service Basic Training Manual (Ambulance Staff Training to National Standard) 3rd Edition 2003 updated April 2006 Section 15 pages 1-13.

- Section 15.1 Maternity (updated October 2004)
- Section 15.2 Pre-Term Babies and Incubators (updated October 2004)

Ambulance Service Paramedic Training Manual (Ambulance Staff Training to National Standard) 2003 Emergency Obstetrics & Early Pregnancy Problems

- Section 9.1, General & Local Organisation of Obstetrics and Gynaecological Services
- Section 9.2, Anatomical, Physiological and Pathological Changes during Pregnancy
- Section 9.3, Assessment and Examination of the Pregnant Woman
- Section 9.4, Normal Labour
- Section 9.5. Abnormalities in Pregnancy and Labour (Updated Dec 04)
- Section 9.6, Resuscitation in Pregnancy

UK Ambulance Service Clinical Practice Guidelines (2006) Issued October 2006 JRCALC / ASA Section 5 Obstetrics and Gynaecological Emergencies Pages 1-9

- Birth Imminent (normal and delivery complications)
- Effects of Pregnancy on maternal resuscitation
- Haemorrhage during pregnancy (including miscarriage and ectopic pregnancy)
- Pregnancy induced hypertension (including eclampsia)
- Vaginal bleeding; gynaecological causes (including abortion)

Complaints Received by the Service That Relate to Obstetric Issues

The Service receives an average of 500 – 600 complaints each year a small proportion of which relate to obstetric cases. Pregnancy and birth can for many be a joyous, magical event. However, in the small number of cases where difficulties arise, the experience can be devastating. This is particularly so when the problem results in the death of the unborn or newly born baby. Such tragedies, although comparatively rare often result in a complaint as the family try to make sense of their loss. Lack of examination/treatment, unhelpful and apparently uncaring comments or attitudes by staff frequently add to the pain and anguish felt by the patient and family and contribute to the belief that an act or omission resulted directly or indirectly in the loss of the baby.

The following is a synopsis of some of the complaints relating to obstetric issues that have been received in the past five years. There is no judgement made on the merit of each complaint or of the eventual outcome. They are reproduced so that staff may reflect on the way that they respond to such incidents and consider what impact their own actions may have on the mother and family in such extremely difficult circumstances. It should be noted that the following complaints should be viewed in the context of the number of letters of thanks received from people following the highest standard of care they received from staff when faced with an obstetric emergency.

- Family unhappy with the way her baby was managed by ambulance crew, believe that the baby suffered brain damage and this was related to the way the crew handled their child.
- Patient was made to walk down 3 flights of stairs, wasn't helped and fell. Crew did not report this to the hospital staff - patient also pregnant.
- Patient 38 weeks pregnant, called for an ambulance. It was suggested that she should make her own way to hospital. Ambulance was sent - crew assumed pains were normal labour pains but were in fact due to placenta separating. Baby died.
- Complainant gave birth to premature baby, an ambulance was delayed in responding to her '999' call and baby later died.
- Complainant unhappy with the attitude of the crew that attended her pregnant friend. They apparently told her that the call was a waste of their time.
- Delayed response of an emergency ambulance, then crew took her to the wrong hospital, delivered a stillborn baby by Caesarean Section.
- Crew refused to take a pregnant woman to the hospital she requested then discussed the patient with one of her neighbours.
- Patient states baby's head must have been showing at her home, ambulance crew made her walk - no evaluation was carried out by the ambulance crew that attended to her.
- Patient pregnant and was worried that she was going to lose her baby. Female member of the crew was rude and told her if her husband was following in the car he should have driven her to the hospital and not called an ambulance.
- Patient pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
- Pregnant woman fell, crew did not convey to hospital.
- Patient believes that the crew did not treat her situation as an emergency. She was pregnant and was experiencing continuous abdominal pain (suggestive of Placental Abruption). The baby was later stillborn.
- Pregnant patient booked into St Thomas, taken to Kings College and left in the A&E.
- Patient was 35 wks pregnant, suffering from severe stomach pains. Crew failed to recognise obstetric emergency. Walked patient to ambulance and drove with no urgency. Patient suffered a placental abruption. Delivered stillborn baby girl few hours later
- Crew took pregnant woman with PV bleed to A&E instead of delivery suite.
- Complainant unhappy with the crews attitude to being called out to his pregnant wife. She had high blood pressure. Later had a premature birth.
- Parents concerned about the treatment offered to new born baby. Baby subsequently died.

- Patient unhappy with crew's attitude following her calling them out to her when she was vomiting, had severe back ache, was pregnant and concerned for her unborn child. Patient kept in hospital for 3 days and given morphine for pain relief.
- QEH not happy that patient was brought to their hospital, when she was in fact booked into Lewisham and QMS was nearer if the patient had complications. Maternity unit was stretched to cope.
- Woman pregnant with twins, in labour. Delay (30-45 mins) for ambulance, crew members offered no assistance and did not examine patient. On arrival at the hospital discovered that babies were dead.
- Patient 24 weeks pregnant, waters broke and she was bleeding. Crew told her they were not a taxi service and that she should have paid for a cab. Patient lost her baby.

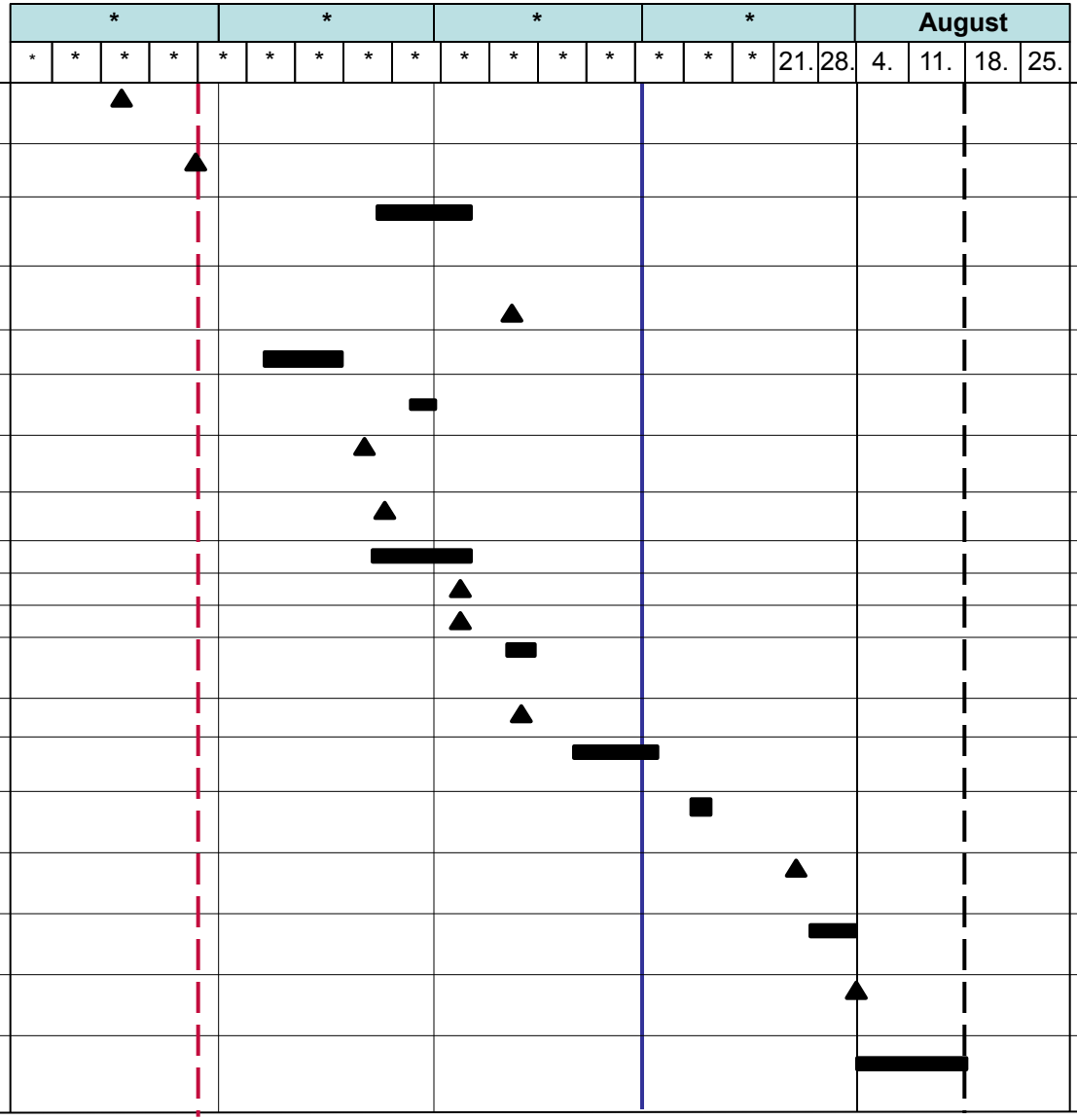
It is sad to note that, of the 22 complaints cited above, the death of the baby featured in eight.

There are some emerging trends suggested in these complaints and lessons that may be learnt:

- Whilst childbirth is a perfectly natural event, it is frequently a painful, traumatic experience to the mother.
- Whilst the vast majority of births are relatively straightforward, things can and do go wrong. The results can then be devastating.
- Our words and actions can be construed as extremely hurtful and distressing, whether or not they were intended as such.
- All patients should receive a thorough clinical examination, observations taken and recorded and treatment initiated when indicated.
- Staff must acknowledge that they are not experts in this area. It is for the specialist to decide whether a problem exists and ambulance staff should refrain from making comments that the patient should not have called for an ambulance and other related observations.
- Staff should endeavour to be part of the positive experience that childbirth is to the majority of women and should not contribute in a negative manner in the small number of cases that result in trauma or tragedy.
- The patient is often extremely vulnerable, frequently emotional, in pain, fearful that the baby will arrive fit and healthy and, being in the hands of experts, their lives are out of their control. The aim should be to recognise and alleviate the negatives and provide professional caring support.
- Constant abdominal pain experienced by a pregnant woman may be an indication of a Placental Abruption which carries a very poor prognosis.

27-07-07
R Morris

LAS Diagnostic Timetable



	Date
Project initiation meeting (SHAs and PWC) Project commencement	17 April 10am 28 April
Launch event for LAS	23 April
LAS Trust site visit & interviews – 2 days Executives and Non Executives	W/C 19, 26 May and 2 June
Board self assessment completed	W/C 9 June
LTFM training session	W/C 5 or 12 May
Commissioner workshop	W/C 26 May
Board observation	20 May
First submission of IBP, LTFM & gov. etc	22 May
Review of first submissions by SHA & PWC	23, 27 May
LTFM feedback	2 June
IBP feedback	2 June
Convergence meeting (trust & cmmr)	W/C 9 June
Second submission of IBP & LTFM	13 June
Clarification meeting	W/C 16 or 23 June
Board to Board meeting with SHA	W/C 7July
Diagnostic report issued by SHA	21 July
LAS develop action plan	W/C 21 and 28 July
LAS action plan submitted to SHA	31 July
LAS action plan approved by SHA	W/C 4 and 11 August

Dates in bold red are confirmed. Dates in bold black are preferred dates

Version 3, 7 May 2008

LAS Diagnostic detailed timetable

Workstream area	Tasks included in workstream	Dates	Actions	Outcomes and additional comments
Trust site visit and interviews	• Meet with a selection of the Executive and Non Executive Directors plus the governance leads. • Meetings to be grouped • Initial list provided to Ashley Young on 30 April	• Executive and Non Executive Directors the weeks commencing 19 May, 26 May and 2 June.	• LAS to organise meetings using list provided by GR on 30 April and liaise with the diagnostic team to agree dates.	All exec interviews performed by 5 June.
Board self assessment	• NHS institute tool ideally to be used. • Executive and Non Executives to complete within a 2 week period. • The NHS Institute takes 4 weeks to process from start to finish. • Diagnostic team to feedback results to the LAS Chair.	• Profile document to be circulated for LAS to fill in w/c 5 May. • Results expected w/c 9 June. • Feedback meeting with the Chair TBC.	• PwC to brief LAS on tool and instructions for use. • PwC to provide the profile document for LAS to complete and send to the NHS Institute w/c 5 May. • PwC to arrange meeting with the Chair to feedback.	Board members complete the tool and NHS Institute report received and fed back to the Chair by mid June.
LTFM training session	• PwC expert to hold training with LAS to go through the model and discuss the potential areas of difficulty and uncertainty. Will also provide an opportunity for LAS to ask questions. • PwC to be available to answer LTFM queries throughout the process.	• As soon as possible. Preferably the w/c 5 or 12 May.	• PwC and LAS to agree a date for training.	Trust is a position to be able to submit a good LTFM at the first submission.
Commissioner workshop	• Activity and commissioning arrangements templates to be filled out in advance by LAS and commissioners. • Workshop with commissioners to discuss projected activity levels. Diagnostic team to also attend. • To understand how aligned the Trust and Commissioners are in respect of future activity projections. • Diagnostic team also to meet separately with main commissioner.	• Meeting in weeks commencing 26 May.	• LAS to take this forward and discuss with Richmond and Twickenham PCT about how to take this forward and agree a date. LAS to then liaise with diagnostic team. • LAS to inform diagnostic team when they can contact lead and other commissioners to hold separate meetings.	Better understanding of (i) activity and (ii) the degree of Strategic alignment between the Trust and Commissioner.

LAS Diagnostic detailed timetable

Workstream area	Tasks included in workstream	Dates	Actions	Outcomes and additional comments
Board observation	• Diagnostic team to observe the Trust Board in both the public and private part of the meeting.	• 20 May	• LAS to provide diagnostic team with timings and papers for the meeting.	To get a good understanding about how the Board is run.
First submission of the LTFM (historic data only), SDS and self assessments (governance, external relationships, risk and service performance).	• LAS to submit all documents to the diagnostic team.	• 22 May • This has to be early in the process so the diagnostic team have time to review and feedback to the Trust before the second submission.	• LAS to keep diagnostic team updated on progress and any challenges/issues as they arise to ensure that the deadline is met.	Documents demonstrate clarity about business strategy and how the Trust will achieve its targets/ goals
Review of the first submission by the SHA and PwC	• The diagnostic team to review submissions and pull together comments in a log to feedback to LAS.	• w/c 27 May and 2 June	• PwC to agree dates and locations for review	Documents demonstrate clarity about business strategy and how the Trust will achieve its targets/ goals.
LTFM and IBP feedback	• The diagnostic team to feedback to LAS using a findings log.	• 2 June	• PwC to agree a feedback date with LAS.	Issues are fed back and understood by the Trust
Convergence meeting	• LAS to meet commissioners to discuss any findings from the first submission feedback and broadly agree on a final position in respect of future activity levels. • Diagnostic team also to be present in the meeting.	• w/c 9 June • Has to be done before the 2nd submission to ensure that the SDS and LTFM are fully up to date.	• LAS to agree a date with commissioners for the convergence meeting.	Better understanding of (i) activity and (ii) the degree of alignment between the Trust and Commissioner.

LAS Diagnostic detailed timetable

Workstream area	Tasks included in workstream	Dates	Actions	Outcomes and additional comments
Second submission of the SDS and LTFM (full submission of the LTFM including future projections).	• LAS to submit the revised SDS and full LTFM to the diagnostic team. • This submission will take into consideration the feedback received on the first submission and necessary amendments/adjustments will have been made.	• 13 June		Trust is a position to submit a good LTFM and SBS at the second submission. Documents demonstrate clarity about business strategy and how the Trust will achieve its targets/ goals
Clarification meeting	• An opportunity for the diagnostic team to clarify areas in advance of the draft report being issued. • To be attended by diagnostic team plus Damian Reid. • LAS to determine who they want to attend the meeting.	• w/c 16 June or 23 June	• LAS to determine who needs to attend this meeting from the Trust.	Meeting held and all areas/point of fact clarified and agreed between the Trust and diagnostic team.
Board to Board meeting	• LAS mock Board to Board meeting with NHS London and Gareth Oakland (Partner from PwC).	• Sometime the w/c 7 July.	• Very important that a date is agreed for this as soon as possible. • LAS to get back to PwC with suggested dates.	B2B panel members sufficiently briefed and date in diary for the w/c 7 July.
Diagnostic report issued by the SHA	• Report to be issued by the SHA to LAS. • This can only be issued once all the work has been completed including the B2B.	• w/c 21 July		Reports produced and submitted by 21 July deadline.
Trust to develop action plan	• Trust to develop action plan in response to the report findings.	• By 31 July		Action plan drawn up in sufficient detail and action taken as soon as possible.
SHA to approve action plan	• SHA to approve the plan and	• Mid August		

FINAL REPORT ON DIAGNOSTIC VISIT TO LONDON AMBULANCE SERVICE

The following document is a report of our findings following a diagnostic visit to the London Ambulance Trust on 8th/9th April 2008. The visit was undertaken at the request of the Chief Executive, Peter Bradley.

The visiting team were:

Lis Nixon – National Ambulance Performance Implementation Lead
Martin Reddy – Management Advisor
Dave Whiting – Ambulance Advisor
Richard Bowen – Management Advisor

We would firstly like to extend our thanks to everyone we met and would commend their openness and welcome.
We would also note that the visit was extremely well organised.

Terms of Reference

The terms of reference for the visit are summarised as follows:

- Ascertain the robustness of the Trust's Performance Improvement Plan and their consequent ability to deliver Call Connect
- Advise the executive team on any priorities or risks identified in their plans to deliver Call Connect
- Explore the partnerships and key requirements and responsibilities across the whole health economy

Methodology

The review was carried out over a two-day period in April. The methodology comprised:

- Interviews with key personnel across the health economy
- Observation of operational practice across the Trust

- Review of systems and processes
- Review of informatics and data availability
- Presentations from key team members
- Informal discussions with staff

Background

London Ambulance Trust covers the Greater London area, within the M25 ring. It was not involved in the recent mergers of ambulance services.

Strategic and Executive Leadership

London Ambulance service is a high performing organisation with an executive team that have consistently demonstrated service delivery and high quality clinical care. This approach was evident throughout our visit and the organisation has clearly benefited from having a stable top team.

As 'New Ways of Working – Transforming Clinical Leadership' clearly articulates, the organisation has a clear focus on patient care and staff development and is creating a culture to support sustainability and excellence whilst delivering both performance standards and financial balance.

On the ground, the operational staff were clear about the strategic direction of the organisation and were complimentary about the openness of communications and decision making. In particular, we would commend the Chief Executive and Medical Director for the personal time commitment they take to visit each and every station and team on a regular basis. As a result of this, and many other aspects of the communications strategy, staff were very clear about delivering the Call Connect standard and were confident in achieving this position – there was however a healthy degree of scepticism around sustaining the standard in the medium to long term.

Call Connect Plan

The Trust provided a clear overview of their call connect plans and the associated project management arrangements and key objectives. At the time of our visit the Trust were already delivering the Call Connect standard but were open about their reliance on a combination of technical enhancements and a substantial increase in operational staffing levels.

The individual commitment from the Director of Operations through to individual call handlers should be sincerely commended and the approach taken over the

last few weeks has clearly demonstrated to everyone within the organisation that this standard can be achieved. The impact this has had on individuals and other organisational priorities however should not be under-estimated and we would question the sustainability of this approach in the longer term.

Recommendation

- *Determine the longer term plans for supporting the delivery of Call Connect standard, with a clear 'winding down' of management time and input*

Control

LAS operate a single emergency control centre serving the three operational areas, East, West and South. Within the control centre call handling is separate from the dispatch and support functions.

There are extremely effective processes in place for performance managing the call answer process and further plans are in place to strengthen the supervision by call taking team. The recent reconfiguration of the call handling floor has complimented the management arrangements in place.

The trust has almost eradicated all 120 second delays as reported by BT.

LAS has placed a great deal of emphasis on improving call answer teams and is exceeding the best practice indicator of 95% within 5secs call answer, which have supported the improvements seen in Category A performance.

Currently dispatch is based upon a three Ambulance desk configuration (East, west and South); with a dedicated solo car desk, and a separate cycle / motorcycle and helicopter desk. The dispatch system is well supported by a Loggist desk (for recording and disseminating information relating to lost hours or resource problems) and a resource desk that provided a link between Operations / Control and support functions such as Fleet / make Ready.

A key feature of the dispatch function is the automated dispatch function – FRED and FREDA. The version for dispatching cars (FRED) offers real efficiency savings through reducing time taken to firstly identify an incoming call, and then search for a suitably skilled resource as well as the nearest available resource. All cars are included in the system and the trust has well established deployment rules built in to the system. This technology allows for on average 100 cars to be

managed / deployed mainly by a single dispatcher, although there are a small team supporting the main dispatcher in managing the system.

This area of best practice has now been applied to the dispatch of Ambulances on the area desks and an increasing number of Ambulances are now been automatically tasked to incidents.

London Ambulance also operates a separate Urgent Operations Centre which has an active system for dealing with Category C calls; operating a fast call back system where necessary. This centre dispatches the Urgent care vehicles and also includes the Emergency Bed Bureau.
The UOC operates to a very high clinical standard and is well managed; the various activities within the Centre are well co-ordinated.
The Emergency Bed Bureau is a valuable resource and is currently determining further developments which it could undertake.

Areas of best practice;

- The automated dispatch technology is a key critical success factor in delivery LAS performance.
- The configuration and management of the call answering process is excellent.

Recommendation

- *The trust were aware of the need to further integrate cycles / motorcycles in to core response system, once appropriate technology becomes available through the national radio replacement programme*
- *Review the additional functions which the Emergency Bed Bureau could contribute*
- *Determine whether there is further capacity for the Urgent Operations Centre to take responsibility for more of the calls*

Operations

The team visited the South Area Coordination centre based in Bromley within the South Area, and met the management team and some members of staff. The management team had a clear understanding of their role in delivering the new targets and understood the trust direction of travel.

The whole team was connected in to the local health economy and was engaged in proposals to reconfigure acute services in the patch.

The team had established an Area Delivery Unit, and was very aware of the factors and issues that affected their performance and were equally aware of how their contribution supported the whole trust delivery of call connect.

The team observed the 1600hrs conference call between each Area Delivery Unit and the Central Delivery Unit. There is a strong commitment to the conference call system which takes place four times daily between the CDU and each area. The team recognised the importance of this arrangement and consideration will need to be given to how the best practice arising out of this call connect initiative can be embedded in future daily practice.

The team was also very focused on supporting staff and the need to develop clinical competencies of their staff. The team explained how the individual performance reviews were conducted within the division and the importance placed on feedback given by team leaders to their teams.

The team had access to information highlighting the division's performance in undertaking feedback sessions to staff through the team leader network. It was clear that the comprehensive individual performance review system and feedback to staff was embedded within the division and integral to management practice

Areas of best practice;

- Use of conference calls to monitor area performance and resolve operational / control issues.
- Programme of planned feedback by Team Leaders to staff.
- Establishment of the Area Delivery Unit.

Recommendation

- *The trust needs to consider how to embed the best practice derived out of the ADU / CDU arrangements in to future management practice and systems.*

Clinical Education and Development

During our visit we had the opportunity to visit one of the Trust's training and education centres in Fulham and met with members of the team implementing this core strategy. We were very impressed with the organisations approach to training and their commitment to having a workforce fit for purpose. It was recognised that working practice modernisation will be the most challenging aspect of this agenda, however the clinical development support posts and the

three pilot 'early adopter' sites will demonstrate the benefits of new ways of working, innovative practice and being part of the wider unscheduled care agenda.

Currently there is slight tension between delivering Call Connect performance and the clinical/training duties of the service; however this is not an issue unique to London Ambulance service.
The Training and Development Plan (2007 -09) and the New Ways of Working (January 2008) documentation clearly articulate the priorities for addressing these concerns and ensuring that staff have dedicated time within the rotas for training and education.

In the short term, the recruitment activity required to train 510 additional staff (310 of whom will be student paramedics) will be considerable and increasing the number of training officers and keeping the high standards of clinical supervision will be a key priority.

Recommendations

- *Structured placements for individuals are currently managed on a 'grace and favour' basis and we would strongly recommend that the Trust ensures that this is given closer attention and links with your local Commissioners plans*
- *A risk assessment needs to be undertaken on the impact of workforce modernisation within the three pilot sites. It was estimated that performance would drop by approximately 5% however this has not been accurately quantified*
- *There is no unification of care pathways within the health community although City and Hackney Primary Care Trust are currently piloting a single point of access. The role of the Emergency Care Practitioner varies across the various Primary Care Trusts; these issues require closer attention and will require more active engagement between the Trust and the local Primary Care Trusts*

Performance Management

Trust Call Connect performance has increased significantly over the last few weeks, with the trust returning over 73% for the first week in April, and during the DH visit the trust was operating at 75% for the month to date.

The trust has strengthened their position through improving core cover ahead of new staff entering the service and through the flexible use of managers to cover

meal break periods and expected peak demand times. The complexes (ambulance stations) aim to supply an additional 25 response cars staffed by Managers / Tutors / Team Leaders each day to supplement current resources.

The service has also implemented more recently a performance delivery unit structure to provide the necessary focus on delivery of Call Connect and to reduce any lost hours relating to staffing or fleet issues. Each operational area has an Area Delivery Unit (ADU) feeding in to a Central Delivery Unit (CDU) based in the Gold Command Suite at Headquarters.

The management teams have a very good understanding of their contribution to the delivery of call connect and are performance focused. There is a real commitment to the Area Delivery Unit model and most managers realise that this may have to continue given the success of the system. LAS will need to consider how it maintains this system or embeds areas of best practice from the CDU / ADUs in to normal business.

The real time information available to managers is exceptional. The teams / individual managers are able to access live information relating to performance, call answering, resource availability, contribution of cars to performance and the proportion of calls being undertaken by cars. This information can be presented in a multitude of ways that enable managers to quickly identify performance related issues and then take appropriate action. Managers locally can either access this information through the trust network or remotely via a web browser function on their mobiles.

In addition to CAD related information, managers also have access to individual performance information at a complex, team and individual level. Each team member has a range of performance (call cycle) Key Performance Indicators as well as a range of clinical performance indicators. There is a strong performance management culture but with a clear emphasis on clinical care and future outcomes.

The trust has recognised that in delivering further improvements in performance and clinical care, there are a number of issues which require further attention, such as roster changes, how resources are deployed more dynamically, improving productivity and clinical leadership within the trust. Many of these issues are captured within a programme of change called New Ways of Working.

<u>Areas of best practice;</u>

- The CDU and ADUs provide additional focus to the delivery of Call Connect targets.

- The delivery units have an exceptional suite of live information that enables managers to quickly identify problems and take appropriate action.
- Individual performance reports maintaining a balance between performance and clinical based indicators.

Recommendations

- *Consider how to embed the ADU/CDU model in a sustainable and manageable way, particularly review the frequency and length of the conference calls*
- *Undertake a review of work rostas and seek agreement with staff*
- *Review and agree further systems for dynamic deployment of vehicles*

Communications/Public relations

There is a clear communications strategy for London Ambulance service.

The Trust communications team has a wide remit covering internal and external communications and press function but they are also developing a wide range of publications and materials for specific developments such as Call Connect.

It was apparent that the Trust has engaged with both staff and mangers in relation to Call Connect and this was borne out during the divisional visit. Through a series of events the Trust has endeavoured to ensure staff understands the clinical benefits of the new targets as well as the organisational imperative of delivering the target.

The communications team have been fundamental in this programme of work.

Staff Relations

The Trust has clearly, over a significant period of time, made staff engagement an organisational priority. This has been achieved by traditional methods; email, intranet, newsletters, cascades and face to face and as previously mentioned the personal time given by senior executives.
This approach is clearly successful as all the staff we met was aware of their executive team and were also clear about their role in the success of the organisation.

There is an agreed Partnership agreement in place but we were told that the role and meaning of this agreement is not always fully understood by staff.

Whilst it was clear that there are good working relationships between the unions and management it is also c ear that there are some workforce issues that have not progressed as quickly in the LAS as in most other ambulance trusts, these include roster changes to improve weekend cover and the dynamic deployment of staff. These will need to be addressed if performance is to be sustained in the longer term.

Recommendations

- That the LAS management continues to work with the unions to improve cover to meet demand, especially at weekends and to come to introduce dynamic deployment

Commissioning

London Ambulance Service operates across 31 PCTs with Richmond & Twickenham PCT taking responsibility for leading on Ambulance commissioning. The team met the new lead commissioner and one of the five sector leads to discuss the relationship and interface between commissioners of the service and LAS.

It was clear that there is a strong relationship between LAS and the lead commissioner and there is a healthy level of challenge in the system. The commissioner sees LAS as a key strategic partner in developing and shaping services and recognizes the contribution LAS can make in sharing data.

There is a clear structure in place with regular strategic meetings planned between LAS, the Lead Commissioner and the five Sector Leads. There appears to be a commitment to utilize this forum to discuss broader issues other than monitoring delivery, such as future service developments and Payment by results.

There is also a network of local forums where locality based managers can work jointly with PCTs on specific areas of work. This feeds in to the strategic group to ensure there is a degree of control and consistency across all PCTs.

Patient and Public Involvement

During the visit the team were unable to meet with patient/carer representatives although various areas of their involvement were described to us and it was clear that their engagement was important to the Trust.
The team felt there could be further opportunities to engage patients through developing an 'expert patient 'model in some of the high usage conditions

Recommendation

- *Review possibility of engaging with 'expert patients' in looking at management of patients with high use of unscheduled care*

Conclusions

We would reiterate our impression of a committed and cohesive executive team with clear leadership and clinical priority being demonstrated. This clear leadership and vision is apparent throughout the organisation.

We would also particularly commend a number of things:

- Strong, focussed programme management arrangements
- Commitment of Chief Executive and Medical Director to station visits and staff engagement
- Best practice performance management arrangements
- Clear communications strategy
- Good working relationships with external stakeholders

We are confident that London Ambulance service is and will continue to be a successful and delivering organisation.

Lis Nixon
April 2008