LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 30th September 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 29th July 2008 Part 1 and synopsis of the Part II meeting held on 29th July 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 5 2008/09 Including report re. Invest to Save benefits realisation	MD	Enclosure 4
8.	Annual Audit & Inspection Letter	MD	Enclosure 5
9.	Report of the Medical Director	FM	Enclosure 6
10.	For noting: the final SUI report regarding the death of Paramedic Ron Pile	PB	Enclosure 7
11.	Approve two strategies: • Long Term Conditions • Older People	KJ	Presentation & Enclosure 8
12.	Ratification of Chairman's Urgent Action: amended LAS Risk Management Policy	MD	Enclosure 9
13.	Approval of FT Programme Plan	MD	Enclosure 10

14.	Presentation: Estates Update Approval of Business Case relating to 4th Floor, Loman Street	MD	Presentation & Enclosure 11
15.	Receive Business Continuity Update	MD	Enclosure 12
16.	Receive Update regarding Service Improvement Programme 2012	PB	Enclosure 13
17.	Receive Annual Charitable Fund Committee's minutes	CS	Enclosure 14
18.	Receive Audit Committee's minutes	CS	Enclosure 15
19.	Receive Clinical Governance Committee's minutes	BM	Enclosure 16
20.	Report of the Trust Secretary on tenders opened and use of the Seal since the last Trust Board meeting.	CMc	Enclosure 17
21.	Opportunity for members of the public to ask question		Oral

Date of next meeting: 10.00 am on 25th November 2008, Conference room, LAS HQ, Waterloo Road.

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 29th July 2008

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive (from 11am)
	Non Executive Directors	
	Beryl Magrath	Non Executive Director
	Caroline Silver	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Executive Directors	
	Martin Flaherty	Director of Operations
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
Apologies:		
	Brian Huckett	Non Executive Director
	Roy Griffins	Non Executive Director
	Sarah Waller	Non Executive Director
In Attendance:		
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	David Jervis	Director of Communications
	Malcolm Alexander	Chairman, Patients' Forum Ambulance Services (London) Ltd
	Chris Vale	Head of Operational Support
	Chris Miles	Project Manager, Fleet Support Services
	Anne Fulcher	Vehicle Resource Centre Supervisor
	Jo Brice	Fleet Administration Manager
	Bob Buck	Fleet Staff Representative (Amicus)
	Christine McMahon	Trust Secretary (Minutes)

74/08 **Declarations of Further Interest**

There were no declarations of further interest.

75/08 **Opportunity for Members of the Public to ask Questions**

There were no questions from members of the public.

76/08 **Minutes of the Meeting held on 20th May 2008**

Agreed: The minutes of the meeting held on 20th May 2008.

77/08 **Synopsis of the Trust Board's Part II meeting held on 20th May 2008**

Noted:

1. **The contents of the synopsis of the Trust Board's Part II minutes.**
2. **That the Chairman of the Patients' Forum Ambulance Services (London) Ltd requested that, as he believed there was reference to that organisation in the Trust Board's Part II minutes, those minutes should be shared with the Patients Forum.**
   Post meeting note: **the Chairman sent a copy of the Part II minutes to the Chairman of the Patients Forum for information.**

78/08 **Matters arising from the minutes of the meeting held on 20th May 2008**

Agreed : **That the Chairman will write to David Nicholson, Chief Executive Officer of the NHS, who was quoted as saying that although he intellectually understood the role ambulances could play in reducing inappropriate A&E presentations, he had yet to see the evidence. The Chairman's letter will cite the Trust's achieving the target agreed with Commissioners of 28,000 fewer admissions to A&E in 2007/08 through initiatives such as the introduction of Clinical Telephone Advice. ACTION: the Chairman**

79/08 **Chairman's remarks**

The Chairman said Cynthia Bower has been appointed as the Chief Executive of the Care Quality Commission and that the appointment of a new Chief Executive of the NHS Confederation was imminent.

The Chairman met with Sir Cyril Chantler, Chairman of the Clinical Advisory Group for NHS London and of Great Ormond Street Hospital for Children NHS Trust and the Kings Fund, to discuss how the LAS could contribute to implementation of integrated urgent care provision in London. The Chairman said it was unfortunate that there has been slow progress in implementing Lord Darzi's vision for London's healthcare.

The SHA has clarified the views expressed at the board to board meeting held on 7th July 2008 as to the timing of the LAS' application to become a Foundation Trust in respect to the implementation of the CAD 2010. The LAS was expected to apply sooner rather than later, circa April 2009, with a timetable yet to be agreed.

80/08 **The Chief Executive's report**

In the absence of the Chief Executive, the Director of Operations presented the report and highlighted the following:

The LAS was actively involved and contributing to NHS London's work on Healthcare for London. Clinical and policy staff were engaged in most of the workstreams, in particular those on unscheduled care, stroke and trauma. Work has also commenced in respect of the workstreams on polyclinics and on diabetes.

Agreement has been reached regarding Active Area Cover which will be implemented from 4th August 2008; this will enable the Trust to deploy resources

more effectively and will reduce patient waiting times. The number of Resource Centres has decreased from three to two and these are based at Ilford and Croydon. A new 999 call handling telephone system was implemented on 21st July 2008. This will provide greater stability for 999 call taking and will enable the Control Room to have an additional ten call taking positions in the room.

The Hazardous Area Response Team (HART) has now been made a permanent resource for the service to deploy to serious incidents. During the autumn the LAS will commence Urban Search and Rescue training and the existing HART team will be expanded to 42 staff to incorporate these skills.

The LAS Emergency Preparedness Department hosted a national conference in July targeted at emergency planning leads UK wide. The following events were discussed and learning shared: the Sussex Fireworks Factory Explosion; the Greyrigg Rail Crash; the Yorkshire & Gloucestershire floods; the Glasgow Airport Bomb and the changes made to the LAS major incident plan following the 7th July 2005 London suicide bombings.

PTS was successful in its tender to be added to the framework for the provision of PTS services in London and will be invited to participate in mini-competitions for 13 contracts. In addition PTS has been invited to tender for South West London and St George's Mental Health Trust. There was a restructure of the senior management team with effect from 1st June 2008. There will be a restructure of the remaining management grades in line with changes to the operational model and this is due for completion by October 2008.

London Ambulance Radio Project (LARP): due to issues with the software and hardware the original roll out date of 30th November for the new digital system was unlikely to be achieved. The new plan schedule shows the service commencement to be 19th September and for a number of reasons (installation, testing, training of staff) was considered to be high risk as there was a possibility that full implementation would not be completed prior to the Christmas period. The LAS was not in favour of a partial implementation during the Christmas period and has informed the Airwave Management Board that, if necessary, the LAS will wait until January 2009 to implement the new system.

Performance:

- 78.1% of Category A calls were reached within 8 minutes in April; 75.1% in May; 72.1% in June and 70% in July to date.
- 88% of Category B calls were reached within 19 minutes in April; this fell to 80.8% in June and 81.3% in July to date.

The Director of Operations said that to give some perspective, in June 2007 Category A 8 minute call connect performance was 58%.

Overall demand increased by 3.6% between April-July 2008 with the number of Category A calls rising by 6.7% in the same period. In addition, staffing levels in June and July were poor. The Trust has used a number of incentives to encourage front line members of staff to work overtime. Control Services has continued to perform well although there was a fall off in call taking performance during the end of June and early July.

Discussions were taking place with Commissioners concerning responding to 95% of Category B calls within 19 minutes. In 2008/09 the Trust was commissioned to respond to 90% of Category B calls within 19 minutes. The Commissioners were informed that the offer of additional financial support to recruit more members of

staff would not lead to an immediate improvement in performance as there would be a time lag of five months whilst the recruits were recruited and trained.

The HR Director said that to date the Trust received over 2,000 initial requests for information when it recently advertised for operational personnel. Due to the complexity of the recruitment and training of 400 members of staff the HR department has established a formal project team to manage the process. Efforts were also being made to recruit existing NHS professionals (Nurses and Physiotherapists) who would be invited to undertake conversion courses.

The Trust undertook retrospective CRB[I] checks in early 2008. To date 16 members of staff have failed to comply with the process and the Trust was taking the necessary follow up action. There have been 92 'positive' checks, including 12 cases which had already been disclosed to the Service by the individual. 23 investigations were undertaken under the disciplinary procedure; one member of staff has been dismissed.

The level of sickness has shown a positive downward trend with 4.5% recorded for May and 4.8% reported for April. The HR Director said the improvements in the trend of sickness levels could, in part, be attributable to the overtime incentive in place for Operational staff during this period together with a greater focus on absence management.

Communications: there were a number of enquires received from the media following incidences of knife crime in London. There was some interest expressed concerning the retrospective criminal records checking undertaken by the Trust.

The annual London Ambulance Service Awards was held on the 11th July. It was attended by 300 members of staff and was considered to have been a very good evening.

It was NOTED that:

The delay in implementing LARP was a risk for every ambulance service in England. If the LAS delayed implementing LARP until January 2009 it would be relying on its existing analogue radio system, however if the current system were to fail the Trust had 200 digital airwave radios in place as a back up. The consensus of the meeting was that it would be better to implement the new airwave system properly in January 2009 rather than in a piecemeal during a period of high demand such as Christmas.

The Trust's application to become a Foundation Trust may be adversely affected if the Trust is not achieving performance targets in a sustainable manner.

Although the Trust received significant additional funding to reach 75% of call connect Category A calls within 8 minutes, the Chairman said the Trust Board had been given a reasonable explanation as to why the performance target was not achieved in June.

Although overtime was offered to front line staff there was an issue concerning the take up of overtime; the recruitment being undertaken in 2008/09 of 400 members of staff will mean that the Trust will be far less reliant on operational staff working overtime. The Non-Executive Directors advocated using the funds that were being set aside should the Trust not reach 90% of Category B calls within 19 minutes to pay for overtime.

[I] CRB: Criminal Record Bureau

The Director of Operations said that although the performance target for Category B had not been achieved, overall performance has improved year on year. ORH[I] has been asked to undertake a further piece of modelling to ascertain the staffing required to reliably, year in year out reach 95% of Category B calls within 19 minutes. Previous modelling by ORH was based on 3% p.a. growth in call volume (based on experience in 2006); however, in the year to date Category A demand increased by 6.7% and this has hit the Trust's ability to deliver the Category B 19 minute performance target. If, in September or October, the Commissioners agree extra funding for 2009/2010, further recruitment will be undertaken to ensure the Trust can achieve Category B 19 minute performance targets for the year as a whole in 2009/10.

The Finance Director said that £2.1m had been set aside in April and May to pay for overtime. The Finance Director said that the Trust was currently forecasting £1m surplus and he said the Board may wish to take a view on whether the surplus should be used to further support Operations. The Finance Director said the voluntary threshold agreed with the Commissioners regarding extra funding being received in response to a rise in demand required total demand to change rather than just Category A demand.

The Director of Operations said that a number of measures were being taken to improve performance: the use of overtime and bonus schemes; the acceleration of the recruitment of 400 members of staff; the implementation of active area cover; decreasing multiple sends[II] as well as technical innovations in the Control Room. The Directors of Operations and Finance weekly discussed the level of overtime required and it was felt there was sufficient flexibility in the system for the incentives offered to be reviewed and adjusted as necessary.

CRB checks were undertaken on recruitment or when existing members of staff changed jobs internally. Members of staff had a contractual duty to inform the Trust if convicted of a criminal offence.

Although an example of positive interest from the media about the work of the Trust, the picture of the Cycle Responder featured in the Daily Mail article was considered to be inappropriate as it identified Class A drugs being carried in the kit bags used by members of staff. Information shared with the media in the future would not contain such sensitive information.

It was important that the further modelling being undertaken by ORH fully reflected the anticipated needs of the Trust for the next few years. The Chairman said frequent and repeated remodelling would raise credibility issues and needed to be explained carefully.

The current high level of utilisation was a key factor in the Trust's challenges in meeting its performance targets, particularly in regard to responding to 95% of Category B calls within 19 minutes.

The Director of Operations believed that although the current performance levels were disappointing, it was still possible that the target of responding to 75% of Category A calls within 8 minutes could be achieved through successfully responding to 76% of Category A calls within 8 minutes from October onwards. The Director of Operations was asked to circulate an updated version of the list of

[I] ORH: Operational Research in Health

[II] Multiple sends: despatch of more than one resource i.e. a fast response unit (cars, bikes or bicycles) as well as an ambulance to an incident.

measures being undertaken or proposed to achieve the target performance for Category A calls. **ACTION: Director of Operations.**

81/08 Financial Report, Month 3, 2007/08

The Finance Director presented the Month 3 financial report 2008/09; the Trust was forecasting a surplus at year end of £1.193m against a planned surplus of £1.140m. The trend of expenditure was consistent with the Trust's £21m spend in April, May and June. The Finance Director said that the last two pages of the Month 3 report needed to be restated and the cash flow statement reissued. **ACTION: Finance Director.**

The Finance Director said expenditure on overtime was expected to decrease in July and August and increase from September 2008. The money being set aside for the Category B penalty will be amended, reflecting the Board's support for additional funding being made available for overtime. **ACTION: Finance Director**

The Trust expected to receive CBRN funding and education and development funding in August 2008.

It was NOTED that:

The CBRN funding reported included funding for HART and this would be clearly shown separately in future financial reports.

PTS had an action plan in place to address the loss to date of £360k and was forecast to break even for 2008/09.

82/08 Auditor's Report on 2008/09 Annual Accounts.

Approved: The 2008/09 Annual Accounts which will be presented at the Annual Public Meeting in September 2008.

83/08 Report of the Medical Director

The Medical Director highlighted the following from her extended report which had been expanded to be more patient focused:

A problem was identified during a medically supervised interhospital transfer where a paediatric laryngoscope was found to have missing batteries. A bulletin was issued in May and again in July instructing Paramedics to check their PALS[1] kit to ensure the laryngoscope functioned correctly.

Procedures for ratification: four procedures, previously approved by the Clinical Governance Committee, were presented for ratification by the Board. The procedures related to:

- The clinical handover of patients;
- Ambulance observers;
- Responding to enquiries and giving evidence at Coroners Inquests and Statements at Police interview
- Actions on scene indirectly related to the patient.

Assistant Medical Director: Dr Fenella Wrigley has been appointed Assistant Medical Director with responsibility for Control Services and will join the LAS on 6th October. Dr Wrigley who was previously a Consultant in Emergency Medicine at Lewisham University Hospital is currently at the Royal London Hospital. She is a senior doctor in St John Ambulance with extensive experience in managing the

[1] PALS: Paediatric Advance Life Support kit.

clinical aspects of major planned events in London. She is also an Emeritus HEMS Consultant.

JRCALC[I] recommendations July 2008 re. airway management: at the main Committee meeting held on 9th July 2008 JRCALC members studied the findings of the working group report entitled 'a critical reassessment of ambulance service airway management in pre-hospital care'. The Committee accepted the group's conclusion that '..paramedic intubation can no longer be recommended as a mandatory component of paramedic practice and should not be continued to be practiced in its current form' and that' for the majority of paramedics, greater emphasis should be placed on airway management using an appropriate supraglottic device (SAD)'.

The LAS remains one of the Services that currently expect trainee paramedics to undertake training in advanced airway management and achieve 25 intubations, under supervision, in the operating theatre environment. The LAS will continue to do this but will emphasise the importance of becoming competent in the placement and management of supraglottic devices. The LAS will stress the shift in anaesthetic practice and expect to see this mirrored in prehospital practice over time. The LAS will continue to insist that for all intubations, robust governance arrangements are in place; that a bougie is available for all attempted intubations and that not only is end tidal carbon dioxide monitored but that for patients transferred to hospital, a print out is handed over to the receiving clinical staff.

It was recognised that there have been difficulties in securing placements in hospitals to enable paramedics to receive the necessary training of undertaking intubations in an operating theatre environment. In addition, as Paramedics may only undertake two or three intubations a year, there was the difficulty of maintaining competency and skill decay. Paramedics will be expected to abide by the robust governance arrangements that were in place in regard to intubations. The Medical Director said the College of Paramedics was unhappy with the JRCALC's recommendations. However, with fewer training opportunities and with changes to the airway management in hospitals the change in practice is inevitable.

Drugs: Oral morphine supplies will be delivered next week and will be available to Paramedics from early August.

The LAS will be implementing the British Thoracic Society Guidelines for Emergency Oxygen use from 1st October. Colleagues in Emergency Medicine have been asked to bring this to the attention of staff working in their departments to ensure they are familiar with the implications of the changes.

Appendix 5 of the Medical Director's report provided a summary of findings from the National Ambulance Clinical Performance Indicator Pilot. This study looked at five CPIs developed by the National Ambulance Clinical Audit Group and included material gathered between May 2007 and March 2008. The five CPI areas selected were: stroke (including transient ischemic attack); acute myocardial infarction (STEMI); cardiac arrest; asthma, and hypoglycaemia.

The Clinical Support Desk, staffed 24/7 by a small group of experienced Paramedics, has been running in the Control Room since 21st April 2008. Initial findings suggest that this service was valued, being accessed on average 10 times a day. The common

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[I] JRCALC: Joint Royal Colleges Ambulance Liaison Committee
[II] PSIAM: decision support software used by Clinical Telephone Advisers
[III] PALS: Patient Advice and Liaison Service

reasons for calling were to check on guidelines and to discuss capacity and consent issues. Recognition of Life Extinct was another reason for accessing support. In addition to answering queries from staff on ambulances and cars, the Advisers have an important role in 'trouble shooting' within the Room. The Board's attention was drawn to the graphs showing CTA staffing and recruitment; CTA call volumes and Calls passed to CTA, the percentage that were triaged using PSIAM[II] and those that were reviewed only. This was translated as 5102 total ambulances sent and 4010 ambulances saved in June 2008.

The Trust received a total of 98 complaints in the first quarter of 2008/09, a drop of 29% compared to the total received in the same quarter in 2007/08. There was also a drop in the number of written complaints received. In 2007/08 written complaints made up 45% (62 out of the 138) of the total complaints received and in 2008/09 this percentage was 36% (35 out of the 98). 'Delay', 'Non-physical abuse' and 'Treatment' were three of the main subject areas. All three of these main subjects have fallen in 2008/09 when compared with the total amount received.

In keeping with the 'Making Experience Count' programme, the Trust will be combining the PALS[III] and Complaints functions to maximise the potential learning from these important feedback mechanisms and adopting a more patient centred approach. This will help the Trust to understand emerging themes and trends in patient and stakeholder concerns.

Frequent Callers: All files held by PALS referring to Frequent Callers have been reviewed and allocated by postcode to a Complex and Borough. These reviews established whether patients were still active, had stopped calling, moved to a different address or deceased, and where our intervention has promoted a change to care provision or initiated other action. Where it was found that the patient is a high volume caller, using CTAK facility, the patient was moved into the 'Top 20'. The case was then reviewed and appropriate action undertaken without delay. A Social Worker (with ASW experience) has been appointed and will take up post in October 2008. Since November 2007 the Frequent Caller Unit closed 182 cases, of which 40 patients have died, 5 patients re-housed to nursing home, 1 person in prison. 206 cases remain open

Patient property scheme: disappointingly, following the introduction of the scheme on a trust wide basis, the LAS received almost as many enquiries as before the scheme was introduced. From 1st August 2008 where crews have not recorded the use of the patient property bags any enquiries received will be referred to the local Ambulance Operations Manager (AOM) to resolve. Where crews were familiar with using the bags (for example Hillingdon which undertook the initial pilot) no enquires have been received concerning lost property. Posters will be placed in every ambulance, to remind crews and alert patients.

Infection Control: the post of Infection Control Co-ordinator has been advertised and suitable candidates will be interviewed at the end of July. A second Trust wide Infection Control Audit commenced in May and returns were being collated.

London Medical Directors Forum: the Medical Director attended the inaugural meeting of the London Medical Directors Forum on 28th July and shared the outcomes of Serious Untoward Incidents with other Trusts.

The Medical Director said that one of the difficulties in hospital placements was that the requirement for CRB checks to be done for each placement rather than accepting the CRB check undertaken when a member of staff join the LAS or change their roles within the organisation. The Medical Director said she will again raise the issue

with the Director of Public Health at the next meeting of the London Medical Directors' forum

It was NOTED that :

Those patients who frequently call the ambulance service will inevitably have a high mortality rate (in the Medical Director's report it was stated that of the 434 frequent callers identified by the Trust since November 2007 40 had died) reflecting that the callers were often very vulnerable and very frail individuals.

Following a query raised by the Chairman of the Patients Forum Ambulance Services (London) Ltd in regards to the Ambulance observers procedure, it was clarified that should representatives of external bodies wish to visit ambulance stations they would be expected to give reasonable notice as the stations were busy transport sites and health and safety issues would need to be managed.

There were continuing difficulties recruiting the full establishment of 70 Clinical Telephone Advisers (CTA); the average number of staff in post was 45-50. The Trust was proposing that experienced members of staff, such as Emergency Care Practitioners and Student Paramedics at the end of their course, undertake a rotation in CTA. It was recognised that the current necessity for CTA function to be based at Waterloo was adversely affecting recruitment and it was suggested that if the CTA function were to be undertaken at different locations across London, recruitment might be more successful.

The Chairman said he had witnessed the CTA system in operation many times and he was confident that the Advisers struck the right balance in not sending an ambulance unless it was necessary and resolving many of the calls on the telephone. The Medical Director said there were two categories that reflected on the assessments being undertaken by the Advisers: when calls were referred back to EOC and when they are not referred for transport.

Agreed: To ratify the decisions of the Clinical Governance Committee and approve the following procedures:

- **The clinical handover of patients**
- **Ambulance observers**
- **Responding to enquiries and giving evidence to Coroner Inquests and Statement at Police interview**
- **Actions on scene indirectly related to the patient.**

84/08 **<u>CAD 2010 Full Business Case</u>**

The objective of the CAD 2010 Project is to replace the Computer Aided Despatch system, the Trust's mission critical command and control system. Full details of the project have been regularly reported to the Trust Board.

Under delegated authority from the Trust Board, the Service Development Committee in June 2008 noted the contents of the evaluated tender report, the recommendations of the Procurement Team and the CAD 2010 Project Board's selection of Northrop Grumman Information Technology Global Corp. as the preferred supplier. The Committee also accepted the draft Full Business Case ahead of finalisation and approved work to commence with the preferred supplier on the basis of a letter of intent, in accordance with standard financial instructions capped at £750k, with an agreed reporting structure back to the Board. The money would only be paid if there was a failure to agree contract terms and the procurement did not proceed.

The next stage of the process is to gain approval from the Trust Board to submit the Full Business Case to the Strategic Health Authority (SHA). Following approval by the SHA, the Trust Board will be able sign a contract with Northorp Grumman.

Noted: That, due to the commercially sensitive information contained in the document, the Trust Board would consider the Full Business Case in its Part II meeting.

85/08 Update on Foundation Trust (FT) Diagnostic

The Finance Director gave a brief presentation outlining the milestones in the FT application process: the project stages; the proposal for work streams and inter-linkages; the work that would be undertaken in respect of the Integrated Business Plan; the draft business planning cycle and the Trust's FT project plan.

The Chairman received a letter from Malcolm Stamp, CEO of the London Provider Agency, which contained feedback on the Board to Board meeting between the LAS' Trust Board and representatives from the SHA on 7th July 2008. It was suggested that the Trust's Integrated Business Plan (IBP) be revised to include: additional material on market strategy; the management of risk and the management of the timing of the application for FT status vis a vis implementation of the CAD2010. Further work will be undertaken to clarify how the Trust managed its Cost Improvement Programme.

It was recognised that, in addition to the further work being undertaken in respect of the IBP, there would also need to be buy-in from the 31 London Primary Care Trusts as to the Trust's proposed direction of travel, particularly as multi-year commissioning will need to be negotiated.

It was NOTED that:

In 2007 the Director of Service Development visited the majority of London's PCTs giving presentations on the developmental work being undertaken by the LAS. Building on this, and recognising that there remained some ignorance about the different services offered by the LAS, the Chairman said he will invite the Chairmen of the London PCTs to visit the LAS. ACTION: the Chairman

Following the grouping of the PCTs into five geographical sectors, presentations will be given to the PCT's management boards explaining the LAS' role in delivering emergency and urgent care to Londoners and sharing the Trust's future market plan. ACTION: the Chief Executive.

86/08 Receive Fleet Workshop Review recommendations.

The review of Fleet Support Services commenced in December 2006 and involved a comprehensive review of Workshop numbers and locations, operating hours, shift patterns, and potential additional services. A report published in August 2008 by the Working Group set up to review the Workshop configuration recommended a number of options for the future delivery of services. Consultation was carried out in the Autumn of 2007 with Fleet Workshop staff and Operational colleagues. ORH was then commissioned to produce modelling based on a number of Workshop sizes and configurations and hours of operation. KPMG was asked to prepare Business Case information around the risks, costs, and benefits of the various options. A further round of consultation was carried out with Fleet and Operational staff following receipt of the ORH and KPMG data.

The conclusion, drawn from the various strands of work, was that there will be significant operational benefits in establishing 2 large Workshops, supported by mobile facilities, working a 24/7 shift pattern. This will reduce Vehicle Off Road (VOR) time and assist in reducing the overall size of the vehicle fleet. In addition a number of additional services, such as bodywork repairs and MOT work could be introduced.

It was NOTED that:

Bob Buck, Fleet Staff Representative, said that although fleet staff had supported and fully participated in the review of fleet operations they requested that further discussions be held around the implementation of the review's findings. He said that staff had serious concerns as to whether the proposed efficiencies would be delivered. He said that although the number needed to be less than it currently was he disagreed with the proposal of two workshops.

The Director of Operations said he had previously discussed the findings of the review with the Fleet Staff representative. There was agreement on many of the proposed changes. It was accepted that fewer, bigger workshops would improve the relief factor; that extended hours were necessary and that expanding services would improve the skill-set and therefore the salary of fleet staff. The Fleet Staff Representative said that the Trust should consider piloting a large workshop in the West, evidencing that it will deliver the anticipated performance improvements rather than moving to a two workshop configuration immediately.

The Finance Director said that a business case per site would be presented to the Trust Board for approval as the building would be approximately 21,000 square feet. The Finance Director said that the proposal for two workshops was primarily focussed on achieving improved efficiencies in how the Trust manages its fleet.

The Director of Operations said that a compromise acceptable to all parties would be for the Trust Board to approve the recommendation of a phased implementation of a smaller number of larger workshops. A Full Business Case, which would inform the final configuration, would come back following further work being undertaken.

Approved: The phased introduction of a smaller number of large well equipped workshops operating extended hours with expanded skills set. This should begin by opening a large workshop in West London. Experience gained in operating this facility would then be used to inform the final configuration in terms of numbers of workshops and their geographical locations. This would in turn lead to a Full Business Case which would then come back to the Trust Board for final approval.

87/08 Workforce Development Update

Training and Development Plan, update for 2007-09.

The HR Director presented the updated Training and Development Plan 2007 – 2009 which had been amended to include the provision of training for the new Student Paramedic role and Practice Placement Educators.

The provision of Student Paramedic training was significant; it was seen as a priority to achieving immediate performance challenges and future provision of quality services and was being supported by a comprehensive recruitment project. The Plan

also contained the revised Paramedic training for existing staff so as to take account of requirements introduced by the validation of this training by the Health Professions Council due in September 2008.

The Plan recognised the current pressures on the Trust to achieve its patient response standards and the associated recruitment plan to increase staffing levels to support this.

During the remainder of the period of this plan (2008-09), the delivery of Continuing Professional Development (CPD) modules has been modified in response to these challenges and will focus on those staff identified as not having accessed existing modules.

It was NOTED that:

253 members of staff have undertaken training since April 2008.

Five additional CPD modules have been developed and were ready for future roll out.

Student Paramedic Pathway

The Trust has developed a Student Paramedic training programme to support the implementation of the Workforce Plan. The training programme has been designed to meet the requirements of the existing awarding body (IHCD) and the registering body (Health Professions Council).

Students will undergo training over a three year period and the programme will be a mixture of classroom, clinical and practical placements, at the end of which they will be eligible to apply to the Health Professional Council for registration as a fully qualified paramedic.

It was NOTED that:

Further work will be undertaken through the Organisation Development and People Programme to develop and introduce the Diploma level training programme in the future.

The Trust has commenced recruitment to the Student Paramedic Programme; the selection process was endeavouring to ensure that successful candidates have the capability to complete the three year programme.

During their training the Student Paramedics will be supported and mentored by Practice Placement Educators. The role of Practice Placement Educators was a new role in the Trust; a robust selection process was in place to ensure that a high calibre of staff is recruited. The Student Paramedic's clinical training will be consolidated with a period of practice placement under the supervision of a qualified Practice Placement Educator.

The Student Paramedics, when they are deployed operationally, will be expected to function as part of the ambulance crew and to practice only at the level they have been trained. There will be ongoing classroom teaching and appraisal throughout the Programme and there will be clear guidelines as to what they are competent to practice as they progress through the different levels until graduating as a Paramedic.

The HPC will be undertaking a validation review of the proposed Student Paramedic Programme in September 2008

Emergency Care Practitioner – education and future role

Lizzy Bovill, Assistant Director of Operations, gave a presentation on the education and future role of Emergency Care Practitioners (ECPs).

There were currently 53 ECPs in post, based at 12 of the 26 LAS complexes; the Trust will be recruiting 30 new ECPs in 2008/09 and establishing ECP schemes at both New Ways of Working (NWOW) sites in Barnehurst and Chase Farm

The presentation highlighted the following issues associated with ECPs:

- Operational performance;
- Management structures;
- The interest being expressed by PCTs in working with the LAS' ECPs to meet their urgent care agenda;
- The inclusion of the clinical leadership programme model as part of the New Ways of Working.

It was NOTED that :

There were 41 internal applications received to become ECP; 38 were shortlisted and of these 28 were successful following interview; ten remain to be assessed and interviewed.

The duration of the current ECP course was 18 months; discussions were being held with the higher education providers to shorten the course to reflect the national ECP curriculum.

ECPs were primarily deployed to respond to Green or Amber calls (urgent as opposed to emergency incidents) as these patients often had quite complex medical histories and occasionally involved patients with multiple illnesses. The Trust was also despatching ECPs to red calls (emergency calls) as FRED[I] and FREDA were able to identify red calls that would benefit from ECPs attending and support by other vehicles, i.e. ambulances, would not be required.

ECPs will be able to provide patients with optimal clinical care as additional alternative referral pathways were developed across London

The Trust's draft ECP Strategy will be shared with ECPs at a conference in September; the Strategy will be presented to the Trust Board in the autumn for approval. The Chairman said that the ECP Strategy should include reference to Healthcare For London's Urgent Care Network. **ACTION: Director of Operations**

It was recognised that there was potential for the ECPs to have a much greater impact than they have to date due to their small numbers and because they have not been sufficiently concentrated in one area. As only a few PCTs were willing to fund ECPs in their areas the decision was taken to mainstream the ECPs as part of the LAS' workforce because it was an initiative the Trust wished to support.

88/08 **<u>Update regarding Service Improvement Programme 2012</u>**

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

Noted: That the majority of the projects were on track; one project (referral pathways) was not on track but was under control.

[I] FRED & FREDA: Fast Response Electronic Dispatch for Ambulance

89/08 **Draft Minutes of the Service Development Committee, 24th June 2008**

Noted: The draft minutes of the Service Development Committee, 24th June 2008.

90/08 **Draft Minutes of the Audit Committee, 16th June 2008**

The Chairman of the Audit Committee, Caroline Silver, presented the draft minutes and highlighted the following:

- The 2007/08 Annual Accounts were reviewed prior to their presentation to the Trust Board;
- There was a lengthy discussion as to whether a provision should be included in the 2007/08 annual accounts for the remounting work that will be undertaken in October 2008 under the terms of the leasing agreement taken out between October 2003 and September 2006;
- The process for tendering the internal audit service;
- The issues that led to Brent PCT incurring a £25m deficit in 2007/08.

It was NOTED that:

The Internal Auditors will contact the Medical Director to discuss the scope of any future clinical audits.

Noted: The draft minutes of the Audit Committee, 16th June 2008.

91/08 **Draft Minutes of the Clinical Governance Committee, 2nd June 2008**

The Chairman of the Clinical Governance Committee, Beryl Magrath, presented the draft minutes of the Clinical Governance Committee's Working Party that met on 2nd June 2008.

The Committee undertook a self-assessment (75% response rate) which was used to inform the Working Party's review of the terms of reference and the Committee's future workplan. The Committee will discuss the proposed revised terms of reference when it met on 4th August 2008. The amended terms of reference will be presented to the Trust Board as part of the annual review of the Trust's Standing Orders and Financial Instructions.

It was NOTED that:

A process will be introduced to ensure that the Senior Management Group considers new policies and procedures following their discussion by the Clinical Governance Committee. **ACTION: Trust Secretary**

92/08 **Report on tenders opened and the use of the Trust Seal since the last Board meeting**

Four tenders have been opened since the last Trust Board:

1. *Conversion of Vauxhall Movano: PTS Stretcher Vehicles*
   Oughtred & Harrision (facilities) Ltd U V Modular Limited Wilkes UK Limited

2. *Internal Audit & Counter Fraud*
   RSM Bentley Jennsion

3. *Web Based Psychometric test*

Criterion	Previsor	SHL
Kenexa	Selby & Mills	Calibrand

Global Technologies	IDN Ltd	Stuart Robertson & Assoc
OPP	Montpellier	t-three consulting
Assergent Technologies Solutions		

4. Replacement of asbestos roof: Friern Barnet

Advanced roofing services Ltd	RKC Industrial Rfg and Cldg Ltd
Brandclad Ltd	Westfield Roofing Co. Ltd

Use of the Trust's Seal: there have been two entries, reference 117 and 118 since the last Trust Board meeting. The entries related to:

No. 117 Lease of Unit 4, Lea Bridge Industrial Centre
No. 118 Lease of Unit 2, Lower Hook Farm, Shire Lane, Down, Kent.

Noted:
1. **The report of the Trust Secretary on tenders received**
2. **That the Trust's seal had been used twice since the last Trust Board meeting.**

93/08 Any Other Business

There was no other business.

94/08 Opportunity for members of the public to ask questions

There were no members of the public present.

95/08 Date of next meeting

Tuesday, 30th September 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road followed by the Annual Public Meeting at 2.30pm

Meeting concluded 13.09

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 29th July 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 July 2008 in Part II the Trust Board AGREED:

That, as the Patients' Forum Ambulance Services (London) Ltd is no longer a statutory body, the Trust Board requires Forum members who attend non-public meetings of the Trust to give an undertaking to respect confidential matters that may be discussed at those meeting.

That the CAD 2010 Full Business Case be submitted to the Strategic Health Authority for further scrutiny, seeking authority for the Trust to sign the contract with the preferred supplier.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 30th SEPTEMBER 2008

Chief Executive's Report

1. SERVICE DEVELOPMENT

1.1 Healthcare for London

Work continues to ensure that the ambulance service is involved in and contributes to NHS London's work on Healthcare for London (HfL).

Clinical and policy staff are now engaged in all of the workstreams, to an appropriate extent. Current progress includes:

Stroke
HfL have now produced a preliminary acute stroke strategy. It proposes three options, all of which involve 24 hour operation of stroke units (SUs), rather than some operating 24 hours and some 12, as in the original Healthcare for London document. The options are:

1. A large number of small-sized (five to eight beds) Hyper-Acute Stroke Units (HASUs) situated within SUs, some of which will cater for thrombolysis and others which will not.
2. A large number of medium-sized (10-14 beds) HASUs situated within SUs, catering for all patients within the first 72-hour stabilisation period, and then transferring patients to adjacent SU beds or repatriating patients to a SU nearer to home.
3. A small number of large-sized (20-28 beds) HASUs, catering for all patients within the first 72-hour stabilisation period, and then transferring patients to adjacent SU ward or repatriating patients to a SU nearer to home

We have responded to the consultation in favour of option 3. This is because larger units see more patients and therefore develop and maintain their expertise and therefore patient outcomes are better. The pilot in South West London is planned to continue for the foreseeable future but there is a possibility that London-wide implementation might not take place until well into next year due to the thorough consultation process. We will, in the meantime, seek to move towards implementation through the commissioning process, as some PCTs are keen for us to proceed.

Trauma
As reported to the last meeting five hospitals were shortlisted to develop their proposals for trauma networks. They have all submitted proposals and are working on fuller ones to be submitted by early October. The criteria are hard to meet and we should anticipate that one or more hospitals may not meet them. Most of the units have involved us actively in their planning.

The LAS internal working party continues to meet and is currently focussing mainly on data gathering, while its members are also participating in the local discussions with the shortlisted hospitals.

Unscheduled Care
Following the Unscheduled Care Board meeting attended by the Chief Executive in July, the trust has submitted to HfL a short paper proposing how a three digit telephone number for urgent healthcare needs could be operated (the response hub concept). We are now working this up into a fuller proposal that may be taken to the HfL Urgent Care Board in early October. We are working with NHS Direct on the possibility of making this a joint proposal.

Local Hospital Feasibility
The detailed work on the clinical and financial viability of the model for a local hospital proposed in *Healthcare for London* has concluded that:

The Local Hospital can function effectively clinically, but attention needs to be paid to enabling measures, which ensure safety, such as:

- clinical networks with clear governance arrangements
- clear protocols on pre-hospital care and transfers
- development of staff skills in different settings

The Local Hospital can manage financially, so long as:

- the transition is well-managed and resourced
- Trusts tackle cost reduction rigorously
- clinical organisation is geared to ensuring high levels of productivity
- PCTs are supportive of Trusts diversifying in their provision or hosting of services

Kathy Jones and Fionna Moore will shortly meet with the project manager for this workstream to discuss how to ensure that LAS would continue to take as many patients as appropriate to these units and to any community-based services they will run in due course, as it would affect their viability if this did not prove possible.

Polyclinics
This workstream is now entering a phase of involving providers. Nick Lawrance will present at a workshop in October, explaining the potential for LAS to contribute to the development of polyclinics.

Diabetes
As we now test the blood sugar levels of most patients over 40, we can play a role in early identification of diabetes. We have made the project team aware of this.

The NHS London Healthcare for London team will shortly be establishing three more workstreams: Children, mental health and women's health. We have identified lead LAS people for each of these.

1.2 A&E Operations

Barnehurst Complex held the first ever New Ways of Working Away Day on 9th and 10th September at a Hotel in Dartford. This extremely successful event aimed to bring together all the complex staff with the NWOW implementation support team and senior managers to agree the future direction and benefits of NWOW for Barnehurst staff. The event included external speakers from the East Midlands Ambulance Service who presented their learning and best practice in

introducing new rotas. In addition, staff were provided with basic skills such as training in participating and managing meetings, negotiation skills and developing clinical leadership in order to support their future involvement in the New Ways of Working programme. Barnehurst complex forums have now been established in order to lead station based developments and pilot new projects such as new training and rotas designed to meet the needs of the local population.

The Trust's Emergency Care Practitioners and other related staff gathered for the ECP Conference on September 11th 2008. The purpose of the conference was to review current ECP performance and clinical development in preparation for the development of the ECP strategy which will be submitted to Service Development Committee. Over 40 delegates gathered to discuss how performance and tasking for this group could be improved and new ECP clinical competency guidelines were launched. How ECPs could fit into the future NHS Urgent Care strategy and the potential benefits to patient care and the LAS were also debated.

1.3 Patient Transport Services

As reported previously we are completing our bid response to the above for submission to PASA/LPP by the 22nd September. Our intention is to submit bids on the following contracts

- Barking, Enfield and Haringey Mental Health Trust (new business)
- Barking, Havering and Redbridge Hospitals (part existing business)
- Bromley Hospitals (existing business)
- Lewisham Hospital (new business)
- Moorfields Eye Hospital (new business)
- North East London Mental Health Trust (existing business)
- North West London Hospitals (new business)
- Queen Mary's Sidcup Hospital (existing business)
- Royal National Orthopaedic Hospitals (existing business)
- South London and the Maudsley Mental Health Trust (existing business)

We have agreed not to submit bids for the following contracts due to history, activity profile and volume and suitability to absorb within the new operational model at this stage.

- Guys and St Thomas' Hospital (new business)
- Kings College University Hospital (new business)
- Moorfields Eye Hospital (new business)

The following Trusts have withdrawn from the process

- Great Ormond Street Hospital (new business)
- Royal Marsden Hospital (new business)

The revised timetable is as follows :

- Completion of tender documentation to be returned by 22nd September 2008
- Announcement of successful bidders November 2008
- Commencement of new contracts 1 April 2009.

Outside of the above process the LAS has submitted on the 8th September a detailed tender bid for South West London and St George's Mental Health Trust (existing business)

We are now waiting to see if we will be short listed to go through to the next stage. This tender timetable is as follows:

- Presentation by short listed bidders 23rd September 2008
- Announcement of successful bidder end of November 2008
- Commencement of new contracts 1 April 2009.

We are still awaiting a response from Newham General Hospital NHS Trust (new business) following our submission of our tender bid to them.

Vehicles and Equipment

The replacement vehicle program will see twenty five replacement PTS stretcher vehicles arriving on contracts from mid October to end of November. A further twenty five sitting case vehicles are being ordered for delivery in the New Year. We are also ordering to meet the growing demand and requests, three special purpose vehicles to convey Bariatric patients for our contracts. These vehicles will also be used for appropriate A&E patients

With the new Meridian Software now operating successfully, we are now moving to the second stage of the project where we will be issuing out to the road staff, vehicle PDAs to allow patient journeys to be allocated, tracking of the resource and updating from the crews electronically, further improving on the quality of the data and locations of the resources in real time. This work will begin with a pilot rollout commencing in October in the South East cluster covering the Bromley contract.

1.4 Information Management & Technology

London Ambulance Radio Project (LARP) Project Update

As previously reported there have been ongoing delays with the project at a national level. At the last report to the Trust Board in July it was still anticipated that it would be possible to complete full implementation in London within this financial year. However, since then the national testing of the control room dispatcher equipment (the LAS participated in this) has run into further difficulties, with the latest release of software having a large number of recorded faults. The overall result is that it will now not be possible to implement Airwave in the LAS during this financial year, and a new timescale cannot be given at this stage.

In addition, the LAS has also had issues with the use of the Airwave terminals at this year's Notting Hill Carnival. As with New Year Eve 2007 and last years Notting Hill carnival there was a loss of service that the user experience would describe as congestion. Once again the Trust reverted to it's analogue system that provided effective cover without operational effectiveness being compromised.

Given the problems described above, the Department of Health and Airwave have been informed that of the following:

1: The LAS will continue to support the DH team in their efforts to resolve the problems with the control room equipment and ultimately fully deploy the Airwave system.

2: The LAS will continue to use the 200 Airwave terminals for spontaneous events / LAS only Major Incidents where evidence has shown the system to work satisfactorily.

3: The LAS will not plan to deploy the Airwave terminals for major pre-planned events, namely New Year's Eve and Notting Hill Carnival until there is fully implemented control room solution and the re-occurring congestion problem (user experience, not necessary the actual technical problem) has been satisfactorily resolved and proved by Airwave.

CAD 2010

Following selection of NG (Northrop Grumman) as the preferred CAD system supplier, work continues to finalise the contract schedules. The Project Manager and members of the Procurement Team met with Northrop Grumman in the USA during the week commencing 25 August to progress this work and further meetings in London took place during the week of 8 September. Key NG staff, including the project manager, were introduced to key Project Board members and members of the Project Team based at Fielden House.

As planned, both the LAS and NG have now agreed and signed a pre-contract agreement or 'letter of intent', allowing NG to commence work on the project. The letter of intent allows for up to three months work with clearly defined scope and payment points. The final contract will be signed once the LAS receive NHS London approval of the Full Business Case.

The Full Business Case was submitted to NHS London on 1 August. NHS London has responded with a list of areas where they require further information to which a full response has been provided. The Director of IM&T has confirmed with the SHA Chief Information Officer that he is happy with the business case and has signed it off from his perspective. It is anticipated that the approval of the CAD2010 FBC will be on the agenda of the October meeting of the NHS London Capital Investment Committee. It is planned to formally present this to the Trust Board in November with actual contract signature taking place the first week in December.

2 SERVICE DELIVERY

2.1 A&E Operations

In light of the poor performance and deteriorating staffing position, the Trust has remained at REAP Level 3 'Critical' and has been implementing the relevant actions associated with this level. This has included each area setting up and running an Area Delivery Unit (ADU) and the three are now fully operational with dedicated staff overseeing performance on a 12-hrs a day basis. To oversee this, a Central Delivery Unit (CDU) has been set up and established in the Gold Command Suite on the first floor at Waterloo. From the 1st September it has been staffed at ADO/ACAO level 24 hours a day 7 days a week with plans to maintain the Gold level Officers in place until the end of the

financial year. They are facilitating the appropriate focus and ensuring that changes such as Active Area Cover and high levels of Rest Breaks allocation are becoming embedded and that performance is focused on consistently across the entire 24 hour period. The first two weeks of September have shown a marked improvement on performance overnight as a direct result of the focus and has been the determining factor in many of the current improvements being attained.

In my last report I advised that after some ten months of difficult consultation the Trust had agreed the 'Active Area Cover' policy with our Trade Unions. The new arrangements were implemented from Monday 4th August and are due for joint review early next year. The implementation has allowed us to deploy resources much more effectively and has achieved its objective of a reduction for patient waiting times. A 14-day comparison for a similar period prior to implementation has shown a 3.5% increase in Cat A performance and a 3.3% increase in Cat B performance .We are now averaging around 350 deployments per day rising to as many as 500 on some days. Snapshot audits have shown an average time for crews to receive a call is 18 minutes and feedback is indicating that just one or two out of ten deployments result in no call. These have tended to be early in the day and on the edges of the Trusts area. I anticipate further improvements as the Active Area Cover becomes further embedded.

There were two separate and unrelated technical issues that caused the CTAK system to be taken down over four separate occasions during August and September. The first was related to a hardware issue and took place on the 5th and 27th August. The second was related to a software issue and occurred on the 2nd and 4th September. A more detailed report into the technical aspects appears elsewhere in this report, but the operational impacts are covered here. On all four occasions the control room reverted to pen and paper successfully, but the overall impact on reported performance was relatively significant with regards Category B performance, the monthly figure being reduced in total by over 0.5%.

The new telephone system has continued to support call-taking with EOC now benefiting from the additional positions that it has provided. The new and more comprehensive 'Gazeteer' has also continued to produce benefits as staff have learnt to navigate their way around more effectively. Consequently we are now seeing more accurate locations being identified quicker. This is resulting in crews being more effectively navigated to the calls and thus arriving sooner, particularly in the more difficult to identify locations such as housing estates.

The Control Services management re-structure has now become embedded, with Area Controllers assuming responsibility for each of the three area desks. Their principle focus has been on achieving performance targets, managing 'Active Area Cover' and improving rest break allocations. This has been a key link in the chain of performance improvement in September.

In August once again the Emergency Planning Unit put in place its well exercised plans for the Notting Hill Carnival. This event was managed successfully across the bank holiday weekend with our partners, St. John Ambulance, with 400 persons treated and 100 persons taken to hospital.

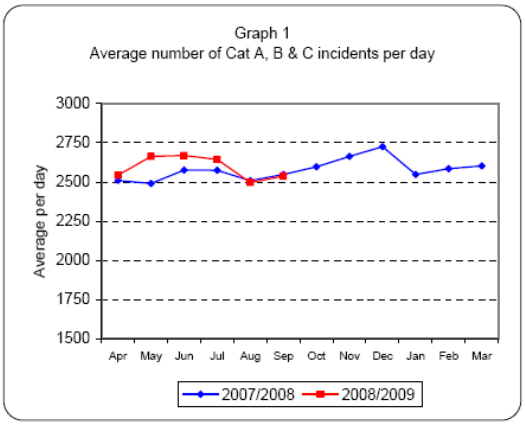
Recruitment for HART has been ongoing throughout the reporting period and I am pleased to report that HART is now up to strength with a full team of 30.

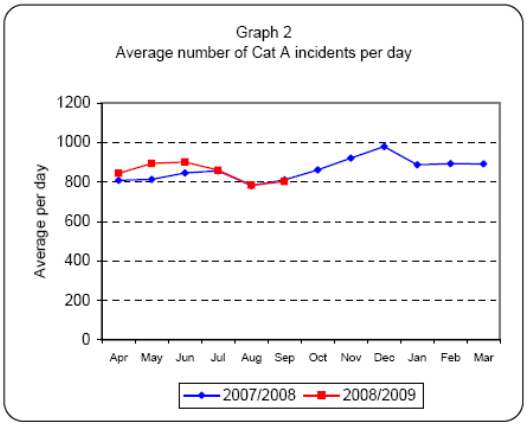
In September 6 LAS paramedics from HART started Urban Search & Rescue (USaR) training. There will be a further two courses which will bring the strength up to 18. This will give the LAS a

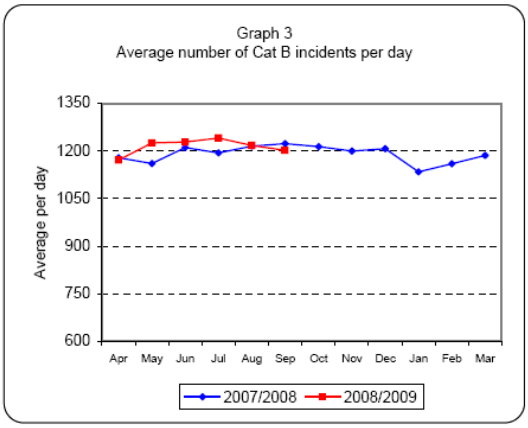
full urban search and rescue capability and will allow paramedics to treat patients trapped in collapsed structures and provide clinical support to the fire brigade in prolonged incidents.

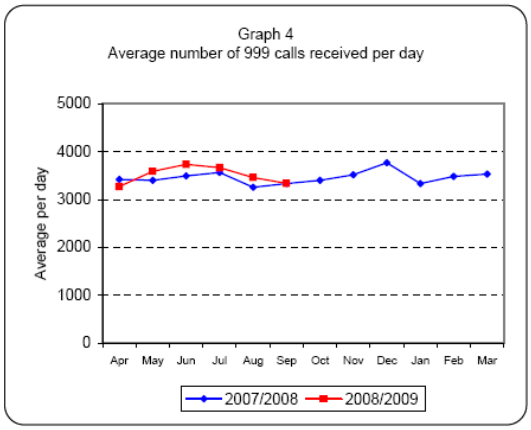
CBRN decontamination team recruitment is ongoing. This is designed to bring the overall team size up to 350 by December this year.

Accident & Emergency service performance and activity







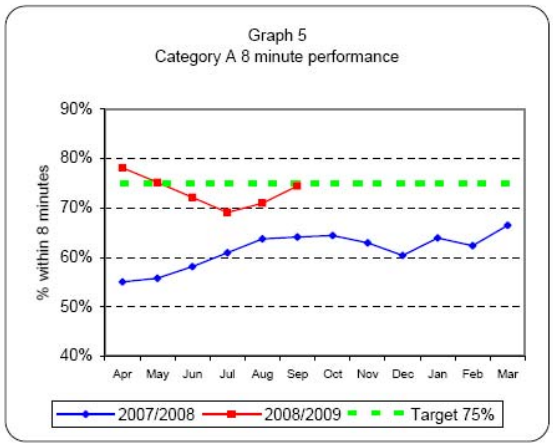


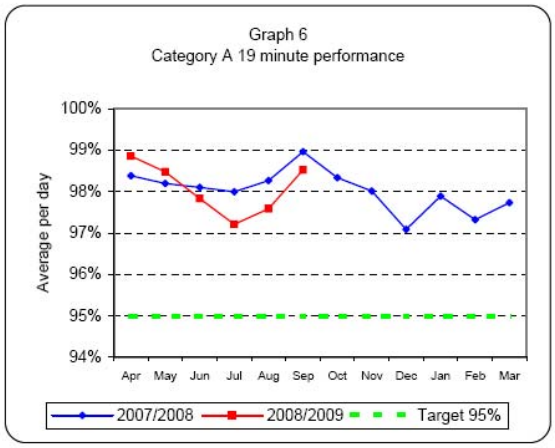
The table below sets out the A&E performance against the key standards for the first half of 2008/9 and for the first 18 days of September.

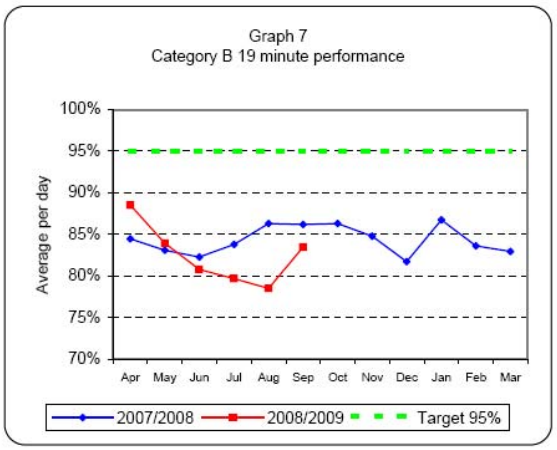
	CAT A8	**CAT A19**	**CAT B19**
Standard	***75.0%***	***95.0%***	*90.%**
Year to date	73.22%	98.04%	82.35%
July 2008	69.04%	97.20%	79.67%
August 2008	70.97%	97.58%	78.53%
1-18 September	74.48%	98.48%	83.47%

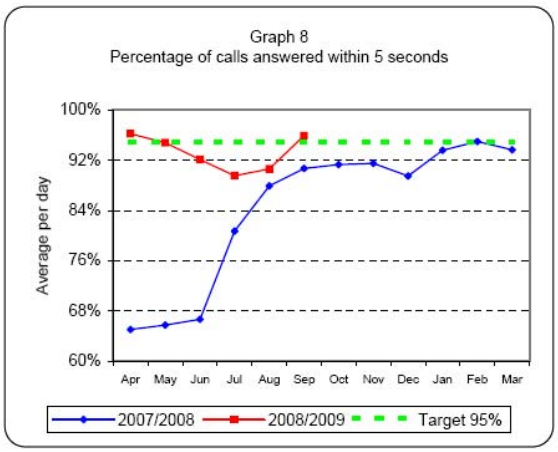
* Commissioned Target for 2008/9 (Please note National Target is 95%)

- Category A performance has been poor across July and August which has been broadly caused by rising workload and falling staffing levels. The start of September has been much more encouraging with performance returning to the levels agreed in the trajectory submitted to the SHA in late August.
- It is important to retain some perspective here in that Call Connect performance last July and August was 61% and 63% with virtually identical staffing levels. The levels now being achieved against a higher workload still represent a step change in performance.









- Category B performance has also declined for similar reasons but is now making a good recovery, as can be seen by the figures in the table above.
- The performance difficulties have been the subject of extensive discussion with Commissioners and the Provider Agency. The Board will recall that we were commissioned at 90% on Category B this year which reflected the degree of performance challenge associated with meeting the Cat A call connect targets for the full year, whilst at the same time improving Cat B performance. We have produced a comprehensive recovery plan for Cat B which is designed to deliver greatly improved performance. This was agreed with NHSL at the end of August and has been shared with Commissioners who have agreed some additional funding to support us, subject to achievement of the agreed trajectory on a monthly basis.

- We produced circa 237,000hrs of Ambulance resourcing for July and August this year, which is about 20,000 hrs less than for the same period last year. However FRU hours produced have increased by 19% for July and 24% for August. Total FRU hours were 108,000hrs compared to 89,000 for the same period last year. This has meant that whilst the overall hours produced has shown only a very slight improvement, it has been at the expense of Ambulance staffing. This has supported the significant improvement in Cat A call connect performance but has not provided comparable performance in Category B performance, which has traditionally been largely achieved by Ambulances.
- Control Services have managed to perform better than last year, but did show a reduction in call taking performance from the levels recently noted. Reasons for this were the technical difficulties associated with CTAK and staff becoming familiar with the new gazetteer. However performance is now back on track during September and is achieving over 95% consistently.

2.2 CTAK Issues

From the period 5 August to 4 September there were four serious disruptions of service to CTAK. These occurred as two different faults, the first on 5 and 27 August, the second on 2 and 4 September. Both were completely different issues and were not connected.

The fault on 5 August was a hardware failure. As a result of this, preventative work was planned for the live system on 27 August, having first been successfully undertaken on 22 August on the back up system at Bow. During the planned work on 27 August, mistakes were made by the hardware maintainer that resulted in the subsequent failure. A full debrief took place and letter of apology was received along with a detailed action plan from the maintainer to ensure there will not be a repeat of the issues during future work.

The fault on 2 and 4 September was caused by a software bug. This was an interaction of code that had been in CTAK for many years and changes that were most likely to have been made to some display screens in the last two years. The circumstances for this fault were extremely rare, hence the obscurity of it's occurrence. During diagnostics on 4 September a fix was implemented to stop its occurrence, and a full patch has now been implemented to completely eradicate it.

As a result of these problems a number of actions have been undertaken:

- As part of a wider IM&T restructure, a Senior IM&T Manager has been allocated to focus solely on CAD, directly overseeing the current CTAK arrangements, CAD 2010 requirements and the overall migration approach.
- CTAK support has been increased by an additional specialist contractor (who previously worked on CTAK as part of the 'invest to save' initiative). He will be trained to provide supplementary support to the Systems Manager.
- The CTAK hardware maintainer has implemented a number of enhanced support options. This includes a complete review of the current hardware platform, with recommendations for proactive upgrades (e.g. disks) and regular on-site reviews. Inevitably, some hardware upgrades will be necessary.
- A review is being undertaken on the existing hardware configuration and the fallback arrangements for the existing servers. Further testing will be initiated at Bow, with considerations of also undertaking this on the live system, albeit this will require not an insignificant amount of downtime.

- The problems experienced on 2 and 4 September highlight the issues around making changes to CTAK code. While no guarantee can be made to future stability, it is clear that continued changes increase the risk of further failures. Therefore, excluding urgent system repairs, no changes will be made to the CTAK environment for the next month to allow a period of stability. Serious consideration will then be given to any further changes, balancing operational benefit against stability and impact on CAD 2010 slippage (due to development changes).

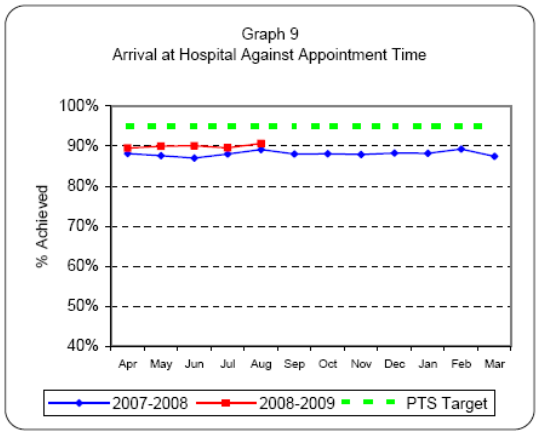
The way forward with CAD (in terms of stability) is to replace the current CTAK system as soon as reasonably possible. The following update on CAD 2010 is positive in this respect.

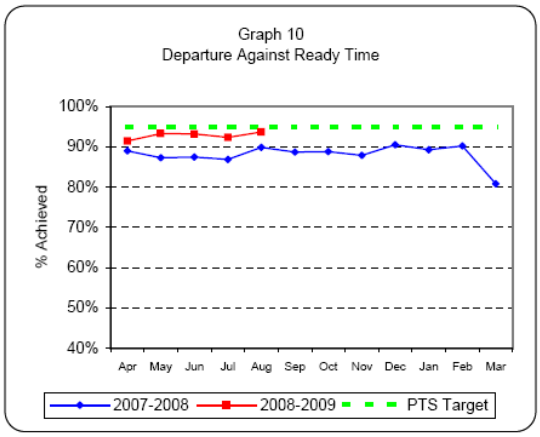
2.3 Patient Transport Service performance and activity

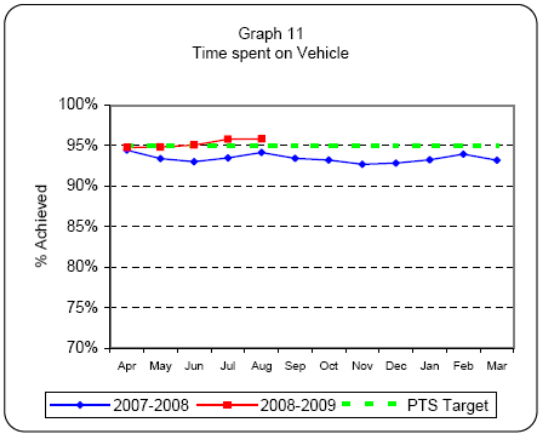
Performance on the quality statistics continue to remain static even though there is an increase in activity. Figures for August 2008 were:

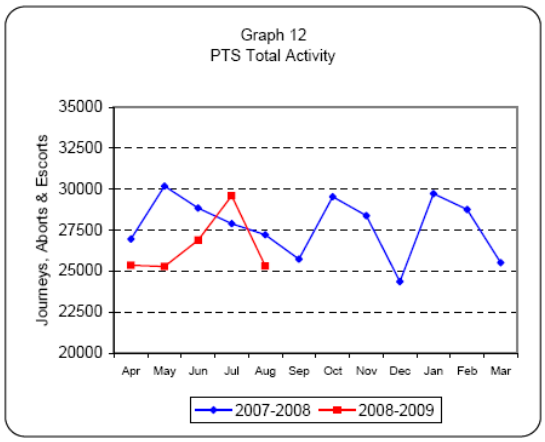
- Arrival time: 90%
- Departure time: 93%
- Time on Vehicle: 95%

Patient Transport Service
Activity and Performance - August 2008









PTS again provided a manager, five double crews and PTS Blue Light vehicles, along with two Hospital Liaison Officers to support and cover as part of the overall LAS response to the Notting Hill Carnival, working within the footprint and at the nominated receiving hospitals over the two days of the event.

This proved to be another successful deployment and use of PTS resources and provided experience and exposure to those involved and will prove beneficial to the Service if PTS is required at times of extreme pressure or at any incident.

3. HUMAN RESOURCES

Workforce Plan implementation

The Workforce Plan Implementation project continues to progress well and the response to the latest advertisement in the Evening Standard group (including Metro and London Lite) week commencing 8 September has been good.

Over the coming weeks three further advertisements are planned for the Evening Standard at staggered intervals, plus one half page with editorial on 6th October. We are also arranging radio advertising (Kiss FM), which will give us access to a diverse audience together with posters on the outside of buses, at bus stops and advertisements in tube trains. We are hoping that this sustained campaign will give us the ability to have sufficient candidates in the system to satisfy the training plan.

The 'Super Saturday' initiative, held on 30 August was a great success. The planning was impeccable and the day ran very smoothly. Candidates left with a very good impression of the LAS. The initiative provided a "one stop shop" for shortlisted candidates to undertake all assessments and interview if successful at the assessment stage. We successfully appointed 20 candidates on the day. We will repeat this initiative in October when the current advertising campaign has produced sufficient numbers to make it worthwhile.

For course start dates from commencement of the Student Paramedic programme in May up to the end of September, we have filled 84 places out of a potential 111. This is significant achievement with the majority of slippage in the early stages of local training of internal candidates.

The number of people who do not have C1 driving licence continues to rise but there is now significant turnover of these candidates accessing their licence and becoming available for course allocation. The experience with these candidates is that cost does not appear to be an issue as had been assumed. Ninety three percent of those needing a C1 licence are white, dispelling the assumption that this requirement disproportionately disadvantaged candidates from BME communities.

To support other areas of the Service, we continue to ensure that staff appointed from A&E Support and EOC are not all scheduled to commence their training at the same time. However it is encouraging that staff do wish to progress their career with us (thus far 32 from A&E Support and 12 from EOC).

The work on the 2nd floor on Hannibal House is progressing well and is on schedule. The first students will be going into Hannibal House week commencing 6th October having begun their training programme on 8 September with induction and driver training. The lease on the 3rd floor is secured and work has begun to refurbish this area.

The resourcing of the training courses and the practice placements is progressing well with the main area of concern being periods of high activity driver training in the New Year. Additional external resource is currently being sourced to support this activity.

Unions and Partnership Arrangements

At the July meeting of the Staff Council proposals for revised joint consultative arrangements and committee structure developed in consultation over a period of several months, and derived from local and national partnership principles, were tabled for approval. The Staff Council membership provides for seats for each of the recognised trade unions (Unison, GMB. TGWU, Amicus). A meeting of the trade union side had already voted to accept the proposals, but the representatives of GMB and TGWU had voted against. Representatives of these unions declined the opportunity to

sign up to the new arrangements, but Unison has endorsed them and formally signed the document. The lay representative from Amicus was also in favour, but could not sign the document due to the impending creation by merger with TGWU of the single union, Unite.

GMB and TGWU/Unite have each subsequently requested that a formal "dispute" be accepted, but have been unable to clearly state their grounds or concerns and these requests have been rejected. Lines of communication with these unions remain open in the hope that it will be possible to resolve any issues once these are understood, and meanwhile the invitation remains open to accept seats on the new staff council and to participate fully in the revised consultative arrangements for the Trust. Meanwhile, the joint Secretaries forum provides an opportunity for on-going discussion and dialogue about employee relations matters.

NHS London

The Trust, through the Director of Human Resources and Organisation Development, continues to work closely with NHS London in supporting the development, launch and future implementation of a "Workforce for London - A strategic framework" and associated Healthcare for London workforce implications.

The Service Level Agreement for the financial support for Education and Development has now been agreed for 2008/09 and work is progressing with NHS London to develop a three year development and funding plan.

The workforce development at the London Ambulance Service has been recognised and promoted as good practice within the Strategic Framework document which was launched on 16 September.

Retrospective CRB checks

The exercise of retrospective CRB checks is almost complete. All relevant staff are now at some stage in the process. 11 people are on long term sickness absence which has delayed the progress of their check. A further 12 individuals have still to complete the process.

According to our records these are the only checks which remain outstanding. In accordance with normal process we will continue to re-check staff on promotion and on return from maternity leave.

Senior Leadership Programme

This programme of development has been designed to provide managers up to and including Assistant Directors with the opportunity to develop their leadership and management skills. It is being designed and delivered by Management Futures, who were awarded the contract following an extensive tendering and selection process. The course is designed to complement our Exploring Leadership & Self Awareness (ELSA) programme which is targeted at junior managers, and continues the theme of successful leadership based around knowing and managing yourself, and awareness of the strategic context. The first cohort of managers have now attended their second

module of the Senior Leadership programme and a further intake is planned for early in the new year.

Equality & Diversity

Following an extensive recruitment and selection process, a new Equality & Diversity Manager has been appointed. Her name is Dr. Janice Markey, and she is currently working as an equality & diversity consultant with Westminster Council. Janice's joining date has not yet been finalised, but should be during October/November. Equality & Diversity Officer Ricky Lawrence is returning from his secondment with the Department of Health in October, which will bring the team back up to full strength.

PTS Restructure

The new PTS senior management team are now turning their attention to the restructure of the remaining management grades in line with changes to the operational model and this is due for completion by November 2008. New job descriptions have been completed and are currently being assimilated and graded through the AfC KSF process.

We have successfully recruited a further 10 new PTS Ambulance Persons who commence their training course on the 22nd September for four weeks at Bromley Training School.

Policy

The Trust published its "Second Jobs - Management Policy Statement and Procedure" in August clarifying the contractual requirements of staff when considering taking up secondary employment.

The Lease Car Scheme policy is well developed and with the Senior Management Group for final consideration and will be presented to the Trust Board in November 2008.

Paramedic Training Programme – Healthcare Professions Council validation

From September 2008, all new paramedic training courses, whether delivered in universities or in-house by ambulance trusts, must comply with standards set out by the Health Professions Council (HPC). Following several months of preparation, the HPC carried out its validation visit with the LAS on 16th & 17th September 2008. The outcome of the visit, including any conditions or recommendations from the HPC on meeting validation, will be available to the Trust in mid-October.

Workforce information

The workforce information report provides current data relating to sickness levels, staff turnover and A&E staff in post against funded establishment.

Whilst sickness levels for the Trust are slightly increased in the month of July, levels remain low at 4.96%. Monthly sickness management audits are conducted to ensure that focus on robust absence management is maintained, particularly during periods of operational pressure with appropriate application of the Trust's Managing Absence Policy.

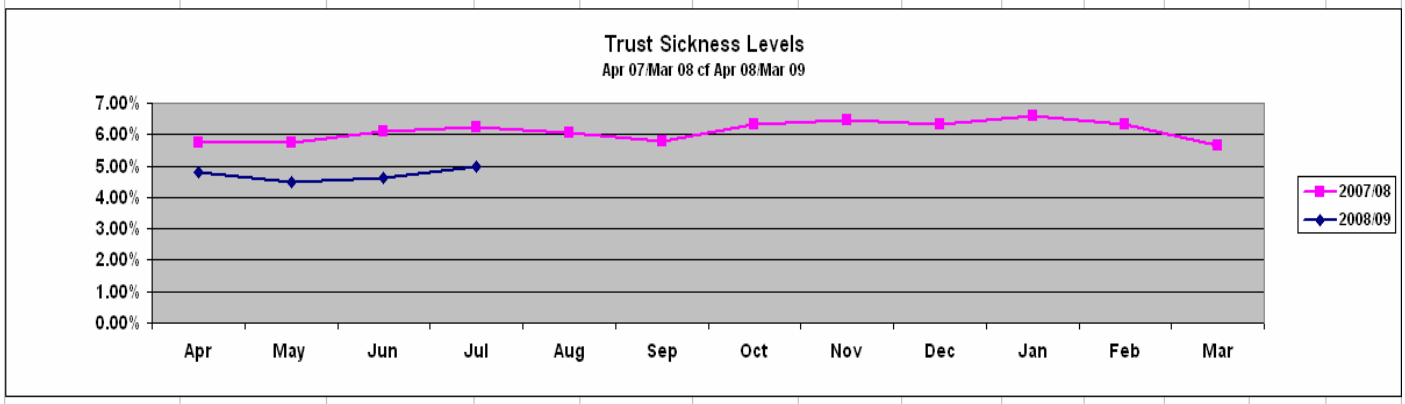
Staff turnover remains stable within the year and is slightly higher than the previous year in the areas of CTA, EOC and PTS. This does not however give rise for concern at present but trends will continue to be monitored.

We have posted circa 80 A&E support staff to all three areas in this year with 16 within this period. We have also, within this period, posted 16 Student Paramedics and an additional 7 from the 1st bridging course. By the end of September we will have written rotas and posted 82 University students, the majority of which are 0.5 whole time equivalent (WTE) but 25 of them are 0.8 WTE, thus giving us the equivalent of nearly 50 more staff. 22 Paramedics have recently qualified and now returned to their complexes which will assist the skill-mix issues across the services.

For the month of August, the A&E establishment of 2913 shows a vacancy of 313.42 WTE. The recruitment report to the contained earlier in this section describes the plans and progress in reducing this vacancy factor and achieving full establishment within the year.

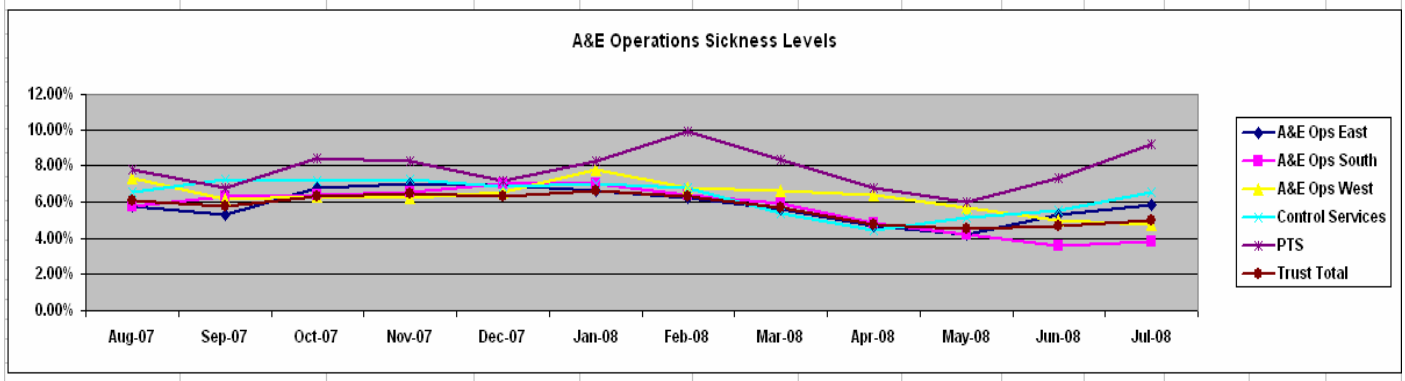
Trust Sickness Levels

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



A&E Ops Sickness Levels

A&E Ops Areas	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08
A&E Ops East	5.76%	5.31%	6.78%	7.03%	6.92%	6.64%	6.23%	5.63%	4.67%	4.18%	5.27%	5.88%
A&E Ops South	5.76%	6.35%	6.39%	6.58%	7.00%	7.02%	6.36%	5.91%	4.86%	4.18%	3.62%	3.85%
A&E Ops West	7.34%	6.12%	6.32%	6.23%	6.52%	7.78%	6.77%	6.61%	6.41%	5.69%	4.96%	4.79%
Control Services	6.53%	7.25%	7.19%	7.27%	6.83%	6.98%	6.79%	5.40%	4.45%	5.11%	5.55%	6.53%
PTS	7.79%	6.76%	8.43%	8.24%	7.13%	8.27%	9.86%	8.36%	6.80%	6.02%	7.30%	9.22%
Trust Total	**6.05%**	**5.80%**	**6.33%**	**6.47%**	**6.34%**	**6.61%**	**6.32%**	**5.66%**	**4.79%**	**4.49%**	**4.64%**	**4.96%**



Staff Turnover

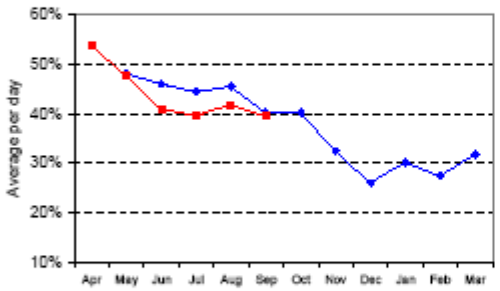
Staff Groups	Apr-06/Mar-07	Apr-07/Mar-08	May-07/Apr-08	Jun-07/May-08	Jul-07/Jun-08	Aug-07/Jul-08	Sep-07/Aug-08
A & C	11.04%	13.13%	13.48%	15.29%	14.20%	14.79%	13.35%
A & E	4.64%	5.13%	5.36%	5.46%	5.75%	5.58%	5.47%
CTA	0.00%	5.13%	11.11%	10.26%	10.00%	8.51%	10.87%
EOC Watch Staff	11.04%	11.70%	12.80%	11.85%	13.57%	12.57%	12.20%
Fleet	5.08%	10.91%	13.21%	13.21%	13.21%	13.21%	7.55%
PTS	6.16%	11.02%	11.86%	12.60%	12.50%	12.34%	11.97%
Resource Staff	1.96%	2.04%	2.08%	2.08%	2.08%	2.08%	2.08%
SMP	6.72%	6.74%	6.99%	7.83%	8.12%	7.36%	7.32%
Trust Total	**5.87%**	**6.83%**	**7.24%**	**7.51%**	**7.80%**	**7.57%**	**7.27%**

A&E Establishment as at August 2008

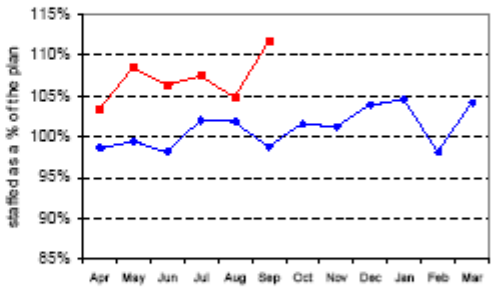
Position Titles	Funded Establishm	Staff in post	Variance	Leavers
Team Leader	175.00	163.58	-11.42	2.00
ECP	86.00	49.87	-36.13	0.00
Paramedic	830.00	822.89	-7.11	2.73
EMT	1220.00	1341.86	121.86	7.09
Student Paramedic	300.00	28.00	-272.00	0.00
A&E Support	232.00	148.32	-83.68	0.00
CTA	70.00	45.06	-24.94	0.75
Total	**2913.00**	**2599.58**	**-313.42**	**12.57**

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

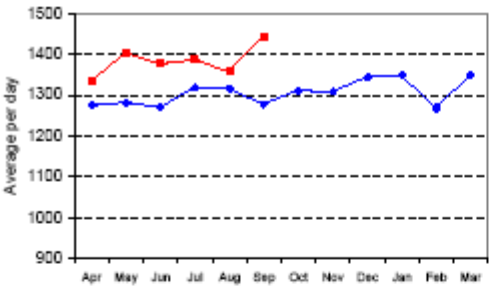
Graph 14
% of vehicles given a rest breaks



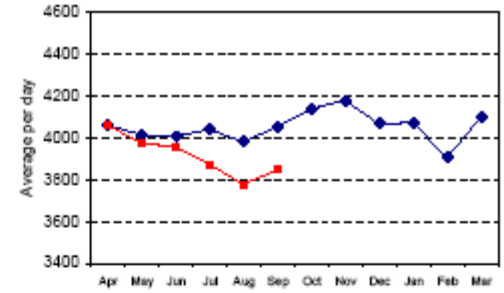
Graph 15
EOC Staffing as a % of the plan



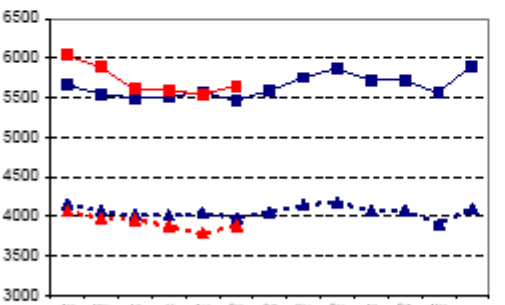
Graph 16
EOC hours staffed per day



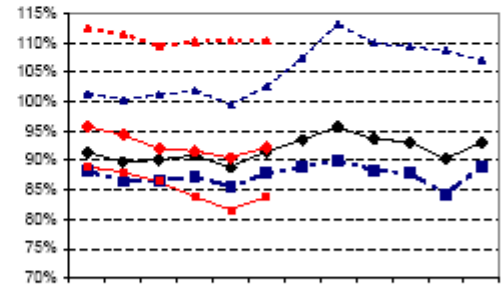
Graph 17
Ambulance hours per day (Avg 170hrs VOR)



Graph 18
Hours staffed AEU + FRU per day (Avg 224hrs VOR)



Graph 19
Staffing as % of plan (Avg 54hrs VOR FRU)



4. COMMUNICATIONS

4.1 Media

Support to bomb survivor Gill Hicks: The support given by staff to 7 July bombings survivor Gill Hicks on a 200-mile walk from Leeds to London gained widespread media coverage. Gill and her husband, Joe, aimed to bring people together from different communities during WALKTALK. A team of staff from Islington gave up time between shifts to support Gill on her journey – travelling in a spare back-up fast response car, they were on hand to provide any medical support or treatment that was needed. Emergency Medical Technician Tracy Russell, who treated Gill on 7 July, was interviewed on ITV London Tonight when the party reached Trafalgar Square at the end of the walk.

Cycle response unit: After a cycle response unit was reported to have attended the address of a celebrity, the Daily Mail and BBC London ran features on the work of the team.

Problems with call-taking system: The Evening Standard reported on technical problems experienced in the control room on 5 August. A statement was issued explaining that details of emergency calls were being recorded on paper while the issue was being resolved. The Standard's article was followed up by the Computer Weekly website.

Call connect – Health Service Journal (HSJ): An article in the HSJ entitled 'Urgent call target triggers cash crisis' reported that the new call connect target was causing major overspends for ambulance trusts. London was quoted as having a £360,000 year to date loss and reaching 68.9 per cent of life-threatening calls in eight minutes (figure for July). The article did not acknowledge that, at the time of publication (6 August 08), the service was at 73.3 per cent on the Government target for the financial year to date.

Other issues: Stabbings in the Capital have continued to attract widespread media coverage. On a more positive note, a number of local papers ran stories about staff who had been recognised at the service's awards night.

Filming

'London Ambulance': A second six-part series of the television show 'London Ambulance' was broadcast during August and September on ITV1 (London area). The fly-on-the wall look at the work of the service followed staff from Oval complex, and featured the control room, clinical telephone advice team and the cycle response units in the West End and Heathrow. The first episode attracted 300,000 viewers, a 12 per cent share of the total viewing audience and a similar number to that which would have watched News at 10 in London.

Publications

Annual report: The annual report for 2007/08 has been published, along with a special six-page pull-out on the story of the Trust, containing photos taken over the years and a chronology of the organisation's history. The report's 'now and then' theme coincides with the 60th anniversary of the NHS.

4.2 Staff recognition

Pride of Britain awards: Emergency Medical Technician Frank Samaras was short-listed to the final four of the Daily Mirror's Pride of Britain awards. He was nominated for showing outstanding bravery during an incident in 2006 when he confronted a violent attacker to protect two members of the public. As part of the awards process Frank appeared on GMTV with Carol Vorderman and viewers were invited to vote for the winner of the category. The Pride of Britain awards are to be held on 30 September.

NHS Champions: The Trust has nominated several members of staff for the 2008 NHS Champions awards, organised by the King's Fund. The Evening Standard, as media partner for the awards, profiled one of our nominees, paramedic Rob Bentley, for resuscitating a seriously premature baby born at home. Nominations are open to the public until 16 October.

4.3 Patient and Public Involvement (PPI)

New Ways of Working project: The first two Community Involvement Officers started work on 1st September at Barnehurst (Julie Carpenter) and Chase Farm (Russell Carpenter). They both have extensive experience of working with patients, the public and partner organisations, and are settling into their new roles very quickly.

Tower Hamlets project: The first training session for expectant mothers in Tower Hamlets is being held on 16th September at the Montefiore Children's Centre. This has been designed by a local EMT (Beverley Jeal) and will focus on basic life support, choking and bleeding. The aim of these sessions is to reduce infant mortality rates, which are higher in Tower Hamlets than other boroughs.

Other PPI activity: We have taken part in a number of public events over the summer, including:

- Knife and gun crime awareness events in Bexley, Beckton and North Kensington.
- Community events in Newham and Merton.
- Steph Adams, ambulance operations manager (AOM) at Barnehurst, gave a talk about the LAS to a large group (75-100 people) at the Bexley Pensioners' Forum.

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 2008

Invest to Save 2007/08 Programme
Programme Closure Report

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For noting

3. Summary

The Invest to Save (2007/08) Programme commenced in December 2007 and was expected to spend £8.3m by 31st March 2008. The paper sets out the spend actually incurred and the benefits which will be delivered as a result.

4. Recommendation

THAT the Trust Board NOTE the report.

Enclosure 4b

LONDON AMBULANCE SERVICE NHS TRUST

Invest to Save 2007/08 Programme

Background

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.

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.

Programme Business Case

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."

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.

Expenditure

2007/08

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.

2008/09

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.

Benefits Realisation

Benefits Realisation is currently underway on all projects. A full report will be presented later, which it is planned to be audited by our Internal Auditors.

The list of benefits to be delivered by each completed project is listed in APPENDIX 3. As the Invest to Save (2007/08) Programme is being wound-up the delivery of benefits will need to be managed, as set out within MSP, by the SIP2012 programmes. The process for agreeing the list of benefits for each programme is in progress.

Projects which incurred expenditure against the Invest to Save (2007/08) Programme but continue under the auspices of another programme in 2008/08 are excluded from APPENDIX 3 as any benefits accruing will form part of the main programmes' Blueprint.

Lessons Learnt

An analysis of Lessons Learn included within each project's closure report produces a list of lessons which need to be logged for future reference. These can be separated into two lists, those which relate generally to the management of projects within the SIP2012 and those relating specifically to a short-term programme like Invest to Save (2007/08) Programme.

Future Invest to Save Programmes

Table 1 below sets out those lessons learnt from this programme, which needs to be borne in mind if the Trust was ever to embark on such a short duration programme in the future.

Table 1

No.	Description (Inc. specialist methods used)	Recommendation
	What Went Well	
1	**Having a dedicated Programme Support Officer who could provide administration support to the SRO and Programme Manager was invaluable, especially as the level of work would swamp the PPMO.**	**As soon as a programme is envisaged appoint a Programme Support Officer.**
2	**Having a dedicated Financial Analyst who could provide financial support to the SRO and Programme Manager was invaluable, especially as the level of work would swamp finance.**	**As soon as a programme is envisaged appoint a Financial Analyst.**
3	**Reduced documentation, which was specifically designed, accelerated the production of control documents enabled projects to be initiated more quickly. It also allowed project managers and executives to concentrate on managing the product delivery rather than managing the project.**	**Use reduced documentation to short circuit initiation stage.**
	What Went Badly	
1	**Poor quality of project briefs, which lead to scope creep and confusion of what was to be delivered.**	**All project briefs should be completed by programme team, if possible.**
2	**SMG agreed the scope of the overall programme. However this was not necessarily communicated to middle managers, which meant little buy in. This in the case of 3 A&E operations projects lead to late cancellation of projects and some difficulty with the SHA as they were to deliver significant operational benefits.**	**SMG to ensure all relevant staff are briefed before programme is started.**
3	**Poor return of highlight reports, which made it difficult to see progress at a programme level, especially as there were up to 107 projects live.**	
4	**Poor change control, especially on**	**Tighter change control**

N$^{o.}$	Description (Inc. specialist methods used)	Recommendation
	IM&T projects. This meant that it was difficult for the programme team to be clear what was being delivered and the benefits.	**rules especially around all tolerances, including scope.**
	What Was Lacking	
1	**Clear agreement within SMG of project scopes, e.g. A&E projects. The result was that three key operational projects did not start as key senior managers, including one DDO, were not committed to the concept outlined in the brief.**	

The main driving force behind the programme was to spend the money allocated and pressure was applied by the SHA throughout the life of the programme to this end. Reflecting on the lessons learnt does indicate that this became of more importance than delivering sustainable benefits to the LAS.

Other LAS Programmes

Table 2 below lists those lessons learnt from this programme, which are applicable to other programmes within SIP 2012.

Table 2

N$^{o.}$	**Description (Inc. specialist methods used)**	**Recommendation**
	What Went Well	
1	The use of conference calls instead of getting all programme board members into a meeting room worked well, with a structured agenda	Consider the use of programmes more frequently.
2	The allocation of a cost centre for each project and the creation of a separate reporting structure within Integra allowed close monitoring of project and programme expenditure.	This should be replicated across all SIP2012 programmes.
	What Went Badly	
1	Poor quality of project briefs lead to confusion on what was expected and in some cases there was significant scope creep.	Clear project mandates agreed by the programme board should form the basis of all project briefs.
2	**The huge order for IM&T equipment, particularly PC, printers and scanners caused major storage problems for the Deptford store at a time when Logistics were also ordering large volumes of equipment and consumables.**	**Review IM&T procurement processes and introduce 'Lean Thinking'.**

N$^{o.}$	Description (Inc. specialist methods used)	Recommendation
3	Although many of the managers had been on Prince2 or internal project management courses their project governance skills not sufficiently developed. This has required considerable hand holding to ensure even the limited amount of governance has been completed effectively.	Provide a refresher briefing when a project manager is appointed to a project. Ensure there are detailed process maps of project governance supported by detailed templates.
4	Highlight reports were difficult to obtain from project managers every two weeks. Collecting them took considerable time.	Improve briefing for project managers and consider using some form of workflow software.
5	Closure reports were difficult to obtain as many project managers had gone back to their 'day jobs'.	Improve briefing for project managers and consider using some form of workflow software.
	What Was Lacking	
1	Clear project mandates were not produced. This led to poorly produced project briefs, in some instances, and uncontrolled scope creep.	Follow the approach being developed by PPMO to ensure project start up and initiation is delivered effectively.

Conclusions

Overall the programme came close to spending the money allocated within the short time frame allowed. While some sustainable benefits were delivered by the programme, which will need to be monitored by the programmes within SIP2012 more could have been done if better communication with management had been carried out and change control processes had been better.

M. Dinan
Director of Finance
25 September, 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 manageme	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**
Wireless Access LAN	60167	90	321	541	862	139	0	**1,000**
Procurement Software	60171	23	97	0	97	0		**97**

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
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**
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**

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
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

Invest to Save Programme 2007/08 - Project Benefit Summary

Project ID	Ben No.	Project Title	Benefit	Benefit Measures
AS10	1	Procurement Software	*Improve tender process within Procurement Dept*	*Reduced cycle time for tender result. Increased number of tenders processed*
AS10	2	Procurement Software	*Cost saving with less paper wastage*	*Reduced stationary budget*
AS10	3	Procurement Software	*Improved compliance with EU procurement (ie. web ad'vertising of contract opportunities)*	*Improved response levels from businesses*
AS12	1	Supplier Information Database Phase III	*Improved management of suppliers to the LAS*	*Increased number of supplier reviews*
AS12	2	Supplier Information Database Phase III	*Improved procurement process for use within the ongoing business of the LAS*	*Increased number of supplier reviews*
AS12	3	Supplier Information Database Phase III	*LAS procurement process becomes more pro-active rather than re-active*	*Retender contracts without emergency contract extensions*
AS16	1	Strategic Planning Model	*Ability to model strategic scenarios without recourse to ORH*	*Reduction in annual spend with ORH*
AS16	2	Strategic Planning Model	*Simpler models for compiling reference costs without purchasing new software*	*Reference costs submitted on time*
AS17	1	Governance Support	*Enhanced evidence reporting to GDU*	*Area Governance Reports to Clinical Governance Committee produced on time.*
AS17	2	Governance Support	*More detailed reporting to GDU*	*Area Governance Reports contain complete details.*
AS17	3	Governance Support	*Better evidence of compliance with accreditation requirements of Healthcare Commission and other external agencies*	*Improved compliance with standards – NHSLA rating. SBH rating*
AS19	1	Counter Fraud Support	*To reduce the risk of the Trust being affected by fraud by increasing the amount of proactive counter fraud work, via the employment of additional time from the Trust's LCFS.*	*Reduced incidents of fraud. Increased reporting of fraud*
AS20	1	Business Continuity Support	*Improved business continuity arrangements in place within a shorter timescale to that originally envisaged*	*Compliance with annual submission*
FP3	1	Plasma Screens	*Improved information on performance around the Service*	*Improved Cat A & Cat B performance*
FP3	2	Plasma Screens	*Immediate real time information from multi media resources*	*Improved Cat A & Cat B performance*
FP3	3	Plasma Screens	*Improved management intervention based on real time data*	*Improved Cat A & Cat B performance*
FP3	4	Plasma Screens	*Allows for monitoring of vehicles and response times*	*Reduction of VOR*
FP6	1	Rules of the Road	*Staff updated with latest Highway Code*	*Reduced RTAs*
IC10	1	Psychometric Testing	*Enhanced psychometric measurement capability for use in support of leadership development, particularly in support of the imminent New Ways of Working implementation*	*Reduced staff turnover.*
IC12	1	Enhancing Audit Processes	*Strand 1: Paper saving, cost saving, increased data security*	*Reduced stationary budget*
IC12	2	Enhancing Audit Processes	*S1: Improved consistency in selection of PRFs for audit (less bias & more accuracy of CPIs)*	*Improved accuracy of CPIs*
IC12	3	Enhancing Audit Processes	*S1: Team leaders' time saved through audits performed electronically*	*Increased CPIs per team leader per month*
IC12	4	Enhancing Audit Processes	*S1: Second computer monitor saves time and resources e.g. Printer cartridges etc..*	*Reduced stationary budget*
IC12	5	Enhancing Audit Processes	*Strand 2: Improved integration of CARU database with one another and other datasets (including hospital cardiac outcomes database)*	*Reduced cycle time for report generation*
IC12	6	Enhancing Audit Processes	*S2: Ability for more than one staff member to view and edit data – greater efficiency of processing*	*Reduced cycle time for report generation*
IC12	7	Enhancing Audit Processes	*S2: Improved data entry and enhanced, faster outputs (e.g. Reports produced more efficiently)*	*Reduced cycle time for report generation*

LONDON AMBULANCE SERVICE NHS TRUST

Invest to Save Programme 2007/08 - Project Benefit Summary

Project ID	Ben No.	Project Title	Benefit	Benefit Measures
IO7	1	Patient Property bags	*Reduction in Patient Property related issue being brought to the Trust*	*Reduced complaints & PALS queries.*
IO9	1	Paediatric Equipment	*Clinicians accurately administer appropriate quantity of drugs to children*	*Improved customer satisfaction.*
O1	1	Communications Support	*Provide fresh and up to date information which is more informed and accessible to the public*	*Reduced 999 calls*
O1	2	Communications Support	*The project produced up to date merchandise informing the public of the choice of services*	*Reduced 999 calls*
O1	3	Communications Support	*Enabled Communications to purchase industry leading equipment for "Public Events" e.g.. Tricaster Portal Media Production System*	*Reduced 999 calls*
O1	4	Communications Support	*Deliver/and Subscription to Political information*	*Foundation Trust Application*
O10	1	Benefits Realisation Consultancy	*Benefit maps and quantified profiles for all live SIP2012 programmes plus SIP2012 as a whole to feed Business Cases for the live programmes to make the Trust fully MSP compliant prior to Health check by the OGC late in the year*	*Complete benefit maps for all programmes.*
O10	2	Benefits Realisation Consultancy	*Knowledge of SMG and senior programme staff as to how to effectively plan and manage benefits realisation for the Trust*	*SRO and Service Development Director satisfaction*
O14	1	Laptops for Training	*Ability to meet reasoning target, as set out in the SIP*	*% calls answered within 5 seconds.*
O14	2	Laptops for Training	*The ability to deal effectively with ever increasing call volumes*	*Calls per call taker per annum.*
O14	3	Laptops for Training	*Ability to work on standalone- useful when system crashes*	*Improved resilience*
O14	4	Laptops for Training	*Allows remote training & flexibility over training locations*	*Reduced vacancies*
O14	5	Laptops for Training	*More family friendly as allows more flexible approach to work*	*Reduced vacancies*
O15	1	EIA & PPI Stakeholder Events	*Refinement of project scope and definition for projects to be implemented in 2008/09 and 2009/2010 and the business changes consequently made using the enablers delivered by these projects.*	*Patient & public feedback*
O15	2	EIA & PPI Stakeholder Events	*LAS compliance with PPI and Equality legislation - avoidance of a non-compliance order and damage to reputation*	*Patient & public feedback*
O16	1	New EOC Call-taking desks	*Improve working environment of staff*	*% calls answered within 5 seconds.*
O2	1	Recruitment Advertising	*Improved patient care and the reduction of clinical risk*	*Improved number of applicants per vacancy.*
O2	2	Recruitment Advertising	*Potentially the advertising will help fill the current shortage in staff e.g.. Junior Paramedics*	*Improved number of applicants per vacancy.*
O5	1	Migration to IFRS	*The Trust will comply with the DH requirement to have re-stated the 2007/08 accounts into IFRS format by Sept/Oct 2009*	*Number of audit adjustments.*
O5	2	Migration to IFRS	*The Trust will comply with the DH requirement to have prepared its 2008/09 and comparatives in IFRS format by May 2010*	*Number of audit adjustments.*
O7	1	Museum Audit/Evaluation	*The audit has given clarity as to the exact contents and value of the collection.*	*Valuation report with images*
O7	2	Museum Audit/Evaluation	*The LAS can now dicate whether the collection is adequately insured.*	*Reduced insurance risk*
O7	3	Museum Audit/Evaluation	*With the valuation complete, the LAS can make an informed decision regarding options for the museum's future.*	*Production of museum Business Plan*
O7	4	Museum Audit/Evaluation	*The value of the vehicles (whether monetary or historic) will hopefully influence a move to finally having the mall kept undercover. A restoration plan must also be drawn up.*	*Number of vehicles stored under cover.*
O7	5	Museum Audit/Evaluation	*Close working relationships formed with other Emergency Services and health museums in London.*	*Number of contacts made & meetings held*

LONDON AMBULANCE SERVICE NHS TRUST

Invest to Save Programme 2007/08 - Project Benefit Summary

Project ID	Ben No.	Project Title	Benefit	Benefit Measures
C8	1	Met Police DVD	*This DVD will update the video that was jointly produced by the LAS & Met Police in 1999. It will provide education and training materials to re-enforce the policies and procedures of the LAS staff when dealing with a range of patients who have come into*	*Number of times staff receive refresher training in this subject.*
C8	2	Met Police DVD	*A drop in the number of incidents where LAS staff can be/are criticised for not following best practice/ LAS policy/ procedures in these areas. This in turn will lead to a reduction in actual or potential claims against the LAS*	*Reduced number of complaints and PALS queries.*
C9	1	Capitalisation Review (Rev to Cap)	*Correct accounting treatment of capital projects*	*Reduced capital charges in future years*
CS17	1	Logistics/Fleet	*Increased resources for achieving performance targets*	*Improved VOR*
CS17	2	Logistics/Fleet	*Reduction in Vehicles Off Road (VOR) due to increase in Mobile engineer provision*	*Improved VOR*
CS17	3	Logistics/Fleet	*Improved vehicle availability through enhanced Flexible Fleet scheme and Vehicle Resourcing Centre package*	*Improved % shifts covered by vehicles.*
CS17	4	Logistics/Fleet	*Increased blanket provision*	*Reduced blanket 'stock outs'.*
CS17	5	Logistics/Fleet	*Enhanced quality of vehicle maintenance/repair and a reduction in VOR due to additional Workshop equipment*	*Reduced time vehicles wait to be maintained*
CS17	6	Logistics/Fleet	*24/7 Flexible Fleet*	*Improved % shifts covered by vehicles.*
CS18	1	Business Case Production	*Better understanding of cost differentials between options*	*Closed*
CS18	2	Business Case Production	*Better understanding of feasibility, costs, benefits and issues around outsourcing*	*Closed*
CS19	1	Winter pressures	*Improve Christmas manning.*	*Improved hours available against plan.*
CS20	1	CHH (EOC) Call-Taking Review	*Consistent achievement of 95% of Call answering in 5 seconds*	*% calls answered within 5 seconds.*
CS20	2	CHH (EOC) Call-Taking Review	*Reducing ORC ON Cat. A performance to Call Connect difference from 26% noted in May-July 2006 to 12% by April 2008, thus supporting the achievement of the Trust's objective of achieving 75% Call Connect performance*	*Improved Cat A & Cat B performance*

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th September 2008

Audit Commission's Annual Audit Letter

5. Sponsoring Executive Director: Peter Bradley

6. Purpose: To inform the Trust Board of the findings of the Audit Commission

7. Summary

The purpose of this Annual Letter is to summarise the key issues arising from the work that the Audit Commission has carried out during the year. The key messages are set out on page 41.

The details of the Auditor's Local Evaluation (ALE) are set out on page 43.

4. Recommendation

THAT the Trust Board NOTE the recommendations contained in the Audit Commission Annual Audit Letter.

Annual Audit Letter

London Ambulance Service NHS Trust

Audit 2007-2008

September 2008

The Audit Commission's Trust Practice

audit commission

Contents

Summary

Key messages

1 The following key messages are brought to the attention of the Board.

- One significant issue on the accounting treatment of a lease provision was drawn to the attention of the Audit Committee on 16 June 2008. However, it did not result in a material amendment and was resolved before the audit opinion on the financial statements was given on 20 June 2008.
- The Trust achieved a surplus of £398,000 for the 2007/08 year and met its key statutory financial performance targets, continuing its record of sound financial management.
- There were no material matters to draw to the attention of the Audit Committee before giving the audit opinion on the value for money conclusion.
- The Trust had proper arrangements in place to secure value for money in the use of resources.
- The Trust has made improvements to its performance under the Auditor's Local Evaluation, but the Board should continue to monitor progress and outcomes against the various plans in place to further improve the Trust's performance.
- Early completion of the 2008/09 ALE self assessment would also support the Foundation Trust application, as the ALE criteria have been updated to include some Monitor metrics.
- The Trust should continue preparations in the run up to International Financial Reporting Standards in 2009/10.

Recommendations	
R1	Monitor the Mercedes lease provision, revisiting the calculation of this liability as the timings and amounts involved become clearer in 2008/09.
R2	Implement the Trust's planned actions in 2008, including an early self assessment, against the KLOE criterion, to further improve the Trust's performance under the Auditor's Local Evaluation.

Purpose, responsibilities and scope

2 This Annual Audit Letter (letter) summarises the key issues arising from our work carried out during the year. I have addressed this letter to the directors and members of the Trust as it is the responsibility of the Trust to ensure that arrangements are in place for the conduct of its business and that it safeguards and properly accounts for public money. I have made recommendations to assist the Trust in meeting its responsibilities.

3 The letter also communicates the significant issues to key external stakeholders, including members of the public. I will publish this letter on the Audit Commission website at www.audit-commission.gov.uk. In addition the Trust is planning to publish the letter on its website www.londonambulance.nhs.uk

4 I have prepared this letter as required by the Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission. This is available on the Audit Commission website.

5 As your appointed auditor, I am responsible for planning and carrying out an audit that meets the requirements of the Audit Commission's Code of Audit Practice (the Code). Under the Code, I review and report on:

- the Trust's accounts; and
- whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

6 Also, the Audit Commission uses my assessments to provide scored judgements for the Healthcare Commission to use as part of its Annual Health Check.

7 This letter summarises the significant issues arising from both these areas of work and highlights the key recommendations that I consider the Trust should be addressing. I have listed the reports issued to the Trust relating to the 2007/08 audit at the end of this letter.

Audit of the accounts

8 I issued an unqualified opinion on the Trust's accounts on 20 June 2008, before the deadline set by the Department of Health for NHS bodies to submit audited accounts. In my opinion the accounts give a true and fair view of the Trust's financial affairs and of its income and expenditure for the year.

9 Before giving my opinion I reported to those charged with governance, in this case the Audit Committee, on the issues arising from the 2007/08 audit. I issued this Annual Governance Report on 12 June 2008 and only the most significant issues arising are repeated in this letter.

Accounting issues

10 The Trust had included a £1.7m creditor in the financial statements for the cost of replacing the chassis' on the leased Mercedes ambulances. This was based on accruing for the cost as if it were in the original lease. Following discussions and clarification between ourselves and the Trust, we concluded that this should be treated as an onerous lease and provision made in full for the liability.

11 The Trust amended for four non-trivial adjusted misstatements, and received four other recommendations; summarised here:

- reach a full and final settlement on the subsistence provision with HMRC in 2008/09;
- the Trust should adhere to the Better Payment Practice Code;
- the Trust should develop the fixed asset system to produce a breakdown of assets under construction; and
- all PCT agreements should be signed at the beginning of the financial year.

12 The Audit did not identify any material weaknesses in controls and the Trust met its statutory performance targets.

13 Going forward, the Trust has started to prepare for the introduction of International Financial Reporting Standards (IFRS) and should continue to progress towards the full introduction in 2009/10.

Trust's use of resources

14 I am required to conclude on whether the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money conclusion.

15 I am also required to assess how well NHS organisations manage and use their financial resources by providing scored judgements on the Trust's arrangements in five specific themes. This is known as the Auditor's Local Evaluation (ALE). The Audit Commission provides the scores to the Healthcare Commission (HC) to use as part of its Annual Health Check.

Value for Money conclusion

16 I concluded that the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in the use of resources.

Auditor's Local Evaluation judgement (including financial standing)

17 I assessed the Trust's arrangements in five themes. I scored each theme from 1 to 4 where:

- 1= inadequate and below minimum standards,
- 2 = adequate,
- 3 = performing well; and
- 4 = performing strongly.

18 I issued a detailed report supporting my assessment and highlighting areas for improvement to the Trust on 8 September 2008. At this stage the scores are draft, but the Trust has consistently performed well.

Table 1 ALE scores

Theme	Assessment
Financial reporting	3
Financial management	3
Financial standing	4
Internal control	3
Value for money	3

19 The Trust improved five of the thirteen sub-scores from their 2007 assessment, and Internal Control improved from a level 2 to a level 3.

20 The Trust should complete an early self assessment against the 2008/09 KLOE criterion, to help further improve the Trust's ALE performance. This would allow the Trust to address any changes to the criterion well in advance of the 2009 assessment. It would also support the Foundation Trust application, as the ALE criteria for 2008/09 have been updated to include some Monitor metrics.

21 Undertaking a self assessment would also prompt the Trust to draw together areas of notable practice and highlight these to the attention of the auditor.

Specific risk-based work

22 The audit work reviewing the Estates Strategy and how it fits into the overall objectives of the Trust will now be completed in 2008/09. Although the Estates Strategy was formulated in 2003 and is reviewed on an annual basis, the introduction of a new Service Plan through which significant operational changes are being proposed, has meant that the Trust is undertaking a much more comprehensive review of the current Estates Strategy. The audit has been delayed to fit with the completion of the new Estates Strategy by the Trust. We expect to deliver the revised Estates Strategy review by the end of 2008 and progress on the audit work will now be monitored in 2008/09.

23 We reviewed the Computer Aided Dispatch (CAD2010) project Full Business Case and addendum, evaluating the accounting methodology and procurement process. We did not find anything in the FBC or addendum that would lead us to challenge the decision to proceed with the project as described.

24 There were no significant issues arising from the work in these areas.

National Fraud Initiative

25 The National Fraud Initiative is a data matching exercise that compares sets of data to identify inconsistencies or other circumstances that might indicate fraud or error. It also helps auditors to assess the arrangements that audited bodies have put in place to deal with fraud.

26 The Trust, supported by the local counter fraud specialist, has completed its investigation of cases within the NFI data. All cases, including those relating to invalid National insurance numbers have now been investigated and cleared.

Closing remarks

27 I have discussed and agreed this letter with the Chief Executive and the Director of Finance. I will present this letter at the Audit Committee on 8 September 2008 and will provide copies to all Board members.

28 Further detailed findings, conclusions and recommendations on the areas covered by our audit are included in the reports issued to the Trust during the year. Reports issued as follows.

Report	Date of issue
Audit plan	March 2007
Report to those charged with governance	June 2008
Opinion on financial statements	June 2008
Value for money conclusion	June 2008
Final accounts memorandum	September 2008
Auditor's Local Evaluation	September 2008
Annual audit letter	September 2008
CAD2010 Full Business Case letter	August 2008
Estates	TBC in 2008/09

29 This has been another challenging year for the Trust. The Trust has taken a positive and constructive approach to our audit. I wish to thank the Trust's staff for their support and cooperation during the audit.

Name Sue Exton

District Auditor
September 2008

The Audit Commission

The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

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Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 30th September 2008

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

In this Trust Board Report I would like to give an overview of all SUI activity in 2008 to date and to make a comparison against last years activity.

Overview.

In the period 01/01/07 to 31/12/07 there were 49 incidents considered as potential SUI's. Of these, 7 were declared SUI's by the LAS. One of the 7 was downgraded within three days on the basis of information revealed in the initial investigation. During the same period, 12 of the 49 incidents were declared an SUI by Partner NHS Agencies and LAS assisted with their investigations.

In the period from 01/01/08 to 31/08/08 the service considered 39 incidents as potential SUI's. Three were declared as SUI's by the service. 6 of the 39 incidents were declared SUI's by Partner NHS Agencies and LAS assisted with their investigations as required.

Of the three SUI's declared since the beginning of the year, two investigations have been completed – the final report and action plans were approved by the SMG and sent to the Trust Board. The third incident involved a Road Traffic Collision in which a member of LAS staff was killed. The Inquest into the tragic death has recently taken place (24th July). The Coroner recorded a verdict of accidental death and highly commended the training course and the provision of this training for Motor Cycle Unit staff. A further delay has occurred as the LAS were required to formally request a copy of the Police Investigation Report from HM Coroner and this has only recently been received. A final report has now been produced and approved by SMG and is presented to the Trust Board.

A full explanation of this overview is at Appendix 1.

Safety Alert Broadcasting System:

The Safety Alert Broadcasting System (SABS) is run by the Medicines and Healthcare products Regulatory Agency (MHRA). When a SAB is issued the LAS is

required to inform the MHRA of the actions that it has taken to comply with the alert. If no action is deemed necessary a "nil" return is still required.

Twenty alerts were received from 21/07/08 to 05/09/08. All alerts were acknowledged; only 1 requires any action, relating to NPSA/2008/PSA001: Clean Hands Saves Lives (National Patient Safety Agency) received on 04/09/08. The actions required are being reviewed by the Infection Control leads within the LAS.

2. Second domain – Clinical and Cost Effectiveness

Clinical Update Newsletter

The July edition (issue 11) covers an article about awareness of carbon monoxide (CO) poisoning and the role HART are taking in the ability to detect CO levels at an incident. Also covered was the introduction of oromorph – liquid morphine sulphate for use in pain relief, and the increasing use of buccal midazolam by parents to control seizures in infants and children.

The August edition (issue 12) covers the adoption by the LAS of the British Thoracic Society (BTS) Guidelines for the use of oxygen in emergency situations. Adoption of the BTS guidelines will occur in October when they are published in Thorax, the BTS Academic journal. The guidelines provide the best available evidence based guidelines on oxygen use, and support the stance that the LAS took some years ago on the use of medium concentration oxygen masks for treating acute coronary syndromes.

Both editions contain the 'ECG of the Month'.

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

Falls research

The National Institute for Health Research's Health Technology Assessment Programme has awarded a grant of £1,014,548 to undertake a research project measuring the costs and benefits of a new protocol that enables paramedics to assess and refer patients aged 65 or over who have fallen to a community based falls service. Helen Snooks (Swansea University) will be leading the study with the LAS participating in the project alongside the Welsh Ambulance Service and East Midlands Ambulance Service.

The study is a randomised controlled trial in which ambulance stations in each of the three participating services are randomly allocated to either implement the new protocol (intervention group) or continue to provide care according to their standard practice (control group). The LAS has proposed that the study be conducted in the Bromley, Croydon and Barnehurst areas. Paramedics based at the stations selected for the intervention group will receive additional training, protocols and clinical support to enable them to assess older people who have fallen and decide whether they need

to be taken to the Emergency Department (ED) straight away, or whether they could benefit from being left at home, with a referral to a falls service.

The costs, processes and outcomes of care for patients in the intervention and control group will be assessed at 1 and 6 months. The outcomes that will be measured are those related to further falls i.e. subsequent 999 calls and ED attendances for falls. The study will also compare operational impacts for the services e.g. time spent on jobs, the costs of care and any effects on the NHS and other services and to patients and carers. The study will also gather in-depth information from patients, carers and health care providers (ambulance service and falls service staff) about how the new protocol works, and about any factors which encourage or hinder its use.

The research costs include funding for a trial co-ordinator (based in Swansea) and three research assistants; one to be based at each of the participating ambulance services. NHS costs related to training, clinical support and implementation are also included.

The trial is planned to start in July 2009, which includes a one year period to ensure the services and trial data collection and management processes are in place. Therefore, patient recruitment is expected to take place from July 2010.

Improving Stroke Recognition by Ambulance Services (ISRAS) research study

The LAS has been successful in a bid for research funding of £117,000 from the Stroke Association to undertake a research project aimed at enhancing the recognition of stroke by ambulance personnel. The study is a collaborative project being undertaken in partnership with Barts and the London NHS Trust, Homerton University Hospital NHS Foundation Trust and the University of Hertfordshire.

Currently, all UK ambulance services use the Face Arm Speech Test (FAST) to identify if a patient has experienced a stroke. While the FAST has been shown to be a valid and reliable tool in the out-of-hospital setting, it does have its limitations in identifying posterior circulation strokes that are characterised by visual field disturbances. This study aims to test if an in-hospital stroke recognition tool, the Recognition of Stroke in the Emergency Room (ROSIER) which has been demonstrated to increase the diagnostic accuracy amongst A&E physicians, improves the identification of stroke in the out-of-hospital setting.

Ambulance staff from Newham, City and Hackney and Tower Hamlets Complexes that convey patients to the Royal London and Homerton hospitals will be asked to use the ROSIER tool instead of the FAST. The final diagnosis will then be followed up for each patient at the participating hospitals to allow the researchers to assess if the ROSIER has improved the recognition of stroke. A second strand to the research will involve focus groups with staff at each of the study complexes, to ascertain views on the ROSIER, including its benefits and any perceived barriers to its use.

We are currently recruiting for a study researcher who will collect the data and run the study on a day-to-day basis. Patient recruitment is planned to start from 2nd March 2009 and data collection will run for 12 months.

National Clinical Performance Indicators

The national Clinical Performance Indicators (CPIs) programme has been developed to enable benchmarking of clinical care across ambulance services in England, to drive forward quality improvement and ensure consistency of care. Five CPI areas relating to stroke (including transient ischemic attack); acute myocardial infarction (STEMI); cardiac arrest; asthma, and hypoglycaemia have been selected using input from the Directors of Clinical Care of ambulance services. Following an initial pilot, three cycles of data collection from May 2008 to November 2009 have been set. Data from the first two of these cycles will be used by the Healthcare Commission (HCC) in the 2008-09 performance ratings

Funding has been awarded by the Department of Health under 'Clinical audit, registries and related activities' to develop the national CPI registry. The LAS has been provided with £10,000 of this funding to facilitate our contribution to the National CPIs during 2008-09.

Expansion of the SMART CPR study

The SMART CPR study examines the impact of a predictive algorithm on the Philips FR2+ AED on survival from cardiac arrest. The algorithm analyses the patient's initial cardiac rhythm and predicts whether an immediate defibrillation shock is likely to result in return of a pulse or if a period of CPR prior to the delivery of a shock would be more beneficial. The study has been running for two years in the East and South Areas and additional funding has been secured from Phillips Medical Systems to expand the study to the West Area and to extend data collection until June 2009.

Book chapter

Rachael Donohoe, Head of Clinical Audit and Research, has published a chapter in 'Foundations for Paramedic Practice' by Amanda Blaber examining the role of clinical audit and clinical governance in Paramedic practice.

Cardiac arrest publications

The LAS has prepared two publications examining the incident and characteristics of out-of-hospital cardiac arrests that are attended to by the LAS using data from a four year period. These publications will be submitted to leading peer reviewed journals that specialise in the cardiac field.

3. Third Domain – Governance

NHS Litigation Authority (NHSLA) Assessment

The Trust is being assessed by the NHSLA on 7th & 8th October 2008. This assessment is in essence a complete review of the Risk Management & Governance framework of the LAS. In response to an initial assessment of paperwork submitted earlier this year to the NHSLA, the Medical Directorate and the Governance Development Unit have further refined and developed a number of existing LAS

Policies and Procedures. The following Policies and Procedures have been passed by the SMG:

- Policy for consent to examination or treatment
- Procedure for the handover of patients
- Procedure for the issue and use of drugs by LAS staff
- Claims handling policy and procedure
- Incident reporting procedure
- Stress management policy

New policies and procedures are in the process of being formulated to be presented to SMG and then the NHSLA assessors. These polices and procedures are:

- Policy on paediatrics*
- Policy on Obstetrics*
- Policy on Resuscitation*
- Policy on Emergency Care Practitioners
- Policy for deviating from policy or procedure*
- Medical Directorate Protocol*

* These policies are in essence formally acknowledging the fact that the LAS is following the JRCALC Guidelines, and also where applicable other National guidelines pertinent to ambulance service pre-hospital care.

Controlled Drugs Local Intelligence Network Meeting

Richmond and Twickenham PCT (RTPCT) Controlled Drug Local Intelligence Network (LIN) have recently agreed to act as the lead LIN on behalf of all the other London LINs as far as the reporting structure for incidents involving controlled drugs are concerned. The agreed structure is that the LAS will submit a quarterly LIN Report to RTPCT, (nil returns are mandatory), and that the Medical Director as the Accountable Officer, or in her absence The Senior Clinical Adviser to the Medical Director, will attend the scheduled meetings. The first meeting held under these arrangements was on 10th September 2008 and attended by the Senior Clinical Adviser to the Medical Director.

The LAS had submitted a report covering the period from 1st April 2008 to 30th June 2008. We reported three incidents which are detailed in Appendix 2. All names are and other person / patient identifiable information are deleted in this version of the report. However the original supplied to RTPCT, and conversations between the Medical Directorate and the Chair of RTPCT LIN always discussed names of individuals. The incident involving Newham Hospital has been closed as far as the LAS is concerned with no fault being ascribed to any member of LAS staff, and at the time of writing this report we are awaiting the final report from Newham Hospital. The two incidents involving the loss of individual ampoules of morphine resulted in staff being reminded of the importance of using LAS issued bags, and the need to physically check remaining morphine stocks prior to leaving scene. The LAS Controlled Drugs Policy will be amended again following the imminent NHSLA Assessment to incorporate both lessons learnt from these incidents as well as any comments the NHSLA may make.

The RTPCT LIN are satisfied that the LAS investigated the incidents in a timely and proper manner, and that actions taken were appropriate and proportionate. The next meeting will take place on 4th February 2009.

4. Fourth Domain – Patient Focus

Sandell Paediatric Tape Measures – Are now being issued on a personal basis to all paramedics. These tape measures are an aide memoire and adjunct to the JRCALC Guidelines. They greatly assist the practitioner in the event of serious injury / illness when the age / weight of a child is not known to use the correct sized equipment, dose(s) of drugs etc... All paramedics still carry the JRCALC pocketbooks and they may choose to use either the "Age per Page" approach in the pocketbooks, or the Sandell Tape as either circumstances or personal preference dictates.

Tourniquets – Are in the process of being deployed onto front line vehicles in the coming months. The LAS has chosen the Combat Application Tourniquet, but manufactured in a bright orange material. The tourniquet will be carried in the Primary Response Bag. Their introduction is as a result of recommendations from many sources, but in the main from the NCEPOD – Trauma Who Cares Report, and data from theatres of conflict such as Iraq and Afghanistan.

Oxygen Guidelines – The LAS has formally adopted the British Thoracic Society Guidelines for the emergency use of oxygen. Given the stance taken by this Trust some years ago, there is in the main little change in our overall approach to oxygen therapy. It may be remembered that some years ago we advocated the practice of using medium concentration oxygen therapy for cardiac chest pain. These guidelines now formally acknowledge that approach to oxygen therapy for the cardiac chest pain patient. They also lay out in four tables the recommended approach to oxygen therapy in the emergency setting for the whole range of patients likely to be encountered.

The complete Medical Directors Bulletin is at Appendix 3.

Oramorph – Now available for use by paramedics and is stored in the paramedic drugs pack. Because the drug is currently only available in 100ml bottles it has to be decanted in to smaller 30ml bottles by Frimley Park Pharmacy, this in turn shortens the shelf life to 90 days. One bottle is placed in each paramedic drug pack and we are currently monitoring usage to establish if this is sufficient, if the packing of the packs has increased dramatically then the content of the packs will be reviewed. There is 20mls of 10mg in 5ml concentration (40mg) in a 30 ml bottle this allows for wastage or the administration of additional doses on authorisation by the clinical support desk.

Clopidogrel – Now recommended for use by JRCALC, available in 300mg tablets. Two tablets will be required for patients with ST elevation being conveyed directly for PCI. We are currently sourcing small bottles of water to allow for the administration of this drug.

Infection control –There are several items to be introduced in to the service in order for LAS to comply with the infection control guidelines issued by the DoH. The following items are currently being sourced:
Sleeve protectors

Disposable tourniquets
Hand wipes
Alcohol gel
Surface wipes

Cannulation packs to include:
Chloraprep (2% chlorhexidine vial)
Sterile sheet
Clear vecafix
Labels to identify sterile / non sterile placement
Gauze

The alcohol sterets have now been replaced with 2% chlorhexidine wipes. This now complies with the infection control guidelines that have been issued by the DoH.
The LAS must explore cost effective avenues to ensure linen and blankets are used for only one patient then laundered / replaced.

ROLE in children – HM Coroners and the London Safeguarding Children board have finally reached an agreement regarding ROLE in children. All children over the age of 2 years if found deceased and resuscitation is NOT appropriate will remain on scene and the ROLE procedure will be adhered to. Infants under the age of 2 years found deceased and resuscitation is NOT appropriate will be taken to the nearest A&E that accepts paediatrics where they can be examined by the on call paediatrician.

New Ways of Working (NWOW) – We are currently waiting for the post of Clinical tutor to be banded and advertised for expressions of interest. At present neither of the two NWOW complexes have any clinical tutors, or a full complement of team leaders. This is a risk to the progress of delivering the patient care agenda at the NWoW complexes.

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

Nothing further to report

7. Seventh Domain – Public Health

Nothing further to report

Recommendation

That the Board RATIFY the attached policies and NOTE the Medical Director's report

Fionna Moore,
Medical Director
19th September 2008

Appendix 1.

SUI Activity 2008 (01-01-08 to 31/08/08)

In the period 01/01/07 to 31/12/07 there were 49 incidents considered as potential SUI's. Of these, 7 were declared SUI's by the LAS. One of the 7 was downgraded within three days on the basis of information revealed in the initial investigation. During the same period, 12 of the 49 incidents were declared an SUI by Partner NHS Agencies and LAS assisted with their investigations.

In the period from 01/01/08 to 31/08/08 the service considered 39 incidents as potential SUI's. **3 were declared as SUI's by the service**. 6 of the 39 incidents were declared SUI's by Partner NHS Agencies and LAS assisted with their investigations as required.

Of the three SUI's declared since the beginning of the year, two investigations have been completed – the final report and action plans were approved by the SMG and sent to the Trust Board. The third incident involved a Road Traffic Collision in which a member of LAS staff was killed. The Inquest into the tragic death has recently taken place (24th July). The Coroner recorded a verdict of accidental death and highly commended the training course and the provision of this training for Motor Cycle Unit staff. A further delay has occurred as the LAS were required to formally request a copy of the Police Investigation Report from HM Coroner and this has only recently been received. A final report has now been produced and approved by SMG and is presented to the Trust Board.

	Number of incidents considered as potential SUI's	Number of incidents declared as SUI's (LAS)	Number of incidents declared as SUI's by Partner Agencies
2006	23	6 (26%)	Not recorded
2007	49	7 (14%)	12
2008 (up to 31/08/08)	39	3 (7.7%)	7

The table above demonstrates:

- That increasing numbers of incidents are being reported by staff as potential SUI's year on year.
- These increases suggest that staff are more aware of their responsibilities in respect of reporting serious incidents and feel more confident to report their concerns..
- These increases also suggest that the Service SUI Policy is being read and followed by more staff.
- All incidents that are brought to the attention of the service as potential SUI's are reviewed and considered by a panel comprising largely of the same members. It is reasonable therefore to suggest that a uniform standard has been applied over the above time-frame and that the reducing number of SUI's that are being declared

reflects a sustained improvement in general standards together with the greater enthusiasm of staff to report incidents.

Emerging Trends.

	2007	2008
Subject	Number	Number
Delayed response	9	6
Clinical Issues	7	5
Police involvement	6	1
Maternity/Obstetric	6	2
Not conveyed	5	2
Other Agency SUI	12	6
Critical Transfer	3	1
Wrong Address	2	0
Rest Break Issues	2	0
Awaiting Police	2	0
Jumped from Amb	1	0
Psychiatric Patient	1	3
Access to Heathrow T5	1	0
Driving Issue	1	3
Data Security	0	1
Hospital/Dr. Delays	0	2
Internal IT issue	0	1

The above table illustrates the main items of concern in respect of all incidents that have been brought to the attention of the service and been the subject of examination and review to establish if it was appropriate or necessary to be classified as Serious Untoward Incidents:

Delayed responses and clinical issues continue to head the list of subjects that are likely to be considered a potential SUI and if current trends continue these may exceed the totals from 2007. Non-conveyance issues in 2008 are broadly in line with the numbers experienced in 2007. SUI's declared by other NHS agencies show a similar trend to 2007 at approximately one per month. Incidents where police were involved i.e. collapse following violent struggle etc are significantly lower than in 2007 as are maternity and obstetric related issues. There have been no incidents relating to wrong address, rest breaks or delayed attendance by the police in the first 7 months of 2008. Incidents affecting patients who are mentally ill or disabled are already three times higher than in 2007 and may require a more in depth study to establish if there is any underlying cause which may then indicate the need for specific action.

Incidents in 2007 relating to Heathrow Airport and a patient jumping from a moving ambulance were probably one-off's and are not likely to be repeated in subsequent years. Of interest are the incidents relating to delays caused by hospitals and doctors

which have not previously been the subject of concern. In 2007, one incident related to serious injury to a pedestrian following a collision with an LAS Vehicle.

Three incidents have been reported as SUI's in the first seven months of 2008 although one of these relates to the tragic death of a member of staff whilst attending a motor cycle training course.

Time-frames.

All actual or potential SUI's have been entered into the LAS Risk Management Database, "DATIX", and the three declared SUI's have been entered onto the NHS London Governance Database "STEIS" and are in full compliance with the requirements of the Strategic Health Authority SUI management guidelines. The SUI relating to the death of the motor cycle trainee has exceeded the NHS London deadline for completion although this has been entirely caused by external influences (awaiting completion of the Police investigation and for the Inquest to be held). The other declared SUI's were completed and closed within the timeframe set out by the Strategic Health Authority.

Richmond and Twickenham PCT, as lead Commissioners, are alerted to all incidents that are declared an SUI. In addition, where it is appropriate, the Local PCT is also informed of declared SUI's.

The National Patient Safety Agency are alerted to all incidents that are declared an SUI.

Notifications of all incidents that are declared an SUI are sent to Legal Services, PALS, Complaints, Safety and Risk, Communications and Head of Governance.

Management Updates.

All members of the Senior Management Group are emailed directly whenever an SUI is declared. They receive an Interim report within 48 hours and are regularly updated as the investigation proceeds either at weekly diary meetings or at other appropriate scheduled meetings.

The Medical Director regularly updates the Trust Board, Senior Management Group and Clinical Governance Committee on all aspects of SUI Policy compliance including the discharge of actions from Action Plans etc.

Action Plans.

Action Plans have been produced in respect of the SUI's declared. These arise from the recommendations contained in all final reports. Both NHS London and the LAS consider that an SUI is not closed until all actions have been discharged.

Action plans that contain outstanding actions are monitored continually, the owners of each action are reminded of timeframes etc. and actions are only considered closed when evidence has been produced to support that the action has been discharged.

There are no outstanding actions from any SUI and all Action Plans are up to date and complete.

Lessons Learnt.

The main outcome in SUI management is to ensure that lessons are learnt from each incident and that the lessons are circulated in an appropriate way to other staff. The objective is to ensure that a similar event does not occur in the future.

A comprehensive report was produced in May (2008) which demonstrated a considerable number of lessons that have been learnt by the organisation and provided evidence on how these lessons had been circulated to staff through the media of the staff magazine. The report has been updated and is attached at the end of this document.

Conclusion.

Increasing numbers of incidents are being reported for consideration as SUI's. The percentage of these that are declared as SUI's is reducing although we are able to demonstrate that there has been no change in the process or the identity of the individuals who sit on the panel that reviews each reported incident and decides if the declaration of an SUI is appropriate. The increased number of referrals may indicate better awareness of staff of their responsibilities and also of the SUI Policy.

Delayed responses continue to be the largest factor associated with a potential or declared SUI. Clinical issues also need to be kept under review although the number of such incidents should be set against the total number of patient contacts each year in order that a sense of perspective is achieved. Similarly, incidents related to aspects of driving should also be compared against the number of vehicles and the number of patient journeys undertaken each year.

Although the numbers involved are small, the percentage of incidents where mental illness or disability is a factor has risen and this requires a degree of monitoring and may suggest more detailed analysis if the trend continues. No other common factors appear to be present to suggest increasing trends.

One final report is outstanding and is currently being produced. All other reports have been completed, approved and submitted on time.

All appropriate internal and external individuals and organisations are properly informed of incidents that have been declared an SUI and the Senior Management Group and appropriate monitoring groups are kept updated.

Action Plans are being produced, based on the recommendations made in each report. These have been completed and no outstanding actions remain. Action plans are rigorously monitored and are not considered closed until evidence is produced to support that the action has been discharged.

Lessons are learnt by the organisation and these are circulated in a variety of ways to staff. The desire to learn lessons in order to prevent similar incidents from occurring in the future is well understood by staff.

Ralph Morris
31-08-08

Serious Untoward Incidents

Sharing information with staff and ensuring that lessons are learnt.

In addition to EOC, Operational and Medical Bulletins, formal training events and the cascading of information by management teams the LAS is able to share information with staff via the in-service magazine "LAS NEWS" which is widely read and appreciated.

The following is a list of articles that have appeared in the LAS NEWS and, where these have been directly associated with Serious Untoward Incidents or other serious adverse events, these have been highlighted in yellow.

LAS News – Patient Care Section

July 2001	Main	The Heart of the Matter (Cardiac Care Strategy)
November 2001	Main	Clinical Governance
	Case Studies	Good Judgement and documentation
		The intoxicated patient
December 2001	Main	Clinical Governance Forum
	Case Studies	Calling the GP or taking to Hospital?
February 2002	Main	Conveying to a hospital that is not the nearest
	Case Studies	Paediatric brain tumour
		Ectopic pregnancy
March 2002	Main	Ecstasy
	Case Studies	Spinal injuries and immobilisation
April 2002	Main	Blue Calls
	Case Studies	Non conveyance
		CAC AED
May 2002	Main	Training Bulletins, Clinical Governance Local
Leads		Forum
	Case Studies	Drug errors
		Fluid regimens
June / July 2002	Main	Obstetric emergencies
	Case Studies	PV Bleeding
		Precipitate labour
		Pregnancy and abdominal pain
Aug / Sep 2002	Main	No Article
	Case Studies	

October 2002	Main Case Studies	The case for Case Studies – (Change in style) Stabbing RTAs
November 2002	Main Case Studies	Oxygen therapy, Confidentiality
December 2002	Main Case Studies	No Article (Consultation Meeting Article)
February 2003	Main Case Studies	CAC Pre Arrival Instructions Life threatening Asthma X 2 – (Protocol change)
March 2003	Main Case Studies	Patient Care Records, Clinical Incident Reporting Neck breathers
April 2003	Main Case Studies	How can crews register complaints about Healthcare Professionals, Electronic Learning Resources Patients on Rescue Boards
May 2003	Main Case Studies	Placental abruptions, Pretibial lacerations Diabetic ketoacidosis
June 2003	Main Case Study	Stroke / CVE, Electronic Learning Patient specific protocols
August 2003	Main	Primacy of care Abdo pain Diabetes
September 2003	Main	Cycle Response Unit Cocaine abuse
October 2003	Main	Penetrating Trauma Triage Warfarin
November 2003	Main	Warfarin Myocardial Stunning Occulogyric Crisis
December 2003	Main	Clinical Performance Indicators - Falls and Chest Pains “Black Boxes” Clinical Governance in Action

Feb / March 2004	Main	Children & Vulnerable Adults Clinical Governance in Action
April 2004	Main	Driving Licences and Illness
May/June 2004		No Article
July/August 2004	Main	Patient Care Record Keeping
September 2004	Main	Increasing use of Buccal Midazolam for the treatment of seizures.
	Second	Eight minutes too long for cardiac patients.
October 2004	Case History	Chain of Survival (cardiac case)
December 2004	Main	NICE Guidelines on self harm
February 2005	Main	Responding to Sickle Cell Crisis
March 2005	Main	Medic Alert Foundation
April 2005	Main	Which Journal?
	Main	Introduction of Morphine Sulphate to LAS
May 2005	Main	Wound Care
June 2005	Main	Physiology of Wound Healing
August 2005	Main	Principles of Wound Management
November 2005	Main	Principles of Wound Management
December 2005	Main	Guide to Triage Procedure
February 2006	Main	Positional Asphyxia
April 2006	Main	Acute Behavioural Disturbance
	Main	Patient Report Forms
May 2006	Main (+ case studies)	Adverse Incidents
June 2006	Main	Pain relief in children
	Main	Patient Report form audit report
	Main	Training Video available to staff (Acute Behavioural Disturbance)
July/August 2006	Main	Pulmonary Embolism
	Main	Capnography Certification Programme

September 2006	Main	Obtaining Consent from Patients
	Main	Recognition of Life Extinct Form
November 2006		No Article
December 2006	Main	Patient Specific Protocols
	Main	Medic Alert Foundation
February 2007	Main	Neutropenic Sepsis
	Main	Spinal Cord Injuries
March 2007	Main	Restraint Hypoxia and Suspension Trauma
April 2007	Main	Future of Intubation in the pre-hospital Field
May 2007	Main	Reporting, referrals and completing statements
June 2007		No Article
July August 2007		No Article
Sept 2007	Main	Assisting Police when dealing with a suspicious death
Nov 2007	Main	Cardiac Care
	Main	Complaints relating to Obstetric Issues
Dec 2007	Main	Lessons Learnt from SUI's and Complaints
Feb 2008	Main	Positional/Restraint Asphyxia
April 2008	Main	Learning and making changes from feedback - (PALS/Complaints) Frequent caller project.
May 2008	Main	Forced marriages.
June 2008	Main	Safeguarding Children.

Appendix 2.

Richmond and Twickenham NHS Primary Care Trust

Occurrence Report – Controlled Drugs Concerns

This draft template form may be adapted for use by accountable officers for quarterly reports of any concerns that their designated body has regarding management and use of controlled drugs (clause 29). It has been produced by the Healthcare Commission controlled drugs regulation team, and should be further developed within the local intelligence network in the light of experience in use.

Name of designated body	London Ambulance Service NHS Trust
Name of accountable officer	Miss. Fionna Moore – Medical Director
Report for three-month period	April - June 2008
Name of local intelligence network (LIN)	Richmond & Twickenham PCT
Name of LIN lead accountable officer	Diane Adams
I confirm that my designated body has **been the following concerns** regarding the management or use of controlled drugs during this period	
Accountable officer signature	(Fionna Moore)
Date signed	

Description of concern[9]	**Date aware**[10]	**Actions taken**[11]
One ampoule of morphine was lost whilst in the possession of a Cycle Response Unit (CRU) paramedic on duty in the Fulham area on 11th April 2008.	12th April 2008	Police informed 11th April 2008-05-06 AOM Informed 11th April 2008-05-06 Investigation started 11th April 2008 Member of staff interviewed 11th April 2008 and immediate solution to the problem identified. In essence the ampoule container that is in use by all LAS Paramedics and had been used with no previous problems by CRU staff to date. However the CRU member of staff

[9] Short description of the cause for concern, including date(s). Details may be attached in a separate document. Note regulations 25 and 26 regarding the need not to disclose information which relates to and can identify a patient.
[10] Date the accountable officer of the designated body became aware of the concern.
[11] Action already undertaken (if any) within or outside the designated body e.g. as part of internal incident investigation process, including the reference number within the internal incident investigation process (where relevant), and whether the incident is closed or still open.

		had the container in non-standard issue equipment. (This CRU had just been set up). The standard equipment was obtained within 24 hours and the incident closed. This is the first instance of a loss on the CRU (15 bicycles in total – 28 members of staff) since we introduced morphine in 2006. The remainder of the CRU unit were checked to ensure they had the correct equipment which they did. The LAS is satisfied that there was no deliberate intention in the use of non-standard equipment.
<u>Background information</u> Mrs XX was an 88 year old widowed female who was terminally ill and was being cared for at home by the District Nursing Team from the Royal Docks Medical Centre, members of the Community Matron's Team and the Marie Curie Cancer Care nurses. <u>Chronology of Events</u> 14.03.08 07.45 hrs District Nurses documentation states ***'10 ampoules of morphine sulphate 10mgs supplied : Lot No 766014 : Expiry date 30.01.10. 5mgs administered to patient as prescribed and 5mgs discarded. Balance remaining 9'.*** The drug chart reflects this. 15.03.08 03.30hrs Mrs XX became increasingly unwell and an ambulance was called to the house and Mrs XX was taken to the A&E department at NUHT. YY, The Marie Curie Cancer Care Nurse, who was on duty at the time stated ***'the ambulance men took the whole bag of drugs***		Mrs XX was later admitted on to West Ham Ward from the A&E department. She was discharged back into the community on 19.03.08 with her TTA's from the hospital which did not contain the morphine sulphate. When the Community Matron arrived to set up the syringe driver the morphine sulphate was found to be missing. Checks were made of both the A&E department's CD cupboard and West Ham ward's CD cupboards and neither was found to contain the morphine. The pharmacy department was also checked but without success. <u>Findings</u> It would appear that there were three points of transfer where the morphine sulphate could have gone missing: Drugs handed to the paramedics at the home address. Transfer by the London Ambulance Service into the A&E department. Transfer from the A&E Department on to the ward.

in the ambulance with them'. There is no documentary evidence to support this.		Recommendations • A continuous record of the CD's received and administered should be held at the house. • CD stock checks should be performed by a third party at least every 2 weeks by a Healthcare Professional independent from the Professional administering the patient's CD's. • Documentary evidence should be completed when patients are transferred to hospital via LAS stating which drugs have accompanied the patient, who was responsible for the drugs during transit and who received the drugs on the patient's admission to A&E and the hospital ward.
One ampoule of morphine was lost whilst in the possession of a Fast Response Unit (FRU) paramedic XX whilst attending XXXXXXXXXXXX. XX on 10th June 2008 (CAD XXX timed at 20:16)	11th June 2008	At the start of his shift his two ampoules were drawn from stock and placed in a plastic container locked within his paramedic bag – This is in accordance with LAS policy on CDs. On arrival at scene XX administered 10mg morphine to the patient at 20.29hrs on 10/06/08. XX believes he may have left an ampoule on scene after administering one ampoule of morphine to the patient at the above address– This usage is recorded on the Patient Report Form for the patient as per LAS policy. He noticed the ampoule missing when he returned to Islington Ambulance Station at 06.40hrs (11/06/08) prior to end of shift and during his signing back into the CD Cupboard of his morphine. – This is when he realised that one ampoule was missing.

		Action Taken Investigation undertaken. Police and Home Office informed on 10th June 2008. Accountable Officer and Mr. Whitmore Informed 11th June 2008 Medical Directors Bulletin issued 12th June 2008.

Notes

The Controlled Drugs (Supervision of Management and Use) Regulations 2006 came into force in England on 1 January 2007,see:
http://www.opsi.gov.uk/si/si2006/20063148.htm#29

Regulation 29 concerns occurrence reports, and is shown in full below. In brief, regulation 29 requires accountable officers to give an occurrence report to the accountable officer for the PCT that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report).

> Occurrence reports
> 29. —(1) An accountable officer (other than an accountable officer nominated or appointed as accountable officer for a Primary Care Trust or Health Board) must give, on a quarterly basis, an occurrence report to the accountable officer nominated or appointed as accountable officer for the Primary Care Trust or Health Board that is leading any local intelligence network of which he or his designated body is a member.
>
> (2) The occurrence report may contain the following information—
>
> (a) details of any concerns that his designated body has regarding its management or use of controlled drugs; or
>
> (b) confirmation by his designated body that it has no concerns to report regarding its management or use of controlled drugs.
>
> (3) Nothing in this regulation requires or permits any disclosure of information which is prohibited by or under any other enactment.
>
> (4) In determining for the purposes of paragraph (3) whether disclosure is not prohibited by reason of being a disclosure of personal data which is exempt from the non-disclosure provisions of the Data Protection Act 1998 by virtue of section 35(1) of that Act (disclosure required by law or made in connection with legal proceedings etc.), it is to be assumed that the disclosure is required by this regulation.

Some designated bodies (such as ambulance trusts that cover a large area) may relate to more than one local intelligence network. They need to discuss engagement with the LIN leads and the reporting of concerns; perhaps sending a copy of their occurrence reports to all.

This document will be held securely by the LIN lead in accordance with the LIN agreed locally policies for handling information.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 2008

Final Report into SUI – Paramedic Ron Pile

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: For noting

3. Summary

Key conclusions of the Serious Untoward Investigation undertaken following the accidental death of Paramedic Ron Pile.

- The selection process for potential motor cycle riders is appropriate and exceeds the standard applied in comparable organisations and was correctly followed;
- Avon and Somerset Constabulary are accredited to provide this training and the training complies with nationally recognised standards.
- HM Coroner ruled that this was an accidental death.
- There were no influencing or causative factors involved.

4. Recommendation

THAT the Trust Board NOTE the findings of the Serious Untoward Investigation into the accidental death of Paramedic Ron Pile.

London Ambulance Service NHS
NHS Trust

Report into a

ROAD TRAFFIC COLLISION

Resulting in the Death of

Paramedic RON PILE (RIP)

Whilst Attending a Motor Cycle Training Course

23 April 2008

CONTENTS

1. Executive Summary

1.1 London Ambulance Service NHS Trust received a telephone call from the Chief Constable of Avon and Somerset Constabulary on 23rd April 2008 to advise that a member of LAS staff, who had been attending a motor cycle training course, had been fatally injured in a Road Traffic Incident during the course of the training.

1.2 A decision was taken to declare the incident an SUI (Serious Untoward Incident)

Purpose of the report

1.3 To review the selection and recruitment procedures in use for prospective Motor Cycle Paramedics to ensure:

a. that these are in accordance with the processes used by other organisations (Police and other Ambulance Services etc)

b. that the procedures were adhered to in respect of the application made by Ron Pile (RIP) in this instance

c. if any changes are indicated in the selection procedure in the light of this review.

1.4 To receive and consider the report conducted by the Avon and Somerset Constabulary into the cause of the Road Traffic Collision that resulted in the death of Paramedic Ron Pile.

1.5 To establish if there are any lessons to be learnt or action that needs to be taken to prevent any further incident of this nature.

1.6 To reassure the London Ambulance Service NHS Trust Board that the death of Ron Pile was dealt with by the service in an appropriate manner, and that the bereaved family were fully supported at every stage

Findings

1.7 The Competence, Skills and Knowledge of all three of the LAS who attended the Motor Cycle Training Course were all assessed throughout the application and selection process in accordance with accepted LAS practice which exceeds the process used by Police Services to select Police Officers for Motor Cycle Training.

1.8 Motor Cycle handling skills and knowledge were all verified by City of London Police Motor Cycle Instructors and each member of staff was required to demonstrate the required level of skill in order to qualify for inclusion on the course.

1.9 The training of staff (police and ambulance service) to undertake motor cycle duties conforms to a uniform standard wherever this training takes place. This specific training is only provided by a select number of Police Services in the UK. The police service that provides the training must be accredited to award the Police Driver and Rider Training Award and be designated as "CENTREX" training establishments. The NPIA is the body responsible for the accreditation of police training facilities to the CENTREX standard. London Ambulance Service sends staff exclusively to CENTREX accredited training centres for all aspects of motor cycle training and assessment.

Police Incident Report

1.10 Forensic examination of the incident scene and the other vehicle involved in the collision with the motor cycle driven by Ron Pile confirms that the other vehicle was in very good condition with no mechanical faults. Marks left on the road confirms that the other driver was correctly positioned on the left of the road, had taken avoiding action but was not able to avoid a collision with the motor cycle which had been propelled towards the oncoming vehicle at an acute angle.

1.11 The police report states that the presence of the other vehicle involved in the incident had no part in the causation of the incident and its position at the time that the motor cyclist lost control was a matter of tragic chance.

1.12 The police report also stated that no action was indicated in respect of the driver of the other vehicle involved in the collision.

1.13 The police report also confirms that weather conditions were not a factor in this incident and that the condition of the road was good. Traffic conditions were light and there was no history of previous traffic incidents at the location.

1.14 All aspects of staff support provided by the LAS were available to the staff attending this training course even though they were situated in Somerset at the time. The ratio of one instructor to three students also leads itself to higher than normal levels of support for each student and the instructor had access to and would be able to direct any student to all the support mechanisms provided by the police service.

Conclusions

1.15 Selection for this specific training is appropriate and exceeds the selection processes used by the police.

1.16 All applicable selection processes are utilised correctly in respect of potential motor cycle operators within the LAS.

1.17 The selection process was fully utilised in the case of Ron Pile (deceased).

1.18 There has been nothing revealed throughout the investigation to suggest the need for any changes in the selection process for motor cycle staff.

1.19 The use of Avon and Somerset Police as a provider for motor cycle training is appropriate in every respect.

1.20 Avon and Somerset Police are recognised as a "CENTREX" registered organisation accredited by the National Police Improvement Agency. They are therefore entitled to award the Police Driver and Rider Training Award.

1.21 The Road Traffic Collision Final Report was produced by the most experienced investigating officer in Avon and Somerset.

1.22 The report confirms that all vehicles directly or indirectly involved in the incident were completely road-worthy with no mechanical defects.

1.23 The report confirms that no blame lay with any other driver and that no police action would be taken against any person including the driver of the other vehicle involved.

1.24 The report concludes that the most likely cause of the incident was that the motor cycle was incorrectly positioned to undertake a manoeuvre (negotiate a bend in the road) which resulted in the motor cycle mounting an embankment on the near side and striking a boulder with its front wheel which resulted in the machine being thrown diagonally across the road into an on-coming vehicle.

1.25 Having considered the evidence, the Coroner declared a verdict of accidental death.

1.26 There are no lessons identified or learned in this tragic case that may help to prevent a similar incident occurring again.

1.27 The support arrangements for the family of Ron Pile immediately after the incident, in the time leading up to the funeral, at the funeral and the inquest have been described as exemplary.

1.28 The support arrangements for friends and colleagues of Ron Pile were considered by all as first rate and totally in accordance with the level of sorrow felt by staff at the loss of a well respected and much loved colleague.

2. Introduction

2.1 The London Ambulance Service received a telephone call from the Chief Constable of Avon and Somerset Police on 23rd April 2008 to advise that a member of LAS staff who had been attending a motor cycle training course had been fatally injured in a Road Traffic Incident during the course of the training.

2.2 Members of the LAS Senior Management Team were involved in a number of meetings in relation to the news of this tragic incident.

2.3 A decision was taken to declare the incident an SUI (Serious Untoward Incident).

3. Terms of Reference

3.1 Gather all documents relating to this incident.

3.2 Obtain copies of any relevant policies/procedures and training material that relate to this incident.

3.3 Produce an analysis of the selections process for motor cycle training as conducted by the LAS compared to the process followed by other organisations (police ambulance etc) and highlight any differences.

3.4 Consider influencing or causal factors to establish if any had any contributory effect on this incident:

3.4.1	**(Influencing factors:)**	Those that influenced the occurrence or the outcome but that would not have prevented the occurrence.
3.4.2	**(Causal Factors:)**	Led directly to the incident – removal will prevent or substantially reduce the chances of a similar type of incident from re-occurring.

3.5 Clarify the roles of the staff involved in the incident.

3.6 To identify any apparent departure from appropriate policies, procedures or guidelines.

3.7 Investigate risk management awareness within the working areas involved in the incident.

3.8 To report on the route cause of the incident.

3.9 To advise if any lessons can be learnt as a result of the incident.

3.10 To produce a report on the findings of the investigations, to be presented to the Trust Board. The report to include recommendations on the actions to be taken to remedy any unsatisfactory matters and to ensure that, as far as is possible, no similar incident is repeated.

3.11 To produce an action plan with named individuals and strict timeframes if this is indicated.

3.12 To ensure that the final report is completed within the time-frame required by the Strategic Health Authority.

4. Purpose

4.1 To review the selection and recruitment procedures in use for prospective Motor Cycle Paramedics to ensure:

a. that these are in accordance with the processes used by other organisations (Police and other Ambulance Services etc)

b. that the procedures were adhered to in respect of the application made by Ron Pile in this instance

c. if an changes are indicated in the selection procedure in the light of this review.

4.2 To receive and consider the report conducted by the Surrey Constabulary into the cause of the Road Traffic Collision that resulted in the death of Paramedic Ron Pile.

4.3 To establish if there are any lessons to be learnt or action that needs to be taken to prevent any further incident of this nature.

4.4 To reassure the London Ambulance Service NHS Trust Board that the death of Ron Pile was dealt with by the service in an appropriate manner, that the bereaved family were fully supported at every stage and that the incident has been thoroughly investigated to ensure that every possible effort has been made to identify lessons that need to be learnt and the risk of another incident of this nature is reduced to the lowest reasonable level.

5. Methodology

5.1 To review existing LAS Policies/Procedures/Guidelines and Practices relating to the selection of staff to attend Motor Cycle Training.

5.2 To compare existing LAS Policies/Procedures/Guidelines and Practices to those operated by other Ambulance Services and Police Services that employ Motor Cycle Riders on emergency duties and establish a gap analysis which identifies any significant discrepancies/omissions or areas of good practice.

5.3 To review the records of all documents relating to the application and selection of Paramedic Ron Pile to establish that all aspects of the criteria were adhered to.

5.4 To review the actions taken by the LAS in response to being informed of the death of this member of staff to establish that the response was adequate and appropriate to the needs of Ron Pile's immediate family and to colleagues and friends of the deceased within the service.

5.5 To receive and understand the report into the incident that has been produced by Avon and Somerset Constabulary for HM Coroner and ensure that this is produced for consideration by the LAS Trust Board.

6. Incident Summary

6.1 Incident occurred near Priddy, Wells in Somerset.

6.2 Three members of LAS staff were attending the Motor Cycle Response Training Course run by Avon and Somerset Police. The names of the other two members of staff are on record. The three trainees were under the instruction of a Police Motor Cycle Instructor.

6.3 First week bike course was on 650cc unmarked motor cycle.

6.4 The final report completed by Avon and Somerset Police into this fatal road traffic collision states that RP mounted the grass verge on the near side, the front wheel of the motor cycle struck some boulders and he lost control of the machine, veered abruptly towards the opposite carriage of the road and collided with an oncoming car.

6.5 Ron Pile suffered fatal injuries. Not conveyed to hospital – air ambulance on scene.

6.6 LAS Senior Management Group & other key personnel informed

6.7 LAS Response on the 23/04/08

6.7.1 15:30 hours
LAS CEO received a phone call from the Chief Constable of Avon & Somerset Constabulary informing the service of a fatal collision involving trainee Motor Cycle Response Unit rider (R P).

6.7.2 LAS CEO was informed that the incident had occurred about 20-30 minutes previously

6.7.3 The Chief Constable offered all possible assistance to the LAS either directly or through his Assistant Chief Constable.

6.7.4 In the light of this information the Chief Executive asked the Deputy Director of Operations (RS) to convene an SUI Group.

6.8 15:30 hours

SIT REP Meeting
Attendees: PW, JK, TE, SI, RS, GC, AA, FM, AB, DJ

6.8.1 (R P) 43 years - DOB 16.08.64
20 years service - Paramedic
Recently of ROMFORD station
Now attached to Silvertown Ambulance Station and also the Motor Cycle Response Unit.
Home address and telephone number were obtained from LAS Records. Name and Contact details of registered Next of Kin were obtained from LAS records.

6.8.2 Actions.
Avon & Somerset to liaise with Kent Police and Metropolitan Police to arrange for next of kin to be informed.

6.8.3 LAS – appointed a senior manager as Family Liaison Officer. Arrangements were made for him to meet with police and accompany them when they went to the next of kin.

6.8.4 Staff Support: Another LAS manager was mobilized from home (Swindon) to attend Somerset Police HQ to support the other two LAS riders.

6.8.5 The LAS Medical Director confirmed that she will also meet with the two LAS staff in Somerset later in the evening.

6.8.6 As a courtesy, the Branch Secretary and Chairman of the London Branch of UNISON were informed of the incident.

6.8.7 Internal Communications – staff briefing cascade
TO ONLY OCCUR AFTER NEXT of KIN HAD BEEN INFORMED:
STAFF: Managers were standing by at a nearby ambulance station to attend (RP's) station when staff are informed of the tragedy to provide assistance and support to RP's former colleagues.

6.8.8 A bulletin & Pulse notice being drafted by Communications Department managers.

6.8.9 Arrangements were made for Control Room staff to be advised of the tragedy by the Manager in charge after it had been confirmed that next of kin had been informed.

6.8.10 Arrangements were made for existing in-post Motor Cycle Response Unit staff to be advised of the tragedy by their line manager after it had been confirmed that next of kin had been informed.

6.8.11 All ambulance station management team were asked to lower Union Flags (where flown) to Half Mast.

6.8.12 Arrangements were made for the senior Resource Manager to provide additional support to East London where RP's former colleagues worked so that staff could deal with their grief when they were advised of the incident. Staff to be moved from other areas to deal with calls at this difficult time. Instructions were prepared to manage crews sensitively with regards to the allocation of rest breaks & standbys.

6.9 17:00
SUI Control Group Meeting

6.9.1 Confirmed that Avon & Somerset were contacting Kent and Met Police to arrange for their FLO to attend next of kin addresses.

6.9.2 Confirmed that Family Liaison Officer was to meet up with police FLO at Sidcup police station.

6.9.3 Senior HR Managers confirmed as lead LINK worker.

6.9.4 East Area Assistant Director of Operations to arrange conference call with all East Managers

6.10 18:30
SUI Control Group Meeting

6.10.1 It was confirmed that the incident was to be dealt with as an SUI by the Director of Operations.

6.10.2 Family Liaison Officer was waiting to meet up with Police FLO

6.10.3 Senior Manager was at Wells police station awaiting return of riders and to make tentative enquiries regarding Police investigation process.

6.10.4 South West Ambulance Service confirm call time as 15.07 (on scene at 15.24).

6.10.5 Staff support offered at the time & Clinical Support Officer deployed.

6.10.6 Staff welfare arranged with AC to coordinate further resources if required.

6.10.7 Unison Branch Secretary provided some additional background information regarding family & children.

6.10.8 Expected ETA with next of kin at 19.30.

6.10.9 All further communications being contained until family are advised.

6.10.10 Obituary & internal Communications prepared & ready

6.10.11 Instruction were reiterated to manage East resources sensitively regarding meal breaks and no standby etc

6.10.12 SUI process to be managed in the same way as any other SUI

6.10.13 The Motor Cycle Response Unit selection process to be examined in detail to ensure that the process is robust and that no changes are required before any other staff attend this training.

6.11 20:35
Family Liaison Officer reported to ADO that next of kin had now been informed

6.12 20:50
Managers briefed local ambulance staff, Motor Cycle Response Unit staff and control room staff.

6.13 21:23
Obituary notice sent to 'all active users'.

6.14 Instruction issued for flags to be lowered to half mast.

7. Background

7.1 London Ambulance Service Motor Cycle Response Units (MRU's) are operated at a variety of locations within central London. Being able to navigate through typical levels of heavy traffic, they more rapidly respond and reach critically ill and injured patients with the least amount of delay compared to conventional ambulance and car responses and are therefore considered a crucial resource in the drive to deliver optimum levels of patient care.

7.2 Staff that work on the MRU's are currently all Registered Paramedics who have gained considerable experience riding large motor cycles in their private lives. When vacancies occur they respond to an internal advertisement by submitting an application form which is further supported by a report from the Ambulance Operations Manager (AOM) who is in overall command of the Complex at which the applicant works.

7.3 Managers within the MRU then check the application form to ensure that all essential criteria have been met (short-listing).

7.4 Candidates that have been successfully short-listed are then required to attend an assessment of their riding ability conducted by Police Motor Cycle Instructors. They use a structured assessment requiring close control of the machine at slow speed through a series of pre-determined obstacles. Riders are

penalised if they strike a traffic cone, stall the engine or put their feet down onto the road etc.

7.5 The objective of the check Test Ride is to determine if the candidate is at a suitably high enough level of proficiency to be able to undertake and benefit from the demands of the three week training course.

7.6 Upon successful completion of the Test Ride, the candidate is required to attend an interview before finally being allowed to attend the motor cycle training course.

7.7 Motor Cycle Training Courses are run by the Police and candidates are expected to reach the level of rider proficiency and knowledge of "Roadcraft" and the "Highway Code" that is expected of Police Motor Cyclists. Each course consists, typically, of a Police Motor Cycle Training Instructor and two to three candidates.

7.8 The instructor and candidates are usually able to maintain contact with each other via a radio system and the Instructor is able to coach each rider as required through this medium.

7.9 The candidates rotate through positions one three and four with the Instructor in position two monitoring the rider who is currently in position one.

7.10 At the end of each drive segment the riders stop and discuss the previous ride by self analysis and extensive feedback provided by the instructor.

7.11 The course is pass or fail and each candidate must reach a minimum level of proficiency in order to be successful.

7.12 At the end of this training the candidate is attached to the MRU Unit and will be accompanied by Motor Cycle Unit Team Leaders until considered to be proficient in all aspects of the work of the MRU.

8. Context

8.1 Motor Cycle Blue Light Training is provided by a select number of Police Services.

8.2 To be able to train both Police Officers and Ambulance Staff, the Police Service must be able to award the Police Driver and Rider Training Award.

8.3 Only Police Training Centres that have been designated as "CENTREX" (Centres of Excellence) may provide this training.

8.4 The National Policing Improvement Agency (NPIA) is the body responsible for the accreditation of police training facilities to the CETREX standard.

8.5 Police Services that do not operate a CENTREX accredited training facility send their staff to other accredited Police Services for specific training such as the Motor Cycle Training Course.

8.6 London Ambulance Service NHS Trust sends staff exclusively to CENTREX accredited training centres for all aspects of motor cycle training and assessment.

8.7 Ron Pile joined the LAS in 1988, working initially in Patient Transport Services (PTS). He moved to Accident and Emergency work and held the position of Emergency Medical Technician from 1989 to 1994 and then qualified as a Paramedic in 1994.

8.8 Ron Pile gained wide experience in all types of driving including working as a bus driver in central London prior to joining the LAS.

9. Examination of Potential Causative Factors

9.1 Individual (Staff) Components

9.1.1 The Competence, Skills and Knowledge of all three of the LAS who attended the Motor Cycle Training Course were all assessed throughout the application and selection process in accordance with accepted LAS practice which exceeds the process used by Police Services to select Police Officers for Motor Cycle Training.

9.1.2 The Paramedic qualifications of all three members of staff were all verified as part of the application and selection process..

9.1.3 Previous Experience of riding large motor cycles was verified by the Line Manager responsible for each member of staff.

9.1.4 Motor Cycle handling skills and knowledge were all verified by City of London Police Motor Cycle Instructors and each member of staff was required to demonstrate the required level of skill in order to qualify for inclusion on the course.

9.1.5 There were no known physical or mental stressors. All members of the course were well motivated and were pursuing the acquisition of the Motor Cycle Riders qualification for their own reasons as this training is not mandatory and is only available to highly experienced and therefore enthusiastic motor cyclists.

9.1.6 No evidence of any mental or physical stressor has been revealed by the investigations that have taken place since this incident. No record of any illness and, as this was only day two of a three week training course it is not likely that workload would have had any impact on performance on the 23/04/08..

9.2 Team Components

9.2.1 Verbal Communication was achieved through a radio system which allowed all members of the driving course to keep in contact.

9.2.2 It is normal practice for each student to critically analyse his previous drive and for the course instructor to feed back his observations at the end of each drive. The course itself is not competitive and each driver will support and assist each other as the course progressed. The skills being learnt are technically demanding and an honest appraisal is necessary so that each student is able to acquire the desired skills.

9.2.3 Day one of the course was largely taken up with administration and written copies of the course plan, objectives, Health and Safety/Risk Assessment documents were discussed and issued.

9.2.4 The course consisted of three students and one Instructor who was responsible for all aspects of supervision and support throughout the course. The ratio of three to one is typical on driving courses but almost unheard of in normal classroom based training. It does, however, allow a close relationship to develop and for the instructor to become very aware of the individual needs or concerns of each student and respond accordingly.

9.2.5 Congruency and consistency between successive courses and those held at different training establishments and locations in Police Services throughout England is assured by the CENTREX, Police Driver and Rider Training Award administered by the National Policing Improvement Agency (NPIA).

9.2.6 Following the incident, and LAS MRU Supervisor travelled from his home address to Taunton to be with the two other LAS staff who were attending the training Course.

9.2.7 The LAS Medical Director also travelled from her home address to Taunton to offer additional support to the LAS staff.

9.2.8 AOM at Romford Complex, travelled to RP's home in Kent to support RP's widow and family. He conveyed family members to Taunton and remained with them, returning them to their home address when they were ready

9.2.9 The Chief Constable of Avon and Somerset Police spoke to the LAS CEO and other senior managers to convey his sincere condolences and to offer his personal assistance should any help be required.

9.2.10 The LAS established a substantial communications exercise to ensure that colleagues were properly informed at the earliest time and that developments were shared with staff as these became known.

9.3 Task Components

9.3.1 The course is based around the publication "Roadcraft" – the Police Motor Cyclist Diving Manual. This is available from any bookshop and was provided to staff attending the training course. A thorough knowledge of the "Highway Code" is also a prerequisite for attendance on the course and this too is widely available at any bookshop and a copy was provided to each member of the training course.

9.3.2 Roadcraft promotes the application of what is termed the "System" of vehicle control. This breaks down each manoeuvre into common component parts which are repeated on every occasion. It is the application of this system that is the core of each driving course.

9.3.3 The system of vehicle control has been taught and practiced by professional police drivers for many years and is considered the optimum methodology for driving in blue light and also non emergency conditions while maintaining the highest degree of safety to all road users. As such it is the method used by generations of police and other emergency service staff ensuring consistency and proving its resilience.

9.4 Resource Components

9.4.1 The equipment in use on the day of the incident was a 650cc motor cycle.

9.4.2 Under normal operational conditions MRU units are required to carry a considerable amount of operational equipment and the motor cycle must bear the weight of this equipment when responding to emergency calls. The weight of this equipment is therefore one of the factors that dictates the type and engine size of these vehicles. Whilst engaged in driver training, the bulk of this equipment is not carried and it is therefore reasonable for a slightly less powerful motor cycle to be used without any appreciable loss of speed or power. A 650cc motor cycle would therefore be an appropriate vehicle to be used for this training where the emphasis is one of close control and application to a driving system.

9.4.3 Vehicles are checked for roadworthiness at the commencement of the days training. Following the Road Traffic Incident the motor cycle involved was taken away for detailed forensic examination. Part of this examination includes scrutiny of the vehicles maintenance records.

9.4.4 The Police Incident Report confirms that all vehicles in use on the day of the incident were completely roadworthy and had no mechanical faults.

9.5 Education and Training

9.5.1 The training course being undertaken is exactly the same as previous courses attended by London Ambulance Service Staff for many years together with countless hundreds of Police Motor Cycle Drivers at all accredited Police Motor Cycle Training Establishments across the UK.

9.5.2 The training of staff (police and ambulance service) to undertake motor cycle duties conforms to a uniform standard wherever this training takes place. This specific training is only provided by a select number of Police Services in the UK. The police service that provides the training must be accredited to award the Police Driver and Rider Training Award and be designated as "CENTREX" training establishments. The NPIA is the body responsible for the accreditation of police training facilities to the CENTREX standard. London Ambulance Service sends staff exclusively to CENTREX accredited training centres for all aspects of motor cycle training and assessment.

9.6 Other Contributory Factors

9.6.1 Weather conditions on the day of this incident were described as good. No rain, dry roads and good visibility was reported by the other course participants and in the Road Traffic Incident Final Report submitted to HM Coroner.

9.6.2 The road is described as a single carriageway maintained in good condition with no previous history of traffic incidents occurring at the location of the incident.

9.6.3 Traffic conditions were light – occasional other vehicles using the road in question.

9.6.4 Forensic examination of the incident scene and the other vehicle involved in the collision with the motor cycle driven by Ron Pile confirms that the other vehicle was in very good condition with no mechanical faults. Marks left on the road confirms that the other driver was correctly positioned on the left of the road, had taken avoiding action but was not able to avoid a collision with the motor cycle which had been propelled towards the oncoming vehicle at an acute angle.

9.6.5 The police report states that the presence of the other vehicle involved in the incident had no part in the causation of the incident and its position at the time that the motor cyclist lost control was a matter of tragic chance.

9.6.6 The police report also stated that no action was indicated in respect of the driver of the other vehicle involved in the collision.

9.6.7 Hours worked were within acceptable levels –this was at an early stage in the training course and all drivers were within recognised drivers

hours limits and had been taking regular periods away from actual driving conditions throughout the day of the incident.

9.7 Risk Management – Staff Support

9.7.1 The report from the course instructor confirms a vigorous safety culture on the course. Much of the previous day had been devoted to Health and Safety issues and briefings relating to safety considerations.

9.7.3 All aspects of staff support provided by the LAS were available to the staff attending this training course even though they were situated in Somerset at the time. The ratio of one instructor to three students also leads itself to higher than normal levels of support for each student and the instructor had access to and would be able to direct any student to all the support mechanisms provided by the police service.

9.7.4 The support arrangements made by the service in terms of informing colleagues and friends of the tragic death of Ron Pile and of keeping them informed of developments and allowing them time and the ability to come to terms with the news have been recognised throughout the service as being beyond comparison. Considerable numbers of managers and other appropriate staff were brought in to ensure that anyone needing counselling or other welfare arrangements could be accommodated without delay. Staff at other ambulance stations provided additional cover to allow their colleagues time away from operational pressures at this desperately sad time.

9.7.5 A comprehensive communications strategy was set in motion and staff across the service were advised and updated on developments through the intranet ("The Pulse") and through advisory bulletins. Articles also appeared in the staff magazine "LAS NEWS".

9.8 Funeral

9.8.1 The funeral of Ron Pile took place at Romford Cemetery on Tuesday 6th May 2008.

9.8.2 More than 250 LAS staff attended the funeral. A ceremonial squad, motor cycle outriders and a fly past by HEMS were typical of the arrangements made to honour the memory of this popular member of staff.

9.8.3 Communications around the funeral arrangements included bulletins to staff, information on the intranet ("THE PULSE") and news releases to the National and Local Press and other media.

9.8.4 The funeral was reported in the service magazine "LAS NEWS".

9.9 Inquest

9.9.1 The Inquest took place in Taunton on the 24th July 2008.

9.9.2 The LAS Family Liaison Officer conveyed Mrs Pile and other members of the family to Taunton and returned them at the end.

9.9.3 An Assistant Director of Operations and other members of LAS staff attended the Inquest.

9.9.4 HM Coroner recorded a verdict of Accidental Death due to a road traffic collision.

9.9.5 The Coroner stated that this was a tragic incident and that it was essential for ambulance services to be able to get to scenes as soon as possible and that using motor cycles was a good way of achieving that.

9.9.6 The Coroner stated that it was reasonable for the LAS to send staff on motor cycle training courses run by the police and to the course run by Avon and Somerset police.

9.9.7 The Coroner stated that both Ron Pile and the driver of the other motor vehicle were driving at a reasonable speed and that the car driver had taken evasive action.

10. Findings

10.1 The LAS was informed about the incident in an appropriate, timely manner by the Chief Constable of Avon and Somerset Constabulary.

10.2 Senior Managers within the LAS acted in accordance with the Service Vision and Values on receiving the news.

10.3 Family Support arrangements were initiated without delay and continued without a break up to and beyond the Inquest Hearing.

10.4 A comprehensive communications strategy was established to ensure that all staff were informed of the tragic news through a variety of communication tools including bulletins, intranet and verbal briefings by senior managers and they continued to be informed as information became available.

10.5 A substantial relief arrangement was established to allow staff at Romford Station to come to terms with the news whilst other staff covered calls within the area.

10.6 A large number of managers were drafted in to support staff at Romford and other stations and offer to arrange counselling and other welfare arrangements as required.

10.7 The funeral arrangements were in absolute accord with the wishes of the family and were considered completely appropriate and mirroring the sense of grief experienced by friends and colleagues.

10.8 Support arrangements for the family and colleagues continued to the Inquest and beyond.

10.9 The selection procedure used by the LAS for prospective motor cycle riders has been compared to the procedures used by police services and it has been established that these exceed the standard used by other organisations by a considerable extent.

10.10 Records of the process used to assess the competence, skills and knowledge and thus to select Ron Pile for this training have been carefully examined to reveal that all aspects of the selection procedure were adhered to in every respect and that Ron Pile complied with all entry requirements.

10.11 Motor cycle handling skills and levels of knowledge were verified by City of London Police Motor Cycle Instructors.

10.12 Motor cycle training under blue light conditions is provided by a select number of Police Services in the UK. To be able to provide this training the Police Service must be accredited to award the Police Driver and Rider Training Award. Accredited Police Services are designated as "CENTREX" (centres of Excellence) by the National Policing Improvement Agency NPIA).

10.13 LAS only send staff to CENTREX accredited services for training.

10.14 All vehicles were checked for roadworthiness at the start of each days training.

10.15 Forensic examination of the machine that was used by Ron Pile revealed that it was roadworthy in every respect and no mechanical defects were identified.

10.16 Forensic examination of the other motor vehicle involved in the collision similarly revealed no mechanical defects and confirmed the vehicles roadworthiness.

10.17 The police investigation revealed that the driver of the other vehicle had tried to take avoiding action to prevent a collision with the out of control motor cycle.

10.18 The investigation confirms that weather conditions, condition of the road surface or presence of other vehicles had no impact on the cause of the collision.

10.19 HM Coroner ruled that this was an accidental death caused by multiple trauma as a result of a road traffic collision.

10.20 HM Coroner stated that it was wholly appropriate for this type of training to take place and that it was absolutely reasonable for the LAS to send staff to Avon and Somerset Constabulary to receive that training.

10.21 HM Coroner stated that both vehicles that were involved in the collision had been travelling a reasonable speed and that the collision was a tragic incident.

10.22 The report into the investigation of the road traffic collision completed by Avon and Somerset Constabulary describes in forensic detail the process followed by the expert fatal accident investigators in this case in examining all aspects of the incident. The findings are reflected in the information provided in this report.

11. Conclusions

11.1 The selection process in use by the LAS to select staff to be trained in the safe use of motor cycles under blue light conditions is appropriate and exceeds the standards in use by other organisations.

11.2 No changes in the selection process are indicated.

11.3 Ron Pile complied with all requirements and was therefore eligible to be selected as a potential candidate for this training.

11.4 The selection of Ron Pile was compliant in every respect to the established selection procedures and no departure from normal practice occurred.

11.5 Avon and Somerset Constabulary are an accredited CETREX organisation entitled to award the Police Driver and Rider Training Award.

11.6 The use of Avon and Somerset Constabulary as a supplier of motor cycle training was appropriate in every respect.

11.7 Avon and Somerset Constabulary demonstrated a risk averse culture and no aspect of Health and Safety appears to have been overlooked on this training course.

11.8 The LAS support and management arrangements to Ron Pile's family and Service colleagues were impeccable in every regard and should be cited as an example of best practice should the need arise in the future.

11.9 The LAS' communication strategy was thorough, appropriate and flawless in its application and is a further example of best practice.

11.10 HM Coroner ruled that this was an accidental Death and there were no influencing or causal factors involved in the incident.

11.11 The root cause can therefore be stated as an accident caused by an apparent error in the positioning of the motor cycle while negotiating a bend in the road resulting in loss of control of the machine and the collision that followed.

11.12 There are no actions indicated or are required to be implemented by the LAS in respect of the use of motor cycles to respond to emergency calls, the selection of staff to ride these machines or the training that is necessary to equip them with the skills needed to operate these machines under operational conditions.

11.13 There are no lessons to be learned by the LAS as a result of this investigation that may prevent a similar incident from happening in the future.

12. Recommendations

12.1 There are no recommendations indicated in this instance.

12.2 There are no actions indicated.

Ralph Morris
Assistant Chief Ambulance Officer

29th August 2008

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 2008

Older People & Long Term Conditions Strategies

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For approval

3. Summary:

4. Two trust strategies, providing an action plan to achieve these priorities over the following five years, outlining the key priorities in treatment of
   - Older people
   - Patients with long term conditions;

5. Recommendation:

   THAT the Trust Board APPROVE the two strategies and action plans

London Ambulance Service NHS
NHS Trust

Older People's Strategy

Claire Garbutt
Policy, Evaluation & Development

July 2008

London Ambulance Service NHS Trust

Older People's Strategy
2008

Contents

1.0 Introduction

Older people's health is an important aspect of the service provided by the London Ambulance Service (LAS). The health needs of older people can be complex, with many older people suffering from long term conditions, particularly coronary heart disease, stroke, diabetes, cancer and chronic obstructive pulmonary disease (COPD). The prevalence of these illnesses and physical disabilities among older people makes them frequent users of health services; with people over the age of 60 representing 70% of medical admissions to hospitals. In 2006/7 the LAS responded to 945,776 incidents of which 647,811 were in relation to people over the age of 60. This equates to 68.5% of all incidents.

Older people can be a vulnerable population and often have special needs when accessing emergency and urgent care services. Greater understanding is needed of how to deliver personalised healthcare to older people[12]. The six senses framework[13] illustrates that in the best care environments all participants experience a sense of *security* to feel safe, *belonging* to feel part of things, *continuity* to experience links and connections, *purpose* to have a goal to aspire to, *achievement* to make progress towards those goals and *significance* to feel that you matter as a person.

It is essential to ensure that the LAS are providing equal access to services for all, without prejudice based on age, gender, sexual orientation or ethnicity.

The objective of this strategy is to develop key priorities in older people's ambulance care and set out the actions required to achieve these priorities over the following five years.

2.0 Background

England is an aging society; one fifth of our population are over the age of 60 and the greatest population increase is occurring in those aged 85 years or older[14]. While London has a relatively young population compared to the rest of England[15], there are currently more than 1 million people over state retirement age, and older people make up a significant proportion of those using health services.

The term older people can be relative and there are a number of definitions at which people are referred to as older. In order to ensure LAS staff are not making judgements on age but making decisions based on clinical and personal need, older people may be assessed by their phase of their life. Staff can then determine the issues likely to affect each patient.

The three key stages of life for older people are[3]:

Entering old age: Those people who have completed their career and are active and independent.
Transitional phase: Those people who are in transition between having an active, healthy life and frailty.
Frail older people: Those who are particularly vulnerable because of their health problems.

2.1 The case for change

Approximately 68% of all calls received by the LAS in 2006/7 were in relation to an older person. The most common reasons for these calls are shown in the table below.

Illness type	**Number of incidents**	**%**
Other medical conditions	56,261	8.7
No injury or illness	42,333	6.5

[12] Bridges, J. (2008). Listening Makes Sense: Understanding the Experiences of Older People and Relatives Using Urgent Care Services in England. City University London.
[13] Nolan, M.R., Brown, J., Davies, S., Nolan, J., Keady, J. (2006). The Senses Framework: Improving Care for Older People Through a Relationship-centred Approach.
[14] Older People National Service Framework (2001). Department of Health.
[15] Focus on London (2007). Office for National Statistics.

DIB/SOB/dyspnea	41,057	6.3
Generally unwell	39,170	6.0
Pain – other	32,289	5.0
Abdominal pains	27,312	4.2
? fracture	21,035	3.2
Collapse – reason unknown	17,535	2.7
Pain – chest	15,841	2.4
Head injury (minor)	15,717	2.4
Cardiac chest pains	14,052	2.2
Other	325,209	50.2
Total	647,811	

2.2 Policy context

National Service Framework (NSF) for Older People[16]

The NSF for Older People provides a 10 year programme of action for improving quality of care, and tackling existing variations in care. Four main themes of the framework are; respecting the individual, intermediate care, providing evidence-based specialist care and promoting an active healthy life. Within these themes, the following eight standards were developed:

Standard 1: Rooting out age discrimination
NHS services will be provided, regardless of age, based on the basis of clinical need alone.

Standard 2: Person centred care
NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Standard 3: Intermediate care
Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Standard 4: General hospital care
Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard 5: Stroke
The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation.

Standard 6: Falls
The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

Standard 7: Mental health in older people
Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

Standard 8: The promotion of health and active life in older age
The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

Improving care of older people at the LAS: A strategy and action plan[17]

The previous LAS Older People's Strategy was written in 2003. 36 recommendations for action were presented in the strategy and these can be classified into the following themes:

- Care strand recommendations (relating to the way staff interact with older people)
- Intermediate care
- General hospital care
- Stroke

[16] National Service framework for Older People (2001). Department of Health.
[17] Improving Care of Older People at the LAS: A Strategy & Action Plan (2003). London Ambulance Service NHS Trust.

- Falls
- Mental health in older people
- Promotion of health and active life in older age

Since the development of this strategy the LAS has undergone significant service development relating to the way in which we respond to our patients. The Older People's Strategy therefore needs to reflect the changing culture of The Service. For a status report of the recommendations provided in the 2003 strategy see appendix 1. The following summarises the key points of the current strategic direction of the LAS.

Taking Healthcare to the Patient: Transforming NHS Ambulance Services (2005)[18]

A national review of ambulance services was undertaken in 2005 and provided a vision for the following five years to improve the speed and quality of call handling, provide and co-ordinate an increasing range of mobile healthcare, provide an increasing range of other services and improve the speed and quality of service provided to patients. Key targets include an increase in the number of older people receiving care in their homes. Envisaged benefits of implementation include the right response first time, fewer A&E admissions, greater job satisfaction, more effective use of resources and improvements in self care and health promotion.

London Ambulance Service Strategic Plan 2006-2013[19]

The LAS has traditionally been perceived as an emergency service responding to 999 calls and a survey carried out by IPSOS-MORI in 2005 found that over 75% of respondents indicated that the most important role of the Service was to provide an emergency service. The Trust has traditionally focused on this activity with a 'Blue Light' response being provided to convey patients taken ill or suffering trauma to hospital Emergency Departments (A&E) as quickly as possible.

The strategic plan focuses on greater independence in decision making for staff, with strong clinical leadership and increased use of guidelines rather than protocols. The prime objectives for The Service are to:

1. Redefine ourselves as a provider of urgent care in London as much as a provider of emergency care and to demonstrate to our partners and the public that this new role is of equal significance to the health service.
2. Develop an organisation which responds appropriately to all our patients whether their need is emergency or urgent in nature.

New Ways of Working (2008)[20]

The implementation of the New Ways of Working programme (NWOW) is going to have a huge impact on the service LAS deliver. There are a number of opportunities for improving patient care and experience that by be provided by the implementation of NWOW. The Older People's Strategy seeks to anticipate these opportunities and provide further suggestions for utilising the benefits of the programme.

3.0 Strategy Method

The key methodology for development of the Older People's Strategy involved development of a gold standard service description, a gap analysis and establishment of a set of priorities to improve the standard of care provided to older people in London. These priorities were determined through policy research and stakeholder engagement including a stakeholder event held on the 15th May 2008. Representatives from patient groups, Primary Care Trusts (PCTs), voluntary organisations and LAS staff participated in the event. The 37 delegates discussed what the priorities for older people's ambulance care should be, the changes needed and barriers to achieving these priorities, outcome measures and health equality issues. The feedback from the event was analysed and from this five key priorities were determined. For a summary of the feedback from the event see appendix 2.

[18] Taking Healthcare to the Patient (2005). Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114269?IdcService=GET_FILE&dID=2256&Rendition=Web

[19] Strategic Plan 2006/7 – 2012-13 (2007). London Ambulance Service NHS Trust

[20] New Ways of Working: Transforming Clinical Leadership (2008). London Ambulance Service NHS Trust. http://www.londonambulance.nhs.uk/ABOUTUS/publication_scheme/publication_scheme_files/Strategic%20Plan%20(Jan%2007%20TB)%20v6.pdf

4.0 Strategy Priorities and Recommendations

4.1 Gold Standard Service Description

'An accessible service which works in partnership to provide appropriate care for older people; treating them with dignity and respect.'

4.2 Professional development of LAS staff

The way in which LAS staff interact with patients affects patient experience and effective information exchange between the patient, their carers and LAS staff. Active listening, communication skills, maintaining confidentiality of information and sound decision making without making assumptions have been identified as important factors contributing to a positive patient experience. Staff attitude represents a large proportion of the complaints received by the LAS, with 8.5% of the complaints received by the LAS PALS department in relation to an older person. It is of note that older patients had a higher proportion of complaints relating to delays than other patient groups and a lower proportion of complaints in relation to staff attitude and treatment.

The previous role of Older People's Champion has been replaced with Dignity in Care Champions who raise the profile of dignity in care within the service however there has not been wide uptake of the role within the service.

Action: Increase awareness of older people's issues within LAS staff

Action: Promote dignity in care networks within the LAS.

Action: Improve partnership working to better provide for vulnerable adults

4.3 Patient Transport Service (PTS)

LAS currently hold the contract for approximately one third of the PTS provision within London. Stakeholder feedback has identified that levels of satisfaction with the PTS provided by LAS were generally high, however a number of issues have been identified by service users relating to the London-wide provision of PTS. Issues relating to timing with patients often required to be ready for pick up hours before the appointment, unreliability of the service and a reported poor standard of English spoken by PTS staff were highlighted. PTS related complaints received by the LAS PALS made up 13.9% of all complaints, with 9.7% of these related to the PTS provided by LAS. Stakeholders felt that the LAS should play a role in the development of London-wide PTS standards.

It was also identified that PTS clients are often disinclined to contact the Patient Advice and Liaison Service (PALS) as they do not know the complaint process and often feel uncomfortable complaining about a service they need to continue to use. Feedback on the service we provide is vital for service improvement.

Action: LAS to support groups involved in lobbying for the development of London-wide PTS standards.

Action: PALS information including contact details to be made available on all LAS vehicles.

4.4 Improving pubic perception of the LAS

Older people often do not contact the ambulance service when they should; because they do not recognise the significance of their symptoms, do not want to burden what they see as an emergency only service or do not understand the process for requesting an ambulance. Encouraging older people to call the LAS when they are in need, increasing awareness of the role of the LAS, building relationships and communicating with patients and carers is important to improve access to health services for older people.

Action: Undertake a public awareness campaign targeted towards older people.

Action: Hold station open days for older people to increase awareness of the LAS and build local relationships.

4.5 Partnership working

Building strong relationships with partners, voluntary organisations, local services and out of hours providers is essential to ensure cohesive service delivery and seamless care for patients. With the introduction of the New Ways of Working programme (NWOW), namely the role of the Community Involvement Officer; it is anticipated that engagement with patients, partners and local services will become more consistent across the service.

The relationship between care homes and LAS has been identified as a priority for improvement, as there is currently a lack of clarity of role between LAS and care home staff in emergency or urgent care situations. The failure to deliver basic first aid and lift non-injured fallers by care staff have been highlighted as issues by LAS staff.

Action: LAS staff to actively deliver public health messages targeted to the needs of the local population in partnership with local healthcare providers.

Action: Carry out relationship building between LAS complexes and care homes. This will include setting out responsibility agreements between LAS and care homes, upskilling of care home staff in basic first aid and increasing awareness within care homes of LAS recognition of life extinct protocols.

4.6 Use of care plans

The use of care plans such as the message in a bottle scheme, advanced directives, do not attempt resuscitation orders (DNAR) and patient specific protocols have wide support among our stakeholders, however the use of care plans is currently variable by locality. As the only pan-London healthcare provider LAS is in a key position to be able to drive the promotion of these schemes in collaboration with our partners.

Action: Investigate the success of existing care plan schemes LAS are involved with and roll successful schemes out London-wide.

4.7 Medicines management

Older people may often be taking a large number of medicines. It was identified that medicines management including regular review of a patient's medication is an issue. Some medicines can also have an impact on the condition or forms of treatment that are suitable for an individual patient. The LAS has introduced a patient pharmacy bag to facilitate all patients' medication accompanying them to hospital, to ensure hospital staff are aware of the medications patients are taking and can carry out a medicines review. This scheme also ensures a patient has all necessary medication with them while in hospital.

Action: Continue use of the patient pharmacy bag and increase utilisation of the resource.

5.0 Implementation Structure

The priorities for the strategy will be agreed and fed into the work streams defined by the Service Improvement Programme. Suggested actions are provided to achieve the priorities identified within a five year period. For an action plan outlining implementation of the recommended actions see 5.1.

It is important that implementation of these actions is not undertaken in a directive manner; there is sufficient evidence to suggest that an approach that engages the individuals who will be responsible for delivering the strategy recommendation will be most effective. The risk of not using this approach is significant failure to produce the intended outcomes, and for local action to block the desired direction of progress.

5.1 Action Plan

Supporting actions	Resources required	Benefits	Timescale	Outcome measures	Workstream
Increase awareness of older people's issues within LAS staff					
•Introduce older people's issues in the Patient Care section of the LAS News •Develop CPD training package relating to older people	•Identify and engage potential contributors •Training capacity •Communication team guidance •Identify internal and external professionals who could assist in providing training	•Increased awareness about issues pertaining to older people will allow front-line staff to make more informed assessments when visiting older patients •More appropriate care for patients	6-12 months	•Articles in the LAS news •Training sessions provided by suitable professionals •Improvement in relevant staff survey result (would require adaptation of standard staff survey questions) •Improvement in patient satisfaction survey results	E-learning
Promote dignity in care networks within the LAS					
•Identify current number of Dignity in Care Champions within LAS •Scope the role of Dignity in Care Champion •Recruit new champions for those complexes currently without champions •Ensure champions have an effective mechanism for communicating with one another to ensure co-ordination of activities and identification of new areas for improvement	• Staff released to carry out Dignity in Care duties	•Increased awareness of Dignity in Care throughout the service •Opportunity for partnership working through national Dignity in Care Network. •Staff development •Improved patient care	12-18 months	•Number of Dignity in Care Champions within the LAS •Improved patient satisfaction survey results •Reduced number of complaints relating to staff attitude •Positive feedback from staff •Increased knowledge of Dignity in Care code among LAS staff	Business as usual

Improve partnership working to better provide for vulnerable adults					
•Identify agencies involved in care of and response to referrals of vulnerable adults •Foster relationships with agencies involved in care for vulnerable adults	•PALS team input to manage process	•More joined up care for vulnerable adults •Faster and more effective response to vulnerable adult referrals •Improved stakeholder engagement	Immediate	•Increase in number of vulnerable adult referrals •Improved outcomes for vulnerable adults •Stakeholder feedback regarding referrals received	Business as usual
LAS to support groups involved in lobbying for the development of London-wide PTS standards					
•LAS to provide support and representation when requested to groups involved in the lobbying for development of London-wide PTS standards	•Input from staff as and when required	• Improved standard of service for PTS London-wide •More standardised care	Ongoing	•Reduction in the number of complaints received in relation to PTS •Improved patient satisfaction results for PTS	Business as usual
PALS information to be made available on all LAS vehicles					
•Assess the number of vehicles with poster display units •Identify who is responsible for installing poster on vehicles • Distribute PALS posters	• Poster display units for vehicles which do not currently have them • Staff to distribute posters to vehicles	• Increased awareness of LAS PALS • More feedback received regarding service provision	ASAP	• Increase in the number of PALS enquiries received •Number of posters displayed on vehicles	Access programme

Undertake a public awareness campaign targeted at older people					
•Determine key messages to deliver to older people regarding use of the ambulance service •Launch public awareness campaign •Evaluate success of public awareness campaign	•Communications department support	•Older people contacting the LAS sooner resulting in better patient outcomes	October 2008	•Increase in number of category C calls received in relation to older people, with a corresponding decrease in the number of Category A calls •Improved patient outcomes for older patients	Business as usual
Hold station open days for older people to increase awareness of the LAS and build local relationships					
• Identify stations in areas with high populations of older people •Agree stations to hold open days • Agree programme for open days •Assess resourcing required to deliver open days •Carry out advertising with stakeholders (such as Age Concern, Greater London Forum for Older People)	•Communications department support for planning and advertising events •Staff to run events	•Improve relationships with the public locally •Increase awareness of the LAS and our role •Opportunity to deliver key health messages to an at risk population	6months-ongoing	•Number of people attending open days •Analysis of feedback from attendees at open days • Increase in the number of calls received relating to older people	Business as usual

LAS staff to actively deliver public health messages targeted to the needs of the local population in partnership with local healthcare providers					
• Determine the public health priorities locally •Engage with stakeholders locally to assess what work is being carried out by partner organisations •Develop outline of communication strategy locally •Regular evaluation of project	•Complex staff to co-ordinate delivery of public health messages •Input of the PPI and Communications Department to advise on methods of public engagement	•Improved health outcomes for local communities, particularly those at high risk of health inequalities •Improved relationships with the public locally •Increased awareness of local health issues •Potential to gain additional funding for formalising delivery of health promotion messages	12 months – ongoing	• Attitude and behaviour change in the local population • Established communications channel to local community • Broad community awareness of health issues • Increased visibility of the role of the LAS	Development of a public health strategy
Carry out relationship building between LAS complexes and care homes					
•Carry out a pilot with a complex to engage more effectively with care homes •Identify the issues relating to each care home and determine ways of best working together to improve care •Where need is identified provide basic first aid training to care home staff •Set out agreements with care homes with regard to LAS response (including provision of CPR, DNAR orders)	•Staff resource to carry out project •Community resuscitation team input to provide first aid training to care homes staff	•Improved relationships between LAS and care homes •Improved care for patients in care homes	Initial pilot: 12 months Roll out service-wide: 18months–4 years	•Reduction in number of category C responses at care homes •Feedback from care home staff •Increase in the number of patients for whom CPR has been initiated upon LAS arrival at the scene	NWoW

Investigate the success of existing care plan schemes LAS are involved with and roll successful schemes out London-wide					
•Identify areas of good practice and determine why these are working well •Consult with AOMs about barriers to success •Develop a project to roll-out the scheme London-wide if desirable and practicable •Design a system to monitor usage	•Personnel •Buy-in from local complexes and providers (e.g. PCTs, Age Concern, etc.) •Bottles for message in a bottle scheme	•More information available when crews attend patients, thereby creating more opportunities to provide personalised, appropriate care •Greater patient satisfaction with service received	18-24 months	•An increase in the number of patients linked in with primary and secondary care practitioners •Improved patient satisfaction survey (indirect) •Reduction in hospital admissions (indirect)	Business as usual
Continue use of the patient pharmacy bag and increase utilisation of the resource					
•Continue stocking patient pharmacy bags on vehicles •Encourage crews to utilise patient pharmacy bags	•Patient pharmacy bags •Personnel from the Make Ready Team to ensure vehicles are stocked	•Savings for the NHS on wasted medications •Better management of conditions •Additional opportunity to carry out medicines reviews for patients •Reduction in time taken for patient to recall and record all medications they are currently taking	Ongoing	•An increase in the need for restocking patient pharmacy bags on LAS vehicles •Feedback from acute trusts	Business as usual

6.0 Measurement, Review & Evaluation

This strategy will need to be evaluated to ensure that any changes are an improvement in the services provided, and to enable communication and dissemination of successes achieved as well as to enable the LAS to learn from any challenges.

Each recommendation is accompanied by suggested outcome measures and these will be indicators for success in each area.

Evaluation does need to include patient outcome measures and satisfaction where possible however, and not just focus on reducing demand or decreasing A&E attendances for example – though these remain valuable indicators.

There is a particular need for ongoing conversation with the front-line staff about their perceptions of the strategy, to ensure that there is fit with their experiences of the operating environment.

It is anticipated that the overall strategy will be reviewed in five years' time. It is acknowledged, however, that what works for one complex may not work for another; ongoing local evaluation is therefore required to be undertaken in addition to wider strategy evaluation to ensure that projects remain relevant to practice. It is recommended that annual status reports are provided to monitor the status of implementation of the Older People's Strategy.

Appendix 1: Status update - Improving care of older people at the LAS: A strategy and action plan (2003).

The previous older people's strategy – Improving care of older people at the LAS a strategy and action plan was developed in 2003. A number of recommendations were provided and implementation initiated. However due to environmental and internal changes including the loss of key drivers of the strategy some recommendations have not been fully implemented. In the development of the 2008 Older People's Strategy the status of the previous recommendations have been considered and included where deemed still appropriate.

Recommendation	Work to date	Actions to be brought forward into 2008 strategy
A non-executive director is appointed as the lead for older people within the LAS	No director appointed as older peoples lead. A member of the Policy, Evaluation & Development team leads for older people within the LAS.	Dignity in care network to be established and led by a non-executive director.
A clinical or practice champion is appointed to lead professional development	Dignity in care champion (1) is now carrying out role of older person's champion. Leading on professional development however, is not a current function of this role.	
Data protection requirements regarding consent and referral outside of the LAS and A&E are clarified	Completed through referral pathways project and development of a consent policy.	
Process mapping for other areas of care or conditions particularly applicable to older people is carried out	Not implemented specifically, however the implementation of referral pathways outlines care pathways specifically for older people.	
Monitoring and evaluation of the strategy is carried out	Individual actions implemented have been evaluated, however the strategy as a whole not robustly evaluated.	Annual updates on actions implemented will be carried out for the 2008 strategy in addition to formal evaluation.
A coordinated approach is taken to communicating the strategy	Communication carried out locally with LAS crew staff.	
Time and effort is given to ensuring that LAS staff feel developed and supported in their changing roles	This will be one of the benefits resulting from implementation of NWoW.	
The role of PTS in the delivery of this strategy is given consideration	A separate PTS listening event was carried out.	
Carry out an audit of policies and procedures for any reference to age-related decisions about treatment and care	Not carried out.	
Carry out a piece of qualitative work on attitudes of staff	Not actioned.	
Ensure representation of older people across the organisation	The LAS patients forum has older peoples representatives who are involved in consultation and stakeholder engagement.	
Implement guidelines on gaining informed consent from older patients	New consent documents have been developed and implemented.	

Recommendation	Work to date	Actions to be brought forward into 2008 strategy
Undertake a review of training and education on the care of older people	Not actioned.	
Build up links with other parts of the NHS and social services	LAS actively engages with PCTs and other providers. Establishment of referral pathways also requires significant local engagement.	
Promote the use of language line by ambulance staff in the clinical setting	Language line widely used by LAS staff.	
Carry out consultation/listening exercises with older people	PTS listening event, PPI events.	
Learn from other ambulance service schemes	No evidence found of implementation.	
Continue to make LAS operational resources available to the existing District Nurse/Paramedic scheme in Havering PCT	Referral pathways now established with a number of services.	
Pilot admission avoidance using agreed pathways and access to community based services with the ECPs.	Links established through ECP role & referral pathways project.	
Pilot a direct entry for older people to the appropriate speciality scheme (Kings College)	Referral pathways now established with a number of services.	
Continue to support existing 'message in a bottle' schemes	LAS support but do not actively promote scheme.	
Continue to participate in the research trial of rapid treatment and transfer of patients with acute stroke	Carried out via stroke pilot in SW London & engagement with HfL workstream.	
Carry out an audit of the accuracy of recognition of stroke	No longer applicable with implementation of the stroke pathway.	
Give consideration to providing information for GP registers	Vulnerable adult form introduced however links with GPs are limited.	
Work with GPs to ensure the patient with acute stroke who accesses care via their GP receives the appropriate fast care	Carried out through implementation of stroke pathway.	
Develop a research project with Guy's and St Thomas' & Lewisham Hospital testing the impact on patient outcome of the whole system process change	No evidence of implementation.	
Training and education on stroke is reviewed	Carried out.	
Continue to participate in the research trial of rapid treatment and transfer of patients with acute stroke to a rapid assessment unit	Carried out through South West London stroke trial.	
Give consideration to providing information for GP registers being developed for the prevention of coronary heart disease	No evidence of implementation.	
Continue to support the ambulance stations involved in providing information for older people on falls prevention services & roll this out if successful	EBS support desk carry out this function.	

Recommendation	Work to date	Actions to be brought forward into 2008 strategy
Give consideration longer-term to the identification of people at risk of falling to be added to GP falls registers	Dependant on locality/PCT.	
Offer full LAS support to the work that has commenced to reduce the current identified risk associated with variations in non-conveyance	Training improvements have been made regarding both assessing and completing documentation.	
Work with care providers in the community; particularly care homes, social alarm providers and domiciliary carers to reduce the use of the ambulance service for 'assistance only' calls.	Carried out.	
To review training on mental health with particular attention to the differences and needs associated with older people	Redesigning CPD course to include both mental health and older people.	
Build up links with mental health services	Links continually being developed.	
Build up links with services providing health promotion	Local links continually being developed.	
The rationale and objectives for promoting healthy and active life in older age underpin this entire strategy and all its recommendations.	Included in strategy.	

Appendix 2: Older People's Strategy Stakeholder Workshop Summary

London Ambulance Service NHS Trust

Older People's Strategy Workshop
15th May 2008

WORKSHOP SUMMARY

The Policy, Evaluation and Development team ran a successful workshop to develop priorities for the London Ambulance Service (LAS) Older People's Strategy on the 15th May 2008. The objectives of the workshop were:

- To provide a forum for stakeholders to share current strategies for older people's health and perceptions of these
- To generate options for how the LAS can better support patients and local strategies and initiatives
- To determine how success in these areas can be measured

This document summarises the outcomes of the discussions, and outlines the suggested next steps for the LAS.

1. ATTENDEES

Violet White	Chair – Older People's Reference Group	Newham PCT
Vicky Kankam	Adults Commissioning Team	Newham PCT
Joyce Conway	Chair Patients Forum	Greenwich PCT
Yemisi Osho	Clinical Services Manager for Older People	Waltham Forest PCT
Nicole Price	Community Services Commissioner	Richmond & Twickenham PCT
Peter Ebenezer	Commissioner for Continuing Care	Kensington & Chelsea PCT
Andrew Gawthorpe	Senior Strategy & Commissioning Manager &	Islington Council Housing Adult Social Services & Islington PCT
Margaret Vander	Patient & Public Involvement Manager	London Ambulance Service
Claire Garbutt	Policy Manager	London Ambulance Service
Kiran Chauhan	Policy Officer	London Ambulance Service
Emma Williams	ECP Programme Manager	London Ambulance Service
Alison Oakes	EBS Operations Manager	London Ambulance Service
Nick Lawrance	Head of Policy, Evaluation & Development	London Ambulance Service
Daryl Mohammed	GP, Assistant Medical Director (Primary Care)	London Ambulance Service
Sara Sandven-Burnett	PALS Officer	London Ambulance Service
Paul Ward	Ambulance Operations Manager	London Ambulance Service
Alan Clark	Team Leader, Dignity in Care Champion	London Ambulance Service
Martin Cook	Ambulance Operations Manager	London Ambulance Service
Jenny Palmer	Project Manager	London Ambulance Service
Shirley Murgraff	Member	City & Hackney Older People's Reference Group
Caroline Tella	Member	City & Hackney Older People's Reference Group
Grace Olaiynka	Member	City & Hackney Older People's Reference Group
Brigid Doherty	Assistant Director of Care	St Josephs Hospice
Pat Notton	Volunteer	Blackfriars Settlement
David Hart	Member	LAS Patients Forum
David Singh	Treasurer	Haringey Forum for Older People
Gordon Deuchars	Policy & Campaigns Manager	Age Concern London

Pamela Moffatt	Transport Advisor	Age Concern London
Lynn Strother	Director	Greater London Forum for Older People
David Prichard-Jones	Member	Lambeth Older Persons Forum
Fiona Gowen	UK Assistant Director	RSVP
Louise Lakely	Senior Policy Officer	Alzheimer's Society
Celia Bower	Member	Haringey Forum for Older People
Ellen Lebathe	Chair	Lambeth Pensioners Action Group
Shu Pao Lim	Patient	

2. MAIN THEMES

The highest priority changes that were suggested by the discussion groups can be categorised into the following broad themes:

- Professional development of LAS staff
- Patient Transport Service (PTS)
- Public perception
- Partnership working
- Use of care plans
- Effective service delivery

The following provides a summary according to these themes.

➢ PROFESSIONAL DEVELOPMENT OF LAS STAFF

Staff treating patients with dignity and respect was a key priority in a number of the group discussions. This involves addressing patients in an appropriate manner, treating the patient rather than the condition, engaging in active listening to avoid making assumptions, communicating effectively with a range of patients and ensuring confidentiality is maintained.

It was identified that staff development and education in specific clinical areas and in identifying vulnerable adults and assessing mental capacity would be beneficial. Use of referral pathways was acknowledged as important to ensure patients receive the most appropriate care and it was suggested that triggers could occur when calls were received into the Emergency Operations Centre (EOC) to highlight more appropriate pathways early in the process.

➢PATIENT TRANSPORT SERVICE

The Patient Transport Service (PTS) was identified as an important part of the service provided by the LAS. LAS does not hold the contract to provide PTS services London-wide, with this service tendered for locally. A number of issues relating to provision of PTS (not limited to that provided by LAS) were discussed including timing, with many patients required to be ready for pick up hours before the appointment, unreliability of the service and a poor standard of spoken English by PTS crews, resulting in patients feeling their needs were not effectively being met. LAS currently hold the contract for approximately one third of the PTS in London however it was suggested that LAS should lead in driving for the development of London-wide PTS standards.

When wanting to make a complaint some older patients did not know the procedure for complaining, and others felt uncomfortable making a complaint when they would be using the service again in the future. It was suggested that PTS staff distributing information for complaints procedures and PALS contact details would help to facilitate people feeding back on the quality of the service.

➢ PUBLIC PERCEPTION

The public perception of the LAS was discussed and it was identified that many older people did not call an ambulance when they should. This may be because they do not recognise the significance of their symptoms, do not want to burden what they see as an emergency only service or do not know they can contact an ambulance directly. It was also identified that older people may have perceptions of ambulance staff and their ability to meet their needs, particularly relating to pain management and reassurance.

Improving access by encouraging older people to call the LAS, increasing awareness of the role of LAS, building relationships and communicating with patients and carers were seen as priorities. Suggestions for achieving these included providing an alternate number for people to contact for advice rather than calling the EOC. There was some debate about the effectiveness of an additional number as it may create confusion with NHS Direct. Links with NHS Direct were seen as vital to ensure that care is joined up and patients know when they should be calling 999 and when it is more appropriate to call NHS Direct. Older People's Forums may be an effective method of disseminating this information. It was suggested that providing feedback on calls that may be more appropriately dealt with by another service – which may be NHS Direct, the GP or a community health worker would be useful.

It was also suggested that open days at local ambulance stations would be an effective way of raising public awareness and also building local relationships between LAS staff and the public.

➢ PARTNERSHIP WORKING

Building strong relationships with partners, local services and out of hours providers was identified as a key priority to ensure cohesive service delivery and seamless care to patients. Local engagement is currently variable by locality however with the introduction of New Ways of Working (a LAS programme to create a greater range of options for patients by creating an environment focusing on clinical leadership) and the role of the Community Engagement Officer it is anticipated that engagement with partners and local services will become more standardised across the service. It was suggested that Community Engagement Officers should establish links with local community centres, publicise when people should be calling 999 and deliver public health messages targeted specifically to local need.

Information sharing is an important aspect of partnership working and ambulance crews having access to patient records would ensure relevant patient details are available to ambulance crews. Information technology is therefore important, and was viewed as currently being a barrier to information sharing. It was suggested that LAS should link in with the RIO system (a web based electronic care record system) to identify high intensity users.

The perception of the skills of care home staff and the relationship between LAS and care homes was discussed and a need was identified to develop the relationship between crew staff and the staff working at care homes. Particular issues were cited including the varying quality of care, level of skill and differences in care provided outside of business hours, particularly relating to knowledge of care plans and ability to carry out specific tasks such as lifting a patient who has fallen or performing basic first aid.

➢ USE OF CARE PLANS

There was widespread support from many of the delegates for the use of care plans, whether these are in the form of a message in a bottle, living wills, do not resuscitate orders (DNAR), patient specific protocols or medicines management programmes. Many felt that LAS should contribute to clinical treatment plans and take a lead role in the promotion of having a care plan, particularly the message in a bottle scheme. In order to ensure wide-spread use of the scheme, it was recommended that mapping is carried out to determine what currently exists and that re-implementation should be on a rolling programme targeted at vulnerable people and audited to ensure its effectiveness.

➢ EFFECTIVE SERVICE DELIVERY

The need for a quick response and sending the appropriately skilled crews to each call is important. In order to ensure assistance is provided as quickly as possible the assessment process was identified as being key and provision of telecare (as is currently provided by the Clinical telephone Advice Service) and linking in with Connecting for Health were seen as important.

3. EQUALITY IMPACT ASSESSMENT

The equality impact of implementing the changes suggested above was discussed, to identify if any groups would be disadvantaged.

Cultural diversity is an important aspect of equality assessments, and culture has an impact on the health seeking behaviours of populations. It was identified that some cultures may be more inclined to seek help within their own family or community rather than contact an ambulance service, even in an urgent situation. Willingness to share personal information to someone not known to the patient can also be difficult for some people. This may be particularly relevant for older people in sharing information regarding their sexuality as older people may feel there is a stigma associated with lifestyle choices and sexuality because of the environment which they have been brought up in.

Language is also a common barrier particularly as for people for whom English is not their first language, communicating on the telephone and with ambulance crews can be difficult especially in a high stress situation.

The current make up of the LAS workforce does not match that of the population of London, with a high proportion of white British staff which may influence some communities' willingness to access, or join the service.

While there was a lot of support for use of alternative pathways rather than conveying patients to A&E, it was identified that while most A&E departments have established public transport routes other locations such as minor injuries units may not. This would present difficulties for those reliant on public transport or with specific mobility requirements.

Older people with disabilities including learning disabilities, visual and hearing impairment may not always disclose this information which may impact on the information they are both able to provide to ambulance staff and also their ability to process the information they receive.

In order to reduce the impact of these inequalities health promotion activities such as advertisements, particularly on television, ensuring information is distributed in a manner which is accessible to all (for example not just by email) targeting health education to the younger generation to cascade through their families were suggested.

For further information, please contact:

Claire Garbutt
Policy Manager
Policy, Evaluation and Development
London Ambulance Service NHS Trust
Ground Floor, 8-20 Pocock Street
London SE1 0BW

Tel: 020 7463 3116
Email: claire.garbutt@lond-amb.nhs.uk

London Ambulance Service NHS
NHS Trust

Long Term Conditions Strategy

Kiran Chauhan
Policy, Evaluation & Development

June 2008

London Ambulance Service NHS Trust

Long Term Conditions Strategy

Contents

1. Introduction

This paper sets out an update and the next steps for the London Ambulance Service NHS Trust's (LAS) strategy for involvement with the management of long term conditions in London's health communities.

Recent information from the Department of Health reports that over fifteen million people in the UK live with a long term condition (LTC)[i]. These are conditions that at present cannot be cured, but can be managed by medication and therapies. They include asthma, diabetes, epilepsy, chronic obstructive pulmonary disease, conditions related to old age and cardiac and stroke-related conditions. While various mental health conditions are long term conditions, they are addressed within a specific mental health strategy and therefore outside of the scope of this strategy.

Treatment for exacerbations of these conditions accounts for a significant proportion of resource use in the National Health Service; people with LTCs, and especially those with co-morbidities, are reported to be the most intensive users of the most expensive services. The government is keen to see these conditions better managed using whole-systems approaches, broadly following lessons learnt from the United States adapted to fit the social care model. One aspect of this is enabling patients living with LTCs to self-care more effectively; another is ensuring that support services are adequate, responsive, and joined-up to provide case- and disease-management as appropriate.

As a key part of front-line care and the only pan-London provider NHS organisation, the LAS will need to be an integral part of any improved or reconfigured system.

2. Background

The case for change

A limited, high level analysis of 2006/07 hospital episodes data restricted to LTCs provides some interesting results[ii]:

- 16% of patients admitted to hospitals in England had primary diagnoses coded as relating to LTCs ("LTC admissions" hereafter). These admissions accounted for 24% of all occupied bed days.
- Mean and median lengths of stay for LTC admissions (14 and 5 days, respectively) were more than double the averages for total admissions (6.3 and 2 days respectively).
- 41% of LTC admissions were coded as emergency admissions compared to 36% of all admissions indicating that patients with LTCs are more likely than average to require emergency admission to hospital.

Chronic care models, such as those used by Kaiser Permanente, Pfizer and Evercare groups in the United States are seen to be a means of reducing the number of unscheduled LTC admissions through case management strategies. As well as being indicative of poorly controlled illness, unscheduled admissions for exacerbations of LTCs clearly create what could be seen to be avoidable expenditure for the NHS; adopting versions of these systems has understandably been strongly advocated by the current government in keeping with its broad aim to encourage greater efficiency within the health service set out in the 2000 NHS Plan.[iii]

High level outcomes for people with LTCs

The Department of Health's document *Raising the Profile of Long Term Conditions Care* [iv] suggests the following high level outcomes for patients with LTCs:

- People have improved quality of life, health and well-being and are enabled to be more independent.
- People are supported and enabled to self care and have active involvement in decisions about their care and support.
- People have choice and control over their care and support so that services are built around the needs of individuals and carers.
- People can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs.
- People are offered health and social care services which are high quality, efficient and sustainable.

These indicate broad aims for improving care for patients with LTCs; more detail regarding the role that Ambulance Services can play in providing this is found in the *National Service Framework for Long Term Conditions*, issued in March 2005. This document sets out a strategy for improving the integration of services for patients with chronic illness and disease.

The National Service Framework for Long Term Conditions

The National Service Framework for (neurological) Long Term Conditions[v] is arguably the most important recent relevant publication that mandates the development of this strategy. The NSF sets out eleven Quality Requirements for an integrated system for long term neurological conditions but states that "much of the guidance […] can apply to anyone living with a long-term condition." These quality requirements are listed in Box 2.1.

Quality requirement 1: A person centred service
People with long term neurological conditions are offered integrated assessment and planning of their health and social care needs. They are to have the information they need to make informed decisions about their care and treatment and, where appropriate, to support them to manage their condition themselves.

Quality requirement 2: Early recognition, prompt diagnosis and treatment
People suspected of having a neurological condition are to have prompt access to specialist neurological expertise for an accurate diagnosis and treatment as close to home as possible.

Quality requirement 3: Emergency and acute management
People needing hospital admission for a neurosurgical or neurological emergency are to be assessed and treated in a timely manner by teams with the appropriate neurological and resuscitation skills and facilities.

Quality requirement 4: Early and specialist rehabilitation
People with long term neurological conditions who would benefit from rehabilitation are to receive timely, ongoing, high quality rehabilitation services in hospital or other specialist settings to meet their continuing and changing needs. When ready, they are to receive the help they need to return home for ongoing community rehabilitation and support.

Quality requirement 5: Community rehabilitation and support
People with long term neurological conditions living at home are to have ongoing access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs, increase their independence and autonomy and help them to live as they wish.

Quality requirement 6: Vocational rehabilitation
People with long term neurological conditions are to have access to appropriate vocational assessment, rehabilitation and ongoing support, to enable them to find, regain or remain in work and access other occupational and educational opportunities.

Quality requirement 7: Providing equipment and accommodation
People with long term neurological conditions are to receive timely, appropriate assistive technology/equipment and adaptations to accommodation to support them to live independently, help them with their care, maintain their health and improve their quality of life.

Quality requirement 8: Providing personal care and support
Health and social care services work together to provide care and support to enable people with long term neurological conditions to achieve maximum choice about living independently at home.

Quality requirement 9: Palliative care
People in the later stages of long term neurological conditions are to receive a comprehensive range of palliative care services when they need them to control symptoms, offer pain relief, and meet their needs for personal, social, psychological and spiritual support, in line with the principles of palliative care.

Quality requirement 10: Supporting family and carers
Carers of people with long term neurological conditions are to have access to appropriate support and services that recognise their needs both in their role as carer and in their own right.

Quality requirement 11: Caring for people with neurological conditions in hospital or other health and social care settings
People with long term neurological conditions are to have their specific neurological needs met while receiving treatment or care for other reasons in any health or social care setting.

Box 2.1: The National Service Framework for (neurological) Long Term Conditions: Quality Requirements

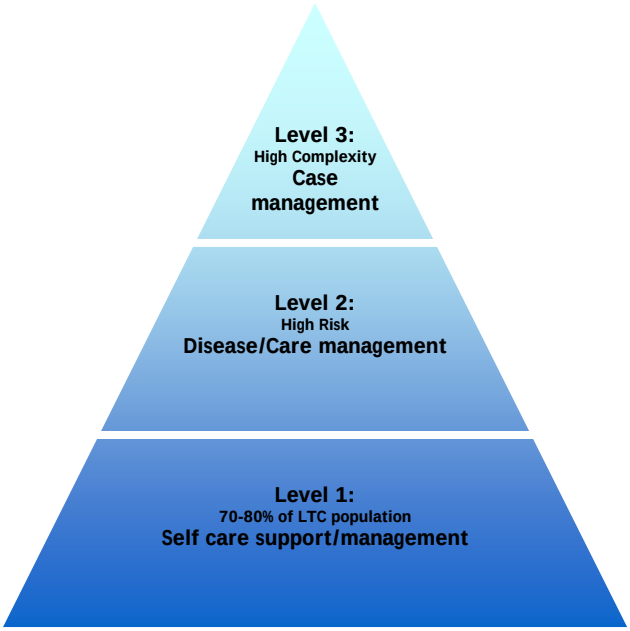
Schematically, Quality Requirements 1 – 3 relate approximately to pre-diagnosis phases of care, and 4 – 11 to post-diagnosis phases of care. Ambulance services will be particularly important for the pre-diagnosis phase, and so this paper will consider the LAS's role in relation to QRs 1 – 3 in the first instance.

2.3.1 Quality requirement 1: a person centred service

People with LTCs are offered integrated assessment and planning of their health and social care needs. They are to have the information they need to make informed decisions about their care and treatment and, where appropriate, to support them to manage their condition themselves.

For ambulance crews, there is a clear drive to ensure that treatment ultimately follows the wishes of the patient. At the same time, however, there is a need for crews to ensure that patients are provided with enough information to be able to make informed choices so that those wishes are in the patient's best interests. This may involve informing the patient about local services and will rely on establishing a common language between ambulance staff and their Primary Care Trust colleagues.

Primary Care Trusts are in the process of developing case and care management systems using variations of the Kaiser Permanente, Pfizer and Evercare models. These are at various stages of implementation and consequently it is difficult for ambulance crews to approach patients in a systematic way.



(Source: DH 2008)

There is also a need for robust communication channels so that all ambulance encounters can be reported back to primary care practitioners (GPs, community matrons, case managers, etc.) so that appropriate action can be taken if necessary.

2.3.2 Quality requirement 2: early recognition, prompt diagnosis and treatment

People suspected of having a long term condition are to have prompt access to specialist expertise for an accurate diagnosis and treatment as close to home as possible.

Intuitively, there seems to be great scope for crews to assist in the identification of patients with LTCs, and in particular high-risk patients who might benefit from pro-active case management. The cost benefits of reducing admissions through better management are potentially huge and the LAS is well-placed to contribute to this significantly.

The LAS has a role beyond emergency first aid within a patients care pathway. Shifting the culture of the LAS is perhaps the most difficult barrier to be overcome, but work is underway in the form of the *New Ways of Working* initiative to address this.

The first phase of this programme, entitled 'Transforming Clinical Leadership' brings together various strands of the overall Service Improvement Programme and focuses them on the delivery of patient care by staff working on station complexes. The aim is to create the best possible environment for clinical leadership, and so improve both the care given to patients and the job satisfaction of staff.

Within the current provision, Emergency Care Practitioners (ECPs) are well-placed to contribute to the management of patients with LTCs. Already having additional training in chronic conditions, ECPs can build and use referral routes in their areas to ensure patients receive the most appropriate care in keeping with PCT initiatives. These referral routes are available to all front-line ambulance staff, but uptake has been variable.

Many ECPs are already involved in projects around LTCs and, in the areas they are operating, have formed a natural link between primary and secondary care and the LAS. In turn, many community teams, GPs and professionals in the acute sector are keen to learn more about the role and skills of ECPs, and are also keen to have more of them operating in more areas. The LAS will be significantly increasing the numbers of ECPs it employs by April 2010. The challenge will be to keep ECP work on specification while performance pressure inevitably mounts for the ambulance service. There is a strong argument to suggest that ensuring this work remains focussed will bring significant long-term benefits to the health population thus *reducing* demand on the service.

2.3.3 Quality requirement 3: emergency and acute management

People needing hospital admission for a long term condition-related emergency are to be assessed and treated in a timely manner by teams with the appropriate resuscitation skills and facilities.

However well cases and diseases are managed, there will still be LTCs related emergencies. These should continue to be managed using local specialist centres and Accident and Emergency departments as appropriate in keeping with the outcomes of the Healthcare for London review. There may be opportunities to refer these patients to alternative practitioners if suitable case management structures are available within the local Primary Care Trust's provision and the Policy, Evaluation and Development team, and complexes' Pathway Champions are working with London providers to forge links and establish pathways accordingly.

3. Strategy Method

This strategy has been developed with the input of interested people from a range of professions, both from within the LAS and external organisations.

In additions to interviews with relevant members of LAS and PCT staff, a half-day stakeholder event was held in April 2008 to look at:

- the opportunities available for the LAS to help manage patients with LTCs in London's health population; and
- how success could be measured.

A summary of the feedback received from this workshop can be found in Appendix A.

4. Implementation Structure

The priorities for the LTCs strategy that have been determined through stakeholder and policy research are largely concerned with making improvements to existing protocols, or using existing mechanisms. The strategy recommendations in this document specify areas of work; these will be adapted to produce project plans that will need local adaptation. The recommendations will be ratified and fed into the workstreams defined by the Service Improvement Programme.

It is important that implementation of these project plans is not undertaken in a directive manner; there is sufficient evidence to suggest that an approach that engages the individuals who will be responsible for delivering the projects will be most effective. The risk of not using this approach is significant failure to produce the intended outcomes, and indeed for local action to block the desired direction of progress.

5. Strategy Priorities and Action Plan

5.1 Options analysis

- The following actions are methods by which the LAS could help to better manage LTCs in London.

- Feasibility and indicative timescales are considered for each option in the suggested action plan.

- These are subject to ratification and subsequent resource allocation.

5.1.1 PCT/LAS Joint Contact List

It is recognised that, if local solutions to LTC management are to be developed, there needs to be good communication between Ambulance Operations Managers and local LTC leads in primary care. Currently, many PCT leads do not know who their local AOMs are, and vice versa, and this is not unique to the LTC workstream. A local 'directory' maintained by the Community Involvement Officer is therefore recommended as a means of improving communication channels. This is, however, only the first step: the aim is to initiate local dialogue between PCTs and the LAS about how to work in partnership to produce service improvement.

ACTION: **Produce a local directory of service** in which PCT and Complexes can share contact details that include the AOM, PEDT staff at the LAS, PCT leads for LTCs, Older People, Pharmacy, etc. This could briefly outline current strategies for each workstream. This should be kept under review by Community Involvement Officer and be sent out via e-bulletin/in hard copy on a quarterly basis.

5.1.2 Increase awareness of LTCs

It is recognised that LTCs do not have a high profile in the LAS's field of vision because of the tendency for front-line staff to approach patients as a 'first aid' service. A theme that runs through the NSF quality requirements is to deliver care in more holistic way; this is supported by the LAS's own strategic plan which advocates the appropriate treatment of each patient, rather than conveying to an Accident and Emergency Department by default.

Currently, the Emergency Care Practitioner programme is engaged with this kind of approach, and the scheme is undergoing a rapid expansion in the near future. It is understood that a change in the focus of front-line staff is a difficult task, and that the *New Ways of Working* initiative, amongst others, is aiming to tackle this issues. These large-scale cultural changes will take time to produce results.

The actions that can currently be taken, however, are to raise the awareness of LTCs, so that when the *New Ways of Working* initiative becomes more wide-spread, front-line staff will already be more aware of the conditions they might encounter.

The training programme for front-line staff already includes aspects of LTC care, however, additional work is required if these conditions are to gain a higher profile.

ACTIONS: • Include articles focussing on specific LTCs in the LAS News on a regular basis
• Increase training in LTCs more generally where possible and appropriate

5.1.3 Patient specific protocols

Patients suffering from LTCs will often have established care pathways/contacts for dealing with exacerbations of their conditions. These can be created in conjunction with all of the providers (in primary and secondary care) involved in the patient's care, and can be recorded in their Care Management folder, on an instruction sheet, or using the Message in a Bottle.

ACTION: Improve use of Message in a Bottle/Ambulance Instruction Cards systems to better tailor care to the individual

5.1.4 Reporting non-conveyance of patients to primary care

Currently, attendance of a patient who does not go on to get conveyed to an Emergency Department is not reported back to that patient's primary care practitioner. A copy of the Patient Record Form (PRF) is given to the patient to deliver to their General Practitioner; this may or may not happen. It is clearly important for the primary care practitioners involved in the care of patients with LTCs to be notified of any attendance by the LAS, as calls to emergency services may indicate poor disease control in some cases.

ACTION: Create a method for feeding back non-conveyances to primary care practitioners

5.1.5 Referral Pathways

When a patient doesn't need to be conveyed to an Emergency Department but does require some follow up, it is possible for front-line ambulance staff to refer these patients to suitable community services. These may be community nurses, physiotherapists, falls teams, etc., with whom the LAS has a referral pathway agreement.

A number of such pathway agreements are established in various parts of London, but the uptake of these pathways is variable. This is for a number of reasons: sometimes pathways are under-resourced and so cannot meet the needs of the LAS; services may not be available 24 hours a day; crews may not feel confident in making referrals; patients may not want to be referred to another service; crews may consider conveyance to hospital a safer option; or, it is sometimes just easier to take the patient to hospital.

ACTION: Continue to monitor and increase use of referral pathways

5.1.6 Avoidable use of ambulance services

It is important for PCTs to understand where their current care provision is lacking so that appropriate measures can be taken to fill the gaps in service. Calls to emergency services from patients for avoidable reasons (eg. exacerbations of LTCs due to inadequate management) are a good indicator of the adequacy of provision so a means of feeding back this information would be useful. PCTs already receive feedback from the Commercial Analysis department of LAS, but it is not certain that this is well-utilised.

ACTION:
- Adapt feedback capability to highlight service provision gaps
- Liaise with PCT colleagues to better utilise this information

5.1.7 Screening for LTCs

In relation to the NSF's second quality requirement, there is a requirement for local health services to find ways to identify patients who are at risk. As well as broader public education campaigns, it is recommended that avenues by which LAS staff could be involved in pro-actively screening all patients attended for detectable LTCs are explored.

ACTION: Complexes to liaise locally with PCTs to identify areas where LAS crews can assist in early identification and screening for long term conditions.

5.2 Suggested Action Plan

Supporting actions	Resources required	Benefits	Timescales	Outcome measures	Workstream
5.1.1 Produce a local directory of service for PCTs and Complexes					
• Engage AOMs/NWOW team • Compile data • Establish roles for updating data • Compile distribution lists	•Local network researcher, e.g. the Community Involvement Officer •Communications team guidance on style	•Developed and maintained local networks •Better communication between agencies • Greater awareness of local initiatives • More joined-up care for patients	•Constrained only by availability of CIO/ local network development capacity. •Go-live in line with NWOW timeframes. **SHORT/MEDIUM TERM**	•Existence of up-to-date directory, held by PCTs and Complexes, and updated regularly. •Higher levels of patient satisfaction	Access programme
5.1.2 Increase awareness of LTCs • Include articles focussing on specific LTCs in the LAS News on a regular basis • Increase training in LTCs more generally where possible and appropriate					
•Identify and engage potential contributors to the LAS news •Liaise with Communications Team •Develop training package for LTCs (esp for PTS and Urgent Care teams) •Identify internal and external professionals who could assist in providing training.	• Clinical staff to provide information for articles • Communication team guidance • LAS news • Training capacity • Professional expertise/trainer	• Increased awareness about particular LTCs will allow front-line staff to make more informed assessments when visiting patients with these conditions •More appropriate care for patients	•This project should be initiated as soon as possible. **SHORT TERM**	•Articles in the LAS news •Training sessions provided by suitable professionals •Improvement in relevant staff survey result (would require adaptation of standard staff survey questions) •Improvement in patient satisfaction survey results	Business as usual

5.1.3 Patient specific protocols • Improve use of Message in a Bottle/Ambulance Instruction Cards systems to better tailor care to the individual					
•Identify areas of good practice – find out why these are working well •Consult with AOMs about barriers to success •Develop a project to roll-out the scheme London-wide if desirable and practicable •Design a system to monitor usage (via PRF or other audit mechanism)	•Personnel •Buy-in from local complexes and providers (eg. PCTs, Age Concern, etc.)	• More information available when crews attend individual patients, thereby creating more opportunities to provide personalised, appropriate care • Greater patient satisfaction with service received	Timescales will depend upon what arrangements are currently in place in local stations, but conversations should begin as soon as possible. **SHORT/MEDIUM TERM**	•An increase in the number of patients linked in with primary and secondary care practitioners •Improved patient satisfaction survey (indirect) •Reduction in hospital admissions (indirect)	Business as usual
5.1.4 Reporting non-conveyance of patients to primary care • Create a method for feeding back non-conveyances to primary care practitioners					
•Identify the information that needs to be fed back •Identify who the information needs to be sent back to (presumably the patient's primary care practitioner) •Communicate the need for a feedback system to the LAS team developing the hand-held computers so that this may be part of	*(dependent upon the solution devised)*	•Primary care practitioners (who are responsible for ongoing care) will have more clinical information about their patients •Primary care practitioners will have the potential to identify changes in illness patterns •Better clinical outcomes for the patient	•Currently, it is not feasible to engineer a paper-based solution to feeding back information about non-conveyances to primary care. There are plans in plans, however, to introduce hand-held computers for front-line crews to use on-scene. **MEDIUM/LONG TERM**	•Better clinical outcomes	Access programme

the design. •Devise an auditable system – eg. record on PRFs					
5.1.5 Referral Pathways • Continue to monitor and increase use of referral pathways					
•Devise a means of identifying LTC patients using the PRF •Establish expected/current usage & bring actual usage more into line with expected usage •Develop crew confidence in using pathways (via NWOW) •Improve technological data management – eg. palm pilots, EMS, CSD •Encourage 24 hour services from providers and, eg. ECPs.	•Training capacity •Primary care services	•Patients will receive appropriate care without being transferred to hospital. •Primary care practitioners will be more involved in looking after patients within their own catchment areas, thereby providing a more joined-up service •Financial benefits to the health economy due to reduced hospital episodes	•Already in progress and linked in with *New Ways of Working* **SHORT/MEDIUM TERM**	•Increase in the number of referrals made •Decrease in the number hospital admissions relating to LTCs.	Operational model
5.1.6 Avoidable use of ambulance services • Adapt feedback capability to highlight service provision gaps • Liaise with PCT colleagues to better utilise this information					
•Establish how information received is used by PCTs •Develop the existing feedback function to highlight	•Management Information capacity to adapt current data set •Data management skills in primary care to make use	•A better understanding of the needs of the local community for primary care providers •Awareness of trends in illness to better inform service planning/ gap	Information of this sort is already available in some form, so resource will indicate timescales for further software development work.	•Fewer attendances to patients with LTCs in both quantity and proportion of all attendances (indirect)	Access programme

LTC patients	of the data produced for business planning	analyses	**SHORT TERM**		
5.1.7 Screening for LTCs • Complexes to liaise locally with PCTs to identify areas where LAS crews can assist in early identification and screening for long term conditions.					
•Identify which LTCs could be screened for in liaison with PCTs •Establish resource requirement, eg. training, test kits •Establish how to feedback information received to primary care •Carry out an audit on crews routinely screening those over 40 years for diabetes	•Training capacity •Screening kit •Method for referring/feeding back any suspected cases •?Central database •CARU input for audit	•Earlier identification of LTCs •Prompter referral and treatment for patients with LTCs	This will depend upon the allocation of resources for scoping and purchase of necessary kit. **MEDIUM TERM**	•increased referrals to LTC management services (eg. diabetes team)	Development of a public health strategy

6. Measurement & Evaluation

This LTCs strategy will need to be evaluated to ensure that any changes are an improvement in the services provided, and to enable communication and dissemination of successes achieved as well as to enable the LAS to learn from any problems.

Each recommendation is accompanied by suggested outcome measures and these will be good indicators for success in each area.

Evaluation does need to include patient outcome measures and satisfaction where possible however, and not just focus on reducing demand or decreasing A&E attendances for example – though these remain valuable indicators.

There is a particular need for ongoing conversation with the front-line staff about their perceptions of the strategy, to ensure that there is fit with their experiences of the operating environment.

It is anticipated that the overall strategy will be reviewed in five years' time. It is acknowledged, however, that what works for one complex may not work for another; ongoing **local** evaluation is therefore required to be undertaken in addition to wider strategy evaluation to ensure that projects remain relevant to practice.

References

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[1] Primary diagnosis: 3 character 2006-07, HES online, accessed online on 02.01.2008 at http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=203; extracted codes sourced from "Disease coding from HES to assist with case finding" accessed online on 02.01.2008 at http://www.networks.nhs.uk/80.php

[1] Ham, C. & Singh, D. (2006) *Improving Care for People with Long-Term Conditions: A review of UK and international frameworks* accessed online on 02.01.2008 at http://www.improvingchroniccare.org/downloads/review_of_international_frameworks__chris_hamm.pdf

[1] DH – *Raising the Profile of Long Term Conditions Care* accessed online on 02.01.2008 at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

[1] DH – *The National Service Framework For Long Term Conditions,* accessed online on 02.01.2008 at http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/Long-termNeurologicalConditionsNSF/DH_4128647

Enclosure 9

Urgent Action Sheet

Date: 22 September 2008 No. 02/08

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;

Approve the revised and updated Risk Management Policy which has been discussed in full at the Risk Compliance and Assurance Group (20/8/08), the Audit Committee (8/9/08) and the Senior Managers Group (17/9/08).

The deadline for submission of the Risk Management policy to the NHS Litigation Authority for assessment is 16.00hrs, Tuesday 23rd September 2008.

Urgent Chairman's action is being sought, as this deadline occurs prior to the next Trust Board meeting on 30th September 2008.

Ratification of the Risk Management Policy will be requested at the next Trust Board Meeting.

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 30th September 2008

Enclosure 10

London Ambulance Service NHS Trust

TRUST BOARD 30th September 2008

Foundation Trust update

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: To agree the plan to progress the Trust's application to become a Foundation Trust and to note progress so far

3. Summary

Following the pilot Board to Board meeting and submission of the draft Integrated Business Plan the Trust received a diagnostic report accompanied by a letter from Malcolm Stamp highlighting key issues that needed to be addressed in the development of its approach to becoming a Foundation Trust. Using the headings from the letter the issues can be summarised as follows:

- **Business Strategy** –the feedback was that an agreed business strategy needs to be developed, in the context of market opportunities and threats. It should include details of strategic and business risks and how these will be managed.
- **Delivery of CAD 2010**- this was identified as a significant risk and the requirement was stated that the SHA Capital Investment Committee would need to review the FBC and agree it once the committee was satisfied that the governance and oversight of the project were effective.
- **Finance -** the feedback pointed to specific agreement to be achieved by the Trust with Commissioners through increasing its engagement with them on income, growth and activity projections

The plan (shown as attachment one) that you are asked to approve today addresses the key issues from the feedback in Malcolm Stamp's letter. In addition it has been discussed with the NHS London FT lead who is impressed by the detail shown in the plan. Before it can be submitted back to NHS London we need Trust Board approval.

The following progress has already been achieved since we received the Malcolm Stamp letter.

- A project manager has been appointed to take forward the programme including development of the integrated business plan.

- Further development of the Business Strategy is planned to happen at two SMG away days within the next six weeks.
- A workshop has been arranged with our commissioners to agree demand projections as part of our revised integrated business plan
- Scenarios are under development by the Finance team and work has been done with regard to Payment by Results.
- Details of board development are being scheduled to reflect the timetable in the plan for producing the integrated business plan.
- Interviews for the membership manager took place last week and an appointment will be made shortly
- Discussions have been held with Membership database providers to support the membership strategy

The programme management arrangements include a strategic level programme board chaired by the Chief Executive supported by the SRO, (Director of Finance) the Programme lead and SMG members. These arrangements will be reviewed once the senior management team restructure has been completed.

A work stream group chaired by the SRO will progress the details in the plan using the reporting structure for programme management used by the Olympics programme to ensure interdependencies with existing programmes are fully realised. Non Executive Directors are welcome to join either the programme board or working group meetings to progress the workstreams. The timetable for these two groups to progress the work is included in the plan and will aim to have us in a position to submit our FT application to Monitor in the first quarter of the next financial year.

Mechanisms for engaging with key stakeholders (PCTs, Unions, NHS London etc) to gain support for all aspects of our application include briefings at commissioning meetings and working with a PCT champion.

4. Recommendations

THAT the Board.

1. Approves the attached action plan

2. Notes progress so far

3. Approves FT progress reports as a standing item at all future Trust Board meetings

Author:
Mike Dinan
Director of Finance

Attachment 1

Foundation Trust Programme Planning

Contents

1. Foundation Trust Action Plan

The LAS has formulated the following action plan in response to NHSL diagnostic report, with the aim of achieving FT status.

Foundation Trust Action Plan							
Task ID	Gaps and comments Identified in Diagnostic Report (Issued 17/07/08)	Risks	Proposed Action Points	Workstream	Proposed Due Date	How do we know?	Tracking
BP1	Absence of an adopted business strategy set out explicitly in the context of market opportunities, and related to the Trusts strengths and capabilities.	Without a clear, formal business strategy confirmed and an understanding of these other factors, there is less clarity about the financial implications, in terms of risk to income, investment and income growth forecasts.	*Out of the Market Assessment and Market Strategy work defined in BP2, see below, this will enable the Trust to define its Long Term "Business Strategy".*	*BSM*	*Nov 08 (SMG Process complete Dec or Jan, Trust Board)*	*The completed Business Strategy will be reviewed and agreed by SMG & Trust Board.*	*Senior Management Group (SMG) and Trust Board (TB)*
BP2	Market and Market Strategy Assessment has not been fully developed.	Consistent with BP1 above	*Detailed strands*	*F*	*Nov 08*	*SMG approved marketing approach set out in strategies*	*TB, Programme Board (PB) and Senior Managers Group (SMG)*
BP3	Dependency on Cost Improvement Plan (CIP) and relatively small surpluses to sustain growth.	The need for CIPs is significantly driven by the differential between income inflation of 2.3% and pay inflation of 4% (plus AfC drift of 0.6%). Scenarios are required to check if the risk ratings will survive the Monitor downside case which could be predicted to reduce CIPs and activity growth.	*The Cost Improvement Programme (CIP) will be reviewed together with the appropriate modelling options to reduce its cost base.* *Further modelling work will include revisions for pay inflation and how the Trust will manage*	*F*	*Mar 09*	*CIP reports received routinely by board, in format to be determined by DoF and received by SMG.*	*SMG and TB*

			recurrent and non recurrent costs.				
BP4	CAD2010 is a critical to the future running of the service but is a highly complex / risky project.	The change to a new computer aided despatch is considered relatively high risk and has the potential to have a significant operationally and clinically impact on the Trust. Every other ambulance service has changed their CAD in the past 18 months and will identify lessons from implementations.	*The Trust will build a robust implementation plan and ensure the Final Business Case is tracked at each stage of its lifecycle (e.g. using best practice). Moreover, the Trust will review and test it's business continuity plans to mitigate against downside operational and clinical risks.*	*F*	*July onwards*	*Final Business Case signed off by SHA committee.*	*Audit Committee* *Strategic Steering Group (SSG)* *SMG* *PB* *Commissioners meetings* *TB*
BP5	Managing Business Risks	*See BP1above*	*Risk Management Arrangements*	*F*	*Jan 09*	*RCAG reviews business risks* *Audit Committee Monitor controls on business and strategic risks.*	*Audit Committee* *Risk Compliance and Assurance Group (RCAG)* *SMG* *TB* *PB*
BP6	Payment by Results (PbR) - weaknesses in the Trusts assessment of the impact on income.	Lack of understanding of the potential impact of PbR on future income. The relatively high RCI increases the risk to income.	*Develop PbR scenarios based on the four main currencies*	*F*	*Dec 08 - onwards*	Scenarios with detail to meet monitor scrutiny assessment levels agreed with NHSL.	*PB, SMG*
BP7	Healthcare for London (HfL) - the Trust has not completed detailed modelling to understand the potential implications.	Consistent with BP6 above, there's a risk to income, investment, etc.	*The LAS will continue to nurture and develop established relationships to promote HfL initiatives for e.g. Trauma and Stroke. Consideration of HfL will be taken in the "Market" context under BP2 identifying possible risks and opportunities.* *ORH have been requested to model the impact of coronary syndrome & stroke*	*BSM*	*Ongoing*	*Trust engagement with HfL team using monthly meetings with commissioners to progress and agree actions*	*PB, SMG and SSG*

			patients travelling further whilst further scenarios will be developed once HfL developments progress.				
BP8	Organisational Development and HR (Behavioural/Culture) – it will be a challenge to adapt staff to changes.	Will have an impact on successful delivery of SIP 2012 and performance targets.	*New Ways of Working programme partnership agreement and Internal communications strategy.*	*WFD*	*Mar 09 - onwards*	*New Ways of working highlight reports Partnership meetings and agreed actions. O&D strategy implemented*	*SSG and SMG*
BP9	Uncertainty of Income due to commissioning arrangements.	See BP1 and ER1	*See Commissioning Engagement Strategy in ER1 below.*	*CE*	*Nov 08*	*Commissioning meetings with CEOs and commissioners.*	*TB* *SMG* *PB*
G1	Finalised and adopted assurance framework not yet in place.	Weaknesses in ability to see problems coming and take mitigating actions.	*The assurance framework has been recently updated and will be reviewed in Oct 08 and will be changed if the findings of the review identify any gaps.*	*F*	*Nov 08*	*The Assurance Framework is amended to include strategic risks that threaten achievement of FT status.*	*Audit Committee* *TB*
G2	Board lacked strategic thinking although has the capability to think more strategically.	*Weaknesses in ability to see problems coming and take mitigating actions* *Board may be less effective at directing the organisation towards its strategic aims and challenging on critical issues and decisions.*	*The Board has existing development plan which will be reviewed over the next 3 months to include capability assessments. Any shortcomings will be remedied early next year.* *The business strategy work being developed, in essence, will focus the Board to think more strategically.*	*WFD*	*Feb 09*	*Work plan to be upgraded into full development programme for board as part of project workstream.*	*SMG/TB*
G3	Business/Strategic Risks should be monitored in addition to the strong focus on operational risks.	Weaknesses in ability to see problems coming and take mitigating actions.	*The business strategy being developed in BP1 above will build on how the Trust manages business risks, with*	*BSM/ GM*	*Jan 09*	*Revised Risk Management Policy, Assurance Framework Business Strategy. Strategic level risks included on trust-wide risk register and monitored through RCAG and*	*PB and TB* *SMG* *RCAG*

			respect to market they operate in, whilst considering opportunities and taking appropriate action to mitigate against threats in achieving its objectives.			*SMG*	
G4	Membership and Engagement not developed.	Attracting the right type of member across the pan-London demo-graphics.	*Even though this area was not covered in the Diagnostic Report, the Trust proposes to develop a membership strategy, which includes profiling for membership, defining the Trust's membership, developing its membership, etc.*	*GM*	*Oct 08*	*Governance rationale completed, including consultation process defined and underway.* *Membership Services Manager to be appointed*	*PB* *PPI committee* *SMG* *TB*
G5	Governance – current board reporting does not appear to identify financial problems at a lower operational level.	Could contribute to a lack of local level capability and devolved budgets which may be an issue for Monitor.	*As part of the action to review the financial controls (SP10 below) the Trust will assess the impact of financial issues at operational level and make its recommendations to the Programme Board by Nov 08.*	*F*	*Dec 08*	*Financial review delivers detailed information reports including complex budget statements.*	*PB and TB*
G6	Does the Organisation Structure support its strategy	Impact ability to achieve business strategy	*The business strategy being developed in BP2 above will be reviewed together with the new Governance arrangements, set out in the Trust's new Model Core Constitution.*	*GM*	*Jan 09*	*Organisational Structure amended to reflect governance requirements.* *Plans to further strengthen senior management team.*	*SMG and TB*
G7	Performance Management – No costing for HfL; framework for action.	Impact overall performance	*The Trust needs to first understand the opportunities and threats In order to develop some costing for HfL, moreover a number of factors needs to be*	*F*	*Feb 09*	*Develop modelling options for HfL and for ORH to develop options related to coronary and stroke.*	*SMG*

			considered; (1) The business strategy needs to be agreed with the Primary Care Trusts (PCTs); (2) The Trust has to understand the demand and direction of travel within the Acute and Mental Health sectors. *The Trust is very active with the aforementioned and will produce some costing, once (1) and (2) has been properly assessed, by the end of the Year.*				
G8	Risk management systems support the Trust's Strategy.		*Risk management policy needs to be updated with relevant factors pertaining to being an FT.*	*GM*	*Jan 09*	*New Risk Management Policy Revised Risk Register and updated risk assessments included in IBP*	*RCAG, Audit Committee*
G9	Trust Governance Self Assessment – Performance Management.	More financial data on their complexes may enable the Board to have a better sense of how the financial position differs across the London operations. Further work needed measuring Cat C. Introduction of balanced scorecard presents a positive opportunity to help the Board achieve better performance management and governance of the organisation.	*The cost centre management will be reviewed and will be updated where appropriate.* *Produce and Implement improved KPIs performance measurement* *The Balanced Scorecard is currently being re-engineered by PwC with any recommendations being implemented over the next 6 months*	*F*	*Feb 09*	*Cat C measurement criteria defined and routine reports produced appropriate for boards and management groups.* *Balanced scorecard completed with scorecard now visible at board level*	*SMG* *TB* *PB*

G10	Board Meeting Observations (No evidence of widely differing opinions between NEDs and EDs).	Some comments in the questionnaire suggest that the extent of NED challenge needs to be addressed in the context of what a FT Board would need to demonstrate. Similarly, Executives should also challenge outside their own areas of expertise.	*Board Development Plan will carefully review the Boards role and implement any changes, where appropriate.*	*WFD*	*Feb 09*	*Board Development programme in preparation for FT application including B2B.*	*SMG* *Audit Committee* *TB* *PB*
G11	Board Questionnaires – ability to follow through decisions needs more summarisation of decision, action and timetable.	Impact operational and business strategy	*As part of the Trust Board's role, any gaps in decisions and the actions thereof are managed by Chairman. Any potential gaps will be picked up the Board Development Plan, followed by a reasonable response by the end of Oct 08.*	*WFD*	*Jan 09*	*Board development and training plans in place*	*SMG* *TB* *PB*
SP1	Underperformance on CAT B; change to Call Connect is a much greater pressure on Category A & B and C Targets.	*Risk of income loss; Loss of Credibility as a service to PCTs and attitude to LAS strategy and possibly to Monitor.*	*National Picture; Re call connect achieved a 40% performance gain to meet targets over the past year. Whilst the business development function is already working with the commissioners to bridge the gap in CAT B, and is an integral part of the commissioning engagement strategy which will be drafted by Oct 08.*	*BSM*	*Nov 08*	*Commissioning Engagement Strategy & operational plan delivers reports and progress as required to external stakeholders.*	*PB, TB and SMG*

SP2	Non urgent calls (CAT C) requiring a more sophisticated measurement of successful service performance.	Lack of Cat C targets may reduce ability to manage performance. Trust misses opportunity to demonstrate impact and added value it contributes to NHS system.	*Covered by SP1 above and also by the Market Strategy to assess market opportunities.*	*BSM*	*Jan 09*	*Commissioning Engagement Strategy & Market Strategy include delivery of Cat C measurement system*	*PB, TB and SMG*
SP3	Benchmarking in relevant areas against ambulance trusts would be critical.	Less clarity on Vfm or benchmarked efficiency and effectiveness of the service.	*The Finance Directors are establishing an Ambulance National Framework to properly baseline performance. This framework will feed into a balanced scorecard, which the Trust has commissioned PwC to review and recommend and any changes.*	*F*	*Feb 09*	*Benchmarking data incorporated into Balanced Scorecard reporting cycle.*	*TB* *SMG* *Ambulance Leadership Forum*
SP4	Workforce development, education and Investment Programme.		*The New Ways of Working (NwoW) strategic programme to develop clinical leadership, currently being implemented aligns with the organisation development plans.*	*WFD/ F*	*Now – Mar 09*	*New Ways of Working Plan and Organisation Development Strategy.*	*PB, SSG and SMG*
SP5	Further clarification is required on PTS/EBS service lines.	Both of the service lines have the potential to have an impact on wider system outcomes.	*PTS and EBS service lines are reviewed annually and will form part of the detailed competencies of what services and new opportunities the Trust needs to focus on.*	*F*	*Jan 09*	*Service line reporting is used to determine any impact on business planning.*	*PB and SMG*
SP6	CBRN Income	CBRN Income – large percentage of income at risk	*Work with DH to agree a Service Level Agreement by Feb 09.*	*F*	*Feb 09*	*Signed SLA by DH*	*SMG*

SP7	Call Connect (Clinical Risk)	Clinical Risk Assessment	*Call Connect Performance Management Plan*	*BSM*	*Jan 09*	*Performance Management Plan*	*SMG* *TB*
SP8	HR- recruitment of 400 extra staff	Slippage/problems in achieving this recruitment will affect operational and business strategy.	*HR need to closely manage the accelerated recruitment process (workforce plan) and ensure that the additional staff have a clear development path, without disrupting existing operational capability.*	*WFD*	*Nov 08*	*Workforce strategy*	*TB* *SSG*
SP9	HR – challenge of getting staff to adapt to organisational/cultural change.	Will have an impact on successful delivery of SIP 2012 and performance targets	*Through New Ways of Working programme the Trust will deliver changes to all complexes in terms of clinical excellence and behavioural changes. The NwoW is being implemented over the next 5 year.*	*WFD*	*Nov 08*	*NwoW, OD strategy, SIP, vision and values. Measurable improvement in clinical leadership Paramedic consultant recruited to strengthen leadership model*	*SSG, SMG and PB*
SP10	Appears to be central control of key areas of expenditure (overtime and subsistence).	Could contribute to a lack of local level capability and devolved budgets which may be an issue for Monitor.	*Through the Cost Improvement and Corporate Processes Programme all business processes will be reviewed during the financial year, with any inefficiencies being eliminated.*	*F*	*Nov 08*	*Business systems review*	*Audit Committee* *TB*
SP11	Risk that the Trust will incur financial penalties for failure to meet service performance targets.	Impact on financial position, given low level of budgeted surplus in 2008/09 (£1.3m) this could result in the Trust reporting a deficit position.	*See ER1 below which references the Trusts strategy to ensure that financial penalties are minimised*	*F*	*Nov 08*	*Board Performance Reports*	*SMG* *TB*
SP12	Reasonable to assume that LAS has to address some serious	Patient safety and well being.	*The Trust's has two strands of work to*	*G*	*Dec 08*	*Clinical risk update to CGC* *RCAG monitoring of clinical risks*	*RCAG* *Audit Committee*

	clinical risks in their service delivery, but these are not described in their self assessment. Interviews described risks re lack of resource at break times and paediatric equipment.		*minimise clinical risk;(1) Firstly there's a clear Clinical Strategy which is reviewed annually (reviewed March 2008) – this need reviewed before of the Year; (2) Secondly the NwoW aims to also transform clinical leadership.*			*Audit Committee* *NHSLA Compliance Assurance Framework* *Strengthen board reporting as part of the Medical Directors report, reporting on key risks and long patient waiting times*	*Clinical Governance Committee (CGC)* *TB* *SMG*
SP13	Funding for Olympics	Impact service performance	*Funding for the Olympic Programme is assigned in Tranches (or years) with funding for 09/10 being discussed with the International Olympic Committee and Security Committee and NHS London.*	*BSM*	*Mar 09*	*Funding mechanism confirmed with NHSL/DoH.*	*TB* *SSG*
ER1	Progress to be made with PCTs on demand definition, negotiation of multi-year contract and future activity. .	Difficult to carry out long term planning and have some degree of certainty about income. Ability to engage with Commissioners reduced if they are distracted by system reconfiguration.	*The Trust is developing a Commissioning Engagement Strategy to address the many aspects of the relationship e.g. agreement on definition, multi-year agreement although it's challenging to agree a 3 year contract when the PCTs adopt annual business planning.* .	*BSM*	*Nov 08*	*Evidence of multi year contract and detail i.e. activity level agreed.* *3 yearly commissioning cycles developed with commissioners.*	*PB and SMG*
ER2	• Impact of Healthcare for London (HfL) PCT configuration.	Ability to engage with Commissioners reduced if they are distracted by system reconfiguration.	*Consistent with BP7 above – the LAS will update and review its HfL policy documents in order to drive forward*	*BSM/ CE*	*Nov 08 - onwards*	*Commissioner engagement in FT Programme*	*PB* *SMG* *TB*

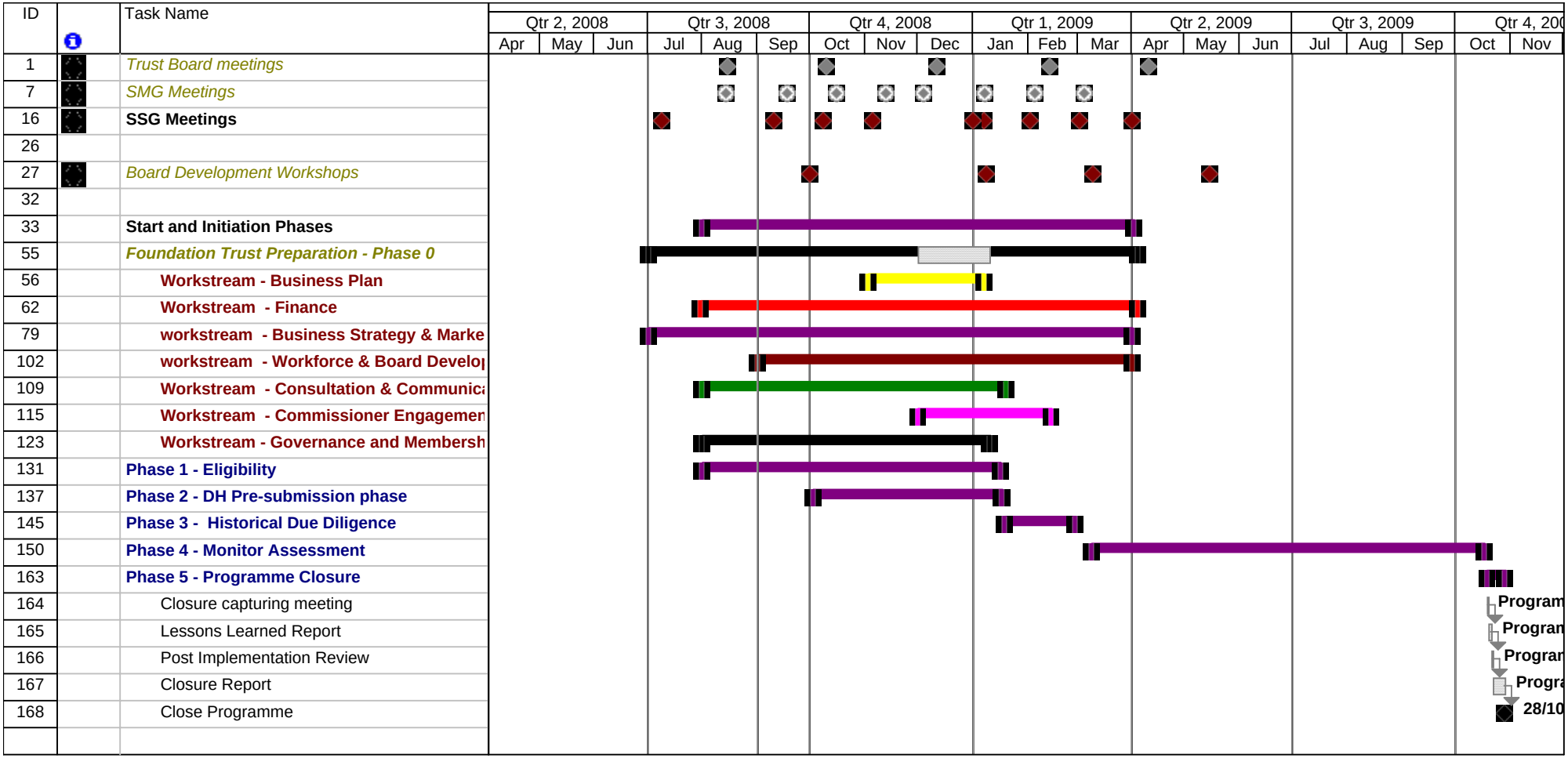
			Darzi's Healthcare for London; A Framework for Action.				
	• Whilst LAS has maintained engagement with HfL development to date, it will need to escalate its pro-activeness in response to growing HfL delivery momentum.	Ability to participate in the delivery of HfL, maximise business opportunities, and demonstrate impact is compromised.	*HfL is included as part of the Marketing Assessment and Marketing Strategy plans, and will require service development to petition external parties any perceived gaps in business opportunities or any threats identified.*		*Nov 08 - onwards*		
	• Trust should continue to engage robustly and positively with Commissioners who are becoming more challenging and demanding.	Trust/Commissioner relationship affected with consequent impacts on contract agreement, activity, demand and support for Trust strategy and FT application.	*See Commissioning Engagement Strategy*		*Nov 08 - onwards*		
	• PCTs are emphasising the need for the Trust to provide better management information and data.		*The Trust has already developed a new reporting pack for the PCTs.*		*Done*		
ER3	There appears to be some adverse patient perceptions about LAS staff attitudes and behaviour. Formal and regular patient survey appears to be missing, other than the complaints procedure.	Impact on Trusts ability to understand patient needs and preferences during what will become a period of significant change in NHS service delivery as a result of HfL.	*Patient involvement strategy, Patient Education Strategy, Stakeholder engagement work intrinsic to SIP development and delivery. Although there's been no complaints from 900,000 responses.*	*CC*	*Dec 08*	*PPI strategy and work plan Governance rationale.* *Community involvement managers appointed*	*TB, SMG, SSG and Patient and Public Involvement (PPI) committee*
ER4	Relationships with Acute Sector focus on supporting the achievement of A&E targets and reducing A&E pressures.	Self Assessment Risks – no implication was noted	*As part of a major review to understand the Trusts relationships, service development is developing a relationship*	*BSM*	*Dec 08*	*Feedback from acute trusts/NHS London that pressure on A&E has been reduced and recognised by Acute trusts/NHSL.*	*PB and SMG*

			management programme to define its relationship and who needs to own these. Moreover, it will establish a best practice framework which aims to ensure that relationships are treated as long term partnerships with joined up approach.				
ER5	Keen to secure greater direction from NHSL on HfL implications.	Self Assessment Risks – no implication was noted	*Relationship management programme*	*BSM*	*Dec 08*	*HfL agree LAS plans/input to service delivery.*	*TB* *SMG*
ER6	Acute Trusts perceptions of EBS needs to be better understood, to improve effectiveness of the service and better understand its benefit to the achievement of system outcomes.	Self Assessment Risks – no implication was noted	*This will align with the Relationship Management programme and Business Strategy*	*BSM/F /CC*	*Dec 08*	*Relationship Management Strategy delivers greater awareness of EBS to Acute trusts through planned contact and communication programmes.*	*PB and SMG*
ER7	Development and implementation of a Pan London divert policy that can enable proactive management of the demand and capacity of the current Accident and Emergency services served by the London Ambulance Service and therefore support target delivery and reduce risks to patients.	Self Assessment Risks – no implication was noted	*See ER6 above*	*BSM/F*	*Dec 08*	*Divert policy tested for impact with A&E services*	*PB and SMG* *RCAG*
ER8	Agreement required with NHSL on a workforce development and education strategy that is aligned with the SHAs 10 year workforce plan with agreed performance and outcome measures.	Self Assessment Risks – no implication was noted	*Integral part of the relationship management programme and the dependency on the Trust's NwoW programme.*	*WFD*	*Dec 08*	*Workforce plan, Workforce Strategy*	*PB and SMG* *TB*
ER9	Challenges of securing and engaging a membership from a large and diverse London population, in ways which are manageable and cost effective.	Self Assessment Risks – no implication was noted	*Governance rationale to be developed with membership strategy , constitution and governance arrangements ready for consultation*	*GM*	*Dec 08*	*Governance rationale and consultation in draft.*	*SMG* *PPI* *PB*

ER10	*Other Relationships (Self Assessment)* • St Georges Healthcare • Department of Health • Metropolitan Police • NHS London Strategic Health Authority • Thames Gateway Development Corporation • London Fire Brigade	Self Assessment Risks – no implication was noted	*Part of the Relationship management programme and will require regular meetings and understanding how to foster relationships.*	*BSM/ CE*	*Dec 08*	*Memoranda of understanding in place with key stakeholders -10- as required by NHSLA,HCC and Trust's business continuity policy*	*SMG, TB Business Continuity Group*

2. Programme Planning

The Programme plan below sets out the Trust's response to the Diagnostic Report and the primary objective of achieving Foundation Trust status.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Task Name
Qtr 2, 2008
Qtr 3, 2008
Qtr 4, 2008
Qtr 1, 2009
Qtr 2, 2009
Qtr 3, 2009
Qtr 4, 200
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov
1 Trust Board meetings
7 SMG Meetings
16 SSG Meetings
26
27 Board Development Workshops
32
33 Start and Initiation Phases
55 Foundation Trust Preparation - Phase 0
56 Workstream - Business Plan
62 Workstream - Finance
79 workstream - Business Strategy & Marke
102 workstream - Workforce & Board Develo
109 Workstream - Consultation & Communic
115 Workstream - Commissioner Engagemer
123 Workstream - Governance and Membersh
131 Phase 1 - Eligibility
137 Phase 2 - DH Pre-submission phase
145 Phase 3 - Historical Due Diligence
150 Phase 4 - Monitor Assessment
163 Phase 5 - Programme Closure
164 Closure capturing meeting
165 Lessons Learned Report
166 Post Implementation Review
167 Closure Report
168 Close Programme
Program
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28/10

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 2008

Presentation on the Trust's Estate & Business Case for the lease of additional office space in the Waterloo area

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

Additional accommodation is required to host both the Olympic 2012 Planning team and the FT Programme team. An extra floor is available at Loman St where the Finance team is currently based. An additional 3,460 sq ft is available on a 5 year term at £198,000 p.a. from year 2 which in part will be funded from additional Olympic funds.

A business case is attached

4. Recommendation

THAT the Trust Board:

1. APPROVE the signing of a 5 year lease based on the attached Business Case
2. NOTE the contents of the presentation concerning the Trust's estate.

BUSINESS CASE

OLYMPICS/FOUNDATION TRUST TEAMS OFFICE ACCOMMODATION

Authorisation:

Proposed by:

Executive Trust Director of Finance **Date**

Concurrence:

Executive Trust Director **Date**

Approved By:

Chief Executive **Date**

Contents

Executive summary

This Business Case has been has been compiled in order to secure funding for the rental of 3,460 sq. ft of additional office accommodation on the 4th floor at 46 Loman Street, London SE1, for a period of 5 years. The accommodation is approx 8 minutes walk from LAS HQ. The proposed offices are on the floor above the existing finance department's offices that are also located in the building.

The additional office accommodation is required in order to provide suitable office space for the Olympics team and the Foundation Trust team. The Olympics team are currently based at Pocock street on 3 hot desks, which are not suitable for permanent occupation. The team is expanding and there is no surplus capacity at LAS HQ or any of the other annexes.

The LAS is also working towards Foundation Trust status and already have a number of staff working on this project, which is likely to rise. These staff also need a permanent place of work as they are currently accommodated on two sites using hot desk positions.

The investment needed for this proposal is a recurrent revenue amount of £65,400 and a non-recurrent revenue amount of £47,000 for year 1 and a recurrent revenue amount of £198,000 for years 2-5 inclusive.

This investment in needed within the London Ambulance Service in order for the organisation to fulfil its long-term service plan. The costing have been based on information provided by the landlord and his agents and the LAS Estates department.

Strategic Case

The requirement for funding for the additional accommodation is to enable the LAS to provide suitable accommodation for staff working on preparation for the 2012 Olympic Games and the Foundation Trust application. Furthermore, it will allow departments that have expanded and that are short of space to be provided with suitable office accommodation and will substantially reduce the need to rent external meeting rooms. This will improve Health & Safety and enable departments to function more effectively, which are compatible with organisation philosophy of service delivery and the Corporate Service Improvement programme

2.1 Present Service Configuration & Facilities

The London Ambulance Service Headquarters has a mix of office accommodation, vehicle workshop, operational ambulance station, control rooms and substantial car parking. In addition to the HQ building there are three office annexes-

Pocock Street. Ground floor

Loman Street – 3rd floor.

Fielden House - 1st and 3rd floors.

Hannibal House – 2nd floor.

A number of additional meeting rooms had been provided at the LAS HQ, but some of these are now being used as offices for additional staff recently employed by the Trust. This has once again led to a shortage of meeting rooms. The building is occupied to capacity and there is no scope to provide any more office accommodation on the site.

Pocock Street provides approximately 6,800 sq ft of office space and accommodates approximately 50 staff from a number of different departments. The property is held on a 30-year lease expiring in 2030 with a mutual break clause after 15 years. Current rent, rates and service charge for the office is £253,000 p.a. The office space is being used to capacity and there is a lack of storage space at the site. A number of teams based there have more staff than they do desks and are set to increase in number significantly in the next 12 months.

Loman Street provides 3,400 sq ft of office space on the 3rd floor of the building and is occupied by the Finance department. The property is held on a 10 lease expiring in 2013. Current rent, rates and service charge is £176,000 .p.a. The offices have a number of spare desk but theses are used by the internal and external auditors.

Fielden house is occupied by IM&T, the 1st floor being used by the CTAK, LARP and CAD2010 teams. The 3rd floor is occupied by Customer Services, Networks and Systems teams. The combined rent, rates and service charge for the offices is £232,000. The leases for both floors expire in 2011.

The LAS has also recently agreed a 2 year lease for the 2nd floor of Hannibal House and is currently negotiating a similar lease for the 3rd floor. Both floors provide approximately 4,500 sq ft of office space. These offices are to be used by the HR department as training schools for the new paramedic intake. The rent for the 2nd floor has been agreed at £51,000 and a similar figure is being negotiated for the 3rd floor. Rates and service charges are circa £40,000 per floor.

The LAS is also negotiating a lease for 4,447 sq ft of office space in Southwark Bridge Road for use by the CAD 2010 team as a testing and training facility. The agreed rental for these offices is £126,750 and annual rent and rates will be circa £45,000. The lease is for 5 years with a break clause in July 2011.

2.2 Future Service Configurations & Facilities

Whilst there are proposals to establish a new HQ building for the Trust, this is at the very early stages and is likely to take a minimum of 3-4 years to achieve. In order to function effectively the Trust has a pressing demand for more office accommodation until a new HQ is established.

The LAS Olympics team are currently based at Pocock Street on what were 3 hot desk positions, which are not suitable as permanent workstations. The Olympics team is planned to increase in number to 15 in the next 12-18 months and will require dedicated office space until after the Olympic Games. It is preferable that these offices are close to the existing LAS office as there will be close interaction with other HQ departments, other emergency services and Home Office.

The LAS is also working towards Foundation Trust status and already have a number of staff working on this project, which is likely to rise. These staff also need a permanent place of work as they are currently accommodated on two sites using hot desk positions.

In order for the LAS to continue to look for efficiencies both in terms of functional suitability and space utilisation, it is necessary to provide the requisite level of office accommodation to enable the departments central to the operations of the Trust to operate effectively in accommodation that is suitable for their needs. It is also important to maintain a high-level profile in respect of the public perception of the Service, therefore the image that we project is important.

Therefore, there is a requirement to provide additional office accommodation in close proximity to the London Ambulance Service Headquarters, to enable the organisation to continue to fill its objectives in terms of the Service Plan.

2.3 The Case for Change

In order to provide additional floor space, which can be used as office accommodation, there is a need to lease suitable offices in close proximity to the London Ambulance Service Headquarters for a period of 4-5 years.

An exhaustive search of areas within walking distance of LAS Headquarters was undertaken and numerous property agents contacted. Various vacant office accommodations were found. The distant from the HQ building varies between a 5 15 minute walk. The size of the offices available in the area varies from as little as 1,000sq ft, rising to above 10,000 sq. ft. The minimum that it would be advisable for the LAS to lease would be 3,000 sq. ft, less than this amount would not provide sufficient accommodation for the Olympics and Foundation Trust teams.

The office accommodation available in the area differs in style and facilities available. Some provide open plan offices, which could be sub-divided and some provide more cellular based accommodation. There is also a mix of self-contained offices within a separate building and shared accommodation in larger buildings.

The greatest difference between most of the offices available for lease is the condition of the offices and the services. Some would require extensive refurbishment, whilst other offices are ready to occupy. Offices have the benefit of raised floors and category 2 lighting, whilst some are of traditional construction and do not benefit from such facilities.

Very few offices have car-parking spaces included in the lease, but there are a number of contract car parking facilities available in the SW1 area where car parking spaces could be rented on a yearly basis. Car parking spaces cost approximately £1,500 p.a.

As the type of accommodation available varies considerably, so does the asking rental value. Generally, the asking rental starts from approximately £30 per sq. ft and rises to about £45 per sq. ft. The rental will depend greatly on the heads of terms of any lease, but generally are dependent on the term of the lease, the greater the period of the lease, the cheaper the rental. The LAS are also considered to be a very good covenant.

Option Appraisal

Investment Objectives & Benefit Evaluation Criteria

Objectives

1. To provide accommodation that is within 10-15 minutes walking distance of the LAS HQ building and other annexe buildings
2. To provide accommodation for approximately 30 staff.
3. To provide additional meeting rooms, including a meeting room for private manager/staff discussions.
4. A small staff rest area, which can also be used for informal meetings.

Benefit Criteria

The preferred option should be able to fulfil all of the following benefits:

- Better working conditions for staff
- Increase flexibility for expansion/reorganisation
- Improved meeting room facilities
- Reduced risk exposure

Intangible Benefits

- Improved staff morale
- Improved image to public and visitors

Options

1. **Do Nothing**

   Whilst this option has been included, it is for comparative purposes only. It is recommended that this option is not adopted as the preferred option. This option does not fulfil any of the objectives in Section 0 above and does not solve the long-term problem of shortage of space at the LAS Headquarters and its annexes, therefore exposing the Ambulance Service to continued risk.

2. **Loman Street 4th floor offices.**

   The 4th floor at Loman Street will be available to lease from September 2008 for a 5-year period, when the current tenant vacates. These offices are directly above the existing offices the LAS rent on the 3rd floor, providing 3,460 sq ft of office space. The annual revenue cost associated with this site are shown in Table 3, below:

Table 3

Option 1 - 4th Floor Loman Street	Cost for GEM	VAT (or other taxes)	Total Cost
Recurrent Costs			
Rent	130	0	130
Rates	27	0	27
Service Charge	21	4	25
Cleaning	3	1	4
Maintenance	5	1	6
Photocopier	4	1	4
Utilities	2	0	2
Sundries	1	0	1
Total Recurrent Costs	**192**	**6**	**198**
Non-Recurrent Costs			
Furniture	40	7	47
Delapidations	20	4	24

The condition of the offices are such that there is minimal work that would need to be undertaken. There would be some IM&T costs, such as the provision of telephone handsets and the provision of A/V equipment. It is suggested that a capital allowance of £40,000 is included in the budget costs.

The terms of the lease for the 4th floor include for a one off payment to be made by the existing tenant to the LAS to cover existing dilapidation costs at the end the 5-year term.

While the rent for Loman Street is higher than some sites it has the advantage that there is no great capital expenditure required. At both Southwark Bridge Road and Hannibal House, the LAS are spending circa £150,000 at each site to put the accommodation into reasonable condition.

As long as no further alterations are made at Loman Street, the only dilapidation costs that will be incurred are those that the LAS have already been compensated for by the current tenant and we will have had the benefit of the meeting rooms and kitchen that they have provided.

There will also be the advantage of being collocated with the finance team, especially for the Foundation Trust team who are likely to work closely together.

The rent review for the 3rd Floor at Loman Street took place in March of 2008 and at that time, the District Valuer acted on behalf of the LAS to negotiate the new rent. At that time, the District valuer agreed a rent of £37.50 per sq ft and confirmed that he considered this a fair and reasonable rent.

3. **Southwark Bridge Road**

The LAS is already negotiating a lease for 4,447 sq ft of office space in Southwark Bridge Road for use by the CAD 2010 team as a testing and training facility. These could be extended to include a further 3,500 sq ft. A lease for 5 years with a break clause in July 2011would give the following costs:Table 4

Option 2 - Southwark Bridge Road	Cost for GEM	VAT (or other taxes)	Total Cost
Recurrent			
Rent	98	0	98
Rates	25	0	25
Service Charge	22	4	26
Cleaning	0	0	0
Maintenance	10	2	12
Photocopier	4	1	4
Utilities	2	0	2
Sundries	1	0	1
Total Recurrent Costs	**161**	**7**	**168**
Furniture	40	7	47
Delapidations	50	9	59

At both Southwark Bridge Road and Hannibal House, the LAS are spending circa £150,000 at each site to put the accommodation into reasonable condition. It is likely that a similar sum would be required for any further accommodation leased at this site. The costs would include the installation of IM&T facilities, meeting rooms and kitchen facilities.

4. **Serviced Office Accommodation**

The LAS has, in the past used serviced office accommodation within the Waterloo area. There is significant capacity available however, there are a number of disadvantages, including:

- The costs and difficulties of providing IM&T facilities, which meet the new stringent DH requirements, would be costly.
- The other emergency services and Olympic partners would view the use of serviced offices as insufficiently secure and would refuse to provide many of the confidential documents required to plan the Trust's response to the Olympics.
- Costs would be higher than renting offices for a fixed period.

This option was not pursued.

Financial Benefits

There are limited financial benefits arising from this proposed investment. Currently, the annual cost of hiring meeting rooms is £441,000. Of this, some £47,000 is incurred in the Waterloo Area. It is assumed that this could be reduced by some £12,000 for either Option 1 or Option 2.

Non-Financial Benefits

The benefits listed in section 0 above have been ranked, as shown in Table 5 below:

Table 5

Benefit Criteria	Rank	Pairings 1st	2nd	3rd	4th	5th	6th	7th	8th	9th	Raw % Weights	% Weights
Increase flexibility for expansion/reorganisation	1	100									100	42.9
Reduced risk Exposure	2	50	100								50	21.4
Improved meeting room facilities	3		75	100							38	16.1
Better working conditions for staff	4			75	100						28	12.1
Improved staff morale	5				50	100					14	6.0
Improved image to public and visitors	6					25	100				4	1.5
	7							100			0	0.0
	8								100		0	0.0
	9									100	0	0.0
	10										0	0.0
										Totals	233	100

Each of the three options has been scored, out of 10, against each of the non-financial benefits. These scores are then weighted by the results of Table 5 above and are shown Table 6 below:

Table 6

Benefits	Weight	Options: Do Minimum score	Do Minimum WxS	1 score	1 WxS	2 score	2 WxS
Increase flexibility for expansion/reorganisation	42.9	0	0	8	343	7	300
Reduced risk Exposure	21.4	9	193	8	172	2	43
Improved meeting room facilities	16.1	0	0	7	113	6	96
Better working conditions for staff	12.1	0	0	6	72	6	72
Improved staff morale	6.0	5	30	3	18	2	12
Improved image to public and visitors	1.5	0	0	3	5	3	5
	0.0	0	0	0	0	0	0
	0.0	0	0	0	0	0	0
	0.0	0	0	0	0	0	0
	0.0	0	0	0	0	0	0
Total	**100**		**223**		**722**		**528**

Table 6, above, indicates that Option 1 (4th Floor Loman Street) provides the highest level of non-financial benefits.

Discounted Cash Flow Statement of Options

The costs identified in section 0 above have been entered into the DH's Generic Economic Model (GEM) and using the prevailing HM Treasury, discount rate of 3.50% has generated the following analysis of the short listed options:

Table 7

SUMMARY	Appraisal Period	EAC
		£'000
OBC Do Minimum Do Nothing	5 Years	1,432.0
OPTION 1 4th Floor Loman Street	5 Years	1,601.1
OPTION 2 Southwark Bridge Road	5 Years	1,608.7

..

Table 7, above, indicates that Option 2 Lease Loman street provides the lowest Equivalent Annual Cost (EAC)[21].

At this point in the analysis, the EACs shown in Table 7 above are divided by the scores from Table 6

to show a value of EAC per weighted benefit point. This is shown in the table below:

Table 8

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score
		£'000		£'000
OBC Do Minimum Do Nothing	5 Years	1,432.0	223	6.421
OPTION 1 4th Floor Loman Street	5 Years	1,601.1	722	2.217
OPTION 2 Southwark Bridge Road	5 Years	1,608.7	528	3.044

The Preferred Option

Preferred Option

Table 8, above, indicates that Option 1 (4th Floor Loman Street) provides the lowest EAC per Weighted Benefit Score and is, therefore, the preferred option.

[21] DH guidance indicates that where the options have different appraisal periods the Equivalent Annual Cost (EAC) should be used instead of the Net Present Cost (NPC).

Sensitivity Analysis

A sensitivity analysis has been carried out to identify the robustness of the preferred option. Two sensitivity tests were performed.

Firstly, it was assumed that there would be no reduction in the cost of hired meeting room accommodation. This generated an EAC per Weighted Benefit Score of 2.232 for the Preferred Option, which is lower than the score for the Do Minimum Option shown in Table 8.above.

Secondly, the switch point was calculated to see the level of capital expenditure required on Option 1 before its EAC per Weighted Benefit Score was greater than Option 2's. This revealed that only if the cost of converting the 4th Floor of Loman Street was greater than £2.79m would Option 1 produce a worst EAC per Weighted Benefit Score than Option 2. It is considered that this demonstrates the preferred option is robust.

Financial Implications

Preferred Option

The expected costs of the Preferred Option used in the calculation of the EAC are set out in section 0 above. The total capital costs of the preferred option would be £41,000 including VAT. This would be funded from the Trust's capital allocation.

The revenue costs can be summarised as:

Table 9

	2008/09	2009/10	2010/11	2011/12	2012/13
Recurrent Costs					
Rent	42.9	130.0	130.0	130.0	130.0
Rates	8.9	27.0	27.0	27.0	27.0
Service Charge	8.1	24.7	24.7	24.7	24.7
Cleaning	1.2	3.5	3.5	3.5	3.5
Maintenance	1.9	5.9	5.9	5.9	5.9
Photocopier	1.4	4.1	4.1	4.1	4.1
Utilities	0.6	1.8	1.8	1.8	1.8
Sundries	0.4	1.2	1.2	1.2	1.2
Total Recurrent Costs	**65.4**	**198.1**	**198.1**	**198.1**	**198.1**
Non-Recurrent Costs					
Furniture	47.0				
Delapidations	(23.5)				23.5
Total Non-Recurrent Costs	**23.5**	**0.0**	**0.0**	**0.0**	**23.5**
Capital Charges					
Depreciation	2.1	8.2	8.2	8.2	8.2
Cost of Capital	1.4	1.1	0.8	0.5	0.2
Total Capital Charges	**3.4**	**9.3**	**9.0**	**8.7**	**8.4**
Recurrent Savings	(4.0)	(12.2)	(12.2)	(12.2)	(12.2)
Net Revenue Costs	**88.3**	**195.2**	**194.9**	**194.6**	**217.8**

Over the 5 year period of the lease on the 4th floor of 46 Loman Street there would be revenue costs of between £88,000 in 2008/09 and £218,000 in 2012/13. The intermediate years would have increased revenue costs of £195,000.

There has been no allowance for the rental of car parking spaces.

No allowance has been made for the provision of Catering facilities, other than providing the existing kitchen area with microwave, hydroboil, fridge/freezer and a number of kitchen utensils. Provisions have not been made for vending machines, as there are a number of shops close by.

From the approval of the business case, it will take approximately 4 weeks to complete the relevant alterations, data cabling, BT lines, procurement of furniture and arrange the moving of departments.

This Business case does not include any costs associated with refurbishing areas vacated by the staff moving to the proposed offices.

Private FINANCE Initiative (PFI)

As the funding required for this option is below the limit above which investigations into PFI must be made this has not been considered. If the Service were to consider this option, they should consider the viability and the difficulties of trying to attract the Private Sector partner in a project of such a low value.

Project management

The project will be managed using the PRINCE 2 methodology, which will be tailored to suit both the London Ambulance Service organisation and the requirements of the project. The Project Board, Project Management Team Leader roles will need to be delegated and confirmed.

Post Project Evaluation Plan

The Project Closure meeting will take place within 3 months of the completion of the project and will review the Project Managers Post Project Evaluation Report. This meeting will set an appropriate date for the Project Evaluation Review Meeting.

The Project Evaluation Meeting will assess whether the expected investment benefits of the project have been realised and if any problems have occurred in the use of the product(s).

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 2008

Business Continuity Update

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

A summary of current business continuity was presented to the Senior Management Group on July 16, 2008. An updated summary is attached

Much work has been completed in the Business Continuity area. Future emphasis will be on training and testing the actual plans by both department and process.

4. Recommendation

THAT the Trust Board NOTE the contents of the report.

Business Continuity

Introduction

The Civil Contingencies Act 2004 requires the London Ambulance Service NHS Trust (LAS) as a Category 1 Responder to produce and maintain a comprehensive Business Continuity Plan (BCP) that will enable the LAS to manage major disruptions to the delivery of services whilst continuing to provide critical services to the public.

The Business Continuity Policy and BCP were completed in November 2005 and approved by the Trust Board in January 2006. Since this time the Plan has been further developed and expanded. Updates have been made as and when required and a major revision to both the Policy and Plan was produced in August 2007.

The Director of Finance has overall responsibility for Business Continuity, the Head of Records Management & Business Continuity has responsibility for the development and day-to-day management of Business Continuity, and a cross-functional Business Continuity Steering Group (BCSG), chaired by the Director, ensures that both compliance and the Policy and Plan are effectively implemented, trained, practised and reviewed by the LAS.

Since Business Continuity arrangements were originally put in place in the Trust work has been ongoing to improve Business Continuity Management and this update outlines recent developments and initiatives that have taken place and plans for the future.

Audits

A Civil Contingencies Act Audit of all English ambulance trusts was carried out on behalf of the DH in September 2007 and while the LAS achieved the highest compliance score in the country and it was commended for the quality of its BC Plan it identified the need to tackle the following three main Business Continuity issues in the Trust:-

1) There was relatively little internal expertise in Business Continuity and no managers who have had formal training. The LAS should consider creating a pool of trained managers.
2) No department had exercised their plans and no apparent work done to understand 'pinch points' such as over-reliance on IM&T capability.
3) Some of the structure and content of the BC Plan suggests it may not have been reviewed with the benefit of guidance now available.

Whilst the second point had already been recognised and a programme to tackle this had already been formulated before the audit took place the training issue has subsequently been reinforced by the results of a subsequent Business Continuity Audit which was carried out by the Trust's internal auditors in March 2008. The draft recommendations received on 13th June 2008 included one significant recommendation:-

- The Trust should consider developing a Training Strategy specifically designed for the benefit of Business Continuity, outlining key objectives and targets for the year. Key Performance Indicators should be incorporated to allow the Trust to monitor progress and that sufficient training has been provided to members of staff concerned, including members of the Steering Group and other senior management staff.

The report was presented to the BCSG on 4th July and included seven Merits Attention recommendations, some of which had already been addressed or were underway.

Risk Management

BS 25999 Business Continuity Management, which was launched in the latter part of 2007, states that Business Continuity is 'complementary to a risk management framework that sets out to understand the risks to operations or business, and the consequences of those risks'. The BCSG had maintained and regularly reviewed a list of BC risks but in order to raise their profile it was important that BC risks were managed within the overall Trust risk management framework and in July 2007 nearly all of the existing risks were added to the Trust Risk Register in a new BC category. The BCSG constantly monitors progress with the mitigation of these risks.

Plans

Although the corporate BC Plan has been developed and expanded to include further practical departmental information such as staff redeployment and restored service requirement tables it was recognised that there was a need to develop planning in other areas including improving the management of business continuity within IT systems and networks. Accordingly an IM&T Business Continuity Systems Recovery Plan has been under development for some months and will shortly be finalised. This will incorporate lessons learned from the recent CTak failures. On the operational side a draft template has been produced for a business continuity plan for complexes which will be further refined over the next few months.

The testing programme for departmental plans began last year and is now well under way. IM&T departmental plans were first exercised at their conference on 1st November 2007 and this was recently followed up by a 2.5 hour exercise at the conference held on 12th June where the latest draft of the Business Continuity Systems Recovery Plan was also launched. Communications Department held a tabletop exercise on 12th December 2007 and Estates on 4th January 2008. HR plan to test their Safety & Risk and Staff Support plans on 16th July and Payroll on 29th August; Logistics will be testing their revised plan on 28th July and Purchasing plan to test theirs on 31st July. Finance is slated in for September and other areas such as PTS, PPMO, EPU, and Chief Executive's Office are planned for the future.

Training

The testing programme is in itself a training opportunity as it provides an opportunity to raise awareness and enables staff to focus on the practical aspects of the operation of their plans in the event that they are invoked. The Head of RM & BC facilitates at most of these exercises which usually consist of a small number of scenarios tailored to the individual needs of the department. They ensure that staff become familiar with their individual responsibilities and roles and they frequently lead to changes and improvements to their plans. In addition basic training continues to be provided to new staff as business continuity management forms part of the Governance presentation at the Corporate Induction Programme. However, both the CCA Audit and the recent BC audit have stressed the need for further training opportunities to be provided and we are currently looking at available options in order to move this forward.

Other Initiatives

Suppliers

The importance of logistics in ensuring the continuity of supply to Operations has been fully recognised and work has recently been carried out to review supplier contracts in order to map the robustness, or otherwise, of suppliers and their continuity plans. Risk assessments have been carried out on suppliers, alternative sources of supply identified and further work will be carried out to mitigate the major areas of risk.

Fallback Control

Concerns remain about Fallback Control and a new risk has now been added to the Trust Risk Register. Although a test carried out in October 2007 was largely successful it was carried out in a technically heavily supported environment which is unlikely to be replicated operationally were there to be a future live requirement to move rapidly from HQ to Bow at short notice. It was planned to follow up this test with a regular programme of testing which would enable participants to familiarise themselves with procedures, but this has had to be put on hold. The fallback testing group meetings will resume on 27th July and will need to agree a new testing schedule. In the meantime the existing Control Services fallback procedures and associated risks will be reviewed and rationalised to ensure they are clear and reflect recent developments and the outcomes of ongoing discussions with the MPS.

Business Critical IT Systems

An issue initially identified by a previous IM&T Business Continuity Audit carried out in early 2007 and subsequently reinforced by the requirements of the Audit Commission was the need to ensure that manuals and procedure notes, especially back-up procedures, for business critical systems are fully documented, available, reviewed and in the case of back-up procedures tested on at least an annual basis. Some of this will be covered by the new BC Systems Recovery Plan but a system needs to be set up within IM&T to ensure that this is evidenced and managed effectively for the business. The Head of RM & BC is working with the IM&T representative on the BCSG to move this forward.

Emergency Preparedness

The Head of RM & BC is a member of the Emergency Preparedness Strategy Group and is currently working with the Head of Emergency Preparedness to determine the best approaches to ensure that business continuity becomes an integral part of major incident planning, both strategically and tactically as there needs to be a greater understanding of business continuity requirements to support the front line in the event of a major incident. Some progress has already been made as a representative

from EPU has now been nominated to join the BCSG and it has been agreed that EP plans will be reviewed to ensure the incorporation of business continuity elements where appropriate. The draft of the new version of the LAS Pandemic Flu Plan is currently under review and the next version of the Major Incident Plan will incorporate a more in depth approach to business continuity issues following a major incident.

Workplan & Resourcing

In order to accelerate the work of the BCSG in moving forward on the BC agenda throughout the Trust a Workplan was developed towards the end of 2007 and High, Medium and Low priorities were agreed at the BCSG meeting held on 15th January 2008. It was realised that, although the Head of Records Management and Business Continuity would be able to lead on this, additional resource would be required if the work was to move forward in a timely manner and a proposal was originally approved within the Invest to Save Programme for the Trust to utilise the services of a MBCI qualified person to carry out the high priority tasks identified in the Workplan. For a number of reasons this was not able to go ahead within the timescale available and after further discussions it was agreed at the BCSG meeting held on 4th July 2008 that the Trust should employ a consultant for a short period of a few days to work with the Head of RM & BC to determine the recommended way forward and the resources required to carry out the agreed work. The BCSG will consider the report from the consultant and, if agreed, will decide on the resource required to take the work forward. A MBCI qualified (or similar) professional will be engaged to carry out the tasks within the agreed budget. If there is insufficient resource to complete the identified tasks the work will be continued by the Head of RM & BC and members of the BCSG, as appropriate.

The following work has been identified as high priority in the Workplan:-

- Review the structure and content of the BC Plan to ensure that it fully meets the needs of the LAS and reflects best practice. This will include:-
    - Review and develop the Flooding element of the BC Plan
    - Focus on the robustness of the Estates, IM&T, Fleet & Logistics BC Plans
    - Develop BC links between internal LAS departments
- Develop a comprehensive training strategy, package and programme for staff at all levels of the Trust
- Progress the programme for the development and testing of departmental plans with special emphasis on links and dependencies

In addition to the high priority activities identified above the contractor will be required to:-

- Recommend and develop a practicable approach to the undertaking of Business Impact Analyses

- Complete all non-core and non-vital support departments plans and add to BC Plan

- Investigate and, if appropriate, draw up a specification for an electronic system for managing Business Continuity

- Review requirements for, and identify, ongoing resources necessary to ensure effective BCM throughout the Trust and progress towards Trust compliance with BS 25999.

Further ahead it is planned that an additional resource will be identified for BC work, but this is dependent upon staffing changes within GDU which it has not yet been possible to implement.

Enclosure 13

London Ambulance Service NHS TRUST

TRUST BOARD 30th September 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 Service Development Committee was approved by the Trust Board in September 2007:

a. Trust Board – every meeting;

b. 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, 30 September 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 (not individual milestones) identified as being of red status (i.e. not on track and cause for concern).

Improving our Response

Mobile Office

Agreement has been delayed on a remote access solution for the Mobile Office project and the timescales for implementing one has to be agreed. A meeting to discuss this issue was delayed and the next steps are to draft a Project Initiation Document.

Referral pathways

The project manager is on sick leave which is causing a delay. An interim solution is being progressed to aid delivery of this initiative with the approval of a six month secondment and once the results of the banding exercise are finalised the role will be advertised internally.

Corporate Processes and Governance

Re-engineer Income Collection

The project has been on hold due to the project manager working full time on the CAD2010 Full Business Case. The project manager will produce a new plan which will include implementation of the stadia income collection process which has already been redesigned.

Asset Tracking

The project is on hold due to capacity constraints on power to the server room, IM&T have steps in hand to address this issue at which point the project can progress.

Performance Measurement Phase 2

Following the departure of the project manager it emerged that little progress has been made over the past couple of months. A new project manager has been appointed and the next steps are to establish a revised milestone plan and ensure all project documentation is brought up to standard.

Access

London Airwave Radio Project (LARP)

The latest version of the radio control software (ICCS) has failed in its testing. This means that the current plan needs revision, as yet no plan has been issued. As Senior Users have indicated that a rollout of digital radios cannot be completed during January (winter pressures) or February and March (year-end performance pressure). A draft migration plan has been completed with input from key operational staff, this is being held until there is a better understanding of the new timeline and will be discussed by the Project Board.

Some progress is being made however: the Service Level Agreement is in final draft; an interim service has been introduced via the Service Desk and the Duty Engineers for the MRU and CRU users have early access to Airwave via fixed Mobile terminals; vehicle installations are being wound down and the installation sites are being rationalised as it becomes harder to find vehicles that have not been fitted; all MRU's have been fitted and agreement to fit the 12 new MRU's has been finalised; operational trainers have been trained and the user training folders have been sent to the 'Print Shop' although training will be put on hold until we have further information on the rollout schedule.

PTS Mobile Data Solutions

The project is temporarily delayed as progress cannot be made because work on the network configuration cannot start until the exact location of the server has been agreed. The project plan is currently being updated to reflect major factors affecting the installation and commissioning of servers. The timescale for the test environment is unknown due to uncertainty surrounding the re-housing of the servers at the co-location site. Agreement has been reached as to the preferred suppliers of the GPRS network. The bandwidth issue is being addressed site by site within the context of the current IM&T network upgrade programme. It remains highly likely that the kit may take longer to install than previously anticipated.

5. Recommendation

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

Kathy Jones
Director of Service Development

OVERVIEW OF ACCESS / CONNECTING for HEALTH PROGRAMME

CAD 2010
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
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
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)
As a regional component in the national programme to replace analogue voice and data radio services for ambulance trusts in England, the LARP Airwave Implementation Project will manage the LAS implementation of this managed digital radio service including the distribution network, mobile and hand portable radios, EOC / UOC dispatcher equipment and the integration with CTAK

PTS System; Meridian Mobile Technology
The intension of this project is to introduce handheld information terminals to build upon the functionality of the upgraded Meridian booking, billing and management reporting system used to support Patient Transport Services operations.

The system eliminates paper-based dispatching. The use of handheld terminals to receive and feed back operational and management

information related either to the patient or of relevance to the customer in a more timely manner and in a secure technological environment, is expected to deliver efficiency savings over time and a more flexible operation on a day-to-day basis.

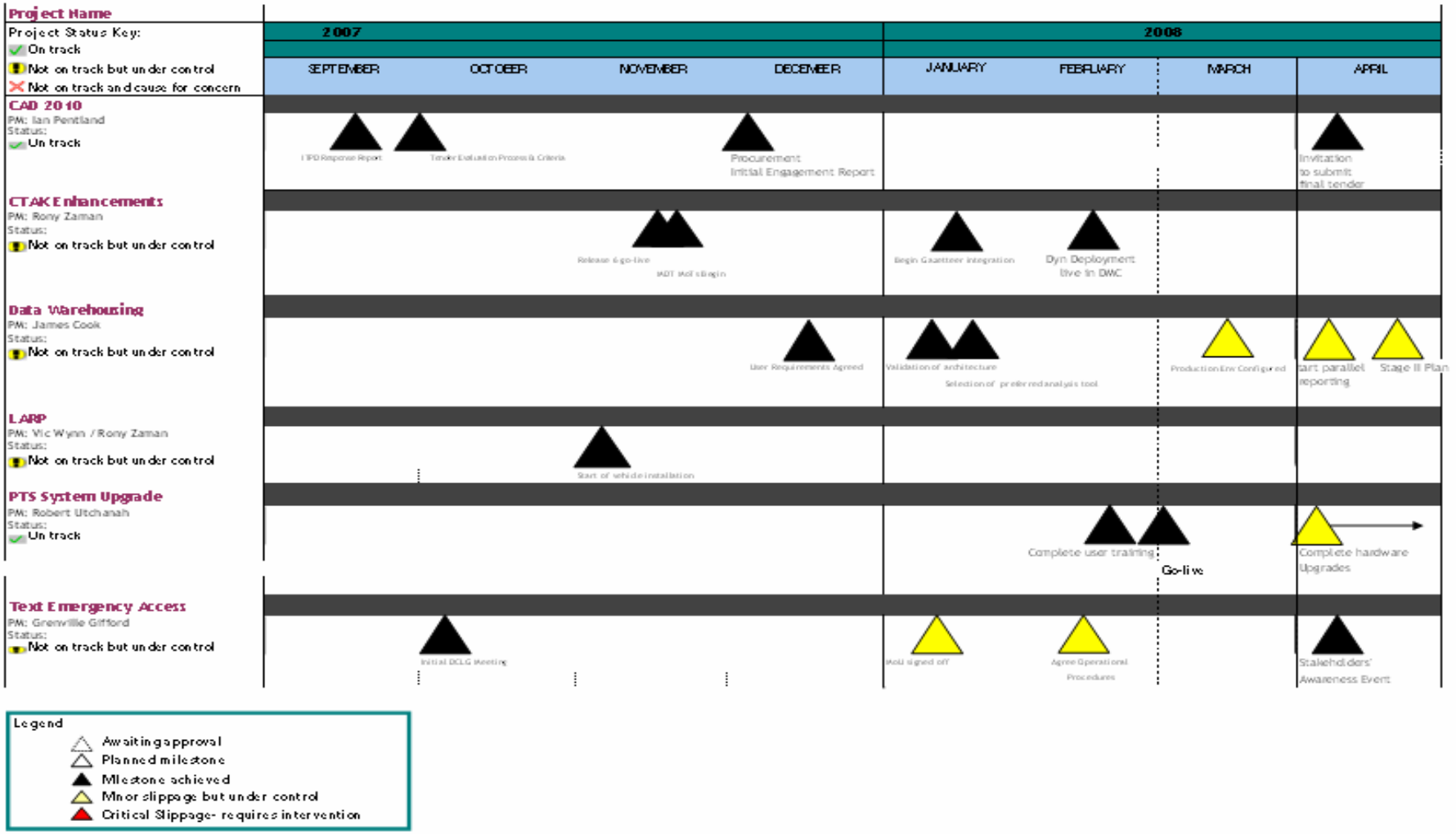
TEASHIP (Text Emergency Access for Speech or Hearing Impaired People)

The objective is to provide the capability to respond to patients or their carers who have a speech or hearing impairment that prevents use of the normal '999' facility.

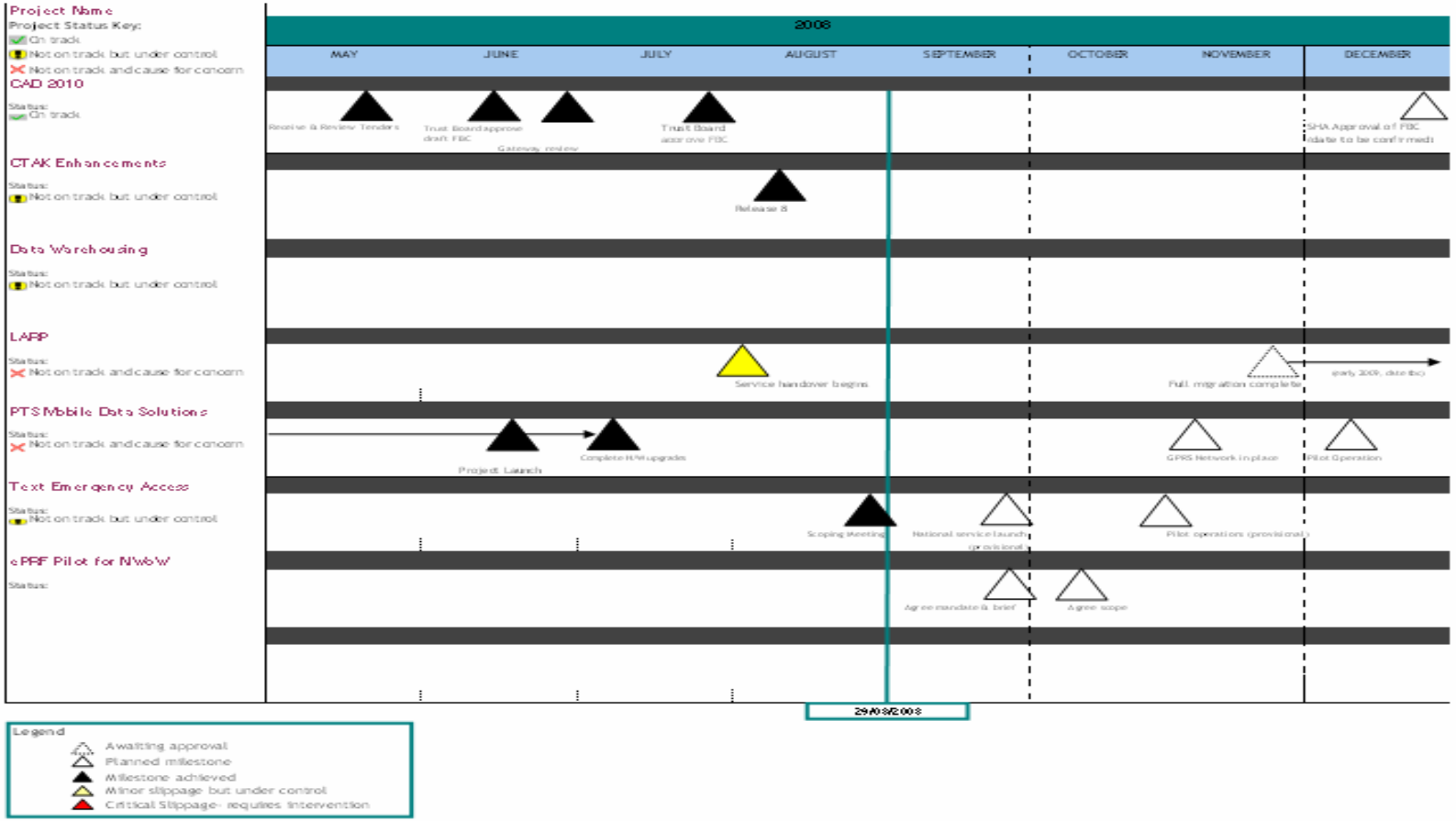
A method piloted by several U.K. police services is to use texting from mobile telephones and at present this would appear to offer the most promising solution to meet our users' needs to summon assistance or seek advice.

Our intention is to adopt this solution for call taking and this was initially expected to be achieved by proactive engagement and alignment with a national trial of SMS texting technology to be set up during 2008.
Because of continuing delay and uncertain surrounding the national initiative the project is also investigating the feasibility of establishing an in-house solution that would deliver text messages directly to ambulance control rooms.

Access CfH Schedule Summary



Access CfH Schedule Summary



Access Programme Report to SSG 10/09/2008

OVERVIEW OF OPERATIONAL MODEL AREA PROJECTS

Clinical Support Desk
This project is aiming to establish as system to provide immediate clinical support to both operational clinicians and to call handlers. A desk in the Emergency Operations Centre (EOC) will be staffed by senior paramedics, who will be able to access a range of databases to assist with staff queries.

First and Co-responding schemes
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.

Active Area Cover (phase 2)
Following extensive consultation with staff and staff representatives it has been decided to implement Active Area Cover (AAC) for ambulances and FRUs with effect from 9 June 2008.
The implementation will be gradual, over a number of months, until it is routine business for the Trust. This project is tasked with establishing the steps towards initial implementation on 9th June and the subsequent steps to achieve full implementation.

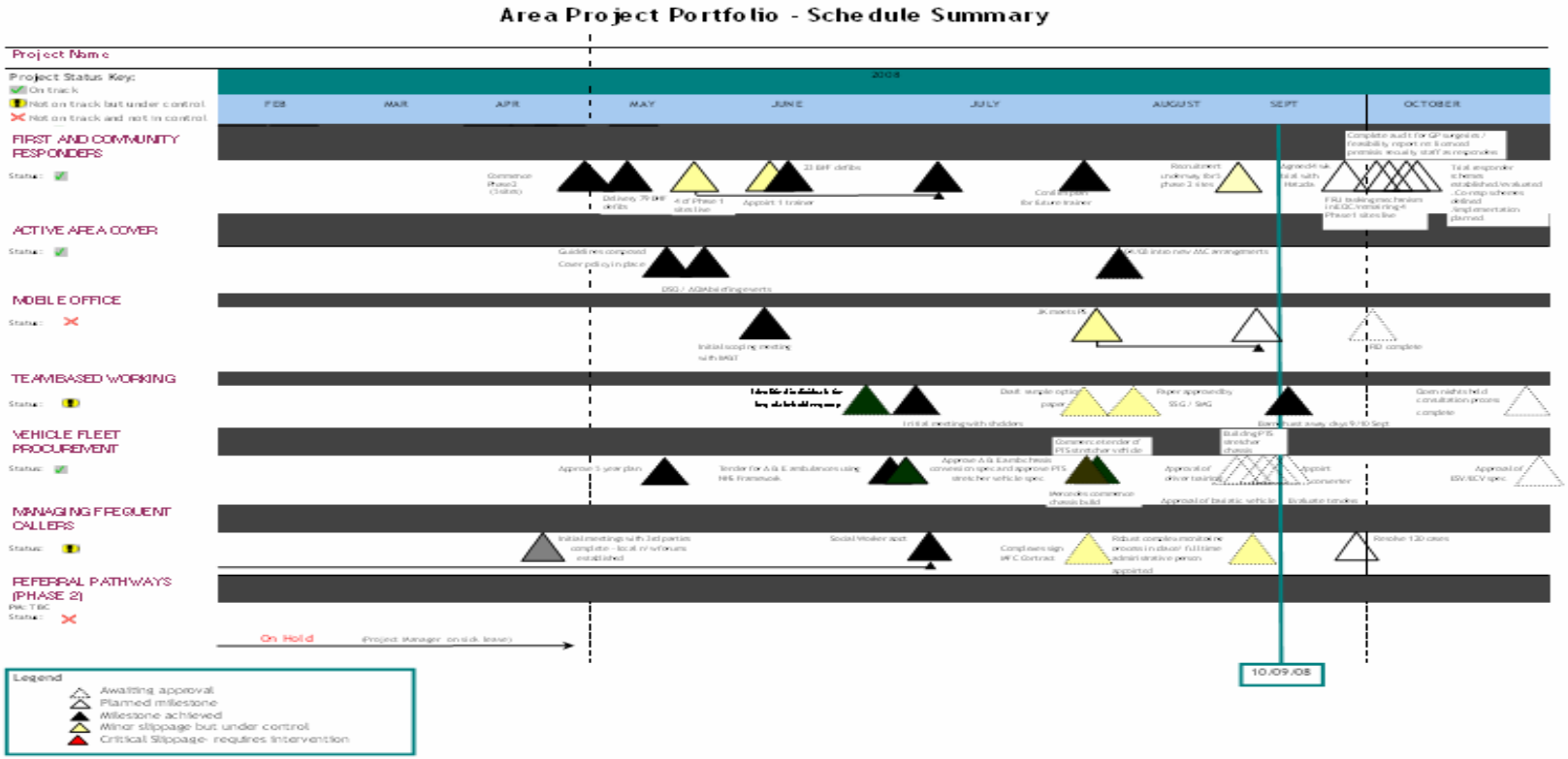
Mobile Office
This project is tasked with equipping DSO vehicles with laptops to enable staff to work remotely, giving them immediate access to information whilst also allowing them to spend more time out in the field. The project will establish hardware and software requirements, examine security concerns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

Team Based Working
This project is tasked with undertaking a review of current working patterns and providing a series of alternative options which can be piloted as part of the NWoW initiative. The aim is ultimately to introduce working patterns to each individual complex which reflect the needs of staff and provide an efficient and manageable system for the Service

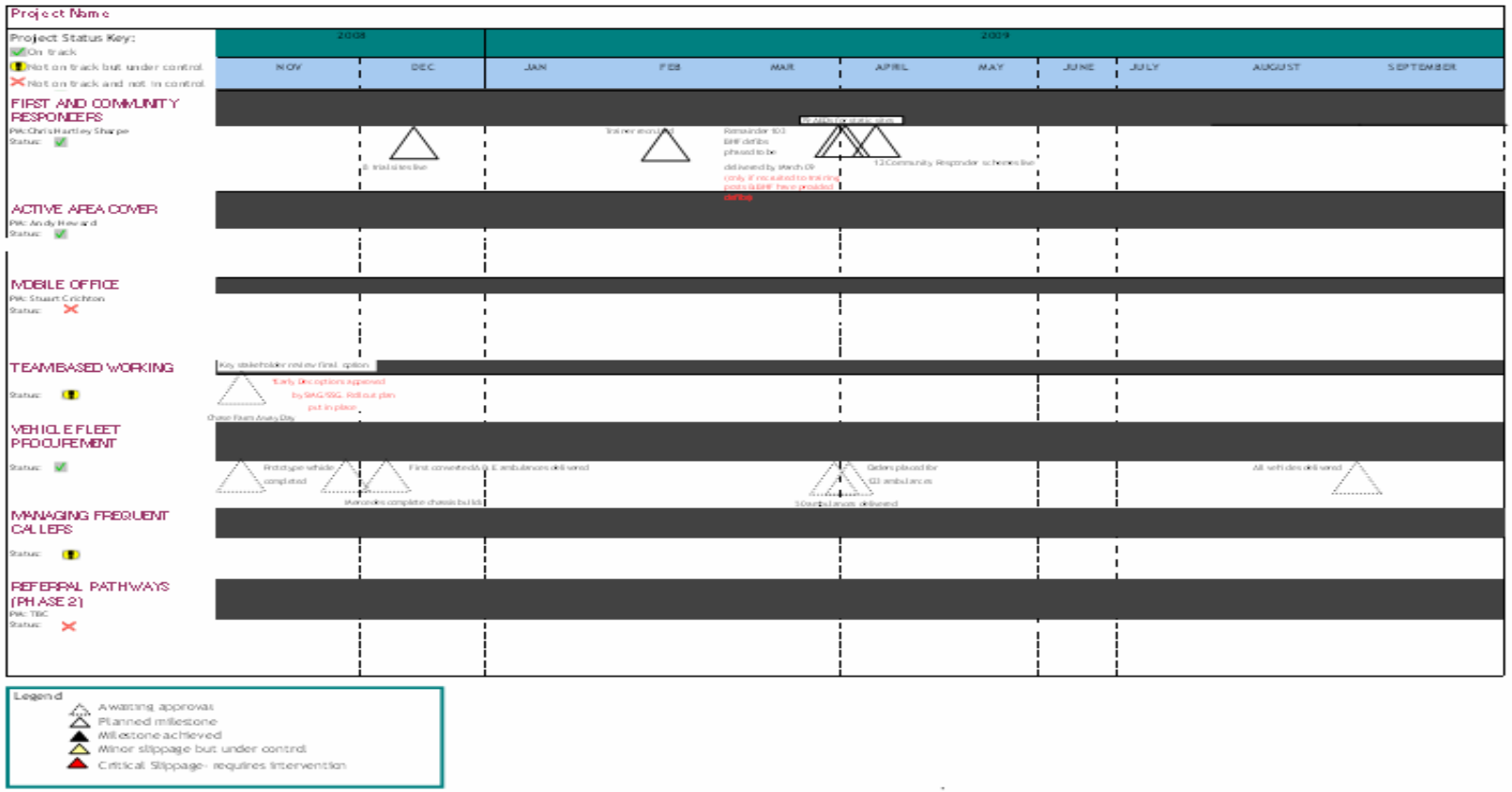
Vehicle Fleet Procurement
This project is responsible for delivering a 5 year fleet procurement and policy plan. This includes; ambulances, PTS, bariatric and training vehicles

Managing Frequent Callers
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.

Referral Pathways
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.


Area Project Portfolio - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
2008
FEB
MAR
APR
MAY
JUNE
JULY
AUGUST
SEPT
OCTOBER
FIRST AND COMMUNITY RESPONDERS
ACTIVE AREA COVER
MOBILE OFFICE
TEAMBASED WORKING
VEHICLE FLEET PROCUREMENT
MANAGING FREQUENT CALLERS
REFERRAL PATHWAYS (PHASE 2)
On Hold
10/09/08
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage- requires intervention

Area Project Portfolio - Schedule Summary



OVERVIEW OF OD & PEOPLE PROJECTS

Recruitment & Induction

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

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

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

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

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

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

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

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

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

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.

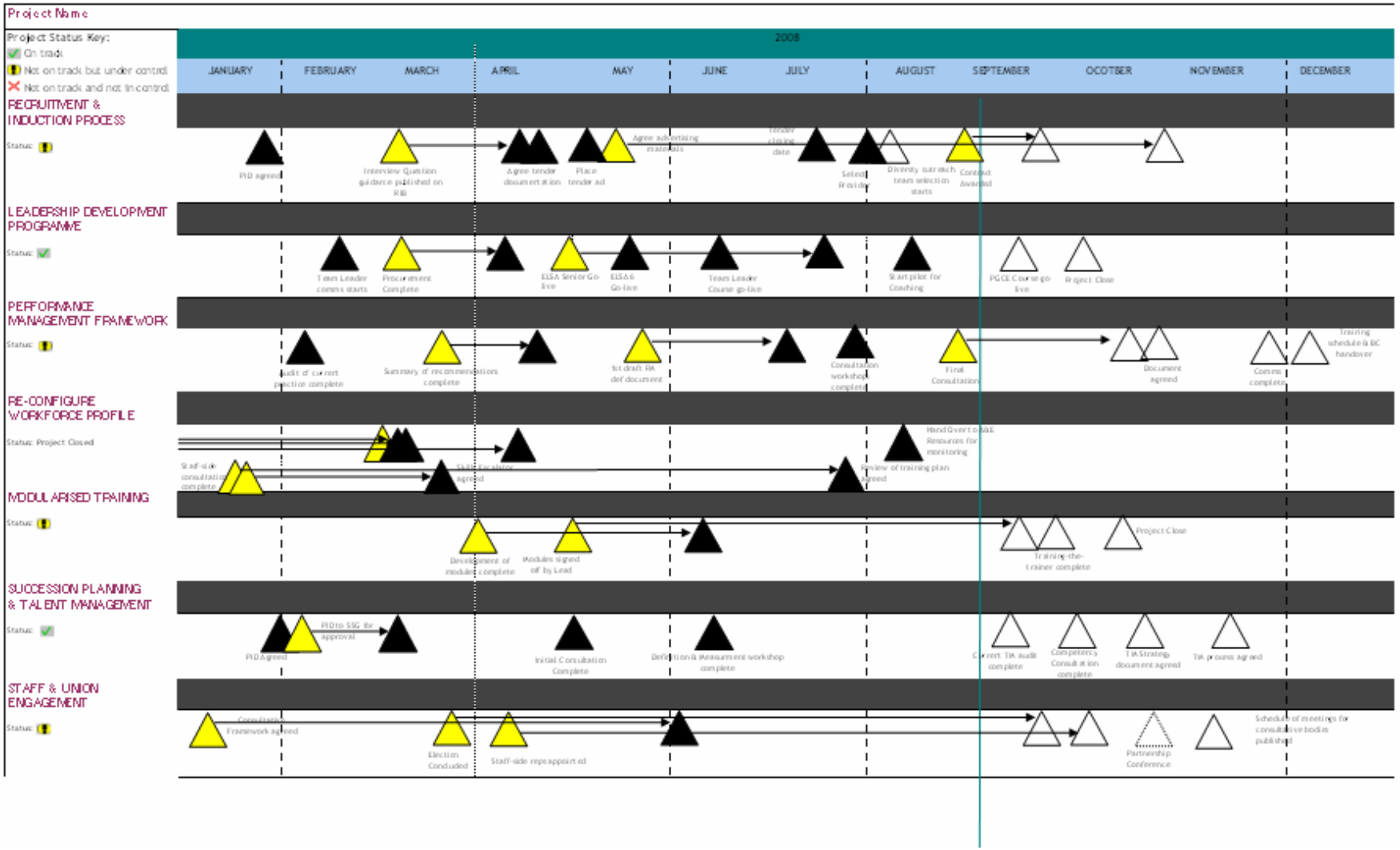
Learning Management Systems

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

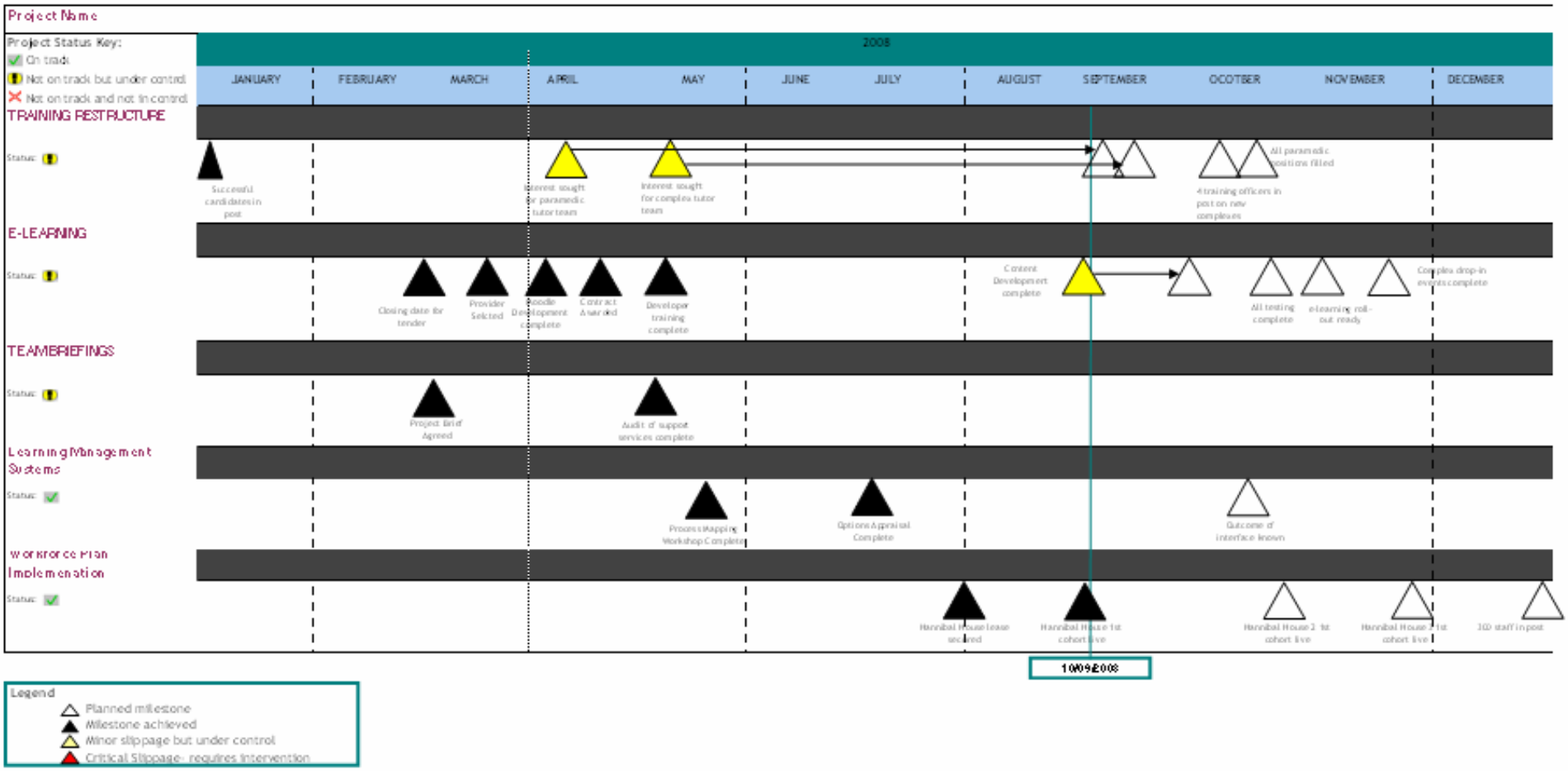
Workforce Plan Implementation

The project is stage 2 of the workforce re-configuration with the scope to recruit 400 student paramedics by 31st of March, and deliver the student paramedic course. The project has been split into three mainstreams, the sourcing and operationalisation of additional external training facilities, the recruitment of the 400 staff, and the running of the student paramedic training course.

OD and People Project Portfolio - Schedule Summary



OD and People Project Portfolio - Schedule Summary



OVERVIEW OF OLYMPIC PROGRAMME PROJECTS

T1P1: Operations

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

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

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

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

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

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

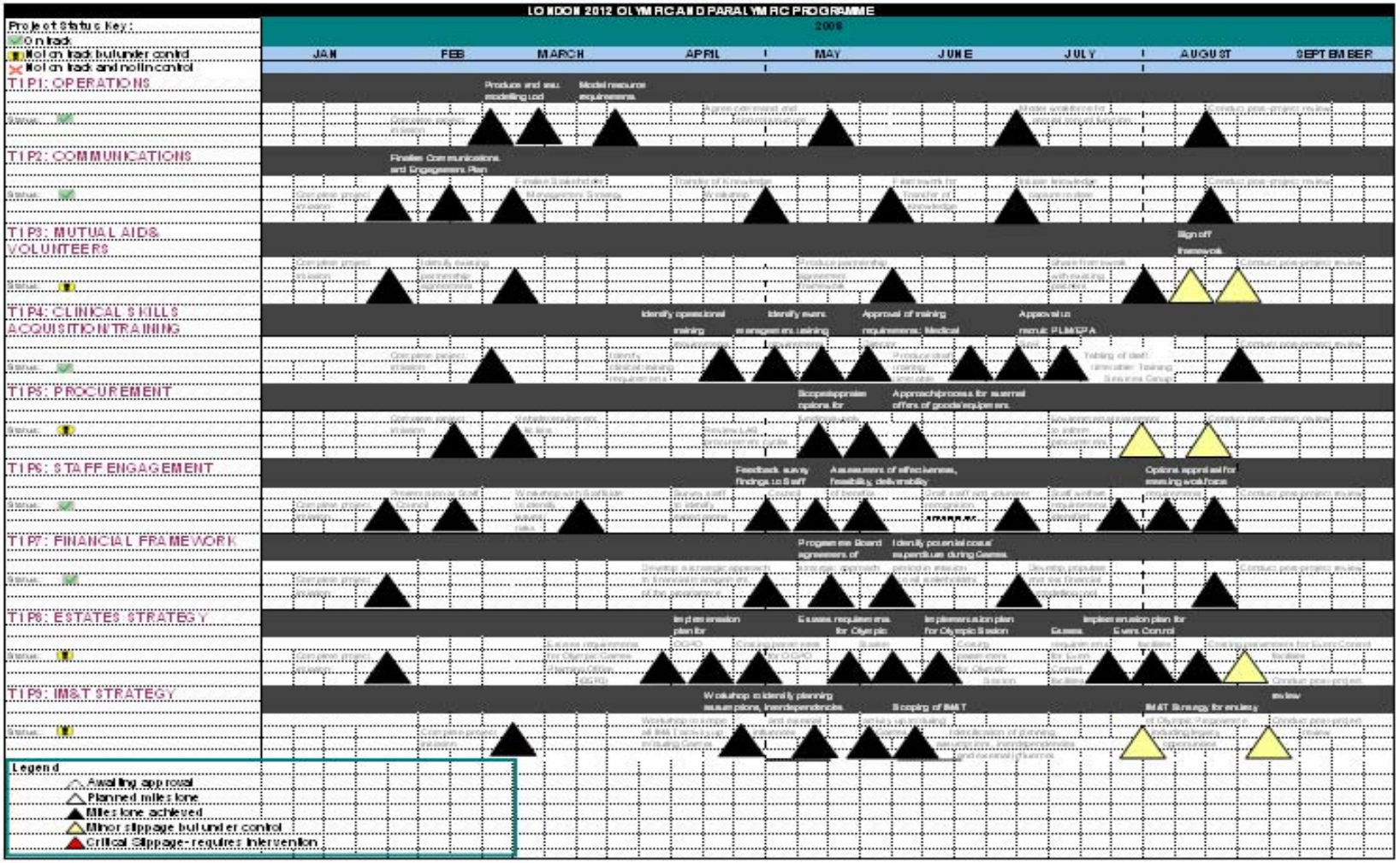
The objective of this project is to ensure that the Olympics Programme has adequate financial controls and management in place to successfully deliver the programme on time and within budget. The project will consist of the development of a strategic and operational approach to financial management at programme-level.

T1P8: Estates Strategy

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

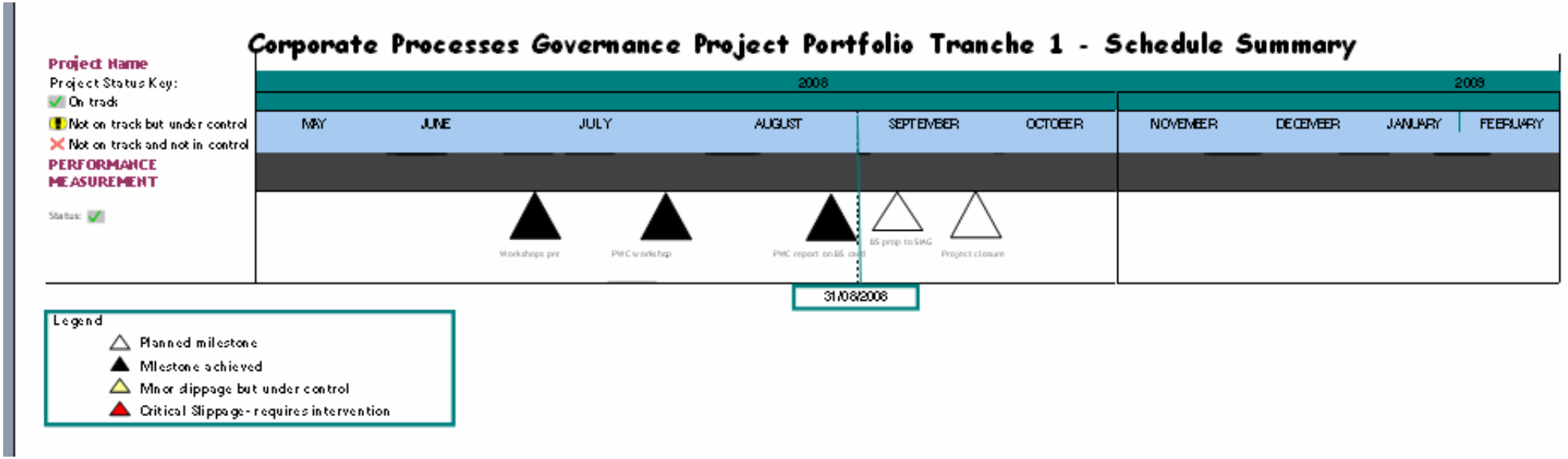
This project will consist of the identification of a strategic approach to IM&T for the duration of the Olympic Programme. Planning assumptions, interdependencies and external influences will be identified and the potential for realising legacy benefits will be explored.


LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME
2009
Project Status Key:
On track
Not on track but under control
Not on track and not in control
JAN
FEB
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
TIP1: OPERATIONS
Produce and ass. modelling cod
Model resource requirements
Status:
TIP2: COMMUNICATIONS
Finalise Communications and Engagement Plan
Status:
TIP3: MUTUAL AIDS& VOLUNTEERS
Sign off framework
Status:
TIP4: CLINICAL SKILLS ACQUISITION/TRAINING
Identify operational training
Identify event management training
Approval of training requirements: Medical
Approval to recruit: PLMICPA
Status:
TIP5: PROCUREMENT
Scope/appraise options for
Approach/process for external offers of goods/equipment
Status:
TIP6: STAFF ENGAGEMENT
Feedback survey findings to Staff
Assessment of effectiveness, feasibility, deliverability
Options appraisal for ensuring workforce
Status:
TIP7: FINANCIAL FRAMEWORK
Programme Board agreement of
Identify potential cost/ expenditure during Games
Status:
TIP8: ESTATES STRATEGY
Implementation plan for
Games requirements for Olympic
Implementation plan for Olympic Station
Implementation plan for Games Events Control
Status:
TIP9: IM&T STRATEGY
Workshop to identify planning assumptions, interdependencies
Scoping of IM&T
IM&T Strategy for ensuing
review
Status:
Legend
Awaiting approval
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage - requires intervention

OVERVIEW OF CORPORATE PROCESSES AND GOVERNANCE - TRANCH 1 PROGRESS REPORT

Performance Measurement

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


Corporate Processes Governance Project Portfolio Tranche 1 - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
PERFORMANCE MEASUREMENT
Status:
2008
2009
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
Workshops pre
PMC workshop
PMC report on BS out
BS prop to SMG
Project closure
31/08/2008
Legend
Planned milestone
Milestone achieved
Minor slippage but under control
Critical Slippage - requires intervention

OVERVIEW OF PROGRAMME: CORPORATE PROCESSES AND GOVERNANCE TRANCH 2 PROGRESS REPORT -

Map all Processes

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

Staff Administration

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

Real-Time Fleet Management Information

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

Re-Engineer Income Collection

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

PRF Handling and Processing

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

The Intelligent Trust

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

Foundation Trust Diagnostic Project

Carry out the diagnostic processes, which will enable the Trust to proceed to making a Foundation Trust application.

Electronic Expenses

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

Asset Tracking

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

Inventory Management

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

Performance Measurement Phase 2

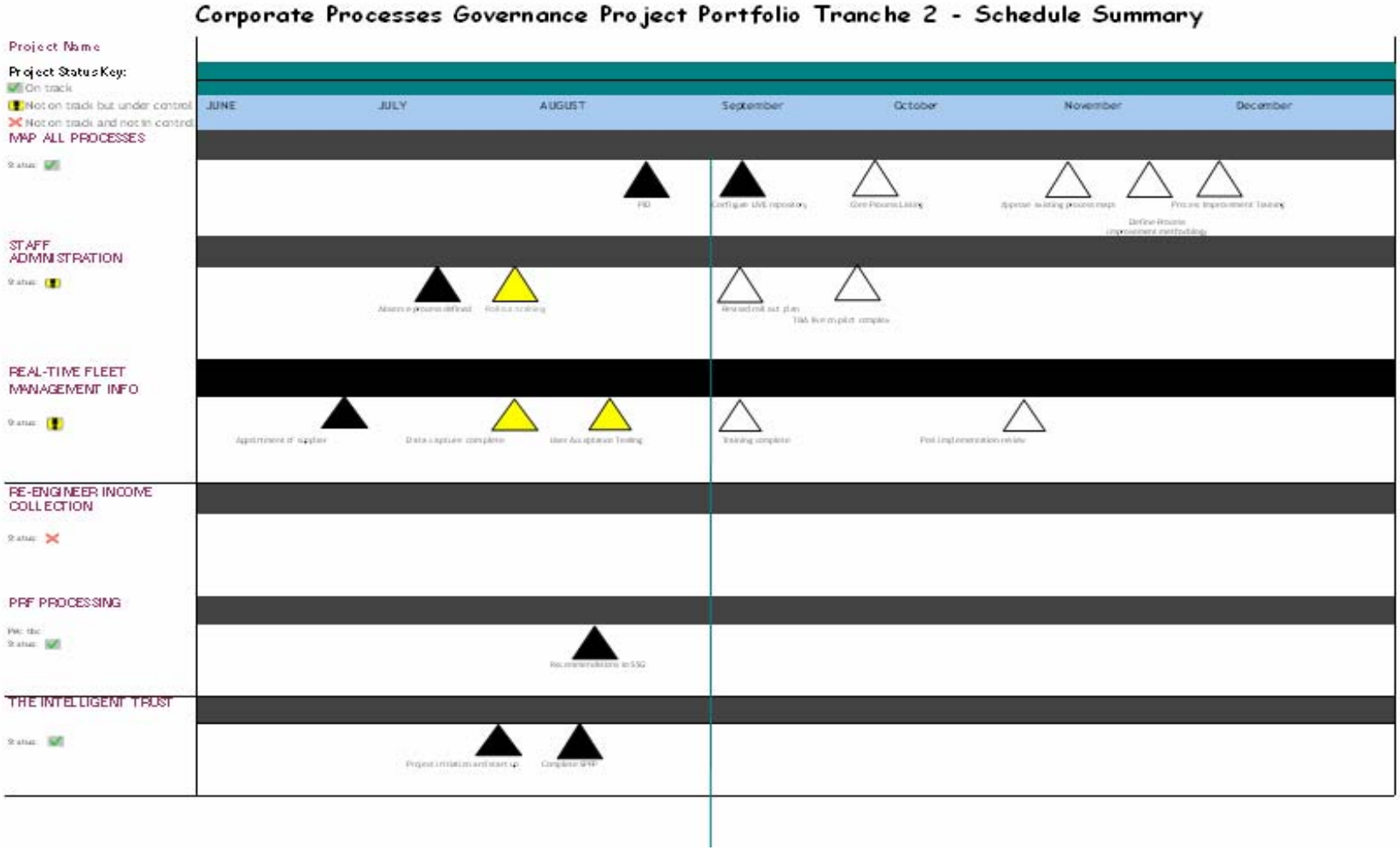
This project is to implement Performance Accelerator, which will provide a repository for all the evidence required by external agencies, e.g. Healthcare Commission.

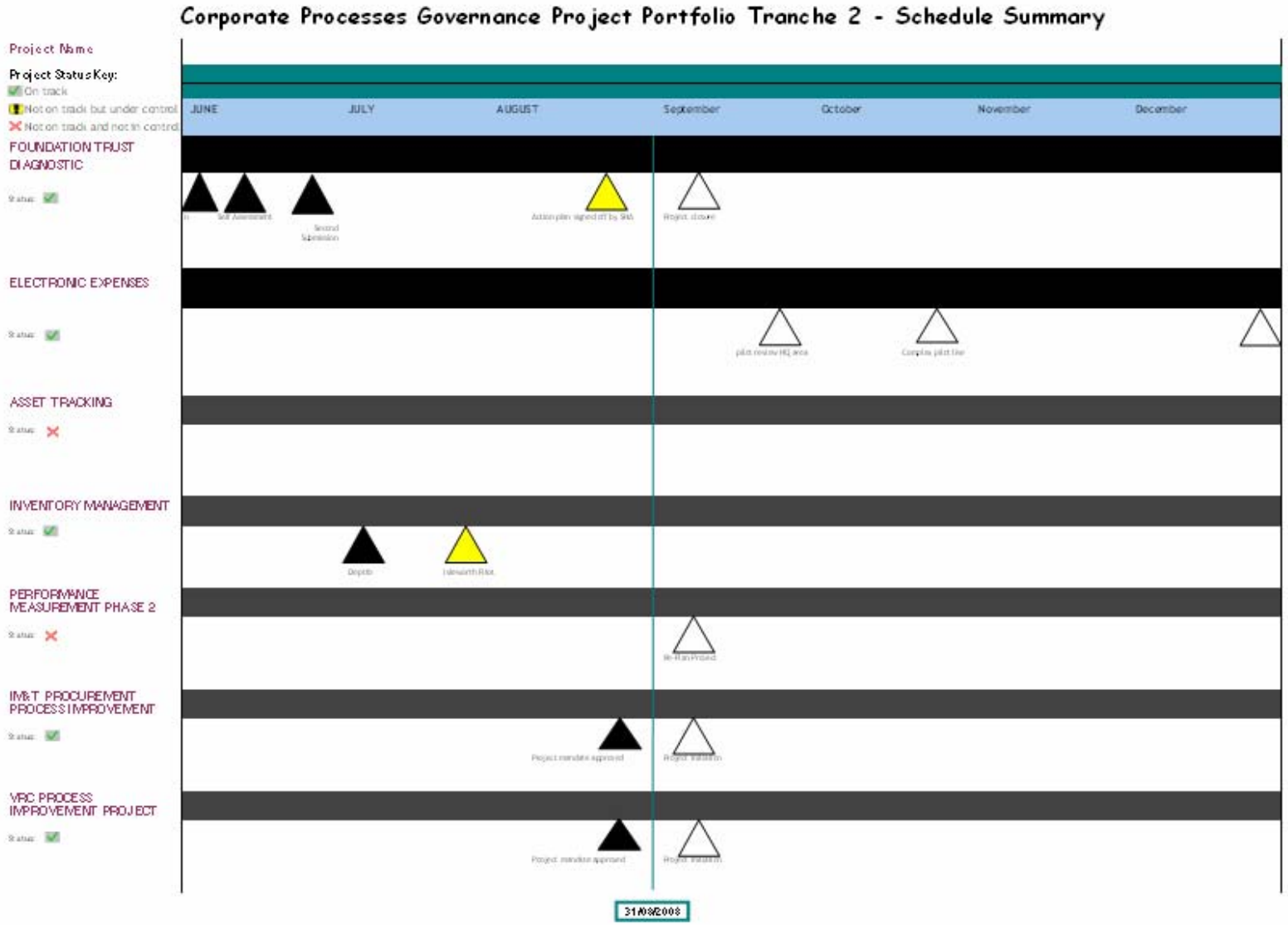
IM&T Procurement Process Improvement

This project will use process improvement techniques to document and analyse the existing process. The process will be redesigned with a clear customer focus and will include the collection of metrics to monitor the performance of the process into the future.

VRC Process Improvement

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


Corporate Processes Governance Project Portfolio Tranche 2 - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
JUNE
JULY
AUGUST
September
October
November
December
MAP ALL PROCESSES
Status:
PID
Configure LIVE repository
Core Process Library
Approve 'existing process maps'
Process Improvement Training
Define Process Improvement methodology
STAFF ADMINISTRATION
Status:
Absence process defined
Policies finalised
Revised roll out plan
T&A live in pilot complete
REAL-TIME FLEET MANAGEMENT INFO
Status:
Appointment of supplier
Data capture complete
User Acceptance Testing
Training complete
Post Implementation review
RE-ENGINEER INCOME COLLECTION
Status:
PRF PROCESSING
PM: tbc
Status:
Recommendations to SSG
THE INTELLIGENT TRUST
Status:
Project initiation and start up
Complete SHP


Corporate Processes Governance Project Portfolio Tranche 2 - Schedule Summary
Project Name
Project Status Key:
On track
Not on track but under control
Not on track and not in control
JUNE
JULY
AUGUST
September
October
November
December
FOUNDATION TRUST DIAGNOSTIC
Status:
Action plan signed off by SMT
Project closure
ELECTRONIC EXPENSES
Status:
ASSET TRACKING
Status:
INVENTORY MANAGEMENT
Status:
Depots
Isleworth Rise
PERFORMANCE MEASUREMENT PHASE 2
Status:
IM&T PROCUREMENT PROCESS IMPROVEMENT
Status:
Project mandate approved
Project initiation
VRC PROCESS IMPROVEMENT PROJECT
Status:
Project mandate approved
Project initiation
31/08/2008

Enclosure 14

London Ambulance Service NHS TRUST

Summary of the minutes
Charitable Funds Committee - 8th September 2008

1. Chairman of the Committee **Caroline Silver**

2. Purpose: **To provide the Trust Board with a summary of the proceedings of the Charitable Funds Committee.**

3. **Agreed:**

1. **The adjustment to the financial statements as set out in the report submitted by the Audit Commission and the contents of the draft management representation letter.**
2. **The LAS' Charitable Funds Annual Accounts and Annual Report, which will be presented to the Trust Board in November 2008 and submitted to the Charitable Commission by January 2009.**
3. **The 2008/09 budget for the LAS Charitable Funds; the planned deficit amounted to £44,688 which was in line with the stated policy of running down the funds over a period of 10-15 years.**
4. **To respect Mrs John O'Grady's request that £300 be donated to the Benevolent Society in honour of her late husband John O Grady.**
5. **That, following further investigation of the EDHI Foundation and clarification as to the funding the Trust may receive in 2008 and 2009, consideration will be given as to the best usage of the additional income to further the aims of the Trust.**

Noted:

6. **That the Audit Commission will be issuing an unmodified report including an unqualified opinion on the financial statements.**
7. **That the final Annual Governance Report will be presented to the Trust Board in November 2008**
8. **The contents of the annual Investec report and that the portfolio had a poor year, producing a total return of -12.2%.**
9. **That the Charitable Funds sub-group met in March and August 2008 and considered requests from members of staff for contributions to the cost of pool tables, fish tanks and garden furniture. The Fund contributed to the cost of holding the Trust's Cricket match.**

Recommendation:

THAT the Trust Board NOTE the minutes of the Charitable Funds Committee 8th September 2008.

`LONDON AMBULANCE SERVICE NHS TRUST

Charitable Funds Committee

1.30pm, Monday, 8th September 2008
Conference room, LAS HQ

Present:	Caroline Silver (Chair)	Non Executive Director
In Attendance:	Caron Hitchen	Director of HR & Organisation Development
	Michael John	Financial Controller
	Eddie Brand	Staff Side Representative
	Nicholas Row	Investec
	Christine McMahon	Trust Secretary (minutes)
Apologies:	Tony Crabtree	Head of Employee Services
	Eric Roberts	Staff side representative

01/08 The Minutes of the last Charitable Funds Committee 30th October 2008

Agreed: 1. The minutes of the previous meeting held 30th October 2008.

Noted: 2. Minute 10/07 (2), the sub-group will consider applications from staff who were leaving the Service involuntarily [22]

3. Minute 10/07 (4), the HR managers were updated on the staff entitlement in relation to the Fund as agreed at the meeting held in October 2007.

4. Minute 11/07 (5), the Financial Controller said that the uncashed cheques were due to teams/departments not holding Christmas parties and subsequently returning the cheques to Finance.

5. Minute 12/07 (3), the Financial Controller said the forms requiring signature in line with the Market in Financial Instrument Directive had been signed and returned to Investec

6. Minute 12/07 (4), that the Charitable Funds wished to continue its current investment strategy which included funds being invested in the Special Situations Fund which is a portfolio of shares. Nicholas Rowe said that a recent review of the Portfolio revealed that a small percentage of stock was held in Imperial Tobacco. The amount of the Fund available to invest in the stock market meant that the best return was probably achieved by continuing the existing investment strategy.

02/08 Audit Commission's annual governance report 2007/08

The Financial Controller presented the Audit Commission's draft Annual Governance report for 2007/08. He highlighted that the Audit Commission had identified a number of minor errors in the financial statements were rectified in the final annual accounts.

Approved 10. The adjustment to the financial statements as set out in the recommendations and the contents of the representation letter on behalf of the Charity

Noted: 11. That the Audit Commission will be issuing an unmodified report including an unqualified opinion on the financial statements.

12. That the final Annual Governance Report will be presented to the Trust board in November 2008.

[22] **(e.g. when they have to take early retirement due to capability or ill health, and would not be entitled to claim their pension and would be eligible to claim from the Fund).**

03/08 Annual Investec Report

Nicholas Rowe of Investec presented the Investment Adviser's report to the Committee. He highlighted that the equity markets (and the portfolio) had struggled over the year with the impact of the credit squeeze proving to be greater than expected. However, since the end of the period under review, markets have recovered to a small degree, but it remains to be seen whether this marks the bottom or is a short term rally in a longer term bear market.

Noted:

1. **The contents of the annual Investec report and that the portfolio had a poor year, producing a total return of -12.2%.**
2. **That the investment policy of the LAS' Charitable Fund will remain unchanged for the next 12-18 month but will be kept under review. If necessary a telephone conference may be arranged to discuss the merit of changing the Charitable Fund's investment policy.**
3. **That the Charitable Fund's funds were invested via holding in the Investec UK Special Situations Fund (formerly known as the UK Value Fund) which has an investment approach based on a contrarian view on the timing of buy and sell decision.**

04/08 2007/08 Charitable Funds Annual Accounts and Annual Report

The Financial Controller presented the annual accounts and annual report to the Committee. He highlighted that the deficit of £35k was less than the budgeted sum of £45k this was due in part to higher than usual donations being received from an organisation called the Edi Foundation.

The Committee was informed that, to date, the Charitable Funds has received £5,500 from the Edi Foundation which upon investigation was found to be a Pakistan based charity whose founder wished to make donations to the 'best ambulance service in the world'. Although there was no formal notification of the grant the communication received thus far suggests that the total donation may amount to £25,000 over a two year period.

Following discussion it was suggested that the Foundation be contacted and additional information obtained as to the nature of the donation and confirmation of the total amount. ACTION: Trust Secretary. It was considered highly unlikely that there was any sinister objective behind the donation to the LAS but it would be prudent for the Trust to undertake further investigation.

Approved:

1. **The LAS' Charitable Funds Annual Accounts which will be presented to the Trust board in November 2008.**
2. **The annual accounts and annual report will be submitted to the Charitable Commission by January 2009.**

Noted:

3. **That the Fund incurred a deficit for the year of £35k (£37k deficit in 2006/07) with income received amounting to £21k (£15k in 2006/07) and the value of investment as at 31 March 2008 was £318k (£416k as at 31 March 07.**

05/08 Charitable Funds Management Accounts 2007/08

The Financial Controller presented the 2007/08 Management Accounts for the Charitable Funds.

He highlighted that there were less claims received in respect of Christmas Amenities than previous years which did not tally with the figures provided by the Electronic Staff Record system; 3,096 staff in 07/08 compared to 3,422 staff in 6/07 with ESR showed 3,946 staff in post in 07/08. The Financial Controller was asked to check whether the decrease was due to the decision not to have a corporate event at Christmas. ACTION: Financial Controller.

When the fund is promoted via the Routine Information Bulletin in the late autumn attention will be drawn to the Christmas amenities fund. ACTION: Trust Secretary

Noted:
1. **The 2007/08 Management Accounts report for the Charitable Funds that showed a favourable variance against budget of £10,387 due to income being higher than budgeted by £6,432 and expenditure being lower than budged by £3,955.**
2. **The movement on Investment was £97,588 since 31 March 2007, comprising of a fall in value of £50,048 and disposals of £47,540. This is based on the value of Investment held as at the 31st March 2008.**

05/08 Draft Charitable Funds budget for 2008/09

The Financial Controller presented the draft Charitable Funds budget for approval. The budget was drafted assuming investment income and donations will be lower than last year; the income for 2008/09 was determined using the average income for the last three years. The possible income from the Edi Foundation was not included as there was no guarantee of receipt.

Approved:
1. **The 2008/09 budget for the LAS Charitable Funds**

Noted:
2. **That the planned deficit amounted to £44,688, this was in line with the stated policy of running down the funds over a period of 10-15 years.**
3. **That there will be no increase in the contribution to staff parties or other events held around Christmas (£8 per head, permanent staff only) as the review which was undertaken in 2007 demonstrated that the LAS' Charitable Fund was relatively generous in comparison with equivalent funds for other NHS/public bodies.**

06/08 Report from sub-group

The Trust Secretary briefly outlined the work undertaken by the sub-group since October 2007. The sub-group met twice in March and August 2008 and considered a number of requests for contributions towards a wide range of goods which generally improved the environment of station complexes.

The Committee considered the suggestion that some of the additional funding be used as seed money for the work being undertaken which will enable the Trust to support Ghana to develop its ambulance service. The Committee did not feel this would be an appropriate use of the money which was being donated to the LAS. The HR Director said the proposal would be considered by the Senior Management Group in 2009/10 when the resource requirements would be known.

The Committee considered the request by Mrs John O Grady that instead of receiving a gift in recognition of her husbands long service (30 years service) that an equivalent sum be donated to the Benevolent Fund Assistant Director in his honour. The Assistant Director, Employee Support Services, supports this request. The Committee felt that, although it was unusual situation, the Fund should respect Mrs O Grady's wishes and authorised the transfer to the Benevolent Fund.

Agreed:
1. **To respect Mrs John O Grady's request that £300 be donated to the Benevolent Society in honour of her late husband John O Grady.**
2. **That, following further investigation of the EDHI Foundation and clarification as to the funding the Trust may receive in 2008 and 2009, consideration will be given as to the best usage of the additional income to further the aims of the Trust.**

Noted:
3. **That the sub-group met in March and August 2008 and considered requests for contributions to the cost of pool tables, fish tanks and garden furniture. The meeting in August agreed to support the annual Cricket**

match as in previous years it had support pool tournaments and five a side football.

4. **That when advertising the Charitable Funds attention would be drawn to the support offered to events that promoted health and well-being (football, cricket etc) as well as social events (i.e. Christmas parties).**

07/08 **Any Other Business**

There was no other business

Date of next meeting: 2pm, 28th July 2009

The meeting concluded at 2.25pm

Enclosure 15

London Ambulance Service NHS TRUST

Summary of the minutes
Audit Committee - 8th September 2008

3.	**Chairman of the Committee**	**Caroline Silver**
4.	**Purpose:**	**To provide the Trust Board with a summary of the proceedings of the Audit Committee.**

3. **Agreed:**

1. **The workstreams being undertaken to ensure the Trust complies with the requirements of the International Financial Reporting Standards (IFRS).**
2. **Amendments to the Audit Committee's terms of reference.**
3. **A number of amendments to the Risk Management Policy**
4. **That the Committee's meeting on 10th November will include a review the Trust's External financial reporting process (e.g. FIMS).**

Noted:

5. **That the Audit Commission will be giving an unqualified opinion on the Trust's 07/08 annual accounts.**
6. **The contents of the Internal Auditors reports, which gave assurance on Standards for Better Health; Debtors; Accruals and pre-payments but highlighted the issues of non-compliance revealed by the Records Management audit of the handling of Patient Report Forms, and the measures being taken by Management to address those issues.**
   The Chairman of the Audit Committee said there was a theme emerging from the internal audits undertaken suggesting that corporate policies and procedures were not being complied with throughout the organisation.
7. **The contents of the Local Counter Fraud Service (LCFS) report, there was a substantial amount of work in progress. Two local proactive exercises were undertaken since the last Audit Committee meeting: Trust on call arrangements and Volunteer Drivers Arrangements.**
8. **The contents of the Assurance Framework which has been updated using the evidence complied by the Standards for Better Health Group; work is being undertaken as part of the preparation for FT status to closely align the Assurance Framework with the business activities of the Trust.**
9. **That a review of Senior Management Expenses for 2007/08 found that, in general, all AMEX expense were correctly submitted with supporting invoices and, where appropriate, included in the hospitality register**
10. **That in October 2008 the NHSLA will be assessing the Trust against Level 1 of the Risk Management Standards for Ambulance Trusts.**
11. **That the Healthcare Commission will publish the 2007/08 ratings in October 2008, and also the new healthcare standards for 2009/10.**
12. **The agreed scope of the audit of CAD 2010 being undertaken by the Audit Commission as part of its 2008/09 workplan. It was anticipated that there will be no overlap of the work being undertaken by the Audit Commission and the Gateway Review team.**
13. **The declarations of hospitality by the Chairman and the Director of Communications. That there no waiving of the Standing Orders since the Committee met in June 2008.**

Minutes/oral reports received from:
Clinical Governance Committee, 4/08/08 and Risk, Compliance & Assurance Group 20/08/08.

Recommendation:

THAT the Trust Board NOTE the minutes of the Audit Committee 8th September 2008.

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

Monday, 8th September 2008

Present:	Caroline Silver	Non-Executive Director (Chair)
	Sarah Waller	Non-Executive Director
	Brian Huckett	Non-Executive Director
Apologies:	Roy Griffins	Non-Executive Director
In Attendance:	Peter Bradley	Chief Executive
	Mike Dinan	Director of Finance
	Michael John	Financial Controller
	Stephen Moore	Head of Records Management & Business Continuity
	Christine McMahon	Trust Secretary (Minutes)
	Chris Rising	Bentley Jennison
	Sue Exton	Audit Commission (until 3.10pm)
	Dominic Bradley	Audit Commission
	David Foley	Local Counter Fraud Specialist

31/08 Minutes of the last Audit Committee meeting held 16th June 2008 and Matters Arising

Agreed:

1. **The minutes of the last Audit Committee meeting held on 16th June 2008.**

Noted:

2. Minute 17/08 (1)**: the Trust was still awaiting a decision by HRMC regarding the subsistence provision.**
3. Minute 17/08 (3)**: further to the recommendation contained in the Audit Commission's 2007/08 governance report, the Finance Director said that to date 16 of the 31 PCTs have signed the 2007/08 Service Agreements; work is on-going to have the remaining agreements signed by both parties. ACTION: Finance Director**
4. Minute 17/08: **the Finance Director tabled the agreed scope of the work to be undertaken by the Audit Commission in regard to CAD 2010. The Finance Director said that the Board's Adviser on the CAD 2010, Carrie Armitage, was aware of the proposed audit by the Audit Commission. It was anticipated that there will be no overlap of the work being undertaken by the Audit Commission and the Gateway Review team.**
5. Minute 18/08**: the debate regarding the provision for the Mercedes Lease in the 2007/08 annual accounts was concluded.**
6. Minute 20/08 **referred to an internal audit report concerning CTAK resilience as 'a work in progress which would be reported to the Audit Committee later in the year'. The Trust Board in November will receive a report on the recent problems experienced with the CTAKsystem and an update on the Trust's Business Continuity arrangements.**

32/08 Risk Management Policy

The Committee reviewed the Risk Management Policy which contained the Audit Committee's terms of reference.

Agreed:

1. **The Audit Committee's terms of reference with the following amendments:**

- **Page 23: re. attendance, paragraph beginning the Chief Executive to become second paragraph instead of third; new third paragraph – delete reference to Chief Executive and sentence to start 'Other executive directors'**
- **Page 24: Duties i.e. governance, internal audit etc to be listed under item 6 rather than as separate headings.**
- **Page 13: … ensures that the Trust Board via the Audit Committee is kept informed on issues.**

2. **That the following amendments be made to the Risk Management (RM) Policy:**
   - **Page 3: amend the paragraph stating that RM provides a process which will allow the Service to improve upon the high quality of service already being provided….. and the statement that the RMP is the 'strategy' for the LAS**
   - **Page 4: delete 'provide a safe environment and facilities for patients, employees and visitors', and 'maximise the resources available for patient services and care'.**
   - **Page 4: delete reference to 'problem' in paragraph beginning 'in identifying the context.' The Chairman of the Audit Committee said that risks were not problems; they were simply risks that an organisation has to manage.**

Noted:

3. **The establishment of the Claim and Liability Review Group, whose terms of reference were recently approved by the RCAG**
4. **That SMG will review and approve any final amendments on 17th September prior to the Trust making a submission to the NHSLA prior to the Level 1 assessment scheduled for October 2008.**

33/08 Planning & Preparation for International Financial Reporting Standards (IFRS)

All public bodies are being required to prepare their annual financial reports using IFRS for the year ending 31st March 2010 and to prepare comparative figures for 2008/09 in IFRS format.

The Financial Controller highlighted the work undertaken to date to identify what impact the IFRS would have on the Trust. The significant areas of change for the LAS will be the accounting treatment of: property leases; segmental reporting; financial instruments; annual leave carried forward; ambulance leases and inventory.

In response to a question from the Chairman of the Audit Committee the Financial Controller said that to date there were no areas of concern identified. The Director of Finance said it was possible that the restatement may have a negative impact on the Trust's financial negotiations with Commissioners which would need to be added as part of the commissioning process. The Trust was working closely with the DH and the SHA to fully understand the possible financial consequences for NHS trusts. The Chairman of the Audit Committee said consideration should be given as to whether the introduction of IFRS represented a financial risk for the Trust. ACTION: Financial Director.

A lot of detailed work will be undertaken in the next six weeks so as to fully ascertain the impact in financial terms on the Trust. The Audit Committee will receive an update at its next meeting on the progress with preparation for the implementation of the IFRS. ACTION: Financial Controller

Agreed:

14. **The work streams going forward as outlined in the report presented by the Financial Controller.**

Noted:

15. **That training in respect of IFRS will be primarily focussed on the Finance Team and the Estates team as they would be most directly**

affected by the introduction of IFRS. The provision of training to other departments will be kept under review.

16. **That the accruing for annual leave will be undertaken using a manual system as the Trust currently records annual leave using two systems. In due course one system, PROMIS, will hold the details of all staff.**
17. **That the Trust will work closely with the Audit Commission in respect of the restating of 2008/09 accounts, including the balance sheet in line with IFRS.**

34/08 Audit Commission

Sue Exton, Audit Commission, referred the Committee to the draft Annual Letter which drew together the findings of the other reports and highlighted the issues that have previously been discussed with the Committee. The key messages from the Audit Commission included:

- The issue of the provision of the Mercedes lease was resolved prior to the audit opinion on the financial statements being issued on 20th June 2008;
- That the Trust achieved a surplus of £398,000 for 2007/08 and met its key statutory financial performance targets, continuing its record of sound financial management;
- The Trust had proper arrangements in place to secure value for money in the use of resources;
- The Trust has made improvements to its performance under the Auditor's Local Evaluation (ALE), but the Board should continue to monitor progress and outcomes against the various plans in place to further improve the Trust's performance.

The Audit Commission made two recommendations:

- Monitor the Mercedes lease provision, revising the calculation of this liability as the timing and the amounts involved become clearer in 2008/09
- Implement the Trust's planned actions in 2008, including an early self assessment, against the Key Lines of Enquiry (KLOE) criteria, to further improve the Trust's performance under the ALE.

ALE: in response to a question from the Chief Executive, Sue Exton said that the attainment of the highest score for the ALE required 'something extra' or a notable practice not seen elsewhere. The attainment of 3 reflected that the Trust has good systems in place to deliver value for money. Sue Exton said that she would send the Chief Executive a paper outlining the assessment criteria used to ascertain a Trust's rating. ACTION: Sue Exton

Noted:

1. **That the Audit Commission will be giving an unqualified opinion on the Trust's 07/08 annual accounts.**
2. **The contents of the Audit Commissioners' reports, completing the 2007/08 audit plan:**
   - **Draft 07/08 ALE report including the recommended improvement areas;**
   - **Final Accounts Memorandum;**
   - **Draft 07/08 Annual Audit letter;**
   - **2007/08 audit progress report.**
3. **The Auditor's Annual Letter will be presented to the Trust Board in November.**

35/08 Internal Auditor's report

Chris Rising of RSM Bentley Jennison presented the Internal Auditor's report which contained the following finalised reports:

- Standards for better health: good processes established to monitor progress with the achievement of these throughout the year;

- Debtors: only one 'merits attention' recommendation, this represented a very positive outcome for the Trust;
- Accruals and pre-payments: three 'merits attention' recommendations which would enhance current processes and represented a very positive outcome for the Trust.
- Records Management Audit: the audit identified a number of instances of non-compliance with Trust policies and procedures at a sample of stations visited. The audit focussed on the processes carried out in the completion, management and distribution of Patient Report Forms (PRFs). The three 'significant' recommendations and two 'merits attention' recommendations were accepted by Management.

  The PRF Project Group was set up in response to the findings of the audit; it recently made a number of recommendations to the Senior Management Group (August 2008) concerning the management of PRFs. The Project Group's recommendations (which included management action being taken to ensure compliance and training for station staff) were accepted. Work is on-going to ensure that the Trust's policies and procedures were adhered to and a follow up audit will be undertaken in 2009.

The Chairman of the Committee queried why there had been a delay in presenting the final report; the work was initially undertaken in October and the report received by Management in 2007. She requested that, in future, there was no undue delay in presenting internal auditor's final reports to the Committee.

The Chairman of the Audit Committee said there was a recurrent theme emerging from the Internal Audits in regards to non-compliance with corporate policies and procedures. It was recognised that the findings of the Records Management (PRF) audit was yet another example of the difficulties involved in managing a dispersed organisation such as the LAS in comparison with an Acute hospital. In an Acute hospital it was easier to ensure compliance with policies and procedures, which was further reinforced by a continuity of clinical care between clinicians and patients. It was one of the cultural issues that the Trust was seeking to address through the implementation of New Ways of Working.

Noted:
1. **The contents of the reports, in particular the issues of non-compliance highlighted by the Records Management audit of the handling of Patient Report Forms, and the measures being taken to address those issues.**
2. **The client briefing re: new commissioning assurance framework**

35/08 Audit Recommendations Database

The Committee reviewed the report that outlined progress with implementing recommendations; as at 8/09/08, 18 had been completed, 12 were underway and 1 had not yet started. The latter referred to PTS having detailed policies and procedures in regards to responsibilities of central services, Extra Contractual Journeys , contracted journeys and excess journeys; the Finance Director said work had commenced to implement recommendations regarding PTS.

Noted:
1. **The contents of the report, including the summary of:**
   - **Reports in draft (medical devices, budgetary control, record management, business continuity and payroll),**
   - **Audits that had commenced but not yet completed**
   - **Audits planned but not yet started.**
2. **That the presentation of the implementation of the Auditor's recommendations will be reviewed so as to make the report more transparent.**
3. **That the Trust recently experienced problems with the Electronic Staff Records (ESR) and this will be reported as part of the Business Continuity update to the Trust Board in September.**

36/08 Report of the Local Counter Fraud Specialist (LCFS)

David Foley, who has taken over from Robert Brooker as the Local Counter Fraud Specialist, presented two reports to the Committee: the Progress report for the LCFS workplan 2008/09 (April-August 2008) and a Fraud Risk Assessment for the LAS written by Robert Brooker.

Noted:

1. **That there is a substantial amount of work in progress which is either awaiting responses from management or awaiting final drafts for completion. The work plan for LCFS will be completed prior to the end of the financial year;**
2. **That two local proactive exercise were undertaken: Trust on call arrangements and Volunteer Drivers Arrangements. Reports have been submitted to Management for consideration;**
3. **The details of three current investigations of possible fraud;**
4. **The findings of the Fraud Risk Assessment and the key recommendations concerning Assets, Complaints and Litigation, Contracts, Finance, Gifts and Hospitality, Facilities and IT.**

37/08 Assurance Framework

Stephen Moore, Records Management and Business Continuity, presented the Assurance Framework which had been update using the evidence complied by the Standards for Better Health Group. The Assurance Framework included the controls in place to manage the twenty-five most serious risks (with the highest risk score) currently held on the Trust's Risk Register. The Assurance Framework is considered by the Audit Committee and the Trust Board twice a year.

Noted:

1. **The report contained some minor errors which would be corrected i.e. updating the names of the risk leads.**
2. **That the reference in the report to 'investigating a benefits or a reward scheme' referred to recognising/rewarding in some way members of staff who do not have Road Traffic Accidents (RTAs).**
3. **That the Assurance Framework would be enhanced by the inclusion of assurance provided by external bodies such as the NHSLA etc.**
4. **That work is on-going as part of the preparation for FT status to closely align the Assurance Framework with the business activities of the Trust.**

38/08 Review of Senior Management Expenses

With the Chief Cashier, the Finance Director undertook a review of the Senior Management Group's Expenses for 2007/08 and found that, in general, all AMEX expense were correctly submitted with supporting invoices and, where appropriate, included in the hospitality register.

Noted:

1. **The findings of the review and the recommendations on how the current processes could be improved:**
   - **Sign-off procedures to include approval by either Chief Executive or Director of Finance**
   - **Updated procedure to be issued to SMG with specific emphasis on invoice/receipt completeness;**
   - **That the Chief Cashier will provide quarterly analysis of expense compliance which will be reviewed by the Trust Secretary for hospitality compliance.**
2. **That the Finance Director was reviewing the current arrangement and where appropriate issuing purchase cards rather than credit cards.**

39/08 Update re. HCC/NHSLA

Noted:
1. **That, in October 2008 the NHSLA will be assessing the Trust against Level 1 of the Risk Management Standards for Ambulance Trusts. Work is on-going to ensure the Trust can evidence that the necessary policies and procedures were in place.**
2. **That the HCC will publish the 2007/08 ratings in October 2008 and also the new standards for 2009/10 against which Trusts will be measured.**

40/08 Standing Committee Items

Noted:
1. **The declarations of hospitality by the Chairman of the Trust Board and the Director of Communications.**
2. **That there no waiving of the Standing Orders since the Committee met in June 2008.**

41/08 Draft minutes of the Clinical Governance Committee

Sarah Waller presented the draft Clinical Governance Committee minutes. The Committee reviewed its terms of reference, amongst the changes were that the Committee would meet 4 rather than 6 times per annum and that the meetings will be held in the afternoon to facilitate attendance by the Assistant Director of Operations. The Committee also approved the revised format of the Area Governance Report which ensure it become a more informative document. The Committee received presentations concerning two strategies, Long Term Conditions and Older People, and an update on obstetrics from the Trust's Consultant Midwife Adviser.

Noted: The draft minutes of the Clinical Governance Committee, held 4th August 2008

42/08 Draft minutes of the Risk Compliance and Assurance Group (RCAG)

The Chief Executive presented the draft RCAG minutes. The Group discussed the recent problems experienced with CTAK and arrangements in place to use the Fall Back Control (FBC) Room. It was recognised that although the FBC does not fully mirror Emergency Operations Centre (EOC) it could be used to provide a service if required.

Noted: The draft minutes of the RCAG meeting, 20th August 2008.

43/08 Audit Committee work plan and timetable for meetings in 2008.

Agreed:
1. **That the Committee's meeting on 10th November will start at 9.30am and be held at Loman Street. Matters to be addressed will include a review the Trust's External financial reporting process (e.g. FIMS).**
2. **That the Committee will review the proposed revisions to the Standing Orders and Financial Instruction prior to the Trust Board in November.**

Noted:
3. **That the draft agenda for the Committee's November meeting will be shared with the auditors before the meeting; the auditors will have a 10 minute pre-meeting with the Committee in March 2009.**
4. **That the Committee will review the criteria of the ALE (KLOE) and have a discussion as to how it could improve its performance.**

44/08 Any Other Business

There was no other business

Date of next Audit Committee meeting: 9.30am, 10th November 2008, Loman Street.

Meeting finished at 4.25

Enclosure 16

London Ambulance Service NHS TRUST

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

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

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

3. Agreed:

1. Revised terms of reference (Risk Management Policy (agenda) includes the revised version).
2. The revised format of the Area Governance reports which will be used for all Area Governance reports from October 08 onwards.
3. The two strategies, Older People and Long Term Conditions, which were subsequently presented to the SMG (13/08/08). They will be presented to the Trust Board in September for ratification.
4. That the key clinical performance indicators will be included in the Balanced Scorecard being produced for the Trust.
5. That from 2009/10 the LAS will switch to relying solely on National Strategic Tracing Service (NSTS), to track survival of patients who have suffered an out of hospital cardiac arrest. This will enable comparisons to be undertaken between ambulance services in respect of cardiac arrest outcomes.
6. That risk ID 71: *Not learning and changing practice, following receipt of complaints, due to inadequately trained officers or any other cause* should be proposed to the RCAG for downgrading rather than deletion. ACTION: Trust's risk matrix to be used to assess what the amended risk grading.
7. That risk ID 211: *Drug errors and adverse events not being reported* should not be deleted but was to remain on the Risk Register at current risk level as there was insufficient evidence for deletion
8. That risk ID 133: *Risk of potential legal action/negative publicity due to inadequate processing of safeguarding children referrals* should not be deleted. It was to remain at current risk level and will be reviewed at the Committee's next meeting.
9. That risk ID 20: *Failure to fully complete the PRF causing data not to be captured for analysis and feedback to staff* should not be downgraded as the Trust's target for CPI audit was 95% and 68% was the current average rate of compliance.
10. That the new risk '*Misuse of the LA4H Single Responder Handover form*' will be proposed to the RCAG for inclusion on the Trust's Risk Register with a risk rating of 12 (significant).

Noted:

11. That posters will be placed in ambulances advertising the use of lost property bags
12. That work was being undertaken in regard to a Memorandum of Understanding between the LAS and Helicopter Emergency Medical Service (HEMS). The two organisations currently have a Service Level Agreement and information sharing arrangements are in place.
13. That the Trust was in the process of recruiting a Diversity Manager.
14. The contents of the Area Governance Reports
15. The contents of the Medical Director's report which included a detailed update regarding infection control; interviews were being held for an Infection Control Co-ordinator.
16. The contents of the Consultant Midwife Adviser's presentation regarding Obstetrics which advised that the London maternity service was under pressure and the measures that were being taken to support crews in respect of obstetrics.
17. The contents of the Training Activity report, April-June 08

Minutes/oral reports received from:
Infection Control Group (20th June 08); RCAG (21st May 08) and PPI Committee (17th July 08).

That the SfBH Group; the Clinical Steering Committee; CARSG; the Race Equality Strategy Group; the Complaints Panel and the Training Services Group have not met since the last CGC meeting (June 08).

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

London AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee (full)
9.00am, 4th August 2008, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director (until 12.30)
Sarah Waller	Non Executive Director
Ingrid Prescod	Non Executive Director
Dr Julian Redhead	Consultant, St Mary's (until 12.25)
Malcolm Alexander	Chairman,Patients' Forum Ambulance Services (London) Ltd (until 12.20)
Kathy Jones	Director of Service Development (until 12.30)
David Jervis	Director of Communications (until 12.30)
Nicola Foad	Head of Legal Services
John Wilkins	Head of Governance
Stephen Moore	Head of Records Management & Business Continuity
John Selby	Senior Health & Safety Adviser
David Selwood	Corporate Logistics Manager, Deputising for Head of Operational Support
Bill O Neill	Assistant Director, Operations Development
Margaret Vander	PPI Manager
Rachael Donohoe	Head of Clinical Audit & Research (until 11am)
Richard Webber	Deputy Director of Operations (until 11am)
Paul Woodrow	Assistant Director of Operations (ADO), South (until 11am)
Peter McKenna	ADO West (until 11am)
Jason Killens	ADO East (until 11am)
Lizzy Boville	ADO (until 11am)
Christine McMahon	Trust Secretary (minutes)

In attendance:

Paul Gates	Performance Improvement Manager (PIM) (East)**.**
Dr Anne Weaver	Consultant in Emergency Medicine and Pre-hospital care & Clinical Lead, HEMS (until 11.20)
Claire Garbutt	Policy Manager, Service Development Directorate
Andrew Lingen-Stallard	LAS Consultant Midwife Adviser.

Apologies

Gary Bassett	Complaints/ PALS Manager
Chris Vale	Head of Operational Support
Tony Crabtree	Assistant Director, Employee Support Services
Paul Tattam	Ambulance Operations Manager - D Watch
Jenny Goodridge	Interim Head of Governance

41/08 Minutes of the Clinical Governance meeting held on Monday April and June 2008

Agreed The minutes of the previous meetings held in April and June 2008.

42/08 Matters Arising

Noted: 1 *Minute 17/08:* the Medical Director said that interviews would be taking place on 20th August to appoint an Infection Control Co-ordinator.

2 *Minute 17/08:* Posters advertising the availability of lost property bags would be placed in ambulances. Any enquiries received by the PALS office regarding lost property will be referred back to the local AOM to resolve.

3 *Minute 18/08:* There was currently no Memorandum of Understanding between LAS & HEMS or between HEMS and other medical services in London. A project group will be meeting to discuss the creation of a Memorandum of Understanding between the two organisations; the Head of Records Management and Business Continuity is a member of

this working group. There is currently a Service Level Agreement between HEMS and LAS and there were information sharing arrangements in place.

4 *Minute 19/08:* the Clinical Handover policy was ratified by the Trust Board in May 2008.

5 *Minute 20/08:* the DVD, co-produced with the Metropolitan Police Service, 'Preventing death in custody' will be shared with the Trust Board in due course.

6 *Minute 22/08*: a Clinical Audit of Clinical Telephone Advice (CTA) calls was presented to the Trust Board in July 2008 part of the Medical Director's report. The Head of Clinical Audit asked that the audit undertaken by Sue Watkins be shared with CARU.

ACTION: Deputy Director of Operations

7 *Minute 23/08*: That an update regarding the implementation of the internal auditor's recommendations concerning drug management (specifically morphine) was considered by the Risk Compliance & Assurance Group in May 2008. The Internal Auditors will ensure that the Medical Director is involved when the follow up internal audit is undertaken in 2009/10. The Corporate Logistics Manager said that the internal auditors had been critical that the Trust's policies and procedures (of which there was no criticism) regarding the drug management were not being adhered to at complex level. The necessity of adhering to the Trust's policies and procedures had been reinforced with Ambulance Operation Managers (AOMs).

8 *Minute 25/08(4):* that the Director of Finance will be presenting a benefits realisation report to the Trust Board in September concerning the Invest to Save programme.

The Deputy Director of Operations said that caution needed to be exercised in stating that the Frequent Callers Project will save £2m as any money saved by not despatching ambulances unnecessarily will be reinvested in the LAS to improve health care for London. The Medical Director said that the PALS/Complaints office has recruited a Social Worker to work with patients who call the Service frequently. These callers generally have complicated medical and social needs and were often quite vulnerable individuals.

The Medical Director's report to the Trust Board in July 2008 stated that, since November 2007 182 cases involving people who were identified as frequent callers were closed, and there were 206 cases that remain outstanding. The Medical Director said that all but three complexes have nominated a representative to work with the PALS/Complaints office.

9 *Minute 30/08:* the Trust was in the process of recruiting a Diversity Manager. Sajjad Iqbal, previous LAS' Diversity Manager, was continuing to work with the LAS to prioritise work to be undertaken around diversity i.e. screening the Trust's policies and procedures in respect of the Equality Impact Assessment.

10 *Minute 30/08:* the Health & Safety Manager said that a review had been undertaken of LA52s and there were relatively few related to failings in the Make Ready process.

11 *Minute 30/08:* following up a question raised at the last meeting, the Assistant Director - Organisation Development said that he had authorised the LAS joining Stonewalls' diversity champions programme. Sarah Waller said she was satisfied the Trust was participating in a programme under the aegis of Stonewall rather than joining the organisation, which as a campaigning organisation, might have unintended consequences for the Trust.

12 *Minute 30/08*: the Deputy Director of Operations said that CTA were undertaking ethnicity monitoring.

43/08 Review Committee's terms of reference

The Committee reviewed its terms of reference and membership.

Agreed

1. **The terms of reference with amendments (attached)**
   - **That the quorate will comprise the Chairman and an Executive Director (the Assistant Medical Director will deputise if the Medical Director is unable to attend) and the Deputy Director of Operations (with an ADO deputising if necessary).**

- **That ADOs were now members of the Committee (full and core) and will present the area governance reports to the Committee with AOMs deputising when necessary;**
- **That the Director of Communications continue as a member of the full meeting;**
- **That annual clinical governance reports will be requested from Voluntary Aid Societies (such as St John Ambulance) and private providers. ACTION: Deputy Director of Operations**
- **BASICS will also be asked to provide the CGC with an annual clinical governance report. ACTION: Dr Redhead to liaise with the Chairman of BASICs.**

Noted:

2. **That in respect of the key performance indicators, the Head of Governance said these will be informed by the requirements of the Annual Healthcare Standards.**
3. **That the frequency of the Committee's meetings had been reduced from 6 to 4 per annum and the time of the meeting changed to Monday afternoons to facilitate attendance by the ADOs.**
4. **That policies and procedures presented to the CGC will be reviewed by the Senior Management Group (SMG) prior to being presented to the Trust Board for approval; these were policies which had been significantly amended and discussed/agreed by other fora as appropriate e.g. staff council. Equality impact assessments will have been undertaken in respect of these policies and procedures.**
5. **That an annual review will be undertaken as part of the Risk Management Strategy to ensure that the different committees/groups terms of reference complemented each other and there was no overlap.**
6. **That the reference to patient representative(s) was deliberate in that when the Trust becomes a Foundation Trust in 2009 it was hoped that a patient or a member of the Board of Governors may join the Committee.**
7. **That the Committee's Annual Clinical Governance report will be comprised of the quarterly clinical governance reports as these will outline the previous quarter's clinical achievements.**

44/08 **<u>Format of future general area governance reports</u>**

The Committee considered the proposed format of future area governance reports which had been informed by the discussions at the meeting of the working party in June 2008.

Agreed

1. **The proposed format drafted by Paul Gates, Performance Improvement Manager (PIM) (East).**

Noted:

2. **That, if possible, one page trend analyses report will accompany each of the area governance reports (similar to the performance trend reports received by the Trust Board).**
3. **That the Area Governance reports will not include material reported elsewhere e.g. complaints which were reported as part of the Risk Information Report.**
4. **That the Director of Service Development said that the Committee should primarily be focussing on areas of a *clinical* nature and queried whether all the reports received by the Committee met this criterion.**
5. **A template for the agreed new format will be circulated and in future all Area Governance reports will have a consistent content and appearance.**
6. **That the Clinical Audit department can provide Areas with data on the number of CPI audits taking place and the ensuing number of feedback sessions held.**

45/08 **Area Governance Report**

Control Services: the Deputy Director of Operations presented the Control Services Report and highlighted the following:

The level of compliance with AMPDS dropped from 97% to 96.25%; however the LAS continues to be a centre of excellence as it was above 95% benchmark. There were a number of issues that arose when Version 11.3 of AMPDS was uploaded onto the system and these have now been resolved**.**

NOTED that currently no clinical reviews were taking place as calls assessed as eligible for Clinical Telephone Advice (CTA) were transferred to experienced staff to resolve or to take a decision as to whether an ambulance was required; if the call was not deemed eligible for CTA a vehicle was despatched. The Medical Director said that a random selection of reviewers' calls should be formally reviewed, e.g. when PSIAM was not used, and there were judgements made as to whether calls were deemed to a Category A/B/C call as there were significant inconsistencies occurring.

The Medical Director said it would be interesting to see if there was a correlation between the Service being at REAP 3 and the level of complaints. It was recognised that delays in responding result in a higher number of complaints being received.

There have been a number of occasions when Area governance meetings have not taken place due to the Service being at REAP 3 (severe pressure). The Head of Legal Services suggested that governance could be included on the regular management meetings taking place in order to disseminate learning from complaints etc. The Head of Governance said that it was not acceptable to submit area governance reports with data incomplete with the REAP level stated as an explanation for the shortfall.

The Deputy Director of Operations said that learning was disseminated via the monthly newsletter; the most recent contained lessons learnt following a complaint and a SUI.

The Medical Director would like to see evidence of clinical development and training taking place. The Deputy Director of Operations said that discussions were being held with the Training Department concerning the appointment of a Clinical Trainer for Control Services and a financial bid was being drafted for a dedicated Clinical Trainer for the Control Services.

NOTED: the Category C response times which showed 54.35% received a response within 30 minutes; 30.7% within 31-60 minutes and 10.2% within 61-90 minutes with 4.2% over 90 minutes.

East Area: the PIM for East presented the report, the format of which reflected the discussion at the meeting of the CGC's working group in June 2008. He highlighted the following from the report:

Due to a lack of Team Leaders there was a fall in the number of Clinical Performance Indicators (CPIs) being reviewed; this was being addressed in the short term by members of staff who were on alternative duties being trained to undertake the task. In the meantime efforts were ongoing to fill the team leader vacancies.

Driving licence checks: there were currently 255 (32%) members of staff requiring their driving licences to be checked following their last inspection.

A Clinical Governance Case study was considered and the next area governance meeting will receive evidence that the actions arising from the complaint and ensuing claim were undertaken.

In response to the Medical Director's querying the use of an incident that took place four years ago as a case study, it was explained that the claim had only recently been settled. The actions arising from the original incident had been undertaken soon after the event and

evidence of their implementation would be considered at the next Area governance meeting.

Multi disciplinary forums in Areas: due to REAP 3 there has been little progress made in setting up these forums. Work was being undertaken to encourage these forums to take place and the Committee will be kept informed of progress.

NOTED: the minutes of the Clinical Governance Meeting (EAST) 1/05/08. The Head of CARU said that the minutes were very useful, particularly the inclusion of actions being taken to improve CPI performance.

South Area: Paul Woodrow, ADO South, highlighted the following from the South Area Governance reports prepared for April and May.

Despite recent performance pressures the South has been able to evidence compliance with a number of key performance indicators (the overall CPI compliance rate of 93%, slightly higher than the LAS average of 92%) and maintain the level of audits undertaken by Team Leaders with the number of feedback sessions being undertaken remaining high. In May the average Team Leader CPI completion rate across the South was 77% (LAS average was 68%). In May 171 CPI feedback sessions were undertaken against the LAS target of 179.

PDR: there was little activity in April and May, with only 4% of PDRs completed by the end of May 08.

The Deputy Director of Operations said that he was pleased at the number of feedback sessions that have been undertaken with staff following CPI audits, as this was a proven way of improving clinical care for patients.

Rest breaks: 64% of staff across the South received a form of rest break in May; the percentage of staff across the Area not receiving any form of break had risen slightly since April to 21%. 20% of all staff were opting to take breaks at the end of their shifts, down 7% from April's figures.

The Deputy Director of Operations said that he believed there was an under-reporting of rest breaks taking place as the reported figures did not tally with the level of allocation taking place. This matter was being investigated. According to the reported data 20% of staff did not receive rest breaks and were consequently finishing their shifts 30 minutes early which was a clinical risk for the organisation at the time of shift change over.

West Area Peter McKenna, the ADO for the West Area highlighted the following from his report:

CPI completion was 72% with a number of complexes underperforming; the ADO said that this was disappointing as there had been previously been an upward trend. Feedback to staff remains good and well ahead of target with 584 meetings against a planned 456 sessions being held.
At the last Area meeting there was a review of the most recent Information Risk report broken down for the West area. Those complexes that were doing well received recognition while those that were not doing well received assistance. It was noted that there was a downward trend in terms of the number of road traffic incidents; there was a robust process for dealing with repeat offenders involved in road traffic incidents.

In response to a question from the Chairman of the Patients' Forum Ambulance Services (London) Ltd the West ADO said that the reference to 25 days was the length of time taken by the Area to produce an outcome report for the Complaints/PALS department. There were no significant learning outcomes identified; attitude and behaviour continue to the main cause of complaint.

In response to a query raised by the Chairman of the Patients' Forum Ambulance Services (London) Ltd as how the Trust responded to these two forms of complaint continuing to be an issue, the Assistant Director, Organisation Development, said that the Trust will be

introducing a module centred on improving customer care. When recruiting the Trust was emphasising the urgent care work undertaken as well as the emergencies that required blue light responses.

46/08 Medical Director's Update

1 Healthcare Commission's review of Staffordshire Ambulance Service

The Committee received a summary of the findings of the Healthcare Commission's review which highlighted concerns regarding the management of medicines, the process for introducing new equipment, the management of First Responders; risk management and leadership style.

The Deputy Director of Operations said that the lessons learnt from the enquiry were being shared with LAS colleagues, particularly in regard to the implementation of the Community First Responders. The Head of Governance said that the management of First Responders was an area where evidence of risk management would be needed for the NHSLA assessment visit in October.

2 Achievement of Strategic Goals; scoring and setting priorities

Following the introduction of the Patient Care Development Plan in 1999 the members of the Committee undertook a self assessment exercise, looking at all the areas of development being undertaken across the Service. This considered the progress in both 'Achievement of Strategic Goals' and each area of work was scored from 0 (no progress) to 10 (strategic goals achieved), and alongside this a prioritisation score, looking at the initiatives which we intended to progress over the next five years. This was accepted as a consensus view at the time, but provided a 'best guestimate' which proved useful as we assessed progress at approximately six monthly intervals over the next six years.

With the introduction of assessments first by Commission for Health Improvement (CHI) and more recently by the Healthcare Commission this scoring exercise appeared to be superfluous. In 2005 the Clinical Governance Committee agreed to remove it from the agenda. The Medical Director asked whether, given that 'Standards for Better Health' addresses nationally set targets, the Committee wishes to use these goals as valuable markers against which progress against local clinically set targets can be measured.

AGREED: that key clinical performance indicator will be included in the work being undertaken by in respect of a Balanced Scorecard.

A workshop had been held to consider what measures should be included on the balanced scorecard and how they should be measured; it was hoped that representatives from Operations would be able to attend the next workshop scheduled for 14th August. The Deputy Director of Operations said that the Trust could consider including the 24 Healthcare Standards and measuring compliance against these on a quarterly basis.

3 Infection Control

Annual Programme and Plan: the Trust is in the process of producing an Annual Infection Control Programme as required by the Code of Practice for the Prevention and Control of Health Care Associated Infections. In addition an annual report is prepared by the Infection Control Steering Group for the LAS Trust Board.

Audit: *Essential Steps to Safe, Clean Care – Self Assessment Tool for Ambulance Services* The Department of Health provided a self assessment tool for Ambulance Services to assess their compliance with infection control measures As a result of the assessment, a number of actions were identified that will form the basis of the 2008/09 Infection Control Programme. The actions identified included: responsibility for Infection Control being included in all job descriptions; ensure Infection Control leads have appropriate training; formally develop an Infection Control Prevention Programme and record work carried out;

formalise systems to review policies and procedures every two years and review results of infection control audits and incorporate these in improvement plans

Quarterly Station Complex Audits: infection control audits were carried out on station complexes each quarter along with Health and Safety audits. These cover areas such as cleanliness of vehicles and premises, disposal of clinical waste, use of sluice facilities, and availability of protective equipment.

NOTED: that the First quarterly audit in June 2008 was commenced but insufficient data was received and it has been decided to simply instigate the second quarterly infection control audit. ACTION: ADOs were asked to encourage local AOMs to fully co-operate with the audit.

Infection Control Co-ordinator: the Trust will shortly carry out interviews for a newly established post of Infection Control Co-ordinator. The successful applicant will lead the implementation of the Trust's infection control programme and seek to embed best practice throughout the service. A key task will be the establishment of local infection control "champions" at station complex level to co-ordinate training and auditing.

Products and Facilities: the Infection Control Steering Group has initiated a range of projects to improve practical infection control arrangements. These include: disposable laryngoscope blades, masks and bacterial filters; disposable Bag and Mask kit; new safety cannula's; new latex free gloves and inoculation storage fridges purchased for local sites

Advanced Airway management

4 The JRCALC, after careful consideration, accepted its working group's conclusion that **"…paramedic intubation can no longer be recommended as a mandatory component of paramedic practice and should not be continued to be practiced in its current format",** and that "…for the majority of paramedics … greater emphasis should be placed on airway management using an appropriate supraglottic device (SAD)".

The LAS remains one of the services that currently expect trainee paramedics to undertake training in advanced airway management and achieve 25 intubations, under supervision, in the operating theatre environment. The LAS will continue to do this but will emphasise the importance of becoming competent in the placement and management of supraglottic devices, will stress the shift in anaesthetic practice and expect to see this mirrored in prehospital practice over time. The LAS will continue to insist that for all intubations, robust governance arrangements are in place; that a bougie is available for all attempted intubations and that not only is end tidal carbon dioxide monitored but that for patients transferred to hospital, a print out is handed over to the receiving clinical staff.

5 **NSTS and Out of Hospital (OOH) cardiac arrest figures**

Currently LAS cardiac arrest outcomes are collected from two sources: National Strategic Tracing Service (NSTS) records and hospital records. If a date of death is reported for a patient on NSTS, then the patient are recorded as 'dead' (this data is highly accurate). If there is no date of death, no assumption is made that the patient is alive as it may be that NSTS has not been updated. Instead attempts are made to track the patient through the hospital to obtain an outcome. If none is available, then the outcome is reported as 'missing'.

NSTS claim that if there is no date of death recorded, then it can be assumed that a patient is alive. If the LAS was to assume this, then our survival rate would increase because the majority of missing cases (with neither a date of death or an outcome status) would be assumed to be alive. So, at present our survival figure can be described as conservative.

NSTS obtains data from death certificates (formal notification) and GP/PCT records (informal notification) for patients who are registered. As the new PAS systems are rolled-out through the hospitals, hospitals will be able to add their outcomes data to NSTS. However, currently, only two hospitals in London are able to add data onto NSTS. It is

hoped by the end of 2008/2009 that 6 more hospitals will be on board and all remaining hospitals by 2009/2010 (source: personal communication between Gurkamal Virdi and an NSTS technical architect).

The question is whether the LAS should stop collecting hospital outcomes and rely solely on the information provided by NSTS. The difficulty for the Trust is that a small amount of the population will be missed – those that are visitors to the country, those not registered with GPs, where names are missing on the PRF, and where coroners' investigations have yet to be concluded. The LAS are unable to tell how much of the population this accounts for (because, for example, it is unknown whether or not our patients are registered with GPs).

If the LAS relied solely on NSTS and made the assumption that all patients with no date of death were alive, the figures could be inflated.

As part of the ambulance service objectives set by Peter Bradley, Utstein survival will be measured for all ambulance services in England. The aim is that from 2009/2010 ambulance services will use NSTS to collect cardiac outcomes and allow comparisons.

The Medical Director and the Head of Clinical Audit and Research were of the view that NSTS data is currently not robust enough to be used as the only source of cardiac arrest survival data collection and whilst the LAS should continue to use it to identify deceased patients, there can be no assumption that those with no date of death are alive. Rather, the LAS should continue to trace patients through hospitals and report them as missing if no outcome is found. It is better for the LAS to report consistent and conservative figures, rather than risk over inflating survival rates.

AGREED: that from 2009/2010 the LAS will switch to relying solely on NSTS to track survival of patients who have suffered an out of hospital cardiac arrest. This will enable comparisons to be undertaken between ambulance services in respect of cardiac arrest outcomes.

Medical Support to Control Services

6 Dr Fenella Wrigley has accepted the post of Assistant Medical Director, with responsibility for Control Services and will join the LAS in October.

Mental Health update

7 The Joint Agreement between LAS and MPS for conveying members of the public has now been signed off.

New Drugs

8 Clopidegrel trial: awaiting ethical approval from the London Chest. Anticipated go live from September 2008. Oral Morphine: supplies will be delivered next week and will be packed into paramedic bags from early August.

British Thoracic Society Guidelines for Emergency Oxygen

9 The LAS will implement the British Thoracic Society Guidelines for Emergency Oxygen use from 1st October. Colleagues in Emergency Medicine have been asked to bring this to the attention of staff working in their departments to ensure they are familiar with the implications of the changes.

10 **Feasibility studies:**

- Therapeutic hypothermia: LAS crews working from Fulham, Chiswick and North Kensington Ambulance Stations are trialling therapeutic hypothermia in patients with ROSC and a GCS of less than 9, in conjunction with the Emergency Departments at Hammersmith and Charing Cross Hospitals. 4 patients recruited so far, 2 of whom have survived to hospital discharge.
- CPAP: Crews working from the Whipps Cross Complex are trialling CPAP in patients presenting with acute LVF. 9 staff trained, used once in practice

- iGEL: selected staff at Pinner and Islington are trialling the iGel supra glottic device. Positive feedback in the main (75%)

47/08 **Clinical policies/procedures**

The Committee considered the 'Procedure for the Maintenance of the High Risk Address Register, Notification of High risk Addresses and Verbal Abuse Reporting' and 'Frequent Caller Policy'

Procedure re. High Risk Address specified the actions to be taken by ambulance personnel who have been physically assaulted, intimated or verbally abused in cases where an entry tin the High Risk Register may be appropriate.

Concern was expressed that people living in multi-occupancy dwellings (a converted house containing flats) might experience delays when they call the LAS to go to an address listed as a High Risk Address. Although this was something the Trust was mindful of, it also had to balance the health and safety of front line staff who were being asked to enter a building that had been the location of threats of violence against LAS personnel. Staff responding to such calls would be expected to undertake dynamic risk assessment on the scene and, if they felt it was necessary, await Police support before entering a building identified as being a high risk address.

The Trust was in the process of writing to members of the public who have been reported as being violent towards LAS personnel and the consequences explained to them. Letters will be sent to individuals informing them about the registry entry and they will be given the choice to pursue matters using the NHS complaints procedure or via application to the Information Commission. The notification letters will give notice that enquires about the including on the registry may be made to the PALS in the first instance. Entries on the Registry will be reviewed periodically to check that the information is still relevant.

The Management of 'Frequent Callers' policy sets out how those callers who call the LAS frequently, who often have complex health and social care needs, will be managed. The aim of the policy was to adopt a patient-centred approach by working across health and social care organisation boundaries. Positive outcomes should be appropriate car packages in place for the frequent callers and freeing up of resources.

Following discussion, it was suggested that the Management of Frequent Callers policy be re-presented to the Committee in October when further work was undertaken, for example a flow chart clarifying the process, and that it should be accompanied by a procedure explaining how the policy would be implemented. **ACTION: Head of Complaints/PALS.**

The Director of Communications said that the Head of Complaints/PALS had been working on the management of frequent callers for the last two years with some notable successes (previously reported to the Committee via the Risk Information Report). The Medical Director said that the work undertaken highlighted the multi-disciplinary work that was taking place as part of managing frequent callers who are often amongst the most vulnerable in society.

Agreed **1. The Procedure for the Maintenance of the High Risk Address Register, Notification of High Risk Addresses and Verbal Abuse Reporting which had been agreed by the Senior Management Group on 27th July 2008.**

Noted: **2. That the Management of Frequent Callers Policy will be re-presented to the Committee in October following some clarification regarding procedure.**

48/08 **Clinical Risk**

The Committee discussed the following proposed and existing risks.

New Risk: Misuse of the LA4H Single Responder Handover form

The LA4H was introduced to assist single responders (MRU, CRU,RRU) in completing clinical findings to allow a hand over to the attending ambulance; at the same time this new way of working
would reduce the need for a full PRF to be completed and therefore free the single responder sooner and therefore available to attend another call.

It has become clear that staff are not completing the form correctly (information is missing) and when a full PRF was required (Non conveyed, paramedic skills used & cardiac arrests) the form was not being used. It was also apparent that the LA4H are not being handed in at the end of shift so Team Leaders were unable to carry out CPIs.

The end results were that Management Information were unable to gain clear information and data, and the Clinical Audit Department was not obtaining good audit information (for example cardiac arrest data).

Agreed:

1. **That ID 71:** Not learning and changing practice, following receipt of complaints, due to inadequately trained officers or any other cause **should be proposed to the RCAG for downgrading rather than deletion. ACTION: Trust's risk matrix to be used to assess what the amended risk grading.**
2. **That ID 211:** Drug errors and adverse events not being reported **should not be deleted but was to remain on the Risk Register at current risk level as there was insufficient evidence for deletion**
3. **That ID 133:** Risk of potential legal action/negative publicity due to inadequate processing of safeguarding children referrals **should not be deleted. It was to remain at current risk level and will be reviewed at the Committee's next meeting.**
4. **That ID 20:** Failure to fully complete the PRF causing data not to be captured for analysis and feedback to staff **should not be downgraded as the Trust's target for CPI audit was 95% and 68% was the current average.**
5. **That the new risk '**Misuse of the LA4H Single Responder Handover form**' will be proposed to the RCAG for inclusion on the Trust's risk register with a risk rating of 12 (significant).**

Noted:

6. **Risk 296 '**exposure of staff to carbon monoxide fumes**' the wording of this risk was considered to be too general and it was suggested the description of the risk be amended so that it is more specific i.e. at scene of incidence.**

49/08 **Older Persons' Strategy and Long term condition strategy**

Claire Garbutt, Policy Officer, presented the above two strategies to the Committee, outlining the process undertaken and how they would be implemented.

Older People's Strategy: Older people can be a vulnerable population and often have special needs when accessing emergency and urgent care services. The objective of this strategy was to develop key priorities in older peoples ambulance care and set out the actions required to achieve these priorities over the following five years.

The following comments were made: the strategy was welcomed; it was suggested that the Trust consider working with such organisations as Age Concern in the implementation of the strategy and the reference to the involvement of Non-Executives as board champions be

omitted in future as the Chairman and the Board have not been in favour of board members leading on initiatives.

The Long Term Conditions Strategy set out to update the Trust's current strategy and outlined the LAS' approach working with those living with long term conditions. A significant number of the population live with long term conditions that at present cannot be cured but can be managed by medication and therapies. Examples include: asthmas; diabetes; epilepsy etc.

In the ensuing discussion it was suggested that when CTA resolves calls without despatching a vehicle a procedure be put in place to inform GPs about the treatment or advice given to their patient. The Medical Director said that the LAS was endeavouring to educate GPs about the additional services the LAS could provide to patients, particularly those that were treated by Emergency Care Practitioners (ECPs) e.g. screening for such long term conditions such as Type 2 Diabetes. Currently, when ECPs or other LAS members of staff treat patients and do not transfer them to hospital a copy of the PRF was left with them and it was the patient's responsibility to inform the GP. Sarah Waller suggested that a clinician to clinician letter or text could be drafted to inform the GP of the treatment administered and that this could be done centrally rather than by front line staff.

Agreed: **1. The two strategies: Older People's and the Long Term Condition.**

Noted:
2. That the strategies would be considered by the Senior Management Group prior to being presented for ratification by the Trust Board in September 2008.
3. The contents of the action plan that accompanied both strategies, which will be reviewed on a regular basis, and used to evaluate the implementation of the strategies and their continuing relevance.
4. That the strategies will be implemented as part of the Trust's Service Improvement Programme 2012.
5. That a Mental Health Strategy was being drafted and will be presented to the Committee in due course.

50/08 **Presentation: Midwifery Adviser to LAS**

Andrew Stallard-Lingen, Consultant Midwife Adviser, updated the Committee on the work being undertaken in respect of Obstetrics. The maternity services in London were under a lot of pressure.

One of the causes was the effects of immigration; in general immigrants have poorer health and economic circumstances; they also have a rising birth rate; they were often unable to understand or access services and they experience higher death rate in pregnancy

This was compounded by the NHS reconfiguration taking place in London; the shortage of midwives; the rising demand for home birth supported by the Women's choice agenda and the development of stand alone birth centres.

On a positive note there has been no change in maternal and infant mortality/morbidity rates and the evidence suggests it is safe to have a baby in London and the UK (Safer Births Report 2008, Saving mother's lives report 2007). However, the increase in the number of women who are in poor health means there are more risks in childbirth. The encouragement of choice as to where a woman gives birth is not underpinned by sufficient midwives to support women in the hospital or community.

Birthing at home or in the community may affect LAS transfer rates and this will need to be monitored. It was suggested that there may be possibly more transfers taking place, which were of less concern if midwife were present when the transfer was taking place.

The pressures on the midwifery service are likely to remain. The Government was seeking to recruit 4000 more midwives in next 3-5 years. However, the work force was aging and

40% of the 34,000 midwives in the UK were due to retire in the next 10 years. Maternity beds in the capital were at capacity with a high turn around rate and this was not likely to improve. The increased demands on service were likely to remain.

The experience of the LAS: the Service receives a high number of inappropriate calls for transport to hospitals by women experiencing normal labour; of the 30,000 Obs/Mat emergencies responded to by the Trust only 1 in 10 were serious or of real concern. Efforts were being made to education maternity units and pregnant women about the appropriate use of the ambulance service.

Work was being undertaken with LAS staff to emphasise the need for communication and reassurance and emphasising that a woman's birth choices should be respected. Staff were advised to undertake dynamic risk assessment, follow the guidelines relating to Obstetrics; if unsure, seek expert advice and document all findings

Issues that have arisen for the LAS include:

- London maternity units were closing to admissions due to capacity or staffing - so LAS transporting women long distances between units on divert
- Midwives requested inappropriately by crew
- Midwives requested appropriately but not attending or delayed due to staffing issues or staffing cover
- The LAS not dispatching ambulance when needed

The Trust employs a Consultant Midwife Adviser in order to manage the risks posed by Obstetrics. *His role includes: :*

- Advising LAS trust and Medical Director on midwifery issues
- Reduction of transport requested for normal labour through the use of AMPS codes, clinical advice teams use and training (Risk increases when filtering obstetric calls)
- Assisting PALS with issues and complaints
- Reviewing litigation cases
- Reviewing LAS Obstetric guidelines & procedures
- Discussing individual obstetric cases and advise LAS Staff (feedback)
- Reviewing Obstetric teaching module
- Teaching – practical hands on with skills and drills for staff
- Undertaking a review of Obstetric transport cases

Noted:

1. **The contents of the Consultant Midwife's report.**
2. **There has been increased litigation and damages paid to infants with brain and physical impairment**
3. **That CARU were undertaking an audit of Obstetric Emergencies**

51/08 **<u>Preparation for Annual Healthcheck 2008/09</u>**

Noted:

1. **That the Healthcare Commission will be publishing the 2007/08 results in October 09.**
2. **The report, tabled by the Head of Governance, that set out the indicators the Healthcare Commission will be using to assess compliance with the 2008/09 Annual Health Check.**
3. **That the new web-based governance tool, the performance accelerator, was being used to capture evidence of compliance with the NHSLA; ALE and the 2008/09 annual healthcheck.**
4. **That the report will be presented to the Senior Management Group in August 2008.**

52/08 **<u>Update re. compliance with NHSLA standards</u>**

The Committee was informed that the scoring criteria for the NHSLA risk management standards have changed. Trusts were now required to be compliant in seven of the ten

criteria within each domain; this has led to the LAS being non-compliant in domains which it had previously been compliant. A thorough gap analysis was undertaken to identify gaps in compliance and actions required to attain level 1 of the NHSLA's risk management standards. .

Noted:
1. **The current status of compliance which showed a number of policies and procedures as, compliant, not compliant or compliant but further work required.**
2. **That the findings of the gap analysis will be presented to the Senior Management Group in August 2008.**
3. **That some of the policies and procedures being reviewed in preparation for the NHSLA level 1 assessment will require ratification by the Trust Board in September.**

53/08 Reports from Groups/Committees

1 *Risk Compliance & Assurance Group – 21st May 2008*

Noted: The minutes of the RCAG meeting that took place in

2 *Infection Control Group – 20th June 2008*

Noted:
1. **The minutes of the Infection Control Group that met 20th June 2008.**
2. **That only 20% of the Quarter 1 Infection Control Audits were completed; it was hoped that the appointment of an Infection Control Co-ordinator will improve the response rate.**
3. **That information on Intra Venous (IV) inserted lines and Pandemic Flu will be added to the Infection Control Manual.**
4. **That there had been complaints from contractors that clinical waste was not being disposed of correctly. A bulletin will be issued to staff on this reminding them of the correct procedure.**
5. **That, as part of the Cleaner Hands Campaign, consideration was being given to members of staff being randomly tested to evidence the implementation of the training around cleaner hands. It was recognised that the task would be more challenging for the Trust, with its dispersed locations, to implement that for a hospital. It was suggested that the Safety Leads might be asked to take this forward on a local level. ACTION: Corporate Logistics Manager and Senior Health & Safety Adviser to discuss.**

3 *PPI Committee*

Noted:
1. **The minutes of the PPI meeting held 17th July 2008.**
2. **That the NHS Centre for Involvement has given very positive feedback about PPI developments in the LAS over the last year, particularly the introduction of Community Involvement Officers.**
3. **That a new post of PPI & Public Education Co-ordinator has been approved. Recruitment to the two Community Involvement Officer posts (Barnehurst and Chase Farm) was underway.**
4. **Those, as part of the Tower Hamlets project, training sessions have been arranged for expectant mothers in September. Get the Right Treatment - the health education pack designed with the PCT - won a London Health & Social Care Award. A training session in the use of this pack has been held with LAS staff, and a version for teenagers is being designed for roll-out in schools.**
5. **The LAS was a pilot site for a new national survey, looking at the experiences of Category C patients. Most patients in the pilot were**

satisfied with the service received, although there were some concerns about the quality of information given to patients by ambulance staff. It has been decided to wait for the findings of the full national survey (later this year) before taking any further action.

4 **Noted:**
1. **That the recent meeting of the Training Services Committee had focussed on the implementation of the 2008/09 Workforce Plan.**
2. **The contents of the Training Activity report, April-June 08**
3. **That when an update on the 2009/09 Workforce Plan was presented to the Service Development Committee in June one of the challenges facing the Trust was a lack of trainers. Sarah Waller suggested that the contents of the training activity report appeared to indicate that there was instead an over-supply of training places.**

Noted: **That the SfBH Group, the Clinical Steering Group, CARSG, the Race Equality Strategy Group; the Complaints Panel and the Training Services Group have not met since the last CGC meeting.**

54//08 **Dates of next meeting:**

Core: 2pm, 6th October 2008
Full: 2pm, 23rd February 2008

Meeting concluded at 12. 50

Enclosure 17

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 30th September 2008

Report of the Trust Secretary
Tenders Received

1. Purpose of Report

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

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

2. Tenders Received

There have been 2 tenders received since the last Trust Board meeting.

Croydon resurfacing
FM Conway Ltd Millane Contract Services Ltd Coniston Ltd
Frankham Consultancy Group

A&E E Ambulance conversion
U V Modular WAS Vehicles (UK) S MacNellie & Son

3. Use of Seal

There have been 6 entries, 119-124 since the last Trust Board meeting. The entries related to:

No. 119 Lease 69b Bounds Green Road N11 between the LAS and the London Borough of Haringey

No. 120 Lease & Licence for alterations for second floor Hannibal House, Elephant & Castle Shopping Centre between the LAS and Key Property Investments (Number Five) Limited.

No. 121 Assignment of Unit 28, Bermondsey Trading Estate, London between the LAS and Servicetec Limited.

No. 122 Lease of 32 Southwark Bridge Road, London between Equisys Plc and LAS

No. 123 3rd Floor Hannibal House, Elephant & Castle Shopping Centre between Key Property Investments (Number five) Limited and the LAS

No 124	Section 106 Agreements re. 164 Harlesden Road, London NW1 between the Mayor and Burgesses of the London Borough of Brent and the LAS.

4. Recommendations

THAT the Board NOTE this report regarding the receipt of tenders and the use of the seal

Christine McMahon
Trust Secretary

References

[i] DH – LTC background, accessed online on 02.01.2008 at http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_4128521

[ii] Primary diagnosis: 3 character 2006-07, HES online, accessed online on 02.01.2008 at http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=203; extracted codes sourced from "Disease coding from HES to assist with case finding" accessed online on 02.01.2008 at http://www.networks.nhs.uk/80.php

[iii] Ham, C. & Singh, D. (2006) *Improving Care for People with Long-Term Conditions: A review of UK and international frameworks* accessed online on 02.01.2008 at http://www.improvingchroniccare.org/downloads/review_of_international_frameworks__chris_hamm.pdf

[iv] DH – *Raising the Profile of Long Term Conditions Care* accessed online on 02.01.2008 at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

[v] DH – *The National Service Framework For Long Term Conditions,* accessed online on 02.01.2008 at http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/Long-termNeurologicalConditionsNSF/DH_4128647

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD

AUGUST 08 (MONTH 5)

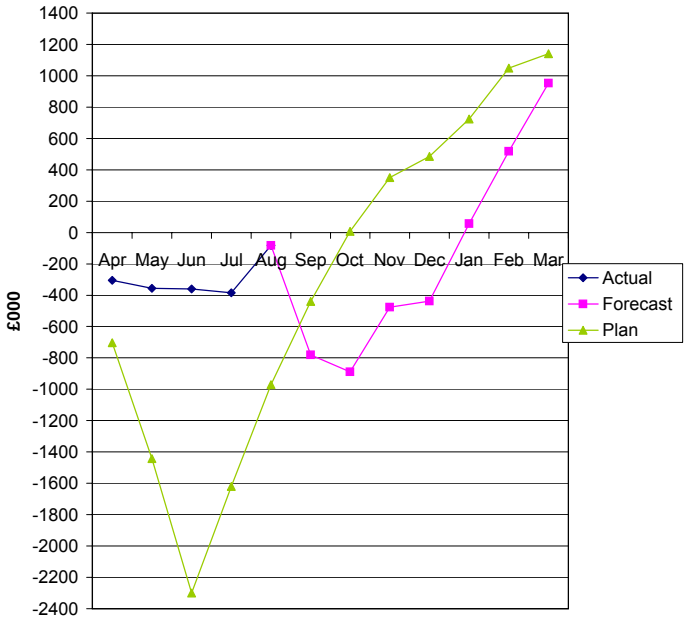
Contents:

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 31st August 08 (Month 5)

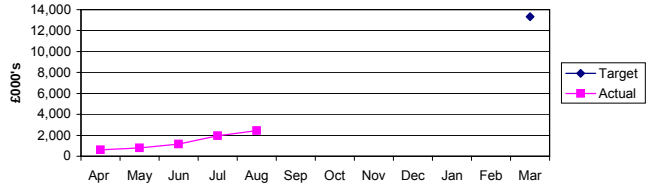
Income and Expenditure

Cumulative Net Financial Position

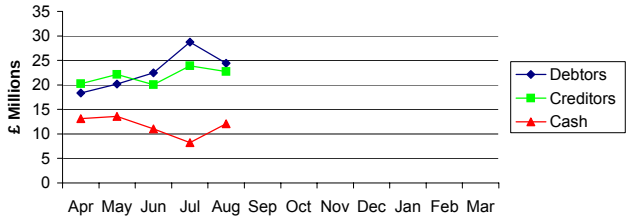


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	June	July	August	
Asset turnover ratio	1.99	1.99	1.99	●
Debtors % > 90 days	16%	2%	3%	●
A&E Debtor days	-0.12	8%	12%	●
PTS Debtor days	-7.58	51%	60%	●
PSPP NHS	82%	86%	90%	●
PSPP Non NHS	78%	85%	78%	●

Key Financial Indicators

	June	July	August
A&E Overtime (£000) / Day (Month)	£63	£53	£51
A&E Overtime (% of paybill)	12%	11%	10%
Subsistence (£000) / Day (Month)	£5	£6	£6
Subsistence per head £	£38	£49	£51
Third Party Transport expenditure / Day (Month)	£2,546	£4,573	£2,871
Total operational cost per incident	£252	£195	£166
A&E Gross Surplus (YTD) (% of Income)	19.9%	20.1%	20.8%
A&E Net Margin (YTD) (% of Income)	0.0%	0.0%	0.5%
PTS Gross Margin (YTD) (% of Income)	-15.4%	-13.2%	-11.6%
Cat B performance (cumulative)	84%	83%	82%

Financial Risks

	Overall risk rating	MED	●
1	Cat B Penalty imposed for not meeting activity targets	MED	●
2	Failure to manage A&E overtime within plan	MED	●
3	Fuel prices rise in excess of planned figures	HIGH	●
4	Failure to meet Trust CIP	LOW	●
5	PTS profitability less than forecast	MED	●

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31 August 2008 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	21,219	21,053	166F	105,799	105,266	533F	0.5%F	260,408	252,638	7,771F
Total Operational Costs	19,799	19,427	(372)U	101,059	101,357	297F	0.3%F	248,142	239,785	(8,357)U
EBITDA	**1,420**	**1,626**	**(206)U**	**4,739**	**3,909**	**830F**	**0F**	**12,266**	**12,852**	**(586)U**
EBITDA Margin	***7%***	***8%***	**-1%**	***4%***	***4%***	**1%**		***5%***	***5%***	**0%**
Depreciation & Interest	952	976	24F	4,657	4,880	223F	4.6%F	11,314	11,712	398F
Net *Surplus/(Deficit)*	**468**	**650**	**(182)U**	**82**	**(971)**	**1,053 F**	**(3.8%)U**	**952**	**1,140**	**(188)U**
Net Margin	***2%***	***-3%***	***5%***	***0%***	***-1%***	***1%***		***0%***	***0%***	***0%***

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending August 31st 2008

Year to Date

- For the YTD, income exceeds expenditure by £82k. The budgeted position to Month 5 is for expenditure to exceed income by £971k, hence there is a year to date favourable variance of £1,053k.
- Compared to plan there is a net surplus of £82k
- PTS is reporting a loss to date of £460k, against a planned surplus of £36k. The loss arises due to the excessive use of third party providers and a recovery program has been put in place to account for this.

Month

- In the month, income exceeds expenditure by £468k against a planned surplus of £650k resulting in an unfavourable variance in the month of £182k against budget.
- Additional Overtime Spend is currently being partially offset by reductions in other costs within the Trust.

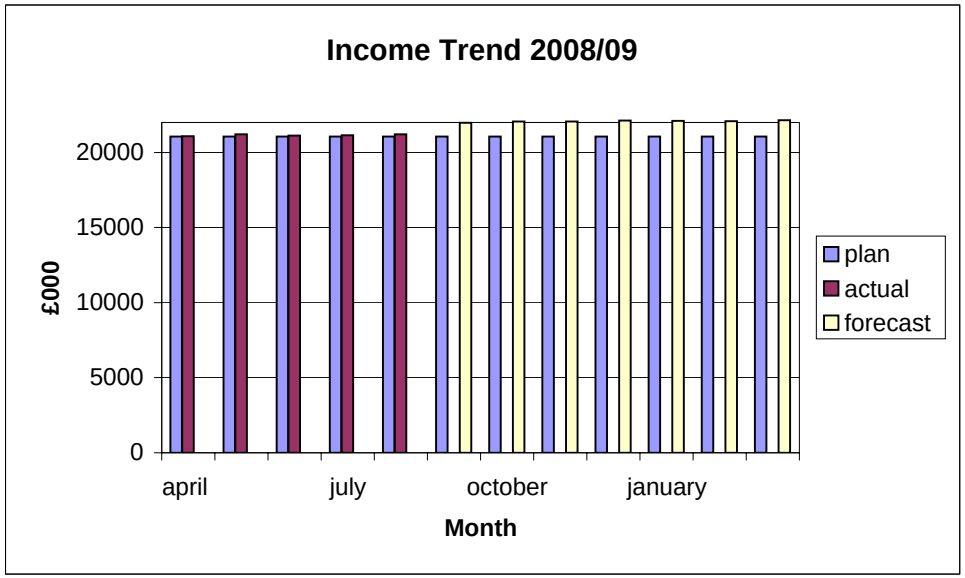
Forecast

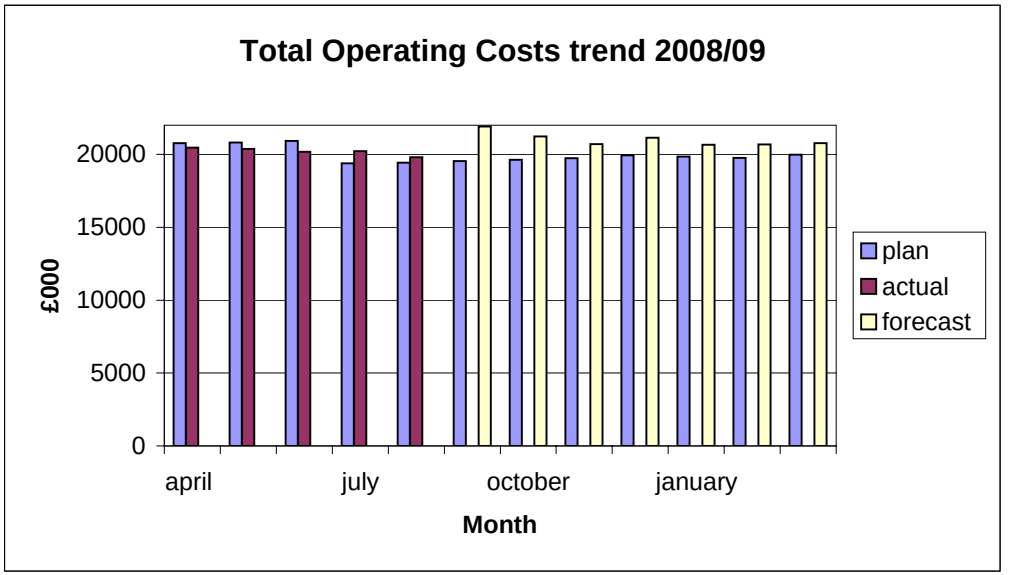
- The year end forecast is a surplus £0.952m against a planned surplus of £1.140m
- The total forecast expenditure for the Trust in July was £20.751m against previous forecast spend of £21.083m. The Month 4 forecast for Overtime in M05 was £1,228k compared to M05 actual spend of £1,556k this has meant an increased spend against forecast of £338k.
- Average additional Overtime spend is currently £1,803k per month being partially offset by reductions in other costs across the Trust.

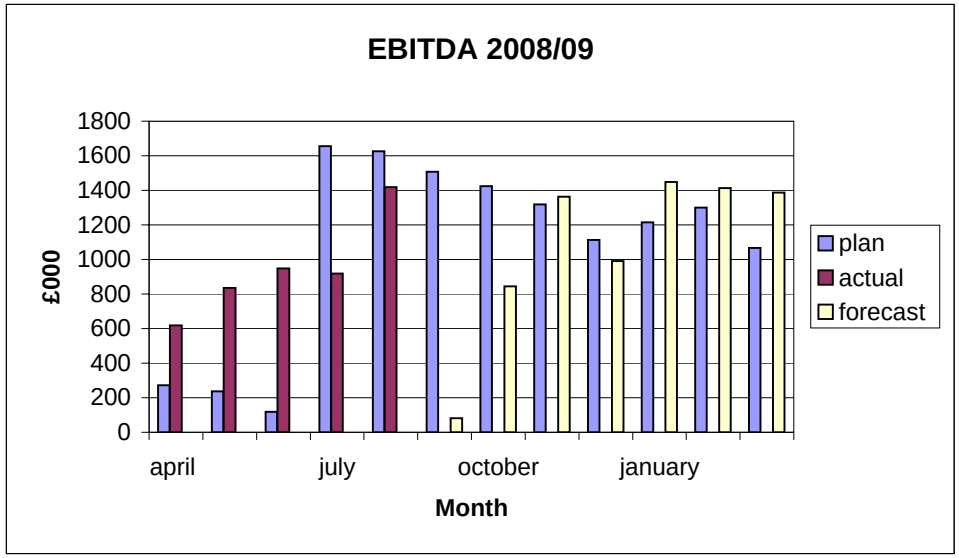
- **Key Assumptions in Forecast**
  - Reflects additional PCT Funding to £5.895m (assumed £3.100m in M04)
  - Non Pay Savings forecast of £0.961m
  - Decreased SPPP Provision £239k
  - Reflects additional Overtime and Incentive Spend to £5.895m (assumed £3.100m in M04)
  - Unfunded Overestablishment of workforce plan £448k
  - Estimated Slippage against workforce plan £847k
  - Funding for Training equipment for Hannibal House £483k
  - PTS Break Even

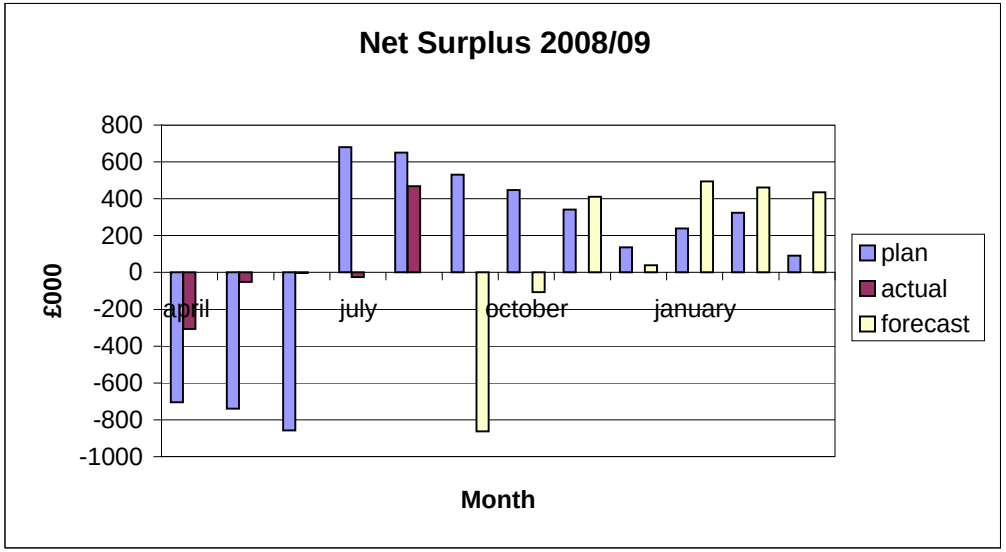
London Ambulance Service NHS Trust

Month 5 Trust Board report - forecast data









LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 August 2008 (Month 5)

£000s

	MONTHLY SPEND												
	April *Actual*	May *Actual*	June *Actual*	July *Actual*	August *Actual*	September *Forecast*	October *Forecast*	November *Forecast*	December *Forecast*	January *Forecast*	February *Forecast*	March *Forecast*	Total
Income	**21,086**	**21,217**	**21,130**	**21,147**	**21,219**	**21,984**	**22,069**	**22,066**	**22,133**	**22,109**	**22,096**	**22,153**	**260,408**
Pay Expenditure													
A&E Operational Staff	9,087	9,030	8,936	8,790	8,779	9,260	9,262	9,329	9,624	9,614	9,764	9,860	111,335
Overtime	1,910	1,994	1,897	1,647	1,566	1,934	1,289	1,289	1,289	967	967	967	17,716
A&E Management	966	963	976	996	978	1,036	1,038	1,043	1,039	1,035	1,035	1,035	12,138
EOC Staff	977	978	979	1,006	982	1,030	1,065	1,049	1,044	1,109	1,064	1,055	12,336
PTS Operational Staff	450	475	468	468	476	462	462	462	462	462	462	462	5,574
PTS Management	57	57	56	56	61	63	63	63	63	63	63	63	728
Corporate Support	2,345	2,672	2,304	2,539	2,581	2,578	2,666	2,645	2,724	2,734	2,730	2,810	31,328
Sub Total	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**16,363**	**15,846**	**15,880**	**16,246**	**15,983**	**16,085**	**16,252**	**191,156**
Average Daily	*526*	*522*	*521*	*500*	*498*	*545*	*511*	*529*	*524*	*516*	*574*	*524*	*524*
Non-Pay Expenditure													
Staff Related	223	251	369	207	258	361	369	327	417	323	359	353	3,816
Subsistence	343	44	149	193	200	176	166	156	156	141	136	131	1,905
Training	64	1	129	54	85	322	249	162	318	144	148	223	1,901
Medical Consumables & Equipment	450	537	410	498	433	607	612	383	388	460	481	506	5,766
Drugs	37	25	9	9	49	37	37	37	37	37	37	37	392
Fuel & Oil	415	455	440	450	399	432	437	443	438	443	438	443	5,233
Third Party Transport	213	183	76	142	89	131	124	119	114	104	104	104	1,503
Vehicle Costs	1,114	1,039	943	1,083	948	1,115	1,050	1,080	1,037	1,022	1,017	1,044	12,490
Accommodation & Estates	783	807	750	928	833	849	849	851	896	853	894	849	10,142
Telecommunications	558	517	718	397	510	533	720	661	545	564	564	563	6,848
Depreciation	577	577	675	630	610	609	616	616	616	616	616	616	7,374
Other Expenses	476	442	585	766	576	976	765	604	550	588	420	260	7,007
Profit/(Loss) on Disposal FA	0	0	12	0	1	0	0	0	0	0	0	0	13
Sub Total	**5,253**	**4,790**	**5,241**	**5,356**	**4,989**	**6,148**	**5,995**	**5,438**	**5,513**	**5,295**	**5,214**	**5,130**	**64,362**
Average Daily	*175*	*155*	*175*	*173*	*161*	*205*	*193*	*181*	*178*	*171*	*186*	*165*	*176*
Financial Expenditure	**348**	**309**	**276**	**313**	**340**	**336**	**336**	**336**	**336**	**336**	**336**	**336**	**3,937**
Average Daily	*12*	*10*	*9*	*10*	*11*	*11*	*11*	*11*	*11*	*11*	*12*	*11*	*11*
Monthly Expenditure	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**22,847**	**22,177**	**21,655**	**22,095**	**21,614**	**21,635**	**21,718**	**259,456**
Cumulative	**21,392**	**42,660**	**63,793**	**84,965**	**105,716**	**128,563**	**150,740**	**172,395**	**194,489**	**216,103**	**237,738**	**259,456**	
Monthly Net	**(306)**	**(51)**	**(3)**	**(25)**	**468**	**(863)**	**(108)**	**411**	**39**	**495**	**461**	**435**	**952**
Cumulative Net	**(306)**	**(357)**	**(360)**	**(385)**	**82**	**(781)**	**(888)**	**(477)**	**(438)**	**57**	**518**	**952**	

LONDON AMBULANCE SERVICE NHS TRUST

Comparison of Annual Forecasts at Month 5 and Month 4
As at 31 August 2008 (Month 5)

YEAR TO DATE

	Month 5	Month 4	Variance	Comment
Income	**260,408**	**259,162**	**1,247F**	Increase in income from PCTs and Other Income adjustments
Pay Expenditure				
A&E Operational Staff	111,335	109,963	1,372	Increase in Overtime Incentive Spend in line with additional funding
Overtime	17,716	16,116	1,600	Increase in Overtime Spend in line with additional funding
A&E Management	12,002	11,831	170	Movement of PIM from PTS Management
EOC Staff	12,336	12,564	(229)	Reduction in Forecast to bring in line with establishment and based on revised training and recruitment schedule
PTS Operational Staff	5,574	5,562	13	
PTS Management	865	1,028	(164)	Movement of PIM to A&E Management
Corporate Support	31,328	31,267	61	Increase due to SPPP spend approval and Increased Agency Forecast for Foundation Trust Project
Sub Total	**191,156**	**188,332**	**2,824**	
Non-Pay Expenditure				
Staff Related	3,816	3,656	160	Uniform forecast adjustment for increased recruits in the Workforce plan
Subsistence	1,905	1,961	(56)	Subsistence reduction now forecast in line with improving rest break management
Training	1,901	2,179	(278)	Reduction in cost of University course fees and revision of non core training spend
Drugs	392	403	(10)	
Medical Consumables & Equipment	5,767	5,678	89	Increase cost of ambulance for ambulance replacments
Fuel & Oil	5,233	5,476	(243)	Decrease in Fuel forecast in line with reducing fuel prices reflected in reducing Monthly cost to the LAS
Third Party Transport	1,503	1,431	72	Increased usage of Third Party for Urgent Care
Vehicle Costs	12,490	12,861	(371)	Insurance Liability adjustment and lower Vehicle maintenance costs
Accommodation & Estates	10,141	10,177	(36)	
Telecommunications	6,848	6,400	448	Approval of SPPPs spend £311k and additional spend on mobile telecoms (£100k) and Audivisual equipment (£50k)
Depreciation	7,434	7,373	61	Amortisation for software licenses
Other Expenses	7,004	8,151	(1,147)	Slippage on the workforce plan (£847k) plus Unfunded Overestablishment costs of Workforce plan (£448k) plus SPPP forecast and Non Pay savings adjustments
Profit/(Loss) on Disposal FA	13	12	(1)	
	64,420	**65,732**	**(1,312)**	
Financial Expenditure	**3,879**	**3,979**	**(99)**	
Total Expenditure	**259,456**	**258,043**	**1,413**	
Net	**-952**	**-1,119**	**167**	

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 August 2008 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*2007/08*	*Var to 2007/08*	*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	YTD Actual	YTD Actual	Forecast	Budget	Variance
Pay Expenditure												
A&E Operational Staff	8,779	8,765	(14)U	44,622	44,651	29F	0.1%F	40,582	4,040	111,335	108,890	(2,445)U
Overtime	1,566	560	(1,006)U	9,014	6,176	(2,839)U	(46.0%)U	4,827	4,187	17,716	9,772	(7,945)U
A&E Management	949	978	29F	4,742	4,871	129F	2.6%F	4,373	369	12,002	11,714	(288)U
EOC Staff	982	1,090	109F	4,921	5,451	531F	9.7%F	4,486	435	12,336	13,084	748F
PTS Operational Staff	476	434	(41)U	2,337	2,172	(165)U	(7.6%)U	2,323	14	5,574	5,212	(362)U
PTS Management	91	95	4F	425	475	51F	10.7%F	411	14	865	1,140	276F
Corporate Support	2,581	2,772	191F	12,441	13,004	563F	4.3%F	10,722	1,719	31,328	31,700	372F
	15,423	**14,694**	**(729)U**	**78,502**	**76,801**	**(1,701)U**	**(2.2%)U**	**67,724**	**10,778**	**191,156**	**181,512**	**9,645**
Non-Pay Expenditure												
Staff Related	258	278	20F	1,307	1,396	89F	6.4%F	1,046	261	3,816	3,362	(453)U
Subsistence	200	115	(85)U	842	575	(267)U	(46.4%)U	705	137	1,905	1,380	(525)U
Training	85	180	95F	333	889	556F	62.5%F	592	-259	1,901	2,195	294F
Drugs	49	43	(6)U	130	217	87F	40.1%F	153	-23	392	521	129F
Medical Consumables & Equipment	433	349	(84)U	2,329	1,743	(586)U	(33.6%)U	1,737	592	5,767	4,301	(1,465)U
Fuel & Oil	399	431	32F	2,159	2,150	(9)U	(0.4%)U	1,568	591	5,233	5,216	(16)U
Third Party Transport	89	63	(26)U	703	332	(371)U	(111.6%)U	318	385	1,503	793	(710)U
Vehicle Costs	948	1,012	64F	5,127	4,955	(172)U	(3.5%)U	4,463	664	12,490	11,801	(689)U
Accommodation & Estates	833	795	(39)U	4,100	3,973	(127)U	(3.2%)U	3,642	458	10,141	9,535	(606)U
Telecommunications	510	532	23F	2,699	2,747	48F	1.8%F	2,146	553	6,848	6,565	(283)U
Depreciation	611	652	41F	3,129	3,258	129F	4.0%F	2,473	656	7,434	7,819	384F
Other Expenses	574	936	362F	2,842	5,578	2,736F	49.0%F	3,550	-708	7,004	12,603	5,599F
Profit/(Loss) on Disposal FA	(1)	0	1	(13)	0	13F	0.0%F	14	-27	(13)	0	13F
	4,987	**5,385**	**398F**	**25,687**	**27,814**	**2,127F**	**7.6%F**	**22,407**	**3,280**	**64,420**	**66,092**	**1,672F**
Financial Expenditure	**342**	**324**	**(17)U**	**1,528**	**1,622**	**95F**	**5.8%F**	**1483**	**45**	**3,879**	**3,893**	**14F**
Total Trust Expenditure	**20,751**	**20,403**	**(348)U**	**105,716**	**106,237**	**520F**	**0.5%F**	**91,614**	**14,102**	**259,456**	**251,497**	**(7,959)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 August 2008 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	20,458	20,343	115F	101,830	101,715	115F	0.1%F	250,429	244,116	6,313F
Sector Services	12,890	11,480	(1,409)U	66,144	61,972	(4,171)U	(6.7%)U	155,164	145,040	(10,124)U
A&E Operational Support	1,158	1,214	56F	5,815	5,324	(491)U	(9.2%)U	14,646	12,994	(1,652)U
Control Services	1,447	1,516	69F	7,758	7,889	131F	1.7%F	18,299	18,472	173F
Planning and Specialised Ops	149	365	216F	911	1,835	923F	50.3%F	2,942	4,391	1,449F
Total Operations Cost	**15,644**	**14,576**	**(1,068)U**	**80,628**	**77,020**	**(3,608)U**	**(4.7%)U**	**191,051**	**180,897**	**(10,154)U**
A&E Gross Surplus/(Deficit)	**4,814**	**5,767**	**(953)U**	**21,202**	**24,695**	**(3,493)U**	**(14.1%)U**	**59,378**	**63,219**	**(3,841)U**
Gross Margin	23.5%	28.4%	(4.7%)U	20.8%	24.3%	-3.5%		23.7%	25.9%	-2.2%
Medical Directorate	77	87	10F	325	407	82F	20.2%F	937	1,015	78F
Service Development	53	68	14F	301	330	28F	8.5%F	795	831	36F
Communications	183	172	(12)U	805	839	34F	4.1%F	2,153	2,154	1F
Human Resources	1,075	1,679	604F	4,756	7,608	2,853F	37.5%F	19,245	19,224	(21)U
IM&T	925	998	73F	5,071	4,999	(72)U	(1.4%)U	13,024	12,368	(656)U
Finance	1,902	2,026	124F	8,892	11,035	2,142F	19.4%F	21,121	25,414	4,293F
Chief Executive	93	97	4F	510	484	(26)U	(5.4%)U	1,151	1,161	10F
Total Corporate	**4,308**	**5,127**	**818F**	**20,659**	**25,702**	**5,043F**	**(19.6%)U**	**58,426**	**62,168**	**3,742F**
A&E Net Surplus/(Deficit)	**506**	**641**	**(135)U**	**543**	**(1,007)**	**1,550F**	**153.9%F**	**952**	**1,051**	**(99)U**
A&E Net Margin	2.5%	3.2%	(0.7%)U	0.5%	(1.0%)	1.5%	-154%	0.4%	0.4%	-0.1%
Patient Transport Service	**(38)**	**9**	**(47)U**	**(460)**	**36**	**(496)U**	**(1376.6%)U**	**1**	**89**	**(89)U**
PTS Gross Margin	(5.0%)	1.3%	(6.6%)U	(11.6%)	1.0%	(14.0%)U		0.0%	1.0%	(1.0%)U
Trust Result *Surplus/(Deficit)*	**468**	**650**	**(182)U**	**82**	**(971)**	**1,053F**	**108.5%F**	**952**	**1,140**	**(188)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 August 2008 (Month 5)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	18,289	18,139	150F	90,446	90,696	(250)U	(0.3%)U	217,070	217,669	(600)U
HEMS Funding	11	11	(0)U	53	53	(0)U	(0.5%)U	127	128	(1)U
Other A&E Income	91	91	(0)U	454	454	(1)U	(0.2%)U	6,984	1,090	5,893F
Foundation Trust Income	27	16	11F	110	80	29F	36.3%F	261	192	69F
CBRN Income	899	897	1F	4,493	4,487	6F	0.1%F	10,784	10,769	15F
ECP Income	5	13	(8)U	131	64	67F	105.0%F	253	153	100F
BETS & SCBU Income	84	76	8F	404	380	25F	6.5%F	921	911	10F
A & E Long Distance Journey	34	37	(2)U	186	183	3F	1.6%F	454	439	15F
Stadia Attendance	101	89	12F	494	447	46F	10.3%F	1,072	1,074	(1)U
Heathrow BAA Contract	44	44	0F	222	222	(0)U	(0.0%)U	532	532	(0)U
Resus Training Fees	5	10	(5)U	10	49	(40)U	(80.4%)U	71	118	(47)U
Education & Training Income	685	686	(1)U	3,431	3,429	1F	0.0%F	8,713	8,231	483F
	20,273	**20,109**	**164F**	**100,432**	**100,544**	**(112)U**	**(0.0%)U**	**247,242**	**241,305**	**5,937F**
PTS Income	761	710	51F	3,969	3,551	418F	11.8%F	9,980	8,521	1,459F
Other Income	185	234	(49)U	1,398	1,171	227F	19.4%F	3,187	2,811	376F
Trust Result	**21,219**	**21,053**	**166F**	**105,799**	**105,266**	**533F**	**0.5%F**	**260,408**	**252,638**	**7,771F**

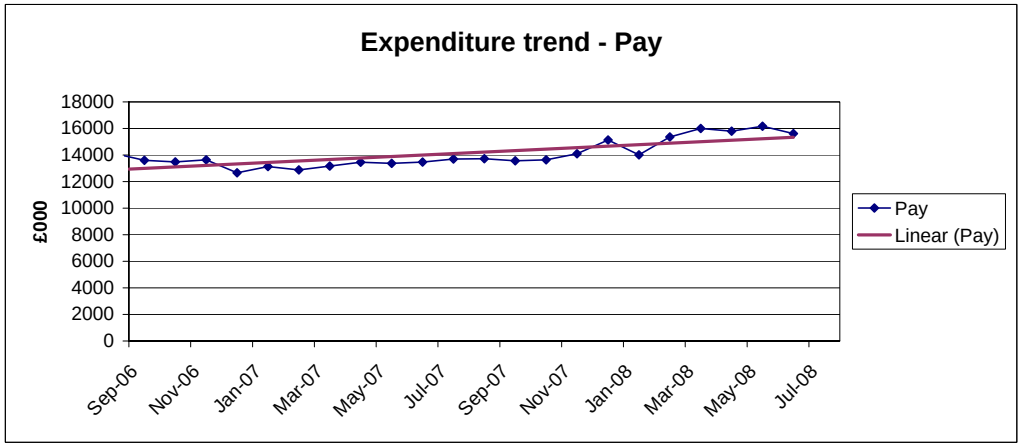
LONDON AMBULANCE SERVICE NHS TRUST

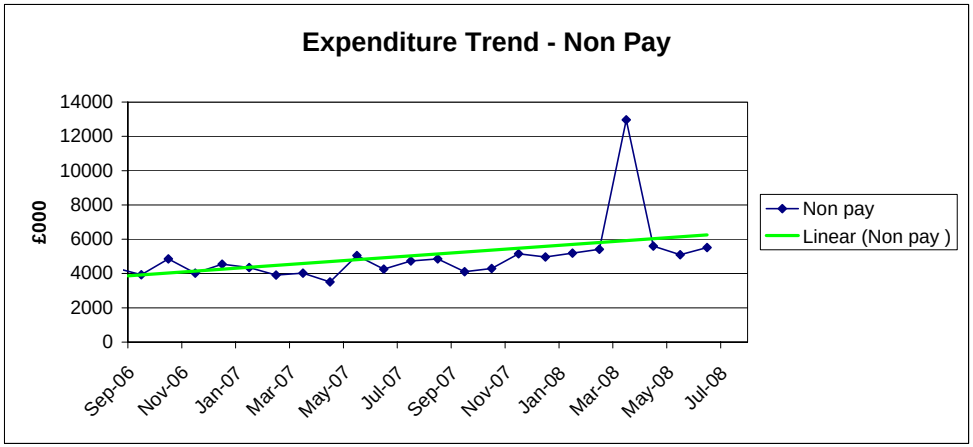
Expenditure Trends Including Last Year
As at 31 August 2008 (Month 5)

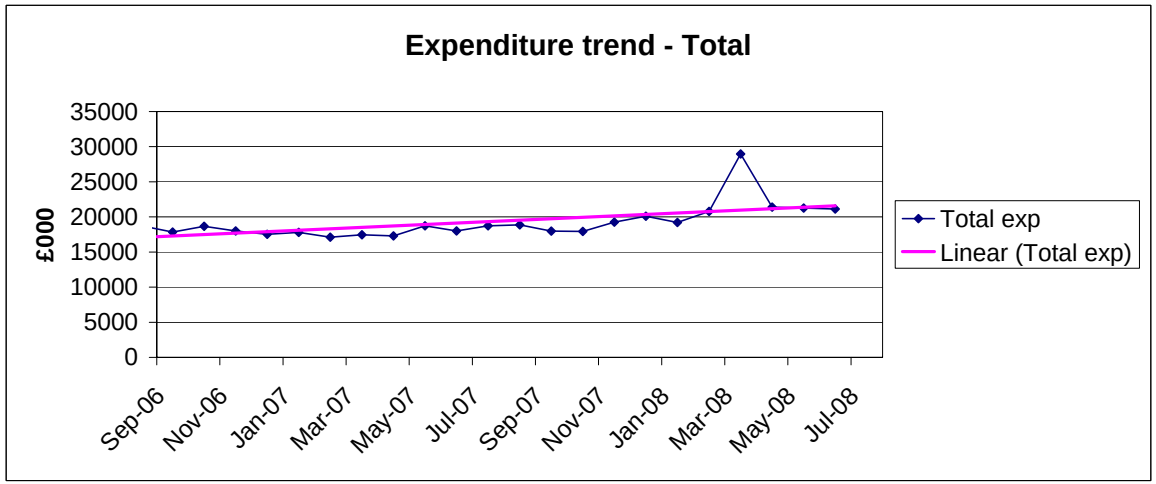
												Current Year	
	August	September	October	November	December	January	February	March	April	May	June	July	August
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**19,373**	**19,646**	**19,486**	**19,282**	**19,154**	**20,068**	**19,641**	**25,743**	**21,086**	**21,218**	**21,128**	**21,147**	**21,219**
Pay Expenditure													
A&E Operational Staff	8,440	8,018	8,088	8,113	9,149	8,227	8,468	8,677	9,087	9,030	8,936	8,790	8,779
Overtime	1,171	1,041	1,045	1,149	1,245	1,168	1,118	1,764	1,910	1,994	1,897	1,647	1,566
A&E Management	881	912	914	904	940	912	1,027	911	942	940	945	966	949
EOC Staff	899	936	920	909	985	954	953	946	977	978	979	1,006	982
PTS Operational Staff	128	457	465	442	487	462	466	459	450	475	468	468	476
PTS Management	94	86	80	87	87	85	84	88	81	80	86	87	91
Corporate Support	2,110	2,119	2,125	2,497	2,239	2,199	3,242	3,154	2,345	2,672	2,304	2,539	2,581
Sub Total	**13,723**	**13,569**	**13,637**	**14,101**	**15,132**	**14,007**	**15,357**	**15,999**	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**
Average Daily	*443*	*438*	*440*	*470*	*488*	*467*	*495*	*516*	*526*	*522*	*521*	*500*	*498*
Non-Pay Expenditure													
Staff Related	189	205	213	198	189	271	231	386	223	251	369	207	258
Subsistence	173	150	175	182	188	244	190	209	343	44	149	193	200
Training	158	24	116	173	30	119	123	258	64	1	129	54	85
Drugs	37	19	46	55	36	22	46	28	37	25	9	9	49
Medical Consumables & Equipment	479	341	312	387	396	510	533	1,814	450	537	410	499	433
Fuel & Oil	319	301	342	373	405	406	391	417	415	455	440	450	399
Third Party Transport	113	55	94	92	84	133	161	173	213	183	76	142	89
Vehicle Costs	925	895	977	1,614	1,681	1,091	1,034	2,895	1,114	1,039	943	1,083	948
Accommodation & Estates	805	605	757	751	543	922	832	1,702	783	807	750	927	833
Telecommunications	407	576	201	489	516	477	677	2,129	558	517	718	397	510
Depreciation	510	523	579	534	542	524	524	706	597	597	695	630	611
Other Expenses	736	461	184	57	109	214	425	2,051	476	442	585	766	574
Profit/(Loss) on Disposal FA	1	0	0	2	0	0	0	29	0	0	12	0	1
Sub Total	**4,850**	**4,107**	**3,999**	**4,903**	**4,719**	**4,932**	**5,167**	**12,797**	**5,273**	**4,810**	**5,261**	**5,356**	**4,987**
Average Daily	*156*	*132*	*129*	*163*	*152*	*164*	*167*	*413*	*176*	*155*	*175*	*173*	*161*
Financial Expenditure	**292**	**292**	**295**	**249**	**244**	**260**	**246**	**170**	**328**	**289**	**256**	**313**	**342**
Average Daily	*9*	*9*	*10*	*8*	*8*	*9*	*8*	*5*	*11*	*9*	*9*	*10*	*11*
Monthly	**18,864**	**17,968**	**17,931**	**19,253**	**20,096**	**19,199**	**20,770**	**28,966**	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends over the last 24 months as at 31st August 2008 (month 5)







LONDON AMBULANCE SERVICE NHS TRUST
Capital Programme 2008/09
Capital Expenditure as at 31 August 2008

	Capital Expenditure Year To Date 2008/09	Forecast Expenditure Profile							Total Capital Forecast 2008/09	Capital Budget 2008/09	Variance 2008/09
		Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09			
Asset Type	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**
Vehicles	353	0	300	383	838	1,427	1,756	1,727	6,784	4,923	(1,861)
Estates	998	150	163	214	119	70	86	64	1,865	2,928	1,063
Equipment	0	0	0	0	0	200	200	100	479	2,733	2,254
IM&T	1,126	431	486	643	588	1,111	980	980	6,347	4,246	(2,101)
Gross Total	2,478	582	949	1,241	1,546	2,809	3,022	2,871	15,475	14,830	(645)
Disposal	0	0	0	0	0	0	0	(1,500)	(1,500)	(1,500)	0
Net Total	2,478	582	949	1,241	1,546	2,809	3,022	1,371	13,975	13,330	(645)
CRL									13,330		
(Over)/Under Commitment									(645)		

Notes to forecast

1) Procurement of PTS, Emergency support, MRU and Driver training vehicles including Ambulances in 0809. Forecast also reflects no purchase of RRUs and Emergency control vehicles. Forecast relects revised treatment of vehicle purchases as finance leases

2) Reflects costs of replacement to Park Royal & Willesden A/S, additional staff accommodation at Tolworth & St Helier A/S, Window replacements at various sites, PTS accommodation at Lea Bridge road and estates costs related to Hannibal house for paramedic training

3) Reflects no purchase of LP12 ECGs in 08/09

4) CAD2010 capital costs higher than planned. Forecast also reflects costs of IM&T Hardware and Software purchases in 08/09 and CTAK & Increased network bandwidth project costs including Off site data centre set up

5) Disposal is as per planned strategy

LONDON AMBULANCE SERVICE NHS TRUST

PTS Financial Recovery Plan

	Apr-08 Act	May-08 Act	Jun-08 Act	Jul-08 Act	Aug-08 Act	Sep-08 Fcast	Oct-08 Fcast	Nov-08 Fcast	Dec-08 Fcast	Jan-09 Fcast	Feb-09 Fcast	Mar-09 Fcast	2008/09 Fcast
Income													
Base	751,271	810,486	842,208	875,030	773,472	799,829	826,490	799,829	826,490	826,490	746,507	826,490	9,704,592
Additional Activity recovery ytd						25,000	25,000	25,000	25,000	25,000	-	-	125,000
Additional billing						-	33,060	31,993	33,060	33,060	29,860	33,060	194,092
Subtotal	751,271	810,486	842,208	875,030	773,472	824,829	884,550	856,822	884,550	884,550	776,367	859,550	10,023,684
Pay													
Ops	454,163	480,748	473,801	474,887	483,437	467,178	482,751	467,178	482,751	482,751	436,033	482,751	5,668,428
Site Mgt	57,562	57,044	56,766	56,902	64,243	57,734	59,658	57,734	59,658	59,658	53,885	59,658	700,501
Overtime	75,463	50,570	57,257	74,990	63,942	47,957	32,222	32,222	32,222	32,222	32,222	32,222	563,512
Agency	15,862	30,911	45,051	37,082	45,782	34,337	17,469	17,469	17,469	17,469	17,469	17,469	313,837
Subtotal	603,050	619,273	632,875	643,861	657,404	607,205	592,100	574,603	592,100	592,100	539,609	592,100	7,246,279
Pay as % of Income	80.3%	76.4%	75.1%	73.6%	85.0%	75.9%	71.6%	71.8%	71.6%	71.6%	72.3%	71.6%	74.7%
Transport													
Fleet	132,241	155,312	140,238	142,449	121,060	136,441	140,989	136,441	140,989	140,989	127,345	140,989	1,655,482
3rd Party	110,658	89,651	128,493	126,869	75,413	56,560	30,165	30,165	30,165	30,165	30,165	30,165	768,635
Subtotal	242,899	244,963	268,731	269,318	196,473	193,001	171,154	166,606	171,154	171,154	157,510	171,154	2,424,117
Transport as % of income	32.3%	30.2%	31.9%	30.8%	25.4%	24.1%	20.7%	20.8%	20.7%	20.7%	21.1%	20.7%	25.0%
Direct surplus/(deficit)	- 94,678	- 53,750	- 59,398	- 38,149	- 80,405	24,624	121,296	115,613	121,296	121,296	79,249	96,296	353,289
Direct margin	-12.6%	-6.6%	-7.1%	-4.4%	-10.4%	3.1%	14.7%	14.5%	14.7%	14.7%	10.6%	11.7%	3.6%
Overhead	25,251	99,350	28,030	23,746	- 42,469	26,782	26,782	26,782	26,782	26,782	26,782	26,782	321,379
Overhead %	3.4%	12.3%	3.3%	2.7%	-5.5%	3.3%	3.2%	3.3%	3.2%	3.2%	3.6%	3.2%	3.3%
Net surplus/(deficit	- 119,929	- 153,100	- 87,428	- 61,895	- 37,936	- 2,158	94,514	88,832	94,514	94,514	52,467	69,514	31,910
Net margin	-16.0%	-18.9%	-10.4%	-7.1%	-4.9%	-0.3%	11.4%	11.1%	11.4%	11.4%	7.0%	8.4%	0.3%

Financial Initiatives	**Measurement**	**How**
1. Bill for additional ytd activity	£25k per month	Site manager target with Head of PTS follow up monthly
2. Increrase in month billing	4% additional in month billing for additional activity plus selected price increases	Site manager target with Head of PTS follow up monthly
3. Reduce overtime	50% reduction from Oct	Deputy Head of PTS to sign off daily
4. Reduce agency	50% reduction from Oct	Deputy Head of PTS to sign off daily
5. Reduce third party	60% reduction from Oct	Deputy Head of PTS to sign off daily

LONDON AMBULANCE SERVICE NHS Trust

Forecast Balance Sheet
For the Month Ending 31 August 2008 (Month 5)

	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Intangible assets	3,765	4,511	4,523	3,784	3,854	3,797	3,797	3,797	3,797	3,797	3,797	3,797	3,797	
Tangible assets	119,652	123,612	123,179	123,607	124,108	123,640	123,504	123,716	124,208	124,981	127,021	129,264	130,068	
	123,417	128,123	127,702	127,391	127,962	127,437	127,301	127,513	128,005	128,778	130,818	133,061	133,865	
Current Assets														
Stocks & WIP	1,930	1,934	1,933	1,933	1,926	1,932	1,932	1,932	1,932	1,932	1,932	1,932	1,932	Trade Debtors
NHS Trade Debtors	1,628	821	1,194	1,717	11,611	6,563	3,555	1,609	1,609	1,609	1,609	1,609	2,093	A&E £-5k > 60 days (0.08%), Jul - £61k > 60 days (0.52%)
Non NHS Trade Debtors	93	139	244	207	105	112	217	199	197	244	227	218	258	PTS £202k > 60 days (2.98%), Jul - £253k > 60 days (2.16%)
Other Debtors	4,337	388	578	452	401	491	134	134	134	134	134	134	134	
Accrued Income	247	2,117	4,028	5,676	2,466	3,760	3,568	3,568	2,264	2,264	2,264	1,611	711	
Prepayments	5,237	5,060	4,334	4,629	4,246	3,510	3,267	3,024	2,848	2,672	2,496	2,496	2,496	
Investments	0	14,000	11,000	10,000	9,000	11,100	13,000	14,518	15,225	13,988	12,445	11,943	0	
Cash at Bank and in Hand	8,965	(936)	2,471	906	(767)	1,099	845	567	421	1,043	1,607	846	5,485	
Total Current Assets	22,437	23,523	25,782	25,520	28,988	28,567	26,518	25,551	24,630	23,886	22,714	20,789	13,109	
Creditors: Amounts falling due within one year														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Trade Creditors	11,660	8,581	9,900	9,279	7,400	7,306	8,201	7,927	7,192	7,046	6,673	6,583	6,508	NHS PSPP - This month (90%), Jul (86%), Ytd (84%)
Other Creditors	1,772	7,066	7,145	7,275	7,663	6,974	7,369	7,152	7,166	7,320	7,210	7,253	2,627	Non NHS PSPP - This month (78%), Jul (85%), Ytd (82%)
PDC Dividend Creditor	0	368	736	1,104	1,472	1,840	0	368	736	1,104	1,472	1,840	0	
Capital Creditors	2,756	104	153	219	659	168	163	518	798	1,079	2,346	2,549	2,610	
Accruals	618	2,145	1,914	1,595	1,388	1,673	1,573	1,473	1,373	1,373	1,373	1,373	1,373	
Deferred Income	152	193	554	586	5,605	4,747	4,092	3,437	2,782	2,127	1,472	817	0	
Total Current Liabilities	16,958	18,457	20,402	20,058	24,187	22,708	21,398	20,875	20,047	20,049	20,546	20,415	13,118	
Net Current Assets	5,479	5,066	5,380	5,462	4,801	5,859	5,120	4,676	4,583	3,837	2,168	374	(9)	
Long Term Debtors	9,875	9,893	9,910	9,858	9,903	9,926	9,926	9,926	9,926	9,926	9,926	9,926	9,926	
Total Assets less current liabilities	138,771	143,082	142,992	142,711	142,666	143,222	142,347	142,115	142,514	142,541	142,912	143,361	143,782	
Creditors: Amounts falling due after more than one year														
Provisions for Liabilities & Charges	18,589	18,532	18,513	18,256	18,236	18,324	18,312	18,188	18,176	18,164	18,040	18,028	18,016	
Total Assets Employed	120,182	124,550	124,479	124,455	124,430	124,898	124,035	123,927	124,338	124,377	124,872	125,333	125,766	
Taxpayers' Equity														
Public Dividend Capital	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	56,488	
Revaluation Reserve	50,605	55,297	55,297	55,294	55,294	55,294	55,294	55,294	55,294	55,294	55,294	55,294	55,294	
Donated Asset Reserve	68	50	30	9	9	9	9	9	9	9	9	9	9	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Income & Expenditure Reserve	13,440	13,134	13,083	13,083	13,058	13,526	12,663	12,555	12,966	13,005	13,500	13,961	14,394	
Total Taxpayers' Equity	120,182	124,550	124,479	124,455	124,430	124,898	124,035	123,927	124,338	124,377	124,872	125,333	125,766	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 August 2008 (Month 5)

	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
EBITDA after exceptionals	619	836	936	918	1,417	82	844	1,363	991	1,447	1,413	1,383	12,249
Excluding Non cash I&E items	(18)	(20)	(21)	0	0	0	0	0	0	0	0	0	(59)
Movement in working capital													
Stocks & Work in Progress	4	(1)	0	(7)	6	0	0	0	0	0	0	0	2
NHS Trade Debtors	807	(373)	(523)	(9,894)	5,048	3,008	1,946	0	0	0	0	(484)	(465)
Long Term Debtors	(18)	(17)	52	(45)	(23)	0	0	0	0	0	0	0	(51)
Non NHS Trade Debtors	(46)	(105)	37	102	(7)	(105)	18	2	(47)	17	9	(40)	(165)
Other Debtors	49	(190)	126	51	(90)	357	0	0	0	0	0	0	303
Accrued Income	(1,870)	(1,911)	(1,648)	3,210	(1,294)	192	0	1,304	0	0	653	900	(464)
Prepayments	177	726	(295)	383	736	243	243	176	176	176	0	0	2,741
Trade Creditors	(3,079)	1,319	(621)	(1,879)	(94)	895	(274)	(735)	(146)	(373)	(90)	(75)	(5,152)
Other Creditors	4,990	(14)	255	415	(902)	382	(230)	1	141	(123)	30	(4,639)	306
Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Accruals	1,527	(231)	(319)	(207)	285	(100)	(100)	(100)	0	0	0	0	755
Deferred Income	41	361	32	5,019	(858)	(655)	(655)	(655)	(655)	(655)	(655)	(817)	(152)
Provisions & Liabilities	(57)	(19)	(257)	(20)	88	(12)	(124)	(12)	(12)	(124)	(12)	(12)	(573)
Net Cashflow from operating activities	2,525	(455)	(3,161)	(2,872)	2,895	4,205	824	(19)	(543)	(1,082)	(65)	(5,167)	(2,915)
Returns on Investments & Servicing of Finance													
Interest received	54	92	125	68	39	65	65	65	65	65	65	65	833
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow from returns on investments & servicing of finance	54	92	125	68	39	65	65	65	65	65	65	65	833
Capital Expenditure													
Tangible fixed assets acquired	(2,981)	(46)	(456)	(787)	(386)	(498)	(493)	(848)	(1,128)	(1,409)	(2,676)	(2,879)	(14,587)
Tangible fixed assets disposed	3,900	0	0	0	0	0	0	0	0	0	0	1,500	5,400
Other	0	0	12	0	1	0	0	0	0	0	0	0	13
Net Cashflow from capital expenditure	919	(46)	(444)	(787)	(385)	(498)	(493)	(848)	(1,128)	(1,409)	(2,676)	(1,379)	(9,174)
PDC Dividends paid	0	0	0	0	0	(2,208)	0	0	0	0	0	(2,206)	(4,414)
Net Cashflow before financing	4,099	407	(2,565)	(2,673)	3,966	1,646	1,240	561	(615)	(979)	(1,263)	(7,304)	(3,480)
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cashflow inflow/(outflow) from financing	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in cash	4,099	407	(2,565)	(2,673)	3,966	1,646	1,240	561	(615)	(979)	(1,263)	(7,304)	(3,480)
Closing cash balance	13,064	13,471	10,906	8,233	12,199	13,845	15,085	15,646	15,031	14,052	12,789	5,485	5,485

London Ambulance Service NHS
NHS Trust

Incident Reporting Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: Procedure to be carried out when reporting incidents.

Sponsor Department: Safety and Risk

Author/Reviewer: Head of Safety and Risk. To be reviewed by Sept 2011

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
19/08/2008	1.1	Roy Chan	Information Security additions
	1.2	John Selby	S&R incident amendments
10/9/08	1.3	Stephen Moore	Information Security & other amendments

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMG		2.0
Ratified by:		
Trust Board		2.0

Published on:	**Date**	**By**	**Dept**
The Pulse		Victoria Smith	GDU

Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Health and Safety at Work Act (1974)	
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995	
TP/006	Serious Untoward Incidents Policy	
OP/025	Exchange in the Event of Equipment Failure	
	LAS Whistle Blowing Policy & Procedure	
TP/004	Complaints Procedure	
	POMs Act	
H&S / 012	LAS Staff Safety Policy	
H&S / 012a	LAS Violence Prevention Procedure	
H&S / 012b	LAS Post Violence Support Procedure	
	Information Security Policy	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1.0 Introduction

Effective Accident and Incident Reporting is important for enabling the London Ambulance Service (LAS) to identify areas of risk. In order for the information to be used fully, it is vital that the management of incident reporting is consistent across the Trust, and that staff working at all locations, are made fully aware of this procedure.

The Standards for Better Health, Clinical Negligence Scheme for Trusts, National Patient Safety Agency, Risk Pooling Scheme for Trusts, Safety Alert Broadcasts and the Counter Fraud Security Management Service place requirements on the London Ambulance Service (LAS) and all other NHS Trusts, to have procedures in place for the reporting of Incidents.

Staff should be aware that this procedure applies equally to incidents involving staff, patients, contractors, visitors and members of the public who are affected by the work of the Trust. For serious untoward incidents including fatalities, major injury, system breakdowns, and information security, managers and staff should refer to the Serious Untoward Incidents Policy (TP/006). For concerns about colleagues working practices, staff should refer to the Whistle Blowing Policy & Procedure.

The aim of incident reporting is not to apportion blame, but to learn from experience and improve practice accordingly. Where errors have been made the preferred option is to provide guidance or retraining to those staff involved. Staff will only be disciplined where there is evidence of wilful negligence, acts of maliciousness or gross/repeated misconduct.

A Health and Safety Incident can be defined as an event or omission that has caused injury or ill health to staff, visitors, or members of the public who are affected by the activities of the Trust. Such events include; work related accidents, ill health brought on by work-related activity, injuries sustained as a result of road traffic accidents, and equipment failings. Staff should also report incidents that occur at home where an injury has been sustained. The term Incident in this procedure, is used for describing Patient Safety Incidents/Near Misses, Health and Safety Events/Near Misses, all acts of Violence or Verbal Abuse and any breach of information security.

Patient Safety Incident includes any unintended or unexpected incident which could have or did lead to harm for one or more patients. Examples of such incidents include clinical error, equipment failures affecting the treatment of a patient, and delays in providing patient treatment. Further examples are detailed later in the procedure. Clinical Governance encourages the reporting of all Patient Safety Incidents in order to identify and reduce clinical risk. The National Patient Safety Agency (NPSA) has been established as a central point for NHS Trusts to report Patient Safety Incidents in order for the wider NHS to learn lessons from events on a national basis

Physical Violence includes any event where physical assault has been suffered by a member of staff. This includes violence that can be attributed to patients' clinical condition, and sexual assault

Non-Physical Abuse includes any act of intimidation, verbal abuse anti-social behaviour, homophobia, sexism, racial abuse or victimization of disabled people.

Patient Safety Near Miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient.

Non Clinical Near Miss includes any event where injury or loss has been avoided, but there is potential for the event to reoccur. Such events include health and safety incidents or dangerous occurrences involving the Trust's fleet or estate.

Hazard includes anything with the potential to cause harm

Information Security includes any event which may result in:

- Loss or release of confidential information
- Loss of personal information

Examples of information security incidents include:

- Loss of electronic or paper documents containing confidential information.
- Loss of portable electronic media such as laptops, PDAs, CD ROMs, or memory sticks which contain personal or confidential data.
- Unauthorised disclosure of user account details.
- Providing information to unauthorised persons.
- Use of another user's account to access resources.
- Identifying that a fax, printout or email containing confidential information was sent out to an incorrect recipient.
- Identifying a physical breach of a secure area.
- Introduction of a computer virus or worm.
- Identification of inappropriate websites.

2.0 Objectives

1. To provide a safe environment for staff, patients, visitors and contractors
2. To raise awareness of the importance of consistent and accurate incident reporting.
3. To ensure managers and staff at all levels are aware of their personal responsibilities in incident reporting, and investigation, and the actions that need to be taken following an incident.
4. To define the categories of incidents that need to be reported.
5. To describe the Grading System to be used for assessing the impact of each incident, and the likelihood of recurrence, and to use the risk score for establishing the extent of the investigation to be undertaken.
6. To reduce the level of untoward incident levels by developing robust systems for minimising the potential for recurrence.
7. To ensure that everyone in the organisation can learn lessons from Health and Safety and Patient Safety Incidents
8. To reduce staff absence attributed to industrial injury.
9. To ensure that all staff are aware of what constitutes an information security incident and how to report any suspected or known incidents.

3.0 Reporting Incidents

3.1 All incidents involving either Physical Violence or Non-Physical Abuse will be reported on the Abuse and Risk Address Information Form LA277 (2005) and

all other Health and Safety and Patient Safety (including Sharps/self inoculation) Incidents should be reported on an Incident Report Form LA52, (2005) following the guidance given in Appendix A. The report should be completed within twenty four hours, of the event occurring. When a member of staff is unable to complete the form due to ill health or injury, their line manager should complete the form on their behalf. The report, together with any associated investigation, should be forwarded to the Safety and Risk Department within seven days.

3.2 It is important that names and contact details of witnesses to all incidents are recorded to assist with subsequent investigations.

3.3 When reporting any incident, staff should report only facts, rather than offering opinions.

3.4 Injuries resulting from Road Traffic Accidents should be reported on an LA52. However damages resulting from Road Traffic Accidents should continue to be reported on form LA420.

4.0 Reporting Physical or Verbal Abuse

4.1 All acts of Physical Violence or Non-Physical Abuse should be reported by completing a LA277 (2004/2005) – see Appendix 2.

4.2 Where physical violence has occurred the investigating manager should notify the Violence Prevention and Security Manager, within 48 hours of the incident. This will allow early liaison with the police, in an attempt to obtain a successful prosecution against the perpetrators of assaults against staff. A major factor for the police when deciding whether to charge someone for an offence is the body of evidence available. This includes independent witnesses to the assault. It is important that contact details for the police officers attending the incident are obtained, in order for the Staff Safety Officer to liaise with the Counter Fraud and Security Management Service, Police, and Crown Prosecution Service.

4.3 The police should be informed of all physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort.

5.0 Reporting Patient Safety Incidents

5.1 When reporting Personal Safety Incidents, staff should provide as much detail as possible about the treatment provided to the patient, both prior and subsequent to an incident occurring. Where known, the outcome should be recorded in respect of how the incident has affected the patient's clinical condition. In the first instance the incident should be reported to the line manager who will decide the appropriate person to undertake the investigation. All Personal Safety Incidents should be brought to the attention of the Senior Training Officer, or the Senior Emergency Operations Centre (EOC) Training Manager.

5.2 All equipment that fails during use, or drug packs with out of date drugs etc., should be taken out of use immediately. Staff should complete an LA52, and attach the yellow copy of the report to the equipment, or the drugs pack and

then follow the Exchange in the Event of Equipment Failure Procedure (OP/025), or return the drugs and LA52 to the used drugs locker as appropriate. Guidance on equipment classified as a medical device can be obtained from the Safety and Risk Department.

5.3 Other examples of Patient Safety Incidents that should be reported include;

- Adverse outcome due to failure to follow National Clinical Guidelines, protocols, procedures or instructions, including Advanced Medical Priority Dispatch System (AMPDS).
- Adverse clinical outcomes as a result of following National Clinical Guidelines, protocols, procedures or instructions, including AMPDS.
- Patient injuries sustained as a result of equipment failure, mishaps or falls whilst in LAS care.
- Drug administration errors.
- Concern about treatment provided by other Health Care Professionals
- Delays in providing treatment that result in an adverse effect on the patients clinical outcome.
- Suspected or proven clinical risk resulting from delays in AMPDS and allocation of calls in EOC.
- Suspected or proven adverse outcome from Clinical Telephone Advice.

5.4 Delays caused by system failures in EOC, in either call taking, or vehicle allocation should be reported, by the AOM in charge of the Control Room, at the time of the incident.

6.0 Health and Safety and Patient Safety near Misses

6.1 The need to report near misses is as important for the LAS as the reporting of incidents that have caused actual injury, ill health, or loss.

6.2 Examples of near misses that should be reported include:

- The failure of clinical or non-clinical equipment during a patient care episode.
- Mistaken clinical judgment.
- Procedures, Clinical Guidelines, protocols or practices, found to be unsafe.
- Hazards associated with the Trust's Estate or Fleet.

7.0 Reporting Information Security Incidents

7.1 Once becoming aware of a potential information security incident, staff are required to inform their manager and fill in a LA 52 form. This form should be sent to Safety & Risk who will pass onto the Information Security Manager as soon as possible.

7.2 Staff may contact the Information Security Manager for advice or to report the incident directly.

7.3 Staff must not discus any matters regarding the incident with anyone except their immediate line manager, the Information Security Manager or law enforcement officer.

8.0 Grading of Incidents

8.1 All reported incidents will be graded according to the actual impact, and also the potential future risk to patients, staff and the organisation should a similar incident occur again. This will help to establish the level of local investigation and causal analysis that should be carried out. Guidance on how to grade Incidents is given in Appendix 3.

9.0 Responsibilities

9.1 Chief Executive

The Chief Executive takes overall responsibility for Risk Management within the LAS.

9.2 Director of Human Resources and Organisational Development

Responsibility for Health & Safety and the Incident Reporting Procedure has been delegated to the Director of Human Resources.

9.3 Director of Information Management &Technology and Medical Director

Responsibility for Information Security risks has been delegated to the Director of Information Management & Technology and the Medical Director (Caldicott Guardian).

9.4 Line Managers

It is the responsibility of managers at all levels to implement this procedure, and to ensure that a book of LA52/LA277 (2005) incident reporting forms are made available in their area of work. It is important that managers make personal contact with all members of staff reporting incidents, in order to provide them with an opportunity to discuss the incident, and for managers to provide immediate support following an incident. Incident Reports should be forwarded to the Human Resources, and Safety and Risk Departments, within seven days of the event occurring. Copies of the Abuse and Risk Address Information Reports should be forwarded to the Operational Information, Safety and Risk Department and your HR Department.

Managers' specific responsibilities include:

- To provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident.
- To refer staff for retraining as appropriate.
- To ensure all acts of physical abuse are reported by telephone to the Safety and Risk Adviser (LSMS) as soon as possible after the incident.
- To offer support, and referrals for occupational health, welfare, counselling services & re-training as appropriate.
- To ensure LA52/LA277 (2005) are completed in full, prior to distribution to the Safety & Risk, Operational Information, Info Sec and Human Resources Departments.
- Ensure that all incidents graded "High" are referred to Complaints Department or Information Security Manager if an Information Security incident within 48 hours of the incident occurring.
- To report all Health & Safety incidents to the Health and Safety Executive,

in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) see Section 14.

9.5 Ambulance Operations Managers, Regional Operations Managers (PTS) Senior Operations Manager – Planning and Risk

Ensuring that Service wide, Complex, Regional and EOC Incident Statistics are monitored, local trends are indentified, and that proactive actions are taken when individual members of staff report disproportionately high levels of incidents.

9.6 Duty Station Officers, PTS Site Managers, Ambulance Operations Managers, (EOC), Training Officers & Department Heads

Ensuring that incidents are graded and investigated, identifying contributory factors pertinent to the event, in accordance with Appendix 2 - *Grading and Learning from Incidents*. To provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident. Where an incident has resulted in either a serious injury, or fatality to either a member of staff or a patient or serious or large scale loss of information, managers should refer to the Serious Untoward Incidents Policy (TP/006).

9.7 Ambulance Operations Managers & EOC Training & Training Officers

- To make staff aware of the importance of incident reporting, and to encourage the reporting of Patient Safety and Health and Safety Incidents all incidents through day to day contact with staff.
- To oversee the investigation of Patient Safety Incidents ensuring lessons learnt from the reporting of incidents, are passed to operational staff through training initiatives etc.
- To ensure that the results of equipment inspections are relayed to the member of staff who reported the fault.
- To ensure the patients clinical outcome is identified as part of the investigation into clinical untoward incidents.
- To identify areas of clinical risk in their Complex or area of responsibility.

9.8 A&E Team Leaders, PTS Crew Team Leaders and EOC Quality Assurance Advisers

- A&E and PTS Team Leaders, EOC Quality Assurance Advisers have the following specific responsibilities in clinical and non-clinical incident investigation. It is expected that they will assist in investigations led by Ambulance Operational Managers, Duty Officers and PTS Site Managers;
- To encourage the reporting of all Incidents, amongst their team and other operational staff;
- To ensure any equipment that has failed during the treatment of a patient is identified with an LA52, prior to being sent to Equipment Stores for repair/inspection as specified in Exchange in the Event of Equipment Failure Procedure (OP/025);
- To provide feedback to the member of staff reporting the incident, following completion of the investigation.

9.9 Information Security Manager

- Review all Information Security LA52s.
- Ensure significant, major and critical Information Security incidents are reviewed by the Information Governance Group.
- Responding to Incidents:
  Upon receiving reports of an incident, the Information Security Manager will classify the incident according to the following grades:

  - Low
  - Moderate
  - Significant
  - High

  The response to the incident will subsequently be determined by either the Information Security Manager or a senior member of staff.

  All potential incident investigations will remain confidential at all times.

9.10 Safety & Risk Adviser (LSMS), and Safety and Risk Adviser (Manual Handling)

The Safety & Risk Adviser (LSMS), and Safety and Risk Adviser (Manual Handling)will review all LA52s to identify reporting trends, and to ensure appropriate follow up action, grading and investigation has been taken following an incident. Specific responsibilities include;

- Supporting staff who have been the victims of assaults in respect of liaison with the police and Crown Prosecution Service.
- Advising managers on their investigation of untoward incidents or accidents.
- Informing the Trust of trends in incident reporting and the issues raised in action plans resulting from incident investigations.
- Providing reports on incident levels to the Clinical Risk Group, and the Corporate Health and Safety Committee.
- Developing procedures and strategies to achieve a reduction in incidents.
- Informing the Counter Fraud Security Management Service of all Physical Assaults (see Section 15)

9.11 All Staff

All staff are required to:

- Report accidents, incidents (including Information Security incidents), near misses, or dangerous occurrences that affect themselves, patients or members of the public.
- Remove immediately from use any piece of faulty equipment.
- Co-operate in the investigation of Incidents, providing witness statements and any other information that will assist with an investigation.

10.0 Central Alerting System (CAS)

The Central Alerting System (CAS) is an electronic system developed by the Department of Health (DOH), National Patient Safety Agency (NPSA), NHS Estates and the Medicines and Healthcare Products Regulatory Agency (MHRA) to ensure that risks that arise from incident reporting can be highlighted to all Trusts

The Safety and Risk Adviser is the nominated manager responsible for distributing Safety Alerts in the LAS and for reporting incidents where issues may have been raised that affect other NHS Trusts.

11.0 Counter Fraud Security Management Service (CFSMS)

The CFSMS are tasked with reducing levels of physical abuse to NHS staff. The Staff Safety Officer will report all incidents of Physical Abuse to the CFSMS. The Violence Prevention Manager is the nominated manager responsible for notifying the CFSMS of all reported incidents where violence is a factor.

12.0 National Patient Safety Agency (NPSA)

The NPSA has established a central point for NHS Trust's to report Patient Safety Incidents. This is in order for the wider NHS to learn lessons from events on a National basis.

13.0 National Health Service Litigation Service Authority (NHSLA)

The NHSLA is a special Health Authority that promotes good risk management and assurance as part of assessment against risk management standards.

14.0 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

There is a statutory duty on all employers, to report notifiable incidents to the Health and Safety Executive. Incidents to be reported include;

- Any absence over three days (not including the day of the incident) that results from an industrial injury.
- Any fracture (other than to fingers, thumbs, or toes).
- Any amputation.
- Any dislocation of the shoulder, hip, knee or spine.
- Loss of sight (whether temporary or permanent) burns (chemical/heat) or other penetrating injuries to the eye.
- Injuries due to electric shock or burns, which require resuscitation, or which result in hospitalisation for more than twenty four hours.
- Unconsciousness due to asphyxia or exposure to a harmful substance.
- Acute illnesses that require medical treatment or that result in unconsciousness due to chemical or biological substances being inhaled, ingested or absorbed through the skin.
- Acute illnesses requiring medical treatment, which are believed to be due to infected material or to biological agents or their toxins.

Managers are responsible for reporting incidents to the HSE on form F2508 within seven days of the event occurring. A further copy of the form should be forwarded to the Safety and Risk Department. F2508s can be forwarded to the HSE via e-mail www.riddor.gov.uk.

IMPLEMENTATION PLAN	
Intended Audience	For all staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	Health & Safety & Information Security training Incident reporting awareness sessions and guidance Training guidance in the use of documentation is provided in the section 25 page II of this policy and the rear cover of LA 52 and LA 277 pads. Health, Safety and Awareness training module – incident investigation provide specific (1 day) training. The training will be evaluated as part of the Training Needs Analysis (TNA) and revised on an annual basis.
Monitoring	Audit of LA52/LA277 forms This policy will be monitored in line with NHS best practice guidance. The Trust will undertake specific monitoring by reviewing:- LA 277 incident reports – collated from completed and approved LA277's that are sent to the Sector Commander (CAC) at Headquarters. The Sector Commander (CAC) is responsible for making arrangements to collate all completed LA277's and for arranging an update to the database on a regular basis. LA52 incident reports - Incident Reporting Data is tabled at the Corporate Health and Safety Meeting, which are held on a quarterly basis, chaired by the Director of HR Feedback from RIDDOR – learning and obtaining guidance on risk management within the workplace, from reported incidents related to injuries, disease and dangerous occurrences Serious Untoward Incident (SUI) – decisions arrived at by the Trust on incidents that arise are passed to the national Patient safety Agency TP/004 Complaints Procedure HR/07/22 Whistle Blowing Procedure

Appendix 1

INCIDENT REPORTING PROCEDURE

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety & Risk Department, or via EOC.

The LA52 (2005) report form must be completed as soon as possible after the event and be accurate and detailed.

The LA52 (2005) replaces all previous versions of the LA52.

On completion of the form:
TOP COPY (White) goes to Safety & Risk Dept, Pocock Street, SE1 (External Mail)
MIDDLE COPY (Gold) goes to Sector/Dept HR Office
BOTTOM COPY (Green) retained in originating Station/Office/Dept

If the incident victim as a result of their injuries (or any other reason) is unable to complete the Incident Report Form, it must be completed on their behalf, preferably by their Line Manager, with the outline details of the incident and probable cause.

All incidents involving physical or non-physical abuse must be reported on an LA277 (2005).

Guidance on Completion

1. Indicate the Station/Department where you are based and who you reported the incident to.
2. Record your personal details, including job title, age etc. Please confirm whether you give consent to a copy of the form being given to your Health & Safety Representative.
3. Cross the appropriate box highlighting the type of incident that occurred.
4. Record when and where the incident occurred, include map references as appropriate.
5. Describe what caused the incident giving factual details only. Continue on a separate sheet if required.
6. Indicate the relevant factors if the incident was of a non-clinical nature.
7. Supply the names and contact details for the incident, attaching witness statements where available.
8. Indicate the relevant factor for incidents of a clinical nature.
9. Confirm whether any Personal Protective Equipment was worn/in use at the time of the incident.
10. Detail any injuries or ill health suffered by anyone involved in the incident.
11. Specify any equipment involved in the incident; Trolley Beds, Chairs, Vehicle Patient Care Equipment etc, recording makes, models, fleet and serial numbers.
12. Provide your signature, record the date of completion and provide a contact telephone number.
13. For completion by the Line Manager – Managers investigating an incident should ensure all actions taken following an incident are recorded, by ticking the relevant boxes. Managers should grade the incident in accordance with the Incident Grading Matrix and confirm the results of investigations and actions taken to avoid a recurrence. The Manager investigating the incident should indicate how long an employee is known/likely to be unable to do their

usual role. It is the duty of the Manager investigating the incident to complete a Health & Safety Form F2508 in accordance with the Reporting of Incidents Diseases and Dangerous Occurrences Regulations (RIDDOR) where an employee has been absent for a period greater than three days not including the day of the occurrence, following the incident. Copies of the form should be sent to the Health & Safety Executive within 10 days, with a further copy forwarded to the Safety & Risk Department.

Appendix 2

PROCEDURE FOR THE REPORTING OF ABUSE AND SUBMISSION OF ADDRESS TO THE HIGH RISK ADDRESS REGISTER

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety and Risk Department or via EOC.

The LA277 (2005) replaces all previous versions of the LA277 and LA52 in terms of reporting Physical and Non-Physical Abuse, and adding addresses to the High Risk Address Register.

The LA277 (2005) report form must be completed as soon as possible after the event, and should be accurate and detailed.

On completion of the form:
TOP COPY (White) goes to the Operational Information Department, Headquarters (External Mail)
SECOND COPY (Pink) goes to Safety & Risk Department, Pocock Street, SE1
THIRD COPY (Gold) goes to Station/Department HR Office
FOURTH COPY (Green) retained in originating Station/Office/Department

If the incident victim as a result of their injuries (or any other reason) is unable to complete the LA277 Report Form, it must be completed by the Line Manager, with the outline details of the accident and probable cause.

1. Record where you are based and who you initially reported the incident to.

2. Record your personal details including job title, length of service etc. Please confirm whether you give consent to a copy of the form being provided to your Health & Safety Representative.

3. Record the category of incident by crossing the appropriate box.

4. Record when and where the incident occurred.

5. Describe what led up to the incident. All occurrences of physical abuse should be reported to the police in order to build up evidence against those who assault staff. Continue on a separate sheet if necessary.

6. Record the names and details of those involved in the above. Please also indicate what factors are relevant to the incident.

7. Record the names and contact details for any witnesses to the incident.

8. Was a stab vest or any other Personal Protective Equipment in use at the time of the incident.

9. Identify any injury, ill health, disease or emotional distress suffered as a result of this incident.

10. Provide your signature, record the date of completion and provide a contact telephone number.

11. For completion by the Investigating Manager. A discussion with the staff member reporting the incident must form part of the investigation. All actions taken following the incident should be recorded by ticking the relevant boxes. All incidents should be graded in accordance with the Incident Grading Matrix. You must also confirm whether the address of the perpetrator of the abuse should be added to the High Risk Address Register. Confirm whether any period of absence followed this incident. It is the duty of the Manager Investigating the incident to complete a Health & Safety Executive form F2508, when a member of staff has been absent for a period greater than 3 days not including the day of the occurrence. Copies of the form should be sent to the Health & Safety Executive, with a further copy forwarded to the Safety & Risk Department.

Appendix 3

GUIDANCE ON GRADING, INVESTIGATION & ROOT CAUSE ANALYSIS OF INCIDENTS

Introduction

This document provides guidance to staff within the LAS on how and when investigation processes should be undertaken following an incident.

Whilst incidents almost automatically lead to reactive risk management i.e. damage limitation and immediate remedial action. They should also be seen as an opportunity for proactive risk management i.e. learning from what has happened and looking ahead to see how such incidents can be prevented from reoccurring; thereby reducing future risk to the Trust.

In order to learn from these events it is necessary to obtain the facts and details of the incident. These must be recorded as soon after the incident as reasonably possible. Further, more detailed information can be gathered and collated as the investigation progresses. The depth and level of investigation will be dictated by the severity of the event/incident. When the key facts of the incident have been identified, then measures can be taken to prevent, or reduce the likelihood of similar circumstances combining again, with adverse results.

All staff therefore have a part to play in this area of risk management, whether it is in terms of completing accurate records (on PRFs, LA52s, LA400s or LA277s,) or if it is acting as an Investigating Officer/manager conducting the investigation and analysing the outcomes.

Definitions

For the purpose of this guidance the term Incident refers to any untoward events relating to Health and Safety, Patient Safety, physical or non-physical violence, near miss (clinical or non-clinical), or information security.

Immediate Cause is defined as the factor(s) which triggered the actual incident.

Contributory Factor is defined as the circumstance(s) which contributed to the occurrence of the incident, but which, by itself or themselves, would not have caused the incident to arise.

Root Cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

Incident Grading

All reported incidents will be graded according to the severity of the actual impact, and also the likely future risk to patients, staff and the organisation should a similar incident occur again. This grading will also help to establish the level of local investigation and causal analysis that should be carried out.

Incidents will be graded by individuals (identified in the procedure) using the matrix below. The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an actual incident or a near miss.

Risk Scoring

Not all incidents need to be investigated to the same extent or depth. To assess the level of investigation required, the impact of the incident and the likelihood of a recurrence both need to be considered. For incidents where Physical Violence, Non-Physical Abuse or Lifting, Handling and Carrying are factors, the likelihood should be based on the staff members previous reporting history. For all other categories the likelihood should be based on general reporting trends. To assess the likelihood of recurrence, managers responsible for grading should refer to the Quarterly Incident Statistics, Complex Statistics and the levels of similar incidents that have been reported. Having assessed each incident against the risk grading matrix, the amount of investigative and analysis effort should be in relation to the risk scoring (see below).

Risk Scoring					
Impact					
Catastrophic	**5**	**10**	**15**	**20**	**25**
Major	**4**	**8**	**12**	**16**	**20**
Moderate	**3**	**6**	**9**	**12**	**15**
Minor	**2**	**4**	**6**	**8**	**10**
None / Insignificant	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency	**Not expected to occur annually**	**Expected to occur at least annually**	**Expected to occur at least every 6 months**	**Expected to occur at least monthly**	**Expected to occur at least weekly**
Probability	**< 1%**	**1 – 5%**	**6 – 25%**	**26 – 60 %**	**>60%**
	Will only occur in exceptional circumstances	**Unlikely to occur**	**Reasonable chance of occurring**	**Likely to occur**	**More likely to occur than not**
Likelihood of Recurrence					
Grading Bands	**1-3 = LOW**	**4-6 = MODERATE**	**8-12 = SIGNIFICANT**	**15-25 = HIGH**	

	1	2	3	4	5
Descriptor	**Catastrophic**	**Major**	**Moderate**	**Minor**	**Insignificant**
Injury (To anyone)	Death or major permanent incapacity	Major injuries, or long term incapacity / disability (loss of limb)	Reportable to external agencies / statutory bodies (e.g. RIDDOR, HSE, NPSA, etc	Minor injury or illness, first and treatment needed	Minor injury not requiring first aid
Patient Experience	Totally unsatisfactory patient care / working practices	Serious mismanagement of patient care – major permanent harm / breach of working practices	Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover / breach of working practices	Unsatisfactory patient experience involving first aid treatment – readily resolvable	Unsatisfactory patient experience no injury
Complaint / Claim Potential	Claims of large value	Multiple justifiable complaints. Claim above excess or significant value	Justifiable complaint involving lack of appropriate care / management. Claim below excess or smaller value claim	Justifiable complaint peripheral to clinical care / management	Locally resolved complaint
Objectives / Projects	>25% over budget / schedule slippage. Does not meet primary objectives	10 – 25% over budget / schedule slippage. Does not meet secondary objective(s)	5 – 10% over budget / schedule slippage. Reduction in scope or quality requiring approval	<5% over budget / schedule slippage. Minor reduction in quality / scope	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality
Service / Business Interruption	Loss / interruption > 24 hours	Loss / interruption > 8 hours and < 24 hours	Loss / interruption >1 hour and < 8 hours	Loss / interruption > 1/2 hour and < 1 hour	Loss / interruption < 1/2 hour
Human Resources / Organisational Development	Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training	Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training.	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Ongoing low staffing level reduces service quality	Short term low staffing level temporarily reduces service quality (<1day)
Financial	> £5M	> £1M<£5M	>£20k<£1M	>£2k<£20k	>£2k
Inspection / Audit	Prosecution Zero rating. Severely critical reports.	Enforcement action. Low rating. Critical report Multiple challenging recommendations. Major non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards. Reportable to associated external/statutory agencies.	Recommendations given. Non-compliance with standards	Minor recommendations. Minor non-compliance with standards
Adverse Publicity / Reputation	Public inquiry National meeting	National Media < 3 days. Local MP concern	Local Media – Long term	Local Media – short term	Rumours

Level and Nature of Local Investigation and Analysis

Once the event has been graded the appropriate response should be actioned, in compliance with the table below. If the investigation reveals issues that were not at first apparent from the LA52, the incident should be re-graded and additional actions undertaken appropriate to the Risk Score.

Dependant on the nature of the incident, e.g.: Violence, Manual Handling; further guidance on additional actions to be taken can be obtained from the Trust's Health & Safety manual (also on the Intranet).

Category	**Actions** **AOMs. DSOs, PTS Site Managers, Senior/Training Officers & Department Heads**	**Analysis**	**Outcome**
Green (Low)	Support and discuss incident with staff member Check that LA52/LA277 completed Identify previous reporting history for this staff member – have similar incidents been reported previously Consider whether appropriate to add this address to High Risk Address Register	Incident to be entered on to incident Database	Carry out immediate Remedial Action
Yellow (Moderate)	Cross reference LA52/LA277 with PRF's and other documentation Carry out Actions as for category yellow	As for category yellow General Analysis of cause and contributory factors	Immediate Remedial Actions, and Recommendations where appropriate
Orange (Significant)	Carry out Actions as for category yellow and green Carry out thorough investigation and consider referring to Complaints Dept. for RCA	As for category yellow and green General Analysis of cause and contributory factors which may lead to RCA	Immediate Actions, or Recommendations and Action Plan
Red (High)	Full investigation by PSU or nominated Investigating Officer	Root Cause Analysis	Action Plan and Improvement Strategy

General Guidance on Investigation Processes

Incident investigations should:

- Identify reasons for substandard performance.
- Identify underlying failures in management systems.
- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm.
- Satisfy mandatory and LAS reporting requirements.

The investigation needs to be prompt and thorough. Where possible, remedial action or solutions should be recommended. If the investigation is not undertaken as soon as practicable after the event, conditions and recollections fade and evidence is lost.

There are five components of any investigation:

I. Collect evidence about what happened.
II. Assemble and consider the evidence.
III. Compare the findings with relevant standards, protocols or guidelines, whether these are particular to LAS or National, to establish the facts, draw conclusions about causation.
IV. Make recommendations for action to minimise risk of recurrence.
V. Implement the recommendations and track progress.

I) Collecting Evidence.

The sources of information and methods that can be used in investigation typically fall into the three following categories:

- **Direct observation** is crucial to avoid losing important evidence about the scene, equipment, environment, vehicles and machinery involved, etc. Where possible photographs should be taken, particularly when it is impractical to preserve evidence or maintain the scene of the incident in a permanent state.

- **Documentation** which identifies what occurred leading up to and at the time of the incident and this should be included as part of the investigation. Evidence of prior risk assessment, work place inspections, servicing and maintenance history may all be relevant to the investigation.

- **Interviews** should be undertaken with the personnel involved in the incident, and any witnesses identified and their full contact details and signatures as soon as possible after the event.

Adverse incidents seldom arise from a single cause; there are usually multiple underlying failures in management systems/procedures which have created the circumstances leading to the incident.

II) Assembling and Considering the Evidence

Investigations should identify both immediate and underlying causes, including human factors/errors. Immediate causes must take into account the patient, the task, the work environment and weather conditions, all the persons' involved (either individually or as part of a crew or team), time of day and any machinery, vehicles or equipment used. Underlying causes can be management and systems failures organisational, cultural, personal/health and contextual factors that all contribute to explain why the event(s) occurred. Getting to the root of the problem will help ensure the development of an effective improvement strategy and if the incident is properly and thoroughly investigated then this should prevent or significantly reduce the likelihood of recurrence.

III) Comparing findings with relevant standards & protocols

The next stage of the investigation is to compare the conditions and sequence of events against relevant standards, guidelines, protocols, approved codes of practice, etc. This will help to minimise the subjective nature of investigations and to generate recommendations which have the maximum impact and relevance. The objectives are to decide:

- Whether suitable and sufficient standards / procedures / controls / risk assessments, undertaken and were they being implemented to prevent untoward incidents occurring in the first place.
- If standards / procedures etc exist, are they appropriate and sufficient?
- If the standards / procedures were adequate, were they applied or implemented appropriately?
- Why any failures occurred.
- Were safe systems and procedures accidentally or deliberately breached?

IV) Make Recommendations

Where an investigation identifies immediate or underlying causes involved, recommendations should be made to take remedial action immediately or make recommendations for possible solutions to prevent recurrence within an action plan. Copies of the action plans should be forwarded to the Staff Safety Officer, together with a copy of the LA52/LA277 (2005), and the findings of the associated investigation. Action plans that have Trust wide implications will be reported to the Clinical Risk Group and Corporate Health and Safety Group.

V) Implement the Changes/Action Plan

Where an investigation has resulted in an Action plan being created or a change in working practice, progress should be monitored and recorded.

Root Cause Analysis

Unless the fundamental, or root causes of adverse events are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in risks. Adverse incidents rarely arise from a single cause; there are usually underlying failures in management systems which have helped to create the circumstances leading to the incident.

Full Root Cause Analysis will in the majority of circumstances; be undertaken by the Professional Standards Unit, with the assistance of other managers with expertise in specific areas. Where necessary, this group will also seek advice from external experts and organizations e.g. the NPSA, NHSLA, HSE.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident.

RCA would normally include the following steps:

- Identify the incident.
- Preserve direct evidence from the scene & make detailed records / complete LA52/LA277 (2005)/F2508.
- Provide a chronology.
- Gather documentary and other evidence.
- Arrange and carry out interviews.
- Identify related factors.
- Analyse related factors.
- Use NPSA RCA models.
- Decide on and cost the options for improvement controls.
- Provide a report.
- Ensure implementation of improvement strategy, phased if necessary.

Communication of Learning Points

Implementing recommendations and Improvement Strategies, and monitoring the effectiveness of action taken, will provide a certain level of evidence to demonstrate that the LAS is learning from adverse events. This may be on an individual or Trust Wide basis. It is necessary to ensure that lessons are learnt and changes are made and communicated so that the Trust can demonstrate continuous improvement as an organization.

It will be the responsibility of Managers and Investigating Officers to feed back to individuals with regard to lessons learned from Incidents and to monitor progress against action plans drawn up.

	**London Ambulance Service NHS Trust** **Policy for Consent to Examination or Treatment** **For Use By: All A&E staff**

Introduction

This policy is for all staff who provide care to patients, irrespective of the route by which they came into contact with them. This policy is based on the Department of Health guidance on consent to examination or treatment of patients (DH 2001), and is in four parts.

- Part A provides a summary of the 12 key points on consent as applicable to ambulance staff.
- Part B contains guidance for ambulance staff
- Part C contains the full consent policy

Objectives

1. To set out and explain the requirements laid down by the Department of Health (DoH) with respect to seeking consent for examination and treatment of a patient.
2. To provide comprehensive information on gaining consent to examination or treatment.
3. To provide guidance for staff in specific circumstances.
4. To ensure staff realise the importance that decisions regarding consent must be documented using the appropriate LAS forms.

Deviation from the advice and guidance given within this policy

Should there be a need to deviate from the guidance contained in this policy then that must decision be documented on the PRF, and if appropriate on an LA5, LA5a or LA5b. Given the comprehensive nature of this policy it is strongly advised that staff contact the Clinical Support Desk in EOC for guidance.

Monitoring compliance with this policy

The adherence of staff to this policy as a whole, and to the JRCALC Clinical Guidelines in respect of consent and patient treatment documentation, will be primarily carried out through Clinical Performance Indicator checks (CPIs).

It is also the duty of all Operational Managers from Team Leaders upwards to ensure that this procedure is adhered to by staff under their management.

The basic tenets of "Consent"

The terms "capacity" and "competence" are used throughout this document. Each term is used where it is felt to be most appropriate. Capacity is assessed by deciding whether you can answer "yes" to the following questions;

- Do you feel the patient is able to communicate a decision effectively?
- Do you feel the patient understands in simple language what is proposed and why it is being proposed?
- Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?
- Does the patient understand the consequences of not receiving the proposed treatment?
- Can the patient retain the information long enough to make an effective decision?

If the answers to all of the above are "**YES**", staff should consider that the patient has **capacity** and able to make **competent** decisions.

PART A – 12 Key Points on Consent

When do ambulance staff need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent. You may wish / need to document this in more detail than is available on the London Ambulance Service (LAS) NHS Trust Assignment Record and Clinical Record (PRF LA4); for example the administration of a treatment or drug whilst it is part of a clinical trial. The three requisite forms are LA5, LA5a & LA5b. You must be guided by the circumstances existing at the time when deciding which form, if any to use. A consideration that must be taken into account is the time taken to explain and complete the form(s), against the imperative for examination, treatment or action existing at the time.

Please note that Form LA5 is specifically designed as an assessment of capacity tool as well as being for patients who are unable to consent to treatment for themselves, or for whom treatment is required without their consent.

The forms used by the LAS are either wholly, or substantially, based on the forms recommended by the DH.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one- off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided to the patient?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

Is the patient's consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter *how* the patient gives consent?

9. Consent can be written, oral or non- verbal. A signature itself does not prove the consent is valid – the most important point is to record the patient's decision and the discussions that have taken place.

Refusals of treatment

10. Competent adult patients are entitled to refuse treatment, even where the treatment would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the *Mental Health Act 1983*. For example a competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. **No one** can give consent on behalf of an adult who lacks capacity. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' are wider than best medical interests and includes factors such as the wishes and beliefs of the patient with capacity, their current wishes, their general wellbeing and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never had capacity, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If a patient who lacks capacity has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary does not cover all situations. For more detail, consult the full London Ambulance Service NHS Trust policy on consent for examination and treatment in Part C of this document.

Documentation of decisions regarding consent

Staff must ensure that decisions regarding consent must be documented using the appropriate LAS form. Explanations of which form is to be used in which scenario is explained further in this document. Also the PRF User Guide gives further explanation of the "Consent Obtained" tick box on the PRF.

It cannot be stressed enough that where consent to treatment is withheld or subsequently withdrawn, having been previously given, that this is documented on both form LA5 and the PRF.

All staff must ensure that they have with them at all times whilst on duty the requisite forms to document consent decisions. This means that they must have as a minimum a PRF and an LA5, LA5a and LA5b available for completion as dictated by the circumstances and patient.

Part B – Guidance for ambulance staff

This guidance is designed to clarify roles and responsibilities of ambulance staff in relation to consent or refusal to examination or treatment.

Gaining Consent

"Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must be competent to take the particular decision, have received sufficient information to take it and not be acting under duress.

Gaining the consent of a patient to examination and treatment will most often happen as a natural progression of the interaction of staff with their patient. However, staff must never assume that the patient will consent to examination and treatment, even if they have called for our assistance. Staff must ensure a full **discussion** takes place with the patient, a course of action is **agreed** and that these decisions and actions are fully **documented.** The staff must respect the patient's wishes and needs throughout this process and always bear in mind that the patient is entitled to withdraw consent at any time.

Actions to take if consent to examination or treatment is refused

It is not uncommon in pre-hospital situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances, an ongoing moral duty and legal responsibility for ambulance staff to provide further care.

If a patient refuses examination or treatment against the advice if ambulance staff, the staff need to use form LA5 to assess whether the patient has capacity

If a patient **with capacity** is refusing treatment, the crew may be acting unlawfully if they treat them against their wishes. In these circumstances they must document carefully both on the LA5 and PRF LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, or an LAS Officer. Staff should notify the Emergency Operations Centre (EOC) of their actions, a timed recording will then be available should one be required.

Where a patient is deemed to **have capacity**, the police may be of assistance. However, remember that the police cannot restrain or forcibly remove the patient unless a breach of the peace, or other unlawful act, is likely to take place.

Where a patient who **does not have capacity** is refusing treatment, the crew must consider the consequences of the patient not receiving treatment. If the crew believes that the patient needs treatment, they should act in the patient's best interests. Crew and patient safety must be paramount in this decision.

In these circumstances they must document carefully both on the LA5 and PRF LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, or an LAS Officer. However, no-one else can give consent on behalf of such a patient, they may only be treated if that treatment is believed to be in their 'best interests'.

Where a patient is deemed **not to have capacity**, the police may also be of assistance if a breach of the peace, or other unlawful act, is likely to take place. However, in these cases all parties on scene have a duty to ensure the patient receives the best possible care and treatment.

<u>Assessment of capacity/assessment for treatment without consent form (Form LA5)</u>

This form is intended to be used where a patient is refusing to be treated, but in the opinion of the member of staff, the patient must receive treatment for life threatening illness or injury. This will therefore mean that the staff member will be treating the patient without their explicit consent. Whilst this is in fact permissible in certain circumstances, it is beholden on the staff member to be able to justify **all** their reasoning, actions and treatments. Crew and patient safety should be a consideration at all times.

The form LA5 has been devised to assist staff in both the reasoning process and the need to document decisions and actions in these difficult circumstances. It is understood that staff may not be able to complete the form as the process develops, but, it must be completed as soon as is practically possible.

To reach a decision on whether you will need to treat a patient without their consent you must first decide if the patient has capacity. Form LA5 has an 'Assessment Capacity' tool for this purpose. The remaining sections of the form are used to guide staff in making the decision to treat a patient without their consent. It also prompts staff to explore alternative treatments and care pathways. Staff are encouraged to use the Emergency Operations Centre (EOC) to facilitate the contacting of other agencies.

A completed copy of the form LA5 is to be retained and handed in with the PRF LA4.

The pink copy of form PRF LA4, appropriately completed at section 11, must be given / offered to the patient, if they are not conveyed to a treatment centre. If the patient is conveyed to a treatment centre the LA5 copy is to be left with the pink copy of the PRF at the treatment centre.

Advanced Directives

Advanced Directives must be respected – see Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advanced Directives (OP/028). An advanced refusal of treatment will be binding where:

- At the time it was made the patient had the necessary mental capacity to make it.
- At the time it was made the patient fully understood the consequences of his/her decision.
- The circumstances that have arisen are the circumstances that were contemplated when the advance directive was made.
- At the time the advance directive was made, there was no duress on the patient.

In order to ascertain the validity of an advance directive, clarification should be sought from either the patient's GP, the clinician involved in that aspect of the patient's care, or another person named on the directive, which may include the patient's solicitor. Where there is real doubt over the validity of an advance directive and any delay in treating and/or transferring the patient is likely to lead to permanent physical or mental

harm, then staff should do what is practicable in order to treat/transfer the patient having consulted with EOC. Where doubt exists as to the validity of an Advance Directive, treatment must be continued until the patient is stable and competent to discuss their current treatment wishes. However, only that treatment, which is immediately necessary and in the patient's best interest should be provided.

Part C – Full LAS policy on consent to examination or treatment. This policy is based substantially on the guidelines on consent issued by the Department of Health.

Why consent is crucial

1. Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind.

This policy

2. The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in the LAS which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

What consent is – and isn't

3. "Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

    - be competent to take the particular decision;
    - have received sufficient information to take it; and
    - not be acting under duress.

4. The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

5. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **no-one else can give consent on their behalf**. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19) and LAS Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advanced Directives OP /028

Guidance on consent

6. The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies, (such as the Health Professions Council's Code of Conduct, Performance and Ethics).

    - *Reference guide to consent for examination or treatment* provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available on the internet at www.doh.gov.uk/consent.

    - *12 key points on consent: the law in England* summarises those aspects of the law on consent which arise on a daily basis and is provided in Part A of this document. Further copies are available from www.doh.gov.uk/consent.

    - Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies

of these booklets are available on the internet at www.doh.gov.uk/consent.

7. For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent. **Within the LAS this will mean that consent will be documented on the Patient Report Form (LA4 PRF).**

Written consent

8. Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

9. It is rarely a legal requirement to seek written consent,* but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the patient's employment, social or personal life
- the treatment is part of a project or programme of research approved by the London Ambulance Service NHS Trust.

* The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

10. Completed forms should be kept with the PRF. Any changes to a form, made after the form has been signed, should be initialled and dated by both patient and health professional.

11. It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

Procedures to follow when patients lack capacity to give or withhold consent

12. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented on form LA5 - Assessment of Capacity and Refusal to Examination or Treatment. This will include an assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient.

13. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

14. Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought. The Head of Legal Services will obtain advice / assistance from the LAS solicitors on seeking directions from the Court.

Availability of forms (LA5)

15. The LA5 is to be used for patients who may be unable to consent for themselves. These forms should be used in the same manner and in tandem with LA4 PRFs.

16. When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition

Single stage process.

17. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

18. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed. This single stage process will be most applicable to Ambulance services.

Two or more stage process

19. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?" This process will be used more in the hospital environment.

Emergencies

20. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

Treatment of children

21. Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

22. When babies or young children are being cared for, it will not usually seem practicable to seek their parents' consent for every routine intervention. However, you should remember that, in law, such consent is required. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

23. Critical situations involving children and young persons involving a life threatening emergency may arise when it is impossible to consult a person with parental responsibility, or if they refuse consent. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable for all carers to undertake treatment to preserve life or prevent serious damage to health.

24. Children under the age of 16, who have sufficient understanding and intelligence to fully understand what is proposed, also have the capacity to consent to, or refuse, an intervention. This means that the level of capacity of children varies with the complexity of the treatment/refusal and its consequences. There is no particular age when a child gains capacity to consent or refusal. In some situations, although the consequences of non-treatment may be evident, these must be fully explained to ensure that the child fully understands the consequences of refusal.

25. As is the case where patients are giving consent for themselves, those giving consent on behalf of children must have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed and be acting in the best interests of the child. If neither the child nor the person with parental responsibility has capacity, ambulance staff must act in the child's best interest.

Provision of Information

26. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the

risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen next.

27. Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

28. Patient information is available via the Patient Advice and Liaison Service (PALS) and the Professional Standards Unit (PSU). Both these services are available via the HQ Switchboard – 0207 921 5100 or via the London Ambulance Service website www.londonambulance.nhs.uk

Provision for patients whose first language is not English

29. The London Ambulance Service NHS Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. All staff have access to Language Line and multi-lingual phrasebooks. Other specific advice can be sought from the Diversity Team based at LAS HQ.

30. It is not appropriate to use children to interpret for family members who do not speak English, or for an adult family member to interpret for a child who does not speak English.

Access to more detailed or specialist information

31. Patients may sometimes request more detailed information about their condition. This information could be provided via PALS, access to NHS Direct, NHS Direct Online, Professional Standards Unit or the Medical Directorate.

Who is responsible for seeking consent?

32. **The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.**

33. Where oral or non-verbal consent is being sought prior to the initiation of the procedure, naturally this will be done by the health professional responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

Completing consent forms

34. The PRF the LA5, and the LA5a and b all provide space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

35. It is a health professional's own responsibility to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and to work within their own competence and not to agree to perform tasks which exceed that competence.

36. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, seek advice from EOC.

Refusal of Treatment

37. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

    - If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented on the PRF and / or LA5a or b. If the patient has already signed a consent form, but then changes their mind, you (and, where possible, the patient) should note this on the form.

    - Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept

treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

- If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

Clinical Photography and Conventional or Digital Video Recordings

38. Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

39. Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 40 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

40. Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication – see also LAS Managing Patient Confidentiality when dealing with the Media – TP/024.

41. If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must

first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it (see TP/024). Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

42. The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

43. If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

Training

Training in consent is provided by the Education and Development Department through both core courses and the Continuing Professional Development programme.

Current forms in use in this organisation

LAS Trust Assignment Record and Clinical Record (LA4, PRF)
Assessment of Capacity and for adults who are unable to consent to investigation or treatment (LA5)
Patient agreement to investigation or treatment (LA5a)
Parental agreement to investigation or treatment for a child or young person (LA5b)
Accident / Incident Report Form (LA52)

Useful contact details

PALS
PSU
NHS Direct
NHS Direct Online
Governance Development Unit
Medical Directorate
Legal Services

References: DoH Good Practice in Consent Implementation Guide.
LAS Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advanced Instructions – OP/028.
LAS Managing Patient Confidentiality When dealing with the Media – TP/024

Signature: Mike Dinan – Director of Finance.

On behalf of:

Peter Bradley CBE
Chief Executive Officer.

London Ambulance Service NHS
NHS Trust

Procedure covering the Issue and use of drugs by LAS staff.

- Section 1: Guidance on indemnification and working with Voluntary Aid Societies
- Section 2: Requisition, Issue, Use, Disposal and Auditing of Drugs

Objectives

1. To ensure that Assistant Directors Operations and Ambulance Operations Managers are aware of their responsibilities with policies and procedures regarding procurement, storage, security and handling for all drugs stocked on their stations / vehicles or carried by their staff.

2. That the Corporate Logistics Manager in consultation with the supplying pharmacy will be responsible for maintaining an ongoing review of the supply arrangements to ensure that they meet London Ambulance Service (LAS) needs and comply with current legislation.

3. That the Logistics Department ensures adequate provision and exchange of sealed drug packs and sealed Paediatric Advanced Life Support packs on every LAS ambulance station and maintains the provision of station based drugs.

4. To ensure that all ambulance staff are aware of their responsibilities regarding the storage and security of drugs within their possession or held on the vehicle during their shift period.

Introduction

This procedure covers all drugs issued by the London Ambulance Service NHS Trust (LAS) for use by its clinical staff. This procedure covers how drugs are to be requisitioned, issued and disposed of. It also covers auditing of these procedures. This procedure **does not** seek to cover the detailed administration of specific drugs that can be administered to a patient. That information is contained in the current LAS pocket book version of the Joint Royal Colleges Ambulance Liaison Committee – UK Ambulance Service Clinical Practice Guidelines (JRCALC Guidelines). Every member of front line clinical staff is issued with this pocket and is required to carry it at all times whilst on duty. This pocket book details the presentation, indications, contra-indications, actions, cautions, side effects, dosage and route of administration for each drug detailed. There is also additional information for some of the drugs. **Any** drug that is administered to a patient must be documented in accordance with the Patient Report Form User Guide and the LAS Handover Procedure - OP 014.

http://thepulse/uploaded_files/Patients/prf_user_guide_final_oct_07__2_.pdf

http://thepulse/uploaded_files/Operational%20Procedures/2008-06-05_op014_patient_handover_procedure_v3.1_cgc_amndts_2008-04-28___-06-02.pdf

Legal authority for staff to carrying and administering drugs

The Prescription Only Medicines (Human Drugs) Order 1997 (Statutory Instrument 1997 number 1830), as amended, empowers a person who is registered via the Health Profession Council, to administer parentally, on their own initiative certain prescription only medicines for the immediate treatment of the sick or injured. This order is commonly referred to as the **'POMS'** order.

The POM's order also provides the following:-

- A list of drugs and infusion fluids approved for use by Paramedics

- A means by which Glucagon, Salbutamol and GTN may be lawfully administered by all Ambulance Staff

- A means by which drugs can be added to the above lists / categories administered by all qualified ambulance staff or registered paramedics only, once they have been approved for use by the Clinical Steering Committee and, in certain instances, by the Medicines & Healthcare Products Regulations Agency.

All staff who are involved in the ordering, storage, carriage, use and administration of drugs held by the LAS are under an explicit obligation to report any discrepancies, no matter how minor, as soon as possible to either an Ambulance Operations Manager / Duty Station Officer / Emergency Operations Centre or other appropriate manager, in order that the matter can be quickly and thoroughly investigated. All discrepancies are to be recorded in the Station Occurrence Book as well.

IN ADDITION:

If ANY drug in the possession of any person by virtue of his/her authority to store, carry or administer that drug is stolen or otherwise lost, the loss shall be reported by that person as soon as possible to Emergency Operations Centre and then to the local police station. As soon as possible thereafter a full L.A.S. Loss / Theft Report (LA154) must be submitted to the Ambulance Operations Manager for full investigation. At the same time the Ambulance Operations Manager must also inform:-

The Chief Inspector
Drugs Branch
Home Office
6th Floor, Peel Building
2 Marsham Street
LONDON SW1P 4DF

Disposal or destruction of unused drugs that have been drawn up but not administered

All medicines no longer required must be destroyed or otherwise disposed of in accordance with safety, legal and environmental requirements.

Home Office legal advice is that 'destruction' under the Misuse of Drugs Act 1971, may also be taken to mean denatured or rendered not readily recoverable. Whilst this guidance applies in the main to controlled drugs staff are required to ensure that any drugs drawn up, but not subsequently administered to a patient are not readily recoverable.

Individual doses of drugs, that are prepared but not administered, must be disposed of safely and in accordance with legal requirements. Syringe contents or part used ampoules should also be disposed of in accordance with guidance

Drugs should not where at all possible be flushed down drains.

Reporting Adverse drug reactions

Any adverse reaction to a drug administered by a member of staff, or any untoward event that occurs as a result of drug administration is to be reported as soon as possible as per the LAS Health and Safety Incident Reporting Procedure.

http://thepulse/uploaded_files/Health%20and%20Safety%20manuals/h_s_-_011_incident_reporting_procedure_-_april_2008_2.pdfm

Monitoring adherence to this procedure and the JRCALC Clinical Guidelines (Drugs)

The adherence of staff to this procedure as a whole and to the JRCALC Clinical Guidelines in respect of drugs usage and administration will be primarily carried out via the Clinical Performance Indicator checks (CPIs) system.

It is also the duty of all Operational Managers from Team Leaders upwards to ensure that this procedure is adhered to by staff under their management.

The LAS Clinical Steering Committee.

The London Ambulance Service (LAS) Clinical Steering Committee has a duty to ensure that any drug or fluid used by the LAS is both safe and appropriate for use in pre hospital care. They may wish therefore to either decrease or increase the number and type of drugs / fluids used by the LAS or, the way in which a particular drug / fluid is used.

Misuse of Drugs - Group Authority.

Diazepam is one of the controlled drugs listed in the POMS order. The Home Office have authorised a 'group authority' under the *Misuse of Drugs Regulations 1985*, enabling Registered Paramedics to carry and administer Diazepam "for the immediate and necessary treatment of sick or injured persons".

The 'group authority' applies to Registered Paramedics that are employed by an NHS ambulance service for the purposes of that service or employment. A condition attached to the 'group authority' is that any drug in the possession of any person by virtue of the authority shall be produced by that person for inspection when so required by a constable, an inspector of the Home Office Drugs Branch or any person authorised in writing by the Secretary of State for the purpose of regulation 25(1) of the *Misuse of Drugs Regulations 1985*.

General Principles - Security of Drugs

The storage of drugs, controlled or otherwise, must be the subject of a clear written policy. This policy must include a specific reporting procedure for the loss or theft of drugs and must take account of the recommendations of the Duthie Report and the requirements of the relevant Home Office regulations.

If ANY drug in the possession of any person by virtue of his/her authority to store, carry or administer that drug is stolen or otherwise lost, the loss shall be reported by that person as soon as possible to Emergency Operations Centre and then to the local police station. As soon as possible thereafter a full L.A.S. Loss / Theft Report (LA154) must be submitted to the Ambulance Operations Manager for full investigation. At the same time the Ambulance Operations Manager must also inform:-

The Chief Inspector
Drugs Branch
Home Office
6th Floor, Peel Building
2 Marsham Street
LONDON SW1P 4DF

Sample Audit

Sample audits of packed paramedic and general drugs packs will be carried out at the Logistics Support Units.

A daily sample of 5% of packs will be carried out by the Logistics Manager (Supply & Materials Management), or a designated member of staff. The sample audit must not be carried out by the person who has packed or checked the packs under scrutiny.

The result of the audit should be recorded on the Stores Drug Sampling Form LA283 (see Appendix 1). Any defective bags should be returned to the packing store.

A further 5% sample audit of packs held at the Logistics Support Unit will be carried out on a quarterly basis, by an outside agency appointed by the LAS. The results of these audits will also be recorded on the Stores Drug Sampling Form (LA283). Any defective packs will be returned to the packing store.

Stations

All drugs and fluids must be stored in a locked cupboard in a room/area to which access is denied by persons not having reasonable cause to enter that room/area. This means that it is acceptable for the drug / fluid store to be in the Station Office or garage area, provided that it is capable of being locked or secured. When formulating individual Station policies the need for staff to have reasonable access to drugs outside office hours must be considered. (see Introduction - General Principles Security of Drugs, also applies)

All A&E Ambulance Staff

It is the responsibility of all Ambulance Staff to ensure that drugs / fluids are securely stored on any ambulance vehicle they are responsible for during their tour of duty.

In reality this means that when the vehicle is unattended the doors are shut and no drugs are left lying about in view. All drugs are to be left in their sealed packs until required for administration to a patient. The theft / loss of any drug must be reported immediately (see Introduction - General Principles Security of Drugs, also applies).

All staff are held personally responsible for all equipment / drugs / fluids issued to them and will ensure that reasonable access is denied to anyone not having reasonable right of access to them.

Section 1 – Management Scheme and Guidance on indemnification and Working with Voluntary Aid Societies.

1.0 Introduction

1.1. This procedure introduces a new management scheme for drugs in the London Ambulance Service (LAS).

1.2 Under this scheme sealed drug packs will be prepared at the LAS Logistics Support Unit and delivered on a daily basis to all ambulance stations. One pack will be for the use of Paramedics, and one for general use by Paramedics and Technicians. A small number of commonly used drugs will continue to be stored on stations, and kept on vehicles in the Primary Response Pack (PRP) within a new black fabric bag.

1.3 A Paediatric Advanced Life Support Pack (PALS) pack is also available and will be carried on all response vehicles.

1.4 Equipment Support Personnel (ESP) will pack and deliver the drug bags to stations. New packs will be exchanged for used packs. Staff will need to sign for the packs at commencement of shift. Packs can be returned to use at the end of shift if they have not been used and are in date. Used packs will be "posted" into a separate locker. The PALS packs will be changed on demand by the ESP or in consultation with the Logistics Support Unit in cases where there are a number to be exchanged at once.

1.5 The scheme will be carefully controlled and monitored by a system of checks and audits. The Logistics Support Unit and Station Management will be required to carry out regular audits of drugs and packs.

2.0 Staff Indemnification:

2.1 LAS staff will be indemnified in the circumstances stated in sections 3.0 and 4.0 below. For anything which falls outside the circumstances

stated below, LAS staff must consider themselves to be uncovered by the LAS and arrange suitable liability insurance for themselves.

3.0 Normal Working Duties

3.1 Staff will be fully indemnified by the London Ambulance Service NHS Trust (LAS) whilst carrying out their normal working duties on behalf of the LAS. This assumes that all legal requirements and LAS procedures and protocols have been adhered to.

4.0 Voluntary Aid Societies / Charities / Voluntary Work & Private Services

4.1 As the LAS cannot be held responsible for the standards and equipment of others, or the fact that the LAS cannot take on the responsibilities of other organisations, the LAS will not indemnify staff in any way whilst they are performing:

- duties with a voluntary aid society,
- charity or voluntary work,
- duties with Private Medical/Ambulance Services.

4.2 LAS Staff are <u>forbidden</u> from using any LAS equipment or drugs whilst working for a voluntary aid society, charity or voluntary work.

Section 2 - <u>Procedure for the Requisition, Issue, Use, Disposal and Auditing of Drugs</u>

5.0 Drug Requisition and Stock Control Procedures

5.1 The procedures detailed below are to allow for the legal and safe ordering, packing, delivery, usage and disposal of drugs. The stock control cards and drug usage cards allow for the accurate recording of drugs issued to and used by staff. They also allow for stock rotation to be utilised to its maximum effectiveness.

5.2 All drugs will be ordered by the Logistics Support Unit using the LAS ordering system: ***INTEGRA***. Once completed this will be processed by the Purchasing Department. Drugs are not to be procured in any other way. In particular no member of staff is to replenish stocks of drugs / fluids from hospital sources.

5.3 Non pre-packed drugs required by stations should be ordered using the LAS Drug Requisition Form LA284/B (see Appendix 2). Once completed the form is to be faxed or emailed to the Logistics Support Unit for processing.

5.4 Any difficulties encountered in obtaining specific drugs from the supplier will be dealt with by the Logistics Manager (Supply and Materials Management) and the Head of Education and Development or his deputy who will refer to the Medical Director for appropriate advice and/or action.

6.0 In Date and Out of Date Stock Control Card for Stations

6.1 This card LA285 (see Appendix 3) is used to record incoming station drug stock (drugs not provided in sealed packs) and the issue of outgoing stock to individual ambulance staff, or to 'Out of Date Stock'. Each card is to be completed on receipt of incoming stock.

6.2 The top of the card is used to record the name of the drug, issuing station, and card number. Incoming stock is recorded on the left hand side and must be completed in full. Outgoing stock is recorded on the right hand side with the person receiving the drugs printing their name in the "to whom" column, signing in the "signature" column and then completing the call sign of the vehicle the drugs are going on to.

6.3 Every unit of incoming stock is to be recorded on a separate line. In instances where there are more than two units of incoming stock it is permissible to enter all details on the first and last lines of the relevant entries, with all intermediate entries being dittoed. If the entries go

across one or more sides of the card then the last entry and the first entry must be completed in full.

6.4 Stock that goes out of date will be removed to the out of date drug stock and recorded on the Out of Date Stock Card LA286 (Appendix 4). On this form the station name and card number should be noted and then the date the 'Out of Date' drugs are being recorded inserted. The Batch number, expiry date and drug description should then also be entered. The quantity of the drugs should also be recorded in the drug description column.

7.0 In Date and Out of Date Stock Control Books for Logistics Support Unit

7.1 *Station Based Drugs*

7.1.1 The stock control book LA287 (Appendix 5) is used to record incoming drug stock and the issue of outgoing stock to individual ambulance stations, or to 'Out of Date Stock'. Each book is drug specific and numbered sequentially, and is completed on receipt of incoming stock.

7.1.2 The top of each page is used to record the date in stock, batch number, expiry date, amount and the signature of the person updating the record. Outgoing stock is recorded on the left hand side with the issue date, receiving station with the amount that is being sent, updated running total of remaining stock and the signature of the person updating the records. If any of this stock becomes out of date a note should be made on the form. This should include the date and amounts of stock being transferred to the 'Out of Date Stock' storage area. Details of 'Out of Date Stock' should be recorded on form LA289 (Appendix 7) – see 7.2.3 below. All the details on the form must be completed in full.

7.1.3 Drugs with a different batch number or expiry date must be entered onto a new page and a line drawn through the remaining space on the current page to ensure that no further additions can be entered.

7.2. *Sealed Drugs Packs*

7.2.1 A similar stock control book to that referred to at 7.1.1 will be used for sealed drugs packs – LA288 (Appendix 6). The book must also be completed as outlined in 7.1.2 and 7.1.3. In this case a drug pack number will be inserted instead of a station name.

7.2.2 All the above drugs are to be stored in the secure drugs store within the Logistics Support Unit. Any drug that requires refrigeration must be stored in a medical fridge and restricted drugs must be kept within the locked cupboards in the drug store.

7.2.3 Drugs that go out of date from the Logistics Support Unit stocks will be isolated in the 'Out of Stock' storage area. Details of this stock should be recorded on form LA289. On this form the card number should be inserted. The date the out of date drugs are being recorded should be inserted. The batch number, expiry date, and drug description should then be added. The quantity of the drugs being recorded should be inserted in the drug description column.

8.0 Sealed Drug Bag Packing Procedure – Paramedic and General (empty bag)

8.1 The accurate packing and checking of sealed drugs packs is of primary importance. The Logistics Support Unit Personnel carrying out these duties must take the utmost care when packing and checking the packs, bearing in mind the clinical risks involved in making errors.

8.2 Before commencing to pack the sealed drugs packs the designated packing area must be checked and clean. Each individual bag must be checked for condition, and all expiry dates and batch numbers are to be rechecked. The drug bag is then packed in accordance with the agreed layout. Drugs are signed out of the main drugs store onto each of the active drug packing stations. Batch numbers and quantity of drugs are then recorded in the drug log on each of the respective drug packing

station. The check lists (see Appendix 8 form LA282 (Paramedic) and Appendix 9 (General) form LA281)) are to be completed with expiry date against each individual drug and placed into the receptacle within the bag. The check lists should be signed by the packer. The contents and expiry dates are then to be checked by another person. If all contents are correct, the check list countersigned by the checker. The pack should then be sealed with a date for return to the Logistics Support Unit if unused, then placed into the appropriate area of the drugs store.

9.0 Sealed Drug Bag Packing Procedure – Paramedic and General (used bag)

9.1 Before commencing to pack the sealed drugs packs the designated packing area must be checked and clean. All drugs that are still in the used bag must be checked for expiry dates and batch numbers. If expiry date is less than seven full days, this drug must be removed and signed into the out of date stock. Each individual bag must be checked for condition, the requisite amount of replacement drugs are replenished from the stock of drugs held at the drug packing station ensuring that the drugs log is amended is such a way that records the quantity issued and the drug pack number. The drug bag is then restocked in accordance with the appropriate layout. The check list is to be completed with expiry date against each individual drug and placed into the receptacle within the bag. The contents and expiry dates are then to be checked by another person. If all contents are correct, the crew drug use sheet should be inserted, the pack should then be sealed with a date for return to the Logistics Support Unit if unused, then placed into the appropriate area of the drugs store.

10.0 Batch Withdrawal Notice

10.1 If the Service receives notice to withdraw a particular drug or batch then the Logistics Manager (Supply and Materials Management) or his designated deputy will be responsible for checking the records to ascertain which packs are affected and their whereabouts and take appropriate action to withdraw and replace as soon as practical.

10.2 All affected drugs will be collated at the Logistics Support Unit and dealt with on the merits of each individual case.

11.0 Sealed Drug Bag Delivery / Collection

11.1 At the beginning of each shift the ESP will load sealed drug packs onto their vehicle in accordance with the drug management plan. Once the drug packs are on the vehicle it must be secured at all times when unattended.

11.2 At each station visited the ESP will check and empty the used drug bag locker updating the delivery / collection forms for each bag removed (Appendix 10 form LA292 (Paramedic) and Appendix 10+ for LA292(A) MRU / CRU and see Appendix 11 General form LA293.

11.3 The ESP will replace each used or out of date bag by putting a sealed replacement into the drugs storage locker, ensuring that all bags are in date order with the earliest expiry date at the top, keeping the paramedic and general bags separate. Paramedic drug bags are to be kept on the lower shelves, with the general drug bags above. Delivery/collection forms should be updated for each bag supplied.

11.4 At each station the ESP should complete the Vehicle Movement Drug Bag Form (Appendix 12 form LA294) stating which pack numbers have been left and collected.

11.5 On return to the Logistics Support Unit used drug bags are to be placed in the identified area. Any unused drug bags are to be returned to the drug store for further use and must not be left on an unattended vehicle and all paperwork including the vehicle drug bag movement form to be handed in.

11.6 Drugs pack movements are to be recorded at the Logistics Support Unit and updated on a daily basis by the Logistics Manager (Supply and Materials Management) or their designated assistant.

12.0 Procedure for Use of Sealed Drugs Packs – Paramedic and General

12.1 On commencement of duty one of the crew staff should undertake the vehicle check whilst the other draws a general and paramedic sealed drug packs from the drugs locker as appropriate in readiness for the next call.

12.2 A check should be carried out to ensure that the seals on the numbered drug packs are intact and that the out of date figure is in date for at least 24 hours (label attached to security tag). If the integrity of the sealed pack is in doubt, or if the pack is out of date, then place the pack into the drug return locker and record the reason on the Drug Pack Issue / Return Form LA295/A (revised) (Paramedic & General / MRU / CRU)- Appendix 13.

12.3 Receipt of the sealed drug packs should be acknowledged by signing for them on the appropriate Drug Pack Issue / Return Form and also recording the date of issue and the pack number.

12.4 The packs should be stored in the vehicle primary response pack and paramedic pack. The contents of the drug pack should be used as per Training Orders .

12.5 Paramedics and Technicians are still responsible for checking drugs prior to administration. This should include a check on dosage. Any packing errors or missing drugs discovered should be reported to Station Management and an LA52 completed. The pack concerned should be isolated, and returned to the Logistics Support Unit with a copy of the LA52.

12.6 On return to station with an opened drug pack the used packs should be signed in on the Drugs Pack Issue / Return Form LA295/A (Paramedic / MRU / CRU) and form LA296 (General) - Appendix 14, and placed in the drugs return locker.

12.7 A note of the reason the pack has been returned should be made using one of the following codes. End of Shift (E.O.S.) Drugs used (D.U.), Seal broken (S.B.), batch number problems (B.N.), Integrity of drugs (heat / cooling) (HC).

12.8 A new drug pack should be drawn as detailed above even if there is only a short time to go to the end of the shift.

12.9 At the end of the shift any unused drug packs should be signed back in using the Drug Pack Issue / Return Form and placed in the drug storage locker ensuring that it is still within date.

13.0 Sealed Paediatric Advanced Life Support Pack (PALS Pack)

13.1 The PALS pack will be packed at the Logistics Support Unit in accordance with the appropriate check list form LA304 (Appendix 20).

13.2 The PALS pack will be issued to stations and placed on every ambulance. Checking that the pack is in date and sealed will form part of the daily vehicle inspection. On the rare occasion that these packs are used, the used pack handed in to station management, who will make arrangements with the Logistics Support Unit for the exchange of the pack.

13.3 The Logistics Support Unit will maintain records of PALS packs and their location and will arrange with station management to exchange them before their expiry date.

13.4 A PALS Pack Delivery and Collection Form LA298 will be completed as appropriate by Equipment Exchange Staff. An entry on LA294 the Vehicle Movement Form should also be made.

13.5 The Station should keep a record of which vehicle fleet number the PALS pack is issued to, and on what date, on the PALS Pack Issue / Return Form LA299 (Appendix 16). When the pack is returned following use or, if it is out of date, a note should also be made on this form.

14.0 Loss of Any Drug Pack

14.1 Should a sealed drug pack be stolen or lost, this must be reported to EOC and a local Police station at the earliest opportunity. On return to station the drug pack issue form is to be updated and a loss report must be completed and passed to station management. The station management will need to report the loss to the Logistics Support Unit and seek advice from the Head Education and Development or his nominated deputy on any further action.

14.2 The Logistics Manager (Supply and Materials Management), or their deputy must update central records to show loss of bag and drugs.

15.0 Drug Usage from – sealed shift based drugs pack documentation – Paramedic and General

15.2 Every drug administered must be recorded on the appropriate line of the Drug Usage Form. The dose issued, date of use, batch number and expiry date. The PRF number should be completed at the top of the form. Should the pack be used on more than one patient a second form is on the reverse. *N.B. the name and dose of drug must also be recorded on the Patient Report Form.*

15.3 If a unit is broken this must be recorded as such on the Drug Usage Form.

16.0 Drug Usage Card – unsealed drug pack (black material bag)

16.1 LA285 is issued to cover the use of drugs drawn from station (currently Hypostop, Aspirin, Salbutamol, Ipratropium Bromide and GTN spray) and should be kept in the Primary Response Pack of each front line ambulance hence the box labeled - “Veh Call Sign” - and if the drug is ‘Out of Date’ then it is recorded on LA286. It is the responsibility of each member of staff to ensure the cards are fully and accurately completed.

16.2 Every unit of incoming stock is to be recorded on a separate line in the "Drawn" section on the left-hand side of the card. In instances where there are more than two units of incoming stock it is permissible to enter all details on the first and last lines of the relevant entries, with all intermediate entries being dittoed. If the entries go across one or more sides of the card then the last entry and the first entry must be completed in full.

16.3 Every drug administered must be recorded on a new line on the Drug Usage Card. The dose issued, date of issue, batch number and expiry date of the drug must be recorded on the Drug Use Card. *N.B. the name and dose of drug should also be recorded on the Patient Report Form.*

16.4 If a unit is broken this must be recorded as such on the Drug Usage Card.

16.5 Any drug that is removed from circulation must be signed off in the "to whom" column of the appropriate form as: 'Out of Date Stock' LA286 (see Appendix 4)

17.0 Out of Date Drug Stock and Out of Date Stock Form Documentation.

17.1 All 'Out of Date' stock is subject to the same security measures as in date stock. 'Out of Date' stock must not be kept where it may inadvertently be mistaken as 'In Date' stock.

17.2 All 'Out of Date' drugs must be placed within the Out of Date stock and recorded as such on the 'Out of Date Stock' form LA286. There is to be no more than one 'Out of Date' drug stock per complex or within the Logistics Support Unit.

17.3 Stations should then make arrangements to return out of date stock to the Logistics Support Unit via the equipment exchange scheme. *Stock must not to be placed in the internal mail system under any circumstances.*

17.4 The Logistics Support Unit will arrange for disposal of out of date stock via the clinical waste contract.

18.0 Out of Date Stock Form

18.1 All out of date stock will be recorded on the out of date stock form LA286 (Stations) and LA289 (Stores). The forms are not drug specific, thus units of different drugs can all be recorded on the card. When the drugs are being returned the form is to be copied. The original is to be retained on station / Logistics Support Unit for record keeping, the copy must be placed with the drugs being returned and is for the use of the disposal contractor. All responsibility for the drugs ceases once the courier has signed for the drugs and removed them from LAS premises.

18.2 Every unit of out of date stock is to be recorded on a separate line. In instances where there are more than two units of stock it is permissible to enter all details on the first and last lines of the relevant entries, with all intermediate entries being dittoed. If the entries go across one or more sides of the card then the last entry and the first entry must be completed in full.

18.3 All out of date drug stocks at stations must be returned to the Logistics Support Unit as required. 'Out of Date' drug stocks should not remain on stations longer than one week.

18.4 All 'Out of Date' stock held within the Logistics Support Unit must be disposed of in the appropriate manner within one month.

18.5 In some instances the Training Centre's may require 'Out of Date' stock for training purposes. In this instance the Training Centre's will contact the Logistics Support Unit and arrange collection of the drugs in person. In this instance they will be signed off in the "to whom column" as; "To *Kenton** Training Centre" (* Enter appropriate name of Training Centre).

19.0 Loss of any Card / Stock Control Book

19.1 Staff must report to their Line Manager any Card / Stock Control Book loss. The Line Manager will issue a new card/stock control book and investigate the loss. The findings of the investigation will be reported in writing to the Assistant Chief Ambulance Officer who will then decide on the most appropriate course of action.

20.0 Retention of Card records / Stock Control Book

20.1 When any card is full it must be kept with the Stations / Logistics Support Unit Drug records. It must be able to be produced on demand for persons having reasonable need to see / check them.

21.0 Checking and Auditing of Drug Stocks

21.1 It is the responsibility of each individual member of staff to check that any drugs or sealed shift based drug packs in their possession are properly accounted for by the relevant paperwork. In general terms this will mean a check being made at the beginning of every shift and/or every vehicle change with the appropriate paperwork being completed. Any discrepancies must be reported to the Ambulance Operations Manager or their deputy for investigation (Introduction - General Principles Security of Drugs also applies)

21.2 Ambulance Operations Managers will conduct a full audit of the drug stocks and sealed shift based drug packs held in the station stores on a weekly basis. This audit will be documented in the following way:

21.3.1 *Station Drugs*

- Draw a line right across the card on the line underneath the last entry on the In Date Stock Card LA285 (Appendix 3)

- On the next line write “Drug Audit Completed – *Date* – *Signature* – *Printed Name*”
- Draw a line right across the card on the next line down

21.4.1 *Sealed Drug Packs*

- The sealed drug pack audit form LA301 (Appendix 17) is to be completed weekly by cross referencing the individual sealed paramedic, general and PALS shift based pack delivery and collection form.

21.4.2 The Ambulance Operations Manager or his / her designated deputy, should make a note in the Occurrence Book to the effect that the Drug Audit has been completed

21.5 Any discrepancies must be investigated thoroughly (see Introduction - General Principles Security of Drugs), with the result of those investigations being noted in the Occurrence Book.

21.6 Drug audits should be kept on station for a period of two years.

21.7.1 ***Audit in Stores***

21.7.2 The Logistics Manager (Supply and Materials Management) or his / her designated deputy will carry out a weekly audit of all drugs held in the main drugs stock and the packing stock, LA302 Equipment Store Audit - Main Drugs Stock and LA302A Emergency Care Practitioners, (Appendix 18) and LA303 Equipment Store Audit -Packing Drugs Stock - (Appendix 19).

21.7.3 The number of sealed bags held should also be audited on a weekly basis using the Sealed Drug Pack Audit Form LA301.

22.0 Form Retention

22.1 Form retention details are listed in Appendix 21.

References:

HM Government (1997) POMS (Human drugs) Order S.I. 1997 No. 1830
HM Government The safe and secure handling of medicines (Duthie Report)
NHS (1993)
Misuse of Drugs Regulations 1985 Group Authority
IHCD (2000) Ambulance Service Paramedic Training Manual
Joint Royal Colleges Ambulance Services Liaison Committee – UK Ambulance Service Clinical Practice Guidelines (Current version at date of reading this procedure)

Cross References – LAS Policies / Procedures:

Patient Report Form User Guide - 2007
OP 014 Patient Handover Procedure

Signature: 

Peter Bradley CBE
Chief Executive Officer.

London Ambulance Service NHS
NHS Trust

PROCEDURE RELATING TO THE CLINICAL HANDOVER OF PATIENTS

DOCUMENT PROFILE and CONTROL

Purpose of the document: To provide guidance when patients are handed over to hospital departments or treatment centres.

Sponsor Directorate/Department: A & E Operations

Author/Reviewer: Deputy Director of Operations. To be reviewed by June 2011.		**Document Status: Final**	
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Amendment Details

Sections relating to admin handover and hospital closures and diversions removed.
Amendments required by CGC 28/4/08 & 2/6/08

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1. Introduction

The London Ambulance Service NHS Trust (LAS) conveys patients, using the Accident & Emergency (A&E) and Urgent Care services fleet, to a variety of departments/units. The majority of patients are, however, conveyed to Emergency departments. It is therefore essential that a close working relationship is sustained between LAS and hospital staff to ensure the patient is handed over in a safe and timely manner. Delays may arise through difficulties in patient placement which can affect the hand over process, delaying ambulance activity.

The principles of this document should be used as guidance when patients are handed over into any other department or treatment centre. It is, however, accepted that there may be times when the transfer of patients to the designated receiving units may take longer than the LAS standard of 20 minutes. In these circumstances the respective control room should be informed so that they can appropriately record the reasons for the delay and actions taken to resolve it.

Comment [J1]: Where did this come from?

The LAS also conveys patients to other units for humanitarian reasons, e.g., a hospice. In these cases the patient's comfort and dignity will be the factors guiding hand over.

2. Objectives

1. To provide clarity for both LAS and hospital staff of their role in the hand over of a patient, ensuring the provision of seamless patient care.
2. To ensure the patient is handed over in a safe and timely manner within the 20 minutes LAS hospital handover time standard.
3. To identify when responsibility for the patient transfers from the LAS to the receiving hospital.
4. To improve communication between LAS staff and receiving unit staff.

Comment [J2]: Where can this standard be found?

3. Procedure

3.1 Clinical Hand Over

3.1.1 A clinical hand over of the patient should be given to the Emergency department nurse/doctor taking responsibility for that patient using the Patient Report Form (PRF) to provide structure and clarity over the information provided. The information should include the patient's vital signs, history, injuries, name and age, further guidance on the completion

of the PRF can be found in the PRF user guide which can be located on "The Pulse"

3.1.2 The patient's privacy must be maintained at all times. Ideally the handover should not take place in a public area.

3.1.3 Once the clinical hand over is complete, the receiving clinician should retain a copy of the PRF. At this point responsibility for the patient is transferred to the hospital staff.

3.1.4 Ambulance staff should also hand over any information on the patient's social circumstances to the receiving clinician which may help hospital staff with discharge planning. All medication and the patient's property must be placed in the relevant patient bag and be handed over at this time along with any other medical information that may be relevant to the patient's condition or treatment.

3.1.5 It is the responsibility of the hospital to ensure that their administrative process is fulfilled. Ambulance staff will leave the PRF with the hospital in the pre-arranged location, but should not be involved in the generation of the hospital patient record. LAS Staff should not carry out a verbal handover to reception staff enter details on the hospital computer or source the patient's hospital notes.

3.1.6 It is critical that the copy of the PRF is clearly legible. Staff should use a black ball point pen; press on a firm surface and sufficiently hard. If this copy is not legible, it should be over-written before being handed in.

4. Completion of Documentation

4.1 Wherever possible the PRF should be completed whilst en route with the patient to hospital, in accordance with the LAS user guide. If this cannot be achieved then the PRF should be completed as soon as possible on arrival at hospital. In the event that a FRU has attended the call prior to an ambulance, a copy of their HRF (handover report form) should be given to the crew conveying the patient so that it forms part of the overall patient record.

4.2 In some situations a clinical handover precedes completion of the PRF, particularly where patients are taken directly into the resuscitation room. If this is the case the PRF should be completed as soon as possible and then left with the receiving clinician to form part of the patient's record.

5. Reporting Availability

5.1 It is essential that ambulance staff ensure their availability is reported promptly to the Emergency Operations Centre (EOC) after patient hand over by the use of the 'green mobile' status button.

5.2 After reporting their availability to the EOC , the ambulance crew may request to remain on active area cover at the hospital and avail themselves of local facilities. This is acceptable providing they remain immediately available to respond to a call.

6. Delays due to assisting Hospital staff when necessitated by the Patient's condition

6.1 Ambulance staff should inform the EOC as early as possible of any potential delays as a result of the patient's condition. Any other delays should also be reported to the EOC at the time of the delay (not retrospectively) a note will then be added to the electronic call log, this should also be documented on the PRF. Actions taken to mitigate and reduce such delays should also be recorded.

7. Staff Welfare

7.1 If ambulance staff subsequently feel they need further support or assistance once the hand over is complete, they should contact the EOC who will contact the appropriate officer.

8. Delays for Patients who are 'Not Ready for Transfer'

8.1 There are times when ambulance staff are committed to the transfer of a patient and the patient is not ready. If the delay is expected to exceed 20 minutes then the EOC must be informed immediately and the crew should remain in contact with the EOC. The final decision on whether ambulance staff should be re-deployed rests with the Operations Centre Manager (OCM). Effective liaison between ambulance staff and the EOC is essential.

9. Hand Over of Adult Patients Where Death has Occurred

9.1 In certain circumstances, and in accordance with the National Clinical Guidelines, ambulance staff are authorised to recognise patient death by implementing the recognition of life extinct (ROLE) procedure. Form LA3

must be completed for all patients where death has been recognised. This constitutes legal confirmation of patient death. Copies of both the LA3 and the PRF relating to the patient must be handed to the attending police officer. In circumstances where death is expected and the ambulance crew feel able to leave the scene before the arrival of the police, this documentation must be handed to the responsible person who will remain on scene with the deceased. EOC must be informed of the name of this person, it must be also be documented on the PRF.

9.2 The introduction of Recognition of Life Extinct (ROLE) for ambulance crews now eliminates the need for patients to be taken to Emergency Departments in order to pronounce life extinct.

9.3 When ROLE has been initiated the deceased patient then becomes the legal responsibility of the Coroner and must not be removed from scene without their authority. This authority is given via the attending police officer. In some circumstances the Coroner may permit the deceased patient to be removed to a pre-determined mortuary of the Coroner's choice.

9.4 When a deceased patient is permitted to be removed to a public mortuary, copies of the LA3 and the PRF should be handed to the police officer escorting the patient, or the mortuary attendants.

9.5 Any delays should be reported to the EOC as normal.

10. LAS Equipment Taken into the Emergency Medicine Department

10.1 All non-disposable equipment and blankets taken into Emergency departments should be retrieved, where possible, before leaving. This may be achieved by a direct swap. In the event of any essential equipment being left this must be documented on the LA1 and EOC staff informed. All equipment must be identifiable to the LAS. Any equipment not retrieved by the end of the shift must be verbally reported to the oncoming crew and documented in the station Occurrence Book. Every attempt must be made to retrieve the equipment during the course of the shift.

NOTE: This procedure adheres to current JRCALC guidelines. Section 9 will be expanded when agreement is reached between Coroners' Courts and the Local Authorities concerning a common approach to Sudden Unexpected Death in Infancy (SUDI).

IMPLEMENTATION PLAN	
Intended Audience	For all operational staff
Dissemination	The Pulse
Communications	Routine Information Bulletin (RIB)
Training	
Monitoring	

London Ambulance Service NHS Trust

Stress Management Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to ensure the London Ambulance Service NHS Trust (LAS) comply with the relevant Health and Safety Executive (HSE) legislative and guidance documents to ensure its staff are not exposed to excessive levels of occupational stress that may affect their health.

Sponsor Department: Human Resources and Organisation Development

Author/Reviewer: Assistant Director Employee Support Services. To be reviewed by Sep 2011.

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Amendment History			
Date	*Version	Author/Contributor	Amendment Details
	0.1	John Selby	Major
	0.2	Fatima Fernandes	Major – added Monitoring and Appendix 1

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMG		1.0
Ratified by:		

Published on:	**Date**	**By**	**Dept**
The Pulse		Victoria Smith	GDU

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Health & Safety at Work etc. Act 1974	
	Management of Health & Safety Regulations 1999	
	LAS Incident Reporting Procedure	
	LAS Whistle Blowing Policy and Procedures	
	Harassment and Bullying Policy	
	Major Incident Plan	
TP013	Claims policy and procedure for clinical negligence, personal injury, property and other liability claims.	
TP015	Procedure for responding to enquiries, giving evidence, coroners' inquests and statements at police interviews	
TP006	Serious Untoward Incidents Policy	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

1.1 London Ambulance Service NHS Trust (LAS) is committed to protecting the health, safety and welfare of its employees, and recognises that workplace stress is a health and safety issue. Consequently, the importance of identifying and reducing workplace stressors is acknowledged.

1.2 This policy will apply to all employees, but managers are responsible for implementation and the Trust is responsible for supporting them in doing so by providing appropriate training and agreed, identified resources as necessary.

1.3 The key role played by an effective, up to date and regularly reviewed range of Human Resources and other corporate employment policies and procedures is fully acknowledged. This policy statement cannot and does not seek to list or identify these in detail, but they are widely available to all staff via the Pulse.

2. Objective

2.1 The objective of this policy is to ensure the London Ambulance Service NHS Trust (LAS) comply with the relevant Health and Safety Executive (HSE) legislative and guidance documents to ensure its staff are not exposed to excessive levels of occupational stress that may affect their health.

2.2 In conjunction with recognised and accredited health and safety representatives, LAS will conduct risk assessments to identify workplace stressors and implement measures to eliminate workplace stress, or to control the identified risks arising from workplace stress. These risk assessments will be regularly reviewed by those accountable for the area of work or the practice.

2.3 LAS will consult with recognised and accredited health and safety representatives on all proposed action relating to the prevention or reduction of workplace stress.

2.4 Training will be provided for managers and other supervisory staff in good management practices, and attendance monitored. Health and Safety management responsibilities will be confirmed in job descriptions, and training needs identified through the Trust's personal development review process.

2.5 Support and assistance will be provided for staff affected by stress caused by either work or external factors. Types of support include:

- Confidential counslling services
- Employee Assistance Programmed
- Linc (Listening, Informal, Non-judgemental, Confidential) peer support network
- Occupational Health Services
- Staff Support Adviser

2.6 In addition, support is available to staff through line managers, team leaders, Human resources Staff, the Diversity Team, Legal Services and Education and Development staff. This list should not be taken to be exhaustive.

3. Definition of Stress

3.1 The Health and Safety Executive defines stress as “the adverse reaction people have to excessive pressure or other types of demand placed on them”. This makes an important distinction between pressure, which can be a positive state if managed correctly, and stress which can be detrimental to health.

4. Responsibilities

Chief Executive/Chief Ambulance Officer (CEO)

The CEO takes overall responsibility for Health, Safety and Risk Management within the LAS.

The Director of Human Resources and Organisational Development

Responsibility for Health, Safety and Risk Management has been delegated to the Director of Human Resources and Organisational Development.

4.1 **Managers have the responsibility for ensuring that this policy is implemented; Ambulance Operations Managers/Duty Station Officers/Site Managers and Department Heads**

- With the support of health and safety representatives conduct, and implement recommendations of, risk assessments within their area of responsibility.
- Promote good communication between management and staff, particularly where there are organisational and/or procedural changes, including changes to working practices.
- Ensure staff are fully trained to discharge their duties.
- Ensure staff are provided with appropriate development opportunities, as identified in the personal development review.
- Ensure that quarterly workplace assessment are jointly undertaken, and that identified actions are implemented.
- Monitor workload as appropriate.
- Monitor working hours and overtime, intervening where necessary if it is felt that hours being worked may compromise staff and/or patient safety.
- Monitor manage absence due to sickness, in accordance with the Trust’s “Managing Attendance Procedure”.
- Ensure that staff who have been absent due to sickness receive a “return to work” interview and that any issues, concerns or trends are identified and appropriate action taken to support staff in turning to work and maintaining their attendance at work.
- Monitor and manage annual leave arrangements to ensure that staff are taking their full entitlement.
- Ensure staff attend training as requested and record attendance on personal file, in good management practiced and adherence to health and safety.
- Ensure that bullying and harassment is not tolerated within their jurisdiction.
- Be vigilant and offer additional support to a member of staff who is experiencing stress outside work e.g. bereavement or separation.
- Be aware of LINC Peer Support Programme and Traumatic Risk Management (TriM) for supporting staff suffering from traumatic stress – see Appendix 1.

4.2 Occupational Health Department/Counseling staff

- Provide specialist advice and support to staff and managers.
- Support individuals who have been off sick with stress and advise them and their management on a planned return to work.
- Refer to workplace counselors or specialist agencies as required.
- Monitor and review the effectiveness of measures to reduce stress.
- Inform the employer and the health and safety committee of any changes and developments in the field of stress at work.
- Provide training for staff and managers in signs and symptoms of stress, and appropriate interventions.

4.3 Human Resources staff

- Give guidance to managers on the stress policy.
- Assist in monitoring the effectiveness of measures to address stress by, for example, collating, analysing and reporting sickness absence statistics.
- Collating, analysing and reporting staff turnover rates.
- Undertake exit interviews, reporting any issues and trends that may be identified.
- Advise managers and staff on training and development requirements.
- Provide continuing support to managers and individuals in a changing environment and encourage referral to occupational workplace counselors or other support where appropriate.

4.4 Staff

- Raise issues of concern with line managers in the first instance or, failing that, with appropriate specialist staff such as those working in Departments such as Human Resources, Safety and Risk, Occupational Health etc.; or with health and safety representatives occupational health.
- Attend all identified training and development opportunities as required.
- Accept opportunities for counseling when recommended.

4.5 Staff Safety representatives

- Staff Safety representatives will be meaningfully consulted on any changes to work practices or work design that could precipitate stress.
- Staff Safety representatives will be able to consult with staff on workplace health and safety issues, including stress, and may conduct workplace surveys.
- Staff Safety representatives will be meaningfully involved in the risk assessment process.
- Via the health and safety committees, staff safety representatives will receive reports relating to reported or identified work place health and safety incidents or issues.
- Staff Safety representatives will be supported in fulfilling their role and function by receiving paid time off, including time for training in workplace issues including stress, in line with existing agreed partnership and facilities arrangements.
- Staff Safety Representatives should conduct joint premises inspections of the workplace at intervals of 3 months to ensure that environmental issues and stressors are properly identified and consideration given to appropriate control measures.

4.6 **Safety Committees**

- Implementation of this policy will be overseen at the Trust level by the Corporate Health and Safety Group and locally through Area Health and Safety Committees.
- Minutes of the Corporate Health and Safety Group will be submitted to the Trust's Risk Compliance and Assurance Group, which will also receive and consider reports of any identified issues or concerns and the associated interventions.
- The Corporate Health and Safety Group will be charged with regular monitoring and review of the effectiveness of this policy and associated measures to reduce stress and promote workplace health and safety.
- This will be undertaken by agreed means that are likely to include consideration and tracking of key indicators such as:

    - sickness absence levels
    - staff turnover
    - adverse incident/personal injury reports (LA52s)
    - patient complaints
    - staff/patient/stakeholder surveys
    - incidents reported under harassment and bullying policy.

IMPLEMENTATION PLAN	
Intended Audience	For all LAS staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	
Monitoring	This policy will be monitored in line with industry best practice potential indicators of stress within staff groups and across Directorates to identify trends and hotspots within specific occupational areas so that further risk management activity can ensue. The Trust regularly monitors potential indicators of work related stress such as: • **Sickness Absence Data** – The Management Information (MI) Department collate the information and produce monthly reports. • **Staff Turnover/Retention Data** – reports can be requested from the MI Department. • **Incident Reporting Data** is tabled at the Corporate Health and Safety Meeting, which are held on a quarterly basis, chaired by the Director of HR • **Exit Interview Information** - Individual HR managers collate their own exit interview data for their areas, which is kept locally. • **National NHS Staff Survey** – is carried out annually by the Healthcare Commission and the full current Report and findings on the London Ambulance Service can be accessed from: http://www.healthcarecommission.org.uk/_db/_documents/AH_NHS_staff_survey_2007_RRU_full.pdf **Trust wide Risk Assessments / Individual and Complex Risk Assessments** - Line Managers are responsible for undertaking risk assessments in accordance with the Risk Policy Guidelines; generic risk assessments are undertaken centrally through the Safety and Risk Department who facilitate the process. The frequency is determined by the level of risk and existing control measures.

Appendix 1

An Overview of the TRiM System

1. Many of our staff work in areas where they are regularly exposed to events considered outside of the experience of a "normal" life. For example, in the course of their working lives, our staff may witness and need to manage incidents involving conflicts or other aggression, extreme suffering, or incidents such as road traffic accidents and fatalities. In order to respond to the potential needs of staff involved in a traumatic incident the LAS uses the TRiM System, which is a proactive, post-traumatic peer group delivered management strategy which adheres to NICE best practice guidelines. TRiM aims to:

    - keep employees of hierarchical organisations functioning after traumatic events
    - provides support and education to those who require it
    - assesses and identifies those with difficulties that require more specialist input.

2. A traumatic event, by definition is physically and emotionally overwhelming (e.g. where emotion overwhelms rational or logical thought processes). This disrupts the basic personal belief systems of the survivor – including trust, security, predictability and controllability.
   People may experience a range of differing reactions to traumatic events including: shock, fear, anger, helplessness, sadness and shame. These are all completely normal reactions to an event that may be considered extraordinary. Other effects may include tension, sleep disturbances, dreams and nightmares, fearfulness, intrusive memories and feelings, numbing, irritability, depression, social withdrawal, physicals sensations, mental reactions and self medication. Usually these reactions are only experienced for a few weeks, and by utilising the LAS support services offered by the LINC Scheme, Occupational Health, the EAP and the External Counselling Service provider staff affected can learn to better manage and understand traumatic stress and also learn to enhance personal resilience.

3. The peer group LINC Scheme TRiM practitioners ensure that the psychological needs of staff involved in a Traumatic Incident are assessed and referred, if required, to Occupational Health for CBT therapy. TRiM is a cognitively based model that aims to help those involved to integrate the incident into their experience and into their lives. This is achieved not only through the asking of specific risk factor questions, but also providing educational information that enables individuals to better understand their normal reactions to an abnormal event. That is, these normal reactions are not signs of weaknesses and inadequacies but are part of the therapeutic process when the mind and body tries to process and make sense of what has happened. Anecdotal evidence suggests that it is well accepted and achieves its aims of improving psychological wellbeing and the theory and practice of the system has been published in a known peer reviewed Occupational Health Journal (Jones *et al* 2003). TRiM appears to be good practice and experts in the field of traumatic stress have stated their supportive view in the scientific literature.

4. According to statistics, used by NICE, immediately after a traumatic event some 60% of people experience a similar set of symptoms. Within 4-6 weeks, however, that figure falls to about 10%. Most people get better without any intervention. The TRiM strategy reinforces people's natural tendency towards wellness and resilience and it also

provides a structure of support and guidance on how staff can learn to look after both themselves and each other. **Understanding that most people will cope with even the most serious events is important. It is the minority who are likely to require extensive support, assistance and perhaps even referral to specialist services.**

5. Managers are given support and advice on how to best manage individuals who may be struggling. (see Managers' Guide to Traumatic Stress below). That is, the focus is to build on a person's resources and resilience. For example, staff should not be sent home but encouraged to stay at work within a familiar environment and with colleagues who have undergone the same experience – this is an important part of the healing process. Sending staff home during these traumatic events is rarely the best option as an individual often goes home to an empty house or to a house where family or partner are there and a staff member will aim to protect these close relationships. Whereas, staying within the workplace with the individuals, who also managed/witnessed the incident, and delegating/carrying out appropriate manageable tasks, will prevent isolation, reinforce psychological containment and encourage the re-building of self-confidence and resilience. And it is also a proactive attempt to normalise the situation within a familiar working environment, which is part of the healing process. In such situations a manager will monitor the staff member give him or her the opportunity to discuss the problem, ensure that the staff member is involved in group activities and gives information about the effects of traumatic stress and self-help measures following Traumatic incidents. Research has shown that appropriate information given before and reinforced after Traumatic incidents can help to decrease levels of distress and build resilience against having to manage future Traumatic Incidents.

6. The TRiM training equips Practitioners to assess the possible psychological aspects of traumatic incidents via conducting a semi-structured risk assessment interview and through the delivery of basic psycho-educational briefings, if appropriate. TRiM Practitioners are also taught how and when to liaise with managers and medical/staff support staff.

7. Psychological threat and risk assessment

At the time of writing, there is no clear profile of the person who may go on to develop a psychological illness. However, there is a growing body of research that has identified certain risk factors that are linked to post-traumatic psychological illnesses. The risk-assessment checklist used in this strategy has been developed from the current literature on post-traumatic reactions and is relatively straightforward for use by someone with the appropriate training.

Studies of Post-Traumatic Stress Disorder and other related symptoms (PTSD) suggest that the intensity and duration of the traumatic event can influence the development of post-traumatic illness. Additionally, previous psychological problems and acute stress disorder can act as predisposing factors in the development of PTSD.

8. The Risk Factors

i. Individuals who feel that their life is threatened, who have a strong sense of shame, or blame others for the trauma are at risk of developing longer-term psychological problems. Appraising the traumatic event as uncontrollable or unpredictable may also predispose individuals towards psychological problems. And finally, a history of previous significant traumatisation increases the risk of developing posttraumatic illness when exposed to further traumatic events. One central and robust finding from research into

both trauma and general mental health is that accessible social support which is perceived as being useful is associated with lower levels of psychological illness. It therefore follows that isolated employees who have poor family and social support are at risk of developing a psychological illness.

ii. Alcohol misuse is common in people who have developed PTSD. Although it is not clear whether this is a coping method, or whether it develops independently, it is associated with a range of psychological problems after a trauma and may develop as a problem in its own right.

9.

1.h. The specific management strategies (see the Traumatic Incident Flowchart below)

i. The planning meeting

Careful planning is required for any effective intervention. Within 48 hours after an incident, a meeting is arranged to engage the organisational management structure and to examine who was involved. The support of line managers is instrumental in ensuring that the strategy is implemented. Traumatic events vary and it is essential that a flexible approach to planning should be taken.

ii. Analysing traumatic events and allocation of staff

At a planning meeting, it is important that a decision is made as to whether any action (and what level of action and implementation) is required. Preliminary research has shown that certain events are more likely to cause psychological distress, including:

a. Experiencing or witnessing serious injury to others, particularly colleagues and vulnerable groups such as women, children and the elderly;
b. Complex or prolonged trauma;
c. 'Near miss' events which could have resulted in serious consequences;
d. If staff experience immediate overwhelming distress.

After deciding whether or not to intervene and then filtering, it is necessary to decide between carrying out individual or small group interviews.
Prior to conducting risk assessments, the 10 risk factors are discussed within the confines of the planning meeting and some preliminary information obtained, especially that relating to exposure to previous traumatic events and previous psychological problems.

iii. Risk-assessment interview structure

A structured interview model, referred to as the BDA (before, during and after) model, is used to conduct risk-assessment interviews with both groups and individuals. **Its purpose is <u>not</u> to eliminate or reduce post-traumatic reactions, but to allow the Practitioner to identify those who may be at risk of developing psychological problems.**

Information disclosed during the interview is considered to be confidential; the only caveat to this (as explained to the interviewees) concerns information that causes a serious concern for the safety of the interviewees or others. With permission, Practitioners are required briefly to inform managers to allow effective management of such risks. Practitioners are advised to seek assistance if they are unclear as to how to proceed.

iv. The 1 month follow-up assessment

The importance of the 1-month follow-up assessment is threefold. **First**, some exposed staff may develop psychological problems after a delay and a stand-alone interview will not detect these. **Secondly**, some individuals continue to experience psychological distress following the initial interview and are at risk of developing long-term psychological problems.
Lastly, an individual's adjustment to the traumatic event can be gauged by comparing their initial psychological and behavioural state (and risk-assessment score) with that assessed at the 1-month follow-up.

v. Staff management and referral

After the initial risk-assessment meeting, managers are informed about the degree of psychological stress that exposed staff members have endured. Ideally, this is done collaboratively with the interviewee. After the 1 month follow-up interview, staff are encouraged to seek help if their distress is not settling (as indicated by persistently raised scores or scores which have increased).

vi. Documentation

Information from the initial assessment is securely stored and used when conducting the follow-up interviews. After completion of the 28-day follow-up, only a simple record is kept in the form of a diary entry of who was assessed, their scores and a brief management plan. This information is kept separately from other staff and health records. From a legal perspective, it is important to record the names of those who were offered the procedure, but declined to take part.

vii It must be stressed that the TRiM strategy is separate from any investigation that might look into why the incident occurred in the first place.

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Education

Support and Monitoring

Traumatic Incident

PSYCHOLOGICAL MANAGEMENT STRATEGY

Operational/Clinical Management of Event

Staff Support Services Manager

Crew/Unit Manager informs Staff Support and Counselling Services Manger

Stabilisation and normalisation by crew/unit Manager

0 – 24hrs

Planning Phase with Staff Support Services Manager and Key Managers

- **Identification of people involved**
- **Formulation of Action plan re: Risk Assessment Interviews and/or Briefing**
- **Plan Individual or Group Interviews**

Risk Assessment BDA

- **Individual (Group intervention ruled out)**
- **Small group (Natural grouping or local incident)**
- **Briefing Meeting (no limit on size of group)**

72hrs

BDA Interviews

Briefing

Stress Practitioners forward documentation to Staff Support and Counselling Services Manager:

- **Who invited but did not attend**
- **Who attended**
- **BDA Scorings**

Person with high risk score may trigger following actions:

- **Consultation with Line Manager**
- **Referral to Occupational Health for CBT**

Therapy

- **Staff Support**

+ 72hrs

28 day follow up

Documentation to Staff Support Services Manager

Ambulance personnel work daily with distressing and traumatic incidents and will have developed effective ways to cope with these experiences. Despite this resilience we know that some incidents can have a significant impact on staff.

Managers have a crucial role in providing support to staff either immediately after an incident or in the days and weeks that follow. Recent research has suggested that the level of perceived support available to individuals following an incident can play an important part in their recovery.

This leaflet gives guidelines on how to recognise and respond to staff who may have been affected by such incidents and information on the range of support services available.

What is a traumatic incident?

Traumatic incident can be defined as 'any incident which overwhelms the normal coping mechanisms of an individual or group'.
Incidents can be classified into:

- Catastrophic Incidents
- Major Incidents
- Significant Incidents which are distressing to the individual for whatever reason.

It is important to remember that it is not just the major incidents which are potentially traumatic and that the more common Significant Incidents can often cause distress.

Incidents which might be potentially traumatic include:

- Multi casualty incidents
- Incidents involving children or vulnerable adults
- Situations which are complex or prolonged
- Situations which change unexpectedly
- Incidents with particularly horrific or gruesome injuries
- Witnessing extreme levels of distress in patients' family or friends
- Situations where the life or safety of staff are threatened
- Incidents with excessive critical media interest
- Personal identification with the victim or their circumstances
- Situations where the person felt out of control during the incident
- Situations where the person felt others were to blame
- Situations where the person felt ashamed of their own actions
- Any incident which by its unusual or extreme nature produces a high level of immediate or delayed emotional response.

Reactions to these or any other incident are likely to be worse if:

- The person feels they should have performed better
- They identify in some way with the person or the situation
- They perceive a lack of understanding, support or blame in others
- There are existing significant personal or work stresses

It is important to recognise that these incidents are *potentially* traumatic and it is the meaning of the incident to the individual that determines the impact of the event.

Remember not to make assumptions.
It may not be obvious to you why someone appears to be distressed by an incident.
The particular factors in a situation which make it distressing are personal to that individual. You will not necessarily know what that person has previously faced in their personal or work life.
Just because a member of staff is experienced or has coped well in the past with similar incidents does not necessarily mean that they will not be affected by this incident.
Just because you have coped well with similar incidents does not mean that they should not or will not be affected.

How do people react to a traumatic incident?

Traumatic stress is similar to the normal 'flight and fight 'stress response only more extreme.
Reactions are highly individual and range from no response to overwhelming emotional distress and can appear immediately or take days, weeks or months to emerge.
They can be triggered by anniversaries of the incident, attending similar incidents or being involved in court hearings or subsequent investigations.
The delay in reactions emerging is particularly relevant for ambulance personnel, as faced with an incident they usually go in to 'coping' or 'auto-pilot ' mode and only begin to experience a reaction once the incident is over.

Below are some common signs and symptoms of traumatic stress reactions

Physical
Feeling shaky or muscle tension
Upset stomach or nausea
Headache or dizziness
Racing heart and breathless
Extreme tiredness and lethargy

Thinking
Preoccupation with the incident, going over what was done and whether it was right
Memories of the incident intruding during waking hours or causing distressing dreams
Poor concentration and memory
Difficulty in making decisions

Emotions
Feeling more jumpy and irritable, with difficulty in relaxing
Feeling more sensitive and tearful
Feeling isolated, withdrawn or numb
Feeling more worried, sad or guilty

Behaviour
Changes in sleeping or eating patterns
Increased smoking or alcohol use
Avoiding other people or work situations
Behaving more aggressively or erratically

These reactions are a natural response to an incident and are part of the normal recovery process and **NOT** a sign of weakness or inability to cope.

Whilst these reactions are common, it is also OK to experience no significant reaction or to have a sense of satisfaction or elation after a difficult incident. This is particularly so if the person feels they performed well and was able to use skills gained in training, regardless of the outcome of the incident.

What helps people to recover from an incident?

It may take a while to recover from an incident and time is needed to process what has been experienced and come to terms with has happened.

From research and experience we know that seeking out support from others who understand, taking time to think through the incident and subsequent reactions, re-establishing normal familiar routines and doing things that are enjoyable, especially exercise, are all helpful in aiding recovery.

We also know that believing it is 'weak' to be affected by an incident, being too self critical about your actions, trying to erase the memories, isolating yourself and bottling up feelings, dwelling too much on wishing things had been different and relying on alcohol or drugs to cope are all unhelpful in the long term and block normal recovery.

Most people will recover given support and the opportunity to come to terms with their experience. However if the symptoms persist over time and there seems to be no improvement, further help may be needed.

If you are concerned about a member of staff, you can either discuss your concerns in the first instance with a LINC worker or a member of the Counselling Team or approach the person directly and advise on support available.
Details of support services and contact numbers are listed at the end of this booklet.

When to seek help

Symptoms which would be of concern include:

- Psychological distress that is not improving, [e.g. constantly reliving the event, nightmares, 'jumpiness', confusion, excessive worrying , blaming others or feeling ashamed of their own actions]
- Persistent avoidance of normal work duties
- Continuing withdrawal from family, friends or activities previously enjoyed.
- Seeming excessively anxious.

- Signs of persistent depression or guilt.
- Uncharacteristic irritability and verbal or physical aggression.
- Signs of persistent sleep difficulties especially if accompanied by nightmares.
- Signs of alcohol or substance abuse.
- Problems in a relationship which prior to the incident was positive.
- Persistent physical symptoms which were not present prior to the incident.
- The persons performance is affected or they seem less able to cope
- A feeling that the person has 'changed' significantly since the incident without any other obvious explanation.
- Additional factors which can increase the risk of problems developing are the presence of psychological problems before the incident, involvement in previous traumatic incidents and current poor social support.

Ways of supporting staff

Research has shown that the level of support that a person is offered and is willing to accept can have a significant impact on recovery from an incident.
Staff may be reluctant to admit to difficulties and it is important that they feel that stress reactions can be experienced by anyone and that there is no weakness or stigma in seeking or accepting help and support. **Therefore your awareness, attitude and approach will be crucial.**

Much of the following you may already be doing and these suggestions are aimed at helping managers provide the best support to their staff.

Immediately after an incident people are often shocked and may not show much emotion. It is helpful to offer them some time to recover, have a cup of tea and talk things through if they want.
If appropriate, consider standing them down. Some may wish to continue the shift after they have had some time to recover and others may need to be stood down.
Returning to station or work base is often particularly valuable as they can meet colleagues and get informal support from others who are likely to understand the situation.
Be wary of sending a person home straight after an incident before they have had a chance to 'decompress' with their colleagues and reduce their immediate stress levels. This is particularly important if they live alone or are due days off.
This is not a hard and fast rule and individual circumstances need to be taken into account. However it is important to convey that any decision is based on ensuring their well being rather than performance targets.

Reactions may take some time to emerge so it is important to ensure that those involved in the incident are followed up.

Remember to give them the information booklet on 'Your Guide to Managing Trauma' which will have contact numbers for support services and to ensure that they are aware of the LINC scheme.

As has been emphasised before, reactions to an incident are individual and depend on a range of factors. Some people may be able to remain at work, whilst others may need some time to recover, however long periods away from work can increase the difficulty in eventually returning to normal duties.

Offering staff support in returning to work after an incident through e.g. 'third manning' and alternative duties, where possible, are effective ways of maintaining a routine, building confidence and aiding recovery.

Tips on how to support staff

If you invite someone to talk about the incident or how they are doing, keep it simple and informal and when in doubt DO LESS.

- Pick the right time and place – preferably somewhere with some privacy and free from interruptions
- Don't interrogate or get into an operational debrief.
- Encourage them to say more by using open questions-How, What, When, Where e.g. 'What was that like for you?' rather than 'Why do you feel angry?'
- Don't belittle or invalidate their experience. 'You'll get over it'. 'It could have been worse'.
- Focus on them and what they are saying and try and tune out your own judgements and opinions on how they are handling the situation.
- Use active listening and look interested and engaged.
- Don't jump to conclusions – listen to what is actually being said and check you have understood.
- Check your own attitude. If you think stress is for 'wimps' it will show.
- Be wary of saying you know how they feel – you could be wrong.
- Be careful about talking about your own experience. You may have been in similar situations but you can't assume that they have reacted in the same way as you or that your way of coping will work for them.
- Be careful about using humour – this may not be the time for dark humour.
- Let them express any emotions that come up but **don't** dig around to get them out. This is *particularly* important.
- Structure the time you have in order to end the discussion clearly and cleanly.
- Think of the mnemonic **FICE** as a useful way of structuring the conversation.

  Facts – [what happened….then what?]
  Impact - [on them of what they have been through. What was the hardest part?]
  Current functioning – [how are you doing now? who is around for you to talk to? is there anything you need?]
  Education – [reactions are normal, not a sign of weakness. Hand out the booklet and remind them of LINC and other support. Arrange to follow up and do it].

Essentially in talking to staff you are aiming to do three things:

1. **Show that you and the Service recognise that they have gone through a difficult experience and that it matters.**
2. **Facilitate their recovery by talking things through and helping them accept that reactions to an incident are normal and not a sign of weakness.**
3. **Identifying staff that are experiencing difficulties and encouraging them to seek and accept help early.**

What support services are available to staff?

The services listed below are available to all staff regardless of role and individuals are free to choose which source of support they feel is most appropriate for them.

1. **LINC**

The LINC peer support programme offers a first line confidential support service to staff who may be experiencing work or personal difficulties.
LINC workers are colleagues who have gone through a rigorous selection process and comprehensive training programme to enable them to offer support on both personal and work issues including potentially traumatic incidents.
The LINC scheme complements existing services and works closely with the Occupational Health Counselling Service.
Individuals do not need to be referred and can contact a LINC worker informally either face to face or by telephone on any matter.

A complete list of LINC workers and contact numbers can be found on the Pulse under 'About me', clicking on 'My Support' and following the links.

Some LINC workers have undertaken additional training to deliver the TRiM response.

1. **TRiM [Trauma Risk Management] Defusing Meeting**

The TRiM response is there to support staff and should be considered routinely after a potentially traumatic incident. The purpose of TRiM is to ensure that the psychological needs of staff are appropriately managed following a potentially traumatic incident.
The Defusing Meeting is not an operational debrief nor is it counselling. It is intended to provide acceptable and credible support to staff who may be affected by an incident and to offer prompt specialist help if required.

After a potentially traumatic incident [as listed above] it is important to consider whether TRiM is required and to initiate a planning meeting.

- Following a **Major Incident** the appropriate LINC worker will attend the hot debrief and planning meeting to decide whether TRiM defusing meetings are required. If required the LINC worker will arrange individual or group TRiM meetings as appropriate.

- Following a **Significant Incident**, if the manager has concerns about an individual/individuals they can contact the local LINC worker, Senior LINC worker, LINC manager or the Staff Support Services manager to discuss the incident. If TRiM is thought to be appropriate, the LINC worker will arrange a meeting and the individuals involved will need to be stood down.

- In the event of a C**atastrophic incident**, the response would be managed at a local 'cellular' level.

If a TRiM response is agreed, those involved are invited to attend an individual or small group TRiM Meeting facilitated by trained LINC workers.
In the meeting the incident is talked through in a factual and informal way with the aim of:

- Identifying trauma risk factors and trauma risk levels
- Normalising stress reactions
- Reinforcing coping strategies
- Raising awareness of support services
- Facilitating early referral to specialist help if required

There are two meetings.
The first is arranged within a few days of the incident and the second follow up meeting about one month later. This allows for natural recovery to take place and gives a more accurate indication of individuals stress levels. Those who may benefit from counselling or specialist help can be encouraged to refer themselves or be referred on.

In addition to these meetings, LINC workers can be invited to local management/debriefing meetings to give information on normal stress reactions and recovery and to raise awareness of support services.

LINC workers are also available to offer informal support to any individual affected by a distressing incident. This support is appropriate for any member of staff affected by a disturbing incident regardless of whether they are operational, EOC or support services.

To discuss arranging a TRiM Meeting, please contact your local LINC worker, the Senior LINC worker on-call on **07900917104** or the Staff Support Services manager on **02074632625 or 07917201676.**

3. Counselling
Confidential counselling for any work or personal issue including traumatic stress is available through Occupational Health. Individuals can refer themselves directly or be referred by their manager. If an individual wishes they can access counselling directly and do not need to have an initial TRiM meeting.
The service currently has 7 venues across Greater London and appointments can be made by telephoning Occupational Health on **020 3299 4919.**

4. EAP
The EAP is a 24hour confidential helpline offering telephone advice and support on a range of personal and work issues and can be contacted on **0800 5878116**

5. Staff Support Advisor
For advice on all aspects of staff support including the Benevolent Fund please ring **02074632636**

6. Chaplain
Available to all staff for pastoral support. **020 8553 2132**

This leaflet is provided as guidance only and for more information or advice please contact:

- **Staff Support and Counselling Services on 02074632625**
- **LINC on 020 7921 5200**
- **Occupational Health Counselling on 02 3299 4919**.

London Ambulance Service NHS Trust

Risk Management Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document Outlines the Trust's approach to all types of risk which may affect its operations, and details the management and mitigation of risk throughout the Service.

Sponsor Directorate/Department: Governance Development Unit

Author/Reviewer: Head of Governance. To be reviewed by September 2009.

Document Status: Final **/ Draft**

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
12/06	1	Head of Governance	Replaced Risk Management Strategy
03/07	2	Head of Governance & Head of RM & BC	Major revision
05//08	2.1	Head of Governance & Head of RM & BC	Revision
13/08/08	2.2	Head of RM & BC	Revision incl. addition of T of R.
28/08/08	2.3	Head of Governance(MB)	Include new ToR for Liability Claims Group Amendments to Audit Committee entries
11/09/08	2.4	Head of RM & BC	Amendments from RCAG & new TofR details
18/09/08	2.5	Chair of CGC, Chair of SBH group	Amendments to TofR for both

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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LAS Website			

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/021	Assurance Framework	
H&S/011	Incident Reporting Procedure	
TP/013	Claims Policy	
TP/004	Complaints Procedure	
TP/034	Being Open Policy	
HR/07/22	Whistle Blowing Policy & Procedure	
TP/006	SUI Policy	
TP/023	Driving and Care of Service Vehicles	
TP/035	Risk Reporting and Assessment Procedure	
H&S/001	Health and Safety Organisation – Policy Statement	
HR/08/01	Disciplinary Policy & Procedure	
	Standards for Better Health (DH July 21 2004)	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

The purpose of the London Ambulance Service (LAS) is to provide the highest standards of triage, treatment and transport to patients requiring our care. In achieving this aim, the service has a duty to limit the potential risk of harm to patients, potential patients, members of staff and the public.

The management of risk is a key organisational responsibility. All members of staff have a major role to play in identifying and minimising inherent risks, both clinical and non-clinical. This will be achieved within a progressive, honest and open environment, where mistakes and untoward incidents are identified quickly and acted upon in a positive and constructive way.

However, risk management extends much further than solely the prevention of physical harm to patients, staff and the public. The Trust sets out its objectives in its long-range Strategic Plan and the Service Improvement Programme (SIP), and annual service plans which implement it. Risk management concerns itself with managing the threats to the achievement of those objectives. This means that the Policy addresses all kinds of risk across the Trust: clinical, financial and corporate, infrastructure, and health and safety.

Risk Management provides a process which will allow the Service to improve upon the high quality service already being provided. It will achieve this through a proactive, ongoing process of risk reporting and assessment, risk recording (the Risk Register), promotion, and monitoring. Risk management will link with service planning to help set spending priorities. The outcome will be the improved identification, control and containment of risk. It will be achieved through the structure of authority and accountability set out in this Policy.

Some external agencies (e.g. NHS Litigation Authority) require NHS Trusts to have a Risk Management Strategy. In the LAS this is the Risk Management Policy.

The overall objectives of the Policy are:

- To ensure organisational well being and make sure that both staff and others can perform their work in a safe and open environment and to raise the quality of care provided by the LAS to patients, through the identification, control and elimination or reduction of all risks to an acceptable level.

- To inform the development of the Trust's clinical and non-clinical operations and support services to facilitate the implementation of the Trust's Strategic Plan and Service Plan.

- To understand the underlying causes of adverse incidents and ensure that lessons are learned from the experience.

- To ensure that managers and staff at all levels in the organisation are clear about their personal responsibilities with regards to risk management and an effective Risk Reporting and Assessment Procedure is in place.

- To understand the risks the Trust faces, their causes and cost and to transfer risks where unacceptable or unavoidable.

- To allocate resources appropriately to reduce risks.

- To ensure that the Trust meets its mandatory obligations in regard to National performance and quality targets

- To ensure delivery of a quality service and business continuity in the event of a major disaster or system failure.

In identifying the context in which the LAS manages risk, full consideration is given to stakeholders. The Trust will identify its principal stakeholders, and consult with them about its approach to risk. When there is a risk that threatens the achievement of the principal objectives of the LAS, stakeholders will be approached to gain their support and engage them in the development of a corrective action plan. As Risk management within the LAS develops it will enhance its systems for systematically involving patients in risk management. It will also ensure that specific risks to patients are identified and acted upon.

1.0 Definitions

The Chief Executive has overall responsibility for risk management. The LAS Trust Board splits its management of risk into Operational, Logistics, Financial, Corporate, Clinical, Health and Safety, HR, Infection Control, Business Continuity and IM&T categories. The definitions and how they are allocated to committees and individuals are set out below:

Operational Risk

The Director of Operations has responsibility to manage all risks relating to A&E matters, including resourcing, and EOC/UOC, which impact upon the ability of the Trust to provide the required level of patient care.

Logistics Risk

The Head of Operational Support has responsibility for all logistical risks relating to vehicles, equipment and supplies which impact upon the ability of the Trust to provide the required level of patient care. The Head of Operational Support chairs the Vehicle and Equipment Working Group and is a member of the Motor Risk Group which monitor Logistical risks.

Financial and Corporate Risk

The LAS has a responsibility to run the Trust in line with Standing Financial Instructions and to ensure corporate risk is reduced by compliance with the Healthcare Commission's Standards for Better Health. The Trust regards as 'corporate' any risks that do not fall under the other category headings. Corporate risks will include those relating to reputation and things which may adversely affect the views held by stakeholders about the Trust.

The Director of Finance has overall responsibility for financial risk, and for any corporate risks not covered by other directors, attends the Audit Committee and chairs the Standards for Better Health Group. Individual executive directors are responsible for, and manage, the corporate risks that fall into their particular spheres of activity.

IM&T Risk

The Director of Information Management and Technology is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems including information security risks. IM&T and other information governance risks are monitored by the Information Governance Group jointly chaired by the Director of IM&T and the Medical Director, who is the Trust's Caldicott Guardian. The Director of IM&T and the Medical Director are the joint Senior Information Risk Owners (SIRO) for the Trust.

Clinical and Infection Control Risks

The LAS has a duty of care to ensure its patients receive appropriate care in a safe environment and that all that can be done is done to minimise the risk of harm coming to its patients. The LAS learns lessons from complaints, claims and clinical incidents reported by staff. The LAS will proactively seek to reduce clinical and infection control risks identified in the Risk Register.

The Medical Director has overall responsibility for clinical risk, infection control and Clinical Governance, and is a member of the Clinical Governance Committee. The Head of Operational Support chairs the Infection Control Steering Group which reports to the Clinical Governance Committee.

Health and Safety and HR Risks

As an employer, the LAS has a specific responsibility to provide a safe working environment for its staff and any other individual (including patients) who are affected by its actions. This is achieved through learning lessons from incidents that are reported by staff and by proactively seeking to reduce identified health and safety risks on the Risk Register.

The Director of Human Resources and Organisation Development has responsibility for Health and Safety, Ergonomics and Back Care and chairs the (corporate) Health and Safety Group. The Director also has responsibility for HR and training risks which are managed under the HR category and is a member of the Training Services Committee. Individual executive directors are responsible for, and manage, the Health and Safety risks that fall within their particular spheres of activity. The LAS also has responsibility for managing the security of premises and property and these risks are reported to the (corporate) Health and Safety Group.

Business Continuity Risk

The Trust has a responsibility under the Civil Contingencies Act 2004 to ensure the continuity of its operations as a Category 1 Responder. The Director of Finance has Board responsibility for Business Continuity Management and chairs the Business Continuity Steering Group which monitors the Trust's Policy and Plan and business continuity initiatives.

2.0 Risk Reporting

When new risks are identified in the Service a risk reporting and assessment form will be completed which includes the proposed grading (as described in the Risk Reporting and Assessment Procedure). These forms are then submitted to the Head of Governance or the Senior Safety and Risk Advisor as detailed in the Risk Reporting and Assessment Procedure.

The Director of Human Resources and Organisation Development will ensure that all Health and Safety risk assessments have been completed and are up to date. This means that the Director of Human Resources and Organisational Development has lead responsibility, through delegated authority to accountable senior managers, for ensuring that Health and Safety risk assessments are conducted by the relevant directorate/department; that assistance is provided on how to conduct the risk assessment by the Senior Risk and Safety Advisor; and that risk assessments are reported /considered at the appropriate risk management group.

The Director of Human Resources and Organisation Development routinely reports the Health and Safety risk assessments undertaken /outstanding to the Risk Compliance and Assurance Group. The Director's report also includes presenting related proposed risks for the Group to consider placing on the Trust wide Risk Register.

Risks cannot be managed unless they are first identified by the LAS. This will be achieved by:

- Carrying out annual Trust-wide risk assessments
- Individual risks being identified through risk management groups
- Corporate directorates and support services departments and locally trained manual handling assessors undertaking local risk assessments on a regular basis.
- When new services are proposed risk assessments must be conducted in accordance with legal requirements and the Trust Risk Reporting and Assessment Procedure, to maximise the resources for patient care services and demonstrate risk is being managed effectively
- All new clinical equipment purchased by the LAS being risk assessed for both clinical and non clinical risk to patients and staff prior to purchase with resulting assessments submitted to the Vehicle and Equipment Working Group for approval.
- All managers (and/or their nominated senior supervisory staff) being trained in risk assessments on the LAS two day Health & Safety Awareness course.
- Any risks identified through self assessment against the Standards for Better Health being assessed by the nominated lead for that standard.
- Serious Untoward Incidents, or other adverse events and near misses identified through the Incident Reporting Procedure or Complaints Procedure should be used to identify risks. Grading of incidents and root cause analysis of adverse incidents will help with this. Wherever possible the fact that the Trust has formally identified a risk as a result will be fed back to staff.
- Risks identified by locally trained Manual Handling Assessors and coordinated by a Health and Safety Advisor on a regular basis.
- Risks identified by locally nominated health and safety representatives and coordinated by the Safety and Risk Team on a regular basis.

Further sources of risk identification are given at Appendix 2.

2.1 Risk Assessment

The LAS will assess risks using a common system of evaluation. This will enable widely differing risks to be put into an order of relative priority. The Trust can then determine its priorities for the management of risks and allocate scarce resources according to those priorities. All risks are evaluated using the Risk Matrix as described in the Risk Reporting and Assessment Procedure.

Using the Descriptor in the Risk Impact Description the level of impact in the Matrix is rated from none/insignificant to catastrophic. If the impact of a risk falls into more than one category, then the category with the most serious rating is used. The next step is that the likelihood of the impact of the risk occurring is rated from certain to rare. The score and grading band are then determined by identifying where the impact and likelihood axes meet.

Assessment of both the level of impact and likelihood of reoccurrence should be evidence based wherever possible. Once evaluated in this way, the risk score determines the priority within the grading bands:

- High priority - Not tolerable and high priority
- Significant priority - Not tolerable and significant priority
- Moderate priority - Not tolerable but moderate priority
- Low - Tolerable – Limited or no action to be taken

Reduction of risk will be considered as part of the assessment of every risk. The extent to which the risk can be managed by reversing or reducing the risk or threat will be considered in its assessment. Reversibility of risk will always be included as part of the LAS common system of evaluation.

The Senior Safety and Risk Advisor will send appropriate H&S risks to the Head of Governance who will then submit risk proposals to the Risk Compliance and Assurance Group. The Group will review and decide whether the risk should be added to the Risk Register. The Risk Compliance and Assurance Group will consider each proposal and approve or modify grading and action plans as appropriate. An appropriate senior manager will then be identified to take responsibility for the highlighted risk and ensure that the action plan is adhered to.

2.2 Risk Register

The LAS will maintain a single Risk Register for all types of risks.

Summary progress reports on the management of high priority risks on the Risk Register will be received at each Risk Compliance and Assurance Group and Audit Committee with an updated version of the Risk Register for reference. Significant, Moderate and Low priority risks will also be reviewed on a periodic basis at the discretion of the Risk Compliance and Assurance Group. Clinical risks will be reported to the Clinical Governance Committee. All risks will be re-assessed on a six monthly basis. This will coincide with the submission to the Trust Board of a progress report on the Risk Register (see attached flow chart Appendix 3).

As risks are successfully managed their priority ratings are likely to reduce, although some risks may be impossible to reduce. The Risk Compliance and Assurance Group will approve changes in priority ratings and any deletions from the Risk Register.

2.3 Promotion and Implementation of Risk Management

Risk Management will be promoted and implemented by:

- Circulating the Risk Management Policy and the Risk Reporting and Assessment Procedure to all managers and to external stakeholders.

- Placing this Policy on the internet and the Risk Reporting and Assessment Procedure on the internet and intranet and referencing it in the Annual Board Report.

- Updating Senior Executives' key responsibilities under the Health & Safety at Work Act and its subordinate legislation.

- Updating managers' key responsibilities in job descriptions and objectives to include risk management.

- Training identified/key staff, appropriate to their role and responsibility to ensure that they understand their obligations to manage risk. This will include the importance of risk assessment using the Risk Reporting and Assessment Procedure for incident reporting.

- Training staff to undertake risk assessments following the Risk Reporting and Assessment Procedure.

- Including risk management in induction and foundation courses, Area and other management meetings.

- Distributing statistics, such as incident reports and complaints investigations to managers and following up to ensure an effective response.

- Identifying and implementing reporting systems which ensure that the Risk Register remains up to date.

- Feeding progress with risk issues back to staff so they know that incident reporting has been worthwhile.

- Providing training relevant to known Health and Safety risks including Personal Safety and Manual Handling

- Providing regular training to the Trust Board on Risk Management awareness, Health and Safety legislation and their responsibilities in terms of compliance with Healthcare Commission and NHS Litigation Authority Standards.

2.4 Linking Risk Management to Service Planning

The LAS continuously works to link Risk management to service planning. The Annual Service Plan contains reference to Risk Management. It makes clear the principal long-term risks that threaten delivery of the Strategic Plan year on year. Each of these risks is then allocated either to the Strategic Steering Group or to one of the five programmes for service improvement. These five programme strands make up the overall Service Improvement Programme (SIP 2012) which will implement the transformational change envisaged in the long-term Strategic Plan to realise the objectives of the Trust: the five strands are set out below.

1. Access and Connecting (the LAS) for Health

Scope: Covers not only access to LAS services by patients and the public but also Connecting for Health and access/connectivity within the LAS and between it and partners:

- Development of an access strategy
- Access for people with impairments
- Connecting for Health
- CAD2010
- Internal IT strategy
- Records and Information Strategy
- High Impact changes to EOC/UOC

2. Operational Model: Strategy For Responding

Scope: Covers service portfolio and the ways of delivering provided to patients/healthcare professionals/public once they have made contact with the LAS:

- Develop an operational model for tasking
- Develop implementation plan for new ops. model
- Implement new operational model
- CTA projects
- Care pathway development projects
- New clock start operational performance – High Impact (excl. EOC/UOC)
- Olympic and Para Olympic Games 2012

3. Organisation Development And People

Scope: Covers Organisation development, culture, HR strategy, education and training (clinical and non-clinical), Diversity and workforce skill mix including recruitment and retention and IR:

- Education and training
- Attitude and behaviour/cultural interventions
- Organisation Development
- Implementation of Diversity Plan
- High Impact changes (workforce)
- Staff engagement

4. Partnership and Communication

Scope: Covers relationships with external stakeholders and their involvement with the LAS especially Patients and the Public but also other healthcare professionals, emergency services, social services, key suppliers etc., most particularly PPI:

Partnership development, involvement and communications projects including:

a. patients;
b. public;
c. NHS partners
d. social services
e. other emergency services

5. Governance and Corporate Processes

Scope: Covers Corporate and Clinical Governance and development of all corporate management processes

a. Audit and quality assurance of clinical care
b. Corporate processes
c. Standards for Better Health and NHSLA
d. Productivity and efficiency
e. Foundation Trust status
f. Managing Successful Programmes

Risk assessment will be undertaken in accordance with the principles and methodologies of Managing Successful Programmes, PRINCE2 and the LAS Risk Management methodology (See Strategic Plan section 5.3 for details).

The lead Director (Senior Responsible Owner) for each programme oversees the delivery of a range of projects. The Risk Assessment undertaken for each project will follow the guidance set out in the Risk Reporting and Assessment Procedure. All appropriate Risk Assessments are reported to the Risk Compliance and Assurance Group with a recommendation on whether the risk should be added to the Trust Risk Register. Risk issues will be considered at each level of business planning ranging from corporate process to individual staff objectives. For example, business cases are produced within the LAS to conform to the requirements from the Office for Government Commerce which include a risk assessment. On completion of the business case, any post project risks transfer to the main Trust Risk Register. At individual level, staff objectives, as part of the LAS Personal Development Review process, will support the management of risks that threaten the achievement of LAS principal objectives as set out in the Annual Service Plan, which is part of the Trust's Strategic Plan 2006/2007 – 2012/13

The Trust will explain its most significant risks when bidding for funds from commissioners.

In making its plans and setting financial priorities the Trust will take account of risks as set out in the Risk Register. A bid for funding that demonstrates that a high priority risk on the Register will be mitigated if approved, will be given preference over a bid that cannot demonstrate such a linkage. The Trust will therefore direct funding to reduce risk as far as it is reasonably practicable.

2.5 Monitoring Progress in Risk Management

The process for monitoring compliance with the organisation's risk management structure detailing the committees and groups with responsibility for risk is that the RCAG will consider the terms of reference for each of them against the activity recorded in the minutes of meetings for the previous twelve months and where gaps are identified give feedback to them so that they have to produce an action plan in response. The committees with responsibility for risk are set out in Appendix one to this policy.

To monitor compliance with the minimum requirements of this Risk Management Policy as defined by the NHS Litigation Authority for the level which the Trust chooses to be assessed against, the Trust will conduct an annual review as part of the Trust's Annual Trust-wide Risk Assessment. This review will be undertaken by the managers identified in this Policy under the heading 'Duties'. The findings of the review will be reported to the Risk Compliance and Assurance Group.

Incidents including Serious Untoward Incidents, PALS enquiries and concerns, complaints, inquests, claims, and actions taken to demonstrate organisational learning are reported in the Risk Information Report, to the Clinical Governance Committee in the case of clinical issues, and to the (corporate) Health and Safety Group where there are issues about the working environment / system of work. These reports are linked together with a joint commentary in the Risk Information Report.

The Risk Information Report is the Trust's systematic approach to the analysis of incidents, complaints and claims on an aggregated basis. The report gives quantitative and qualitative analysis of incidents, complaints and claims. Trends can be identified as a result of the analysis and Action plans and management strategies to control the risks that subsequently arise from them are monitored. The Report also includes information relating to risks that threaten the implementation of the Trust's Race Equality Scheme and Diversity Plan. The Report is presented to the Clinical Governance Committee on a quarterly basis.

Key performance indicators will be continually developed and used by the LAS to indicate what progress has been made in the management of risk and the implementation of the Risk Management Policy. The Trust will take particular interest in how well priority risks are being managed through the management assurance documented on the Assurance Framework. Indicators will include:

Key Indicator	Monitoring Forum
Year on year progress in meeting the requirements of the Standards for Better Health	Standards for Better Health Group
Achievement of identified actions on high priority risks on the Risk Register	Risk Compliance and Assurance Group (RCAG)
Reductions in priority rating scores	Risk Compliance & Assurance Group
Reduction in the level of manual handling incidents and claims	RCAG and (corporate) Health and Safety Group-HSG
Reduction in complaints about attitude and behaviour	Trust Board
Increase in the number of clinical incidents and near misses	Clinical Governance Committee (CGC)
Sickness and Absence statistics	Senior Management Group (SMG)
Performance targets	SMG
Audits	Audit Committee.
Monitoring of the completion of premise inspections	HSG
Monitoring of quarterly industrial incident statistics and industrial injury absence	HSG and Trust Board
An increase in Clinical Performance Indicator checks	Clinical Audit and Research Group, CGC
Year on Year progress in reducing the priority rating of Risks scored as major or significant	RCAG
90% of the actions agreed for hire and catastrophic risk completed in the planned year	RCAG
75% of the actions agreed for significant and major risks completed in the planned year	RCAG
Risk Assessments completed for all projects in the Strategic Plan/ Service Plan	RCAG
Risk Assessments completed for all typical manual handling operations involving the lifting of patients and the use of trolley beds and chairs.	HSG
95% of premises quarterly inspection reports completed within one month of the due date.	HSG
A challenging and realistic proportion of the training needs assessment completed in the programme year.	CGC&RCAG, Training Services Committee
Year on Year progress on percentage	CGC

completion CPIs	
The timeliness in which incidents/accidents/RTAs are reported and investigated.	CGC, HSG, Motor Risk Group and RCAG
Demonstrate organisational learning, actions taken to prevent recurrence from SUIs, Complaints, claims and incidents	Complaints Group
Reducing the number of RTAs and the costs of claims on vehicle damage.	SMG
Monitoring of PALS concerns to measure organisational learning	CGC

Reports on incidents, complaints and claims are received by Clinical Governance Committee and the Corporate Health and Safety Group. Specific actions are agreed, where appropriate, and trends identified. Reports produced are also received by the Clinical Governance Committee and the Risk Compliance and Assurance Group for further action and monitoring purposes where necessary.

Items on the Risk Register are reviewed, as appropriate, by individual managers and groups to ensure that identified risks are being actioned and risks minimised. Having determined risk management objectives for managers, they will be discussed and monitored as part of individual performance review.

Operational staff performance in the completion of Patient Report Forms (clinical record) is currently reviewed by Team Leaders, and information is collected centrally to identify trends. Performance in incident reporting and complaints handling are reviewed by the line managers as incidents occur.

The Assurance Framework contains systems and processes that are used by the Trust Board to monitor what risk management controls are in place to manage and reduce threats to the organisation achieving its principal objectives. Where feasible, contingency plans will be developed for high priority risks to protect the LAS against significant control failure. The Assurance Framework also enables the Trust Board to know whether those controls are working, by relying on inspections from external bodies (e.g. Healthcare Commission) and on internal management processes.

3.0 Authority and Accountability for Risk Management

The Trust Board takes ultimate corporate responsibility for the management of risk in the LAS. To monitor compliance with the process for Board review of the organisation-wide Risk Register the Head of Governance and lead executive director for risk will check that the organisation-wide Risk Register has been presented to the Board on a

minimum of two separate occasions annually and review the minutes of those Board meetings to ensure discussion of the principal risks that threaten the achievement of the Trust's objectives has taken place. Actions taken by the Board in respect of the risks presented to them either on the Risk Register or through the mechanism of the Assurance Framework will be reviewed.

3.1 Committees and Working Groups

The Risk Compliance and Assurance Group has responsibility for the monitoring of all risk management activities within the Trust and ensures that the Trust Board, via The Audit Committee, is kept informed on issues which are not covered by existing Committees of the Trust Board. The Risk Compliance and Assurance Group is responsible for the operation of the whole risk management process within the Trust and ensures that the objectives of the Risk Management Policy are achieved

Figure 1 illustrates the committees and main working groups that feature in Risk Management, analysis and decision making.

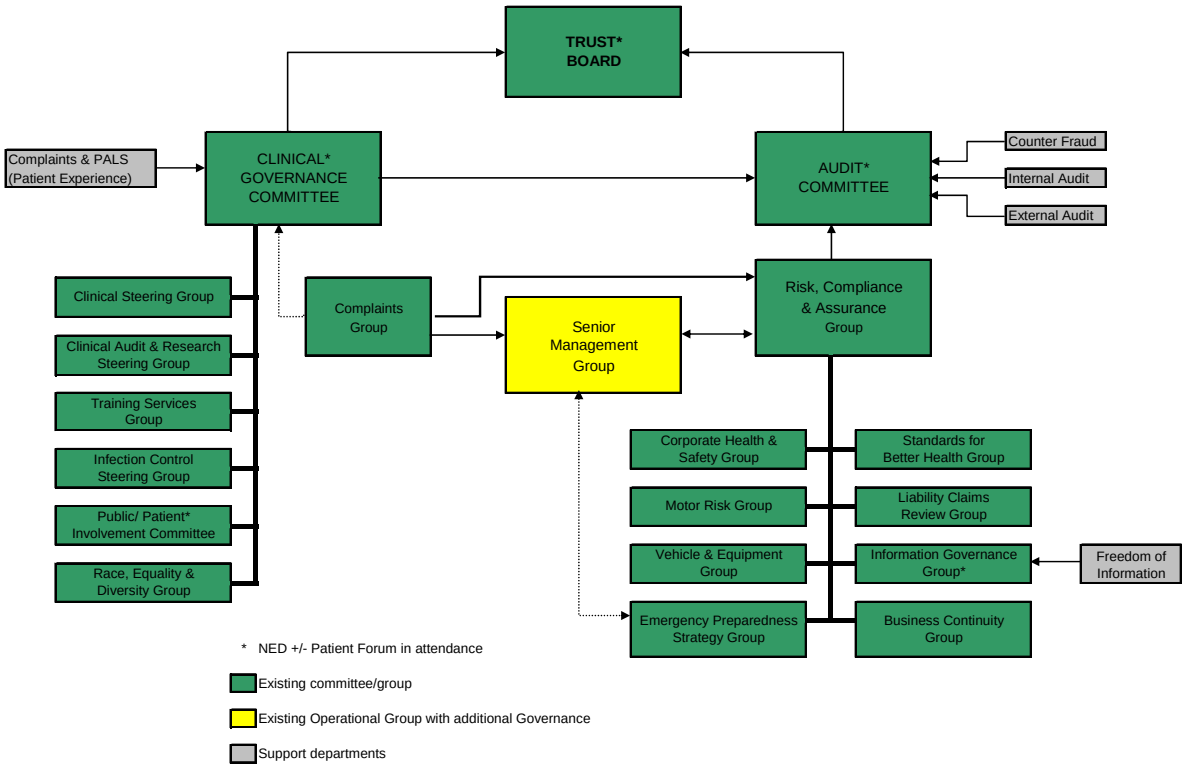

Figure 1 – Risk Management Structure

The Clinical Governance Committee has particular responsibility for ensuring the provision of high quality clinical care within the LAS, and managing the risks associated with that. It works closely with the Risk Compliance and Assurance Group to ensure that the management of all significant risks is monitored through one or other of the committees.

The Audit Committee will advise the Board about how well the Trust is operating the Risk Management process. To carry out this responsibility it will receive reports from the Chief Executive and from both internal and external audit review of the risk management process. The Audit Committee will continue with its existing specialist role of monitoring particular financial risks.

Full details of the membership and functions of these committees and other groups are in Appendix 1.

3.2 Duties

This section describes the duties of the key individuals for risk management activities. In addition to the committee structures, certain individuals in the Trust have specific responsibility to manage risk. The Chief Executive, Medical Director, Director of Finance, Director of Human Resources and Organisation Development, and the Director of Information Management and Technology have already been mentioned. Other key personnel supporting the Chief Executive are:

- Head of Governance – Responsible for the overall management and implementation of the Risk Management Policy, the Standards for Better Health and the development and maintenance of the Trust Risk Register, and the Trust's compliance with external assessment requirements (as defined by the Healthcare Commission, Audit Commission, NHS Litigation Authority, and other Concordat Signatories).

- Head of Legal Services – Responsible for the management of the Legal Services contract and the Trust management of exposure to litigation, advises and assists with the implementation of the Risk Management Policy.

- Senior Health, Safety & Risk Advisor – Responsible for advising on the development of all aspects of Health, Safety and Risk Management, Health and Safety Training and compliance with the Health & Safety at Work Act 1974 and its supporting legislation.

- Health, Safety & Risk Advisor – responsible for advising and taking the lead on the Trust's agreed manual handling policy and its compliance with appropriate legislation and standards.

- Diversity Manager – Responsible for advising on the development and management of the Trust's approach to diversity including compliance with inspection and performance requirements of the Commission for Racial Equality, Disability Rights Commission, Equal Opportunities Commission and Equality and Human Rights Commission.

- Local Security Management Specialist – Responsible for advising on personal staff safety, premises and property security, and assisting staff in respect of police liaison, the collation of all Incident reports, the analysis of statistical information, the maintenance of the Staff Safety Policy and Incident Reporting Procedure.

- Complaints Manager – Responsible for the investigation of external complaints, ensuring complaints are handled effectively and that issues identified are brought to the attention of the Complaints Panel and Clinical Governance Committee by relevant individuals undertaking high priority investigations.

- Head of Records Management and Business Continuity – Responsible for co-ordinating, publicising and monitoring of the Trust's Records Management Strategy and Business Continuity Policy and Plan and reporting on a regular basis to the Trust Board.

- Head of Planning and Programme Management – Responsible for co-ordinating the project management approach to the delivery of the Trust's Seven year Strategic Plan and the Annual Service Plan.

- Head of Operational Support – Responsible for the provision of logistical support to A&E Operations, principally the provision of equipment, supplies and as Chair of the Vehicle & Equipment Working Group responsible for ensuring that all new equipment is risk assessed prior to procurement.

- Director of Communications – Responsible for ensuring that support and advice is provided for the communication of risk management issues when appropriate.

- Senior Management Group – All members of Senior Management Group (SMG) not identified with specific responsibility for the process of risk management have responsibility for the management of risk in their own areas.

3.3 Authority and Responsibilities of Managers

All managers have the authority and must fulfil their statutory obligations for the management of foreseeable risk within the workplace; those risks on the Trust Risk Register for which they have local responsibilities; and conduct assessments for all work based activity where appropriate, fostering a culture of risk awareness throughout their Area or department.

Specific responsibilities will be identified for the roles of Assistant Directors of Operations, Ambulance Operations Managers, Duty Station Officers, Team Leaders and Complex Trainers and for local nominated manual handling assessors with objectives.

3.3.1 Local Risk Management

The management of risk at the local level begins when a risk is identified and it is reported using the appropriate form as set out in the Risk Reporting and Assessment Procedure. It is then assessed and scored using the Risk Matrix in the Procedure, passed to the Head of Governance or Senior Health, Safety & Risk Advisor (if it is a Health and Safety risk) who ensure that an action plan is completed. All appropriate risks are then reported to the Risk Compliance and Assurance Group (RCAG) who decide on whether the risk should be added to the Trust Risk Register. The RCAG monitor the progress of the actions taken to mitigate the risk (as specifically outlined within the Terms of Reference of the RCAG in Appendix 1).

A risk management audit tool will be identified which incorporates mandatory requirements and can be used in all departments.

Managers must ensure that all staff have access to the relevant policies, procedures and protocols to facilitate safe practice and minimise risk, and that they receive feedback on reported risks.

3.4 General Responsibilities of all Staff

All staff have a duty of care to manage where possible foreseeable risks, bringing those that cannot be managed to the attention of their line manager using the Risk Assessment and Reporting Procedure. Staff will be involved as

required in ensuring that actions are carried out to minimise identified risks to an agreed and acceptable level.

All staff must comply with the Risk Management Policy, Risk Reporting and Assessment Procedure, LAS Health and Safety Policy and procedures, and professional guidelines and standards set by the relevant professional bodies and associations.

IMPLEMENTATION PLAN	
Intended Audience	For all staff
Dissemination	Available to all staff on the Pulse and generally on the LAS website
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	Training to be carried out as per the Training Needs Analysis and Training Plan.
Monitoring	Head of Governance to ensure that this policy is monitored annually for compliance by RCAG

Appendix 1

Membership and terms of reference of the risk management committees and groups

1. The Risk Compliance and Assurance Group

Terms of Reference

Introduction

This Group has delegated responsibility from the Trust Board for taking an overview of all risk management activities within the Trust.

It will:

- Be responsible for the provision of a systematic and focussed approach to the management of all foreseeable risks within LAS
- Monitor the implementation of the Risk Management Framework
- Oversee the annual work programme necessary to achieve compliance with the NHSLA Risk Management Standard for the Provision of Pre Hospital Care in the Ambulance Service.
- Accept risks onto the Risk Register and agreeing their priority rating together with a proposed risk reduction plan
- Ensure that any changes in legislation are incorporated into the risk management policies and practices of the Trust to assist in evidencing compliance with the healthcare standards of the Annual Healthcheck.
- Test assurance and controls relating to risks so that the Assurance Framework can be updated by the Audit Committee on behalf of the Board.

It will review the grading of risks and agree the grading of them before accepting them onto the Trust's Risk Register. It will ensure that there are action plans set up to reduce these risks, as a standing agenda item. The Audit Committee will monitor the action plans.

The Risk Compliance and Assurance Group will define which quantitative and qualitative information will be collated in the format of an annual risk management report to the Trust Board.

- The Risk Compliance and Assurance Group ensure the provision of effective trust wide risk management within the LAS. This will be achieved through monitoring and making appropriate recommendations on performance in risk management based on the standards within the NHSLA Risk Management

Standard for the Provisions of Pre Hospital Care in the Ambulance Service (monitored by the NHSLA) and the standards within the Annual Healthcheck (monitored by the Healthcare Commission).

Functions

- Monitoring progress with all risks on the Risk Register and on agreed Key Performance Indicators
- Receiving an annual progress report on trust wide risk management arrangements
- Monitoring take up and effectiveness of training courses relating to clinical and non-clinical risk management as set out in the Training Needs Analysis
- Reviewing the new risks identified by the annual trust wide risk assessment for acceptance onto the Risk Register
- Achievement of risk treatment plans on high priority risks on the Risk Register that deliver reductions in priority rating scores for those risks
- Reduction in the level of manual handling, incidents and claims
- Monitoring the implementation of the Risk Management Policy
- Monitoring and review of the Trust's exposure to litigation claims
- Ensuring there is an effective process to learn from claims
- Provision of advice concerning risk management throughout the Trust to the Audit Committee and the Trust Board
- Ensuring that external communication and consultation takes place with other NHS Ambulance trusts to promote sharing of good practice and lessons learned from effective risk management
- Approving risk-related procedural documents and ratifying such documents approved by reporting committees and groups.

The Risk Compliance and Assurance Group will meet quarterly before the Senior Management Group & Audit Committee and be supported by the Governance Development Unit. The Committee will be chaired by the Chief Executive. The Group's minutes will be reported to, and considered by, the Trust Board. The quorum for this group will be 1 Executive Director, 4 Directors and a member of the Governance Development Unit.

Membership (*deputies to be proposed unless already stated)*
Chief Executive (chair)
Director of Finance
Medical Director
Director of Operations
Director of Human Resources
Non Executive Directors (2) -observers

Director of Information Management and Technology
Chair of Clinical Governance Committee (Non Executive Director)
Director of Communications
Director of Service Improvement

Head of Governance (deputy – Head of Records Management and Business Continuity)
Head of Legal Services

The Risk Compliance and Assurance Group receive regular reports related to its functions (as described above) from:

- (corporate) Health and Safety Group
- Standards for Better Health Group
- Complaints Group
- Clinical Governance Committee
- Information Governance Group
- Vehicle and Equipment Working Group
- Motor Risk Management Group
- Business Continuity Steering Group
- Emergency Preparedness Strategy Group

Recommendations and feedback will be made to these groups as appropriate.

SMG will feedback to the Risk Compliance and Assurance Group strategic development plans for risk management throughout the Trust as they are revised and updated over time.

The Group will take particular responsibility for:

- All Risks on the Risk Register
- Approving and monitoring progress with the management of risk including feedback from the Audit Committee on risk treatment or action plans related to risks
- Monitoring the implementation of the Risk Management Policy and Risk Reporting and Assessment Procedure
- Ensuring the promotion of an awareness of risk management amongst all staff groups.

2. The Clinical Governance Committee

Terms of Reference for Clinical Governance Committee

1. Constitution

- The Committee is established by the Board. Its terms of reference, membership, delegated powers and reporting arrangements are determined by the Board. It will normally meet 4 times a year with 2 of those meetings set aside for core work.
- The Committee will be chaired by a non-executive director or an executive vice-chairman in the absence of the chairman.
- A quorum shall be one non-executive director, one executive director (deputy - Assistant Medical Director) and the Deputy Director of Operations/Assistant Director of Operations.
- The Committee's minutes will be reported to, and considered by, the Trust Board.

2. Functions and how these will be achieved

The Committee's prime purpose is to collect and consider evidence, which indicates that high quality patient care is delivered throughout the London Ambulance Service. To this end, the Committee will, inter alia:

- Oversee the clinical guidelines and protocols that members of staff are expected to follow during their working lives at LAS[1]. The Committee will consider any decision by the Medical Director, not to follow the JRCALC guidelines. This will be reported this to the Trust Board, after reflecting on the alternative proposed by the Medical Director.
- Require evidence on an exceptional basis that procedures and protocols are reviewed and further training is given (where appropriate) in response to the reporting and investigation of clinical incidents and complaints.
- Monitor progress in implementing the Clinical Governance strategic goals and support the production of the Annual Clinical Governance report.

The Committee will invite assurance from groups reporting to the Clinical Governance Committee, that there is adherence to standards for good practice, and will recommend remedial actions where necessary. In so doing, it will use the framework of Standards for Better Health issued by the Healthcare Commission (and its successor the Care Quality Commission), the Integrated Risk Management Standards

[1] NB: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee (JRCALC)

within the NHSLA Framework for the Provision of Pre Hospital Care in the Ambulance Service. To this end, the Committee will work with the Risk Compliance and Assurance Group

- Receive and review regular reports from feeder Groups, in particular Standards for Better Health Group, the Risk Information Report (which combines data about risks reported to the Trust through complaints, claims and clinical incidents and identify emerging trends), the Complaints Panel, the Infection Control Group and the Area Governance Groups.
- Receive and review evidence of compliance and collated information for the final declaration of the Annual Healthcheck using the format of the Assurance Framework and for any submission to the NHSLA

The Committee will review the risks associated with the LAS' clinical practice and will ensure that appropriate action plans have been put in hand to reduce the number of untoward clinical events. To this end, it will:

- Make recommendations to the Risk, Compliance and Assurance Group, which will grade risks and place them on the Risk Register in accordance with the LAS Risk Scoring Matrix.
- Use data from the Risk Information Report and other sources to ensure that there is evidence of progress in managing clinical risks identified on the Risk Register.

The Committee will review reports from the Clinical Audit and Research Steering Group to assure that day-to-day practice is evidence-based and is supported by research and development.

The Committee will satisfy itself that all personnel working for the London Ambulance Service receive education, training, continuing personal and professional development. It will do this by;

- Receiving the relevant information from the Training Services Group and the Area Governance Groups, and other feeder Groups as appropriate
- Monitoring and updating the delivery of the Trust-wide Training Needs Assessment.

The Committee will agree Key Performance Indicators which provide quantitative and qualitative information to be collated in the form of an annual clinical governance report to the Board. This will contribute to a Trust-wide scoring system.

The Committee may recommend policies, as appropriate, to the Trust Board for ratification Further training or clinical service development may also be recommended as a result of evidence presented for consideration by the Committee.

The Committee is responsible for providing assurance to the Audit Committee that there is a reliable clinical risk management system in place; that action plans have been agreed to manage those risks and that these have been appropriately followed up in order to manage/reduce the level of risk.

3. Membership (deputies to be proposed unless already stated)

Core:
1 Non Executive Director (chair)
2 NED
Medical Director (vice chair)
Head of Legal Services
Head of Governance
Deputy Director Operations
All ADOs (PIM to deputise)
Assistant Director – Organisation Development
Assistant Director - Employee Services
Head of Records Management & Business Continuity
Head of Complaints
Senior Safety & Risk Advisor
Head of Operational Support
PPI Manager
Head of Clinical Audit & Research

Attending full committee meetings but not core meetings
Director of Service Development
Director of Communications
Assistant Director of Operations EOC (deputy -Senior Operations Officer)
User Representative(s)
A&E Consultant
Diversity Manager

Special attendance/reports – once a year
HEMS
BASICS
Voluntary Aid Societies/ Private Contractors
Community First Responders Scheme

4. Regular Reports will be received from:
- Standards for Better Health Group
- Complaints Group

- Clinical Audit and Research Steering Group
- Risk Compliance and Assurance Group
- Area Governance Groups
- PPI Committee
- Race Equality and Diversity Group
- Infection Control Group
- Lead for Safeguarding Children and Vulnerable Adults
- Six month update on NICE Guidance applicable to LAS

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3. The Audit Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed Chair of the Committee by the Board. The Chairman of the organisation shall not be a member of the Committee.

3. Attendance

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the External and Internal Auditors.

The Chief Executive should normally attend all Audit Committee meetings and must attend annually to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

Other executive directors should be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Trust Secretary, or whoever covers these duties, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

4. Frequency

Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

The duties of the Committee can be categorised as follows:

6.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of
integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- review and approval of the Internal Audit strategy, operational plan and more detailed
- programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework

- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- ensuring that the Internal Audit function is adequately resourced and has appropriate
- standing within the organisation

- annual review of the effectiveness of internal audit

6.3 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

6.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.) or their successor bodies.

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee and any Risk Management committees that are established.

In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

7. Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

8. Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9. Reporting

The minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and level of embedding of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

10. Other Matters
The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Agreement of agenda with Chairman and attendees and collation of papers
- Taking the minutes & keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

4. The (corporate) Health and Safety Group

Terms of Reference

The joint Health, Safety and Risk Consultation structure provides access from local and Area levels to the Corporate Health and Safety Group, which is responsible for the coordination and implementation of the Health and Safety strategy on behalf of the Risk Compliance and Assurance Group.

Its responsibilities are:

- To oversee the development of an overall strategy to promote a positive Health and Safety culture - Service wide, and actively promote best practice.
- To monitor the progress of the actions taken to reduce Health & Safety Risk on the Trust Risk Register
- Monitor the timeliness of conducting premises inspections and Risk Assessments.
- To approve Health and Safety Policies and Procedures.
- To approve the planned implementation of Health and Safety Policies and Procedures.
- To monitor the organisation's overall performance in relation to Health, Safety and Risk Management, and where appropriate, recommend actions to be taken.
- To review and monitor the effectiveness of Health and Safety training.
- To receive reports from the Area and HQ committees
- To provide regular reports to the Trust Board and Risk Compliance and Assurance Group on Health and Safety issues.
- To review quarterly Health and Safety statistics and to recommend appropriate action.
- To oversee and monitor the progress of equipment trials specifically related to Health and Safety.
- To co-ordinate all relevant information on Health Safety and Risk issues and promote effective communications.

Membership

Director of Human Resources and Organisation Development (chair)
Assistant Director, Employee Support Services (vice chair)
Director / Deputy Director of Operations
Safety & Risk Advisers (2)
Local Security Management Specialist
Head of Operational Support
Head of Fleet
Head of Estates
Logistics Manager
Regional Operations Manager (PTS)
Ambulance Operations Manager
Education Governance Manager
Occupational Health Representative
Area Health & Safety Representatives (as determined through local agreement)

The quorum for meetings requires the chair or vice chair and a Safety & Risk Advisor to be present. Attendees will represent an appropriate match to the agenda, in agreement with area health and safety representatives.

The (corporate) Health & Safety Group has a vital role in ensuring that Health & Safety policies and procedures are acted upon.

5. Complaints Group

Terms of Reference

To ensure that the Trust is dealing with patients' complaints and concerns received by the Complaints department and the Patients Advice and Liaison Service (PALS) in line with the requirements of the NHS Complaints Procedure and the core standards of the Healthcare Commission.

To ensure that the Trust takes any necessary action to ensure changes are made for the benefit of patients, relatives and carers, and that any lessons arising are disseminated for learning across the London Ambulance Service NHS Trust.

- To consider the implications for the Trust of guidance on the management of Serious Untoward Incidents (SUIs), complaints and concerns issued by the Health Care Commission, National Patient Safety Agency, National Health Service Litigation Authority and other advisory bodies as appropriate.

- Provide quarterly reports to the Trust Board via the Risk Compliance and Assurance Group.

- To monitor SUI investigations, specifically timely implementation of recommendations, outcomes and improvements in patient care.

- To review the handling of, and outcomes from, all complaints involving the Trust referred to the Heath Service Ombudsman and Healthcare Commission.

- To monitor outcomes which affect the Service.

- To monitor emerging trends and issues from SUIs, complaints, coroner's inquests, concerns and potential high risk claims.

- To contribute to the production of the Trust's annual complaints report by ;

    i) Providing evidence that learning from patient feedback has taken place across the Trust

    ii) Improving the reporting of outcomes resulting from recommendations developed from the Trust's processes for managing SUIs, complaints and concerns

    - Minutes to go to the Risk Compliance and Assurance Group and Clinical Governance Committee

Membership

Executive Director (Chair)
Director of Communications
Non Executive Director
Senior Operations Manager
Medical Director
Chair of the LAS Patients Forum
Head of Governance
Clinical Education and Training Manager
Complaints Manager
Staff side representative
Frontline staff (A&E,EOC,PTS)
PPI Manager
Head of Urgent Care
Head of Legal Services

A quorum will consist of an Executive and Non-Executive Director, and representatives from PALS, Governance, Operations and Training.

6. Liability Claims Review Group

Terms of Reference

To review, recommend and report action to demonstrate organisation and individual learning from an employer or public liability claim against the Trust where liability was conceded.

This will be achieved by :

- Conducting round table reviews every 6 months of the employer and public liability claims that closed in the previous 2 quarters. In these reviews the findings of the untoward incident / accident investigation, pre and post incident risk assessment, claims investigation and root cause analysis will be considered and actions taken and recommended to minimise the risk of recurrence will be reported to the Risk Compliance and Assurance Group in the Claims Report.
- Proposing new risks to the Risk Compliance and Assurance Group for inclusion on the Trust's Risk Register.

Membership

Assistant Director Employee Support Services (joint chair)
Head of Legal Services (joint chair)
Senior Safety and Risk Advisor
Claims Co-ordinator (Employer and Public Liability)
Performance Improvement Managers E, W, S, and Control Services,
PTS Transport Operations Centre Group Manager
Educational Governance Manager
Head of Estates
Head of Fleet,
Head of Operational Support
Financial Controller

A quorum shall be one chair, one Performance Improvement Manager, Senior Safety and Risk Adviser or deputy, and the Educational Governance Manager or deputy.

7. The Standards for Better Health Group

Membership

Director of Finance (Chair)
Director of Information Management and Technology
Director of Operations
Director of Human Resources and Organisation Development
Medical Director
Head of Operational Support
Head of Governance
Standard Leads and Internal Audit as required.

Terms of Reference

Core Functions

- The group has the responsibility for ensuring that the Healthcare Commission assessment to produce the annual health check declaration and rating is co-ordinated so that core standards are met and progress with developmental standards is made. This will be achieved through self-assessment to produce a baseline which will identify gaps in compliance and what to do about them
- The Group is responsible for overseeing that the Board Assurance Framework is developed in line with the Standards for Better Health to ensure that the principal objectives of the organisation are achieved and provide the evidence base for the Statement of Internal Control (SIC).
- The Standards for Better Health Group is responsible for preparing the SIC so that it is supported by the required evidence as defined by the Department of Health. The Group will ensure that this work is completed so that the SIC can be signed by the chief executive. This task is the core component of the group's role as it will be based on the assurances we receive on the systems that we have put in place to achieve compliance with core standards.
- The Standards for Better Health Group will be directly accountable to the Risk Compliance and Assurance Group and ensure that risk assessment mechanisms as defined in the Risk Management Framework are included on the Trust Risk Register as appropriate.
- Reporting to SMG risks relating to healthcare standards on the Board Assurance Framework and elements of the Balanced scorecard that relate to the Annual Health Check

Responsibilities of Group

A manager should be appointed to take the lead on the implementation of each Healthcare Standard and report on the level of trust compliance with that standard to the Standards for Better Health Group .

These managers will have the initial responsibility of reviewing the standards to achieve a baseline of compliance. Evidence of the means of compliance with these standards should also be documented. From there managers will produce a series of action plans that will establish how each non compliant or partially compliant standard will be progressed. This will include a description of what is to be achieved along with how it will be achieved. The group will review these action plans with each manager as there may be policy decisions along the way to their implementation.

Resource implications and target dates for all identified actions need to be agreed. Other Board Members or Directors will be consulted as appropriate.

Resource and support implications for the Standards for Better Health will be identified by the SBH and referred to the Risk Compliance and Assurance Group as determined by the chair of the SBHgroup.

To ensure that self-assessment and action planning is undertaken and provides assurance to the Trust Board as required of compliance with the healthcare standards.

To monitor the implementation of action plans and, where these are not being achieved, determining the necessary remedial action.

Accountability

The Standards for Better Health Group will be accountable to the Risk Compliance and Assurance Group and provide regular updates for monitoring purposes.

Managers will come to meetings in an ‘attendance’ capacity when their standard is being discussed.

Each standard will also be ‘sponsored’ by a Director in the Senior Management Group.

The group should review these terms of reference annually and provide a report on its effectiveness to the Risk Compliance and Assurance Group

Frequency of Meetings

The groups meetings are quorate when attended by the Director of Finance, Director of Human Resources, the Medical Director or the Director of Operations and the Head of Governance.

The group will meet on a quarterly basis, and additionally, as necessary to complete the Annual health Check requirements ratings return and the SIC in alignment with performance management requirements (internal and external).

8. Vehicle & Equipment Working Group

Terms of Reference

- Appropriate procurement of operational vehicles and equipment by means of assessment, evaluation and trial, both in response to, and in anticipation of operational needs
- Structured evaluation of new market products and developments aiming for improvements to service delivery, as well as ensuring patient and staff safety
- Corporate consistency in the procurement of operational vehicles and equipment in accordance with the new protocol for acquisition, trial and purchase of ambulance aid equipment, medical treatments or devices.
- Reports to Risk Compliance and Assurance Group

Membership

Head of Operational Support (Chair)
Safety & Risk Advisor (2)
Fleet Manager
Principal Project Manager
Logistics Manager
Training Manager – Fulham
Chase Farm Ambulance Station (Rep)
Support Services Officer, Sector Centre Bow
Communications Manager
Station Officer, Barnehurst Ambulance Station
Duty Station Officer, Heathrow
Union Branch Secretary, HQ Waterloo
Workshop Supervisor, Whipps Cross Ambulance Station
Hillingdon Ambulance Station (Rep)
Park Royal Ambulance Station (Rep)
Rotherhithe Ambulance Station (Rep)
Head of Procurement
Team Leader, Oval Ambulance Station
Senior Representative, NE Sector
Staffside Representative, Islington Ambulance Station
Staffside Representative, Woolwich Ambulance Station

Team Leader, Waterloo

9. Motor Risk Group

Terms of Reference

The Motor Risk Group has a key role in the management of motor risk in the LAS. Supported by the Vehicle and Equipment Working Group and Training Services Committee and performance management structures in Operations the responsibilities of the Motor Risk Group are to:

- Monitor the progress of the actions to reduce the motor risks on the Trust Risk Register.
- Consider new motor risk assessments to be recommended to Risk Compliance and Assurance Group to be placed on the Trust Risk Register.
- Report on the action to reduce the incidence of liable motor incidents to the Risk Compliance and Assurance Group.
- Make recommendations to the Risk Compliance and Assurance Group about the efficacy of the mechanisms for reducing the incidence of liable motor incidents.
- Communicate the actions and progress to reduce the motor risks on the Trust's Risk Register.
- Approve policies and procedures on driving and the care of Trust vehicles.
- Set and review the auditing arrangements for the reporting and investigation of road traffic incidents.
- Approve and monitor compliance with the policies and procedures on driving and the care of Trust vehicles.

Membership

Director of Finance (Chair)
Assistant Director of Operations
Ambulance Operations Manager
Duty Station Officer
PTS Site Manager
PTS Contracts Operations Manager
Fleet Engineer
Educational Standards Manager
Head of Operational Support
Head of Legal Services
RTA Claims Assessor / Administrator Incidents / Claims
Safety and Risk Advisor
Staff side representative

10. Training Services Group

The Training Services Group has a key role in the management of risk and development of clinical and educational governance within the LAS.

Terms of Reference

The terms of reference proposed for the Training Services Group are:

- To set the strategic direction for learning and development within Operations and the wider organisation, influenced by organisational objectives and national priorities as appropriate.
- To support the Education & Development Strategy by interpreting organisational requirements into plans for implementation.
- To support the Clinical Education & Training Manager and Learning and Organisation Development Manager in meeting the organisation's learning and development objectives for these plans.
- To prioritise the training programme and determine what training gets delivered in a context of competing pressures. Decisions will be based on managing the organisation's principal risks and improving patient care.
- To sponsor requests for the services of the Department of Education and Development from all parts of the organisation and define what resources are required to fulfil requirements.
- To advise and seek provision of additional resources required from the organisation to enable training and education to take place to fulfil objectives.
- To predict future organisational training and development needs by communicating with key internal stakeholders and feed these requirements into plans as appropriate.
- To report to Clinical Governance Committee and Strategy Steering Group, decisions and progress with learning and development to support the management of clinical risks and highlight any concerns which threaten risk management objectives when these arise.

Membership

Director of Human Resources and Organisation Development (Chair)
Director of Operations
Medical Director
Assistant Director of Organisation Development
Clinical Education and Training Manager

Higher Education Programme Manager
Learning and Organisation Development Manager
AOM Resourcing

11. Infection Control Steering Group

The Infection Control Steering Group (ICSG) co-ordinates the development and implementation of infection prevention and control policy for the Trust. The Group will ensure that Department of Health guidelines and initiatives are applied and developed. The group will oversee auditing activity and ensure effective liaison with the Director responsible for infection control is maintained. The group will promote best practice in all areas of infection control.

Purpose

The aim of the ICSG is:

To provide a robust mechanism for assuring infection control arrangements, providing advice on hygiene, infection prevention & control matters and establishing a framework for developing improvements in order to optimise patient care and staff safety.

Scope

The ICSG is responsible for disseminating national policy in accordance with Department of Health ambulance service guidelines. Under the terms of the Health Act 2006 the group will agree and implement an annual infection control programme.

The group is responsible for the oversight of audit activity, promoting education and development, considering new products and facilities, and monitoring incidents and risks associated with infection control issues.

The group has no authority to approve new products (this falls to the Vehicle and Equipment Working Group) but can make recommendations. The group has no responsibility in the investigation of infection control related incidents (this falls to local complex management, the Medical Department, or Health and Safety Department) but can ask for further information/investigations if a significant infection risk is apparent or trends are developing.

Responsibilities

The tasks of the ICSG are to:

- Ensure that the Trust has sound control of infection arrangements and the availability of advice on infection control issues.

- Develop and implement an annual programme to provide a framework for improving infection control arrangements and regularly review progress and advise the Trust on the most effective use of resources to improve infection control.

- Periodically review the Infection Control Policy and Manual of Procedures.

- Continuously improve infection control throughout the LAS so that staff recognise their responsibility for patient and staff safety.

- Provide a recognised body within the LAS for the co-ordination of infection control issues.

- Raise awareness of infection control issues and to provide recognised communication channels to staff and managers.

- Seek and promote evidence based practice in relation to infection control arrangements.

- Provide a route through which to cement responsibilities in relation to infection control issues including the demonstration of Board level engagement.

- Develop arrangements for robust Infection Control audits, including management arrangements and staff compliance, and the formulation of remedial action plans.

- Identify preferred infection control products based on sound evidence.

- Monitor the LAS OHD Vaccination Policy. The policy explains how the requirements for vaccination are established, how initial vaccination is to be carried out and how staff will be recalled for booster vaccination in due course.

- Raise awareness of sharps and body fluid exposure procedures.

- Ensure that planned estates work takes account of Infection Control issues.

- Develop an evidence based programme of estates works to improve infection control arrangements.

Outcomes

The ICSG will develop an annual programme to improve hygiene, infection prevention and control arrangements
to ensure that they meet the requirements of the Safety standard domain and related Healthcare Standards that form part of the Healthcare Commission's requirements for NHS Trusts.

Membership

Membership of the Group comprises staff representatives, senior managers and other appropriate staff from across the Trust, and an advisor (internal and / or external) in infection control.

Head of Operational Support (chair)
Infection Control Lead
Education Governance Manager
Practice Learning Manager
Senior Training Officer
Assistant Director Employee Support Services
AOM
Staff Side representative
Senior Safety & Risk Advisor
Corporate Logistics Manager
Facilities Manager
Head of Governance
Deputy Director Public Health, Redbridge PCT

Meetings

The Team will meet quarterly and the quorum for meetings will be an infection control lead, a senior manager and educational / operational representatives

Reporting

The Minutes of each meeting are reported through to the Trust Board via the Clinical Governance Committee and the Medical Director who includes a summary of infection control matters within the formal report to the Board. The Group produces an Annual Report on behalf of the Medical Director to the Trust Board.

12. Patient and Public Involvement Committee

The Committee's function will be to monitor patient and public involvement (PPI) activity throughout the London Ambulance Service NHS Trust and ensure that PPI is an integral part of the LAS strategic plan.

This will be achieved through review, monitoring, remedial / corrective action, initiation and proactive planning. The Committee will regularly review implementation of the PPI strategy and provide progress reports to the Trust Board through the Clinical Governance Committee. The Committee will encourage the Trust to involve patients directly in service development and strategic planning.

Functions

1. Ensuring that the Trust's PPI obligations are being met.

2. Utilising a network of managers and leaders to co-ordinate and advise on the methods to achieve the greatest impact for PPI activity.

3. Sharing information on PPI activity, raising concerns and exchanging examples of good practice.

4. Acting as an internal discussion forum to verify issues and trends requiring action through PPI activities and the influence of the Committee.

5. Reviewing key activity within the PPI strategy and informing project approaches so that problems are easily identified and resolved.

6. Managing risks that threaten the implementation of the Trust's strategic approach to patient and public involvement.

7. Ensuring that the Trust's PPI activity relates to the Strategic Plan and enhances the compliance of the Trust to external accreditation systems e.g. the Healthcare Commission, NHS Litigation Authority, National Patient Safety Agency, Health and Safety Executive.

The PPI Committee will meet quarterly and be chaired by the Director of Communications. A quorum for each meeting will be a minimum of five members.

Membership

Director of Communications (Chair)
PPI Manager
Chair of Patients Forum
Chair of Clinical Governance Committee
Director of Service Development
Head of Governance
Diversity Manager
Patient Services Manager
Clinical Education & Training Manager
Education Centre Manager
Head of PTS Modernisation & Performance
Project Manager - Community Responder Project
Performance Improvement Manager
Ambulance Operations Manager (Urgent Care Service)

The Committee will take particular responsibility for :

- Identifying methods for Trust staff to engage and involve patients, the public and the voluntary sector in service delivery.
- Promoting the value of PPI within the Trust.
- Co-ordinating reports on PPI activity across the Trust.
- Monitoring the effective implementation and demonstrating outcome measures from major PPI developments in the Trust e.g. Public Education Strategy.
- Ensuring that the Trust continues to meet external standards for patients' and the public's interests, e.g. Healthcare Standards, Overview and Scrutiny Committees, GLA Scrutiny.

13. Clinical Audit and Research Steering Group

Functions

• To set the objectives for clinical audit at the LAS, in terms of long-term goals and

short term audit projects
- To provide clinical, organisational and training advice and practical support to the LAS clinical audit function
- To ensure that clinical audit results are recognised by the LAS and widely Disseminated
- To approve the LAS's R&D strategy
- To guide LAS R&D funding applications in the context of the strategy
- To oversee the progress of research programmes
- To ensure that LAS acts on research findings, its own and those of other researchers
- To communicate within and outside the LAS the outcomes of research and the way they have impacted on practice
- To ensure that research in the LAS complies with the Research Governance Framework
- To provide expert independent peer review of research proposals and research papers for publication
- To monitor the progress of the LAS Research Governance Implementation Plan

Membership:

Internal

Medical Director (chair)
Director of Service Development
Head of Clinical Audit & Research (vice chair)
Assistant Head of CARU
Research Manager
Clinical Education & Training Manager
Clinical Practice Manager
AOM x1
Team Leader x1
EMT x1

External

Emergency Physician Guy's and St Thomas' Hospital
Senior Research Fellow, St George's, University of London
Obstetric Risk Manager, St George's
Principle Lecturer and Research Lead University of Hertfordshire
Patient Representative
Consultants from NHS hospitals x9

Quorum:
Chair; Head of Clinical Audit & Research; Assistant Head of CARU; Research Manager; and two external members.

Frequency of Meetings:
Six monthly

14. Information Governance Group

Terms of Reference

Constitution and Function

Information Governance provides a framework to bring together the requirements, standards and best practice that apply to the handling of corporate and personal information.

It covers data quality, Caldicott principles, Information Security Management (ISO/IEC 17799 / ISO/IEC 27001), The Data Protection Act 1998, The Freedom of Information Act 2000, the Information Governance Toolkit and records management requirements as defined by the Standards for Better Health, the Public Records Act, and the DH Records Management Code of Practice.

The Information Governance Group is the management forum that will ensure that there is clear direction and visible management support for Information Governance initiatives within the LAS.

It will promote best practice within the organisation through appropriate direction and resourcing.

It will also act as a cross-functional forum of senior management representatives from relevant parts of the organization to co-ordinate the implementation of Information Governance controls.

The Group will meet quarterly, within six weeks prior to the Risk Compliance and Assurance Group (RCAG) where this is practicable, and review its effectiveness against these Terms of Reference annually.

A quorum for each meeting will be one Chair, one Non-Executive Director, one of the Head of Records Management or Information Security Manager and 2 others.

Members may send deputies to attend if necessary provided these are empowered to make decisions.

The meetings will be minuted, and reported to the Trust Board through RCAG. An annual report will be provided to the RCAG.

Group membership

Joint Chairs:
Director (IM&T)
Medical Director (Caldicott Guardian)

Members:
Non-Executive Director
Non-Executive Director
AOM
Senior PTS Manager
HR Manager
Assistant Chief Ambulance Officer
Head of Legal Services
Head of Management Information
Head of Records Management & Business Continuity
Information Security Manager

To attend on an as required basis:
PALS Manager

Responsibilities

1. Pro-actively manage and support Information Governance throughout the Trust by:
    - 1.1 Ensuring that appropriate policies and procedures are developed, approved, implemented and reviewed.
    - 1.2 Ensuring that specific roles and responsibilities for information governance are in place.
    - 1.3 Developing, supporting and monitoring major initiatives, processes, and systems to enhance and ensure compliance with information governance.
    - 1.4 Promoting management support for, and staff awareness of, information governance.
    - 1.5 Reviewing information governance audit findings and ensuring that appropriate actions are taken.
    - 1.6 Coordinating and approving the annual LAS Information Governance Toolkit submission.

2. Ensure that effective information security is in place across the Trust by:
    - 2.1 Promoting information security awareness and best practice

2.2 Assessing the adequacy and co-ordinating the implementation of specific information security controls for new systems or services.

2.3 Reviewing and monitoring information security incidents and weaknesses.

3. Support, monitor and review Trust-wide records and information management initiatives including the Records Management Strategy.

4. Monitor information, and information management systems confidentiality, integrity and availability by: Identifying, managing and reviewing Information risks across the Service and supporting the implementation of any required controls.

   Ensuring that Business Continuity plans are in place which will support continued provision of information and systems.

15. Business Continuity Steering Group

Constitution and Function

In order that both the Business Continuity Policy and the Business Continuity Plan are effectively implemented, trained, practised and reviewed by the LAS and to ensure that the service is compliant with the Civil Contingencies Act and other relevant legislation and standards a cross functional Steering Group has been established.

Membership will comprise one nominated representative from each Directorate, charged with the responsibility of bringing forward to the Group relevant matters relating to any aspect of Business Continuity that is liable to affect the LAS policy or operational plan. Other members may be co-opted as required. A quorum will comprise of the Chair or delegated representative, Head of RM & Business Continuity, and four other members of the Group.

The nominated member from each Directorate must be able to make decisions on behalf of the Directorate in respect of Business Continuity matters. They must also ensure that their Departmental plans are maintained and up to date and any changes are notified to the senior manager responsible for Business Continuity. They are also expected to bring to the Steering Group issues affecting the LAS that require discussion, review, awareness and/or adoption by the whole Group.

The Group will meet monthly, or as required by the Chairman, and submit Minutes to the RCAG. Reports will be submitted to the SMG as required, and an annual report to

the RCAG. The Group will review its effectiveness against these Terms of reference annually.

In the event of the Business Continuity Plan being invoked the Chairman or nominated member of the Steering Group will become a member of the Strategic Coordinating Group (Gold Group), and relevant members (subject to the nature of the Major Incident) of the Steering Group will form into a Emergency Business Continuity Group that will carry out the objectives identified in the Business Continuity Operational Plan.

Membership:

Finance Director (chair)

Supply Manager, Purchasing Department
PTS Regional Operations Manager West
Administration & Support Services Manager
AOM Control Services
AOM Camden
Principal Projects Manager
Executive Officer
Acting Logistics Manager
Head of Records Management & B. Continuity
Business/Systems Analyst
Head of Communications
Financial Systems Manager
Senior Building Surveyor
Emergency Planning Advisor

Responsibilities

The Steering Group will:-

1. Receive and consider changes in the LAS Business Continuity Policy.
2. Receive and consider proposals for major revisions to the LAS Business Continuity Plan, other than those considered to be routine or minor changes. notification of which will be circulated on a regular basis.
3. Review Business Continuity Risks, make recommendations and forward these to the Head of Governance for presentation to the Risk Compliance and Assurance Group.
4. Recommend and oversee the Service Business Continuity awareness, training and exercise programme and ensure that an adequate audit trail of training is maintained.

5. Oversee and conduct internal audits of the Plan in accordance with BS 25999 (or other audit tools that may be adopted).
6. Ensure that at least annually a Business Impact Analysis is carried out and the results acted upon by way of changes to the Service policy or plans.
7. Receive for consideration any de-brief or other report that emanates from a Major Incident or Exercise in order that any Business Continuity aspects raised may be fully considered and necessary actions taken or recommended.
8. Identify and enquire into both past and future potential areas of 'Business Continuity Failure' and make recommendations to appropriate Directorates.
9. Provide annual assurance to the Trust Board regarding Business Continuity.
10. The group will meet quarterly. In-between the group will have either one or two telephone conference meetings

16. Emergency Preparedness Strategy Group

Terms of Reference

1. The London Ambulance Service (LAS) National Health Service (NHS) Trust Emergency Preparedness Strategy Group has been formed to determine the Service policy relating to 'Emergency Preparedness'. The group will comprise of departmental heads who will ensure that the policies relating to Emergency Preparedness can be co-ordinated strategically.

2. The Group will be Chaired by the Deputy Director of Operations or via his delegation

3. The Group will be administered by the Head of Emergency Preparedness

4. The Group will comprise representatives from Operations (1 x ADO + 1 x AOM): EOC/UOC (1 ADO): Head of Safety and Risk: Medical Director: Head of Operational Support: Head of Employee Services: Head of Communications: Head of Records & Business Continuity: LRT LAS representative: Director of IM&T: CBRN Co-ordinator. When approved by the chair, members of the group may invite other representatives to attend as and when required The quorum for the group will be Deputy Director of Operations or delegate, Head of Emergency Preparedness or delegate, and three others. Specified postholder members of the Group may delegate their authority through a representative.

5. The Group will meet quarterly, or more frequently if required.

6. The Group will:-

a. Consider and Approve for adoption by the Chief Executive the contents of the Major Incident Plan & the Catastrophic Plan Appendix

b. Consider the LAS Strategy for Emergency Preparedness in terms of the Major Incident Plan, Contingency Planning, Operational and Event Plans

c. Monitor the overall Emergency Preparedness of the Trust against the Standards for Better Health c.24 & other standards that may from time to time be set.

d. Consider, approve and monitor the level of Emergency Preparedness Training and Exercise that should be adopted throughout the Service. Training to be in line with current at the time DOH guidance**.**

e. Approve policies and procedures relating to emergency preparedness.

f. Monitor review groups that will consider technological and equipment needs and advances (e.g. – new ESVs – updates to the ECVs as required – establish new 'stores provisions to deal with specific threats (e.g. burns/blasts)) and to monitor the adequacy and suitability of equipment and systems.

g. Have an overview of, together with Safety & Risk Dept, risk assessments, control measures and safe systems of work.

h. Receive reports from delegates upon their return.

i. Review recommendations from Head of Emergency Preparedness on DOH guidance.

j. Liaise and co-operate with other ambulance services, emergency services, hospitals, local authorities, stakeholders and other bodies as appropriate - to share strategic information and good practice.

The Group will report through to SMG who will receive the Minutes of the Group.

These terms of reference will be reviewed annually at the first meeting to be held in a new financial year, and formally approved.

17. Clinical Steering Group

Terms of Reference

Function

The Clinical Steering Group (CSG) is a sub-group of the Clinical Governance Committee. The CSG is a forum through which the Medical Director can seek as required, advice and guidance on;

a) All clinical aspects relating to ambulance pre-hospital patient care, and to the interfaces of the ambulance service with both Acute and Primary Care Trusts.

b) Adoption and implementation of nationally agreed clinical guidelines in their entirety, or with omissions / additions.

c) To provide *ad hoc* specialist group(s) as directed by the Clinical Governance Committee (CGC)

Note: Opinions may also be sought by phone or email in between meetings, but these will always be discussed as Agenda items at the next scheduled meeting.

Membership

Chairman	LAS Medical Director
Vice-Chairman	LAS Assistant Medical Director

The Chairman will also be a member of the CGC

LAS Members

Assistant Medical Director (x1)
Senior Clinical Adviser to the Medical Director
Clinical Adviser to the Medical Director (x1)
Clinical Practice Manager – Cardiac Care
Practice Learning Manager (x1)
Consultant Midwife to the LAS
Head of Clinical Audit & Research
Staff Side Representative (x1)

Non LAS members – By invitation of the Chairman CSG, and Chairman CGC

Consultant Cardiologist (x2)
Consultant Anaesthetist (x2)
Consultant in Emergency Medicine (x2)
Consultant in Respiratory Medicine (x2)
Consultant Obstetrician (x2)
Consultant Paediatrician (x2)
Senior Nurse (Must have professional interest in Emergency Care)
Senior Pharmacist

Other members may be invited in order to fulfil Function c) above as required

Quorum – Functions a) & b)

A quorum shall be the Chairman, three LAS members and three non LAS members

Quorum – Function c)

A quorum shall be the Chairman and members nominated by the Chairman of CSG, and Chairman CGC as required

Frequency of Meetings – Functions a) & b)

Meetings will take place every six months. Opinions may also be sought by phone or email in between meetings, but these will always be discussed as Agenda items at the next scheduled meeting.

Frequency of Meetings – Function c)

As directed by the Chairman of CSG

Reporting Lines

The Chairman of the CSG will report to the Chairman of the Clinical Governance Committee. The minutes of the CSG will be presented to the Clinical Governance Committee.

If required the Chairman of the CSG, can in consultation with the Chairman of the Clinical Governance Committee take action outside these reporting lines.

18. Equality & Diversity Plan Implementation Group

Terms of Reference (draft – new Diversity Manager appointed August 2008)

Function

- To interpret guidance from national equality & diversity initiatives and legislative requirements.
- To engage with stakeholders at key stages of the Equality and Diversity Implementation Plan development, implementation and review
- To ensure effective communication methods are used to promote the Equality & Diversity Implementation Plan
- To provide leadership and direction to ensure that the plan is actioned.
- To provide guidance / authority to the Equality and Diversity Plan Implementation Team where appropriate.

Membership

Equality & Diversity Manager
Assistant Director of Operations
Assistant Director for Employee Support
PALS Manager
AOM
Learning & Development representative
Staff Representatives clinical and non-clinical

Appendix 2

Risk Identification

The systematic identification of risks will be undertaken using the following sources:

Source	Management responsibility	Facilitation / co-ordination
Incidents: -Reporting -Investigation - Monitoring trends	 - All staff and managers - Line managers, Safety and Risk, PSU - Line managers, Safety and Risk	 Safety and Risk, training Safety and Risk, training, Complaints Safety and Risk Ergonomics and Back Care Training
Musculoskeletal Disorders	Ergonomics and Back Care Adviser Accredited Assessors/Trainers	Ergonomics and back care adviser Ergonomics and back care training for Key accredited trainers/assessors
Inquests	Staff and managers, training, Legal Services	Legal Services
Claims	Staff and managers, training, Legal Services	Legal Services
Complaints	Staff and managers, training, Complaints	Complaints
Risk assessments	- All managers and trained nominated risk assessor (health and safety) - Safety and Risk Ergonomics and Back Care Trained Assessors and Trainers - Governance Development Unit	Safety and Risk Ergonomics and Back Care Trained Assessors and Trainers Legal Services Governance Development Unit
Health and Safety Executive assessment findings	All staff and managers Safety and Risk Ergonomics and Back Care	Human Resources Operational Development
Internal Audit findings	All managers	Finance
Clinical Audit	Operational staff, team leaders and other managers, training	Clinical Audit
Sickness absence data	Managers, training, ergonomics and back care adviser	Human Resources
Staff surveys	All staff and managers	Human Resources
Infection control audits	Team leaders and other managers, training	GDU, Training
Analysis of vacancies	Managers, Management Information	Human Resources

Assessment of training needs	All staff and managers, training	Human Resources, Head of Education and Development
SWOT analysis	Managers	
Healthcare Commission reviews	All staff, managers, training All staff, managers, training	Chief Executive, Medical Director
Standards for Better Health	All staff, managers, training	Governance Development Unit
Exit interviews with staff	Human Resources	
Patient report forms	All operational staff, team leaders, Operational managers, training	Clinical Audit, Management Information

Appendix 3

Flow Chart for Trust Risk Register

Risk identified

(To assess specific health and safety risks see Risk Reporting and Assessment Procedure on the Pulse)

Part 1 of Risk reporting form completed

Risk assessed with proposed grading and sent to Governance Development Unit or Safety & Risk

Proposal submitted to Risk Compliance and Assurance Group with action plan identifying managerial responsibility

Appropriate group/department identified to take responsibility for ensuring action plan adhered to

Proposal accepted or grading modified – this will include approval of timescales for action

Summary reports on progress received at each Risk Compliance and Assurance Group (High Priority risks) and Audit Committee, and clinical risks to Clinical Governance Committee

Complete risk register submitted to each Risk Compliance and Assurance Group as a reference document (High Priority Risks)

All risks re-assessed every six months to coincide with Trust Board receiving a risk update report