Trust Board

Tuesday, 25th November 2008 at 10:00 am
Conference Room – LAS HQ

AGENDA

1.	Apologies:		
2.	Minutes of the meeting held on 30th September 2008		Enclosure 1
3.	Synopsis of the Part II meeting held on 30th September 2008.		Enclosure 2
4.	Matters arising		
5.	Chairman's remarks	SR	Oral
6.	Report of the Chief Executive	PB	Enclosure 3
7.	Financial Report, Month 6 2008/09	MD	Enclosure 4
8.	Report of the Medical Director	FM	Enclosure 5
9.	**Approve proposed approach to Stroke**	FM	Enclosure 6
10.	Approve CAD 2010 Contract Award	PS	Enclosure 7
11.	Discuss revised Car Leasing Scheme	CH	Enclosure 8
12.	Approve Full Business Case for new A&E and PTS vehicles	MD	Enclosure 9
13.	Approve Information Management & Technology Strategy	PS	Enclosure 10
14.	Approve Risk Management Policy amendments	MD	Enclosure 11
15.	Note update re. Foundation Trust Programme	MD	Enclosure 12
16.	Update regarding Corporate Social Responsibility	MD	Presentation
17.	Approve annual review of Standing Orders and Financial Regulations	MD	Enclosure 13
18.	Update re. SIP 2012	KJ	Enclosure 14
19.	Receive Charitable Funds Annual Report	CS	Enclosure 15
20.	Receive draft Audit Committee's minutes	CS	Enclosure 16
21.	Receive draft Clinical Governance Committee's minutes	BM	Enclosure 17
22.	Receive draft Service Development Committee minutes	SR	To follow
23.	Report of the Trust Secretary on tenders opened and use of the Seal since the last Trust Board meeting.	CMc	Enclosure 18
24.	Opportunity for members of the public to ask question		
	Date of next meeting: 10.00 am on 27th January 2008, Conference room, LAS HQ, Waterloo Road.		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 30th September 2008

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Beryl Magrath	Non Executive Director
	Caroline Silver	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Brian Huckett	Non Executive Director
	Roy Griffins	Non Executive Director
	Sarah Waller	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
In Attendance:		
	Kathy Jones	Director of Service Development
	Peter Suter	Director of Information Management & Technology
	David Jervis	Director of Communications
	Martin Nelhams	Head of Estates
	Mark Mitten	Member of Patients' Forum Ambulance Service (London)
	Gary Orris	Member of Patients' Forum Ambulance Service (London)
	Michaela Neuigan	St George's Healthcare NHS Trust (until 11.30)
	Darren Coyle	South West London & St George's Mental Health NHS Trust (until 11.30)
	Tracey Tyer	British Sign Language Interpreter
	Zane Hema	British Sing Language Interpreter
	Christine McMahon	Trust Secretary (Minutes)

The Chairman apologised to Board colleagues for the lack of quality control exercised in respect of some of the reports circulated with the Agenda as they were unacceptably long and detailed, and not pitched at the right level for the Board.

96/08 Declarations of Further Interest

There were no declarations of further interest.

Although not a declaration of interest, the Chairman informed the Board that he is a member of the Advisory Board of The Foundation (a management consultancy company) which had recently bid for a NHS contract. Following legal advice, he was assured that, as the value of the contract was considered to be immaterial and he would have no direct

involvement in the work that may be undertaken, there was no conflict of interest. (Postscript: The bid by The Foundation was unsuccessful.)

97/08 Opportunity for Members of the Public to ask Questions

There were no questions from members of the public.

98/08 Minutes of the Meeting held on 29th July 2008

Agreed:
1. **The minutes of the meeting held on 29th July 2008.**
2. **That the minutes of the Trust Board be circulated as soon as possible following the meeting. ACTION: Trust Secretary**

Noted:
3. **Minute 80.08: although the reference to the London Airwave Radio Project (LARP) was correct it was clarified that five LAS vehicles had been fitted with the necessary equipment in September 2008 but that the original full implementation date of November will not be achieved due to the delays being experienced by the national Airwave Radio Programme (ARP) programme.**

99/08 Synopsis of the Trust Board's Part II meeting held on 29th July 2008

Noted:
1. **The contents of the synopsis of the Trust Board's Part II minutes.**
2. **That a meeting will be held with representatives of the Patients' Forum Ambulance Services (London) to discuss the requirement that members of the forum give an undertaking of confidentiality in respect of the non-public meetings they attend at the LAS.**

100/08 Matters arising from the minutes of the meeting held on 29th July 2008

Noted:
1. **Minute 78/08: the Chairman said he had not written to David Nicholson concerning the latter's remarks about the potential role of the ambulance service in reducing admissions to hospitals. He said that the points he would have made had been addressed in the Healthcare Commission's report on Urgent and Emergency Services.**
2. **Minute 83/08: that a Social Worker had been recruited to assist the PALS team with the on-going work relating to Frequent Callers Further thought will be given as to how the Social Worker's expertise could be used elsewhere in the Trust e.g. by Clinical Telephone Advisers or EOC.**

101/08 Chairman's remarks

The Chairman said that, following Sir George Greener's resignation, Mike Bell had been appointed interim Chairman of NHS London until Sir Richard Sykes takes up the post in December 2008. Mr Bell will be visiting the Trust to review Healthcare for London including the proposed Stroke Programme and the approach to Unscheduled Care.

The Chairman has invited, Baroness Barbara Young, Chairman of the Care Quality Commission to visit the Trust in the next few weeks. The Care Quality Commission

will replace the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission with effect from April 2009.

Both the Chairman and other members of the Board attended meetings recently at which David Sissling, Programme Director for Healthcare for London, gave a presentation on the progress of the Healthcare for London's programmes. The Chairman said there had been some dissatisfaction expressed by attendees at the meetings concerning the pace of progress in regard to Stroke due to the need for public consultation. Following legal advice from the Trust's solicitors, Capsticks, the Trust is proposing, through the commissioning process, to take patients having a stroke directly to hospitals that have hyper acute stroke units. The Chairman said he did not believe the introduction of a third telephone number (in addition to 999 and NHS Direct) that people could ring for advice was necessarily an appropriate way to respond to people who call 999 with problems that are neither serious nor life threatening.

The Director of Service Development said that work was being undertaken with NHS Direct in the hope of being able to present a joint proposal for an integrated response hub pilot somewhere in London as part of the Unscheduled Care workstream in Healthcare for London (H4L).

The Chairman said the Board of the Ambulance Service Network had decided not to hold AMBEX, its annual conference, in 2009. The Chairman said he accepted that AMBEX did little to publicise the work of the ambulance service to the rest of the NHS but was concerned the opportunity to do a better job of sharing new clinical developments and best practice in the UK and with colleagues abroad (which is what AMBEX was meant to do) would be lost since no alternative has yet been proposed.

The Chairman said the Trust had lodged a complaint on security grounds with Lambeth Borough Council's planning department concerning the application by Transport for London (TfL) to erect toilets in front of headquarters.

POST MEETING NOTE: following the Board meeting confirmation was received that Lambeth Borough Council had rejected TfL's application.

102/08 **The Chief Executive's report**

Chief Executive presented the report and highlighted the following:

The Trust has been involved in every aspect of the implementation of the Healthcare for London in particular Stroke, MI and Urgent Care.

The Patient Transport Service has submitted bids for a number of contracts; the PTS Strategy will be discussed by the Service Development Committee in October prior to its presentation to the Board in November.

The New Ways of Working (NWOW) programme has commenced. Barnehurst, one of the chosen complexes, held the first ever complex away day which was attended by a 100 members of staff based at the Barnehurst complex. The feedback received was that the event was successful and the Chief Executive said that full details of the feedback were available if desired. Work will be undertaken with the management and members of staff of the complex during the next six months to implement the NWOW approach. Chase Farm, the other chosen complex, will be holding an away day in November 2008.

London Airwave Radio Project (LARP): problems were experienced with the airwave radios deployed during the Notting Hill Carnival and the Trust is working with the Department of Health and Airwave to address the matter. The rollout of

LARP across England is unlikely to take place this calendar year and the Trust is awaiting a revised plan from the Department of Health and Airwave.

CAD 2010: the Full Business Case, approved by the Trust Board in July, will be considered by NHS London's Capital Investment Committee in October 2008. The Chief Executive said that a paper concerning the transition arrangements from CTAK to CAD 2010 will be presented to the Board for consideration. **ACTION: Director of IM&T.**

A&E: operationally it has been a difficult few months for the Trust which has coincided with an intense focus by the Commissioners and the Department of Health on the percentage of Category B calls that receive a response within 19 minutes. The Trust will receive an additional £6.4m from Commissioners to support Category B 19 minute performance in 2008/09.

Discussions were continuing with Commissioners in respect of funding for 2009/10; an early decision will enable the Trust to recruit, train and deploy additional members of staff by early 2009/10 in order achieve sustainable 95% Category B 19 minute performance. ORH[1] has been asked to review overall resourcing levels with a view to delivering sustainable performance through to 2011/12. In order to do so it will be necessary to add sufficient resource to reduce overall ambulance utilisation rates to circa 50 to 55%. There will be presentation to the Service Development Committee in October 2008 outlining progress and an initial view on potential staffing requirements. **ACTION: Director of Operations.**

Performance trajectories for the remainder of the year for Category A and Category B calls have been agreed with Commissioners. Additional funding will be received during the remainder of the year which is linked to performance remaining in line with the trajectories. The Trust was on track to achieve the trajectory for September with 74% of Category A calls receiving a response within 8 minutes and 84% of Category B calls receiving a response within 19 minutes. The trajectories for October are 76% for Category A calls requiring a response within 8 minutes and 88% for Category B calls requiring a response within 19 minutes.

The Chief Executive said there was a delicate balance to be struck between the two performance targets, as deploying additional resources to achieve one often had a detrimental impact on the other. Overall demand in September was relatively flat, but this masked significant demand increases at weekends. September had also proved challenging in staffing terms and this had undoubtedly pegged back performance.

Performance in the Control Room was affected by the problems experienced with the computer system which Board Members were informed about as it occurred. The problems experienced with the current computer system demonstrated the fragility of the existing system and every effort is being made to maintain its stability prior to the introduction of CAD 2010.

PTS' performance in September was good, both quantitatively and qualitatively.

The implementation of Active Area Cover has been very successful and the Chief Executive thanked both Board colleagues and Staff Side Representatives for their efforts in reaching an agreement. A review will be undertaken in six months time to assess its impact; to date there have been relatively few adverse comments received from front line members of staff.

Recruitment is ongoing to meet the additional staffing levels required by the Trust. It is planned to recruit 150 posts above establishment of 2913 to allow for slippage in the recruitment process, and in anticipation of additional funding from the

1 ORH: Operational Research in Health

Commissioners to ensure that 75% of Category A calls receive a response within 8 minutes and that 95% of Category B calls receive a response within 19 minutes from April 2009.

The Board's attention was drawn to a Channel 4 documentary series entitled "The ambulance: 8 minutes to disaster". Copies of the programme were available if Board members had not seen the programme.

It was NOTED that:

The deployment of Fast Response Units (FRUs), to approximately 30% of Category B calls had led to a gain of 5-6 percentage points in Category B performance but adversely affected response times to Category A calls by 4-5 percentage points. The response to Category A calls within 19 minutes has remained stable. In recent weeks there have been problems staffing ambulances due to school holidays and people wishing to take annual leave, allied to a low level of interest in overtime. Some FRUs that have been despatched to Category B calls have also had to remain on scene longer than normal because of the poor availability of ambulances. The review of utilisation rates currently being undertaken by ORH will enable the Trust to identify when/where it should deploy resources to ensure lower and therefore safer, levels of utilisation; to improve response times and decrease multiple despatch rates.

The response to the recent problems experienced with the hardware of the existing computer system in the Control Room has included further testing of the fall back control room situated at Bow. The Director of IM&T said that the current system did not allow for a completely seamless switchover between Bow and EOC, though this will be possible with CAD 2010.

The existing contract of employment required members of staff to seek approval from their line manager prior to taking up second jobs. A copy of the revised policy will be circulated to the Non-Executive Directors. **ACTION: HR Director.** The Board requested further information concerning the numbers of staff with second jobs was requested. The HR Director said that the information is held locally and an indicative figure will be obtained. **ACTION: HR Director**

There was support for the recruitment above the establishment figure in recognition of the importance for the Trust to have the additional staff in post. There has been a good response to the Trust's recruiting advertisements with 2,000 applicants being short listed for assessment.

Discussions have commenced with the Trust's Commissioners and NHS London regarding the funding of education and training for a three year period; a decision may be made by December 2008.

An utilisation chart will be included in the next Chief Executive's report. **ACTION: Chief Executive.**

The dates and times of programmes relating to the ambulance services, and in particular the LAS, will be circulated to Non Executive Directors in advance of the broadcasts. **ACTION: Director of Communications.**

The mini Patient Report From (PRF) is completed by FRU members of staff as they arrive at an incident first and is then used by Ambulance Crews to complete the full PRF. The Director of Operations said that work will be undertaken with FRUs that respond to Category B calls to ascertain if they can be redeployed once they are satisfied the patient's condition is stable and their continuing presence is not required.

103/08 Financial Report, Month 5, 2007/08

The Financial Director presented the Month 5 financial report and highlighted the following:

Income exceeded expenditure by £82,000. 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.

PTS reported a loss to date of £460k, against a planned surplus of £36k. The loss arose due to the excessive use of third party providers and a recovery programme has been put in place to deal with this.

Additional spending on overtime was being partially offset by reduction in other costs within the Trust.

The year end forecast is a surplus of £0.952m against a planned surplus of £1.140m.

Key assumptions in forecast included: additional PCT funding to £5.895m; non pay savings forecast of £0.961m; decreased SPPP provision £239k; additional overtime and incentive spend to £5.895; unfunded over-establishment of workforce plan £448k; estimated slippage against workforce plan £847k; funding for training equipment for Hannibal House £483k and PTS breaking even.

Capital programme 2008/09: a detailed breakdown of capital projects was given including information on procurement, estates and the higher than anticipated capital costs for CAD 2010

It was NOTED that:

Consideration will be given to adding the potential risk of staffing being over establishment to the Trust's Risk Register. **ACTION: HR Director**

Funding for the CBRN (Chemical, Biological, Radiological and Nuclear) team was received for 2008/09 and included funding for HART (Hazardous Area Response Team). Discussions were taking place with the Department of Health in respect of a Service Level Agreement for the future provision of HART.

Although no additional funding has yet been received in respect of the work being undertaken by the Trust to prepare for the Olympics, the Finance Director said he was confident the money will be received. The Trust has submitted a detailed paper to the Department of Health, with supporting evidence, setting out its funding requirements.

The Cost Improvement Programme (CIP) has a target of 3% savings of the cost base. There had been some criticism following the undertaking of the FT diagnostic concerning the common practice in ambulance services of achieving savings based on vacancy management and removing the savings from budgets. The Finance Director said that the receipt of additional funding mid-year did not help in the maintenance of the approach outlined above.. An analysis of the CIP will be presented to the Service Development Committee. **ACTION: Finance Director**

The basis for the CIP is to ensure an organisation undertakes a fundamental review of its cost base whilst ensuring it meets its performance objectives. The Chairman said there needed to be more visibility of this matter at board level and said it would be added to the Board's forward planner. **ACTION: the Chairman**

Concern was expressed that PTS was bidding for 11 contracts given its current financial status. The Finance Director said a recovery plan was in place to address PTS' financial situation and that the 11 bids listed in the Chief Executive's report included existing contracts. The Finance Director apologised to the Board for an

error in the report; the reference to PTS bidding for a contract with Moorefield Eye Hospital NHS Foundation Trust was a mistake as this will be a national contract.

The Finance Director presented the Investment to Save benefits realisation report. It was a fairly self-critical review of the Investment to Save programme that outlined the benefits realised from the Investment to Save expenditure. The Finance Director said that a lot of good work had been undertaken, although the savings achieved were less than initially anticipated. The Finance Director said that, in terms of the wider London NHS economy, the LAS had delivered by spending the majority of its allocated funds in 2007/08.

The report stated that CRB (Criminal Record Bureau) checks had not been undertaken for all front line staff. The HR Director said the majority of members of staff who have patient contact did receive CRB checks; it was not possible to complete the project within the deadline of 31st March 2008.

The Finance Director said that a benefits realisation analysis will be undertaken of the Lost Property Bags which were recently introduced.

The Internal Auditors, BSM Bentley Jennison, have been asked to undertake an audit of the benefits realisation programme and report to the Audit Committee.

104/08 **Annual Audit & Inspection Letter**

Noted: The recommendations contained within the Annual Audit and Inspection Letter.

105/08 **Report of the Medical Director**

The Medical Director presented her report and highlighted the following:

An update on Serious Untoward Incidents (SUIs) showed that although the number of incidents considered as potential SUIs had increased the number declared had fallen.

Jan – Dec 2007: 49 incidents were considered as potential SUIs with 6 declared
Jan – Aug 2008: 39 incidents were considered as potential SUIS with 3 declared

The emerging trends were delayed responses and clinical issues. The number of incidents involving the Police due to patients collapsing following violent struggle has decreased from six in 2007 to one in 2008 to date, as have obstetric and maternity cases (six in 2007 compared with two in 2008 to date). There has been an increase in the number of SUIs involving psychiatric patients (one in 2007 and four in 2008 to date). The report included a list of articles featured in the LAS News alerting staff to the learning outcomes of SUIs.

The Trust has received a grant from the National Institute for Health Research's Health Technology Assessment Programme, in partnership with the Welsh and East Midlands Ambulance Services, 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. The trial will commence 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 in 2010.

The Stroke Association is funding 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 Arms Speech Test (FAST) to identify if a patient has experienced a stroke, which has limitations in identifying

posterior circulation strokes that are characterised by visual field disturbances. The study aims to test if an in-hospital stroke recognition tool, the Recognition of Stroke in the Emergency Room (ROSIER), which has been shown to increase the diagnostic accuracy amongst A&E physicians, improves the identification of stroke in the out-of-hospital setting.

Additional funding has been received from Philips Medical Systems to expand an existing SMART CPR study to include the West as well as the East and South LAS Operational Areas. 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 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 LAS has prepared two publications examining the incidences 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.

Governance: six policies and procedures were circulated to the Board for approval. These policies and procedures were previously approved by the Senior Management Group and the Board was asked to ratify these. The Trust is required to have Board approval for these policies and procedures prior to the assessment by the NHS Litigation Authority in mid October.

A further six policies and procedures have been developed which formally acknowledge that the LAS followed the JRCALC guidelines, and also where applicable, other national guidelines pertinent to ambulance service pre-hospital care.

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. Details of the recent report submitted for April –June 200 was included in the Medical Director's report.

Copies of two Medical Director's bulletin and Clinical Newsletter for August were circulated at the meeting.

Drugs: Oramorph was now available for use by paramedics with effect from October 2008. Clopidogrel (super aspirin) was now available for patients with ST elevation (acute coronary event) in accordance with JRCALC guidelines; the Trust was sourcing small bottles of water to allow for the administration of this drug.

Infection Control: the Trust has taken steps to implement the Department of Health Infection Control Guidelines and to support the infection control measures being undertaken by Acute Trusts. These include: sleeve protectors; disposable tourniquets; hand wipes; alcohol gel and surface wipes. The cannulation packs include labels to identify pre-hospital placement.

Recognition of Life Extinct (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.

It was NOTED that:

The Trust's host ethics committee is based at Lewisham NHS Trust and provides ethical approval for trials being undertaken by the Trust. Research proposals include the requirement to assess data arising from the trials at given points.

The receipt of research funding demonstrated the regard in which the LAS and its Research and Audit department were held; the Medical Director said she will pass on the Board's commendation to the department.

The drug Oramorph was being used by front line crews when appropriate i.e. when intravenous access was difficult to obtain. The Board will be kept informed of its usage.

The Chairman and Non-Executives were unhappy with being asked to agree the six policies and procedures at such short notice and wished to see better planning in place in future. The clinical policies and procedures had been reviewed by the Medical Director and the Chairman of the Clinical Governance Committee.

The Chairman said he had recently met Professor Roger Boyle, National Director for Heart Disease and Stroke, who had most complementary about the contribution of the LAS' Cardiac Lead, Mark Whitbread. The Medical Director said she will pass on those comments.

In regard to ROLE, the rationale for two years was that less than two years old the cause of death may be sudden and be related to a cot death syndrome; in children older than two the death is more likely to be due to trauma or be known about in advance due to an existing medical condition.

Agreed: To ratify the six policies and procedures:

- **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**

106/08 <u>The Final Serious Untoward report regarding the death of Paramedic Ron Pile.</u>

The Director of Operations presented a detailed report outlining the SUI investigation into the death of Paramedic Ron Pile who had been killed in a road accident whilst training to be a motorcyclist responder.

The Board expressed its condolences to the widow and family of Ron Pile on their loss. The Chairman said he had spoken to Mrs Pile at the recent Awards Ceremony when Ron Pile was posthumously awarded a twenty year medal, and she expressed her gratitude for the support received from the LAS, in particular from Steve Colhoun, the Ambulance Operations Manager of Romford Complex.

Noted: The contents of the report which included the verdict by the Coroner that Paramedic Ron Pile's death had been accidental and that the procedures in place to select and train LAS motorcycle responders were exemplary.

107/08 <u>Approval of two strategies: Long Term Conditions and Older People</u>

The Director of Service Development gave a presentation outlining the key priorities in the treatment of Older Patients and patients with Long Terms Conditions. The

strategies had been drafted following work with a number of external stakeholders. Once approved by the Board the strategies will be disseminated widely both to staff and the general public. The strategies will be included within the Service Improvement Programme and incorporated into the existing programmes of work with their implementation monitored. The Director of Service Development said that although the strategies may appear to be relatively un-ambitious the resources required to deliver the training to staff and educate the general public will be significant.

It was NOTED that:

There was no mention of Connecting for Health due to the fact that currently the ambulance service does not have access to patient's information held on the data system. It was decided to adopt a low technology approach initially in respect of the immediate implementation of the strategies.

In regard to the education, it was recognised that work will be undertaken to educate General Practitioners concerning the Urgent and Emergency Care provided by the LAS, in particular when the LAS attends a GP's patient and the patient is not conveyed to hospital. The two strategies will be communicated to the various stakeholders who participated in the drafting of the strategies and to the wider public.

The decision had been taken to have an Older People's Strategy rather than one that focussed on dignity as age is a significant factor in health, particularly for people from a social and economically deprived background. In line with Department of Health guidelines it was decided to use the age of 65 as a starting point for the Older People's strategy, although it is recognised that many people who are 65 are still fit and well. The older an individual is the more likely it is that there will be complicating factors involved in addition to the incident for which assistance is being sought, e.g. the interaction of various medications for pre-existing conditions.

Approved The Long Term Conditions and Older People strategies.

108/08 <u>Ratification of Chairman's Urgent Action: amended LAS Risk Management Policy</u>

The Chairman, on behalf of the Board, approved the amended Risk Management Policy which had been revised in advance of the forthcoming assessment by the NHS Litigation Authority. The Risk Management Policy was revised following consideration by the Risk Compliance & Assurance Group (RCAG), the Audit Committee and the Senior Management Group.

Ratified: : 1. The Chairman's Urgent Action approving the LAS' Risk Management Policy further to clarification in paragraph 2.2 regarding the consideration of clinical risks by the Clinical Governance Committee, RCAG and the Audit Committee.

Noted: 2. That the Board will be provided with information concerning the cost of insurance and how much it has to pay over and above the premium. ACTION: Finance Director will provide the insurance report to the Service Development Committee, December 2008.

109/08 <u>Approval of FT Programme Plan</u>

The Finance Director presented the FT Programme Plan and reported that work was being undertaken to recruit staff to support the programme e.g. Membership Managers. The Plan addresses the key issues (Integrated Business Plan; delivery of

CAD 2010 and Finance) identified in the feedback received from Malcolm Stamp following the conclusion of the FT Diagnostic.

The Board's attention was drawn to the work undertaken to date since the feedback received from Malcolm Stamp. This included: the appointment of a project manager to take forward the programme including the development of the Integrated Business Plan; further development of the Business Strategy; a workshop has been arranged with Commissioners to agree demand projections as part of the Trust's Integrated Business Plan.

The Programme will be managed as one of the Service Improvement Programmes with regular monitoring by the Programme Board and the Strategic Services Group.

It was NOTED that:

Section ER3 referred to formal and regular patient surveys not being undertaken. The Director of Service Development said that the Healthcare Commission had ceased conducting annual patient surveys for the Ambulance Service as the results were generally positive with little learning being achieved. In 2006 MORI, on behalf of the LAS, undertook a quantitative and qualitative survey of a sample of Londoners; the findings were quite positive and provided the Trust with some learning points. It was recognised that this survey would be used to provide a benchmark to measure the Trust's future performance.

The 64 page feedback received following the FT Diagnostic will be responded to as part of the application process.

The Northumbria Healthcare NHS Foundation Trust uses text messaging to obtain instant feedback from patients and this is something the Trust may consider in the future.

The reference in section BP4 that 'every other ambulance service has changed their CAD in the past 18 months and will identify lessons from implementation' was incorrect and that statement should be omitted. **ACTION: Finance Director**

Approved:
1. **The FT Programme Plan.**
2. **That FT progress reports will be a standing item on future Service Development Committees and Trust Boards agendas.**

110/08 <u>Presentation regarding the Trust's estate & approval of Business Case relating to 4th Floor, Loman Street.</u>

The Director of Finance gave a presentation outlining the various projects and developments taking place in regard to the Trust's estate.

It was NOTED that:

PTS leases, where possible, are co-terminus with the duration of the contract.

The concern expressed by members of staff regarding the air quality at the proposed new ambulance station in Neasden due to a nearby waste transfer station had received attention from the Estates Department. Representatives of the Estate department had met with the Environmental Agency and had been assured that all the necessary arrangements were in place and that there were no injunctions or restraints in force.

The Chairman said there should where possible be close dovetailing between the Clinical and Estates strategies.

Business Case: 4th Floor Loman Street

The Finance Director presented the business case for the lease of 4th Floor, Loman Street which will accommodate the Olympics and the Foundation Trust team. The cost included a rent free period of one year to take account of the refurbishment work that will take place and so the report should have stated that the rental will be £198,000 from Year 2.

Brian Huckett expressed concern that business case did not set out the number of staff being accommodated in the new property or mention the costs of security. The Head of Estates said that the Loman Street building had its own security during out of hours and that there was a separate access to each floor which required security passes.

Brian Huckett said that he would have liked clarification as to the non-financial benefits reported on page 136 and what the term 'pairings' meant. The Head of Estates said that the approach adopted was standard NHS business case methodology; the advantage of Loman Street was the proximity to the finance department on the 3rd floor as opposed to being situated in a different building. The Director of Service Development said that pairings referred to the ranking system used. The Chief Executive said that in future an explanation will be included.

Brian Huckett asked about the reference to the allocation of car parking spaces for office based staff and it was confirmed that this was standard practice as some members of staff are required to drive and therefore need a car parking facility.

Approved: The business case for 4th Floor Loman Street.

111/08 Receive Business Continuity Update

The Finance Director presented the Business Continuity plan, originally drafted in July 2008 but updated to include the learning from the recent problems experienced with CTAK. One of the amendments referred to the Fall Back Control testing processes support for business continuity systems.

Noted: The contents of the Business Continuity Update.

112/08 Receive update regarding Service Improvement Programme 2012

The Director of Service Development presented an update concerning the Service Improvement Programme which included explanations as to why the following projects had been identified as being of red status (i.e. not on track and cause for concern): Mobile Office; Referral Pathways; Re-engineer Income Collection; Asset Tracking; Performance Measurement Phase 2 and London Airwave Radio Project (LARP).

The underlying reasons for the delays were the availability of resources in respect of people or technology, or to circumstances beyond the Trust's control i.e. delays being experienced by the national ARP. The Director of Service Development said a new manager was being recruited to oversee the continuing development and improved usage of Referral Pathways. Work was being undertaken to address the reported data processing issues through the use of an offsite data warehousing facility.

Noted: 1. The progress of the Service Improvement Programme and the reasons why the projects were not on track and were cause for concern.

2. **That the Chairman commended the style and content of the report which he said was well presented and contained the right level of detail.**

113/08 Draft Minutes of the Annual Charitable Fund Committee, 8th September 2008

Caroline Silver, Chairman of the Charitable Funds Committee, presented the minutes of the Annual Meeting held on 8th September 2008. The Committee received the annual report and management accounts for 2007/08; as planned the Funds were being gradually run down.

Investec, the Fund's Investment Advisers, reported that the return on funds invested in 2007/08 was -12%, which though disappointing was not surprising given the economic climate and the volatility of the financial markets. The Committee had agreed that the current investment policy should continue unchanged but be kept under review. The Committee discussed the ethical component of the investment portfolio. It was recognised as the funds invested in the general investment portfolio were relatively small it was decided to leave the management of the portfolio unchanged and to concentrate on maximising investment income for the Fund.

Noted: The draft minutes of the Annual Charitable Fund Committee, 8th September 2008.

114/08 Draft Minutes of the Audit Committee, 8th September 2008

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

1. That the Audit Commission gave an unqualified opinion on the Trust's 2007/08 annual accounts.
2. That a new Local Counter Fraud Service (LCFS) Officer had been appointed.
3. The contents of the Internal Auditor's reports, in particular the findings of the Records Management audit of the handling of Patient Report Forms.
   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 and that further was needed to improve trust wide compliance.
4. That following a tendering process, RSM Bentley Jennison, had been re-appointed as the Trust's Internal Auditors.
5. A work programme was in place to ensure the Trust complies with the requirements of the International Financial Reporting Standards (IFRS).
6. The Audit Committee reviewed and amended its terms of reference (included in the Risk Management Policy).
7. The Committee's meeting on 10th November will include a review the Trust's external financial reporting process (e.g. FIMS).

Noted: The draft minutes of the Audit Committee, 8th September 2008.

115/08 Draft Minutes of the Clinical Governance Committee, 4th August 2008

The Chairman of the Clinical Governance Committee, Beryl Magrath, presented the draft minutes of the Clinical Governance Committee 4th August 2008, highlighting that the Committee had:

- Revised its terms of reference (contained in the Risk Management Policy);

- Reviewed the proposed revision of the Area Governance report which will improve the quality of the information received by the Committee.

116/08 **Report on tenders opened and the use of the Trust Seal since the last Board meeting**

Two tenders have been opened since the last Trust Board:

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

Use of the Trust's Seal: there have been two entries, reference 119 and 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	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.

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

117/08 **Any Other Business**

There was no other business.

118/08 **Opportunity for members of the public to ask questions**

The members of the public present had no questions for the Trust Board.

119/08 **Date of next meeting**

Tuesday, 25th November 2008, 10.00, Conference Room, LAS headquarters, Waterloo Road.

Meeting concluded 12.42

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 30th September 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 30th September 2008 in Part II the Trust Board noted that:

A meeting will be held with the Patients Forum Ambulance Service (London) to resolve the matter of Forum members giving an undertaking of confidentiality to the Trust when they attend LAS' internal meetings

The LAS will continue its efforts to have all the recognised Trade Unions sign up to the new consultative arrangements.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 25th NOVEMBER 2008

Chief Executive's Report

1 SERVICE DEVELOPMENT

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.

Clinical and policy staff remain engaged in all of the workstreams to an appropriate extent.

Current progress includes:

Stroke
HfL has issued its final stroke strategy and have invited expressions of interest from acute trusts to be designated hyper-acute stroke units. As we understand it, the numbers of such units will be low but acute trusts not in the centre of London are being encouraged to consider seeking designation, as this is supported by the incidence of stroke. HfL is proposing that all acute strokes be taken to these centres, whatever the time of onset of the stroke, since it can be expected that the care will be of the highest standard in these units whether or not the patients are eligible for thrombolysis.

Meanwhile a small number of PCTs have approached the LAS requesting that certain units be bypassed. These requests reflect the current arrangements for stroke treatment and are not intended to prefigure nor determine the outcome of the designation process or the consultation that will follow. This issue is to be discussed elsewhere on today's Trust Board agenda.

Trauma
The five hospitals shortlisted to develop their proposals for trauma networks have now done so and have been visited by accreditation teams. The outcome of that process should be announced shortly.

The LAS internal working party continues to meet and has been working up an options paper on the LAS response to changes in the configuration of trauma units.

Unscheduled Care
Conversations continue with HfL over the possibility of piloting a response hub model. In parallel we are talking with our commissioners over whether this can go forward as a service development.

Local Hospital Feasibility
Kathy Jones and Fionna Moore have met 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
Four PCTs will be early implementers of polyclinics: Harrow, Redbridge & Waltham Forest, Hounslow and Lambeth. We are ensuring contact with each of these developments in order to ensure an LAS presence of some sort. This could range from simply being able to take patients to the polyclinics through to having staff based there as part of the clinical team.

2 SERVICE DELIVERY

2.1 A&E Operations (graphs 1 – 14)

In light of the continuing challenging performance and sub-optimal staffing, the Trust has remained at REAP Level 3 'service pressure' and has been implementing the relevant actions associated with this level. A review of the various REAP actions is underway to ensure that they remain current and that they are routinely being applied across the Trust . There is a danger of course that when we have been at REAP 3 for a long period of time the impact of the actions associated with is diluted. The current review is designed to ensure that this does not happen. As reported at the last Board robust performance management arrangements are in place and working well with both the Central Delivery Unit (CDU) and the Area Delivery Units (ADUs) now permanently staffed through to end April.

Active Area cover has continued to produce benefits. For the month of October there were over 7,700 recorded deployments. A good indicator of the benefits derived from its use has been the fact that 10% more calls have been electronically dispatched to Ambulances than in previous months. The performance difference between electronic and manual dispatch for Category A calls on Ambulances is about 25%, so there is strong potential for further gains as Active Area Cover becomes more embedded and further work is done within EOC to use the automated dispatch function for ambulances more effectively.

Chase Farm Complex held their successful New Ways of Working Away Day on 10th and 11th November at a hotel in Dartford. The aim of this event was to progress the plans for Chase Farm in order to deliver the New Ways of Working programme for their complex. A range of forums including clinical leadership, rostering and staff welfare were convened and aims agreed for the coming months. Presentations included learning from the implementation of team based working in Great Western Ambulance Service that could be applied at Chase Farm.

The new Emergency Care Practitioner Development plan and the Emergency Bed Service Development plan were both presented and discussed at the recent Service Development Committee. Both plans outlined the improvements planned for these LAS services between 2008 and 2012. Debates included the possible inclusion of palliative care beds in the EBS bed finding services and the role of ECPs in delivering clinical leadership at their local complexes.

CTAK was more stable in late September, but there were some outages in October caused by hardware upgrades and various other faults. These are described in greater detail later in the report. As always such failures have a significant impact on performance and have

contributed in part to the poor outturn for October. There were also some issues that affected the secondary triage system PSIAM used by Clinical Telephone Advice(CTA) in mid November when the system was unavailable for several hours and a temporary fix had to be implemented using the Bow server and Laptops until the problem could be resolved.

Work is continuing to ensure that the benefits associated with the new gazetteer are fully implemented. Whilst the gazetteer is now stable and working, many of the anticipated benefits have yet to be enabled. These include the live monitoring of call takers which will give accurate and live information in areas such as log in/log out and call duration which will allow us to more effectively manage down the variations in call-taking performance. In addition the ability to more accurately identify frequent callers will be enabled to allow us to focus our efforts on reducing demand from this cohort of service users.

We are currently carrying out a review of the working arrangements in the Urgent Operations Centre (UOC) to ensure that it is working at its full potential and maximising its support to the core A&E Fleet. The review will be overseen by the new ADO for control services Phil Flower and will be completed by the end of November. .

CTA recruitment is still proving to be problematic both internally and externally. Attempts to recruit from the nursing profession have produced very little success to date. CTA currently has 43 whole time equivalents in post against a funded establishment of 70. This is clearly hindering its ability to achieve the previously agreed levels of workload. The next strand of work is to explore the feasibility of providing remote CTA at LAS sites outside HQ. We are certain that this will improve our ability to recruit further staff to CTA which is an essential component of our performance improvement strategy for the remainder of the year.

The scoping of the project to pilot GPs working in EOC is progressing well. The purpose of this project is to identify any potential benefits from having GPs working in the control room environment. This will involve assisting in the prioritising and ringing back of calls which are being 'stacked' because we have no available resource to send together with general support to CTA in terms of resolving Category C calls. The initial stage of the project will commence at the end of November and will run for four weeks. The plan is then to make adjustments to the scheme and run it again for a further period of four weeks. A final review will then take place and a decision will be taken as to whether to roll it out as a permanent function within control services. The overall aim will be to add value both by decreasing clinical risk to our patients and by reducing overall demand by resolving more calls over the phone.

In October we hosted a Gold training session at headquarters for the LAS and NHS London Golds to help explore each other's role in a major incident. This training was well received by all and plans are in place to carry out a regular programme of joint training and familiarisation in the near future.

November was a busy month for events. The Emergency Planning Unit put in place our well exercised plans to cover the Lord Mayor's show, the central London Remembrance ceremony and the 90th anniversary ceremony for the armistice of the First World War. These events were managed successfully with our partners, St. John Ambulance. The planning for the service response to the challenge of New Year's Eve is now well underway and the Emergency Planning Unit is fully engaged in this process.

Across the weekend of 1st & 2nd November the Emergency Planning Unit put in place plans to cover 20 large public firework displays across the capital.

The new revised copy of the Green Guide (Safety of Spectators at Sports Grounds) has been published. The Emergency Planning Unit is currently reviewing this document to look at the implications for the LAS and it will also be reviewed by the National Emergency Preparedness Board over the coming weeks.

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 16 days of November.

	CAT A8	**CAT A19**	**CAT B19**
Standard	***75.0%***	***95.0%***	*90.%**
Year to date	73.07%	98.06%	82.90%
September 2008	73.92%	98.27%	83.90%
October 2008	72.95%	98.26%	85.36%
1-16 November	70.5%	97.88%	81.93%

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

- The overall demand increase so far this year is running at 2.44% to end October although we expect this to approach the anticipated 3-3.5% as the final quarter progresses.
- Category A performance reached 73.92% in September exceeding Trajectory but has remained poor through October and into early November. This has in the main been due to fluctuations in staffing and workload coupled with some technical problems within the control rooms. In October there was an overall workload increase over the previous year of 3%. The cause of this was mainly Category C calls, where there was an average daily increase of 8% over the previous year. Category B saw an increase of 4% and there was an overall fall in Category A call workload of 1.5%.
- It is important to retain some perspective here in that Call Connect performance last September and October was 63.8% and 64.4% with virtually identical staffing levels. The levels now being achieved against a higher workload still represent a step change in performance.
- Weekend resourcing difficulties remain one of the biggest challenges and each weekend consistently shows a pattern of very high demand through Friday and Saturday night shifts which current resourcing simply cannot match. This leads to ambulance utilisation in the 80 to 90% bracket and the trust runs out of ambulance resource leading to the stacking of multiple 999 calls and poor performance. Plans are in hand to address this issue through the current recruitment processes in 08/09 and the commissioning round for this year which is seeking to attract a further significant investment in staff during 09/10
- Category B performance has shown some slow but steady improvement through September and October but has proved more challenging in November. as can be seen

by the figures in the table above. The number of Category B calls attended by FRUs was increased at the end of September and beginning of October from about 12% to 30%. This brought about an expected improvement in Category B performance of about 5%, but had a significant negative effect on Category A performance. We are currently running with a 'middle ground' position of circa 18% Category B workload on the FRUs .

- Call taking achieved 95% for September which was a healthy improvement over August. However, there was a slight fall back in October to 93%. Whilst two of the weeks did achieve 95%, the other two saw performance fall to as low as 89.5% which in part was caused by the CTAK issues mentioned earlier.
- Hospital pressures have been profound in the recent months with daily delays for ambulances at multiple hospitals across London. These issues, which appear to be worsening , are significantly hampering our ability to deliver call connect targets. Work is in hand with Commissioners and NHSL to raise the profile of these hospital delays and we will begin to provide comprehensive information on such delays to Acute Trusts, Commissioners and NHSL from late November. This detailed quantitative information coupled with ongoing support through NHSL will hopefully provide the improvements which are required.
- Whilst we have clearly had performance improvement plans in place for many months we have now undertaken a comprehensive review of those plans and taken into account not only our own experience of improving performance but also examples of best practice from around the country. The result is a revised plan which contains a number of High Impact/High Priority initiatives coupled with an extensive list of lower priority initiatives and enablers. This is a Pan-LAS improvement plan and will require input and action from each Directorate within the service. Progress against these initiatives is being monitored weekly at SMG level .
- The continuing performance challenge has of course resulted in significantly increased focus from both our Commissioners and NHSL. We are meeting regularly with both and are currently revising our performance trajectories which will need to be submitted by end November. Concern is inevitably growing that the Trusts will not be able to reach the 75% Cat A target for the year and whilst we remain confident that there is sufficient time available to us to do so, it is clear that the next six weeks are a crucial time for the LAS.
- Staffing has generally improved during September and October with the exception of the half term week in October which proved exceptionally challenging. . We remain heavily reliant on high volumes of overtime working and this will not change substantially until post April 09 when the majority of the staff being recruited this year will be fully trained.
- The Board will be aware that we have constructed this year's recruitment of 'Student Paramedics' to create two separate clinical placements of one month duration. We will begin to use these staff in a supervised capacity on front line work from mid December onwards and this will improve the staffing situation in December, February and March.
- The overtime arrangements for December have been published early this year along with an agreement with staff side to suspend the overtime list system to a "first come first served" system during this period which started on the 10th November. This

agreement has allowed us to plan overtime early and early indications are encouraging in terms of the effect on December staffing. As always the most difficult period will remain December 24th through to January 1st .

2.2 PATIENT TRANSPORT SERVICE (graphs 15 – 18)

Commercial

The LAS was invited to make presentations via the London Procurement Project exercise for the following contracts:

- Barnet, Enfield and Haringey Mental Health Trust (new business)
- Barking, Havering and Redbridge Hospitals (part existing business)
- Lewisham Hospital (new business)
- North East London Mental Health Trust (existing business)
- North West London Hospitals (new business)
- Royal National Orthopaedic Hospitals (existing business)
- South London and the Maudsley Mental Health Trust (existing business)

Bromley Hospitals and Queen Mary's Hospital NHS Trusts have dropped out of this process, deciding instead to extend their contracts with the LAS until 31st March 2010.

In the case of Barnet, Enfield and Haringey Mental Health Trust, we were asked to make a further presentation to users of the service, where competition for the contract was limited to the LAS and M&L.

Outside of the above process the LAS has also made a presentation to South West London and St George's Mental Health Trust (existing business). We are in competition with OSL and GSL.

Results of all of these tender exercises are due to be announced at the end of November 2008.

Performance

Performance on the quality statistics continue to remain consistent for October 2008 at:

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

3 HUMAN RESOURCES

Workforce Plan implementation

Recruitment of Student Paramedics is on-going with 300 recruited to date. Of these c80 are waiting to obtain their C1 driving licence and have yet therefore to be allocated to training courses. There are currently an additional 370 applications at various stages of the recruitment process. The recruitment event held on 18th October was very successful. 79 people were assessed; 43 were interviewed; 31 people were appointed.

The second floor of Hannibal House being developed is on track and due to become available as planned on the 24th November 2008.

HPC Validation

The Trust has received the report from the Health Care Professions Council validation team following their assessment visit in September.

This validation was focussed on our training for Paramedics which includes both the existing training programme for Emergency Medical Technicians progressing to qualified paramedic and for the more recently introduced student paramedic programme.

This is the first time ambulance trusts have had their training programmes validated by the HPC and the LAS are pleased with the report received which provides a number of recommendations and conditions to be met within a timescale yet to be determined in agreement with the HPC team. Most of these relate to new mandatory elements of training for Paramedics such as ethics and law. These new elements are in the final stages of development which is being lead by the LAS for potential uptake nationally.

The Trust also received a commendation within the report for the support available to staff and students, in particular recognising the value of the LINC scheme at the LAS.

Unions and Partnership Arrangements

The revised joint consultative arrangements, agreed by the majority Unison members of the Staff Council, are being established from November 2008, with the first meeting of the new Staff Council being held on 20 November. Given the refusal of GMB, TGWU and Amicus unions to sign up to the agreement initially, it was felt appropriate to delay implementation for a short period whilst discussions continued to seek to reassure these unions and gain their acceptance of and involvement in the new structures. Amicus has since signed the agreement, and TGWU has indicated that it will do so. Discussions with GMB continue in the hope that it will also take up its seats.

Nationally, Unite the Union, the new union to be formed by the merger of TGWU and Amicus, has balloted its staff on industrial action up to and including strike action. The ballot has resulted in votes in favour on both counts, albeit the union has indicated that it will not take action that "emergency cover will be maintained at all times". Before taking action the union must give seven days notice, and any initial action must begin with 28 days of the ballot closing (12th November). Unite has fewer than 200 members in the Trust , and once any planned action is known the potential impact on service delivery will be assessed.

Flu

A series of clinics staffed by ECPs has been held to offer flu jabs to all staff on a voluntary basis. Sixteen separate sessions were offered at venues around the trust, an increase on previous years. The trust is also represented on the pan-London HR Pandemic Flu planning group.

NHS London

Work is progressing well and is on track to submit a proposal to the SHA for a three year Education and Development investment plan by December 2008.

The Director of Human Resources and her team are working closely with NHS London representatives and other stakeholders (including commissioners and Health Care for London) to develop the plan and gain support at the earliest stages of development.

The LAS, through the Director of Human Resources and Organisation Development are fully engaged in the implementation of the recently launched "Workforce for London - A strategic framework".

Retrospective CRB checks

All staff approached have now responded to the request to complete the required CRB check.

To date 109 checks have been 'positive'. This includes 13 cases which have already been disclosed to the Service by the individual. Each 'positive' check has been considered by a single panel to decide what further action might be necessary. 26 cases required a full investigation under the disciplinary procedure, and 14 are ongoing. It remains that only one member of staff has been dismissed as a result of this exercise and one member or staff resigned with immediate affect.

This has been a significant exercise which has been conducted smoothly, consistently and with minimum disruption.

Equality & Diversity

The Trust has commenced delivery of its new Diversity training module which has received excellent feedback from those attending. This is being supported by a new e-learning module accessed via the Trust's intranet.

Ricky Lawrence has now returned from his secondment to the Department of Health and Janice Markey, Diversity Manager designate commences with the Trust on 1 December.

Workforce information

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

Sickness levels continue to be monitored and managed closely and have remained stable in September at 5.26% for the Trust continuing to be within target.

Staff turnover remains stable within the year with no significant changes in any area of the Trust.

Against the A&E establishment of 2913 we have 215 vacancies as at 31 October 2008. The report above gives progress of recruitment to these vacancies.

Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%			

A&E Ops Sickness Levels

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

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	Oct-07/Sep-08	Nov-07/Oct-08
A & C	11.04%	13.13%	13.48%	15.29%	14.20%	14.79%	13.35%	14.59%	15.38%
A & E	4.64%	5.13%	5.36%	5.46%	5.75%	5.58%	5.47%	5.44%	5.64%
CTA	0.00%	5.13%	11.11%	10.26%	10.00%	8.51%	10.87%	8.51%	9.09%
EOC Watch Staff	11.04%	11.70%	12.80%	11.85%	13.57%	12.57%	12.20%	12.87%	13.31%
Fleet	5.08%	10.91%	13.21%	13.21%	13.21%	13.21%	7.55%	5.66%	11.32%
PTS	6.16%	11.02%	11.86%	12.60%	12.50%	12.34%	11.97%	12.61%	12.55%
Resource Staff	1.96%	2.04%	2.08%	2.08%	2.08%	2.08%	2.08%	2.13%	2.13%
SMP	6.72%	6.74%	6.99%	7.83%	8.12%	7.36%	7.32%	7.37%	6.88%
Trust Total	**5.87%**	**6.83%**	**7.24%**	**7.51%**	**7.80%**	**7.57%**	**7.27%**	**7.35%**	**7.57%**

A&E Establishment as at October 2008

Position Titles	Funded Establishment	Staff in post	Variance	Leavers
Team Leader	175.00	158.58	16.42	2.00
ECP	86.00	50.19	35.81	0.00
Paramedic	830.00	849.13	-19.13	2.00
EMT	1220.00	1328.78	-108.78	8.00
Student Paramedic	300.00	105.00	195.00	0.00
A&E Support	232.00	163.79	68.21	3.53
EMD1	54.00	64.02	-10.02	1.00
EMD2	90.55	110.95	-20.40	4.22
EMD3	100.76	65.42	35.34	0.00
EMD Allocator	78.00	66.06	11.94	0.00
CTA	70.00	42.78	27.22	0.00
Total	**3236.31**	**3004.70**	**231.61**	**20.75**

5 INFORMATON MANAGEMENT & TECHNOLOGY

CTAK ISSUES

It was previously reported that there were problems with CTAK during August and September 2008. Over this last period problems have continued, causing a varying degree of disruption to EOC and operational performance.

7 and 8 October 2008

Following on from previous hardware problems, there was a planned downtime to complete further remedial work to improve the overall stability of CTAK. At 02:00 on 7 October the system was taken down and EOC reverted to paper as planned. The remedial work was successfully completed by the CTAK Systems Manager and a Senior Dell Support Engineer. However, as the EOC users were brought back on line (at around 06:00), problems were reported with the system issuing duplicate incident numbers. Further work was required to resolve this before EOC could be fully restored at 08:10 and EOC business continued as normal.

The problem was that when the system was restarted, it reset the incident counter and hence, tried to re-issue incident numbers issued between midnight and 02:00. This has never happened previously and is not connected with the remedial work undertaken with the hardware. At 14:45 EOC reported some problems with mapping and associated services on server 1. This continued and overall problems with system stability grew, resulting in the decision at 18:00 to return EOC to paper. Stability was restored by running the entire system on server 0, allowing EOC to commence using CTAK from approximately 19:00, albeit without FREDA (FRED was working) or performance information being available.

Work continued through the evening to effect a repair to allow performance information to be restored from approximately 23:30. The system was left in a stable state for the rest of the night, but without the functionality of FREDA. Work recommenced at 08:00 on 8 October, focusing on effecting parallel repairs and reconfiguration to bring server 1 back on line and to share the load and re-balance the system. Full functionality was restored (FREDA) at 16:30.

There is no one single cause of the problems described above. There is no logical explanation as to why the incident counter reset itself. The system has been restarted on many occasions before and this has never occurred. Investigations into the underlying software code have not yet offered any explanation. The underlying cause of the second problem is clearly linked with the hardware and its complex configuration. Work during this problem and further investigations by the hardware supplier, has identified the preferred option of a complete hardware replacement for the CTAK servers. Since the new hardware has greater capacity, this will simplify the overall configuration. Work has commenced on a sequence of activities to replace the hardware platform, which is anticipated to take place in January 2009. Running the CTAK application on a newer version of the operating system and new hardware will not be without its own risks and problems. However, taking everything into account, it would be a greater risk to leave CTAK on its existing hardware until CAD 2010. There is also the potential for newer hardware to provide some improved performance for EOC.

16 October 2008

At 08:02, EOC experienced problems with mapping and sessions freezing. An operational consideration was made to go to paper, but this did not actually happen. At 08:23 IM&T support staff were on site and commenced investigations. Temporary fixes were implemented to allow users to restore system stability. The underlying problem appeared to be corruption in some database tables, either caused by some software error or a hard disk fault.

During the day, EOC remained fully operational on CTAK while hardware and software investigations continued. The response by the hardware maintainer was very supportive. They put staff and equipment on standby ready in the event of a hardware error being found. However, all diagnostics were run successfully and it was decided that none of the hardware would be changed and the maintainer stood down. A resolution to the error in the database was found and tested; however, implementation required a complete take down of the system.

Given shift changes and operational pressures, this was scheduled for later in the evening. In a planned and controlled manner, EOC reverted to paper and CTAK was taken off-line at 21:00. Remedial work was completed and EOC commenced logging back in at about 22:30. Some problems arose with icons on maps that required further intervention and the system was declared fully stable at approximately 23:55. IM&T staff remained on site until 01:00. As a preventative measure, a new IM&T support team was on site from 07:00 (17 October). However, no further problems arose and the system has remained stable since then.

AWARD WINNING: FRED/FREDA

The NHS London awards evening was held on 30 October 2008. Not only did the LAS win the best software/technology category, but also won the big prize of the night – NHS innovator of the year 2008, on the basis that our innovation had the biggest impact on the most number of patients in London.

This was an excellent achievement for everyone in CTAK Development and Support and also Paul Webster from A&E Operations - an excellent example of bringing business and technology together to deliver real business benefit. As reported above, it has been a particularly difficult time for the CTAK/A&E team recently so a real pleasure for them to have a good news story. This is a fantastic achievement; something that everyone in IM&T and A&E Operations should be very proud of.

DATA CENTRE

The HQ Data Centre has been at capacity (in terms of power) for some time and this has lead to a hold being imposed on a number of projects needing to implement new servers. Work has been undertaken to stabilise the uninterruptible power supply, however, these measures have only recovered the situation to a point of safe stability.

In order to address the main issue, a contract has been let with BT to provide an outsourced data centre in the city. Work is currently on track to commence implementing some new services into this new data centre before Christmas, with the full migration being completed by March 2009.

6 COMMUNICATIONS

New corporate website – www.londonambulance.nhs.uk: The Service's new website was launched this month. The site has been developed to meet a number of objectives.

- To increase awareness of opportunities to work for us.
- To increase understanding of how and when to use our service.
- To educate people about what to do in a life-threatening medical emergency.
- To promote our work amongst healthcare professionals.
- To provide advice and reassurance during a crisis.
- To encourage Londoners to become members of our foundation trust, and facilitate that membership (future).
- To engage with Londoners and encourage their feedback.

Features on the site include a recruitment section where all job vacancies are advertised, and applicants can download the forms they need to apply for a post. Different career opportunities are also explained and are supported by staff case studies.

The site provides advice on when people should call 999 and what to do in life-threatening emergencies, for example when someone is having a heart attack or cardiac arrest. This information has been translated into a number of different languages based on the usage statistics of Language Line.

A section has been developed specifically for other healthcare professionals, outlining the services we can provide to them. And there is also a facility to trigger a special section in the event of a major incident, which will take over the website's homepage.

The new site takes account of accessibility standards, and the content has been written in plain English. Use of the site will be evaluated on a regular basis and the findings will inform future developments.

Media

Media training: Senior operational staff including four assistant directors of operations and nine ambulance operations managers have recently received media training. The training equips staff with the skills to carry out TV, radio and press interviews on a range of Service issues.

Staff safety: The use of risk registers by ambulance services received media attention in early November, and members of staff were interviewed on Radio 5 Live and Radio 2 about their experiences of physical and verbal abuse.

Staff recognition

NHS champions: Three members of staff are finalists in the NHS Champions Awards 2008. Emergency Medical Dispatcher (now student paramedic) Katie Vallis was nominated for helping Guardian journalist Leo Hickman deliver his wife's baby over the telephone. Paramedic Rob Bentley made the finals for saving the life of a seriously premature baby born in the living room of his mother's home. And Romford Ambulance Operations Manager Steve Colhoun was nominated for the support he gave to his complex staff following the

tragic death of motorcycle paramedic Ron Pile. The winners will be announced at an awards ceremony in central London on 11 December.

NHS 60: Camden Paramedic Andrea Gibbs has been recognised for her contribution to the community in a book to celebrate the 60th anniversary of the health service. *Extraordinary*, which was launched this month, features 60 staff across the NHS.

Patient and Public Involvement (PPI)

Tower Hamlets project: The first emergency life support training session for women was held in September at the Montefiore Children's Centre in Tower Hamlets. Eleven young mums, two dads and several babies attended. Feedback from participants was excellent, and the questions they asked demonstrated their understanding of what they had learned.

Following the success of last year's Bengali classes for staff at Silvertown, another course is planned from January for a further eight participants.

Tower Hamlets PCT and Dr Foster held a session for staff on the Get the Right Treatment health education pack. The Silvertown staff who attended are now keen to extend the training to their colleagues. There are also plans to extend Get the Right Treatment to schools, using different scenarios which will be relevant to young people.

Public Education: The pilot development programme for public education staff started in October, with two modules looking at The Developing Practitioner (the value of reflective practice and learning sets) and Coaching (so they can support others through the programme in the future). Twelve members of staff are taking part in the programme, which will continue until January.

The Public Education Strategy Steering Group is considering which books and other resources would be suitable for us to use with children. It has been agreed that resources should be focused initially on key stage 2 (age 10-11), as this is the age group we have the most contact with via Junior Citizens Schemes.

NHS Centre for Involvement: The Centre has compiled a report on our progress since last year's assessment of PPI within the Service. This is extremely positive, particularly highlighting our commitment to PPI by having a non-executive director on the PPI Committee, and the introduction of community involvement officers.

PPI activity:

- A range of community events have been held over the summer, including several focusing on gun and knife crime. We are now considering making an educational DVD on this topic.
- Approximately one to three open days per week have been held to recruit community responders in different areas of London.
- We had a stand at an event in Hounslow for people with learning disabilities, which has led to a request for us to work more closely with this group.
- A mental health stakeholder event was held by the Policy, Evaluation and Development team, to update our mental health strategy. The day was very productive and well-attended, including mental health service users and professionals.

- With the ambulance operations managers, the PPI Manager is beginning to meet the host organisations for Local Involvement Networks (LINks). Initial meetings have been very positive and it is expected that LINKs will be a good way for the Trust to liaise with patients and the public in the future.

Peter Bradley CBE
Chief Executive Officer

18 November 2008

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 25th November 2008

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

No new Serious Untoward Incidents have been declared since my last report in September. Action plans for all previous SUIs are up to date with no actions outstanding.

Central Alerting System (CAS) formerly the Safety Alert Broadcasting System (SABS):

The Central Alerting System (CAS) is run by the Medicines and Healthcare Products Regulatory Agency (MHRA). When a CAS 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.

Seventeen alerts were received from 19th July 2008 to 30th October 2008. All alerts were acknowledged; three requiring some form of action. Two of those requiring action relate to the use of wheelchairs and the method of securing those chairs in ambulances, the third is regarding the use of the NHS Number as a unique patient identifier.

With regards to the wheelchair alerts, (received on the 27th and 28th October 2008), the LAS Safety and Risk Department are still assessing their relevance. That said there is no need to take any immediate action as the LAS has the ability to secure all types of wheelchairs within their vehicles. The completion date for action on these two alerts is 27th January 2009 for the alert issued on the 27th October 2008, and 10th December 2008 for the alert issued on the 30th October 2008.

The alert regarding the use of the NHS Number as a unique patient identifier on clinical records requires a completion date of 18th September 2009. This alert instructs all NHS organisations in England and Wales that provide primary, secondary and all other types of care such as community pharmacy should now ensure that by 18th September 2008 patients are identified primarily by the use of their NHS number. For UK Ambulance Services there appears to be no explicit guidance on this subject. It is therefore suggested that the topic is discussed by the Clinical Governance Committee. Possibly the only practicable solution here is to provide a box on the PRF to record the NHS number of a patient where known.

Update on Safeguarding Children and Vulnerable Adults

Revised Sudden Unexpected Death in Infants (SUDI) procedures presented to NHS London and London Safeguarding Boards. These have now been agreed by HM Coroners, thus resolving an area of potential conflict for crews, and allowing a pan - London approach for the LAS staff who attend children who die at home.

We will be undertaking a work plan based on the report from the benchmark exercise we undertook and will be in close liaison with the (now) London SHA lead who of course sits on our SCAP Group.

We are working on a response to the new *No Secrets* consultation

Work to improve administration of referral procedures is underway although we have some IT issues that we hope will be resolved shortly. We are also planning to pilot electronic direct referrals by crews at the NWOW sites, hopefully from January.

2. Second domain – Clinical and Cost Effectiveness

New Drugs:

Clopidegrel trial: ethical approval for this study has now been granted. However, following the decision by JRCALC to approve the use of this drug in STEMIs we anticipate introducing this drug for the routine treatment of these patients from January 2009

Oral Morphine: supplies are now available to paramedics. An approach is being made through Pharmacists and the Directors of Clinical Care Group, to the Medicines and Healthcare Regulatory Authority (MHRA) to reintroduce unit drug vials, to facilitate the national re introduction of a practical form of oral morphine.

Oxygen: the LAS implemented the British Thoracic Society Guidelines for Emergency Oxygen use on 6th October. A teaching package has been developed for Complex Training Officers to highlight the changes. Despite the Guidelines being publicised nationally we have to support crews who are challenged by hospital staff who are unaware of the changes.

NICE Guidelines:

The only NICE Guideline published recently which is of direct relevance to ambulance services is that on acute stroke. The LAS is currently compliant with these guidelines.

New Research Projects

EVAR study:

The LAS will contribute to a Healthcare Technology Assessment (HTA) funded multicentre study randomising patients with an abdominal aortic aneurysm to either conventional or endovascular repair. Our role in this study will be to transport patients to regional vascular centres and to minimise fluid resuscitation prior to arrival.

DANCE study:

Funding is being sought for the 'Direct Angioplasty for NSTEMI Acute Coronary Events' study, where patients with chest pain and ECG changes suggestive of ischaemia, but not classical ST segment elevation are transported direct to one of the eight heart attack centres for early (as apposed to immediate) angiography. All eight centres have expressed an interest in this project.

Clinical Update Newsletter

The October edition (issue 13) covers issues arising around suspension trauma, emphasises the need for pain relief in acute coronary syndrome, the importance of regarding 12 lead ECGs as part of the clinical record and collecting them centrally. It also highlights the appropriate use of the LA277 form (for reporting violent or abusive patients) and the need to limit the reporting of medically unwell patients for inclusion on the High Risk Address Register.

This edition contains the 'ECG of the Month'.

Copies of this bulletin will be available at the meeting.

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

Appendix 1 provides a summary of findings from the National Ambulance Clinical Performance Indicator for stroke.

3. Third Domain – Governance

Clinical Support Desk - update

A total of 710 calls were logged during the month of October, a significant increase on September. A sharp rise in education questions from the Room and calls from A&E support crews has added to the call volume.

Workload:

The administrative duties being undertaken by the team continues to rise, in particular around Patient Specific Protocols and palliative care plans. Staff have been encouraged to record administrative time, since it is a significant amount of work. Work on frequent callers continues to save a large but unquantifiable number of ambulance journeys. More urgent care crews are accessing the desk with regard to non-conveyance, although it is noticeable in some cases that the desire to leave a patient at home has been inappropriate. UOC controllers have been asked not to contact GPs before talking to the paramedic on the Desk, because experience has shown that a number of these patients require conveyance to hospital.

The team have arranged a large number of referrals – often liaising with senior medical staff at receiving facilities. This has saved significant numbers of journeys with reduced need for inter-facility transfers.

Increasingly calls about Capacity and Consent are being resolved by the team, reducing the number of hospital journeys. However it is evident that many staff are not familiar with the LAS capacity tool.

Nine calls were referred on to the Medical Directorate on call person for further advice.

The continued shortfall in staffing has resulted in cover at some times being provided remotely by mobile telephone, although less so than in previous months. With the increasing volume of work and reliance on documents stored in EOC, this is proving harder to maintain. Recruitment to the vacant positions on the team has been disappointing, though some Team Leaders are now assisting with the cover arrangements.

Appendix 2 provides details of the call volume and types

4. Fourth Domain – Patient Focus

Amendments to the Mental Health Act

The following changes were introduced on 1st November 2008.

Name change to roles
Approved Social Worker (ASW) title replaced with Approved Mental Health Professional (AMHP). For ambulance staff this is simply an administrative change. They should, however, be made aware of the change.

Changes to legislation around 'Place of Safety'.
New legislation allows for patients to be moved between several locations as long as they are assessed within 72 hours of the original detention. This means that patients can be moved from (for instance) the Emergency Department to a more appropriate setting. This change will need to be cascaded to staff.

The introduction 'Supervised Community Treatment Orders' or 'CTOs'.
Allows for a patient to be discharged from hospital to continue treatment at their, or a relative's home. If the conditions of the order are broken then it can be revoked and the patient returned to hospital for detention.

Having undertaken discussions with Camden PCT it appears that the role of the LAS in this process will be no different to that of Section 135 assessments. The volume of recalls from CTOs is expected to be very low. Current estimates are for about 50 such orders to be revoked, per month, across London.

A query was raised re numbers of patients on CTOs and potential for an increase in the number of calls to the LAS as a result. This should not be of concern as:

i) CTO is a similar tool to the old supervised discharge. So this is not a new cohort of patients being discharged to the community which were previously only detained in hospital.
ii) If a patient keeps getting recalled then clearly the CTO is not working and they should be returned to Section 3 detention (which lapses but remains in place when under CTO).

iii) Volume will not be huge. Camden, one of the busier boroughs for MH, estimates 24 patients at any one time being subject to a CTO.

Actions recommended:

These changes will be communicated to staff through articles in the Routine Information Bulletin (RIB), the LAS News and through cascading a briefing by local Mental Health 'champions,' the Clinical Support Desk and the Department of Education and Development.

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.

5. Sixth Domain – Care Environment and Amenities

Infection Control

The post of Infection Control Co-ordinator was advertised but no suitable candidate was identified. An interim part time appointment has been made while the post is readvertised externally. Current initiatives being taken forward include trialling a disposable tourniquet (Ilford area); sourcing an IV cannulation pack to include sterile gloves; sourcing surface wipes, hand wipes and personal issue alcohol gel and sourcing arm protectors. The revised Infection Control Manual will be issued when the format [e.g. electronic / paper] is agreed.

An education and development strategy – which will include LAS News articles, Pulse articles, a personal issue IC pack for each staff member, and e-learning initiatives, is under preparation.

From a national perspective, the Clinical Director of South Central Ambulance Service is undertaking a baseline audit of infection control procedures currently in place in English Ambulance Services.

7. Seventh Domain – Public Health

Nothing further to report

Recommendation

THAT the Board notes the report

Fionna Moore,
Medical Director
14th November 2008

Appendix 1.

Clinical Audit & Research Summary Report for the Trust Board

Summary of Findings from Cycle One of the National Clinical Performance Indicators: Stroke

Author: Stephen Gadd & Gurkamal Virdi

Clinical Audit & Research Unit, Medical Directorate

1. Introduction

The National Clinical Performance Indicator (CPI) programme was developed by the National Ambulance Clinical Audit Steering Group (NACASG) to allow the comparison of clinical performance between ambulance services with the overall aim of improving patient care. All ambulance services in England take part in the programme, which currently evaluates five clinical areas: STEMI, Cardiac Arrest, Stroke, Hypoglycaemia and Asthma. The NACASG has set three cycles (from May 2008 to November 2010) with each clinical area audited three times at six month intervals. The first cycle of the National CPI audit is underway and this report presents the findings from the stroke indicator.

2. Method

The first 300 records with a clinical indication of stroke from 1 July 2008 were examined. Compliance to undertaking three aspects of patient care for patients with suspected stroke was assessed (see table below). In addition, a set of exceptions were established to take into account clinically justifiable reasons for aspects of care *not* being undertaken. These were not included in the calculation of compliance.

Inclusion Criteria	Aspect of Care Assessed	Exceptions
Patients with a clinical diagnosis of stroke	Face, Arm, Speech Test (FAST) recorded	Patient unconscious Patient refusal Patient does not understand Head trauma/injury
	Blood glucose recorded	Patient refusal Patient does not understand Head trauma/injury
	Blood pressure recorded	Patient refusal Time critical features (airway problem, reduced consciousness)

3. Results

- A FAST was undertaken in 94% of cases in comparison to the national average of 87%. The LAS achieved the highest compliance rate of all ambulance services for the FAST indicator.

- For the recording of blood glucose, the LAS achieved 97% compliance against the national average of 85%. This was the second highest compliance rate of all ambulance services for the blood glucose indicator.

- For the recording of blood pressure, the LAS achieved 100% compliance against the national average of 98%. The LAS was one of only two ambulance services that achieved 100% compliance for the blood pressure indicator.

4. Recommendations

The results from the first cycle of the National Stroke CPI audit are positive, with the LAS scoring above the national average for each aspect of care audited.

A problem identified in this audit was the need for an additional exception for the FAST assessment. Previous neurological impairment (e.g. a previous stroke) limits the usefulness of this test and this was not reflected in the exceptions. This suggestion was passed on to the NACASG for inclusion in the following audit cycles.

Appendix 2.

Data from Clinical Support Desk – October 2008

Figure 1: Workload by hour

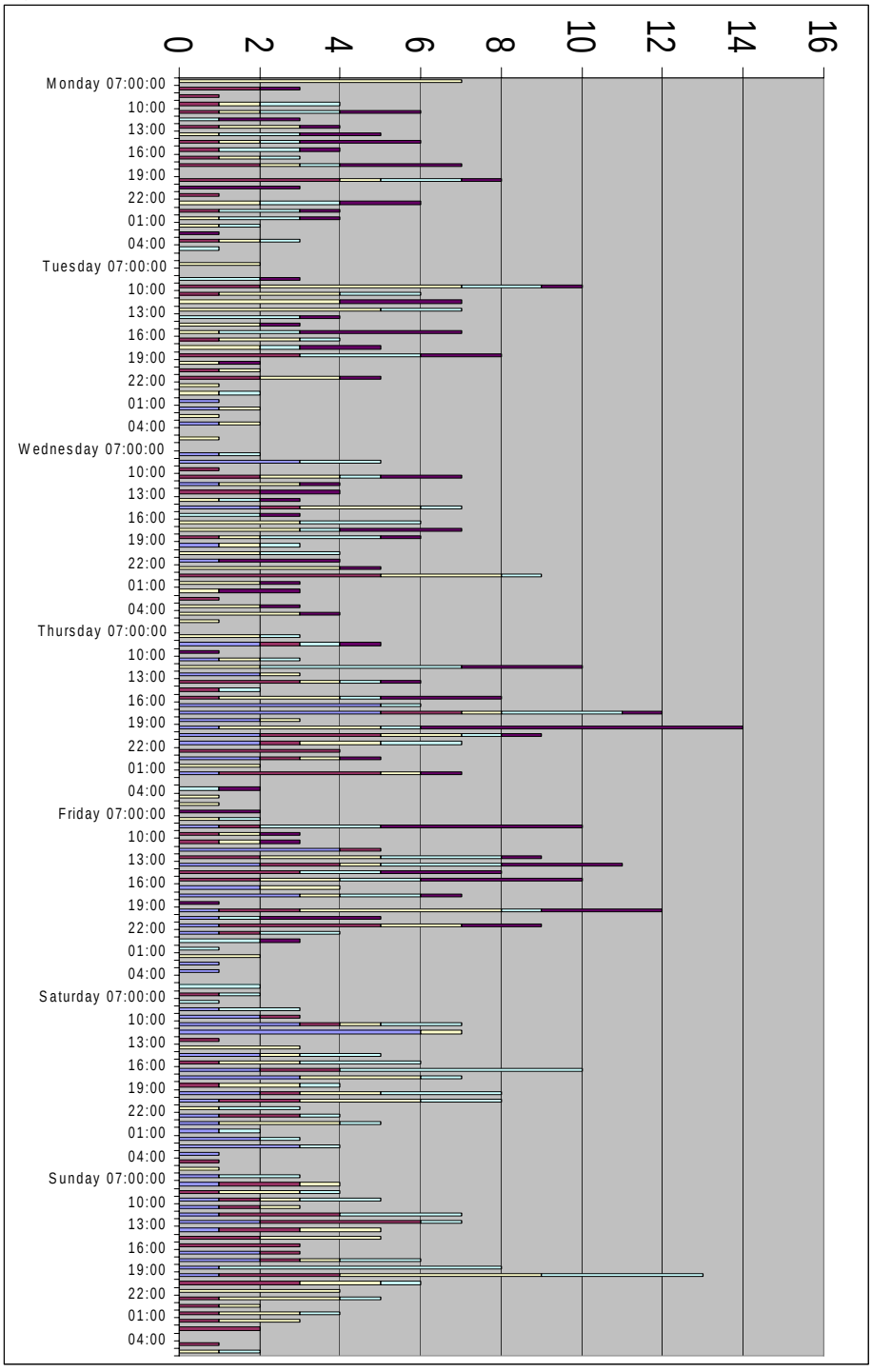
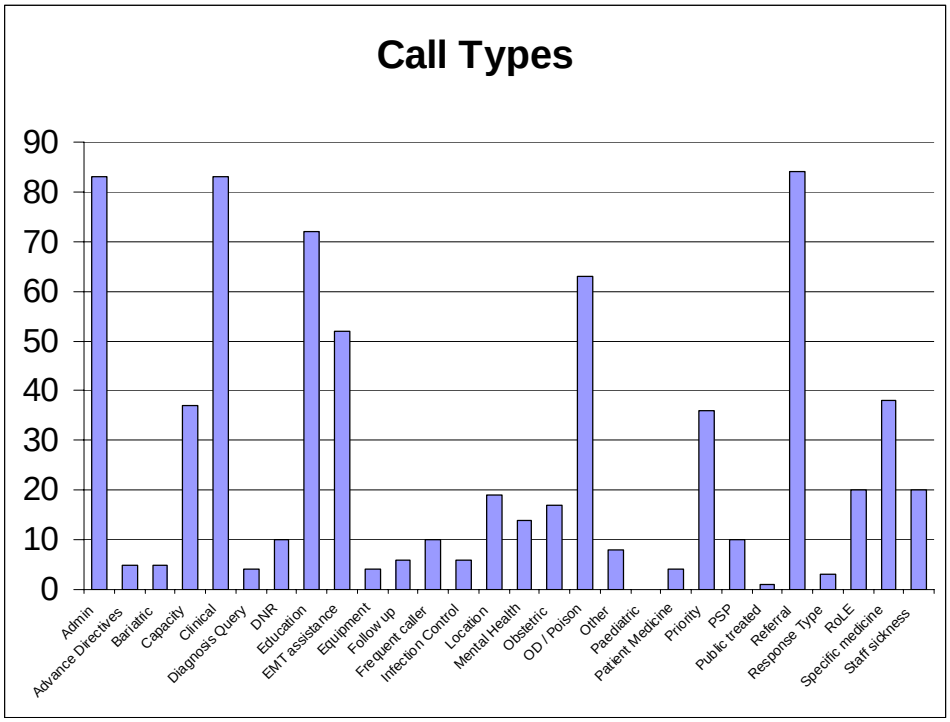


Figure 2: Call Types



Admin refers to duties that do not relate directly to a call (e.g. drawing up Patient Specific Protocols, checking transplant lists etc.)
Advance relates to questions about advance directives
Capacity is defined as any question surrounding capacity / consent
Clinical Questions are any non drug related treatment questions
Diagnosis Query relates to a question about the meaning / significance of a diagnosis
DNR relates to a do Not resuscitate Order
Education relates to learning points raised by EOC staff
EMT1 relates to giving support to an urgent care crew to avoid tying up an A&E crew
Equipment relates to the suitability of a type of equipment
Follow up relates to a crew request to see what happened to a patient
Frequent caller relates to a plan drawn up with PALS
Location refers to a check as to where a service is
Mental Health relates to any issue other than capacity
Obese relates to arrangements to move heavy patients
Obstetrics relates to any aspect of obstetric care
Overdose relates to queries resolved through Toxbase
Patient Medication relates to questions surrounding normal use of a patients own medicines
Priority relates to the order of despatch of calls being held on the sector
Public Treated relates to treating patients – generally in reception
Referral Pathways relates to the appropriateness of a destination
Response Type relates to the type of response (eg. A&E, PTS, EMT1) that might be suitable

ROLE relates to death and bodies (not DNR)
Specific Med relates to a technician or paramedic drug
Staff Sickness relates to the health needs of a member of staff

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Proposed approach by the LAS towards Stroke

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For approval

3. Summary

Several factors are driving acute stroke care in London:

1. Healthcare for London's (HfL) Stroke Strategy For London
2. Availability of 24/7 access to screening, assessment and thrombolysis at certain units in London and the LAS's eagerness to take advantage of this
3. PCT requests to divert their patients away from sites with poor outcomes/towards sites with better outcomes.

HfL's process for designating Hyper Acute Stroke Units and the time permitted for their development of services mean it will be well into 2010 before a pan London network is fully established.

Unilateral decisions to convey patients to where the best care is available could undermine public consultation around the HfL Strategy.

The risk of undermining the public consultation can be avoided by openly engaging with PCTs to set up pathways for their patients into existing 24/7 stroke units **pending the development of local options as part of the HFL process.**

Other actions are required before requests from individuals or groups of PCTs can be delivered. Therefore these diversions should not go live until 01/01/09 at the earliest.

Apart from internal communications the only requirement for LAS to deliver this would be the upgrading of strokes (where an on set of symptoms was within 2 hours) to Red from Amber on AMPDS.

4. Recommendation

THAT the Trust Board AGREE that:

1. A comprehensive survey of PCTs is carried out to establish which of them wish to designate a preferred location for thrombolysis-eligible FAST+ patients, and for discussion to be coordinated via the joint commissioning arrangements.

2. A stakeholder communications plan be agreed to make clear that this is a temporary measure until local services are set up (as part of the HfL strategy), and is no way intended to influence future stroke centre designation.
3. Destination acute stroke units are consulted on their capacity to receive patients.
4. Extra demand on resources is modelled and PCTs approached for extra funding if/where applicable, both for interim measures and full pan-London strategy.
5. For operational clarity, as far a possible, all interim changes take place at the same time, the target date being 01/01/09 at the earliest.

1. Purpose of Paper

To secure Trust Board approval for London Ambulance Service's proposed strategy for

i) meeting changes in the way PCTs ask us to deliver care for their stroke patients;

ii) delivering optimum care for stroke patients (where available) in the light of Healthcare for London's Stroke Workstream schedule.

2. Background

> *Stroke is the second most common cause of death and the single most important cause of physical disability in London. In 2007, stroke accounted for well over 4,400 deaths (both in and out of hospital) in the capital, of which nearly 25% may have been prevented. Nearly one percent of Londoners have suffered a stroke, and many more than one. The impact on hospital services is huge, with over 11,000 Londoners admitted to hospital with a stroke each year.*[2]

The London Ambulance Service (LAS) clearly have a direct impact on the care stroke patients receive and can diagnose c80% of strokes with the simple FAST test. Up to 15% of stoke patients could benefit from thrombolysis but this sub-set can only be identified after a CT scan. Thrombolysis is only effective if administered within three hours of on set of symptoms (although trials are underway to test effectiveness up to six hours) so it is vital that all patients with an onset of symptoms within two hours are quickly delivered to a centre where they will be:

- fast-tracked for a CT scan to identify whether their stroke is thrombolysable;
- thrombolysed (where appropriate) by a trained clinician in a safe environment within 3 hours of on set of symptoms.

3. Healthcare For London –Strategy Update

3.1. Healthcare for London (HfL) have developed a London Strategy for Stroke and their recommendations were published on 14th November 2008. They deal with three distinct parts of the pathway: Public Awareness and Prevention, Acute Stroke Services and Rehabilitation and Community Care.

3.2. The easiest part of this strategy to implement, and the part of specific interest to the LAS, will be the acute section where many centres are already, or already on their way to being, able to accept patients 24/7 and, if appropriate, deliver thrombolysis round the clock.

3.3. Acute Stroke Services

- The preliminary acute stroke strategy offered three options for future stroke care models:
  - Option 1: A larger number of smaller size hyper-acute stroke units (HASUs) to deal with those patients who could benefit from thrombolysis. Those who are not eligible will go to a standard HASU (with no thrombolysis).

[2] Preliminary acute stroke strategy for London: Healthcare for London, August 2008.

- o Option 2: A number (9-14) of smaller (10-14 beds) HASUs to which all stroke patients are admitted before being transferred to a local stroke unit once stable/after 72 hrs.
- o Option 3: A smaller number of larger HASUs to which all stroke patients are admitted before being transferred to a local stroke unit once stable/after 72 hrs.

- LAS favoured Option 3 as the best way of ensuring units received the volume of patients required to deliver world class care, delivered via a pathway that is easy for our crews to use. However, this was qualified by stating that the impact on LAS of longer job cycle times would need to be analysed, and that extra funding was likely to be needed if performance was to be maintained.
- Consultation, and an acknowledgment that current stroke stoke provision is focused in the centre of London whereas incidence (best predicted by age rather than, for example, deprivation) is highest on the outskirts, has encouraged Healthcare for London to recommend option 2.
- HFL felt option 1 would not deliver the step change required and option 3 would be too difficult to implement.

3.4. The HfL strategy is based around all stroke patients being conveyed to a HASU (c 8,600 by ambulance per annum) not just those who would potentially benefit from thrombolysis.

3.5. Next steps in implementing HfL Strategy:

Stage	**Date**
Strategy published	Nov 2008
Applications for centres to become Stroke Units, Hyper Acute Stroke Units and TIA clinics	Nov 2008
Assessment of applications	Dec 2008
Public consultation	Jan-Mar 2009
JCPCT decision on Stroke Centre Configuration	Jun 2009
Go live	From Q3 2009

NB: although the decision to go ahead with specific centres will be taken summer 2009, it is expected that some centres may take much longer (up to a further 18 months) to be in a position to accept stroke patients from LAS. This means we could be well into 2011 before a genuine pan-London pathway is in place.

Furthermore, at the latest HfL stroke conference, Dr Chris Streather (clinical lead for the project) confirmed that it may not be a pre requisite for HASUs to offer 24/7 access to thrombolysis from day 1 of their operation. LAS will need to be aware of those locations where thrombolysis is available and not take it for granted that it will be offered by all HASUs as soon as they open.

The original schedule for implementation was significantly shorter than this. One of the reasons for its extension appears to be that HfL wish the consultation for the Stroke strategy to run alongside that of the Major Trauma strategy.

4. London Operational Update

4.1. Several acute trusts are already ready to receive FAST+ patients from LAS 24/7, whilst in other areas PCTS have requested LAS convey their patients to specific centres, often bypassing local A&Es.

4.2. Two areas of London have requested LAS to divert patients to a different stroke unit to avoid delivering sub-optimal care:

- Bexley PCT, Greenwich PCT and Bromley have requested that thrombolysis-eligible patients be taken to KCH as of 1st November.
- Due to concerns regarding outcomes for stroke patients at their King George's Ilford site, Barking, Havering and Redbridge Hospitals Trust (BHRT) have reconfigured their stroke services onto one site. As of 15th October LAS have been asked not to convey stroke patients to King George's Ilford. They will now be conveyed to either Whipps Cross or Queen's Hospital (Romford) depending on their location.

4.3. In South West London the five PCTs, local acutes and LAS set up a pilot in February 2008 to provide 24/7 assessment and thrombolysis to stroke patients.

Mayday, Kingston and St Helier hospitals provide quick access to CT scans, consultant assessment and thrombolysis 0900-1700, Mon-Fri. Outside of these hours, FAST+ patients who can be conveyed to South West London and St George's (SWLStG) to arrive within two hours of the onset of symptoms are taken there directly as there is 24/7 access to quick CT scans, consultant assessment and, where appropriate, thrombolysis.

This pilot will now run until June 2009 (when the decision of the Joint Committee of Primary Care Trusts regarding HfL's recommendations is due to be published).

4.4. As well as SWLStG, other trusts able to accept FAST+ patients 24/7 and deliver thrombolysis are:

- St Thomas
- Kings College
- UCH
- Charing Cross
- Royal Free

4.5. This piecemeal change in 24/7 provision presents a challenge to PCTs. On the one hand they have services available 24/7 that they may use to potentially deliver better outcomes for patients. On the other, they do not wish to be seen to be reconfiguring ahead of the London-wide consultation on Stroke due to run from January 2009. To do so could see them accused of riding roughshod over the process and introducing significant service change without proper consultation.

4.6. As has been noted (3.3) highest demand for stroke services is in outer London. However, by requesting their patients are conveyed to centres currently able to deliver 24/7 stroke care (see 4.3) PCTs will necessarily be pushing their patients towards central London, inadvertently widening the gap between the provision of good (currently central London) and poor (i.e. outer London – where it is most needed) stroke care. However not do so would be to deny those living on the outskirts access to the best available care.

4.7. LAS are keen to convey patients to the most appropriate location for their condition, and do not wish to delay quick access to 24/7 hyper acute stroke care to patients in specific parts of London.

4.8. LAS have received legal advice stating that if PCTs were to request LAS convey their patients to specific locations *pending the outcome of the HfL consultation*, this would not prejudice the process. The SHA are aware of this advice.

4.9. Research conducted by ORH illustrated that in order to deliver a centralised stroke strategy for FAST+ patients in one old SHA area would require an additional 2 ambulances.

5. Impact on LAS

5.1. LAS attended 8,600 patients who were FAST+ between April 2007 and March 2008, so there is a significant potential impact on job cycle times should we decide to convey all FAST+ patients further distances to specialist HASUs.

5.2. The South West London Experience

- From February 2008 LAS have participated in a Stroke Pilot in South West London designed to offer 24-7 access to thrombolysis in the area through a hub and spoke model. The spokes operate a service with quick access to CT scans from Mon-Fri between 0900 and 1700, whilst the hub is open 24-7.
- Criterion for referral is that onset of symptoms is within 2 hours.
- Despite apprehension around the volume of patients LAS would be asked to convey further distances, demand did not materialise.
- Over an 8 week period from 1st Feb 2008, 42 patients were eligible for the pathway. This equates to slightly more than 1 patient per PCT per week.

5.3. During the design of the pathway LAS ensured that repatriation to a local stroke unit from the hub centre would be the responsibility of local PTS providers and so did not encumber A&E resources.

5.4. In order to improve the number of patients who can be thrombolysed within 3 hours of onset of symptoms, LAS will investigate the impact of prioritising FAST+ patients who present within 2 hours of on set of symptoms from the current level of Amber to Red A.

6. Conclusion

6.1. LAS can have a huge impact on the quality of stroke care received by patients throughout London by identifying those patients who could potentially benefit from thrombolysis, and conveying them quickly to a specialist centre where they will receive an immediate CT scan.

6.2. No extra training for crew staff is required to deliver this but new protocols will need to be issued, advising crews on which patients should be taken where.

6.3. In an ideal world large service improvements such as this would be implemented in one hit across the whole Service. However, given the difficulties presented by HfL's schedule and the differing levels of provision currently available it could be mid 2010 before such a pan-London approach is possible.

6.4. It is therefore right and proper to proceed with referrals to stroke units where:

- The patient would potentially benefit from thrombolysis (i.e. has presented to us within two hours of onset of symptoms)
- We are certain the stroke unit can deliver quick access to CT scans thrombolysis 24/7.
- There is a clear mandate from the local PCT to undertake.
- All parties and stakeholders understand that this is an interim solution pending the decision of the JCPCT.

6.5. The Healthcare for London project envisages that all stroke patients will be conveyed to a HASU. This is not something LAS will be in a position to deliver without extra resources.

7. Recommended actions for LAS

7.1. LAS to open discussions with individual PCTs regarding their preferred location for thrombolysis-eligible FAST+ patients.

7.2. LAS to be absolutely clear that this is a temporary measure until local services are set up (as part of the HfL strategy), and is no way intended to influence future stroke centre designation.

7.3. LAS to consult destination acute stroke units on capacity to receive patients.

7.4. LAS to model extra demand on resources and approach PCTs for extra funding if/where applicable, both for interim measures and full pan-London strategy.

7.5. LAS to model impact of triaging strokes which present within 2 hours of onset of symptoms as Red instead of Amber.

7.6. LAS to upgrade strokes (where an on set of symptoms was within 2 hours) to Red from Amber on AMPDS, in order to support targets for quick access to CT scans for thrombolysable patients.

7.7. Given requirements 4.3 and 4.4, LAS should not go ahead with the proposals put forward by Bexley (and Greenwich and Bromley) PCTs until 01/01/09 at the earliest.

7.8. LAS to ensure only patients who have presented within two hours of on set of symptoms are eligible for interim pathways.

7.9. LAS to gather data on the number of lives which will be saved and disabilities which will be avoided by quick access to scanning, assessment and thrombolysis.

7.10. LAS to liaise with the DH to anticipate the likely impact of their March 2009 awareness campaign.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

CAD 2010 Contract Award

1. Sponsoring Director: Peter Bradley

2. Purpose: *For Approving*

3. Summary

The objective of the CAD 2010 Project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. The objective of this paper is to seek approval from the Trust board to conclude final negotiations with the chosen supplier, Northrop Grumman Information Technology Global Corp (NG) and award the contract in their favour.

The total cost to the Trust over the whole life period is £51.940M, consisting of £33.336M revenue and £18.574M capital. This includes all LAS costs of staff as well as those of NG for hardware, software, implementation and support services.

An independent consultant has been providing independent advice to the lead NED's, that has proved very useful. It is recommended to keep this arrangement and enhance with further support from the consultants associated organisation, Methods consulting.

4. Recommendations

THAT the Trust Board:

1. DELEGATE authority to the CEO to sign the CAD 2010 contract in favour of Northrop Grumman Information Technology Global Corp (NG), subject to:
   - Confirmation from the Director of Finance and Investment, NHS London that he is satisfied with the further due diligence on the financial robustness of NG.
   - Final contract clarifications do not substantially alter the contract in terms of scope, or vary the overall contract value by more than 1%.
2. AGREE that the external consultant who has provided independent assurance thus far is retained along with further support from Methods Consulting

Trust Board – 25 November 2008

CAD 2010 AWARD OF CONTRACT

Introduction

The objective of the CAD 2010 Project is to replace the CAD (Computer Aided Despatch) system, the Trust's mission critical command and control system. Full details of the project have been continually reported to the Trust Board and are not repeated here. The objective of this paper is to seek approval from the Trust Board to conclude final negotiations with the chosen supplier, Northrop Grumman Information Technology Global Corp (NG) and award the contract in their favour.

As reported previously to the Trust Board, the current CAD system has been in use for over ten years. Whilst it has served the Trust well, particularly in terms of its functionality, it is now in need of replacement. Recent reports to the Trust Board have highlighted concerns over its reliability and change is now becoming a priority, particularly ahead of the Olympics.

PROCUREMENT APPROACH

The procurement was conducted according to the Office of Government Commerce (OGC) Competitive Dialogue Model. An advertisement was placed in the Official Journal of the European Union (OJEU) inviting expressions of interest. Thirteen expressions of interest were received and following evaluation of the bids, six bidders were invited to participate in dialogue (ITPD). This was then refined and two suppliers (Intergraph and Northrop Grumman) were invited to take part in further dialogue and were subsequently invited to submit final tenders (ITSFT). Following evaluation of the final tenders submitted by Northrop Grumman and Intergraph, a Final Tender Evaluation Report was produced, recommending the selection of Northrop Grumman as the preferred supplier for CAD2010.

sha approval

Given the overall value of the contract, approval is required from the SHA. The full business case has been subject to full scrutiny by the SHA Capital Investment Unit, and a presentation made to the Capital Investment Committee. A letter confirming approval of the business case, subject to two conditions has been received (Appendix 1). These are defined below along with the current LAS position:

Condition 1: "The CIC requires you to agree robust mitigation plans with commissioners to address the identified risk of a performance dip at the time of implementation."

Current Position: The whole transition process will be subject to very detailed planning that will involve Commissioners and the Trust Board. Part of this will be plans to mitigate the potential for performance dip during transition.

Condition 2: "The CIC notes your plans to conduct further due diligence on the financial robustness of the supplier prior to contract signing. Please share the outcome of this work with me before proceeding."

Current Position Work is currently underway to satisfy this requirement and the Director of Finance anticipates being able to write shortly to the SHA Finance Director confirming suitability.

The overall position of the SHA is taken into account within the recommendations in this report.

Summary timeline

The following summary timeline sets out the key milestones in terms of procurement, evaluation, audit and approval processes.

Dates	**Milestone**
May 2005	Project initiation, including establishment of Project Board
June 2006	Gate 1 Review
July 2006	Strategic Outline Case approved by Trust Board
January 2007	Gate 2 Review
January 2007	Outline Business Case approved by Trust Board
March 2007	Strategic Outline Case approved by SHA
March 2007	OJEU procurement commenced
May 2007	13 expressions of interest received from prospective bidders
June 2007	6 bidders invited to participate in dialogue
June 2007	Outline Business Case approved by SHA
Sep - Nov 2007	1st stage dialogue with suppliers (6 in total)
December 2007	Two suppliers (Intergraph & Northrop Grumman) selected to go forward to next stage
Jan – April 2008	2nd stage dialogue with Intergraph & Northrop Grumman
May 2008	Intergraph and Northrop Grumman submit final tenders
June 2008	Final Tender Evaluation Report – preferred bidder Northrop Grumman
June 2008	Trust Board approves Northrop Grumman as preferred bidder
June / July 2008	Gate 3 Review
August 2008	Full Business Case submitted to SHA
September 2008	Start of working with Northrop Grumman under “Letter of Intent”
October 2008	Presentation of Full Business Case to SHA Capital Investment Committee

November 2008	SHA Approval of Full Business Case

Current Contract Status and Solicitor's report

The contract, based upon an OGC model, has been subject to extensive review and negotiation. There remain a number of open items that are subject to final refinement, none of which materially affect the overall contract.

The Trust solicitors, Capsticks, were engaged to advise on the procurement process, particularly the selected competitive dialogue process. This approach allowed detailed discussions with suppliers throughout. This has been extremely beneficial in terms of defining and understanding both the technical and user requirements. They have remained engaged in the project and have provided advice throughout the negotiation process. For assurance purposes, appended to this report are the following documents from Capsticks:

- a covering letter (Appendix 2)
- a table highlighting the key risks (Appendix 3)

The provision of a mapping product is one issue that is likely to be the subject of early change control, post contract signature. Currently the contract allows for the LAS to retain its current mapping product and for this to be provided under current contract arrangements. Continuing negotiations will review this arrangement to investigate if this service would be better provided under the NG contract.

The Directors of IM&T and Finance have personally reviewed the entire contract (and schedules) with Capsticks, the Project Manager and Head of Procurement. They are both satisfied to recommend this contract to the Trust Board for approval.

Costs and affordability

The whole life project is based upon three years for development and an initial seven years live running period, hence ten years in total.

The total cost to the Trust over the whole life period is £51.940M, consisting of £33.336M revenue and £18.574M capital. This includes all LAS costs of staff as well as those of NG for hardware, software, implementation and support services.

The separated NG costs are £8.664M capital and £2.549M revenue.

Within the NG revenue are the seven year costs for maintenance and support. These are set at a fixed price of £200,694 per year, for each of the seven years.

In addition to the costs above, the maintenance for the additional five years extension (should it be invoked) is set at £232,586 per year, for each of the subsequent five years.

Average annual incremental revenue costs equate to 0.6% of the 2008/09 Trust budget. A capital loan of £10M is included in the FBC. It is the view of the Finance Director that the project is affordable from both the capital and revenue perspectives.

Trust board assurance

One of the recommendations from the SHA at the time of the OBC was to utilise an independent consultant to advise the Trust Board, and in particular the lead NEDs. As a result of this, a consultant was engaged with a view to supporting the Trust Board up to award of contract.

This arrangement has worked particularly well and at this stage has been reviewed by both lead NEDs and the Director of IM&T. There is unanimous agreement that this

arrangement should be continued.

The consultant concerned is an associate of Methods Consulting (who is a significant player in central government). Further discussions have identified that Methods Consulting would be willing to offer one of their Directors to provide an additional quality assurance role. This would then add value to the work of the existing consultant being underwritten by the 'Methods' brand.

Recommendations

The Trust Board delegates authority to the CEO to sign the CAD 2010 contract in favour of Northrop Grumman Information Technology Global Corp (NG), subject to:

- Confirmation from the Director of Finance and Investment, NHS London that he is satisfied with the further due diligence on the financial robustness of NG.
- Final contract clarifications do not substantially alter the contract in terms of scope, or vary the overall contract value by more than 1%.

That the external consultant, who has provided independent assurance thus far, is retained along with further support from Methods Consulting.

Peter Suter
Director of Information Management & Technology

Appendix 1

NHS
London

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SW1E 6QT
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Mr Martyn Salter
Corporate Processes Programme Manager
London Ambulance Service NHS Trust
Headquarters
220 Waterloo Road
London SE1 8SD

7 November 2008

Dear Martyn,

CAD2010 – FULL BUSINESS CASE

Thank you to you and your colleagues for attending the Capital Investment Committee (CIC) this week to discuss the CAD2010 Full Business Case.

I am pleased to confirm that the CIC approved your case, subject to 2 conditions:

1. The CIC requires you to agree robust mitigation plans with commissioners to address the identified risk of a performance dip at the time of implementation.

2. The CIC notes your plans to conduct further due diligence on the financial robustness of the supplier prior to contract signing. Please share the outcome of this work with me before proceeding.

I look forward to hearing from you in due course.

Yours sincerely,

Paul Baumann
Director of Finance and Investment
NHS London

56

Appendix 2

The person dealing with this matter is:
Chris Brophy
Direct dial 020 8780 4674
Direct fax 020 8780 4842
Email cbrophy@capsticks.com

Capsticks

Your ref:

Our ref: CJB/SLC/044444

20th November 2008

Mr Richard Deakins
London Ambulance Service NHS Trust
220 Waterloo Road
SE1 8SD

By email only

Dear Mr Deakins

CAD2010 Project

We enclose the risk report on the contract for the CAD2010 Project, based on the draft of the contract as at 20 November 2008.

Yours faithfully

Capsticks

Capsticks

Appendix 3

CAD2010 Project – Risk report to London Ambulance Service NHS Trust (the "Authority")

A. Introduction

This report highlights the key legal terms in the current draft of the contract for the CAD2010 project. It sets out the significant legal risk to the Authority (if any) attached to those key terms.

Although the contract has been developed and issues have been clarified, the key legal terms of the contract set out here have not significantly changed since the draft of the contract issued at the stage of issuing Invitations to Submit Final Tenders. This report therefore builds on the report we issued at that time and the two reports should be read in conjunction.

The Authority should note that the contract is in its final stages of development and so is subject to further amendment.

Part B of this report highlights the key legal risks to the Authority arising out of the key legal terms of the contract. Part C sets out the key legal terms and the significant legal risks attached (if any) in more detail.

B. Key legal risks

We consider that the key legal risks to the Authority arising from the key legal terms set out in Part C of this report are:

- Clause 4 – procedure for acceptance of non-Tested Deliverables
- Clause 9 – risks associated with not taking a Fully Managed Service
- Clause 44.3 and Schedule 3 – obligation to comply with Authority Responsibilities, especially those with a timeframe attached
- Clause 52.2 – limitations on Contractor's liability
- Schedule 2.5 – absence of Authority Security Policy
- Schedule 6.1 – risks associated with Project Schedule
- Schedule 7.1 – structure of Milestone Payments
- Schedule 10 – cap on claims under parent company guarantee, as compared with caps on liability in contract
- Risks in relation to software provided by third parties that are part of the Contractor System, namely Northgate and Oracle

C. Key legal terms and significant legal risk to the Authority (if any)

Reference	Key legal term	Significant legal risk to the Authority (if any)
Parties and clause 70.4	London Ambulance Service NHS Trust ("Authority") Northrop Grumman Information Technology Global Corp ("Contractor")	Risk to the Authority in contracting with a company outside of the UK, however the Contractor must maintain an address for service in the UK, which addresses this risk.

Clause 2 – due diligence	Acknowledgement from Contractor that it will rely on its own enquiries and due diligence in entering the contract. Further acknowledgement that it has inspected the Authority's system and sites for its suitability.	N/A

Clause 4 – Testing and Milestone Achievement Certificates	Once the Contractor successfully completes Testing for all Deliverables in a Milestone, the Authority must issue a Milestone Achievement Certificate in 10 Working Days. Acceptance of non-Tested Deliverables: • there is no contractual "link" between non-Tested Deliverables and the issue of Milestone Achievement Certificates; and • there is no process for the parties to agree the detail of what is required in each non-Tested Deliverable nor is there any acceptance criteria.	The Authority is at risk of breach if it does not submit a Milestone Achievement Certificate in this time. Acceptance of non-Tested Deliverables; • risk of uncertainty as to the timing of when the Authority must issue the Milestone Achievement Certificate and consequently there is uncertainty as to when the Milestone Payment is triggered (some of which are quite substantial and relate to Milestones where none of the Deliverables in it are being Tested); and • unless the Authority is comfortable that each non-Tested Deliverable is adequately described elsewhere in the contract, there is no detailed, substantive basis which the Authority can use to determine whether a non-Tested Deliverable is acceptable. However, such detail could be agreed between the parties outside of the contract.
Clause 5 – Correction Plans	The Contractor must submit a Correction Plan if it does not Achieve a Milestone. The Authority must notify the Contractor within 7 Working Days if it approves the Plan. If not, the Contractor must re-submit the Plan and the Authority then has 5 Working Days to approve it. If the Authority does not respond to the Contractor within these timeframes, the Contractor may begin to implement the Plan and if the Authority subsequently rejects the Plan, the Contractor may claim its costs from the Authority in following the rejected Plan.	The Authority is at risk if it misses these timeframes. This has been addressed somewhat by a requirement that the Contractor send a notice to the project manager and the contract manager if a timeframe has been missed.
Clause 6 – delay due to Contractor default	If there is a delay to a Milestone due to Contractor default, the Authority may require the Contractor to reimburse it for all proven losses, costs etc incurred by the Authority by reason of the delay.	N/A
Clause 7 – delay due to Authority Cause	If there is a delay to a Milestone due to Authority cause, the Contractor is allowed: an extension of time, relief from failure to achieve the Milestone and compensation from the Authority. Compensation is limited to direct loss and/or expense incurred as a result of the delay caused by the Authority.	The Authority is at risk of paying compensation, although these contractual provisions reduce the risk that the Authority would otherwise have had at common law to pay damages. See also the caps on Authority liability in clause 52.3, discussed below.

Clause 8 – Delay not due to one party	If a delay is not due to one party, the Authority and Contractor must negotiate to determine the extent to which the delay is attributable to each party. If the parties cannot agree, they must refer the matter to dispute resolution for expert determination.	Each party at risk of paying compensation for their own delay, as per clause 6 and 7 discussed above.
Clause 9 – Services	The Contractor must provide the Services in accordance with the Authority's requirements in Schedule 2.1 (Services Description) and the Contractor Solution in Schedule 4.1.	N/A

Clause 9 – Additional Services	The Authority must provide 90 days notice if it requires the Contractor to provide a Fully Managed Service.	The main risk to the Authority here is if it does not take the Fully Managed Service from the Contractor. This is because it brings some of the responsibility – and therefore some of the risk – for support and maintenance of the Contractor System over to the Authority. For example, when not on a Fully Managed Service, the Authority must install any patches and upgrades itself. If, because of an Authority error during installation, the Contractor System becomes Unavailable, or is otherwise not performing in accordance with Schedule 2.1 requirements, then the Authority will not have recourse to the Contractor. The Authority's risk here is minimised to the extent that it is properly resourced and has sufficiently experienced personnel to undertake the activities that would be undertaken by the Contractor under a Fully Managed Service. Having a Fully Managed Service may also help overcome the issue of when a period of Unavailability should be deemed to start, as Contractor personnel will be on-site. The Authority is further at risk of not having the Fully Managed Service at the time it is required if the requisite 90 days' notice is not given.
Clause 10 – Service Levels	The Contractor must provide the Operational Services to meet or exceed the Service Levels.	The risk to the Authority is that Service Levels are its sole remedy (save for in relation to serious default allowing termination).
Clause 11 – effect of Authority default during Operational Services	If the Contractor is unable to provide the Services/meet Service Levels due to Authority default, it will not incur Service Credits and will still be entitled to the Charges as if the Services had been provided/Service Levels had been met.	The Authority is at risk of having to pay the full Charges even though the Contractor has not performed the Services, if such non-performance is due to the Authority's default.
Clause 13 – Quality	The Contractor must comply with the Quality Plan and the Authority may audit compliance.	N/A
Clause 14 – Services Improvement	The Contractor has an ongoing obligation to identify new or potential improvements to the Services.	N/A
Clause 15 – equipment	Title to and risk in the Contractor Equipment listed in schedule 4.1 passes from the Contractor to the Authority at the ATP Milestone Date and the Contractor will have relief	The Authority bears the risk of loss or damage to the Contractor Equipment in Schedule 4.1 from ATP.

	from Service Credits if they are not met due to loss or damage to the Contractor Equipment. Until that time, and in relation to all other equipment, the Contractor is responsible.	
Clause 17 – VAT indemnity	Each party indemnifies the other for any failure to account for VAT, when the indemnifying party was responsible to account and the failure to account has caused the other party to incur liability.	Mutual risk to both the Authority and the Contractor.
Clause 18 – right of set off	The Authority may retain or set off any amount owed to it by the Contractor against any payments it must make to the Contractor.	N/A
Clause 23.1 – Sub-contracting	The Contractor must not sub-contract without the prior written consent of the Authority, which is not to be unreasonably withheld or delayed.	The risk is that the Authority is not able to withhold consent in its absolute discretion and so must consent to sub-contracting if the requirements of clause 23 are met.
Clause 23.10 – Competitive Terms	The Authority may require the Contractor to replace existing commercial terms if the Authority is able to find ones that are more favourable.	N/A
Clause 24 – Audits	The Authority is able to verify the accuracy of the Charges and compliance with the contract.	The Authority bears risk of paying further Charges if it has underpaid the Contractor.
Clause 29 – Employment indemnity	Each party indemnifies the other for any Employee Liabilities arising out of claims made by an employee of the other party that was caused by the indemnifying party's employee(s).	Mutual risk to both the Authority and the Contractor.
Clause 35 – IP licences from Contractor	The Authority obtains a perpetual and irrevocable licence to use the Contractor Software, Specially Written Software and Third Party Software.	The Authority does not obtain ownership of the Specially Written Software, however in this instance such ownership would not be useful without ownership of the core Contractor Software.
Clause 35.5 – use of software by other government bodies	Any other Crown Body or Contracting Authority who wishes to licence the Contractor Software including any Specially Written Software or Project Specific IPRs may do so and shall not be charged any further development fees, or licence fees for the Specially Written Software or Project Specific IPRs (but it may charge maintenance fees).	N/A
Clause 39 – Escrow	The Contractor Software and Specially Written Software is placed in escrow.	N/A

Clause 44 – Contractor obligations	The Contractor must comply with the general obligations set out in this clause regarding eg, resourcing, problem resolution, interface requirements etc.	N/A
Clause 44.3 and schedule 3 – Authority responsibilities	The Authority must comply with the obligations in schedule 3, which arise from the Contractor Solution in schedule 4.1.	The Authority is at risk of breach of contract if it fails to comply with these obligations. However, the main risk is that if the Authority does not comply with its obligations in Schedule 3 – especially where there is a contractual timeframe or deadline attached to the obligation – the Contractor will be able to rely on this as evidence that there has been a Delay due to Authority Cause, allowing the Contractor an extension of time for any of its dependent obligations, as well as allowing it to claim compensation. A particular risk to the Authority in Schedule 3 is in Item 83. The Authority is already aware that the User Acceptance Testing will take longer than specified, meaning that a change control request will need to be issued early in the development phase, which could increase price and impact on scheduling of the Contractor's obligations and timetable for delivery of the Contractor System.
Clause 45.1 – warranties	Each party warrants that it has the power to enter the contract; has duly signed the contract; there are no suits or actions pending against it; and, the contract will be valid and binding on it.	The Authority is at risk of breach of warranty if any of these representations are untrue.
Clause 45.2.4 – warranty regarding software	The Contractor warrants that throughout the term of the contract all software used shall be currently supported versions.	N/A
Clause 46 and schedule 10 – guarantee	The Contractor's parent company must execute a guarantee within 30 days of the date of the contract, which provides a guarantee and indemnity to the Authority for the Contractor's performance of the contract.	N/A
Clause 47 – Change in Law	If there is a Change in Law that impacts the Contractor in its contract with the Authority and in relation to contracts with other customer(s), then the Contractor is able to obtain an amendment to the Charges and/or relief from compliance with obligations. For any other Change in Law	N/A

	there shall be no such relief.	
Clause 49 – BCDR	The Contractor must prepare and comply with a BCDR Plan.	N/A
Clause 51 – IPR indemnity	The parties indemnify each other for claims made by an owner of intellectual property rights if the indemnifying party has infringed those rights by eg, licencing them to the other party.	Mutual risk to the Contractor and the Authority.
Clause 52.2 – limitations on Contractor liability	The Contractor's liability to the Authority is capped as follows: - VAT, employment and IPR indemnity: unlimited - damage to property: £5 million - Service Credits: 30% of the annual Charges - all losses for events occurring during the period: from the start of the term until one year after CPP the cap is the total Charges for that time; from one year after CPP until the end of the term the cap is the total Charges for that time; for the option period is the cap is total Charges for the option period.	The Authority is at risk if its actual losses exceed a cap.
Clause 52.3 – limitations on Authority liability	The Authority's liability to the Contractor is capped as follows: - VAT, employment and IPR indemnity: unlimited - damage to property: £5 million - Termination Payment: £1.18 million - Compensation payment: £1.12 million - all losses for events occurring during a year shall be capped at the Charges for that year.	N/A
Clause 52.4 – indirect loss	Neither party is liable to the other for indirect, special or consequential loss or damage, nor for loss of profits, turnover, business opportunities or damage to goodwill.	Mutual risk to the Contractor and the Authority.
Clause 54 – Term	The initial term is 7 years from the ATP Milestone Date. The extension period is for up to 5 years.	N/A

Clause 55.1 – Authority termination rights	The Authority may terminate the contract following the occurrence of any of the listed termination events.	N/A
Clause 55.3 – Authority termination for convenience	The Authority may terminate the contract at will on written notice, subject to payment of the Termination Payment and Compensation Payment.	The Authority is at risk of paying the Termination Payment and/or Compensation Payment to the caps above, if it terminates for convenience or if the Contractor terminates for Authority default.
Clause 55.6 – Contractor termination right	The Contractor may only terminate for non-payment of undisputed Charges.	The Authority is at risk of termination if this occurs.
Clause 60 – Step-In rights	The Authority may step-in to the contract and perform it on behalf of the Contractor at the Contractor's cost should a step-in trigger occur. Step-in triggers include any default that would allow the Authority to terminate, Force Majeure, Service Credits reaching a specified threshold etc.	N/A
Clause 61 – Alienation	The Contractor may not assign the contract without Authority consent.	N/A
Schedule 2.2 – Service Levels	The Authority may levy Service Points if the Contractor fails to achieve one of the four Service Levels in this schedule. These Service Points then become translated into Service Credits, which are deducted from the Charges during the operational phase. The first Service Level is in relation to Availability and the Contractor accrues Service Points depending on how long during each month the system is Unavailable. This Service Level therefore hinges on what elements of the system must be up and running for it to be considered "Available". Note that this is an open issue and the definition of "Availability" has gone from a general definition, encompassing the call taking and dispatch related functions of the system, to a table of critical transactions.	One risk to the Authority in relation to this schedule is that it is quite complex and it will only be effective to the extent that it allows the Authority to calculate and levy Service Points and then translate them into Service Credits. In relation to the definition of Availability, if using a table of critical transactions as the definition significantly narrows the concept of Availability, then this reduces the opportunity of the Authority to levy Service Points in this regard.

Schedule 2.5 – Security Requirements	In this schedule, the Contractor must develop and implement a Security Plan. Such Security Plan should be developed so as to comply with, and be consistent with, the Authority's Security Policy, however this is not going to be available at completion of the contract. Therefore, provisions have been included in the schedule such that the Authority is able to include the Security Policy as a requirement of the contract through the change control provisions.	The Authority is at risk of having to pay additional costs if they are necessary to compensate the Contractor for compliance with the Security Policy and/or amending its , once it is introduced (although these costs are not completely "at large" i.e. they should be consistent with any rates etc set out in the Financial Model). Also, when putting through the change control, there is a risk that some of the relevant provisions throughout the contract will be forgotten to be amended i.e. those provisions that are required to be amended so that the Contractor must comply with the Security Policy and ensure that the Security Plan is consistent with it.
Schedule 6.1 – Implementation	This Implementation Plan is governed by this schedule and within the Implementation Plan will sit a Project Schedule, setting out timeframes for completion of tasks by both the Authority and the Contractor between Milestone Dates.	If the Authority misses a timeframe for one of its tasks, the Contractor will be able to rely on this as evidence that there has been a Delay due to Authority Cause, allowing the Contractor an extension of time for any of its dependent obligations, as well as allowing it to claim compensation. Therefore, the more detailed the Project Schedule and the more timeframes it imposes on the Authority, the more risk there will be to the Authority. The Authority does have approval rights over the Project Schedule and therefore must ensure that when it is being developed, it is careful to only agree to timeframes that it is confident it can meet and then it must be adequately resourced to meet them.
Schedule 7.1 – charging and invoicing	The Authority must pay Milestone Payments during the development phase and Service Charges during the operational phase.	The Authority must pay the Milestone Payments once a Milestone has been Achieved and the Service Charges are payable monthly. The way in which the Charges have been structured provide an inherent risk to the Authority as: • they are "front loaded", meaning that the Contractor will have recouped most of its costs and received most of its profit from the project during the development phase, such that the financial incentive for it to perform well during the operational phase becomes much weaker; and • the most substantial Milestone Payments are to be paid before Authority to Proceed ("ATP"), rather than at or after ATP, such that the Authority is required to make the majority of its payments regardless of whether it passes Gateway 4 and regardless of whether it ever "goes live" with the Contractor System.

Schedule 7.3 – value for money	The Authority may benchmark the Charges.	N/A
Schedule 7.4 – financial distress	This schedule, which gives the Authority escalating remedies should the Contractor or its parent company come into financial distress (as indicated by credit ratings) is being resisted by the Contractor and is an open issue. The Contractor proposed alternative provisions, allowing the Authority to require bank guarantees be put in place should the credit rating of its parent company fall, but these have now been withdrawn. The Authority is requesting that these alternative provisions be restored.	Without "financial distress" provisions, the Authority will not have the ability to ring-fence some or all of the payments it makes to the Contractor, in case it needs to claws-back some of these in a default or insolvency situation. The Authority also does not have a right to pre-emptively terminate the contract if it sees the financial stability of the Contractor or its parent slipping. However, such protections are not always required and may not be suitable for a contract of its type. Relevant considerations are the confidence of the Authority in the financial strength of the Contractor and its parent and any other protections it may have under the contract, such as the parent company guarantee.
Schedule 9.1 – TUPE indemnity: Authority	The Authority indemnifies the Contractor for costs associated with a staff transfer from the Authority to the Contractor upon commencement of a Fully Managed Service or on the Effective Date or ATP Milestone Date.	The Authority is at risk of claims under this indemnity, although it considers that either no staff will transfer or, if they do, they will be redeployed by the Authority.
Schedule 9.1 – TUPE indemnity: Contractor	The Contractor indemnifies the Authority for costs associated with a staff transfer from the Contractor to the Authority upon termination or expiry of the contract.	N/A

Schedule 10 – Parent Company Guarantee	The Contractor must procure that its parent company provide a guarantee for any payment or other monetary claim that the Authority may have against the Contractor. The Authority must, however, make the claim against the Contractor in the first instance and there is a cap on the guarantee, in the amount of the total Charges over the life of the contract plus £10 million.	As set out above, there are three indemnities in the contract under which the liability of the Contractor is unlimited. If the Authority has a claim under one of these indemnities and the Contractor does not pay out, then the Authority will need to seek recourse under the parent company guarantee. If the amount of the Authority's claim under the indemnity is greater than the cap in the guarantee, the Authority will not be able to make a demand from the guarantor for the total amount of the claim.
Northgate and Oracle	The Contractor is subcontracting part of the Services to Northgate, with whom the Authority has an existing relationship for its current CTAK system. The current proposal is that the Authority will continue its current arrangements with Northgate for the system being provided by the Contractor. That is, its existing licensing and support and maintenance arrangements will continue and the Authority will also supply the hardware required for the Northgate element of the system. It is open in the contract as to whether the Authority should have the option to request the Contractor to take over the support and maintenance of the Northgate software and/or supply the hardware required. The Authority is proposing that it will request Northrop Grumman to take over the support and maintenance of the Northgate software and has requested the Contractor to provide pricing for this. The Authority will also use its current licensing arrangements with Oracle, which is part of the Third Party Software under the contract, and this may or may not include support and maintenance. The provisions in relation to support and maintenance if Third Party Software are open.	The risk to the Authority is that if support and maintenance of some elements of the system is a responsibility that rests with the Authority, then if anything goes wrong with these elements this would provide relief to the Contractor. This is the same for any hardware elements of the system provided by the Authority. The Contractor would be excused from meeting its Service Levels (such as providing 99.999% Availability) and it could make a claim for compensation. It also opens up debate as to what element of the system caused a service failure and who was responsible.

D. Reliance

This report is produced for the Authority in relation to its own internal contractual review process and may not be relied upon by any other entity or for any other purpose. It is not intended to be an exhaustive review of all legal issues and risks, it does not deal with purely technical, commercial or insurance issues and it is not a substitute for a full reading of the contract and taking other advice where appropriate.

CAPSTICKS
20 November 2008

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Lease Car Policy

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

2. Purpose: For discussion

3. Summary

The draft Lease Car Policy (sent electronically) is a new policy aimed at formalising the process of provision and associated conditions relating to lease cars within the London Ambulance Service.

The key areas of clarification & difference between current practice and policy proposal are:

- Clearly set criteria and considerations with regard to eligibility for a lease car:
  - Regular and significant business travel incurring a minimum set mileage
  - Consideration of alternatives such as mileage allowance
  - Regular on call or response requirements
  - Necessary (regular) conveyance of bulky items
  - Vehicles are allocated to the post not to the post holder
- Base car definition (1800cc engine size and CO2 emissions 190 or below)
  - Prohibition of sports & convertible cars from the scheme
  - Clear sliding scale variance to base
- Personal contribution to insurance
  - Excess liability clarified
- New conditions on staff for additional drivers
  - User responsibility for premiums on drivers under 21

Existing users will be consulted prior to the final policy being brought to the Trust Board in January for approval with an intended implementation date of 1 April 2009.

A lease car policy for Directors will be drawn-up for consideration by the Remuneration Committee once this policy has been approved.

4. Recommendation

THAT the Trust Board DISCUSS the draft policy and offer views on its current content.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

LDV Replacement Business Case

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

Attached is an executive summary from the Combined Business Case (CBC) outlining the case for replacing the existing LDV ambulance fleet with 100 Mercedes ambulances over two years. The case is affordable and within the Trusts delegated limit.

Work is underway to analyse the optimal financing route given both current economic conditions and the introduction of IFRS. Approval will be sought from the Trust Board in January 2009 for the recommended financing approach.

The full CBC is available for review and has been circulated separately to the main agenda (electronically).

4. Recommendation

THAT the Trust Board APPROVE the procurement of the vehicles.

1 Executive Summary

Introduction

The purpose of this Combined Business Case (CBC) is for internal London Ambulance Service (LAS) use where combining the Outline and Full Business case requirements can save time and effort, and the overall cost is within the LAS financial approval authority. This business case draws upon both the LAS Strategy Plan 2006/7 to 20012/13 and the Fleet update presented to the Trust Board in March 2008. It refers to recent independent research on fleet size and an urgent requirement to address an ageing fleet of front line ambulances. This CBC draws the conclusion that the Trust should replace 100 of the oldest ambulances with new ones because:

- The need to replace old and worn out vehicles remains strong
- Costs to repair vehicles will become higher as the age of vehicles increases

The preferred option arising from this analysis of costs and benefits is that 100 new ambulances should be purchased to replace older vehicles. The final decision on how these vehicles are financed will be made following a subsequent comparison of lease and purchase options. This business case is based on the option that vehicles are purchased, partially using existing capital resource limit (CRL) for the 08/09 and 09/10 financial years.

1.1.2 This CBC also confirms that the Trust has the capability to manage the project as evidenced by recent projects, the introduction of the PTS range of vehicles since 2002 covering some 140 different specification vehicles, and more recently 148 RRUs during 2006 and 2007/8. Other members of the project team were involved in previous deliveries of the 260 Mercedes AEU's since 2004/5.

Strategic Case

The Trust has an ageing fleet because of under-investment in the 1990s. The age profile of the fleet is improving, but as at March 2008, 35% of the fleet is greater than 6 years old and 20% of the fleet is more then 9 years old. Older ambulances are costly to maintain, increase overall vehicle downtime and reduce the capacity to achieve performance targets, with a consequent impact on patient care.

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

This business case proposes that 100 of the latest LAS specification, CEN compliant, A&E ambulances are procured to replace the 100 oldest vehicles in the fleet. The ambulances will be Mercedes diesel vehicles with a removable box body and tail lift. This will be the fifth batch of this vehicle type that the Trust has procured

The Trust's fleet replacement strategy specifies that ambulances should be replaced after 6 years. The Trust is procuring vehicles in batches of 100 to achieve a more even spread in the age profile of ambulances to avoid too many vehicles needing to

be replaced at one time in the future. However, the requirement for a sensible age spread needs to be balanced against the risks posed by the ageing fleet.

For this reason, this Combined Business Case has been prepared for Trust Board approval in November 2008 in order to allow 100 replacement ambulances to be procured and put into service by July 2009.

Economic Case

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

- Provide 100 CEN Compliance ambulance vehicles designed to the latest LAS Specification ready for deployment commencing January 2009.
- To improve the availability of A&E ambulances by reducing instances of off-the-road downtime caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- Meet Health & Safety requirements to reduce back injuries caused by manual trolley bed vehicle loading; by up to 50% like for like by installing mechanical tail-lifts
- To meet the aims of the Strategic Plan 2006/7 to 2012/13 by responding to our patient's needs with the appropriate service.

1.3.2 This business case has considered two options open to the LAS - Do Nothing and a capital purchase of 100 vehicles, 35 in the 2008/09 financial year and 65 at the beginning of the 2009/10 financial year. It has been found that the preferred option is the capital purchase largely due to the Weighted Benefit Score applied to both these options.

Financial Case

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

The financial case shows that there is a net cost in all years of the project, starting at £0.6 million in year 1, rising to £2.5 million in year 2 as a result of equipment and full-year depreciation costs, reducing to approximately £1.5 million in each year of the remaining life of the project. An overall Trust surplus position is maintained however, throughout the period of investment.

Once the approval to replace the assets has been received, an economic comparison between leasing and purchasing will be undertaken and the affordability of the lease option tested if appropriate.

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

Commercial Case

During 2003/04, the LAS replaced 130 frontline A&E ambulances with new Mercedes ambulances with aluminium modular box bodies. The Trust subsequently replaced two batches of 60 replacement vehicles in 2004/5 and 2005/6. A number of this later batch of vehicles included trial innovations such as carbon fibre bodies, new tail lifts and solar panels to assist with power management. These trials offered operating benefits, in particular the carbon fibre bodies, since these offered a lower operating mass resulting in lower fuel consumption. When the trial vehicles were introduced, however, the vehicle was loaded with other equipment and the expected benefits were not realised. In addition, carbon fibre is reputedly simpler and quicker to repair than aluminium, offering potential reductions in vehicle repair times. Moulded carbon fibre interiors could also improve infection control through reducing dirt trapping joints and seams.

The contract for build of ambulance bodies has been tendered via the newly awarded PASA NHS framework agreement. A formal tender evaluation group was formed and reviewed each supplier's submitted tender response using criteria such as price, quality, compliance to the specification, ability to meet the vehicle delivery schedule.

The tender evaluation has been completed for the build of ambulance bodies therefore, this business case has been drafted using the prices from the tender, and current costs the LAS incurs. Approval for this business case is sought on the basis that final prices are within reasonable proximity of the quoted prices in the financial analysis of this document.

Management Case

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

The stakeholders' expectations are that vehicles commence operational deployment starting from December 2008 and that all vehicles are in service by the end of July 2009. This is an ambitious and challenging schedule to achieve. However, these timeframes cannot be confirmed until contracts are placed with the individual equipment suppliers and their production schedules are known.

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

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

IM&T Strategy 2008/09 – 2012/13

1. Sponsoring Director: Peter Bradley

2. Purpose: For Approval

3. Summary

The objective of the Information Management & Technology Strategy is to set the blueprint for how Information Management & Technology (IM&T) will deliver and support the LAS over the next 5 years. It is focused to ensure that it supports people and clinical issues, not just IM&T. It is important to stress that it is not set in stone and will be revised during this period based upon business need and changing requirements

The attached paper sets out how effective implementation of the IM&T Strategy can support the future business requirements of the LAS, as well as a high level view on the attached summary of the strategy.

The IM&T Strategy has been informally reviewed on several occasions and it was formally reviewed by the Service Development Committee in June 2008. All comments received have been incorporated and the strategy amended accordingly.

The actual IM&T Strategy 2008/09 – 2012/13 document has been circulated separately to the main agenda (electronically).

4. Recommendation

THAT the Trust Board APPROVE the IM&T Strategy 2008/09 – 2012/13.

Trust Board – 25 November 2008

IM&T STRATEGY 2008/09 – 2012/13

Introduction

The objective of the IM&T Strategy is to set the blueprint for how IM&T will deliver and support the LAS over the next 5 years. It is focused to ensure that it supports people and clinical issues, not just IM&T. It is important to stress that it is not set in stone and will be revised during this period based upon business need and changing requirements.

The underlying driver for the strategy is the Trust's Strategic Plan 2006/07 - 2012/13, that sets the direction for the London Ambulance Service NHS Trust (LAS) and outlines how it will be implemented in the wider context of developments in the NHS. The IM&T Strategy is defined as one of the enablers to support the delivery of this plan. There are additional drivers in the form of increasing demand for operational performance, healthcare for London, Lord Dazi's recent review and application for Foundation Trust status. None of these however alter the overall direction set out in the strategy, or require changes that cannot be supported by it.

The next section of this paper sets out how effective implementation of the IM&T Strategy can support the future business requirements of the LAS, while the last section provides a view on the defined approach of the strategy. The actual strategy is appended to this paper.

The future vision

The CAD 2010 project has delivered a new, fully integrated CAD system supporting two control rooms (each with 100% spare capacity for resilience). Reliability is 99.9%+ with complete system failures now unheard of. New functionality is released twice a year through upgrades provided by the commercial provider of the CAD software.

The LAS has fully implemented Airwave. Every crew member carries a digital radio that provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies. Data is now routinely passed across this system alerting staff to calls, and in the case of non MDT vehicles, passing the actual call details.

Electronic PRFs are fully installed in all response vehicles. Details of the call automatically populates the ePRF 'tablet' (hand portable PC device) and where patient details are known, appropriate medical information is downloaded from the Spine. Mandatory fields ensure 100% data compliance. If the patient is to be transported, then all recorded details are downloaded to the receiving centre (hospital or urgent care centre of some type), e.t.a. is automatically calculated, hence reception staff know what to expect and when. The ePRF tablet also acts as information centre for the Paramedic. It has access to various clinical guidelines and provides basic translation software for deaf people and commonly used languages. It is in continuous development as a vital Paramedic aid.

All staff book on/off duty, time recording will therefore automatically satisfy the requirements of the working time directive. Additionally, when booking on duty, all clinically qualified staff will be issued with an Airwave radio, that in turn will show their availability to the CAD system. All clinically qualified staff will be expected to be available to respond to local calls to perform physically local BLS duties, irrespective of

their other duties. 'Hot desking' is common place, with staff having a transportable telephone number (can by moved to any fixed or mobile handset) and are able to log onto their user accounts and files from any LAS PC. All data is input once, as close to the original collection point as possible, normally via a web browser. Hence, through streamlined business processes and work flow applications, paper forms are no longer sent to data input functions. Once entered, data is then re-used by a defined suite of systems, thus removing the need for duplicate data entry.

All managers who have a justified business requirement will have a laptop computer (or similar device) equipped will full remote access, allowing 24 X 7 access to all corporate services. All staff will have access to basic e-mail (known as web mail) from any internet terminal – essentially giving free access to Trust e-mail from home computers or internet cafés. Vitally, a new culture will have emerged where staff use this technology to work smarter, not harder – this access will not simply be work added to the 'day job'.

A new suite of services are now available for people who do not speak English and/or who cannot use the telephone as an able bodied person would. This includes direct internet services and text messaging via translator services that then interact with the control room. New national targets have been agreed for these types of calls, as 8 minutes from initial call answer is recognised as being not realistically achievable.

There is a single repository for all staff data, the national ESR system that includes records of personal issue equipment. Application forms are now all electronic and from moment of initial enquiry, the entire employee process is automated. Extraction routines take data from ESR and populate other systems that need data about people (e.g. telephone directory). This includes setting the access level that each member of staff has for information systems. Self service is fully implemented allowing staff to self-manage certain personal attributes (e.g. Bank details, address, telephone extension).

Management Information is provided by a suite of reporting tools that reside on all desktop and remote access computers. There are different levels of tools and staff are able to generate reports as and when they require them, according to their access rights. The central Management Department provides expert analysis for the most complex queries, reports on overall trends, provides predictions, continually develops the tools and acts as guardian of data standards.

There is a 24X7 IM&T Support desk that acts as a single focal point for ALL IM&T support. Utilising interactive tools, the support technician is able to remotely access the faulty equipment or service. 70% of the calls receive a 'fix' at the point of the call being received. That is, the technician is able to restore at least a basic service to the customer, and where necessary, complete fault resolution to be undertaken in slow time. Increasingly customers will use 'self service'. Through a web browser they will be able to log onto the service desk and report their problem. They will also be able to access a series of tools and help scripts to assist in 'self fix' and also monitor progress of their fault.

Staff training and education has evolved. All employees are required to have a basic level of IM&T literacy, irrespective of their role (e.g. e-mail, basic word processing). Many training modules are now delivered by web-based e-learning packages, including many clinical modules. Traditional classroom based training is still delivered, but it is more an exception rather than normal practice. Importantly, staff accept that they are responsible for their ongoing training – this is not something 'done to them' by managers. The concept of IM&T Super User is now well established. This role is a recognised responsibility undertaken by appropriate staff at each main LAS location. The person provides local user support and has a direct liaison with the IM&T Directorate, which provides ongoing support and training.

The approach defined in the IM&T Strategy

In order to deliver the vision defined above, the actual strategy is delivered in a number of discrete sections, each covering a specific aspect of IM&T. An important element of this strategy is the acknowledgement and full support for the national programme for information technology, also known as Connecting For Health. The approach is to utilise products that are readily available, including N3, the secure national network, NHS Mail and the ePRF solution.

There will be a clear focus on IM&T customer service and delivery. A number of measures will be developed including business benefits realisation, appropriate programme and project management, and ensuring the right IM&T staff, with the right skills, are in place. Customer driven service provision will underpin every activity of IM&T support and delivery, utilising the IT Infrastructure Library (ITIL) best practice framework. There will be empowerment through the creation of an IM&T Super Users Programme - the European Computer Driving Licence (ECDL) will be available as a base-line standard for staff and an effective file management and e-mail archiving system will be implemented.

Compliance to ensure effective Information Governance and Security is rightly mandated. Any data stored on a PC or other removable device in a non-secure area or on a portable device such as a laptop, PDA or mobile phone will be encrypted. There will be clear focus to ensure that security controls are not disproportionate to achieving the desired business objective. An Information Governance Group will oversee all aspects of Information Governance and Security on behalf of the LAS.

Much work will be undertaken in the early years of this strategy to enhance the underlying technical infrastructure. IPT Telephony Voice/data/video will be the cornerstone, where voice information is managed in the same way as traditional data traffic. In terms of performance, the aim is to enable any user to access core services with consistent performance from any LAS workplace. A technical architecture will be implemented to ensure that all data is held in a centralised information repository (data warehouse). Through the provision of appropriate tools, decision makers will be provided with desktop access to their required information. Routine/standard reports will be instantly accessible with the opportunity for managers to create their own reports using various tools.

In terms of new software provision, the starting point will be to gather initial requirements and undertake a feasibility study. Solutions will be delivered through amending an existing system, implementing a third party product, interfacing or by in-house developments, using web technologies where appropriate. There will also be a drive towards working collaboratively with the wider emergency services family to produce joined-up solutions. The replacement of the existing Computer Aided Despatch system will be the cornerstone of work during the next three years.

Recommendation

That the Trust Board approve the IM&T Strategy, 2008/09 – 2012/13.

Peter Suter
Director of Information Management & Technology

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Risk Management Policy

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary

The Risk Management Policy that was approved by the Trust Board in September 08 had to be updated following on from the recommendations from NHSLA Assessment in October 08.

The updates are as follows:

- The attendance of the members of the following committees need to be at least 50% of meetings (RCAG, CGC and Audit Committee)
- The Risk Management Structure of LAS needs to reflect the relationship between Clinical Governance Committee and Risk and Compliance Assurance Group

The Risk Management Structure document and the Risk Management Policy have been circulated electronically with changes highlighted.

4. Recommendation

THAT the Trust Board APPROVE the amendments to the Risk Management Policy and structure

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Foundation Trust update

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: To update the Trust Board on progress with the application for the LAS to become a Foundation Trust

3. Summary

The Foundation Trust application is now being managed as a programme by the Director of Finance who is the Senior Responsible Owner and reports progress made with the application against the high level plan agreed by the Board on September 30th. Programme updates are given to the Strategic Steering Group in a similar way to the programmes of the Service Improvement Programme.

The programme board chaired by the Chief Executive Officer has met twice and oversees the achievement of progress for all aspects of our application against timescales. This work has been subdivided into seven Workstreams led by senior managers and the progress made with each work stream is highlighted below.

Governance and membership workstream

- Interim membership manager appointed.
- Tender prepared for computerised membership database management
- Membership rationale and strategy in draft stage

Consultation and communication workstream

- Drafting of consultation documents underway for consultation to begin on 26th January 2009 for 12 weeks
- Work begun to use internal management meetings to explain the process by which the LAS is applying to become an FT

Business Marketing & Strategy workstream

- 2 Facilitated workshops held with participation by SMG, Chairman and NEDs
- Third workshop to be held to fully develop marketing position which will then be included in the Integrated Business Plan (IBP)

Commissioner Engagement Workstream

- Commissioners have advertised for a Commissioning Manager to support our FT application
- Commissioners invited to join FT Programme Board

Business Plan Workstream

- the structure for the integrated business plan has been agreed building on the work produced from the FT Diagnostic pilot programme

Workforce development

- the HR strategy will be attached as an appendix to the IBP
- New ways of working and Organisation Development and People programmes under review with detail to be included in the IBP

Finance

- Monitor completing work on the modification of the Long Term Financial Model ready to be tested by our finance team
- Strategic Financial Model being developed to allow detailed financial projections to be prepared

4. Recommendation

THAT the work done to progress the FT application is NOTED by the Trust Board.

Enclosure 13

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Standing Orders, Financial Instructions And the Scheme of Delegation

4. Sponsoring Executive Director: Michael Dinan

5. Purpose: For approval

6. Summary

The Standing Orders, Financial Instructions and Scheme of Delegation have been reviewed and updated in line with the NHS Model Rules published in March 2006.

Attached are the proposed changes to the Standing Orders and the Financial Instructions. The documents have been circulated separately to the main agenda (electronically).

The Audit Committee considered the proposed amendments to the Standing Orders and Financial Instructions, including Scheme of Delegation, at its meeting in November 2008 and approved submission of the amended documents to the Trust Board

4. Recommendation

THAT the Trust Board APPROVE the amended Standing Orders, Financial Instructions and Scheme of Delegation.

Review of the Standing Orders, Financial Instructions and Scheme of Delegation.

The Standing Orders and Financial Instructions have been reviewed in collaboration with colleagues and a comparison undertaken against the NHS Model Rules published in March 2006. The Standing Orders, Finance Instructions and Scheme of Delegation were reviewed in 2006/07 and approved by the Trust Board in March 2007.

Please note that in the documents 'strike through' denotes a proposed deletion and underlining indicates an addition or amendment.

1. Standing Orders

The main changes to the Standing Orders are:

Appendix 2 (2.4):	The EU thresholds have been changed to reflect the new amounts in effect from January 1st 2008;
Appendix 2 (9.4)	A section referring to the use of electronic tendering and the safeguards in place has been added.
Appendix 3, 5 & 9.	The inclusion of the amended terms of reference for the Audit Committee; the Clinical Governance Committee and the Charitable Funds Committee. In September 2008 the Trust Board approved the Risk Management Policy which contained the recently revised Terms of Reference for the Audit Committee and the Clinical Governance Committee.

2. Financial Instructions

The main changes to the Financial Instructions are:

11.1.5	This has been updated to include reference to the most up to date guidance from the Department of Health in relation to delegated limits for capital investment.
11.3.2	This has been updated to include reference to the most up to date guidance relating to the maintenance of an asset register recording fixed assets.

The Local Counter Fraud Specialist reviewed the Standing Financial Instructions (SFIs) and considered them adequate and fit for purpose. Suggestions as to how the SFIs could be improved have been incorporated within the document, primarily Section 2.4 – Fraud and Corruption. These include:

2.4	The inclusion of definitions of what constitutes fraud or corruption; providing a definition will provide assistance to those who are unsure what fraud or corruption is;
2.4.2	The inclusion of the contact details for the LCFS;
2.4.6	Reference to the Trust's Fraud and Corruption Policy and where it can be found i.e. the Pulse.
9.1.2(c)	Reference to the London Ambulance Services' authorised signatories list, as well as the authorised signatories' policy.
9.2.6(d)	Cross-reference to the Trust's Gifts and Hospitality policy, which is set out in Appendix VI of the Trust's Standing Orders.

3. Scheme of Delegation

There were no changes proposed to the Scheme of Delegation as it was substantially reviewed in 2006/07.

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 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. Service Development Committee – one of the seven 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, 25th November 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 seven 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 has previously been 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 has also been a supporting *Stakeholder Engagement and Communications Strategy* led by the Director of Communications. It has been decided by the Senior Management Group (October 2008) that two additional programmes should be incorporated within SIP2012 which are also covered by this report:

- *New Ways of Working* led by the Chief Executive;
- *Foundation Trust Application* led by the Director of Finance.

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

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. It is now clear that the deliverable of a comprehensive set of referral pathways in each PCT area which are routinely used by staff will now move into 2008/09.

Corporate Processes and Governance

Re-engineer Income Collection

The project has been on hold due to deployment of the project manager on other work.

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.

Access

London Airwave Radio Programme (LARP)

The centrally-driven project plan needs revision following the testing failure of the last version of the radio control software (ICCS), as yet no plan has been issued. A meeting has been arranged with Department of Health and suppliers to discuss the key issues and agree a way forward. A draft local 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 with migration deferred until the new financial year 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).

However, the Service Level Agreement is in final draft in preparation for the Project Board and the service for the current 200 radios is now being considered for inclusion in the main DH ARP contract. This will provide better service to the users and simplify the management of equipment maintenance and servicing. A budget bid has been presented to SSG for extending radio support from weekdays to weekends. Dual fitting of vehicles has now been completed and it is intended to move on to fit 53 new PTS vehicles, 60 new ambulances and 12 new MRU's. Training is on hold until there is further information on the rollout schedule, MRU/CRU users are to be trained to provide early access.

Text Emergency Access for Speech or Hearing Impaired People (TEASHIP)

There is no new information regarding the lack of progress with the national initiative lead by the Department for Communities and Local Government '999' liaison committee. Progress of this initiative will continued to be monitored with the intention of ensuring call taking and triage procedures cater for any increase in the volume of calls received from the RNID bureau. In the meantime planning of a pilot study to evaluate the feasibility and viability of an in-house solution has begun (whereby text messages will be received directly from the public and handled initially by EBS staff within UOC). It is intended that this study focuses on the needs of deaf or deafened people, drawing upon community links.

New Ways of Working

Team Based Working

Team based working involves:

- Establishment of working arrangements conducive to the formation of real teams (e.g. a watch system, annualised hours and self-rostering);
- Complex roster reviews;
- Review of management/supervisory post numbers and specification of roles;
- Leadership and staff development;
- Establishment of Team Briefings.

Progress is dependent upon and awaiting outcomes of ORH modelling, a clinical leadership paper and work on proposed clinical models to shape what Team Based Working will look like. However, work is beginning on roster/working practice reviews at Barnehurst following the Complex away day. Work also will continue regarding the gap analysis required to define requirements, identify leadership structure changes and develop a local training plan.

5. Recommendation

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

Kathy Jones
Director of Service Development

Enclosure 15

London Ambulance Service NHS TRUST

TRUST BOARD 25th November 2008

Annual Report of the Trustees of the LAS Charitable Fund

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

Charitable funds received by the Charity are accepted and held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Act 1990 and these funds are held on trust by the corporate body.

The Annual Report and the Annual Accounts of the LAS Charitable Funds for the year ended 31stMarch 2008 are attached for the Board's attention; they have previously been reviewed by the Charitable Funds Committee and the Audit Committee.

4. Recommendation

THAT the Trust Board NOTE the contents of the Annual Report of the LAS Charitable Funds for the year ended 31st March 2008.

Enclosure 16

London Ambulance Service NHS TRUST

Summary of the minutes
Audit Committee - 10th November 2008

1. Chairman of the Committee **Caroline Silver**

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

3. Agreed:

- That the revised Standing Orders and Financial Instructions be presented to the Trust Board for approval in November 2008
- The draft 2008/09 Internal Audit Plan, with two amendments suggested by the Committee.

Noted:

The contents of the following presentations given by members of the Finance Department:

- the progress to date in preparing for the introduction of the International Financial Reporting Standards (IFRS) and the possible impact it may have on the Trust's financial accounting practices.
- the Finance Information Management System (FIMS) and how it is reconciled with the monthly financial reports received by the Trust Board and the Service Development Committee.
- the work being undertaken to improve the Trust's Auditors Local Evaluation score in order to achieve 'excellent' for Use of Resources in 2009-10.
- the web based integrated governance tool, Performance Accelerator, which will be used to gather evidence of compliance for the ALE, the NHSLA, the Healthcare Standards as well as the Trust's Balanced Scorecard.
- the 2009-10 budget planning process;
- the routine work undertaken to reconcile the Balance Sheet and the process for cashflow management.
- The progress that has been made in respect of Reference Costs; the Finance Director will present a report to the Service Development Committee in December.

The Charitable Funds Annual Report and Accounts which will be presented to the Trust Board in November 2008.

The declaration of hospitality by the Chairman of the Trust Board and the Director of Information, Management & Technology.

That consideration will be given as to whether a risk should be placed on the Trust's Risk Register in respect of the potential complexities surrounding the financial treatment of CAD 2010. The Director of Finance said he would discuss the matter with the Director of Information, Management & Technology

Minutes received from:
RCAG, 21st October 2008

Recommendation:

THAT the Trust Board NOTE the minutes of the Audit Committee, 10th November 2008.

LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE
9.30pm, Main Meeting Room, Loman Street SE1

Monday, 10th November 2008

Present:	Caroline Silver	Non-Executive Director (Chair)
	Sarah Waller	Non-Executive Director (from 10.25 until 12.30)
	Brian Huckett	Non-Executive Director
	Roy Griffins	Non-Executive Director (until 12.30)
In Attendance:	Peter Bradley	Chief Executive (until 12.00)
	Mike Dinan	Director of Finance
	Michael John	Financial Controller
	Helen Berry	Head of Financial Management
	Martyn Salter	Corporate Processes Programme Manager
	Ken Thompson	Head Cashier
	Michelle Johnson	Capital Accountant
	Andy Bell	Finance Manager, A&E
	Ashal Odedra	Finance Analyst
	Elizabeth Leramoh	Finance Analyst
	Christine McMahon	Trust Secretary (Minutes)

45/08 Minutes of the last Audit Committee meeting held 8th September 2008 and Matters Arising

Agreed:

1. **The minutes of the last Audit Committee meeting held on 8th September 2008.**

Noted:

2. **Minute 31.08: correspondence has been received from the Inland Revenue seeking further information concerning meal breaks relating to PTS staff. They have also requested to renew the existing dispensation arrangements for a further three/four years. Following a decision by the Inland Revenue the Trust will have discussions with the 31 PCTs concerning the back to back agreement that are in place.**
3. **Minute 31.08: the Finance Director said that to date 19 (an improvement on the figure of 16 reported to the Audit Committee in September) PCTS have signed the 2007/08 Service Level Agreement further to the recommendation contained in the Audit Commission's 2007/08 governance report. Work is on-going to have the remaining agreements signed by both parties. ACTION: Finance Director.**
4. **Minute 34:08: Sue Exton provided the Chief Executive with a paper outlining the assessment criteria used to ascertain a Trust's ALE rating.**

46/08 International Financial Reporting Standards (IFRS) Update

The Financial Controller said that work was ongoing to prepare the Trust prior to the introduction of IFRS in 2009-10.

It was likely that ambulance operating leases will be required to be treated as financial leases, which will affect the Income and Expenditure account and the Balance Sheet. The full impact of this change on the Trust should be known by the end of the month. The matter will be discussed with Commissioners and it may be that additional funding is required to offset the impact on the Trust's Income & Expenditure account.

Work was also being undertaken in respect of the Trust's fixed assets; stock valuation and annual leave to ensure they are accounted for correctly under IFRS. The Trust may

consolidate the Charitable Funds within its accounts although the relatively low value of the Fund may mean it is considered immaterial as it is less than £50k. A further report on the progress of implementing IFRS will be presented to the Committee in March 2009.
ACTION: Financial Controller

Baker Tilly, who has been retained by the Trust to advise on the implications of IFRS, are currently reviewing the Trust's accounting policies.

The Finance Director said that the Finance Directors of the Ambulance Services were working closely to ensure a consistent approach was adopted towards the implementation of segmental reporting e.g. in accordance with the spirit of the IFRS guidance PTS was likely to be treated as the only separate business line, with EBS a possibility, although neither exceed 10% of the Trust's turnover.

47/08 Review of the Trust's external financial reporting process (FIMS)

Finance Information Management System (FIMS) is a financial tool used by the Department of Health to monitor the financial performance of the NHS. The Trust is required to submit an annual financial plan to the London Provider Agency (LPA) which is signed by the Chairman of the Trust Board and the Chief Executive. During the year it, along with other NHS bodies, it is required to submit monthly financial updates and detailed quarterly financial reports and to report any significant variation from the plan to the LPA.

Due to timing issues the FIMS is different from the LAS' annual budget. The Internal and External auditors undertake a reconciliation of the information submitted to the LPA and the monthly financial reports received by the Trust Board/Service Development Committee. This year, as the Director of NHS Finance wishes to submit the NHS accounts to Parliament prior to the summer recess; the deadline for NHS Trusts to submit their final accounts has been brought forward. The Trust is working with the external auditors to ensure that a "hard close" of the accounts takes place at Month 9 and is then audited at month 12 in line with the revised deadline for submission of audited accounts.

The Director of Finance demonstrated the reconciliation of the recently submitted FIMS to the Month 6 financial report received by the Trust Board.

In the past, intra-trust balances have been an issue for the Trust but this has improved in recent years, with the Trust using the dispute resolution mechanism as/when necessary. One of the challenges for the finance department will be accounting for PTS' intra trust balances as Trusts are invoiced for journeys that exceed the amount agreed in the contract agreed between the individual Trust and PTS.

The Finance Director said that the Trust's financial risks (which were reported to the Trust Board as part of the regular financial report) included:

- not achieving the Cost Improvement Programme which was currently £600k;
- not receiving the additional funding for the Olympics
- not receiving the additional funding from the Commissioners due to the Category A8 minute and Category B19 minute performance targets not being achieved.

In previous years there were issues in reconciling the FIMS and the monthly finance report to the Trust Board due to timing differences as the FIMS report was usually required before the monthly finance report had been completed. The Finance Director said that work was being undertaken to create a 'technical bridge' between the FIMS and the monthly financial report to the Trust Board which could be included in the report received by the Trust Board as an added assurance.

Foundation Trusts were not required to submit FIMS to the London SHA as they are regulated by Monitor, who in turn reports to the Department of Health.

48/08 Review criteria of the Auditors Local Evaluation

The Committee reviewed the elements that made up the Trust's current ALE score and the measures that were being adopted to enable the Trust to achieve a rating of 'excellent' for 2009-10. The minimum score required to achieve an excellent (4) rating is two level fours from Financial Management, Financial Standing or Value for Money. The Committee discussed the areas of work being undertaken to improve the Trust's ALE score; these included in particular the liquidity ratio, corporate social responsibility; being more proactive in respect of counter fraud and in addressing the needs of hard to reach communities in society.

It was recognised that to date no ambulance service has achieve excellent for use of resources whilst the majority of Foundation Trusts have achieved an 'excellent' score.

It was noted that the Trust's ALE score will be affected by having only 19 of the 31 PCTs have signed the 2008-09 Service Level Agreements (SLAs). **ACTION: The Chief Executive said he would personally intervene if necessary to ensure that the remainder of the SLAs were signed.**

Performance Accelerator

The Corporate Processes Programme Manager gave a presentation on how the web based integrated governance tool, Performance Accelerator, will be used to evidence and to monitor the Trust's compliance with the ALE.

As/when the Audit Commission changes the definitions of the KLOE[3] the system is automatically updated. The system will be used to gather evidence electronically in respect of the Trust's Risk Register, the Balanced Scorecard etc and is expected to be fully operational by the end of this financial year. In due course, the Non Executives will be able access to the system whereby they would be able to 'drill' down and view the evidence for compliance.

The Committee was assured that there were security safeguards in place to ensure that the integrity of the system was protected. The system enables the Trust to capture the required evidence once, to do so electronically and to have an integrated approach to governance across the Trust.

49/08 Business Planning and budgeting process 2009/10

The Head of Financial Management outlined the 2009-10 budgeting process The 2009/10 financial plan, which will be submitted to the SHA, the Department of Health and for FT preparation, will be developed using the Strategic Resource Model which will feed into the Strategic Financial Model.

The Strategic Resource Model will provide the number of crew staff and vehicles needed for an assumed activity level. This model is reconciled with the information provided by ORH to give baseline resources for a given level of activity. Scenario modelling will be done by flexing assumptions build into the model such as job cycle time, relief %'s etc.

The resources calculated by the Strategic Resource Model will feed into the A&E Resources Model to give the numbers of A&E operational staff by staff group. This information feeds into the Strategic Financial Model which will calculate the cost of the LAS for a given level of activity/service.

Baseline budgets for 2009/10 are calculated for each directorate "top- down"; and will be prepared by each directorate by the end of November. These templates will be completed in conjunction with directors, departmental managers and finance analysts. During the New Year detailed budgets will be built "bottom – up"

[3] KLOE – the individual elements that make up the ALE.

The deadline for SPPPs is 19th December and, following an initial review by the Finance Team, the Strategic Services Group will review the bids in January approving some, deferring others,

It is expected that the deadline for the submission of the 2009-20 financial plan to the SHA will be the end of January although no official notification as yet been received. A draft 2009-10 budget will be presented to the Service Development Committee in December with a further draft (possibly final) budget being presented to the Trust Board in January 2009.

Individual budget holders sign off their annual budgets, in terms of Operations this is done at senior management level i.e. by Area Operation Managers. The ratio of support staff to operational staff was reviewed and benchmarked against other ambulance trusts. Requests for extra resourcing, e.g. additional staffing, was reviewed by the Senior Management team.

The Finance Director said that the major capital projects being undertaken in 2009-10, CAD 2010 and LARP, will result in a decrease in the Trust's cash balances and may require the Trust Board to approve a loan facility.

The Financial Director said that the model produced by ORH was reviewed against data held by the Trust; the recent modelling work undertaken by ORH has suggested that to sustain the Category A8 minute and B19 minute performance targets in 2009-10 the Trust will require approximately 500 additional front line staff. This will be a major investment by the Trust.

50/08 Balance Sheet Reconciliation

The Capital Accountant outlined the process for reconciling the control accounts on the Balance Sheet and outlined the process for monitoring capital expenditure.

It was suggested that consideration should be given as to whether there should be a risk on the Trust's Risk Register in respect of the accounting complexities relating to CAD 2010 and if necessary this will be proposed at the next meeting of the RCAG. **ACTION: Finance Director.** The Finance Director said that the finance team were liaising with the Audit Commission on how the Trust accounted for CAD 2010.

Both the internal and external auditors undertake an annual review of the balance sheet reconciliation process.

The payroll / holiday systems having previously flagged by internal audit, the Committee was assured that there were processes in place to ensure that former members of staff ceased to be on the payroll once they have left the organisation, e.g. AOMS review the monthly nominal rolls to ensure that only current members of staff receive a salary. Nationally, the NHS undertakes an annual review of all NHS payroll records to identify individuals employed by more than one organisation.

51/08 Cashflow management

The Head Cashier gave a presentation outlining the Trust's management of its cashflow. Last year's cashflow management was challenging due to the receipt of £8m from NHS London which had to be spent within the 2007-08 financial year. In general the Trust had a relatively simple and straightforward cashflow cycle.

The annual dividend paid by the Trust (and all NHS Trusts) to the Treasury is a public dividend and reflects the cost of finance to the Trust; unlike the dividend paid by commercial organisations it is not discretionary.

The Trust is required to invest any of its surplus cash with the Paymaster General for which it receives interest. Foundation Trusts have greater freedom in how they invest their surplus cash.

52/08 Reference costs

The Corporate Process Programme Manager and the Finance Director updated the Committee on the progress that has been made in respect of reference costs which built on the work initially undertaken by Vicky Clarke, Senior Finance Manager

The presentation outlined the process adopted to identify appropriate reference costs which were produced using Activity Based Costing principles, e.g. incidents analysed into 96AMPDS main categories; emergency transfers/urgents; major incidents/airports; other; transferred for telephone advice and unclassified/uncoded. Costs excluded included: PTS; HEMS; decontamination and EBS.

For illustrative purposes data was presented using information held concerning Category A 8 minute performance which demonstrated the trend of AMPDS codes was similar year on year. The LAS was fortunate in that it held a lot of information concerning the number of incidents; the type of response despatched; the length of the job cycle etc. Benchmarking has been undertaken with other urban based ambulance services with the LAS falling midway in respect of the reference costs. The Finance Director said that as part of the Ambulance Leadership Forum the Finance Directors were in regular discussion as to how reference costs should be calculated e.g. whether PTS should be included.

The Finance Director said that 'downtime' was treated as an overhead. In 2004-5 the National Audit Office undertook an extensive audit of all the NHS Trust's reference costs.

The 90 or so incidents presented to the Committee will eventually be grouped so as to appear as three or four categories of reference costs.

Noted: The progress to date in respect of reference costs and that a further report will be presented to the Service Development Committee in December. ACTION: Finance Director.

53/08 Review standing orders and financial regulations

Good practice requires the Trust to review its Standing Orders and Financial Regulations on a regular basis. Following the substantial number of amendments made in 2007-08 only a few changes were proposed this year, including the updating of the EU threshold; the introduction of electronic tendering and some minor housekeeping changes reflecting changes in job titles etc.

Following a query from Sarah Waller as to whether the limit was too low, the Finance Director said that he would consider whether the level of £3,000 should be revised upwards.
ACTION: Financial Director

Agreed: That the revised draft of the Standing Orders and Financial Regulations be presented to the Trust Board for its approval with the recent amendments to the terms of reference agreed by the Audit Committee and the Clinical Governance Committee being visible.

54/08 2008/09 Audit Plan

Agreed 1. The draft audit plan submitted to the Committee with the addition of two further audits;

- **an audit to provide assurance in respect of the Risk Management & Assurance Framework**
- **an audit to be undertaken following the introduction of a new policy/procedure/other important update to ascertain its implementation and adoption across the Trust.**

Noted: 2. That the amended 2008-09 Audit Plan and a copy of the Trust's Risk Register will be forwarded to the Chairman of the Audit Committee who

will discuss the proposed 2008-09 audit plan with RSM Bentley Jennison. ACTION: Chairman of the Audit Committee.

55/08 Receive Charitable Funds Annual Accounts

The Financial Controller presented the Charitable Funds Annual Accounts which were approved by the Charitable Funds Annual Committee meeting on 8th September 2008. Following their presentation to the Trust Board they will be submitted to the Charity Commission.

Noted:
1. **That the value of the Fund had fallen by 25% between 31st March 2007 and 31st March 2008 and it was likely that it has fallen further given the recent fall in share prices on the Stock Market.**
2. **That the Fund had higher than expected income due a charitable donation received from the Edhi Foundation, and higher than forecasted expenditure.**
3. **That following consideration of the investment policy adopted by Investec the Committee had recognised that it would be unwise to change its investment strategy at this moment in time, but would keep the matter under review.**

56/08 Standing Committee Items

Noted:
1. **The declarations of hospitality by the Chairman of the Trust Board and the Director of IM&T.**
2. **That there was no waiving of the Standing Orders since the Committee met in June 2008.**

57/08 Draft minutes of the Risk Compliance and Assurance Group (RCAG)

In the absence of the Chief Executive, the Finance Director (who was unable to attend the recent RCAG meeting) presented the draft summary sheet and draft minutes of the recent RCAG meeting. The Chairman of the Audit Committee, who is a member of the RCAG and was at the meeting, said the summary of the minutes reflected what was discussed and the decisions taken at the meeting. In particular, the RCAG had discussed the need for better management of morphine on stations.

Noted: The draft minutes of the RCAG meeting, 21st October 2008.

58/08 Audit Committee work plan and timetable for meetings in 2009.

Noted:
1. **That it was not thought necessary to have any work around Foundation Trust discussed by the Audit Committee as it was being discussed on a regular basis by the Trust Board and the Service Development Committee.**
2. **That the meeting in November 2009 will focus in more detail on FIMS and the reconciliation of the Control Accounts. ACTION: Finance Director**

59/08 Any Other Business

Date of next Audit Committee meeting: 2.30pm, 3rd March 2009, Conference Room, LAS HQ which will be preceded at 2.15pm by a private meeting between the Audit Committee and the Auditors.

Meeting finished at 12.45

Enclosure 17

London Ambulance Service NHS TRUST

Summary of the minutes
Clinical Governance Committee - 12th November 2008

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

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

3. Agreed:

1. Minor changes to the Committee's Terms of Reference i.e. job titles and included receipt of an annual report from PTS and BASICs.
2. To approve and ratify a number of policies and procedures which had either being drafted or revised as part of the NHSLA Level 1 assessment. The Trust successfully passed the clinically related standards with further work to be undertaken in other areas, there has been good progress made in completing the action plan drawn up to address those other areas.

Noted:

3. That three themes emerged from the Areas' Clinical Governance reports:
   - a decrease in the level of training that was taking place at complex level due to the Complex Trainers being required to train the recently recruited Student Paramedics.
   - Operational pressures and a high vacancy amongst Team Leaders has led to a fall in the level of PRFs being reviewed, with the overall level of CPI completion falling to 30%.
4. The need for all vehicle drivers to undertake a full Vehicle Daily Inspections (VDI) as soon as practically possible, as drivers were responsible in law for the roadworthiness of the vehicles they were driving .Front line staff have been provided with record sheets to record the VDI which they are expected to undertake at the start of their shift.
5. The approach being adopted by the Trust to the DH's End of Life Care Strategy and that the Trust will be discussing the implications of the Strategy with PCTS and Commissioners.
6. The implications of the Mental Health Act for the Trust.
7. The progress to date in implementing the action plans that were in place to mitigate the clinical risks included on the Trust's Risk Register
8. That the Trust has appointed an Infection Control Co-ordinator, AOM Trevor Hubbard, on a part time, interim basis.
   Work has commenced to implement the DH's 'clean hands' infection control campaign and the Committee will be kept informed of progress.
9. That it was highly probable that as the Trust was under 'severe pressure' there will be an increase in the receipt of complaints due to possible delays in responses.
10. That the Trust's Solicitors were reviewing the revised High Risk Address Register policy; it will be presented in due course to the Trust Board for approval.
11. That the Trust has appointed a Diversity Manager, Janice Mackay, who will be taking up her post with effect from 1st December 2008.
12. The contents of the Medical Director's report
13. The contents of the Risk Information Report

Minutes/oral reports received from:

14. Infection Control Group (7/11/08) It was noted that in future every patient must receive a fresh red blanket, the used blankets are exchanged at hospital, however there is a continuing shortage of red blankets
15. PPI Committee (6/10/08) It was noted that the pilot staff development programme in public education had commenced. Tower Hamlets pregnant women and their spouses had welcomed life support training. The Silvertown ambulance staff were commencing a 2nd course in Bengali;
16. Clinical Audit Research Steering Group (17/10/08) The LAS has been awarded a research project grant by the Stroke Association;
17. Clinical Steering Group (20/10/08) The difficulties in accessing intubation training were noted
18. Training Services Group (20/10/08).
19. RCAG (21/10/08);
20. That the SfBH Group; the Race Equality Strategy Group and the Complaints Panel (reconstituted as the Feedback, Learning and Improvement Group' have not met since the last CGC meeting (August 08).

Recommendation:

THAT the Trust Board NOTE the draft minutes of the Clinical Governance Committee, 4th August 2008.

LONDON AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee (full)
2.30pm, 12th November 2008, Burns Room, Union Jack Club

Present:

Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore (Vice chair)	Medical Director
Nicola Foad	Head of Legal Services
Stephen Moore	Head of Records Management & Business Continuity
David Selwood	Corporate Logistics Manager (deputising for Head of Operational Support)
Margaret Vander	PPI Manager
Gary Bassett	Head of Patient Experiences (formerly Complaints/ PALS Manager)
Tony Crabtree	Assistant Director, Employee Support Services (from 3.05-until 4.10)
Gurkamal Virdi	Assistant Head of Clinical Audit (deputising for Head of Clinical Audit & Research)
Phil Flower	Assistant Director of Operations, Control Services
Stephen Hines	Clinical Support Manager, UOC (until 4.10)
Martin Cook	Acting ADO South (deputising for ADO, South)
Paul Gates	Acting ADO East (deputising for ADO, East) (until 4.10)
Jon Knott	Acting ADO West (deputising for ADO, West)
Keith Miller	Clinical Education Manger (deputising for Assistant Director, Organisation Development)
Matthew Barker	Interim Head of Governance
Christine McMahon	Trust Secretary (minutes)

In attendance:

Dr Fenella Wrigley	Assistant Medical Director, Control Services

Apologies

Sarah Waller	Non Executive Director
Ingrid Prescod	Non Executive Director
John Selby	Senior Health & Safety Adviser
Bill O Neill	Assistant Director, Operations Development
Rachael Donohoe	Head of Clinical Audit & Research
Richard Webber	Deputy Director of Operations
Paul Woodrow	Assistant Director of Operations (ADO), South
Peter McKenna	ADO West
Jason Killens	ADO East
Lizzy Boville	ADO
Chris Vale	Head of Operational Support
Paul Tattam	Ambulance Operations Manager - D Watch

The Chairman welcomed Phil Flowers, ADO Control who recently joined the LAS and Dr Fenella Wrigley, Assistant Medical Director, Control Services

55/08 Minutes of the Clinical Governance meeting held on 4th August 2008

Agreed The minutes of the previous meetings held on 4th August 2008.

56/08 Matters Arising

Noted:

1. ***Minute 42/08:*** **That AOM Trevor Hubbard, who has a nursing background, has been appointed as the Trust's part time, interim Infection Control Co-ordinator.**
2. ***Minute 42/08(6)*****: the data collected concerning the Audit of Clinical Telephone Advice (CTA) calls will be shared with CARU. ACTION: ADO, Control Services**
3. ***Minute 42/08 9(11):*** **the Trust has appointed Janice Mackay as Diversity Manager and she will be joining the Trust on 1st December 2008.**
4. ***Minute 45/08:*** **the ADO Control said that the random review of PSIAM had been included within a general review of the CTA function and the findings will be presented to the next Clinical Governance Committee. ACTION: ADO, Control Services**
5. ***Minute 45/08:*** **it was generally agreed that being at REAP level 3 would see an increase in complaints as delays in responding to calls will result in an increase in the level of complaints.**

6. ***Minute 47/08:*** **the Head of Patient Experiences said that the High Risk Address was being reviewed at complex level and managed by Management Information. The draft revised High Risk Address policy was currently being reviewed by the Trust's Solicitors and would be presented to the Trust Board for formal adoption in due course. The Trust will commence writing to those patients maintained on the High Risk Address Register as soon as possible accordingly.**
7. ***Minute 53/08:*** **the Corporate Logistics Manager said that work has commenced in implementing the 'clean hands' campaign, and adapting it for the ambulance service. For example, the LAS has suggested that regional local champions are recruited rather than 72 local champions from each ambulance station. 13 products will be introduced during the next few months to enable front line staff to comply with the guidance in the 'clean hands' campaign. Work was also being undertaken to review the configuration of the ambulance's interior so as to accommodate the increasing amount of kit that is being required. The Chairman of the Committee said that Baroness Young, Chairman of the Care Quality Commission, will be visiting the LAS and representation will be made in respect of the national health guidelines and how they needed to be made more relevant for the ambulance service.**
8. **That the Complaints Panel is to be reconstituted as the 'Feedback, Learning & Improvements Group' with the objective of enabling the Trust to evidence the development of the LAS as a learning organisation with a focus on using feedback as a driver for change and improvements.**

57/08 **Clinical Governance Committee's terms of reference**

The Chairman of the Clinical Governance Committee, in response to a question from the ADO, Control said that the Committee was more of an integrated governance committee rather than focussing solely on clinical matters.

Noted

1. **That a few of the job titles required amending e.g. Emergency Medicine Consultant. ACTION: Trust Secretary**
2. **That the following will be asked to provide an annual report to the Committee:**
   - **BASICs ACTION: E&M Consultant St Mary's**
   - **other Voluntary Agencies ACTION: Deputy Director of Operations**
   - **PTS ACTION: Head of PTS Modernisation**

58/08 **Area Governance Report**

Control Services:

The ADO Control presented the report for Control Services

- Call taking performance had slipped from 95% to 93% in September due in part to the CTAK system failing four times in the last few weeks.
- With staff side support the shift pattern in Control was reviewed so that there was additional staffing at times of higher demand.
- Demand in September was high, with an extra 5500 calls received. A significant percentage, 60% were Red calls which had a knock on impact on the Trust being able to achieve 75% Category A8 minute performance target.
- Following discussions with the Director of IM&T it has been agreed that in order to maintain the stability of the CTAK system there will be a minimum of upgrades undertaken until after the Christmas/New Year period.
- The Clinical Support Desk has been increasingly utilised by both front line staff and Control Room members of staff. Efforts are on-going to recruit to full establishment.
- A project is being undertaken in conjunction with CAMIDOC to evaluate the role of General Practitioners in providing Medical Support to the Control Room.
- Work around quality assuring the interpreting service provided by LanguageLine was being

undertaken. The Assistant Head of Clinical Audit said that as LanguageLine was on the PASA Framework it would have had to evidence a high degree of quality assurance, e.g. ISO 9000.

The Clinical Support Desk Manager gave a brief report on the work undertaken by the Clinical Support Desk. In addition to providing clinical support to colleagues the members of staff were also reviewing

the Palliative Care files to ensure they were kept current. The Clinical Support Desk Manager was hopeful that the Support Desk would be at full establishment by Christmas 2008.

One of the pieces of work undertaken by the Clinical Support Desk (CSD) is identifying potentially serious incidents that were not triaged using AMPDS, e.g. when critical transfers were being requested key words had to be used in order for the correct response to be obtained. The LAS feedbacks to the national AMPDS group on the anomalies it has identified.

The Committee was informed of work that the CSD has undertaken with other Healthcare Providers in respect of a bariatric patient and a patient under Section 106, both of whom were experiencing delays in being admitted to hospital.

The CGC noted that the work of the CSD was increasing exponentially, which was not sustainable with the existing staffing. A considerable amount of time was taken up with administrative issues in particular PSPs and palliative care plans

East Area:

The A/ADO East presented the Area's Clinical Governance report and highlighted the following:

- The level of CPI completion had fallen by 20% since August; efforts were ongoing to improve the completion of CPIs by having additional staff trained to complete the CPIs. Of those CPIs that have been undertaken there were positive trends in regards to the delivery of care.
- The Area's next report to the Committee will include an analysis of complaints received which will include a review of factors such as the time of day/the nature of the shift or how the call was presented by Control to the crews. Multidisciplinary Forums – further work is required to ensure that these forums fulfil the expectations that Commissioners have and to have full PCT involvement. The Interim Head of Governance suggested that 3-6 months a report should be presented to the Commissioners on joint working arrangements. The introduction of world class commissioning should assist in enforcing this.

The Assistant Head of Clinical Audit and Research clarified that in respect of FR2 95% data this is based on the small number of PRFs audited only and that across the LAS less than 20% of FR2 data cards are being downloaded.

South Area:

The A/ADO South presented the Area's Clinical Governance report and highlighted the following:

- The level of CPI completion had fallen
- Posters will be placed on complexes highlighting the experience of patients
- The level of PDR completed has been uneven across the Area with some complexes having high levels of completion whilst others have faced challenges
- LA52s – DSOs making sure checking and investigation, records keeping not being looked at complex by Health & Safety representatives.
- Due to the Trust's focus on recruiting additional front line staff the Areas have less training resources than normal; the Clinical Education Manager said that the current shortfall of trainers on complexes should be addressed with the addition of 18 new trainers in the early part of 2009.
- The South Area's health and safety meetings have governance as a standing item on their agenda and a case study is considered at every meeting.
- Multidisciplinary forums: there were four multidisciplinary panels operating in the South and the next report to the Clinical Governance Committee would contain details on the work being undertaken.

The Committee's Chairman suggested that members of staff were more likely to complete LA52s in respect of a failure in equipment or other NHS professionals. It was recognised that the culture of the organisation and the NHS in general is not to report near misses because of fear of recrimination. The Medical Director indicated that work was being done to encourage front line staff to do so in order that learning can be shared across the organisation.

The Medical Director said that the rate of CPI completion was poor at 30%. The Assistant Head of Clinical Audit said to ensure accuracy of reporting that CARU can provide the Areas with comprehensive reports concerning the level of CPI completion for their respective clinical governance reports.

There was a discussion concerning the requirement that all members of staff who drive LAS vehicles undertake a VDI check prior to driving on the road so as to assure themselves that the vehicle is roadworthy. A "short" VDI,(taking 2-3 minutes) could be used if called out immediately on starting a shift, however this was no substitute for a full VDI, which should be undertaken as soon as practically possible, as this was the law. Staff will be provided with pads to record the daily VDI of the vehicle as well tyre gauges to ensure that the tyres are at the correct pressure.

West Area

The A/ADO West presented the Area Clinical Governance Reporting, and highlighted:

- That work was being undertaken in respect of the complaints received, the majority of which were concerned with attitude and behaviour, to analyse whether the correct triage was undertaken by AMPDS and if this could have been a contributory factor to incidents that gave rise to complaints about attitude and behaviour. An example of the approach adopted in response to a complaint whereby a front line member of staff undertook reflective journal as part of a learning exercise which was found to be productive, in addition the member of staff was given a four week rotation in a paediatric clinic. The Head of Patient Experiences complimented colleagues on this learning approach and offered his support accordingly.
- Work was being undertaken with the director of Operations in Barnet Local Authority and local Police Service concerning addresses on the High Risk Address Register with information being shared to ensure that records were kept up to date as possible. Similar work is also being undertaken by the AOM for Hanwell. In addition, multidisciplinary work was taking place concerning under age drinkers with information being shared with the necessary authorities as/when necessary.
- Driving licence checks were part of the ongoing PDR process and were a standing item at the local governance meetings. Measures were being taken to ensure that additional training was offered to crews who had more than one RTA. The introduction of the daily record of VDI should decrease the number of 'Found on Inspection' reported by the workshops. The Committee was informed that as/when a central database for vehicles is introduced it will be it will assist with capturing the data on RTAs and FOIs.

The Committee NOTED that a common theme in the Area reports was the shortfall of Training Officers due to the focus on training the Student Paramedics which should be addressed by a further cohort of Training Officers being trained and available to the Areas within the next two/three months. The additional members of front line staff will also facilitate current members of staff being able to be released for training.

59/08 Medical Directorate Update

The Medical Director introduced Fenella Wrigley, Consultant in Emergency Medicine at the Royal London Hospital, who has been appointed Assistant Medical Director with responsibility for Control Services. Dr Daryl Mohammed, Assistant Medical Director (Primary Care) will be extending his role to assist the team managing the South Area. He will continue to support the ECP Programme. Funding has been secured for two further part time Assistant Medical Director posts. Andrew Lingen Stallard has taken up his post as Consultant Midwife Adviser to the LAS. Andrew is acting as a point

of contact for Obstetrics Units, attending the Heads of Midwifery meetings, advising on our protocols and teaching, and providing opinions on potential claims and enquires.

Healthcare Commission rating: the LAS has been rated as 'good' and 'good' for both its quality of services and use of resources for the second year in succession.

NHSLA Level 1: the Trust successfully passed the clinically related standards with further work to be undertaken in other areas; there is an improvement plan in place which if completed successfully by November 21st should allow us to pass all the required standards.

NICE guidelines: the only new NICE Guidance of relevance to ambulance services relates to the management of acute Stroke. The LAS has already implemented the pre hospital guidance. A decision was awaited from Healthcare for London to take forward the next steps in targeting hyperacute stroke units for both thrombolysis and rehabilitation.

Drugs: Oral morphine solution has finally been introduced following negotiations with Frimley Park Pharmacy who agreed to repackage the drug in 20 ml aliquots, Boehringer Engleheim having withdrawn all but the 200 ml bottles. The Directors of Clinical Care, along with some of their allied Pharmacists, are pressing the MHRA to reintroduce Unit Drug Vials of oral morphine solution as a cheaper and more consistently available solution.

Cardiac Care Strategy: survival to discharge following out of hospital cardiac arrest (calculated on the Utstein template) was 15.8% for the year 2006/07. The results for 2007/08 are an Utstein survival rate to survival of 12%. ROSC figures exceeding those of the preceding year. Patients resuscitated following VF arrest in a public place, where a defibrillator has been available and accessed, continue to have a much higher survival rate.

All patients with STEMI diagnosed by LAS staff are currently taken direct to the nearest of the eight locations in London offering primary angioplasty (Heart Attack Centres HACs). A trial is underway in East London where non STEMIs are taken directly to the London Chest Hospital. A pan London randomised trail (the DANCE study) is planned with all HACS prepared to sign up.

60/08 **Clinical policies/procedures**

The Committee **APPROVED or RATIFIED** the following new over-aching policies to illustrate use of JRCALC guidelines and outline roles and responsibilities of staff: The policies were circulated two weeks prior to the Committee meeting to allow adequate time for members of the Committee to review and raise any queries prior to the meeting.

RATIFIED:

1. *Paediatrics* following clarification as to CARU's role.
2. *Resuscitation,* following amendments to the identified responsible post holders (e.g. Head of Clinical Governance) and clarification as to CARU's role.
3. *Obstetrics,*
   ACTION: A/Head of CARU to provide Head of Record Management with appropriate wording to include in the policy re. auditing of Obstetrics CPI.
   ACTION: Interim Head of Governance to amend reference to conveyance to new born babies in section 6.3
4. *Emergency Care Practitioner*
5. *Advising Staff where Deviation from Guidelines is considered*

APPROVED:

6. *Community First Responders*
   ACTION: further feedback from colleagues (e.g. Assistant Director – Employee Support Services and the AOM Waterloo, the Local Community First Responder Co-ordinator)
   NOTED: that as the Community First Responders were not included within the CPI process consideration should be given to developing a mechanism put in place to record their clinical performance). ACTION: Assistant Head of Clinical Audit and Research

Comment [B H D1]: What is this for?

NOTED: that the Committee will receive an update on this policy at its meeting in April 2009. ACTION: Interim Head of Governance

7. *Re-presentation of Frequent Callers Policy: ACTION:* deletion of reference to the LAS having a legal duty to attend a call where key symptoms are reported.

61/08 Additional policies relating to risk management for approval

The contents of the following policies and procedures were reviewed in order to meet the requirements of the NHSLA Risk Management Standards for Ambulance Trusts. The following policies and procedures were circulated two weeks in advance of the meeting to enable members of the Committee to consider the contents and raise any queries prior to the meeting. The Committee **APPROVED** the following polices/procedures:

Hygiene, Infection Prevention and Control

- Infection Control Policy,
- Infection Control Co-ordinator role
- Infection Control Manual

Risk Management Learning

- Health, Safety & Risk Management Training & Provision of Health & Safety Information (including Training Needs Analysis, Education and Development Plan 2008/09)
- Policy Statement on Staff Induction

The Policy for Pre-Hospital Blood Taking

OP/028 The Procedure for Patient Specific Plans

OP/032 the Alternative Response Procedure

ACTION: Head of Records Management to incorporate amendments suggested by the Head of Patient Experience and the Medical Director within the document.

NOTED: that due to the Manual Handling policy not being completed in time to present to the Committee approval will be sought from the Senior Management Group prior to its submission to the NHSLA. ACTION: the Manual Handling policy to be presented to the Clinical Governance Committee in February 2009.

POST MEETING UPDATE: the following documents were approved by the Senior Management Team at their weekly diary meeting on 17th November 2008:

- Hand Hygiene and Care Policy; Organisational Learning and Improvement through Feedback
- Complaints, Incidents and Claims and Manual Handling Policy.

The Senior Management Group was pleased to hear from the Medical Director that the documents had been discussed in detail and consider by subject matter experts as well as being formally reviewed at Clinical Governance Committee.

62/08 End of Life Care Strategy

The Medical Director gave a brief presentation on how the Trust was implementing the Department of Health's End of Life Care Strategy. Work will be undertaken to enhance the knowledge and confidence of front line members of staff so as to offer suitable treatment to patients who are at the end of their lives in order that they can remain at home e.g. staff can legally administer a named drug for a named patient if that drug is in the house (with the proviso that only Paramedics undertake intravenous injections); it is acceptable to stop resuscitation if there is sufficient evidence that of End of Life Care plan and it is acceptable in many circumstances to hold the patient's hand and allow them to quietly die.

The End of Life Care Strategy is based on the best available evidence and builds upon the experience(s) of hospices and specialist palliative care services as well as the Marie Curie Delivering Choice Programme. There will be specific modules in the induction and Continuing Professional Development

courses that will address the issues that can arise when crews are called to attend patients who are at the end of their lives.

Noted:

1. **The contents of the End of Life Care Strategy**
2. **That the LAS is in discussion with PCTs and Commissioners concerning the End of Life Care Strategy.**
3. **That discussions will take place with AMPDS regarding the inclusion of a specific patient category applicable to patients who are affected by the End of Life Care Strategy and a predetermined response time included (to be agreed with the Commissioners).**
4. **That the Trust has forged very good links with Palliative Care Teams on pan London basis.**
5. **That the Clinical Support Desk has been contacted by front line staff for guidance when they were attending someone who is at the end of their life.**
6. **That the different ethnic communities in London will have different attitudes and ceremonies relating to death which front line staff need to be sensitive to.**

63/08 Update re. Stroke

The Head of Policy, Evaluation and Development updated the Committee on the approach being adopted in respect of Stroke. A further report will be presented to the Trust Board in November, requesting that the Trust Board support the approach outlined below.

Noted:

1. **That Several factors are driving acute stroke care in London:**
   - **Healthcare for London's (HfL) Stroke Strategy For London**
   - **Availability of 24/7 access to screening, assessment and thrombolysis at certain units in London and the LAS' eagerness to take advantage of this**
   - **PCT requests to divert their patients away from sites with poor outcomes/towards sites with better outcomes.**
   - **That HfL's process for designating Hyper Acute Stroke Units and the time permitted for their development of services mean it will be well into 2010 before a pan London network is fully established.**
2. ***2.*** **That the risk of undermining the public consultation can be avoided by openly engaging with PCTs to set up pathways for their patients into existing 24/7 stroke units *pending the development of local options as part of the HFL process.***
3. **Apart from internal communications the only requirement for LAS to deliver this would be the upgrading of strokes (where onset of symptoms was within 2 hours) to Red from Amber on AMPDS.**

64/08 Implications of changes to the Mental Health Act

The Head of Policy, Evaluation and Development updated the Committee on the implications of the recent changes to the Mental Health Act, which were effective as from 1st November 2008.

Noted:

1. **That the Approved Social Worker (ASW) title has been replaced with Approved Mental Health Professional (AMHP). For ambulance staff about which crews will need to be informed.**
2. **That the new legislation allows for patients to be moved between several locations as long as they are assessed within 72 hours of the original detention. This means that patients can be moved from (for instance) the Emergency Department to a more appropriate setting. This change will need to be cascaded to staff.**

3. **That the introduction 'Supervised Community Treatment Orders' or 'CTOs' allows for a patient to be discharged from hospital to continue treatment at their, or a relative's home. If the conditions of the order are broken then it can be revoked and the patient returned to hospital for detention.**
4. **That having undertaken discussions with Camden PCT it appears that the role of the LAS in this process will be no different to that of Section 135 assessments. The volume of recalls from CTOs is expected to be very low. Current estimates are for about 50 such orders to be revoked, per month, across London.**
5. **That these changes will be communicated to staff through articles in the Routine Information Bulletin (RIB), the LAS News and through cascading a briefing by local Mental Health 'champions,' the Clinical Support Desk and the Department of Education and Development.**

65/08 **Clinical Risk**

The Committee received an update on the clinical risks on the Trust's Risk Register including the progress made with action plans that are in place to mitigate clinical risks on the Risk Register.

Noted: **The progress to date in implementing the action plans that were in place to mitigate the clinical risks included on the Trust's Risk Register.**

66/08 **Risk Information Report**

The Committee received the Risk Information Report which covered two quarters between the period 1st April to 30th September 2008. It analyses themes and trends that have been identified in each section.

Incident Reporting

- The report outlines the total number of clinical incidents reported to the Safety and Risk Department based on LA52 completion.
- In total 539 clinical incidents were reported, with 121 of these recorded as having an impact on the patient (Q2=63 [191]; Q3=58 [227]).
- When comparing the total number of clinical incidents reported in quarter 1, there is a slight decrease in actual and near miss incidents.

Clinical Negligence Claims, Potential Claims and Contentious Inquests

- The report identifies the caseload opened and emerging themes.
- Of the 514 inquiries by Coroner's Officers between 1 April 2008 and 30 September 2008 in respect of inquests where the Trust was asked to provide documentary and / or oral evidence fourteen inquests were deemed to be contentious for the Trust
- A round table review of clinical negligence / contentious inquest files closed between 1 April and 30 September 2008 was conducted on 9 October 2008 to identify the individual and organisation learning and to recommend any further action to Clinical Governance Committee and Risk Compliance and Assurance Group. The output from the review is reported in Table 3 and 4 of the report.

PALS and Complaints

- The report highlights the issues of delay and attitude and behaviour linkage which continues to be the subject of poor patient and stakeholder experience. It details recent measures that have been implemented to improve performance and address the issue of patient consent to non-conveyance.
    - 62 % of written complaints have been concluded within 25 working days.
    - 168 out of the 214 complaints received in the period required an acknowledgement and of these only
    - 1 exceeded 2 days. 3 complainants progressed to the Healthcare Commission.

- Outcome reporting requires complete a review as currently this is measured by completion rather than quality and should reflect agreed actions once the case has been completed.

- The Head of Patient Experiences also explained that Making Experiences Count programme and the moving towards analysis of the totality of feedback rather than the historic focus on 'complaints'. RTPC and the DH support this approach.

- The PALS/Complaints functions have been combined and the department will be henceforth be known as the Patient Experiences Department. The Head of Patients Experience said that work was ongoing with the Healthcare Commission (and its successor the Care Quality Commission) and the Ombudsman on the small number of complaints that the Trust has not been able to resolve locally.

Work was being undertaken regarding a policy for dealing with intoxicated and violent patients which will be presented for approval to SMG in December, and a policy on Statement of Duties will be presented to the RCAG in February 2009.

The DVD that was co-produced with the Metropolitan Police concerning positional asphyxia was considered to be very informative but that further work was required to ensure that front line crews were aware of the need to continually monitor patients who were being restrained whilst being transported to hospital. It was suggested that rather than an additional DVD being produced the issue for LAS crews could be addressed by additional dialogue being added to the voiceover at the close of the DVD, and by Trainers/DSOs having discussions with front line staff when the DVD was shown in training sessions.

There had been concern voiced at the Round Table held to identify lessons from claims and incidents concerning the level of CPD training being undertaken by the Trust. The Medical Director said that Senior Management Team had recently received a report confirming that 2000 front line members of staff had accessed at least on of the modules in the last two years with 320 front line members of staff not accessing any. It was anticipated that following the training and subsequent deployment of the recently recruited members of staff, existing members of staff will be able to attend the current and additional modules that will be rolled out in 2009.

Noted:
1. **That further efforts would be undertaken to ensure that there is greater analysis undertaken of the trends discerned by the different departments that contribute to the report in order to identify any learning for the Trust. ACTION: Interim Head of Governance**
2. **That the Chairman of the Committee requested that graphical information be presented where possible to illustrate trends.**

67/08 **<u>Review Assurance Framework</u>**

The Interim Head of Governance said that the Trust was using the web based tool, Performance Accelerator, to electronically capture evidence of compliance which will also facilitate monitoring of the Assurance Framework

Noted: **That the Trust was using Performance Accelerator to evidence and monitor compliance with the Assurance Framework**

68/08 **<u>Preparation for Annual Health Check 2008-09</u>**

Noted: **That the Trust was using Performance Accelerator to evidence and monitor compliance with the requirements of the Annual Health Check 2008/09.**

69/08 **Update re. compliance with NHSLA standards**

The Committee received a progress report as to the Trust's compliance with the NHSLA Level 1 standards and what were the outstanding areas of work.

Noted:
1. **The progress in implementing the action plan arising from the initial NHSLA Level 1 assessment, there are two deadlines for completion of the work, 21st November and mid December, and the Trust is on schedule to meet both those deadlines.**
2. **That Laila Abraham has been appointed Interim Head of Governance following Matthew Barker's appointment as Transformation Workstream Lead by St George's NHS Acute Trust.**

70/08 **Reports from Groups/Committees**

1 *Risk Compliance & Assurance Group – 21st October 2008*

Noted: **The minutes of the RCAG meeting that took place on 21st October 2008**

2 *Patient Pubic Involvement Committee – 6th October 2008*

Noted: **The minutes of the recent Patient Public Involvement Committee meeting. The PPI Manager highlighted the following from the minutes:**
- **The commencement of the pilot public education staff development programme**
- **The undertaking of the first emergency life support training session for pregnant women in Tower Hamlets**
- **The continuance of the Bengali lessons for staff based at Silvertown ambulance station**
- **The appointment of Community Involvements Officers by the two NWOW complexes: Barnehurst and Chase Farm.**
- **That work had begun in relation to the recruitment of members for the Foundation Trust application.**

3 *The Infection Control Group, 7th November 2008*

Noted: **The oral update provided by Corporate Logistics Manager, who highlighted that:**
- **work was being undertaken in respect of the red blankets used on ambulances ; these will be swapped out by crews when they transport patients to hospital**
- **front line crews will need to be familiarised with the new process for cannulation**
- **work was being undertaken by the Emergency Preparedness Unit & the Business Continuity Group on the possible practical implications for the Trust of an event such as Pandemic Flu e.g. the impact on the service provided by the Logistics department to the rest of the Trust.**

4 *Clinical Steering Group, 20th October 2008*

Noted: **The oral update provided by the Medical Director; the Clinical Steering Group discussed airway management and the challenges the Trust will face in accessing hospital placements for new members of staff (including student paramedics) to learn and practice advanced airway management.**

5 *CARSG – 17th October 2008*

Noted:

1. **The minutes of the recent Clinical Audit & Research Steering Group meeting. The Medical Director highlighted that:**
   - **The LAS has been awarded a research project grant by the Stoke Association**
   - **That the LAS was a member of two national groups, National Ambulance Research Steering Group (aligns research resources across Ambulance Trusts, raises the profile of research and encourages evidence based practice) and the National Ambulance Clinical Audit Steering Group (develops collaborative projects, including National Clinical Performance Indicators).**
   - **National Clinical Performance Indicators have been developed in the areas of: STEMI; cardiac arrest; stroke; hypoglycaemia and asthma. Each Ambulance Trust has been asked to report fortnightly on one indicator as an ongoing quality improvement measure. The administration of Morphine for STEMI patients will be reported fortnightly as part of the National Clinical Performance Indicators.**
   - **Furosemide audit has been reinstated into CARU's work plan.**
2. **That an interim Head of CARU has been appointed whilst Rachael Donohue was on maternity leave and is expected to take up the post in November 2008.**

6 *Training Services Group, 20th October 2008*

Noted: **The oral update provided by the Clinical Education Manger concerning the Training Services Group meeting on 20th October 2008; the focus of meeting in October had been the development of the Student Paramedic training course.**

72//08 **Dates of next meeting:**

Full: 2pm 23rd February 2009; Core: 2pm, 27th April 2009

Meeting concluded at 18.15

Enclosure 18

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 25th November 2008

Report of the Trust Secretary
Tenders Received & the Use of the Trust Seal

1. Purpose of Report

i. The Trust's Standing Orders require that tenders received be reported to the Board. Set out below are those tenders received since the last Board meeting.

ii. It is a requirement of Standing Order 32 that all sealings entered into the Sealing Register are reported at the next meeting of the Trust board. Board Members may inspect the register after this meeting should they wish.

2. Tenders Received

There have been 4 tenders received since the last Trust Board meeting.

Romford – extension to increase staff facilities

Building Associates	Millane Contract Services Ltd	Coniston Ltd
Lakehouse Contracts		

AEDs

Zoll	Physio Control	Laerdal

Refurbishment & alteration of 32 Southwark Bridge Road

Building Associates	TCL Granby Ltd	Coniston Ltd
Lakehouse Contracts	Fairhurst Ward Abbotts	

Remodelling of Smithfield Ambulance Service

Expert Property Solutions	Coniston Ltd	Fisk Construction Ltd
Lakehouse Contracts		

3. Use of Seal

There have been 2 entries, 125-126 since the last Trust Board meeting. The entries related to:

No. 125 Assignment Lease of Unit 28 , Bermondsey Trading Estate between the LAS, Servicetec Ltd and Industrial Property Investment Fund

No. 126 Lease re. 4th Floor 46 Loman Street between the LAS and Good Harvest Properties.

4. Recommendations

THAT the Board NOTE this report regarding the receipt of tenders and the use of the seal

Christine McMahon
Trust Secretary

London Ambulance Service
NHS Trust

Information Pack for Trust Board

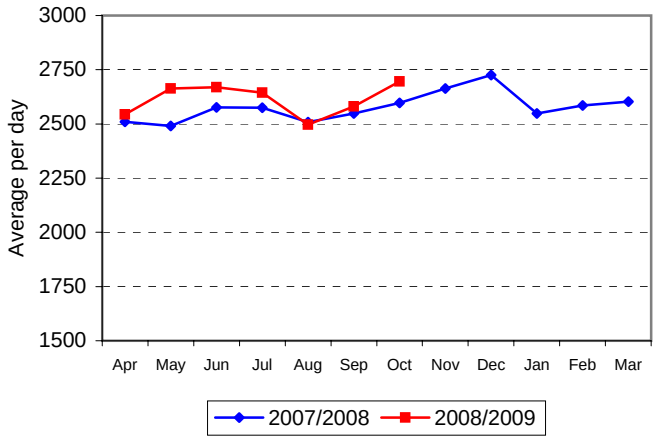
October 08

PRF data entry is not yet complete for October

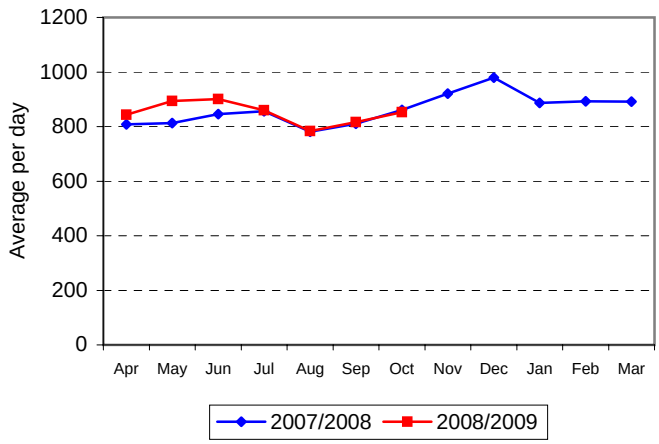
Still awaiting staffing figures from Gareth Hughes

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

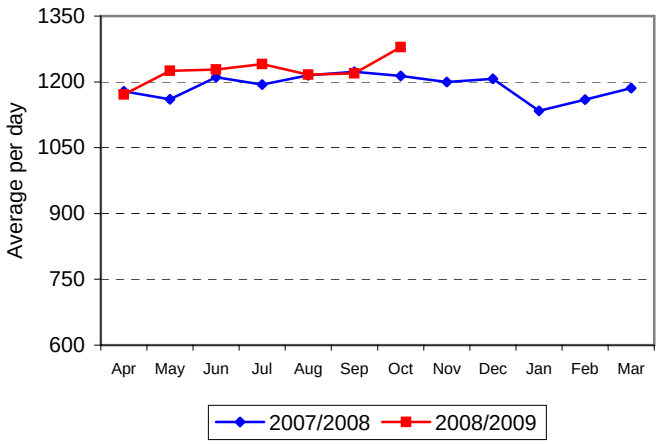
Graph 1
Average number of Cat A, B & C incidents per day



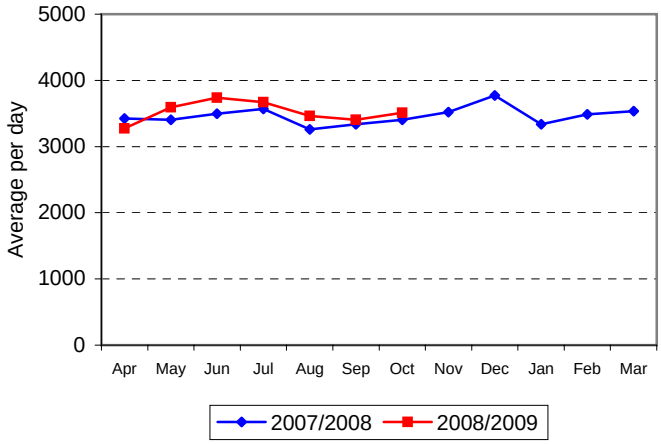
Graph 2
Average number of Cat A incidents per day



Graph 3
Average number of Cat B incidents per day

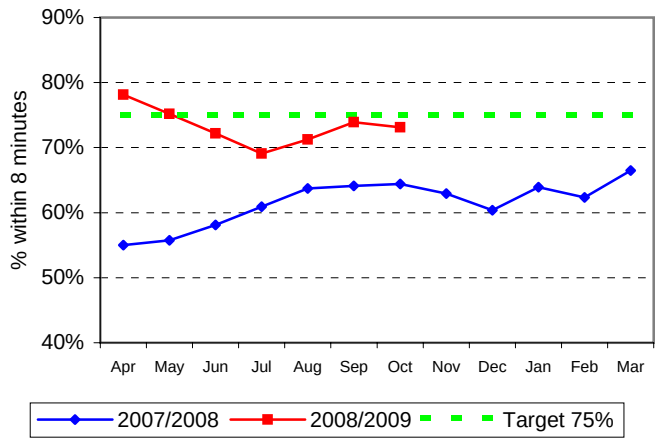


Graph 4
Average number of 999 calls received per day

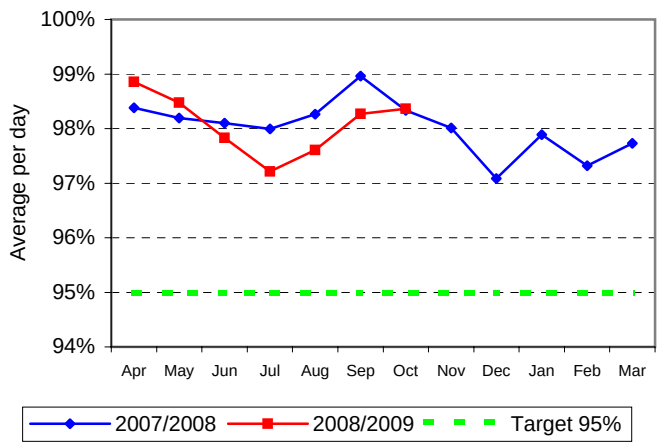


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - October 2008

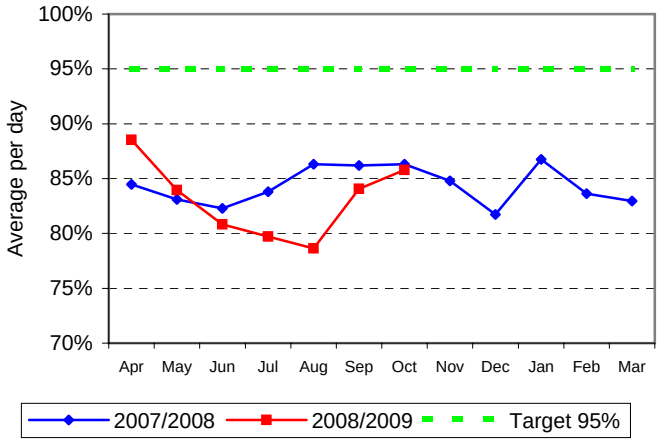
Graph 5
Category A 8 minute performance



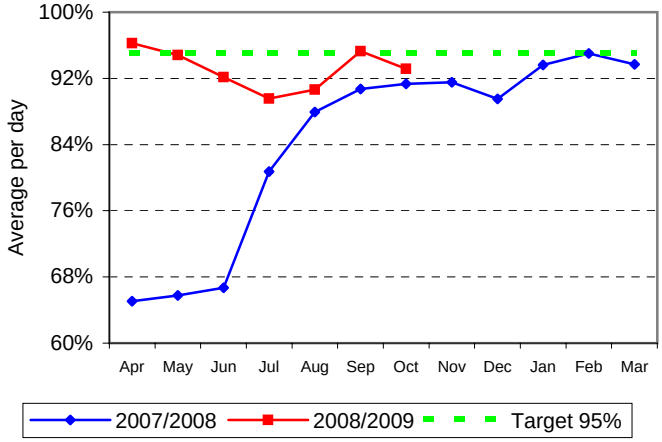
Graph 6
Category A 19 minute performance



Graph 7
Category B 19 minute performance

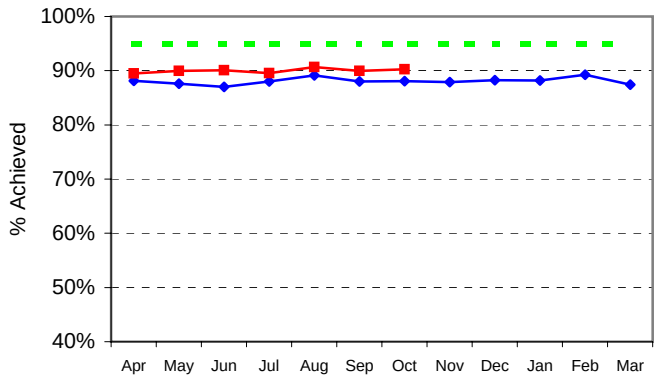


Graph 8
Percentage of calls answered within 5 seconds

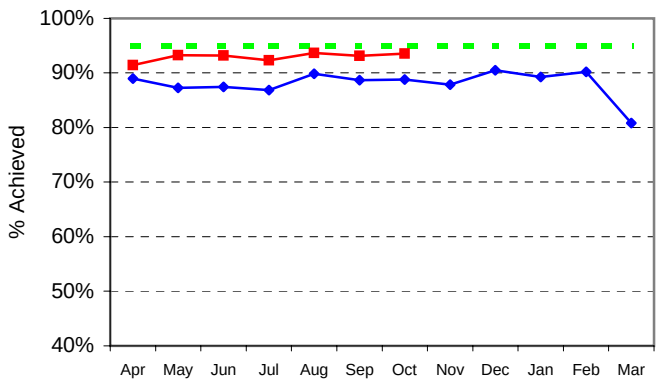


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - October 2008

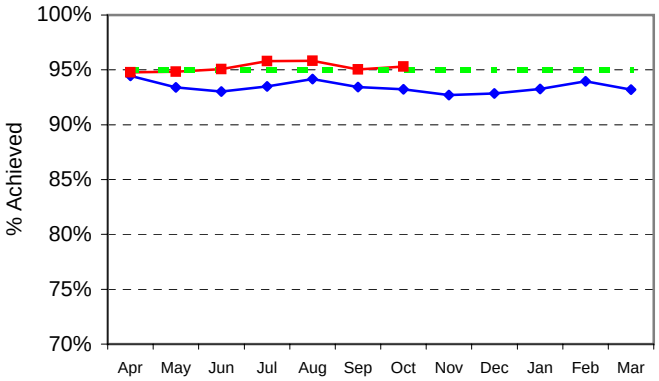
Graph 9
Arrival at Hospital Against Appointment Time



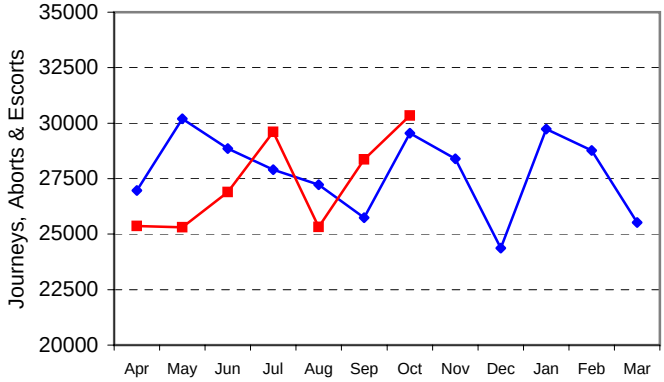
Graph 10
Departure Against Ready Time



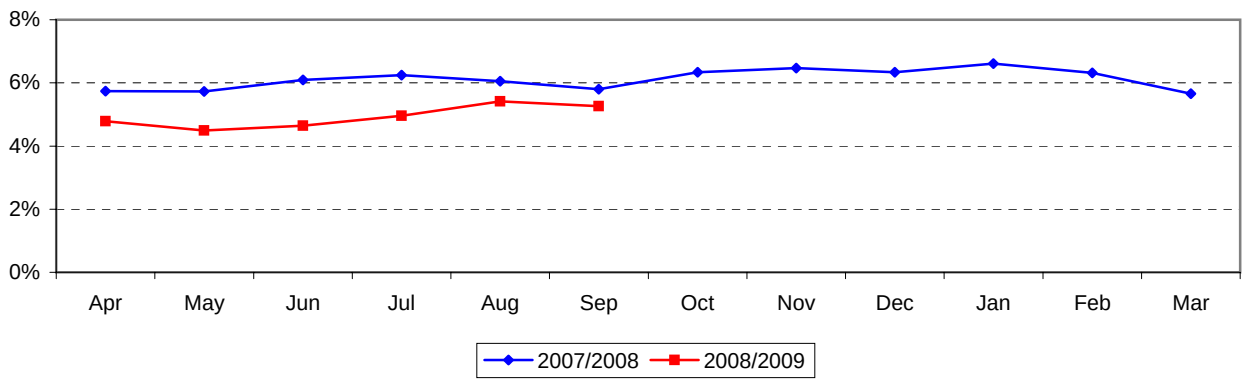
Graph 11
Time spent on Vehicle



Graph 12
PTS Total Activity

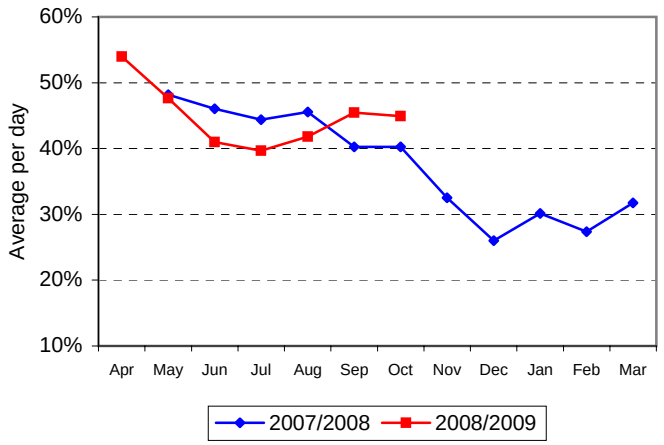


Graph 13
Trust Sickness Levels

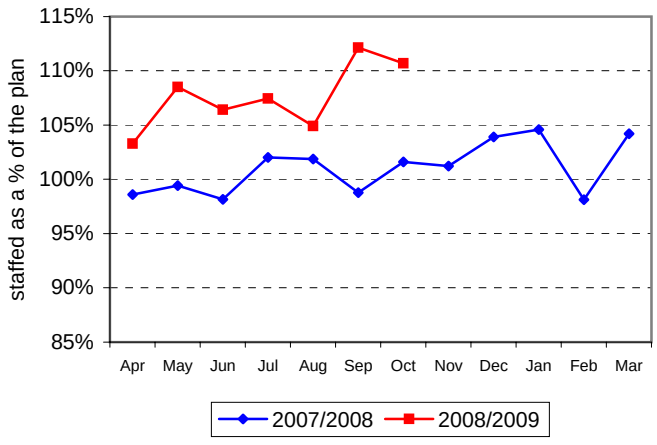


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - October 2008

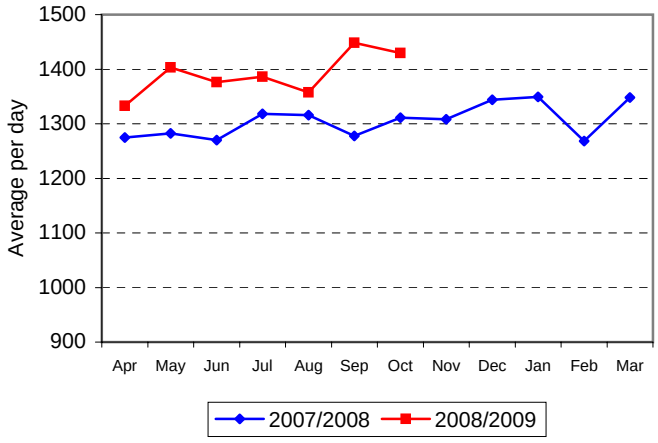
Graph 14
% of vehicles given a rest breaks



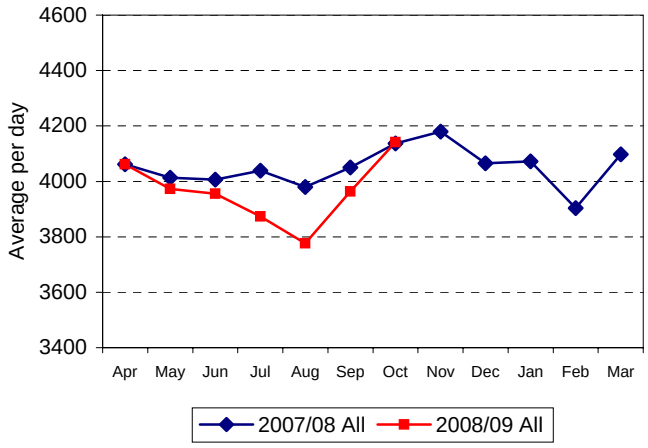
Graph 15
EOC Staffing as a % of the plan



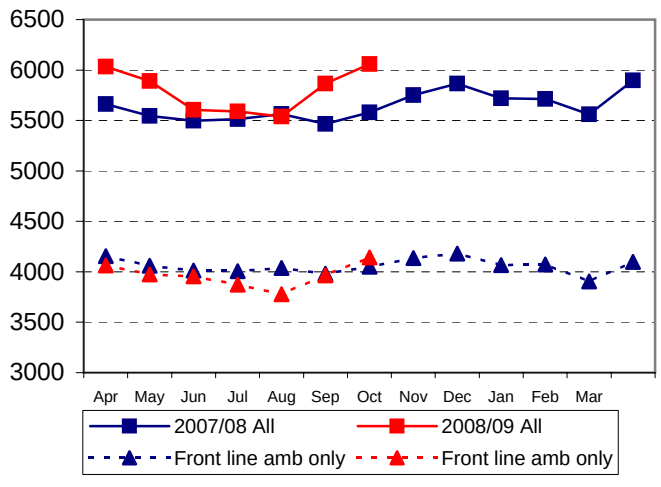
Graph 16
EOC hours staffed per day



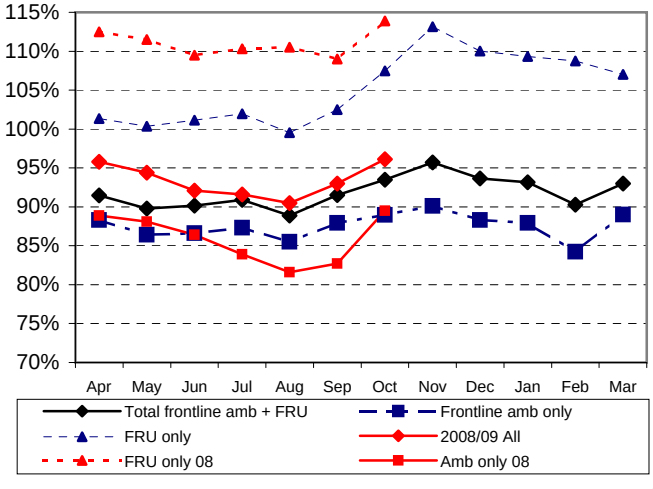
Graph 17
Ambulance hours per day (now with VOR)



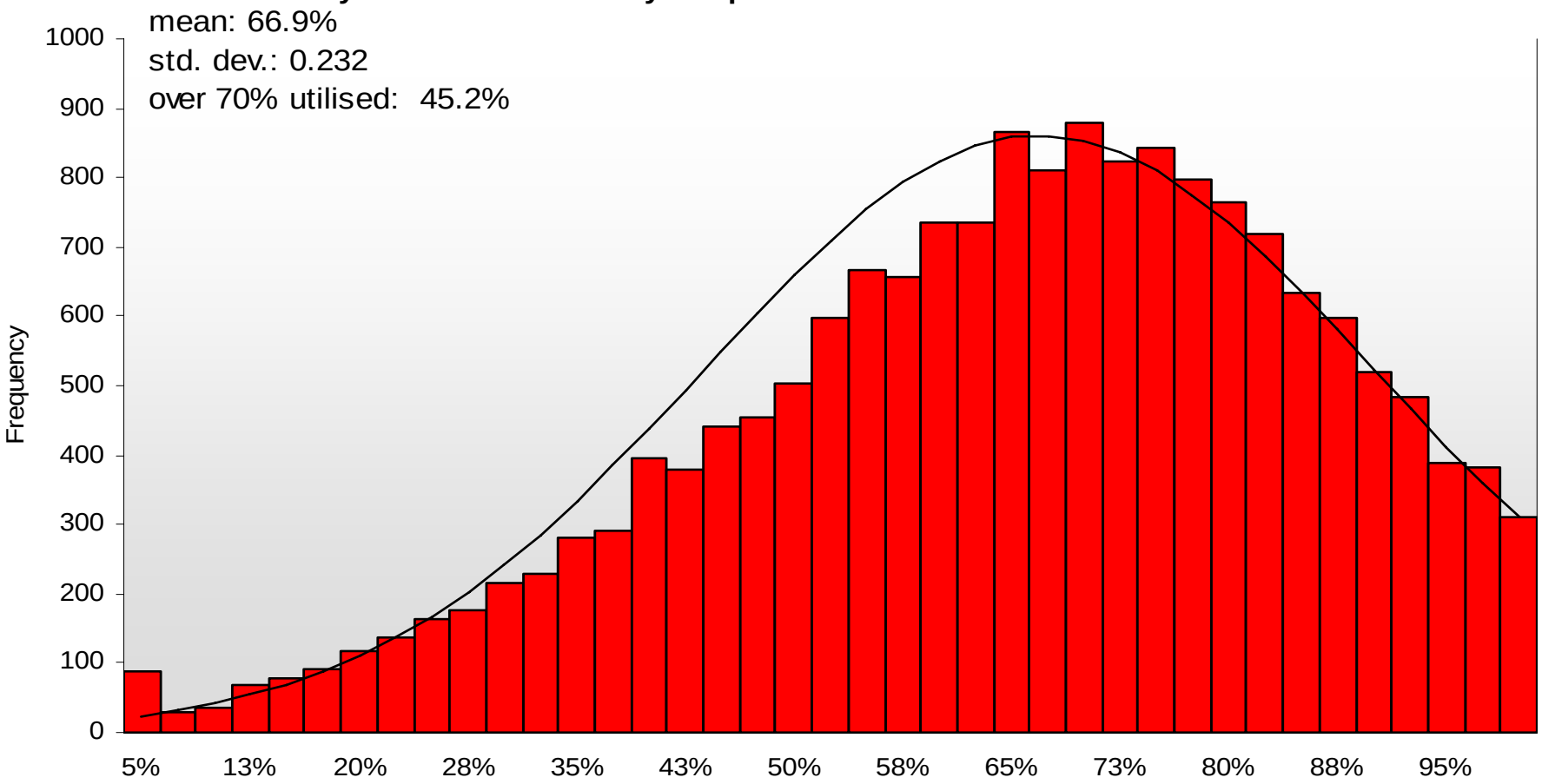
Graph 18
Hours staffed AEU + FRU per day (Avg 224hrs VOR)



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



Distribution of hourly vehicle utilisations by complex - October 2008



LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD
OCTOBER 08 (MONTH 7)

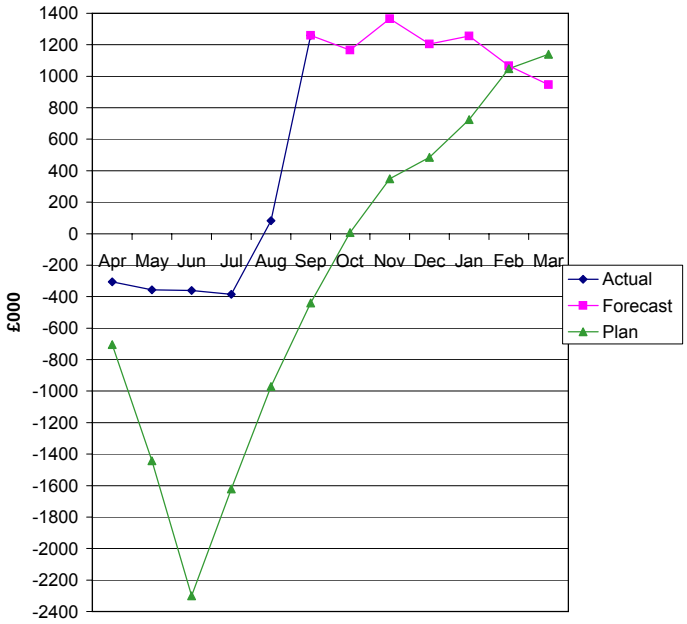
Contents:

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 31st October 08 (Month 7)

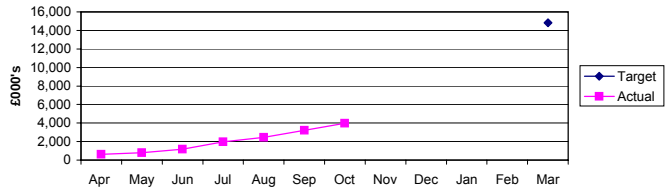
Income and Expenditure

Cumulative Net Financial Position

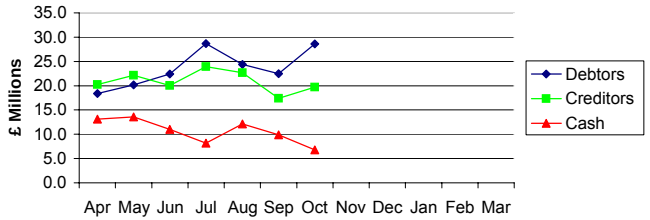


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	August	Sept	Oct	
Asset turnover ratio	1.99	2.01	2.04	●
Debtors % > 90 days	3%	3%	8%	●
A&E Debtor days	12	5	4	●
PTS Debtor days	60	52	57	●
PSPP NHS	90%	79%	83%	●
PSPP Non NHS	78%	82%	89%	●

Key Financial Indicators

	August	Sept	October
A&E Overtime (£000) / Day (Month)	51	54	56
A&E Overtime (% of paybill)	9.97%	10.31%	10.84%
Subsistence (£000) / Day (Month)	6.28	6.49	4.90
Subsistence per head £	49.47	49.47	38.24
Third Party Transport expenditure / Day (Month)	3,400	3,513	3,053
Total operational cost per incident	264	264	255
A&E Gross Surplus (YTD) (% of Income)	20.8%	21.8%	22.9%
A&E Net Margin (YTD) (% of Income)	0.5%	1.4%	1.9%
PTS Gross Margin (YTD) (% of Income)	-11.6%	-8.9%	-6.9%
Cat B performance (cumulative)	82.51%	82.51%	82.92%

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	MED	●
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 October 2008 (Month 7)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	23,328	21,053	2,274F	151,677	147,372	4,305F	2.9%F	260,745	252,638	8,107F
Total Operational Costs	21,277	19,629	(1,648)U	142,802	140,532	(2,270)U	(1.6%)U	248,703	239,785	(8,918)U
EBITDA	**2,050**	**1,424**	**626F**	**8,875**	**6,840**	**2,035F**	**0F**	**12,041**	**12,852**	**(811)U**
EBITDA Margin	***8.8%***	***6.8%***	**2.0%**	***5.9%***	***4.6%***	**1.2%**		***4.6%***	***5.1%***	**-0.5%**
Depreciation & Interest	919	976	57F	6,486	6,832	346F	5.1%F	11,123	11,712	589F
Net *Surplus/(Deficit)*	**1,131**	**448**	**683F**	**2,389**	**8**	**2,381 F**	**(3.8%)U**	**918**	**1,140**	**(222)U**
Net Margin	***4.8%***	***-2.1%***	***7.0%***	***1.6%***	***0.0%***	***1.6%***		***-0.4%***	***-0.5%***	***0.1%***

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report for the Month Ending October 31st 2008

Year to Date

- For the year to date, income exceeds expenditure by £2,389k. The budgeted position is for expenditure to exceed income by £8k, hence there is a year to date favourable variance of £2,381k.
- Income is higher than plan due to increases in contract income to account for changes in the High Cost Area allowance, additional A&E contract income to meet operational pressures and RTA income.
- Expenditure exceeds plan by £1,924k due to additional overtime and incentive payments to meet operational performance.
- PTS is reporting a loss to date of £399k against a planned surplus of £46k. The loss arises as a result of the use of third party providers. There is a recovery plan in place to bring the service into profit by the end of the financial year.

Month

- In the month there is a £1,131k surplus against a planned surplus of £448k resulting in a favourable movement of £683k.
- The forecast position for the month as at month 6 was a loss of £93k against the actual result, a surplus of £1,131k. This variance is made up of income (£816k increase) resulting from the phasing of additional income; Pay (£51k lower than forecast due to slippage in workforce plan as well as lower than expected overtime costs) and non pay (£337k lower than forecast) due to delayed development expenditure.
- Income is favourable against plan due to additional income received from commissioners for operational performance. Expenditure exceeds plan in the month due to overtime worked.
- PTS is showing a surplus of £28k in line with the recovery plan.

Forecast

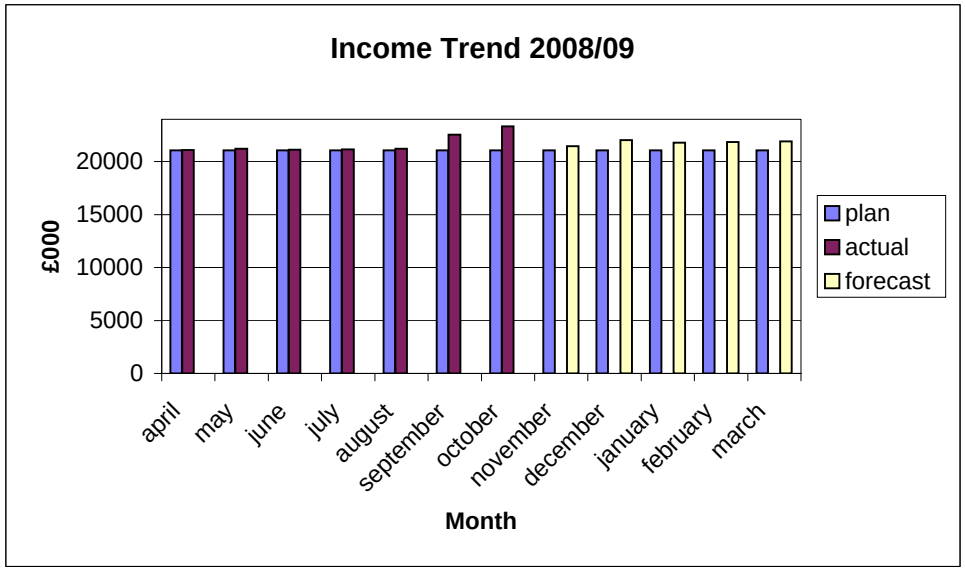
- The year end forecast is £919k surplus against a planned surplus of £1140k.
- The forecast for the year at month 6 was £946k surplus. Forecast income is down by £32k while forecast pay expenditure is lower by £1136k compared to the month 6 forecast due to revised slippage on A&E staff £726k , reduction in transfers from EMT 4's to student paramedics £231k and reduction in overtime incentive in month 07 £98k .Non pay expenditure has increased by £1161k due to reclassification of forecast slippage to pay £659k, revised development expenditure £279k, advertising costs £103k , office and station expenses £79k and legal costs £51k.

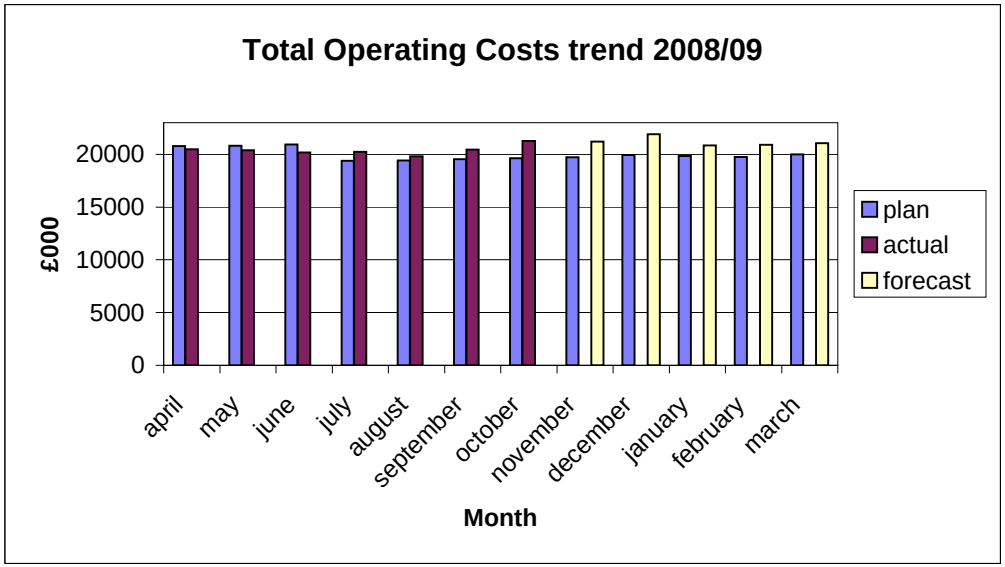
Key assumptions in the forecast:

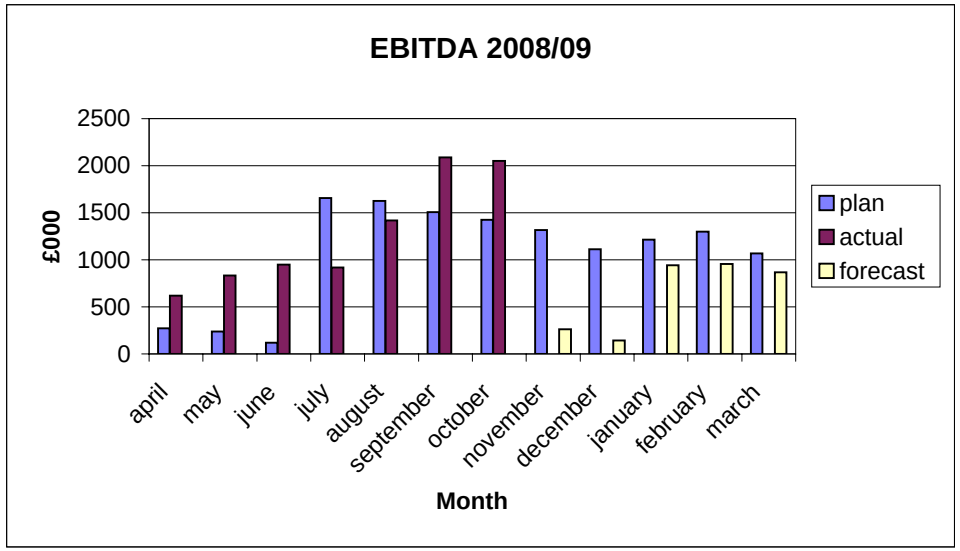
- Additional PCT funding of £5.895m.
- E&D bid funding of £8.4m.
- PTS Breakeven.
- Expenditure on yet to be approved SPPPs £478k.
- Estimated slippage against the workforce plan £400k.
- LARP deferred to 09/10.

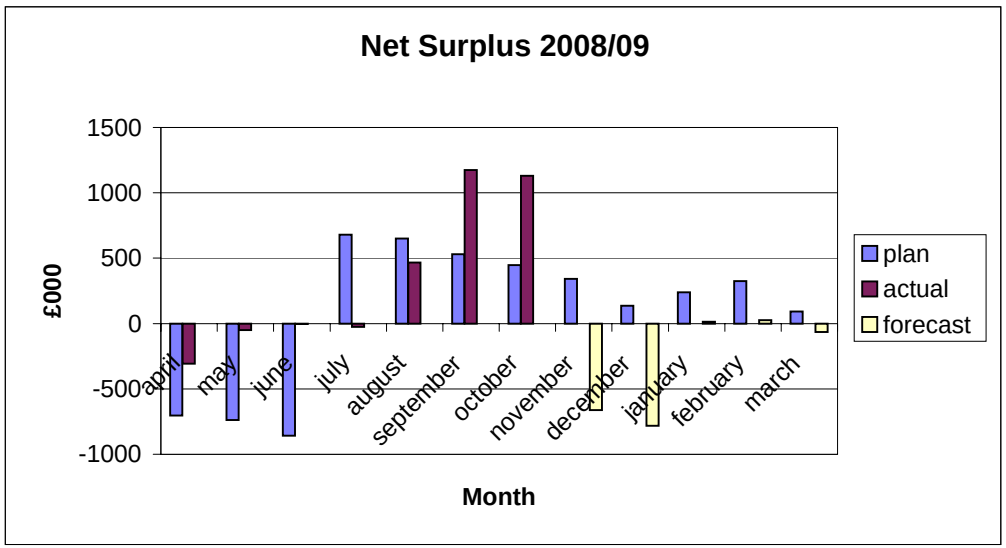
London Ambulance Service NHS Trust

Month 7 Trust Board report - forecast data









LONDON AMBULANCE SERVICE NHS TRUST

Comparison of annual forecasts at Month 7 and Month 6
As at 31st October 2008 (Month 7)

YEAR TO DATE

	Month 7	Month 6	Variance	Comments
Income	**260,745**	**260,777**	**32**	£72k increase in RTA Income. Increase of £92k Stadia Forecast, £134k correction of OCT Income from M06 in M07, £288k decrease in BETS income due to YTD adjustment in Long distance journey income as needs to be given back to commissioners .
Pay Expenditure				
A&E Operational Staff	109,293	110,371	-1,078	Uni Students now not expected to join (£149k), 7 A&E Support Trainee places not filled (£105k), Skill mix reduction for monthly average cost of Paramedic and reduction in transfers to Para from EMT4 (£231k),
Overtime	19,705	19,351	353	Reduction in Overtime Incentive (£104k)
A&E Management	12,043	12,090	-47	Increase in EOC Overtime Forecast in line with reduction in SPPP/AFA and increases in OT usage YTD. A&E Forecast adjusted in line with M06 Forecast spend (as unfunded)
EOC Staff	11,854	12,131	-276	Decrease in EOC Staffing forecast in line with expected levels of recruitment. Overtime forecast has been increased to account for this
PTS Operational Staff	5,588	5,564	24	
PTS Management	691	717	-26	
Corporate Support	31,587	31,573	14	
Sub Total	**190,761**	**191,797**	**-1,036**	
Non-Pay Expenditure				
Staff Related	3,780	3,890	-110	£60k forecast reduction in Training Uniform Spend, £40k reduction in area spend on Travel, Manager's Vehicles and Uniform (Particularly in EPU)
Subsistence	1,985	2,021	-36	reduction in line with Month 7 decreases (reflected in forecast)
Training	1,634	1,681	-47	Training costs in Comms & IM&T reduced by 7k and 30k respectively in line with trend
Medical Consumables & Equipment	5,771	5,863	-92	HH issues
Drugs	400	396	5	
Fuel & Oil	5,129	5,093	36	increased forecast in line with increase in month
Third Party Transport	1,386	1,493	-107	3rd Party savings reflected by YTD usage adjusted for addn use at xmas (estimated at £50k above the norm)
Vehicle Costs	12,551	12,419	132	172k increase in Fleet vehicle maintenance costs offset by savings elsewhere
Accommodation & Estates	10,181	10,083	98	Estates Maintenance costs increase in month
Telecommunications	7,019	6,921	98	Vat on BT Dataline invoices 7mths at 7k pcm (£49k), Unfcast telephone systems (£20k), Increase in BT One bill for last quarter (£20k)
Depreciation	7,331	7,406	-76	
Other Expenses	8,118	6,920	1,198	£659k WF Plan slippage moved to A&E Staffing (and revised) M07 additional SPPPs (£129k), M07 actuals higher than forecast Legal exps of 51k, Advertising of £103k & Office and Station Exps of 79k Offset by other savings.
Profit/(Loss) on Disposal FA	13	13	0	
Sub Total	**65,272**	**64,172**	**1,099**	
Financial Expenditure	**3,792**	**3,861**	**-69**	Amortisation now moved to depreciation.
Total Expenditure	**259,826**	**259,831**	**-5**	
Total Forecast	**919**	**-946**	**27**	

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 October 2008 (Month 7)

£000s

	MONTHLY SPEND												
	April	May	June	July	August	September	October	November	December	January	February	March	Total
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Income	**21,086**	**21,217**	**21,130**	**21,147**	**21,219**	**22,551**	**23,328**	**21,464**	**22,041**	**21,787**	**21,847**	**21,929**	**260,745**
Pay Expenditure													
A&E Operational Staff	8,412	8,341	8,280	8,314	8,249	8,328	8,470	8,752	8,887	8,923	8,967	8,910	102,833
Overtime Incentive	675	689	656	476	530	584	541	520	749	349	346	345	6,460
Overtime	1,910	1,994	1,897	1,647	1,566	1,620	1,739	1,507	1,810	1,364	1,322	1,329	19,705
A&E Management	966	963	976	996	978	992	1,008	1,020	1,011	1,044	1,044	1,044	12,043
EOC Staff	977	978	979	1,006	982	985	948	985	993	995	1,032	995	11,854
PTS Operational Staff	450	475	468	468	476	454	485	462	463	463	463	463	5,588
PTS Management	57	57	56	56	61	57	59	57	57	57	57	57	691
Corporate Support	2,345	2,672	2,304	2,539	2,581	2,690	2,791	2,562	2,740	2,765	2,770	2,828	31,587
Sub Total	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**	**15,865**	**16,711**	**15,960**	**16,001**	**15,971**	**190,761**
Average Daily	*526*	*522*	*521*	*500*	*498*	*524*	*517*	*529*	*539*	*515*	*571*	*515*	*523*
Non-Pay Expenditure													
Staff Related	223	251	369	207	258	260	355	342	417	337	372	391	3,780
Subsistence	343	44	149	193	200	195	152	159	183	159	150	144	1,985
Training	64	1	129	54	85	65	226	230	310	131	129	210	1,634
Medical Consumables & Equipment	450	537	410	498	433	547	486	519	373	445	524	549	5,771
Drugs	37	25	9	9	49	9	47	59	39	39	39	39	400
Fuel & Oil	415	455	440	450	399	400	427	428	450	428	410	428	5,129
Third Party Transport	213	183	76	142	89	105	95	97	142	82	82	82	1,386
Vehicle Costs	1,114	1,039	943	1,083	948	1,013	1,128	1,138	1,066	1,039	1,021	1,021	12,551
Accommodation & Estates	783	807	750	928	833	874	926	828	876	884	846	847	10,181
Telecommunications	558	517	718	397	510	749	582	648	585	585	586	585	7,019
Depreciation	597	597	695	630	611	611	609	604	604	611	611	612	7,393
Other Expenses	476	442	585	766	576	538	813	890	749	756	732	796	8,118
Profit/(Loss) on Disposal FA	0	0	12	0	1	0	0	0	0	0	0	0	13
Sub Total	**5,273**	**4,810**	**5,261**	**5,356**	**4,989**	**5,364**	**5,845**	**5,942**	**5,793**	**5,495**	**5,502**	**5,704**	**65,334**
Average Daily	*176*	*155*	*175*	*173*	*161*	*179*	*189*	*198*	*187*	*177*	*197*	*184*	*179*
Financial Expenditure	**328**	**289**	**256**	**313**	**340**	**302**	**310**	**319**	**319**	**319**	**319**	**319**	**3,730**
Average Daily	*11*	*9*	*9*	*10*	*11*	*10*	*10*	*11*	*10*	*10*	*11*	*10*	*10*
Monthly Expenditure	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**	**22,126**	**22,823**	**21,774**	**21,822**	**21,994**	**259,826**
Cumulative	**21,392**	**42,660**	**63,793**	**84,964**	**105,715**	**127,091**	**149,287**	**171,413**	**194,236**	**216,010**	**237,832**	**259,826**	
Monthly Net	**(306)**	**(51)**	**(3)**	**(25)**	**468**	**1,175**	**1,131**	**(662)**	**(782)**	**13**	**25**	**(65)**	**919**
Cumulative Net	**(306)**	**(357)**	**(360)**	**(385)**	**83**	**1,258**	**2,389**	**1,728**	**946**	**959**	**984**	**919**	

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 October 2008 (Month 7)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	9,011	9,082	71F	62,545	62,721	176F	0.3%F	*109,293*	*108,890*	*-403*
Overtime	1,739	450	(1,290)U	12,374	7,075	(5,299)U	(74.9%)U	*19,705*	*9,772*	*-9,933*
A&E Management	979	978	(2)U	6,688	6,826	138F	2.0%F	*11,852*	*11,714*	*-138*
EOC Staff	948	1,090	142F	6,853	7,632	779F	10.2%F	*11,854*	*13,084*	*1,229*
PTS Operational Staff	485	434	(51)U	3,276	3,040	(236)U	(7.8%)U	*5,588*	*5,212*	*-376*
PTS Management	88	95	7F	595	665	70F	10.6%F	*883*	*1,140*	*258*
Corporate Support	2,791	2,667	(124)U	17,922	18,327	406F	2.2%F	*31,587*	*31,700*	*113*
	16,041	**14,796**	**(1,246)U**	**110,253**	**106,288**	**(3,966)U**	**(3.7%)U**	***190,761***	***181,512***	*-9,249*
Non-Pay Expenditure										
Staff Related	355	286	(69)U	1,922	1,966	44F	2.3%F	*3,780*	*3,362*	*-418*
Subsistence	152	115	(37)U	1,188	805	(383)U	(47.6%)U	*1,985*	*1,380*	*-605*
Training	226	181	(44)U	624	1,269	646F	50.9%F	*1,634*	*2,195*	*561*
Drugs	47	43	(4)U	186	304	118F	38.9%F	*400*	*521*	*121*
Medical Consumables & Equipment	486	350	(136)U	3,362	2,442	(920)U	(37.7%)U	*5,772*	*4,311*	*-1,461*
Fuel & Oil	427	445	17F	2,986	3,020	33F	1.1%F	*5,129*	*5,216*	*87*
Third Party Transport	95	72	(23)U	903	473	(430)U	(90.8%)U	*1,387*	*793*	*-594*
Vehicle Costs	1,128	977	(151)U	7,268	6,918	(349)U	(5.0%)U	*12,551*	*11,801*	*-750*
Accommodation & Estates	926	800	(125)U	5,899	5,568	(331)U	(6.0%)U	*10,180*	*9,592*	*-588*
Telecommunications	582	660	78F	4,029	3,940	(89)U	(2.3%)U	*7,019*	*6,837*	*-181*
Depreciation	609	652	42F	4,349	4,561	212F	4.6%F	*7,393*	*7,819*	*426*
Other Expenses	813	903	90F	4,195	7,538	3,343F	44.4%F	*8,118*	*12,264*	*4,146*
Profit/(Loss) on Disposal FA	0	0	(0)	(13)	0	13F	#DIV/0!	*(13)*	*0*	*13*
	5,845	**5,485**	**(360)U**	**36,898**	**38,805**	**1,907F**	**4.9%F**	***65,335***	***66,092***	*757*
Financial Expenditure	**310**	**324**	**15F**	**2,137**	**2,271**	**134F**	**5.9%F**	***3,730***	***3,893***	*163*
Total Trust Expenditure	**22,196**	**20,605**	**(1,591)U**	**149,288**	**147,364**	**(1,924)U**	**(1.3%)U**	***259,826***	***251,497***	*-8,329*

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 October 2008 (Month 7)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	22,408	20,343	2,065F	145,921	142,401	3,520F	2.5%F	250,664	244,116	6,548F
Sector Services	13,029	11,698	(1,331)U	91,917	85,240	(6,677)U	(7.8%)U	155,459	145,050	(10,409)U
A&E Operational Support	1,279	1,079	(200)U	8,337	7,491	(846)U	(11.3%)U	15,339	12,994	(2,345)U
Control Services	1,554	1,507	(47)U	11,035	10,904	(131)U	(1.2%)U	19,233	18,472	(760)U
Planning and Specialised Ops	148	366	218F	1,263	2,566	1,303F	50.8%F	2,881	4,391	1,509F
Total Operations Cost	**16,010**	**14,650**	**(1,360)U**	**112,552**	**106,201**	**(6,351)U**	**(6.0%)U**	**192,912**	**180,907**	**(12,005)U**
A&E Gross Surplus/(Deficit)	**6,398**	**5,693**	**705F**	**33,369**	**36,200**	**(2,831)U**	**(7.8%)U**	**57,752**	**63,209**	**(5,457)U**
Gross Margin	28.6%	28.0%	3.1%F	22.9%	25.4%	-2.6%		23.0%	25.9%	-2.9%
Medical Directorate	56	87	31F	461	581	120F	20.6%F	768	1,015	247F
Service Development	55	72	17F	414	470	56F	12.0%F	786	831	45F
Communications	174	182	8F	1,156	1,203	46F	3.8%F	1,968	2,154	186F
Human Resources	1,824	1,691	(133)U	7,949	11,029	3,080F	27.9%F	17,869	19,224	1,355F
IM&T	1,071	1,168	97F	7,363	7,189	(175)U	(2.4%)U	12,379	12,621	242F
Finance	1,979	1,952	(26)U	12,499	15,089	2,590F	17.2%F	21,747	25,152	3,406F
Chief Executive	141	97	(44)U	738	678	(60)U	(8.9%)U	1,326	1,161	(165)U
Total Corporate	**5,299**	**5,249**	**(50)U**	**30,581**	**36,239**	**5,658F**	**(15.6%)U**	**56,842**	**62,158**	**5,316F**
A&E Net Surplus/(Deficit)	**1,099**	**443**	**656F**	**2,788**	**(39)**	**2,827F**	**7340.3%F**	**910**	**1,051**	**(141)U**
A&E Net Margin	4.9%	2.2%	3.2%F	1.9%	(0.0%)	1.9%	-7166%	0.4%	0.4%	-0.1%
Patient Transport Service	**32**	**4**	**28F**	**(399)**	**46**	**(446)U**	**(961.2%)U**	**9**	**89**	**(81)U**
PTS Gross Margin	3.5%	0.6%	3.9%F	(6.9%)	0.9%	(9.0%)U		0.1%	1.0%	(0.9%)U
Trust Result *Surplus/(Deficit)*	**1,131**	**448**	**683F**	**2,389**	**8**	**2,381F**	**(30232.4%)U**	**918**	**1,140**	**(222)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 October 2008 (Month 7)

£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	19,843	18,139	1,704F	129,794	126,974	2,820F	2.2%F	220,401	217,669	2,732F
HEMS Funding	11	11	(0)U	74	75	(0)U	(0.5%)U	127	128	(1)U
Other A&E Income	91	91	(0)U	635	636	(1)U	(0.2%)U	4,048	1,090	2,958F
Foundation Trust Income	38	16	22F	166	112	54F	48.3%F	212	192	20F
CBRN Income	899	897	1F	6,291	6,282	9F	0.1%F	10,784	10,769	15F
ECP Income	18	13	5F	116	89	26F	29.6%F	203	153	50F
BETS & SCBU Income	179	76	103F	672	531	141F	26.5%F	617	911	(294)U
A & E Long Distance Journey	42	37	5F	273	256	17F	6.7%F	468	439	29F
Stadia Attendance	66	89	(23)U	679	626	53F	8.5%F	1,165	1,074	91F
Heathrow BAA Contract	44	44	(0)U	310	310	(0)U	(0.0%)U	532	532	(0)U
Resus Training Fees	24	10	14F	37	69	(32)U	(45.8%)U	81	118	(37)U
Education & Training Income	735	686	49F	5,146	4,801	345F	7.2%F	8,785	8,231	555F
	21,989	**20,109**	**1,881**	**144,195**	**140,761**	**3,433**	**2.4%F**	**247,424**	**241,305**	**6,119**
PTS Income	920	710	209F	5,756	4,971	785F	15.8%F	10,029	8,521	1,508F
Other Income	419	234	184F	1,726	1,640	87F	5.3%F	3,292	2,811	481F
Trust Result	**23,328**	**21,053**	**2,274F**	**151,677**	**147,372**	**4,305F**	**2.9%F**	**260,745**	**252,638**	**8,107F**

LONDON AMBULANCE SERVICE NHS TRUST
CIP Monitoring Schedule 2008/09
As at 31st October 2008 (Month 7)

CIP Programme	Dept	Expense type	Target CIP to Month 7 £000	Actual CIP to month 7 £000	Variance to month 7 £000	Target CIP Full Year £000	Forecast CIP Full Year £000	Variance Full Year £000
A&E Productivity	Deputy Director Of Operations	Paramedic	2,787	2,787	0	4,578	4,678	100
Control Services Productivity	Urgent Care Services (Control)	Paramedic	282	282	0	484	484	(0)
Corporate Support Efficiency	Corporate Support	Support Staff	285	175	(110)	432	286	(146)
Non Pay - Facilities	All	Facilities	212	182	(30)	364	323	(41)
Non Pay - Fleet & Logistics	Fleet & Logistics	Fleet & Logistics	197	95	(102)	338	200	(138)
Non Pay - IM&T	IM&T	Technology	30	24	(6)	52	43	(9)
Non Pay - Other	Corporate Support	Other	237	192	(45)	407	345	(62)
Non Pay - Professional Services	Corporate Support	Consultancy	184	161	(23)	316	284	(32)
PTS efficiency	Centrally Held Funds	Efficiency Savings	144	0	(144)	247	0	(247)
			4,359	**3,897**	**(462)**	**7,217**	**6,642**	**(575)**

● To month 7 the Trust made a £3.897m CIP against a target for those programmes of £4.359m. This table shows the position against the original CIP programmes and does not include areas where savings may have been realised but which are outside these listed CIP programmes. The forecast for the year indicates there will be a shortfall of £575k against the target or 8%. This is an improved position since month 6.

● The main reasons for the shortfall against target are:

1. PTS efficiency target has not been met due to the delay in the opening of the Transport Operation Centre in the East Area.
2. Efficiencies in Corporate Support staff have not been realised in part due to vacancies not being realised or staff restructures being delayed.
3. Planned reductions in non pay, especially in fleet have not been realised due to operational pressures.

LONDON AMBULANCE SERVICE NHS TRUST

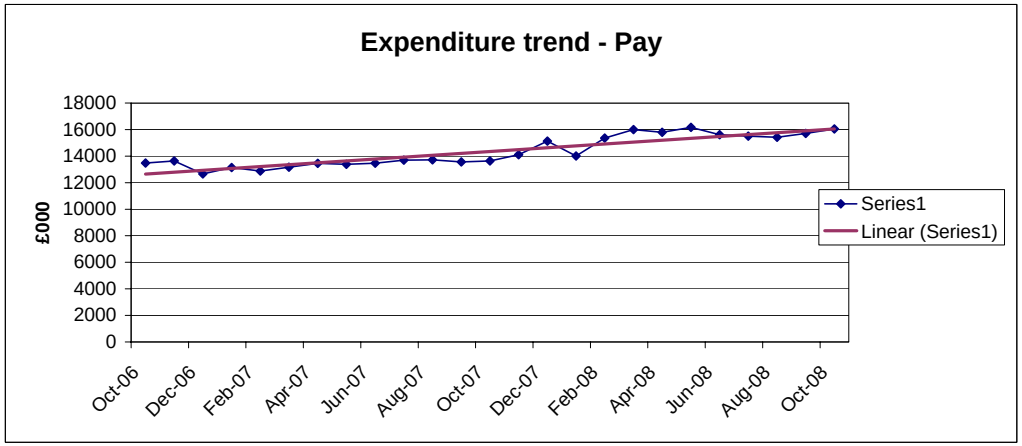
Expenditure Trends Including Last Year
As at 31 October 2008 (Month 7)

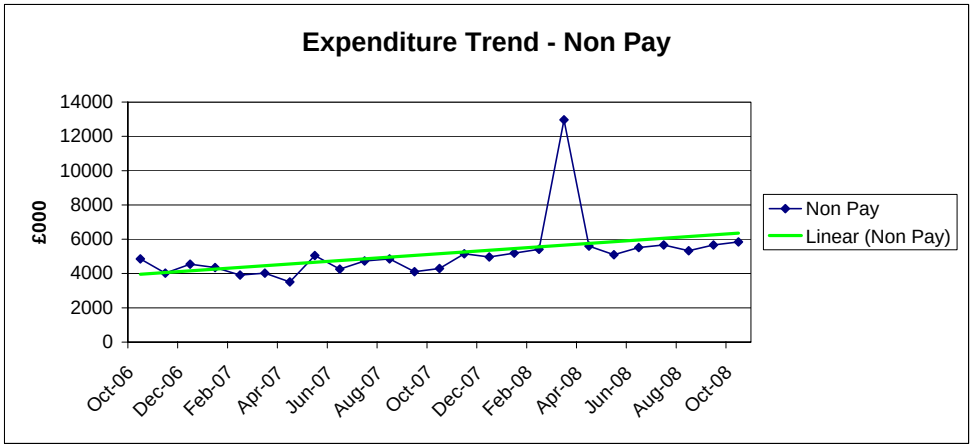
Current Year

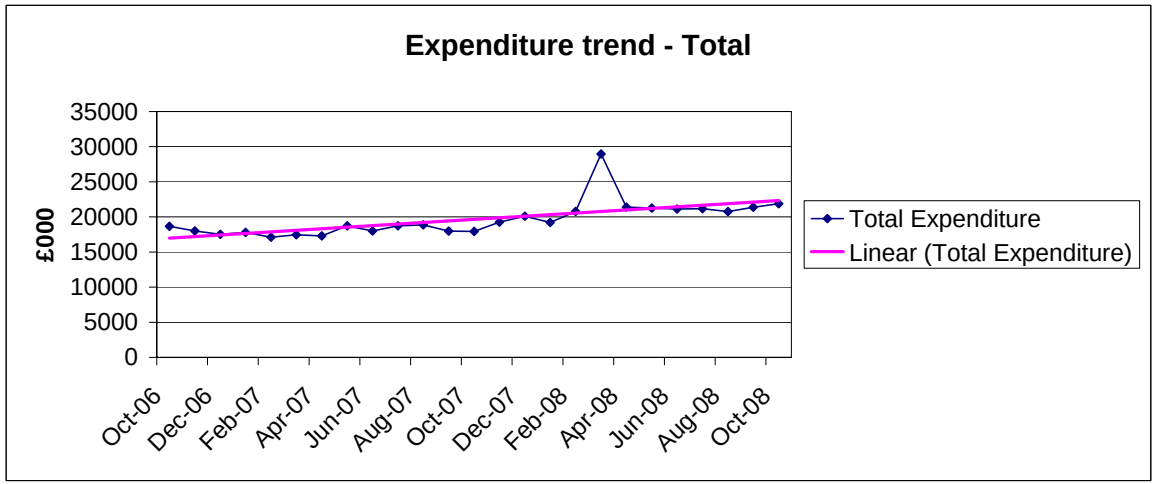
	October	November	December	January	February	March	April	May	June	July	August	September	October
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**19,486**	**19,282**	**19,154**	**20,068**	**19,641**	**25,743**	**21,086**	**21,218**	**21,128**	**21,147**	**21,219**	**22,551**	**23,328**
Pay Expenditure													
A&E Operational Staff	8,088	8,113	9,149	8,227	8,468	8,677	9,087	9,030	8,936	8,790	8,779	8,912	9,011
Overtime	1,045	1,149	1,245	1,168	1,118	1,764	1,910	1,994	1,897	1,647	1,566	1,620	1,739
A&E Management	914	904	940	912	1,027	911	942	940	945	966	949	967	979
EOC Staff	920	909	985	954	953	946	977	978	979	1,006	982	985	948
PTS Operational Staff	465	442	487	462	466	459	450	475	468	468	476	454	485
PTS Management	80	87	87	85	84	88	81	80	86	87	91	83	88
Corporate Support	2,125	2,497	2,239	2,199	3,242	3,154	2,345	2,672	2,304	2,539	2,581	2,690	2,791
Sub Total	**13,637**	**14,101**	**15,132**	**14,007**	**15,357**	**15,999**	**15,791**	**16,169**	**15,616**	**15,503**	**15,423**	**15,710**	**16,041**
Average Daily	*440*	*455*	*488*	*467*	*495*	*533*	*509*	*522*	*521*	*500*	*514*	*507*	*517*
Non-Pay Expenditure													
Staff Related	213	198	189	271	231	386	223	251	369	207	258	260	355
Subsistence	175	182	188	244	190	209	343	44	149	193	200	195	152
Training	116	173	30	119	123	258	64	1	129	54	85	65	226
Drugs	46	55	36	22	46	28	37	25	9	9	49	9	47
Medical Consumables & Equipment	312	387	396	510	533	1,814	450	537	410	499	433	547	486
Fuel & Oil	342	373	405	406	391	417	415	455	440	450	399	400	427
Third Party Transport	94	92	84	133	161	173	213	183	76	142	89	105	95
Vehicle Costs	977	1,614	1,681	1,091	1,034	2,895	1,114	1,039	943	1,083	948	1,013	1,128
Accommodation & Estates	757	751	543	922	832	1,702	783	807	750	927	833	874	926
Telecommunications	201	489	516	477	677	2,129	558	517	718	397	510	749	582
Depreciation	579	534	542	524	524	706	597	597	695	630	611	611	609
Other Expenses	184	57	109	214	425	2,051	476	442	585	766	574	540	813
Profit/(Loss) on Disposal FA	0	2	0	0	0	29	0	0	12	0	1	0	0
Sub Total	**3,999**	**4,903**	**4,719**	**4,932**	**5,167**	**12,797**	**5,273**	**4,810**	**5,261**	**5,356**	**4,987**	**5,366**	**5,845**
Average Daily	*129*	*158*	*152*	*164*	*167*	*427*	*170*	*155*	*175*	*173*	*166*	*173*	*189*
Financial Expenditure	**295**	**249**	**244**	**260**	**246**	**170**	**328**	**289**	**256**	**313**	**342**	**299**	**310**
Average Daily	*10*	*8*	*8*	*9*	*8*	*6*	*11*	*9*	*9*	*10*	*11*	*10*	*10*
Monthly	**17,931**	**19,253**	**20,096**	**19,199**	**20,770**	**28,966**	**21,392**	**21,268**	**21,133**	**21,171**	**20,751**	**21,375**	**22,196**
Net	**1,555**	**29**	**(942)**	**869**	**(1,129)**	**(3,224)**	**(306)**	**(50)**	**(5)**	**(24)**	**468**	**1,175**	**1,131**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends over the last 24 months as at 31st October 2008 (month 7)







LONDON AMBULANCE SERVICE
Capital Programme 2008/
Capital Expenditure as at 31 Oct

	Capital Expenditure Year To Date 2008/09	Forecast Expenditure Profile					Total Capital Forecast 2008/09	Capital Budget 2008/09	Variance 2008/09
		Nov-08	Dec-08	Jan-09	Feb-09	Mar-09			
Asset Type	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**	**£000'**
Vehicles	582	300	795	2,179	2,153	3,203	9,213	6,423	(2,790)
							0		
Estates	1,837	351	505	373	225	145	3,436	2,928	(508)
							0		
Equipment	(21)	0	0	0	0	57	36	2,733	2,697
							0		
IM&T	1,567	241	369	897	1,548	1,548	6,169	4,246	(1,923)
							0		
Gross Total	3,965	892	1,669	3,449	3,926	4,953	18,853	16,330	(2,523)
Disposal	0	0	0	0	0	(1,000)	(1,000)	(1,500)	(500)
Net Total	3,965	892	1,669	3,449	3,926	3,953	17,853	14,830	(3,023)
CRL							15,865		
(Over)/Under Commitment							(1,988)		

Notes to forecast

1) Procurement of PTS vehicles **£2.7m**, Driver training vehicles **£486k**, Ambulances **£3.9m (35)**
Forecast also reflects no purchase of RRU's

2) Reflects costs of replacement to Park Royal & Willesden A/S **£750k**, HQ lift modernisation **£195k** and Smithfields expansion and refubishment **£177k.**

3) Reflects no purchase of LP12 ECGs **£2.7m** in 08/09

4) CAD2010 project (**£4.5m** excluding contingency of £**1.6m**) costs higher than planned. Forecast also reflects costs of IM&T Hardware and Software purchases as well as CTAK and bandwidth project costs including Off site data centre set up

5) Additional Capital funding is being sought from SHA.

LONDON AMBULANCE SERVICE NHS Trust

Forecast Balance Sheet
For the Month Ending 31 October 2008 (Month 7)

	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*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Intangible assets	3,765	4,511	4,523	3,784	3,854	3,797	3,790	4,016	4,016	4,016	4,016	4,016	4,016	
Tangible assets	119,652	123,612	123,179	123,607	124,108	123,640	123,778	123,755	124,043	125,108	127,946	131,261	132,613	
	123,417	128,123	127,702	127,391	127,962	127,437	127,568	127,771	128,059	129,124	131,962	135,277	136,629	
Current Assets														
Stocks & WIP	1,930	1,934	1,933	1,933	1,926	1,932	1,937	1,934	1,934	1,934	1,934	1,934	1,934	Trade Debtors
NHS Trade Debtors	1,628	821	1,194	1,717	11,611	6,563	3,768	4,744	3,518	3,608	3,583	3,587	2,890	A&E £0 > 60 days (0.0%), Sep - £-36k > 60 days (0.92%)
Non NHS Trade Debtors	93	139	244	207	105	112	108	78	53	65	65	75	110	PTS £814k > 60 days (16.73%), Sep - £394k > 60 days (10.11%)
Other Debtors	4,337	388	578	452	401	491	232	385	285	285	285	285	285	
Accrued Income	247	2,117	4,028	5,676	2,466	3,760	5,120	10,010	10,254	12,485	11,463	8,418	3,435	
Prepayments	5,237	5,060	4,334	4,629	4,246	3,510	3,361	3,357	3,231	3,105	2,979	2,853	2,727	
Investments	0	14,000	11,000	10,000	9,000	11,100	9,500	6,000	5,000	1,000	0	0	0	
Cash at Bank and in Hand	8,965	(936)	2,471	906	(767)	1,099	419	856	1,404	1,972	1,980	1,946	3,981	
Total Current Assets	22,437	23,523	25,782	25,520	28,988	28,567	24,445	27,364	25,679	24,454	22,289	19,098	15,362	
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	6,714	8,104	7,919	7,669	7,237	7,102	7,190	NHS PSPP - This month (83%), Sep (79%), Ytd (83%)
Other Creditors	1,772	7,066	7,145	7,275	7,663	6,974	6,437	6,505	6,433	6,788	6,473	6,490	6,479	Non NHS PSPP - This month (89%), Sep (82%), Ytd (83%)
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	365	144	269	1,046	2,826	3,303	2,341	
Accruals	618	2,145	1,914	1,595	1,388	1,673	1,291	1,262	1,202	1,142	1,082	1,022	962	
Deferred Income	152	193	554	586	5,605	4,747	2,654	3,393	2,560	2,070	1,580	1,090	600	
Total Current Liabilities	16,958	18,457	20,402	20,058	24,187	22,708	17,461	19,776	19,119	19,819	20,670	20,847	17,572	
Net Current Assets	5,479	5,066	5,380	5,462	4,801	5,859	6,984	7,588	6,560	4,635	1,619	(1,749)	(2,210)	
Long Term Debtors	9,875	9,893	9,910	9,858	9,903	9,926	9,870	9,981	9,981	9,981	9,981	9,981	9,981	
Total Assets less current liabilities	138,771	143,082	142,992	142,711	142,666	143,222	144,422	145,340	144,600	143,740	143,562	143,509	144,400	
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	18,352	18,139	18,061	17,983	17,792	17,714	17,635	
Total Assets Employed	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	126,539	125,757	125,770	125,795	126,765	
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	57,523	
Revaluation Reserve	50,605	55,297	55,297	55,294	55,294	55,294	55,280	55,280	55,280	55,280	55,280	55,280	55,280	
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	14,712	15,843	15,181	14,399	14,412	14,437	14,372	
Total Taxpayers' Equity	120,182	124,550	124,479	124,455	124,430	124,898	126,070	127,201	126,539	125,757	125,770	125,795	126,765	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31 October 2008 (Month 7)

	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*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
EBITDA after exceptionals	619	836	936	918	1,417	2,082	2,050	261	141	943	955	866	12,024
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	5	(3)	0	0	0	0	0	4
NHS Trade Debtors	807	(373)	(523)	(9,894)	5,048	2,795	(976)	1,226	(90)	25	(4)	697	(1,262)
Long Term Debtors	(18)	(17)	52	(45)	(23)	56	(111)	0	0	0	0	0	(106)
Non NHS Trade Debtors	(46)	(105)	37	102	(7)	4	30	25	(12)	0	(10)	(35)	(17)
Other Debtors	49	(190)	126	51	(90)	259	(153)	100	0	0	0	0	152
Accrued Income	(1,870)	(1,911)	(1,648)	3,210	(1,294)	(1,360)	(4,890)	(244)	(2,231)	1,022	3,045	4,983	(3,188)
Prepayments	177	726	(295)	383	736	149	4	126	126	126	126	126	2,510
Trade Creditors	(3,079)	1,319	(621)	(1,879)	(94)	(592)	1,390	(185)	(250)	(432)	(135)	88	(4,470)
Other Creditors	4,990	(14)	255	415	(902)	(596)	(231)	(86)	341	(329)	3	(25)	3,821
Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Accruals	1,527	(231)	(319)	(207)	285	(382)	(29)	(60)	(60)	(60)	(60)	(60)	344
Deferred Income	41	361	32	5,019	(858)	(2,093)	739	(833)	(490)	(490)	(490)	(490)	448
Provisions & Liabilities	(57)	(19)	(257)	(20)	88	28	(213)	(78)	(78)	(191)	(78)	(79)	(954)
Net Cashflow from operating activities	2,525	(455)	(3,161)	(2,872)	2,895	(1,727)	(4,443)	(9)	(2,744)	(329)	2,397	5,205	(2,718)
Returns on Investments & Servicing of Finance													
Interest received	54	92	125	68	39	82	71	63	63	63	63	63	846
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 &	54	92	125	68	39	82	71	63	63	63	63	63	846
servicing of finance													
Capital Expenditure													
Tangible fixed assets acquired	(2,981)	(46)	(456)	(787)	(386)	(511)	(741)	(767)	(892)	(1,669)	(3,449)	(3,926)	(16,611)
Tangible fixed assets disposed	3,900	0	0	0	0	0	0	0	0	0	0	1,000	4,900
Other	0	0	12	0	1	0	0	0	0	0	0	0	13
Net Cashflow from capital expenditure	919	(46)	(444)	(787)	(385)	(511)	(741)	(767)	(892)	(1,669)	(3,449)	(2,926)	(11,698)
PDC Dividends paid	0	0	0	0	0	(2,206)	0	0	0	0	0	(2,208)	(4,414)
Net Cashflow before financing	4,099	407	(2,565)	(2,673)	3,966	(2,280)	(3,063)	(452)	(3,432)	(992)	(34)	1,000	(6,019)
Financing													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	1,035	1,035
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	1,035	1,035
Increase/(decrease) in cash	4,099	407	(2,565)	(2,673)	3,966	(2,280)	(3,063)	(452)	(3,432)	(992)	(34)	2,035	(4,984)
Closing cash balance	13,064	13,471	10,906	8,233	12,199	9,919	6,856	6,404	2,972	1,980	1,946	3,981	3,981

Draft 2, 1 November 2008

London Ambulance Service NHS Trust

Lease Car Policy

1. Introduction and Aim

1.1 London Ambulance Service NHS Trust recognises that the role of many staff inevitably requires that they undertake regular travel in the course of their everyday duties.

1.2 The NHS terms and conditions handbook (Section 17) allows that "Employers may offer lease cars to employees whom they require to be mobile and where they deem it in the interest of the service to do so" (paragraph 17.2)

1.3 Subject to the eligibility criteria outlined in this policy statement, the Trust has decided to offer the facility of a lease car to support key staff in fulfilling their role and duties.

1.4 This document outlines the policy with regard to the provision of lease cars for staff below Director-level within London Ambulance Service NHS Trust (the Trust).

1.5 The aim of the lease car policy is to outline the framework within which the scheme will operate and against which decisions will be made regarding the allocation/offer of a lease car, taking into account the principles outlined in the national terms and conditions handbook.

1.6 The policy does not cover arrangements for recompense/re-imbursement of travel expenses for non-lease car holders, which are governed by the Trust policy and national agreements.

1.7 The policy is based on the following values and aims;

Reducing complexity
Improving transparency
Ensuring value for money
Improving environmental efficiency

2. National guidance/context

2.1 Annex M of the NHS terms and conditions handbook requires that local lease car schemes should take into account the following principles:

- The scheme is voluntary and is offered to eligible employees
- Employees shall be charged the full cost for private use.

- Transparent arrangements for meeting the cost of NHS business use.

- Where arrangements are based on reimbursement of fuel paid for by the employee on a mileage basis, mileage rates should be subject to regular review to take account of significant changes in fuel costs.

- Employees shall be made aware as fully as possible of any tax implications of having a lease car.

- Local policies shall set out details of early termination costs and the circumstances in which these would apply, and where these would not apply, such as death in service. Wherever possible, provision should be made for options to be explored to obviate the need for the return of the car and early termination costs following a change in the employees circumstances, for example on transfer to another employer.

- The employer will be responsible for any excess insurance charges incurred during business use of the vehicle.

- The base cars of lease schemes shall be consistent with the proper use of public monies, NHS business needs and wider environmental considerations. Any employee choosing a car larger than the base car shall pay the additional full costs of this.

3. Principles of the Policy

3.1 It is the view of NHS Employers and the national partnership working group commissioned to review mileage and travel arrangements in the NHS terms and conditions handbook that lease car policies provide an opportunity to influence employee choice and promote the corporate social responsibility requirements and expectations of the NHS as a major public sector employer.

3.2 The lease car scheme will use specified base allowances.

3.3 Vehicles provided are available for business and private use of the relevant post holders.

3.4 Vehicles are allocated to posts rather than post-holders – in other words it is the nature if the duties required which determines eligibility, not other matters such as seniority.

3.5 The Trust reserves the right to make changes to the lease car scheme where these become necessary for reasons of economy or business efficiency.

3.6 The Trust is committed to its corporate and social responsibilities, and will endeavour to consider steps to reduce vehicle emissions and eliminate unnecessary business mileage.

3.7 The Trust recognises that there may be circumstances where an employee (through personal choice) or the Trust (through need) requires the use of a specialist vehicle or one not covered by the general provisions of this policy. In these instances a written request must be considered by the appropriate Director. Should the request be supported it will be forwarded to the Senior Management Group (SMG) for consideration. Each case will be determined on its own merits and will not set a precedent for any other case. Should an individual request exceed the relevant allowance, or create an unfair tax burden on the employee (e.g. as a result of the Trust imposing a vehicle with high emissions on an employee), the SMG will consider the appropriate amounts payable by the employee whilst at all times being guided by the national principles about cost of private use.

3.8 All vehicles acquired under the scheme will be leased by the Trust rather than the post holder and will be subject to the following standard terms:

- Standard 36 month lease period.
- Full maintenance and service included.
- Breakdown and recovery service included with the appropriate provider.

3.9 The Trust recognises that, as vehicles will be required for private as well as business use, post holders should enjoy a degree of choice in the selection of a vehicle. However, it is imperative that vehicles procured through the scheme are compatible with the ethos, image and requirements of a public sector organisation.

3.10 In line with this requirement, choice for post-holders will not be restricted to particular makes or models, but vehicles acquired through the scheme should, as a guide, meet the following criteria:

- All vehicles must have a minimum of four full size seats.
- The **base** vehicle should have an engine capacity of not more than 1800cc (handbook paragraph 17.3) and meet the requirement (confirmed at section 2 and paragraph 3.8 above) that it shall be consistent with the proper use of public monies, NHS business needs and wider environmental considerations. This does not prevent employees exercising their right to choose a different, larger or better equipped vehicle, in which case the excess cost will be borne in full by the employee.
- "Sports" and convertible cars cannot be acquired through the scheme. It is accepted that providing a comprehensive definition of a sports car is difficult. However, for the purpose of this policy, a sports car is a high performance vehicle the use of which is not commensurate with either the role of the post holder or the needs of a public sector organisation.
- In considering applications for lease cars, the authorising Director must consider the request against this definition/requirement and exercise his/her discretion and judgement.
- CO2 emissions must be 190 or below.

The CO2 emissions threshold will be reviewed annually by the Director of Finance following advice from the Corporate Fleet Manager.

3.10 Departure from the above criteria will only be permitted in exceptional circumstances subject to the approval of the relevant Director.

4. Eligibility criteria

4.1 The key eligibility criteria for consideration for a lease car will be based upon the expectation that the duties of a particular post necessarily involve regular and significant travel on the business of the Trust. This situation may arise for a variety of reasons including:

- The role is corporate in nature and there is an expectation and requirement that the post-holder makes regular visits to sites throughout London or beyond on official Trust business.
- The role includes managerial responsibility for a number of sites covering a significant geographical area, and requires regular travel between the sites.
- The role includes out of hours responsibility which may require short-notice attendance at, or recall to, work.

4.2 Since the NHS terms and conditions handbook provides for regular or standard user mileage rates to be offered where a lease car is withdrawn by the employer, it is logical to be guided by these standards when considering eligibility for consideration of a lease car.

4.3 Regular users are classified as staff who:

- Travel an average of 3500 miles per year OR
- Travel an average of at least 1250 miles per year and necessarily use their car an average of 3 days per week OR
- Spend an average of at least 50 per cent of their time on such travel, including duties performed during the visits OR
- Travel an average of at least 1000 miles a year and spend an average of at least four days a week on such travel including the duties performed.

4.4 For consideration of eligibility for a lease car, the thresh-hold will normally be an expectation or requirement of at least 3500 business miles per year.

4.5 Directors will have discretion for posts which do not meet this requirement but for which a case could be made against the other criteria above. In particular, where total mileage may not be sufficiently high but the staff member is required to transport heavy or bulky equipment the consideration may be favourable.

4.6 Other considerations in determining whether an application is approved will include:

- Are journeys likely to be undertaken only in the London area?
- Would the use of a pool/hire car be more cost effective for the Trust?

- Could journeys reasonably be undertaken by public transport/private car, if this was more cost effective for the Trust?
- Will the post holder be on-call or require a vehicle to respond to emergency calls/incidents outside of normal working hours?

The application of these criteria should result in savings through a reduction in lease vehicles and be environmentally sound by encouraging the use of public transport.

4.7 Applications for a lease car will be considered by and decided upon by the relevant Director, taking account of the criteria and principles of this policy and any national guidance.

5. Allowances

5.1 Approved lease car users in pay bands up to 8a will receive an allowance of £3000, and those in band 8b or above will receive an allowance of £3818 (inclusive of any optional extras specified for the vehicle). These have been set based upon an assumption of total of 12,000 miles per annum of which 3,500 are business and 8,500 private.

5.2 The lease car allowances will be reviewed annually by the Director of Finance in consultation with the Director of Human Resources. Any revisions will be subject to approval by the SMG and applied on the next occasion a vehicle is procured for a post holder.

6. Personal Contributions

6.1 As vehicles are available for both private and business use, employees will be expected to contribute to the insurance of the vehicle. The insurance premium will normally be shared 50/50 between the Trust and the employee. However, where the user chooses to include family members under the age of 21 on any insurance then the full cost of that additional cover will be borne by the user.

6.2 Assuming the lease cost of the vehicle is no more than £3000/£3818 as appropriate then no further contribution to the leasing of the vehicle will be required.

6.3 If the 12,000 annual mileage thresh-hold is breached due to increased private mileage (i.e. > 8,500) then any further lease cost above £3000 will be reimbursed to the Trust by the employee*. (See Appendix 1 – 'How the allowance works').*

6.4 If the 12,000 threshold is breached due to the requirement of the Trust for the employee to undertake more than 3,500 business miles then the allowance will increase according to the impact of the increased business miles on the cost of leasing the vehicle selected. *(See Appendix 1 – 'How the allowance works').*

6.5 If contracted private miles reduce below 8,500 then the reduction in the lease cost can be used to offset the employee's contribution towards insurance up to the amount of their contribution.

If an employee wishes to lease a vehicle which meets the emissions threshold and other criteria but (based on lease cost at 12,000 miles) exceeds the £3000/£3818 allowance the Trust will consider leasing the vehicle but the employee will be required to reimburse the Trust for the cost in excess of the calculated allowance. *Again, an example of this is outlined in Appendix 1.*

7. Travelling Expenses

7.1 The Trust will reimburse lease car users for business mileage at the rates published by HM Revenue & Customs. The rates vary by engine size and type and are subject to periodic review by HM Revenue and Customs.

7.2 In line with Her Majesty's Revenue and Customs (HMRC) guidance, it is the responsibility of all staff to bear the cost of travel to their place of work. Reimbursement will be made only for legitimate business travel, and is made net of home to work mileage. It is unlikely that breaking a journey to visit trust premises nearer than the usual place of work, and claiming the balance of the journey as legitimate business mileage, will satisfy the HMRC requirements.

7.3 Claim Forms for the reimbursement of business mileage are to be completed and submitted for approval, usually by the next-in-line manager, and payment within reasonable time i.e. no later than 1 month after the costs have been incurred. Depending upon the circumstances, claims submitted outside of this period may not be accepted.

7.4 In submitting a claim for reimbursement the lease car user certifies that all mileage claimed has been necessarily incurred as a legitimate business requirement in fulfilling their employment duties. Any false or fraudulent claim could be deemed to constitute gross misconduct and lead to consideration of disciplinary action, including dismissal.

7.5 In approving claims for reimbursement of mileage, the authorising manager is confirming that she/he is satisfied that the business mileage was necessary and was legitimately incurred, and that the amounts claimed appear consistent with the journeys reported. If there should be any doubt as to the legitimacy of the claim, consideration must be given to investigation of the claim which could include reference of the matter to the Trust's Counter Fraud Specialist.

7.6 The Trust will not issue fuel cards for use by lease car drivers.

8. Insurance (see also paragraph 6.1)

8.1 The Trust will arrange insurance cover for all leased cars on a fleet basis. The insurance will be subject to periodic market testing and, as a result, insurance premiums may increase or decrease during the lease period of any given

vehicle. Lease car users should be aware that, in this event, personal contributions are liable to increase or decrease accordingly.

8.2 The Trust will review the lease car insurance policy on a regular basis to ensure value for money.

8.3 Insurance cover will be provided on a comprehensive basis with each claim subject to an insurance excess.

8.4 The Trust will be guided by the national provisions regarding insurance excess incurred on business travel, but will take regard of the circumstances of and responsibility for the incident leading to the excess. Any excess arising form private use will be charged to the lease car user (see 8.11).

8.5 The Trust will make each post holder aware of the specific details of the insurance policy relevant to them.

8.6 A certificate of insurance will be issued to all lease car users on each occasion of insurance renewal and users will be notified of any changes to the insurance cover as and when these occur.

8.7 Lease car users should note that Trust-owned equipment, such as laptops etc, is not covered by the lease car insurance policy. Consequently such equipment should not be transported in a lease car unless absolutely necessary and, if conveyed, should be secured out of sight if the vehicle is unattended (e.g. in the boot area of the vehicle).

8.8 Similarly, cover for the theft of, or from, an unattended vehicle is excluded when the vehicle is:

- left unlocked
- left with the keys
- left with the windows or roof panel open
- reasonable precautions have not been taken to protect it.

8.9 The insurance cover applies in Great Britain, Northern Ireland, the Channel Islands, the Isle of Man and all member countries of the European Community. However, users must request and obtain written approval from the appropriate leasing company before taking leased vehicles abroad.

8.10 In the event of being involved in an incident, lease car users are to complete the appropriate accident report form (supplied by the insurance company) at the earliest opportunity regardless of whether the incident will result in an insurance claim. Accident report forms are available from Fleet administration and all lease car users should keep a blank form with their vehicle log book. The completed form should be forwarded to the Fleet administration department for registration and subsequent transmission to the insurers. Comprehensive instructions for repair arrangements are detailed in the lease car procedure notes.

8.11 All insurance claims will be subject to an excess fee as detailed at the time of lease. Liability for payment of the excess fee will lie with either the Trust or the Lease Car User depending on the circumstances of the accident. Liability will be determined as follows:

8.11.1 Private Use

If an accident occurs whilst the vehicle is in private use the lease car user will be liable for payment of the insurance excess regardless of the circumstances resulting in the accident. It should be noted that journeys from home to base and return are classed as private use.

8.11.2 Business Use

If an accident occurs whilst the vehicle is in business use liability for payment of the insurance excess will be determined by the circumstances of the accident. Where the lease car user is considered blameworthy, for example by driving into the rear of a third party vehicle, then the lease car user will be liable for payment of the excess. Where the lease car user is considered not blameworthy, for example when damage is sustained whilst the vehicle is legally parked and secured etc whilst on Trust business, then the Trust will be liable for payment of the excess.

8.12 The relevant Director will determine whether an individual is blameworthy or not, based upon the evidence contained in accident report forms or other relevant documentation e.g. police reports. Lease car users will have the right to appeal against decisions through the Trust grievance procedure.

9. Contracted mileage

9.1 The procurement of vehicles will be based on a level of contracted mileage. The estimated annual mileage will be proposed by the lease car user, having taken into account both business and private mileage. These should be shown separately when making the application.

9.2 Historical data should be used, where available, to estimate business mileage and private mileage should be calculated on the basis of the employee's return mileage between home and base together with a reasonable approximation of the social, domestic and recreational mileage that they might reasonably undertake.

9.3 Where no historical data is available, for example on allocation of a vehicle to a new post, an estimation of the business mileage is to be made by the relevant line manager based on the nature of the role. Whatever the circumstances, the proposed level of annual mileage must be agreed by the relevant Director prior to submitting requests for vehicle quotations.

9.4 Lease car users are to monitor actual mileage against the contracted level and report any significant variations to their line manager as they occur.

10. Private Use of Vehicles

10.1 All lease car users, including individuals not employed by the Trust (see paragraph 10.3), must be in possession of a current full driving licence. The driving licence of all authorised users will be subject to an inspection not less than annually, or on demand should the Trust deem this necessary.

10.2 Lease car users are to notify the Trust immediately of any notice of intended prosecution, any endorsement on their driving licence, or of any conviction for a motoring offence. Similarly, the trust is to be notified of any medical conditions, permanent or temporary, that may affect an individual's licence entitlement, and may also be required to provide evidence of eyesight tests.

10.3 A partner of the lease car user will be automatically insured to drive the leased vehicle for private use providing that they meet the following criteria:

- The proposed driver is over 21 years of age (for drivers under the age of 21 see paragraph 6.2).
- The proposed driver holds a full driving licence and has a minimum of 12 months' driving experience on that full licence.
- The proposed driver adheres to the protocols and requirements set out in this policy, including those relating to health and to prosecution/endorsement of the licence.

10.4 Written approval, using the relevant form produced by the Trust, must be obtained for any person other than a partner to drive a leased vehicle for private use. The provisions of paragraph 8.3 must be met, and the Trust reserves the right to decline use of the vehicle to any person whom it does not see fit to drive the vehicle.

10.5 Out of working hours leased vehicles must only be used for social purposes. Leased vehicles may not be used for the carriage of passengers for hire or reward or for any type of motor sport, including racing, rallying or pace making, whether on the public highway or on private land.

10.6 The Trust will not, under any circumstances, accept responsibility for parking or other fines (including non-payment of the congestion charge) incurred by lease car users. Payment of any such fine is the sole responsibility of the relevant lease car user.

11. Termination of Lease and Transfer of Vehicles

11.1 The standard lease arrangements will be for a fixed period of 36 months. Where the requirements of a post change and the criteria for a lease car are no longer met, or where a lease car user moves to a post which does not carry an entitlement to a lease car, options include:

- Allowing the user to retain the vehicle, on existing terms, for the remainder of the lease arrangement, but with no renewal or new lease vehicle beyond that point.

- Re-allocation of the vehicle to another user.
- Depending upon the reason for the change of post-holder status in terms of these arrangements, the Trust may agree to bear the cost of early termination.

This will be a matter for the consideration and decision of the relevant Director.

In exceptional circumstances, such as where an employee has been eligible for a lease car for many years but that eligibility is to cease, the Trust will give not less than 12 months' notice of the removal of the employee from the scheme. If necessary the existing lease will be extended by the requisite period in order for this requirement to be met. No other transitional arrangements, for example financial assistance with the purchase of a vehicle, will be available.

11.2 In the event that a lease car user dies in service, the Trust will bear any costs arising from the surrender of the vehicle.

12. Tax Liabilities

12.1 Vehicles allocated through the lease car scheme will attract company car taxation which is based on a percentage of the car's price graduated according to the level of the car's carbon dioxide emissions (CO2).

12.2 Lease car users will incur a tax liability. It is the responsibility of lease car users to ensure that they are aware of the extent of the tax implications when making their vehicle selection. Although the Trust has an obligation to submit returns to HMRC with regard to earnings and benefits in kind, liability and payment of tax is a matter between the individual taxpayer and HMRC.

12.3 For approved "blue light" users, the tax liability will be calculated by reference to HMRC approved guidelines. The list of approved and authorised "blue light" users will be regularly reviewed by the Director/Deputy Director of Operations.

13. Smoking, Eating and use of Mobile Phones etc whilst Driving

13.1 Staff **must not** use mobile telephones or other hand held electronic (or other) devices that distract them whilst driving any vehicle, including lease cars.

13.2 Where a mobile phone cradle and hands-free device is fitted to a Service vehicle, including a lease car, the use of the phone whilst driving is permitted in accordance with current road traffic and road safety legislation.

13.3 Using devices that are not within a suitable hands-free cradle places risks the safety of other road users and places them in danger. Staff cannot be in full control of a vehicle if they are using a hand-held mobile phone whilst driving, and may be deemed to be driving even if parked with the handbrake on and the engine running.

13.4 Hands-free phones are permitted as long as the phone is kept in a cradle, but drivers are still liable to prosecution if they fail to have proper control of their vehicle because their hands-free phone is distracting them. Use of a phone or similar device might justify prosecution on charges of careless or dangerous driving and the possibility of a fine or driving licence endorsement.

13.5 In cases where an accident occurs as a result of the use of a mobile phone, penalties can be far more serious. Such actions could also result in disciplinary action being instigated by the Service.

13.6 Similarly, eating or drinking whilst driving is likely to impair the ability of the driver to maintain full control of the vehicle, and could also lead to the considerations of action above.

13.7 Smoking in the workplace and any enclosed area is against the law, and consequently is not permitted in any service vehicle, including lease cars. Smoking in a vehicle may result in prosecution and/or consideration of disciplinary action.

14. Other considerations

14.1 Where an employee is offered a lease car but prefers instead to use their own vehicle rather than accept that offer, in accordance with paragraph 17.4 of the national terms and conditions handbook reimbursement of mileage allowance will be at the national public transport rates as set out in annex “L” to the handbook.

14.2 Where a lease car is withdrawn, but the criteria for the regular user allowances are met, then those rates of reimbursement may be claimed by the former lease car user (paragraph 17.5).

15. Review

This policy will be reviewed at intervals of not more than three years annually by the Assistant Director, Employee Support Services and the Head of Operational Support, or more frequently should this be required by the Trust or in response to changes to national terms and conditions.

Tony Crabtree
Draft 2, 3 November 2008

Appendix 1 How the Allowances Work

Section 3 outlines a base car allowance of £2,800 with an assumed mileage allowance of 8,500 private and 3,500 business and an emissions ceiling of 190mg CO2. A comprehensive range of vehicles can be obtained via the PASA contract with these base parameters.

This Appendix recognises that these parameters will need to vary given each managers' individual circumstances and outlines the process to be used for allowances and personal contributions, given variances from the base assumption.

A working example for a vehicle that complies with the policy given the base parameters can be demonstrated using a Toyota Avensis Estate 2.0 D T2 5dr

The range of costs for this vehicle using the PASA agreement is as follows

Annual Contracted Mileage	***Lease Cost***
8,000	*2,602*
9,000	*2,640*
10,000	*2,678*
11,000	*2,729*
12,000	*2,780*
13,000	*2,831*
14,000	*2,882*
15,000	*2,933*
16,000	*2,997*
17,000	*3,061*
18,000	*3,125*
19,000	*3,189*
20,000	*3,251*
21,000	*3,286*
22,000	*3,321*
23,000	*3,357*
24,000	*3,391*
25,000	*3,426*

The basis principle in the sliding scale is that if costs rise due to increasing private mileage the employee should pay, if costs rise from base due to increase business mileage then the allowance should rise accordingly.

For example if the business mileage requirement was 5,500 and not 3,500, a mileage increase of 2,000 then the lease cost allowance would increase by 2,000 miles from 12,000 to 14,000 (i.e. a revised allowance of 2,882)

If the private mileage increase above 8,500 to 11,500 then the difference of 3,000 on the base assumption (i.e. the difference in cost between 15,000 and 12,000) of £153 would be payable by the employee.

If the private mileage reduced below 9,000 then the corresponding impact of the reduction will be reduced from the employee's contribution to the vehicle insurance. For example if the private mileage is contracted as 7,000 then the difference of 2,000 on the base assumption (i.e. the difference between 12,000 and 10,000) of £102 would be deducted from the employee's contribution to insurance.

Example of car with base cost > £2,800

A Ford Mondeo 2.0 tdc1 115 Ghia 5 door would qualify under all criteria except cost.

At 12,000 miles the lease cost would be £3,517, an excess of £717 (assuming a 9/3 split on the mileage). The employee would be expected to reimburse the Trust the excess cost.

The same principle of calculating mileage related additional costs or rebates would also apply in these circumstances.

A&E AMBULANCE REPLACEMENT PROJECT 2008/09

BUSINESS CASE

Authorisation:

Proposed by:

Head of Operational Support **Date**

Concurrence:

Director of Operations **Date**

Executive Trust Director **Date**
Finance & Business Planning

Approved By:

Chief Executive **Date**

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CONTENTS

1 EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The purpose of this Combined Business Case (CBC) is for internal London Ambulance Service (LAS) use where combining the Outline and Full Business case requirements can save time and effort, and the overall cost is within the LAS financial approval authority. This business case draws upon both the LAS Strategy Plan 2006/7 to 20012/13 and the Fleet update presented to the Trust Board in March 2008. It refers to recent independent research on fleet size and an urgent requirement to address an ageing fleet of front line ambulances. This CBC draws the conclusion that the Trust should replace 100 of the oldest ambulances with new ones because:

- The need to replace old and worn out vehicles remains strong
- Costs to repair vehicles will become higher as the age of vehicles increases

The preferred option arising from this analysis of costs and benefits is that 100 new ambulances should be purchased to replace older vehicles. The final decision on how these vehicles are financed will be made following a subsequent comparison of lease and purchase options. This business case is based on the option that vehicles are purchased, partially using existing capital resource limit (CRL) for the 08/09 and 09/10 financial years.

1.1.2 This CBC also confirms that the Trust has the capability to manage the project as evidenced by recent projects, the introduction of the PTS range of vehicles since 2002 covering some 140 different specification vehicles, and more recently 148 RRUs during 2006 and 2007/8. Other members of the project team were involved in previous deliveries of the 260 Mercedes AEU's since 2004/5.

1.2 Strategic Case

1.2.1 The Trust has an ageing fleet because of under-investment in the 1990s. The age profile of the fleet is improving, but as at March 2008, 35% of the fleet is greater than 6 years old and 20% of the fleet is more then 9 years old. Older ambulances are costly to maintain, increase overall vehicle downtime and reduce the capacity to achieve performance targets, with a consequent impact on patient care.

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

1.2.3 This business case proposes that 100 of the latest LAS specification, CEN compliant, A&E ambulances are procured to replace the 100 oldest vehicles in the fleet. The ambulances will be Mercedes diesel vehicles with a removable box body and tail lift. This will be the fifth batch of this vehicle type that the Trust has procured

1.2.4 The Trust's fleet replacement strategy specifies that ambulances should be replaced after 6 years. The Trust is procuring vehicles in batches of 100 to achieve a more even spread in the age profile of ambulances to avoid too many vehicles needing to

be replaced at one time in the future. However, the requirement for a sensible age spread needs to be balanced against the risks posed by the ageing fleet.

1.2.5 For this reason, this Combined Business Case has been prepared for Trust Board approval in November 2008 in order to allow 100 replacement ambulances to be procured and put into service by July 2009.

1.3 Economic Case

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

- Provide 100 CEN Compliance ambulance vehicles designed to the latest LAS Specification ready for deployment commencing January 2009.
- To improve the availability of A&E ambulances by reducing instances of off-the-road downtime caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- Meet Health & Safety requirements to reduce back injuries caused by manual trolley bed vehicle loading; by up to 50% like for like by installing mechanical tail-lifts
- To meet the aims of the Strategic Plan 2006/7 to 2012/13 by responding to our patient's needs with the appropriate service.

1.3.2 This business case has considered two options open to the LAS - Do Nothing and a capital purchase of 100 vehicles, 35 in the 2008/09 financial year and 65 at the beginning of the 2009/10 financial year. It has been found that the preferred option is the capital purchase largely due to the Weighted Benefit Score applied to both these options.

1.4 Financial Case

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

1.4.2 The financial case shows that there is a net cost in all years of the project, starting at £0.6 million in year 1, rising to £2.5 million in year 2 as a result of equipment and full-year depreciation costs, reducing to approximately £1.5 million in each year of the remaining life of the project. An overall Trust surplus position is maintained however, throughout the period of investment.

1.4.3 Once the approval to replace the assets has been received, an economic comparison between leasing and purchasing will be undertaken and the affordability of the lease option tested if appropriate.

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

1.5 Commercial Case

1.5.1 During 2003/04, the LAS replaced 130 frontline A&E ambulances with new Mercedes ambulances with aluminium modular box bodies. The Trust subsequently

replaced two batches of 60 replacement vehicles in 2004/5 and 2005/6. A number of this later batch of vehicles included trial innovations such as carbon fibre bodies, new tail lifts and solar panels to assist with power management. These trials offered operating benefits, in particular the carbon fibre bodies, since these offered a lower operating mass resulting in lower fuel consumption. When the trial vehicles were introduced, however, the vehicle was loaded with other equipment and the expected benefits were not realised. In addition, carbon fibre is reputedly simpler and quicker to repair than aluminium, offering potential reductions in vehicle repair times. Moulded carbon fibre interiors could also improve infection control through reducing dirt trapping joints and seams.

1.5.2 The contract for build of ambulance bodies has been tendered via the newly awarded PASA NHS framework agreement. A formal tender evaluation group was formed and reviewed each supplier's submitted tender response using criteria such as price, quality, compliance to the specification, ability to meet the vehicle delivery schedule.

1.5.3 The tender evaluation has been completed for the build of ambulance bodies therefore, this business case has been drafted using the prices from the tender, and current costs the LAS incurs. Approval for this business case is sought on the basis that final prices are within reasonable proximity of the quoted prices in the financial analysis of this document.

1.6 Management Case

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

1.6.2 The stakeholders' expectations are that vehicles commence operational deployment starting from December 2008 and that all vehicles are in service by the end of July 2009. This is an ambitious and challenging schedule to achieve. However, these timeframes cannot be confirmed until contracts are placed with the individual equipment suppliers and their production schedules are known.

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

2 STRATEGIC CASE

2.1 LAS Organisational Overview

2.1.1 Summary of LAS Organisation

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

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

2.1.1.3 The main functions of the Trust are to:

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

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

2.1.2 Business Goals

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

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

2.1.2.3 At the time of writing and in terms of the LAS' primary performance measure set by the DH, as at 14th October 2008 the LAS are tracking at 73.03% of all Category A calls reached within 8 minutes in 2008/09. The timely delivery of this resource is considered a key contributor to the Trust's ability to achieve the 75% target for the year.

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2.2 Investment Overview

2.2.1 Current Facilities

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

2.2.1.2 A report from a recent independent consultancy study has confirmed that to maintain its current vehicle availability the current fleet size of 395 should be maintained.

2.2.1.3 The Wells Inquiry established in 1992/93 by Sir William Wells details the importance of annual investment to replace vehicles. He identified that for a number of years, funding for the LAS and in particular, ambulance replacement was either withheld or reduced by stakeholders resulting in a fleet of unreliable vehicles. This led to poor performance, low morale in all parts of the service and both high running and maintenance costs.

2.2.1.4 As directed by the Wells report, the LAS is to implement an annual replacement programme to maintain the age of the LDV/UVG built A&E vehicle fleet at or under 6 years of age in line with the national standard. This is also in compliance with the consultants reports which recommend the LAS requires 100% availability of all its rostered A&E vehicles and an efficient, effective and reliable A&E vehicle fleet is vital to meet this requirement.

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

2.2.1.6 During 2003, the LAS commenced a replacement programme of 121 of its frontline A&E ambulances with 130 new vehicles, however these are now 5 years old and the Trust is still heavily reliant upon the 142 older LDV vehicles to maintain its performance. Table 1 illustrates the current age distribution of frontline ambulances. As the new vehicles are introduced and changes into the deployment of resources it is planned, the A&E ambulance fleet will remain at 397 vehicles that the Trust uses and deploys in response to 999 calls, doctors urgent calls and non-urgent calls initiated within the NHS.

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

Table 1

Vehicle Age	10-11 Years	9-10 Years	8-9 Years	7-8 Years	6-7 Years	5-6 Years	4-5 Years	3-4 Years	2-3 Years	1-2 Year	<1 Year	
Year in service	(97/98)	(98/99)	(99/00)	(00/01)	(01/02)	(02/03)	(03/04)	(04/05)	(05/06)	(06/07)	(07/08)	
Sectors												**Totals**
South	14	15	0	26	0	5	47	24	25	0	0	156
East	8	17	0	13	0	0	30	21	12	0	0	101
West	9	18	0	22	0	3	44	20	23	1	0	140
Totals	31	50	0	61	0	8	121	65	60	1	0	397

2.2.1.8 The older vehicles, some of which are over 10 years of age are becoming increasingly unreliable. This inevitably leads to lower response and vehicle availability performance, lower morale for those having to use these vehicles but also higher running and maintenance costs.

2.2.1.9 The Trust knows that vehicle reliability/availability is a large factor in providing the level of patient care required of it and that this naturally deteriorates as vehicle age profiles increase further. The older LDVs are recorded as those with the highest VOR, are repeatedly faulted and putting greater pressures on the workshops. Many parts are becoming difficult to obtain and costs continually increasing due to the low number of suppliers.

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

2.2.1.11 The major justification for updating vehicles to CEN includes:

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

2.2.2 Proposed Facilities

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

2.2.2.2 This Business Case sets out the argument for replacing 100 of the oldest LDV

vehicles with new CEN compliant vehicles built to the latest LAS Specification dated June 2008, this has been up-dated from the original 2003 designed vehicles encompassing minor changes to reflect enhancements in medical treatment. The vehicles shown in Table 1, which are in years 9-11, will be the target for replacements. These years make up 81 vehicles and the Fleet Size Review and Control Group will provide the project with a list of 100 vehicles within that period for replacement

2.2.2.3 This case also seeks to demonstrate that the need for this investment enables the Trust to better balance the age of the fleet by resuming the practice of replacing a sixth of the vehicle fleet each year. It is only through annual replacements that the Trust can ensure reliable, cost effective, appropriate and efficient vehicles are available to patients and staff. If the Trust operates aged and inappropriate vehicles then it cannot expect to achieve its performance targets and expected levels of patient treatment and care.

2.2.2.4 In 2003/04, 130 vehicles were replaced which represents almost a third of the fleet. This was done purely out of necessity to replace the same percentage of vehicles that were reaching an unacceptable 10 years old. The Trust seeks to achieve a continuation of vehicle replacements each year for it is good practice and allows more opportunities to review the current specification and make improvements to each vehicle build. This also reduces the disruption caused to operations when vehicle replacements take place.

2.2.2.5 A characteristic of this investment is the treatment of the vehicle as one investment item, with both Capital and Revenue cost implications.

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

2.2.2.7 The Trust will always seek to be as cost-efficient as possible. A significant benefit of the new ambulances is the reduced fuel costs achieved. The reduction in fuel costs through use of a cheaper fuel alternative with greater economic consumption is achieved by using diesel. Evidence from the latest vehicles has shown that they provide us with improved miles per gallon rate of 16.5mpg verses 9mpg.

2.3 Investment Objectives and Targets

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

- To provide 100 CEN compliant ambulance vehicles designed to the latest LAS specification ready for deployment commencing January 2009.
- To improve the availability of A&E Ambulances by reducing instances of off-the-road downtime (VOR) caused by aged, unreliable and/or high maintenance issues.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- To reduce back injuries caused by trolley bed vehicle loading by up to

50% like for like through installing mechanical tail-lifts

- To meet the Strategic Plan 2006/7 to 2012/13 in responding to our patients' needs with the appropriate service.

2.4 Scope of Investment

2.4.1 The scope of this project includes the investment in 100 vehicles to replace the oldest and/or most unreliable vehicles in the current fleet.

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

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

2.4.4 The critical success factors of this investment centre on:

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

2.4.5 The success of this investment will be shown by:

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

2.5 Constraints and Dependencies

2.5.1 Constraints

Constraints identified for this investment include:

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

2.5.2 Dependencies

2.5.2.1 The major dependencies identified for this project are:

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

3 ECONOMIC CASE

3.1 Objectives

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

- Provide 100 CEN compliant ambulance vehicles designed to the latest LAS specification ready for deployment commencing January 2009.
- To improve the availability of A&E ambulances by reducing instances of off-the-road downtime by caused by aged, unreliable and/or high maintenance issues by November 2009.
- To reduce the annual fuel running costs by going from 9 miles per gallon to 16.5 miles per gallon, through adopting diesel powered engines.
- To reduce back injuries caused by trolley bed vehicle loading by up to 50% like for like through installing mechanical tail-lifts
- To meet the Strategic Plan 2006/07 to 2012/13 in responding to our patient's needs with the appropriate service.

3.2 Benefits

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

Financial Benefits

- Less overtime costs through cover of back injuries
- Achieving a better fuel consumption thus reducing running costs
- Reduced maintenance costs due to parts for newer vehicles being cheaper, and the expectation that less maintenance will be required due to vehicles being younger.
- Enhanced operational capability with a reduction in unscheduled breakdowns of vehicles.
- Fitment of Incident Data recorders with overall benefit to reduce accident rate and therefore repair costs, benefit realisation dependent upon other projects.
- Non-Financial Benefits
- Reduced workload on Fleet department
- Improved trolley bed equipment, (intention that it will be more durable – less prone to breakdown) coupled with a greater tail-lift capacity would give a Bariatric capability
- Improved patient care through increased vehicle reliability/availability
- Greater number of CEN compliant ambulances
- Reduced CO2 emissions in line with the Kyoto agreement
- Non-Quantifiable Benefits

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

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

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

Table 2

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

3.3 Generating Options

3.3.1 Long List and Short List of Options

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

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

- **Do Minimum** - No replacement vehicles would be purchased for another three years with repairs being carried out and vehicle equipment being replaced only in the event of failure, accidents or breakages. Disadvantages of this option include high vehicle maintenance costs, vehicle downtime and high fuel costs due to petrol rather than diesel engines. The potential lack of availability and poor reliability of vehicles carries a higher risk of lower staff morale, under-performance against targets and a lower quality of patient care.
- **Procure 100 new A&E ambulances (Option 1)** - Procure 100 Mercedes chassis and 100 bodies of similar type to the Mercedes vehicles currently on lease. This option assumes 100 Mercedes chassis will be procured along with 100 bodies of similar type to the 2005/06 procurement. A new trolley bed will be included. New MDT and communications equipment may be included as part of the work to be completed by the LAS on receipt of approved vehicles from the converter.

3.3.2 Option Ranking

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

Table 3

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

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

Table 4

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

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

3.4 Identification and Quantification of Option Costs

3.4.1 Opportunity Costs

There are no opportunity costs identified against either of the options.

3.4.2 Residual Identified Value Costs

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

3.4.3 Capital Costs

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

Table 5

Option 1 - Purchase 100 vehicles	Number of Units = 100				
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Saloon Build	56,995	9,974	66,969	5,699,500	6,696,913
Lifecycle Costs					
Purchase of chassis	26,583	4,652	31,235	2,658,300	3,123,503
Purchase of trolley bed	8,805	1,541	10,346	880,500	1,034,588
Technology fit (MDT and radio)	6,598	1,155	7,753	659,800	775,265
Totals	**98,981**	**17,322**	**116,303**	**9,898,100**	**11,630,268**

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

- **Saloon Build** – Costs have been provided by Operational Support and are based on a recent tender exercise.
- **Purchase of Chassis** – Costs have been based on a quotation received from Mercedes on 15/08/08.
- **Purchase of Trolley Bed** – This cost is from the tender application received from Supplier A in July 2008 for the supply of a trolley bed and the associated CEN compliant fixings. Supplier B trolley beds are cheaper to purchase but are likely to incur higher maintenance costs. For prudence, the trolley bed cost from Supplier A has been included in this analysis until the outcome of the tender exercise is known.
- **Technology Fit (MDT and Radio)** – MDT and the service radio equipment may be transferred from old LDVs into the new Ambulances, at this time it is uncertain as to whether this will be the best approach, as such costs used are based on previous purchases of MDTs & Radios for the 2007/08 RRU project with estimated installation costs.

3.4.4 Revenue Costs

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

3.4.4.2 The costs for the 'Do Minimum' option reflect the costs built into existing (2008/09) forecasts for retaining 100 vehicles and estimates for maintaining 100 vehicles for a further period. These costs are shown in Table 6.

Table 6

Do Minimum - Retain Existing Vehicles (for 3 yrs)							
	Unit Cost	Cost Driver	Cost Driver Units	Annual Cost per Vehicle	Cost for GEM	VAT (or other taxes)	Total Cost per annum
Existing Recurrent							
Fuel	0.4721	per mile	19,500	9,207	920,653	161,114	1,081,767
Vehicle maintenance (including labour)				4,944	494,389	86,518	580,907
Trolley bed maintenance - Ferno				1,126	112,600	19,705	132,305
				15,276	1,527,642	267,337	1,794,979

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

- **Fuel** – The existing LDV based vehicles operate at just over 9 mpg. The price paid by the Trust, during September 2008, for Cleaner Unleaded petrol was 112.06 pence per litre (incl. VAT). On average, the vehicles are expected to cover 19,500 miles per annum.
- **Vehicle Maintenance** – The costs of maintaining the existing vehicles is calculated with reference to existing fleet records and the professional judgement of fleet managers.
- **Trolley Bed Maintenance** – The costs of maintaining the current trolley bed have been calculated with reference to existing fleet records and the professional judgement of fleet managers and finance.

3.4.4.4 The revenue costs of Option 1 are shown in Table 7.

Table 7

Option 1 - Purchase 100 vehicles							
	Unit Cost	Cost Driver	Cost Driver Units	Annual Cost per Vehicle	Cost for GEM	VAT (or other taxes)	Total Cost per annum
Non Recurrent (Year 0 Costs)							
Initial Clinical Equipment					826,082	144,564	970,646
Trolley Bed Extra Batteries				120	12,000	2,100	14,100
Commissioning costs of vehicles				528	52,800	9,240	62,040
				648	890,882	155,904	1,046,786
Recurrent							
Fuel	0.2867	per mile	19,500	5,591	559,065	97,836	656,902
Vehicle maintenance (including labour)				3,048	304,814	53,342	358,156
Trolley bed maintenance - Stryker				925	92,500	16,188	108,688
Taillift Maintenance				337	33,700	5,898	39,598
				9,901	990,079	173,264	1,163,343

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

- **Fuel** – The current Mercedes ambulances operate at 16.5 mpg. The price paid by the Trust, during September 2008, for diesel was 123.52 pence per litre (Incl. VAT). On average, the vehicles are expected to cover 19,500 miles per annum.

- **Vehicle Maintenance** – The costs of maintaining the proposed vehicles is calculated with reference to existing fleet records for Mercedes ambulances and the professional judgement of fleet managers.

The maintenance cost shown is the average cost over the 6-year life of the vehicle. These costs do not fall evenly over the life of the chassis. Table 8 below sets out an analysis of the vehicle maintenance costs over the life of the vehicle's.

Table 8

Option 1 - Purchase New Vehicles	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
One off costs (not covered by warranty) - Major Repairs	**0.0**	**15.0**	**18.3**	**82.2**	**118.3**	**140.0**	**166.7**
General Service Maintenance Costs							
Air conditioning				2.5			
General Maintenance (Parts only)	0.0	37.2	37.2	37.2	37.2	37.2	37.2
Labour costs	0.0	55.8	57.5	59.2	61.0	62.8	107.9
Brakes	0.0	54.2	54.2	54.2	54.2	54.2	54.2
Battery	0.0	32.5	32.5	32.5	32.5	32.5	32.5
Minor one off repairs	0.0	2.0	2.0	2.0	2.0	2.0	2.0
General Service Costs including labour	**0.0**	**181.7**	**183.3**	**187.5**	**186.8**	**188.7**	**233.7**
TOTAL - PURCHASE NEW VEHICLES	**431.5**	**196.7**	**201.7**	**269.7**	**305.2**	**328.7**	**400.4**

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

3.4.5 Transitional Costs

There are no transitional costs associated with the 'Do Minimum' option. Option 1 incurs transitional costs associated with decommissioning the old vehicles (estimated at £2,484 each, excl VAT) and storing them before disposal (estimated at £1,000 each, excl VAT), also the new Vehicles will need to be disposed of at the end of their expected life (estimated at £2,484 each, excl VAT).

3.4.6 External Costs

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

3.5 Discounted Cashflow Analysis of Options

3.5.1 The costs identified in section 3.4 have been entered into the DH's Generic Economic Model (GEM), applying the HM Treasury discount rate of 3.5%. HM Treasury guidance requires the use of the Equivalent Annual Cost (EAC) where the appraisal periods for each option are not of the same duration. Appraisal is based on all 100 ambulances being in use by the end of July 2009.

Table 9

SUMMARY	Appraisal Period	EAC
		£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	1,208.4
OPTION 1 Purchase 100 vehicles	7 Years	2,597.7

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

3.6 Option Cost Benefit Analysis

3.6.1 Cash Releasing Benefits

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

- **Fuel** - The change of engine type and the consequent increase in miles per gallon of the diesel engine is estimated to save £361,588 (ex VAT) per annum.
- **Vehicle Maintenance** - The change of engine type and body type is estimated to save £214,936 (ex VAT) per annum.
- **Trolley Bed Maintenance** – The change from the current supplied trolley beds to Supplier A trolley beds and the younger age of the trolley beds would save approximately £20,100 (ex VAT) per annum.

3.6.2 Non-Cash Releasing Benefits

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

3.6.3 Quantifiable Benefits

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

3.6.4 Non-Quantifiable Benefits

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

3.6.5 Summary of Option Cost Benefit Analysis

At this point in the analysis, the EACs shown in Table 9 are divided by the benefit scores from Table 4 to result in a value of EAC per weighted benefit score. This is

shown in the table below:

Table 10

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score
		£'000		£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	1,208.4	7	163.80
OPTION 1 Purchase 100 vehicles	7 Years	2,597.7	807	3.22

The calculations above show that Option 1 has a lower cost per weighted benefit score and is therefore the preferred option.

3.7 Assessing Risk

3.7.1 Risk Identification

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

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

3.7.2 Risk Transfer

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

3.7.3 Optimism Bias

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

3.7.4 Assessing the Impact of Risk on Option Ranking

The table below summarises the assessment of risk for the do minimum option

Table 11

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
The business case is not approved.	5%	Fleet ages and becomes less reliable. Maintenance Costs and potential legal liabilities of up to £1,000,000	£50,000	Close liaison with stakeholders to ensure the business case is clear, concise and falls within the guidelines for approval.
Maintenance costs are higher than expected	10%	The service incurs higher than expected maintenance costs increasing the running costs of the vehicles at £450 per vehicle. (£45,000)	£4,500	Assign a financial threshold on vehicle maintenance costs before making a decision on the vehicles operating viability.
Spare parts become increasingly scarce for old vehicles, suppliers charge premium.	70%	More vehicles are off the road due to parts shortage and the service has higher parts costs; increasing costs by £350 per vehicle. (£35,000)	£24,500	Close liaison with suppliers, and create strategy to stock up on parts known to be low or earmarked for deletion from supply.

The table below summarises the assessment of risk for Option 1.

Table 12

Risk	Prob (%)	Effect (Cost £)	Quantified Risk (Probability * Cost)	Management
The business case is not approved.	5%	Fleet ages and becomes less reliable. Maintenance Costs and potential legal liabilities of up to £1,000,000	£50,000	Close liaison with stakeholders to ensure the business case is clear, concise and falls within the guidelines for approval.
New contractor may have lack of LAS specific knowledge which may result in Project schedule over-runs	30%	Delayed start (2 months) meaning old vehicles requiring longer life and extra maintenance at £250 per vehicle (£25,000)	£7,500	Assign high priority. Pressure supplier to perform
Maintenance costs are higher than expected	10%	The service incurs higher than expected maintenance costs increasing the running costs of the vehicles at £100 per scheduled maintenance period. (£90,000 pa)	£9,000	Assign a financial threshold on vehicle maintenance costs before making a decision on the vehicles operating viability.

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

Table 13

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjustment	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score
		£'000		£'000	£'000	£'000	£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	1,208.4	7	163.80	34.5	1,242.9	168.48
OPTION 1 Purchase 100 vehicles	7 Years	2,597.7	807	3.22	16.7	2,614.3	3.24

3.8 Preferred Option Analysis

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

3.8.1 Funding Route Option

The preferred option (Option 1) can be funded either using NHS Capital, or by investigating leasing options. This business case addresses the capital purchase only. Once approved, a lease versus buy analysis will be carried out to determine the most appropriate funding method.

3.9 Sensitivity Analysis

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

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

Table 14

SENSITIVITY ANALYSIS	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjustment	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score
		£'000		£'000	£'000	£'000	£'000
OBC Do Minimum Retain Existing Vehicles (for 3 yrs)	4 Years	1,208.4	7	163.80	34.5	1,242.9	168.48
OPTION 1 - No Changes Purchase 100 vehicles	7 Years	2,597.7	807	3.22	16.7	2,614.4	3.24
OPTION 1 - Only Half Fuel Saving Purchase 100 vehicles	7 Years	2,740.7	807	3.40	16.7	2,757.4	3.42
OPTION 1 - No Vehicle Maintenance Savings Purchase 100 vehicles	7 Years	2,795.5	807	3.46	16.7	2,812.2	3.48

- **Option 1 (Only Half Fuel Savings Achieved)** – This test assumes that the fuel savings achieved will only be half the £361,588 assumed in the base case. The risk-adjusted EAC would increase by £143k to £2,757.4k giving a risk-adjusted EAC per weighted benefit score of 3.42. This is still substantially lower than the 'Do Minimum' option.
- **Option 1 (Maintenance Savings Not Achieved)** – This test assumes that the vehicle maintenance savings estimated in the base case will not be achieved. In this scenario, the risk-adjusted EAC would increase to £2,812.2k giving a Risk Adjusted EAC per Weighted Benefit Score of 3.48. Again, this is still substantially lower than the 'Do Minimum' option.

3.10 Summary of the Economic Case

In summary, the above analysis has shown that replacing the vehicles results in the most cost-effective option, due to the significant non-financial benefits expected to be achieved through replacing the ambulances.

4 FINANCIAL CASE

4.1 Financial Position

4.1.1 The LAS has a track record of meeting all of its statutory financial duties each year. It is expected that this position will be maintained in the current year. The proposed investment will partly be funded from the savings generated from reduced fuel, trolley bed maintenance and vehicle maintenance costs. The investment will proceed on the basis that it will have no material impact on the Trust's financial standing.

4.2 Impact on Income and Expenditure Account

4.2.1 The table below sets out the net impact of the proposed investment on the Trust's Income & Expenditure (I&E) Account. This demonstrates that there is a net cost in all years of the project, starting at £0.6 million in year 1, rising to £2.5 million in year 2 as a result of equipment and full-year depreciation costs, reducing to approximately £1.5 million in each year of the remaining life of the project. An overall Trust surplus position is maintained however, throughout the period of investment.

Table 15

2008/09 Financial Projections
Income & Expenditure Account

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m	£m	£m	£m
A&E Income	247.2	236.1	240.7	246.2	251.9	257.7	263.6
PTS Income	10.0	8.5	8.5	8.5	8.5	8.5	8.5
Other Income	3.2	14.2	21.1	21.6	22.1	22.6	23.1
Total Income	**260.4**	**258.8**	**270.3**	**276.3**	**282.5**	**288.8**	**295.2**
Baseline Pay	(191.2)	(195.5)	(206.3)	(210.4)	(214.6)	(218.9)	(223.3)
Baseline Non-Pay (Drug Costs)	(0.4)	(0.5)	(0.5)	(0.6)	(0.6)	(0.6)	(0.6)
Baseline Non-Pay (Other Costs)	(56.6)	(48.4)	(47.6)	(50.0)	(51.5)	(53.5)	(55.5)
AMB 08/09 - Non-Pay Costs	(0.5)	(0.9)	0.0	0.0	0.0	0.0	(0.3)
AMB 08/09 - Non-Pay Savings	0.0	0.8	0.8	0.7	0.7	0.7	0.7
Total Costs	**(248.7)**	**(244.6)**	**(253.7)**	**(260.3)**	**(266.0)**	**(272.3)**	**(279.0)**
EBITDA	**11.7**	**14.3**	**16.6**	**16.0**	**16.4**	**16.5**	**16.2**
EBITDA Margin	*4.51%*	*5.51%*	*6.15%*	*5.79%*	*5.82%*	*5.70%*	*5.49%*
Profit/Loss on Asset Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Asset Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation & Amortization	(7.6)	(7.8)	(7.8)	(7.8)	(7.8)	(7.8)	(7.8)
Interest receivable/(payable)	0.7	0.3	0.3	0.3	0.3	0.3	0.3
Loan Interest Payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividend	(4.4)	(4.4)	(4.4)	(4.4)	(4.4)	(4.4)	(4.4)
AMB 08/09 - Depreciation	0.0	(2.1)	(2.1)	(2.1)	(1.8)	(1.8)	(1.8)
AMB 08/09 - PDC dividend	(0.1)	(0.2)	(0.3)	(0.2)	(0.2)	(0.1)	(0.0)
Retained Surplus/(Deficit) for the Year	**0.4**	**(0.0)**	**2.3**	**1.8**	**2.5**	**2.6**	**2.4**
I&E Surplus Margin	*0.15%*	*-0.01%*	*0.86%*	*0.64%*	*0.90%*	*0.91%*	*0.83%*

4.3 Affordability Gap

4.3.1 Additional CIP savings of £300k will need to be achieved in the 09/10 financial year to assist with ensuring the project is affordable

4.3.2 Due to CIP savings there is no affordability gap and therefore commissioner support has not been sought.

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

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

4.4 Balance Sheet

Table 16

2008/09 Financial Projections
Balance Sheet

	Notes	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
		£m	£m	£m	£m	£m	£m	£m
FIXED ASSETS								
Tangible and Intangible Fixed Assets		134.5	134.5	134.4	134.4	134.4	134.4	134.4
AMB 08/09 - Tangible Fixed Assets (at cost)		4.1	11.6	11.6	11.6	11.6	11.6	11.6
AMB 08/09 - Tangible Fixed Assets (depreciation)		0.0	(2.1)	(4.1)	(6.2)	(8.0)	(9.8)	(11.6)
Total Fixed Assets		**138.5**	**144.0**	**141.9**	**139.8**	**138.0**	**136.2**	**134.4**
CURRENT ASSETS								
Stocks & Work in Progress		1.9	1.9	1.9	1.9	1.9	1.9	1.9
NHS Trade Debtors		2.0	1.9	2.2	2.5	3.0	2.8	3.0
Non NHS Trade Debtors		0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other Debtors		0.2	0.2	0.2	0.2	0.2	0.2	0.2
Accrued Income		0.2	0.2	0.2	0.2	0.2	0.2	0.2
Prepayments		1.9	1.9	1.9	1.9	1.9	1.9	1.9
Cash at bank and in hand		11.3	1.0	1.2	7.1	13.2	19.5	25.6
Total Current Assets		**17.7**	**7.3**	**7.8**	**14.0**	**20.6**	**26.7**	**33.0**
CURRENT LIABILITIES (amounts due in less than one year)								
Trade Creditors		(11.9)	(7.7)	(5.8)	(8.4)	(10.5)	(12.6)	(14.7)
Other Creditors		(7.8)	(8.3)	(8.6)	(9.0)	(9.6)	(9.6)	(9.9)
PDC dividend creditor		0.1	0.5	1.0	1.6	2.1	2.5	2.8
Capital Creditors		(1.8)	(1.0)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)
Interest payable creditor		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Payments on Account		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Accruals		(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
Deferred Income		(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Total Current Liabilities		**(22.1)**	**(17.2)**	**(15.0)**	**(17.4)**	**(19.6)**	**(21.2)**	**(23.3)**
NET CURRENT ASSETS/(LIABILITIES)		**(4.4)**	**(9.9)**	**(7.2)**	**(3.4)**	**1.0**	**5.4**	**9.7**
Long Term Debtors		9.9	9.9	9.9	9.9	9.9	9.9	9.9
TOTAL ASSETS LESS CURRENT LIABILITIES		**144.0**	**144.0**	**144.6**	**146.3**	**148.9**	**151.5**	**153.9**
Finance Leases		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provision for Liabilities and Charges		(18.3)	(18.3)	(16.6)	(16.6)	(16.6)	(16.6)	(16.6)
Loans		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Assets Employed		**125.7**	**125.7**	**128.0**	**129.8**	**132.3**	**134.9**	**137.4**
Financed by Taxpayers Equity:								
Public Dividend Capital		56.5	56.5	56.5	56.5	56.5	56.5	56.5
Income and Expenditure Reserve (Prev Yr)		13.0	13.4	13.4	15.7	17.5	20.0	22.6
Effect on Reserves Current Year		0.4	(0.0)	2.3	1.8	2.5	2.6	2.4
Revaluation Reserve		56.2	56.2	56.2	56.2	56.2	56.2	56.2
Donated Asset Reserve		0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other Reserves (Government Grant Reserve etc)		(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Total Taxpayers Equity		**125.7**	**125.7**	**128.0**	**129.8**	**132.3**	**134.9**	**137.4**

4.4.1 The table above sets out the net impact of the proposed investment on the Trust's Balance Sheet. This demonstrates that there is a zero impact on total assets employed due to the assumption that assets are purchased and paid for within the same financial year.

Table 17

Return on Assets	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
ROA Before Investment	4.34%	5.29%	6.25%	5.72%	5.88%	5.72%	5.61%
ROA After Investment	3.87%	3.67%	5.50%	4.94%	5.37%	5.29%	5.01%

4.4.2 Return on Assets (ROA) is projected to improve over the life of the investment due to depreciation on the asset value and continued projected income and expenditure surpluses. ROA is lower than before the investment due to equipment costs in the first two years, depreciation charges in all years and disposal costs in the final year.

4.5 Cashflow Statement

Table 18

2008/09 FBC Financial Projections
Cash Flow

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m	£m	£m	£m
EBITDA	**11.7**	**14.3**	**16.6**	**16.0**	**16.4**	**16.5**	**16.2**
Excluding Non cash I&E items	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in working capital:							
Stocks & Work in Progress	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NHS Trade Debtors	(0.4)	0.2	(0.3)	(0.3)	(0.5)	0.2	(0.2)
Non NHS Trade Debtors	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Debtors	4.1	0.0	0.0	0.0	0.0	0.0	0.0
Accrued Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Prepayments	3.3	0.0	0.0	0.0	0.0	0.0	0.0
Trade Creditors	0.3	(4.2)	(1.9)	2.6	2.1	2.1	2.1
Other Creditors	6.0	0.5	0.3	0.4	0.6	(0.1)	0.3
Payments on Account	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Accruals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Deferred Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions & Liabilities	(0.3)	0.0	(1.8)	0.0	0.0	0.0	0.0
CF from Operations	**24.8**	**10.7**	**13.0**	**18.7**	**18.7**	**18.7**	**18.4**
Capital Expenditure							
Capex Spend	(15.8)	(8.6)	(7.9)	(7.8)	(7.8)	(7.8)	(7.8)
AMB 08/09 - Capex Spend	(4.1)	(7.6)	0.0	0.0	0.0	0.0	0.0
Cash receipt from asset sales	1.5	0.0	0.0	0.0	0.0	0.0	0.0
CF before Financing	**6.4**	**(5.5)**	**5.1**	**10.9**	**10.9**	**10.9**	**10.6**
Movement in LT debtors	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in LT Creditors	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest (paid)/ received on cash balance	0.5	0.3	0.3	0.3	0.3	0.3	0.3
Public Dividend Capital received	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Public Dividend Capital repaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Movement in Other grants/Capital received	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends paid	(4.5)	(4.8)	(5.0)	(5.0)	(4.9)	(4.8)	(4.7)
AMB 08/09 - PDC Dividend paid	(0.1)	(0.2)	(0.3)	(0.2)	(0.2)	(0.1)	(0.0)
Net cash inflow/(outflow)	**2.3**	**(10.2)**	**0.2**	**5.9**	**6.1**	**6.3**	**6.1**
Bank Opening Balance	9.0	11.3	1.0	1.2	7.1	13.2	19.5
Net Cash Change in Year	2.3	(10.2)	0.2	5.9	6.1	6.3	6.1
Bank Closing Balance at YE	11.3	1.0	1.2	7.1	13.2	19.5	25.6

4.5.1 The table above sets out the net impact of the proposed investment on the Trust's Cashflow Statement. The project will reduce the projected Cash Position due to the project being funded through existing cash holdings. The overall impact however will be that the LAS will remain in a surplus cash position.

5 COMMERCIAL CASE

5.1 Assessment of the Market

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

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

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

5.1.3 This business case will follow PASA recommendations for evaluating company tender submissions.

5.1.4 As seen in the above list, the industry has sufficient expertise and authority to complete these works since the specification requires a CEN compliant vehicle.

5.2 Alternative Procurement Methods

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

5.3 Concurrent Contracts

5.3.1 There are no concurrent contracts associated with this procurement, although the prime contractor is likely to sub-contract elements of work to other parties. It will be a requirement of the contract that any known or likely sub-contracting work is declared in advance as part of the tender submission.

5.4 Procurement Options/Strategy

5.4.1 The procurement of the vehicles will not involve OJEU tenders but use the Current NHS PASA National Framework agreements for the procurement of Ambulance Chassis and saloon work. As the suppliers on this Framework have already been tested through OJEU, an OJEU notice is not required.

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

5.5 Bid Criteria

5.5.1 The Evaluation of the received bids will be in accordance with the LAS Standing Orders (SOs). The bids will be assessed using criteria, which may include:

- Compliance to specification
- CEN compliance certification
- Financial Standing of the company

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

5.6 Evaluation Model

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

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

5.6.2 The Bids are opened and recorded.

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

5.6.4 The immediate tender evaluation team consists of:

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

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

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

5.6.7 The full evaluation report will be created and will detail the final recommendation. The Directors will receive a short statement detailing who the successful contractor is as well as the agreed price. .

5.7 Key Principles for Contract Type

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

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

5.8 Initial Assessment of the Transfer of Risk

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

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

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

5.9 Procurement Timetable

5.9.1 From approval of the Business case, procurement takes approximately 100 weeks. This includes:

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

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

6 MANAGEMENT CASE

6.1 Project Management

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

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

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

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

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

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

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

Table 19

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

6.2 Resources

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

6.3 Change Management

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

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

6.4 Project Plan

6.4.1 The detailed tasks of the project are defined in the Project Plan, which forms part of the Project Initiation Document.

6.4.2 The procurement timescale of the project covers an estimated 100 week period from compiling the specification, through the business case, tendering for conversion and placement of orders to delivery of the last vehicle into service.

6.4.3 The expected plan is represented in Gantt chart format, shown in Appendix C. A more detailed plan will be constructed during project phase planning, which may result in changes to the durations. The plan has been created around historical and

current information taken from suppliers, which cannot be confirmed until orders have been placed. This is also because each company has a different production capacity.

6.5 Risk Management

6.5.1 A Project Risk is defined as a situation, which may have a negative or positive impact on delivering the project.

6.5.2 Business risks will be assessed and monitored during the lifecycle of the project. An operational risk assessment will also be carried out during the tender evaluation period and vehicle build and approval phases. Once the project is initiated, any risks that are identified will be entered into the project Risk Log. The identified "project risks" are monitored and managed by the Project Manager as part of the Checkpoint Meetings. The Project Manager also monitors the other identified risks during the course of the project for changes in terms of probability. Risk assessment is an on-going process and changes are reported by means of Risk Reports. The Project Manager will take initial action on all Risk Reports and all actions are recorded in the Risk Log. At project closure, the register of remaining risks is handed over to the User Director for continued monitoring.

6.5.3 For the duration of the project, the Project Board will examine the Risk Log at each of its meetings to ensure risk is under control and that where necessary, appropriate actions have been taken.

6.5.4 The Project Board will consider if any risks could arise post-project and these will be handed over to the appropriate Senior Manager for monitoring on project closure.

6.6 Security and Confidentiality

6.6.1 There is no involvement with the patient during or post-project and therefore there are no security or confidentiality issues regarding Caldicott or the Data protection Act.

6.7 Benefits Realisation Plan

6.7.1 The responsibility for ensuring that benefits within this business case are optimised and measured sits with the Project Board.

6.7.2 The Project Board will monitor the benefits as vehicles are introduced into service. The nature of the benefits listed below means a reasonable amount of time must pass before they can be accurately measured.

6.7.3 On Project Closure, the responsibility for monitoring and managing achievement of individual benefits will be transferred to those nominated in the Benefits Realisation table.

6.7.4 The benefit criteria from Table 2 have been brought forward and included in Table 20. This table illustrate the performance indicators and the person responsible for monitoring and reporting back on the benefit.

Table 20

Benefit	**Performance Indicator**	**Responsibility**
Financial Benefits	***How will we know it is achieved?***	***Who is responsible for monitoring achievement?***
Less back injuries & lower resulting overtime cost	A full year total or moving annual total (mat)[1] comparison on back injuries and overtime costs associated with patent vehicle loading with figures obtained from Health & Safety and Management Information,	Senior Health and Safety Advisor
Achieve a better fuel consumption and reduced fuel cost	Analysis of fuel reports measured like for like as moving annual total (mat)	Head of Operational Support
Potentially reduced maintenance costs	Analysis of job card information taken from workshops	Head of Operational Support
Enhanced Operational Capability with a reduction in unscheduled breakdowns of vehicles	Reduction in breakdowns can be recorded through EOC/ fleet logistics.	Head of Operational Support
Reduced workload on fleet dept	Less maintenance hours spent on new vehicles versus old. This data can be captured from vehicle maintenance history on FleetPlan.	Head of Operational Support
Improved trolley bed equipment	Achieved by default of deploying ambulances with the new trolley bed.	Head of Operational Support
Improved patient care	Achieved by default of deploying all 100 ambulances.	Head of Operational Support
Greater proportion of the fleet will be CEN compliant	Achieved by default of deploying all 100 ambulances.	Head of Operational Support
Reduced CO2 Emissions	Recorded by reduction in fuel consumed	Management Accounts

[1] M.A.T (Moving Annual Total)= comparison of 12 months from current period versus same period last year i.e. comparing 12 months June 03-June 04.

Non-Quantifiable Benefits	***How will we know it is achieved?***	***Who is responsible for monitoring achievement?***
Corporate kudos for being environmentally responsible	Non-measurable, however statements on our diesel vehicles should be made where possible by Press dept. Discuss with Press number of occasions this has happened. In addition, meeting controls assurance standards by default of vehicle deployment for fleet & transport management.	Head of Operational Support
Improved public image	Anecdotal evidence or through letters.	Director of Communications
Improved staff morale	Difficult to measure without staff surveys, however A&E working group can be the forum to present staff feedback. This can be captured via a web forum similar to that used for MDT.	Director of Communications

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

6.8 Training

6.8.1 Training will be appropriate and limited to any significant new additions on the vehicle.

6.8.2 If required, staff will receive training and their training record will be updated and signed. No staff will be allowed to use the new vehicles unless their training record has been checked and approved.

6.9 Contract Management

6.9.1 The main external delivery contracts will be managed by the Project Manager who may delegate responsibility for any separately funded procurement activities to various Team Managers.

6.9.2 The Technical, User Acceptance and delivery aspects of all the products are controlled by the Project Manager who will advise the Lessor when financial payment can be made for full or part delivery of completed products (where appropriate).

6.10 Post Project Evaluation

6.10.1 During the three months following delivery of the vehicles, the Project Manager will undertake a Post-Project Evaluation Review and present the report at the Project Closure Meeting.

6.10.2 In particular, it will look at:

- What went right?
- What went wrong?
- Lessons learnt.

6.10.3 The Project Closure Meeting will also set dates for a Benefits Realisation Meeting described in Section 6.7.

6.10.4 Finally, it will be ensured that a Senior Manager is formally nominated with the responsibility for post-project reviews and continuous benefits reappraisals.

7 APPENDIX A - BENEFITS EXPLAINED

7.1.1 *Improved Patient Care* - This benefit focuses on the LAS' ability to serve its patients with a greater level of patient care, achieved by reducing the number of vehicles off the road at any one time and ensuring equipment is up to date and in working order.

7.1.2 *Increased proportion of the fleet will be CEN compliant* - This benefit will be achieved through vehicle replacement.

7.1.3 *Reduced Fleet workload*- This benefit focuses on the increased reliability and lower maintenance times achieved with new vehicles.

7.1.4 *Improved Trolley bed equipment*- This benefit highlights the improved trolley bed equipment that the new vehicles will be fitted with. At this time, options for equipment with bariatric capabilities are being explored.

7.1.5 *Less back injuries and lower resulting overtime costs* - This benefit highlights the evidence that automatic tail-lifts have reduced incidences of back injury and subsequent overtime costs. New Tail-lifts will also have a greater lift capacity to cater for bariatric patients.

7.1.6 *Achieving a better fuel consumption thus reducing running costs* - This benefit highlights that through use of diesel fuel engines on the new ambulances, the LAS can expect to reduce both fuel price and volumes.

7.1.7 *Potentially reduced maintenance costs* - with newer vehicles and the expectation that less maintenance will be required.

7.1.8 *Environmental responsibility* - This benefit addresses the impact on the environment, with vehicles producing less CO2 emissions.

7.1.9 *Improved staff morale* - This benefit focuses on improved morale through use of newer, smarter and more reliable vehicles, measured via annual staff survey.

7.1.10 *Improved public image* - This benefit focuses on the public perception of the LAS. Newer vehicles better position the LAS towards being a word class ambulance service, measured through public feedback.

8 APPENDIX B - BENEFITS SCORE REASONING

Explanation of weighted benefit analysis

The weighted benefit analysis table demonstrates support for the selection of option 1 – Purchase Vehicles.
An explanation for scores awarded is given against each benefit listed below:

Improved Patient Care

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
27.14	0	0	27.14	7	190
A score of 0 was awarded as by keeping the status quo, no value is added to improving patient care.			A score of 7 was awarded as new ambulances are better equipped, safer and designed for more comfortable transportation of patients.		

Improved Vehicle Availability

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
23.07	0	23	23.07	9	207
A score of 0 was awarded to this as the current vehicle availability is problematic, due to high levels of breakdowns, and staff reluctance to use older vehicles.			A high score of 9 was awarded as by default, the LAS can expect an immediate improvement in vehicle availability with newer vehicles and lower VOR.		

Improved Trolley Bed Equipment

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
13.84	0	0	13.84	9	27
A score of 0 was awarded as the old ambulances cannot accommodate the latest style design trolley beds.			A score of 9 was awarded as new design trolley beds could offer a bariatric capability, and will give an enhanced usability through a powered lift.		

Improved Staff Safety

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
18.46	0	0	18.46	9	147
A score of 0 was awarded as the old ambulances cannot accommodate the latest style design trolley beds.			A score of 9 was awarded since the new vehicle with automatic tail-lift will reduce back injuries to staff.		

Environmental Responsibility

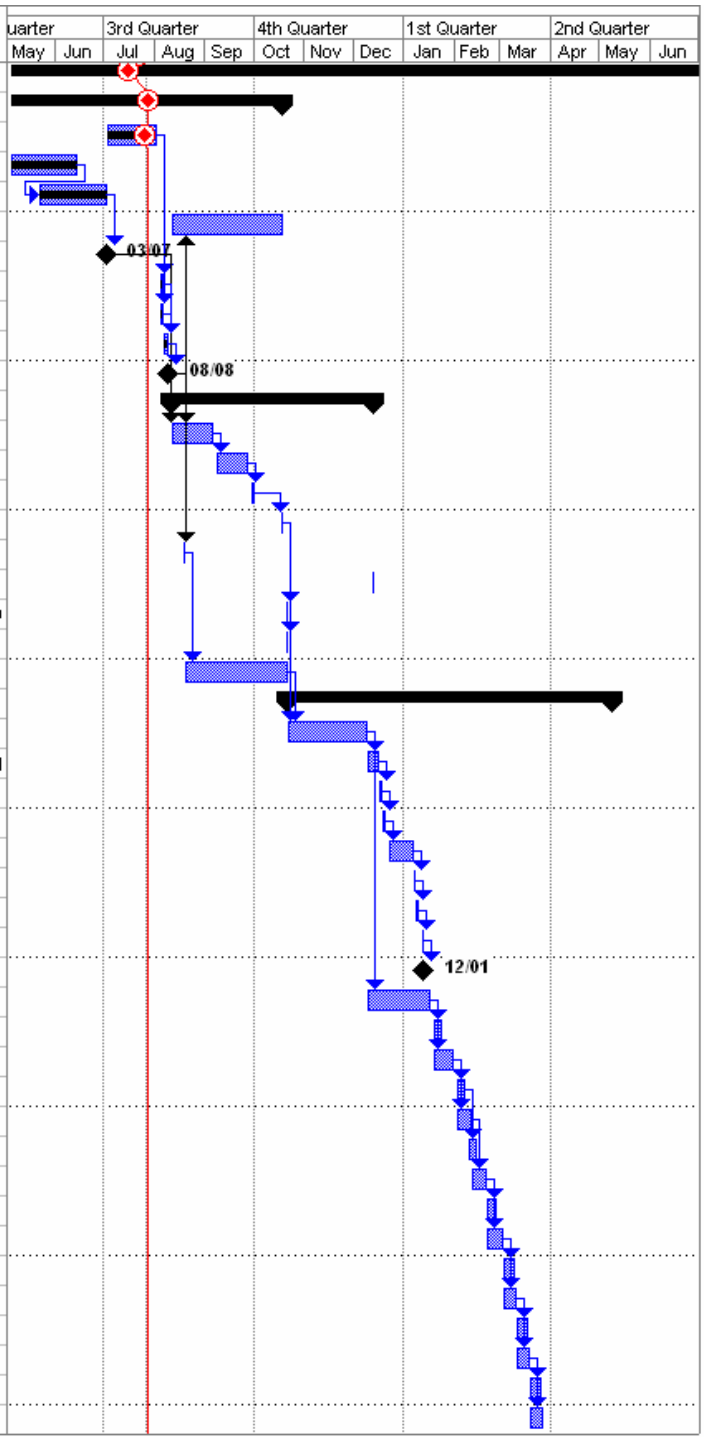
Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
10.11	0	0	10.11	8	70
A score of 0 was awarded as fuel economy will further decrease with the ageing fleet, which increases cost and the level of pollution the vehicles produce.			A score of 8 was awarded as the transition to diesel powered engines meeting euro 4 compliance reduces both fuel consumption and vehicle pollution.		

Meeting Operational Objectives

Do Minimum			Option 1		
Weight	Score	W x S	Weight	Score	W x S
7.38	1	0	7.38	7	59
A score of was 1 awarded as Operational Objectives are difficult to achieve with a high number of vehicles off road. recommendations.			A score of 7 was awarded to reflect the achievement of the operational objective.		

9 APPENDIX C -PROJECT PLAN GANTT CHART

ID	Task Name
1	**A&E UC Merc - AEU x 123 off**
2	**Compile business case x 60 off vehicles**
3	Create business case for 1st review
4	Staff consultation for enhancements
5	Complete vehicle specifications
6	Tender for Lessor
7	VEWG Approval of vehicle specification
8	GEM update Capital
9	GEM update Revenue
10	Business case development
11	Business case Trust Board Approval
12	**Procurement process**
13	Tender for convertor
14	Review bids
15	Award conversion contract
16	Place conversion order > body builder
17	Place order for chassis > MB
18	Place order for Stretcher (following trial)
19	Place orders for Free Issue equipment (Com
20	Place orders for Free Issue equipment (Med
21	Chassis production period
22	**Vehicle Conversion & Build Process**
23	Body build - Prototype
24	Prototype Acceptance (Quality & Spec Com
25	Veh 1 to MB PDI
26	Veh 1 delivered to LAS for PDI
27	Veh 1 to CTS for comms fit
28	Veh 1 for Medical kit fit
29	Veh 1 to Training for evaluation
30	Veh 1 to Operations
31	VEHICLE 1 COMPLETE
32	Veh 2~6 build
33	Veh 2~6 Comms fit
34	Veh 7~11 build
35	Veh 7~11 Comms fit
36	Veh 12~16 build
37	Veh 12~16 Comms fit
38	Veh 17~21 build
39	Veh 17~21 Comms fit
40	Veh 22~26 build
41	Veh 22~26 Comms fit
42	Veh 27~31 build
43	Veh 27~31 Comms fit
44	Veh 32~36 build
45	Veh 32~36 Comms fit
46	Veh 37~41 build



London Ambulance Service
NHS Trust

IM&T Strategy

2008/09 - 2012/13

A World Class Ambulance Service

People & Clinical Issues

Not Just IM&T

Contents

IM&T Strategy 2008/09-2012/13

1. Executive Summary

This executive summary provides a précis of each of the eight sections of this document.

Introduction and Strategic Context: The Trust's Strategic Plan 2006/07 - 2012/13 sets the direction for the London Ambulance Service NHS Trust (LAS) and outlines how it will be implemented in the wider context of developments in the NHS. The IM&T Strategy is defined as one of the enablers to support the delivery of this plan.

Connecting For Health: The primary role of this national programme is to support the NHS to deliver better, safer care to patients, via new computer systems and services. The LAS will fully engage with this programme, utilising such products as N3 (secure national network) and NHS Mail. It is envisaged that the Electronic Patient Report will be delivered as part of the programme.

Delivery Focus: There will be a clear focus on IM&T customer service and delivery. A number of measures will be developed including business benefits realisation, appropriate programme and project management, and ensuring the right IM&T staff, with the right skills are in place.

Information Governance and Security: Compliance is mandated rather than optional and evaluated by the annual submission of the Information Governance Toolkit. An Information Governance Group will oversee all aspects of Information Governance and Security on behalf of the LAS. Any data stored on a PC or other removable device in a non-secure area or on a portable device such as a laptop, PDA or mobile phone will be encrypted.

Information: The vision is to ensure the efficient capture of data and its reuse to support information sharing, analysis and informed decision making. A technical architecture will be implemented to ensure that all data is held in a centralised information repository (data warehouse). Through the provision of appropriate tools, decision makers will be provided with desktop access to their required information. Routine/standard reports will be instantly accessible with the opportunity for managers to create their own reports using various tools.

Customer Driven Service Provision: This will underpin every activity of IM&T support and delivery. The IT Infrastructure Library (ITIL) best practice framework. The heart of which will be a central Service Desk that will act as a focal point for all service co-ordination. There will be empowerment through the creation of an IM&T Super Users Programme, the European Computer Driving Licence (ECDL) will be available as a base-line standard for staff and an effective file management and e-mail archiving system will be implemented.

Infrastructure: The vision of the IM&T infrastructure is to facilitate the movement of digital information irrespective of use. This entails a complete merger of voice/data/video traffic, utilising technologies such as 'IP Telephony (IPT)' where voice information is managed in the same way as traditional data traffic. In terms of overall performance, the aim is to enable any user to access core services with consistent performance from any LAS workplace. In terms of radio, the Trust will implement the O2 Airwave tetra system.

Software Provision and Support: In terms of new software provision, the starting point will be to gather initial requirements and undertake a feasibility study. Solutions will be delivered through amending an existing system, implementing a third party product, interfacing or by in-house developments using web technologies where appropriate. There will also be a drive towards working collaboratively with the wider emergency services family to produce joined-up solutions. The replacement of the existing Computer Aided Despatch system will be the cornerstone of work during the next three years.

2. Introduction and Strategic Context

2.1 Background

The Strategic Plan 2006/07 -2012/13 sets the direction for the London Ambulance Service NHS Trust (LAS) and outlines how it will be implemented in the wider context of developments in the NHS in the fields of emergency, urgent and out of hours care. It describes what the LAS will strive to deliver for its patients, the public of London and other key stakeholders for the period 2006/07 to 2012/13, culminating when the Olympics come to London. The tangible outcomes and programmes of work are intended to deliver:

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

Purpose: *The purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement.*

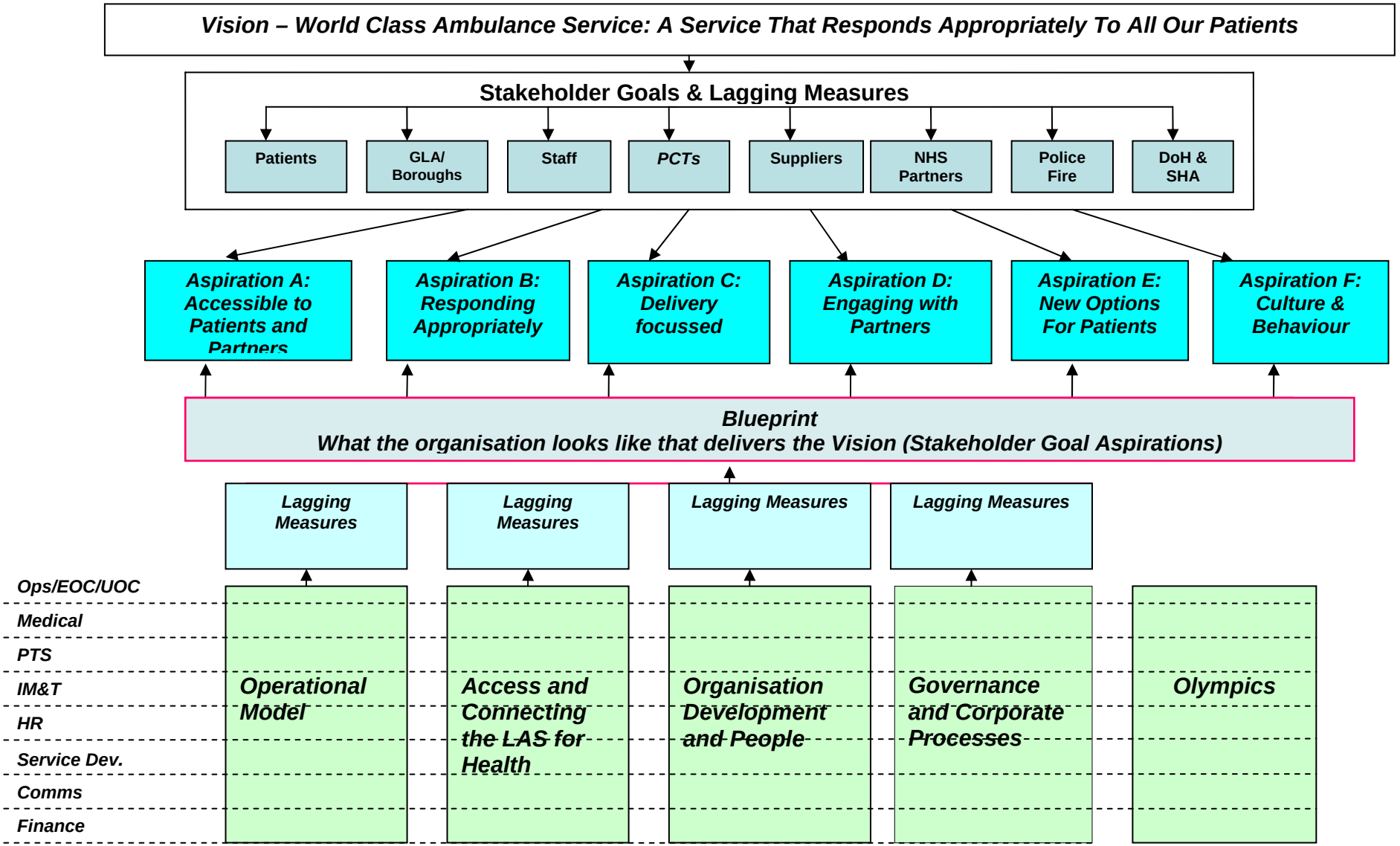
We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London.

This plan clearly articulates the vision, rationale, drivers for change and methodology and hence they are not repeated within this Strategy. It originally identified four strategic programmes of work, underpinned by an over-arching communications strategy. Latterly a fifth programme was added for the Olympics. Collectively these will deliver a new, flexible ambulance service for London in order to realise the stated ambition of becoming truly 'World Class'. The programmes are:

- Programme 1: Operational Model - Strategy For Responding
- Programme 2: Access and Connecting (the LAS) For Health
- Programme 3: Organisation Development And People
- Programme 4: Governance and Corporate Processes
- Programme 5: Olympics

Identified within the Strategic Plan (Appendix 1) is the requirement for this over-arching IM&T Strategy to support these programmes. The Access Programme will be the main vehicle for delivery; however, the components must support all of the other programmes. They will also support flexible and different business models, should the LAS either reconfigure geographically or change and enhance its business functions. Appendix 2 provides a futuristic insight as to how delivery of this IM&T Strategy will support both operational and support aspects of the LAS as well as the aspirations set out in the LAS 2008 concept 'New Ways of Working'.

By way of definition, IM&T is used as an umbrella term; it includes software applications, use of information, network infrastructure and all the associated hardware. A key focus will be the realisation of real tangible business benefits. In this way, all projects and initiatives will be business driven and enabled by IM&T, rather than simply being an IM&T project. There will also be an alignment with best practice industry standards wherever appropriate.


Vision – World Class Ambulance Service: A Service That Responds Appropriately To All Our Patients
Stakeholder Goals & Lagging Measures
Patients
GLA/ Boroughs
Staff
PCTs
Suppliers
NHS Partners
Police Fire
DoH & SHA
Aspiration A: Accessible to Patients and Partners
Aspiration B: Responding Appropriately
Aspiration C: Delivery focussed
Aspiration D: Engaging with Partners
Aspiration E: New Options For Patients
Aspiration F: Culture & Behaviour
Blueprint
What the organisation looks like that delivers the Vision (Stakeholder Goal Aspirations)
Lagging Measures
Lagging Measures
Lagging Measures
Lagging Measures
Ops/EOC/UOC
Medical
PTS
IM&T
HR
Service Dev.
Comms
Finance
Operational Model
Access and Connecting the LAS for Health
Organisation Development and People
Governance and Corporate Processes
Olympics

3. Connecting For Health

3.1 Background

NHS Connecting for Health came into operation on 1 April 2005 as an agency of the Department for Health. Its primary role is delivering the National Programme for Information Technology (NPfIT), to support the NHS to deliver better, safer care to patients, via new computer systems and services. The programme has its origins in the 1998 Department of Health strategy 'Information for Health' that committed the NHS to lifelong electronic health records for everyone with round-the-clock, on-line access to patient records and information about best clinical practice for all NHS clinicians.

A key aim of the National Programme for IT in the NHS is to give healthcare professionals access to patient information safely, securely and easily, whenever and wherever it is needed. The main programmes of work are:

- Creating a NHS Care Records Service to improve the sharing of patients' records across the NHS with their consent. The database that holds these records is also known as the 'Spine'.
- Making it easier and faster for GPs and other primary care staff to 'Choose and book' (the term often used) hospital appointments for patients.
- Providing a system for the electronic transfer of prescriptions.
- Ensuring that the IT Infrastructure can meet NHS needs, now and in the future. This includes provision of the secure national network, known as N3, telephony and secure e-mail.

3.2 Delivery

Accountability for the delivery of NpfIT was transferred to Strategic Health Authorities (SHAs) on 1 April 2007, as part of the NPfIT Local Ownership Programme (NLOP). To ensure relationships with Local Service Providers (LSPs) continue effectively, NHS Programme for IT Management Boards have been established in three geographic areas:

- North, Midlands and East (NME) Programme for IT (NMEPfIT): Computer Sciences Corporation (CSC).
- Southern Programme for IT (SpfIT): *Under review at time of producing this strategy document*
- London Programme for IT (Loft): BT.

Trusts across London are already engaged in implementing the Care Records Service as the lynchpin of the new systems and services. In London the NHS CRS will be built through proven IT systems already in use in trusts throughout England. It joins up 32 hospital trusts, over 1,600 GP practices, 31 primary care trusts, and ten mental health trusts. It will give millions of patients access to their personal health and care information, helping to transform the way the NHS London works.

The LAS, as a London based NHS Trust, will fully engage and be part of the NPfIT programme. Infrastructure products, such as N3 (secure national network) and NHS Mail will be fully embraced. It is envisaged that the Electronic Patient Report will be delivered as part of the programme. This will replace existing paperwork for frontline staff, providing a computer based system upon which patient details will be captured and automatically transferred to appropriate care pathway provider. Where appropriate, it will also provide direct access to a sub-set of the CRS. As future services and applications become available to NHS London, the LAS will implement on the basis of business needs and economic business cases.

4. Delivery focus

The underlying principle of this IM&T Strategy will be a clear focus on customer service and delivery. Recognising that not everything can be achieved at once and that, without an internal financial market, demand for delivery and service will always outstrip capacity to deliver. A number of measures will be developed to address this imbalance, these are detailed below. It is important to note however, that this list is not intended to be exhaustive and during the life of this strategy, other options will be developed.

4.1 Business Benefits Realisation

The principles of business benefits realisation apply consistently throughout this strategy but are not repeated within each section. The overall approach will be to deliver business benefits, not simply to deliver a piece of technology. In principle, projects should be 'business driven' and not considered as IM&T or technology projects.

All activities will commence from the perspective of identifying business objectives and how they will support LAS' overall objectives. There will also be an analysis of the other non IM&T deliverables (e.g. HR or building changes) that are also required. Business (change) managers, often those sponsoring the requirement, will be given specific responsibility to ensure that all the outputs are co-ordinated and that the desired benefits are actually realised - not simply that a piece of technology has been implemented. This will be a complete reversal of the traditional approach to IM&T delivery.

4.2 Project and Programme Management

Individual projects will be managed using PRINCE 2 and the overall plan will utilise the OGC Managing Successful Programmes (MSP) methodology. Central to this approach is the requirement for business change and to ensure that actual benefits are realised by the implementation of new or changed IM&T facilities. This strategy does not set out to adopt a specific methodology of benefits realisation, but will adopt the best industry practice.

4.3 IM&T Staff

Ensuring that there are the right staff, with the right IM&T skills will be fundamental to supporting the ambitious plans set out within both this strategy and the SIP 2012. The main options are to either use only LAS employed staff, outsource or a hybrid of the two.

The first two options both provide advantages and disadvantages in terms of flexibility and control. To only use LAS staff is restrictive in terms of always having staff with the required skills, while fully outsourced leaves the LAS vulnerable to commercial pressures. The approach will be option three; the LAS IM&T function will retain internal staff for development and support purposes, and there will also be a number of strategic partnerships with third party organisations to provide additional resources and specialist services. In this way, the LAS will seek to ensure best value from a strong in-house approach supported by outsourced underpinning contracts. The NHS Personal Development Review (PDR) and Personal Development Plan (PDP) process will form the cornerstone in developing LAS IM&T staff. There will be a clear objective to link personal development in the form of training and education as a positive benefit of employment with the LAS.

Recruitment and retention of IM&T staff has historically been a roller coaster of demand and availability. Open market recruitment will continue to be used, but consideration will be given to an in–house education programme. This would include a recognised IM&T apprenticeship, aimed specifically at people looking for a future in this market place. At the end of a three or four year programme, involving periods of work experience, formal education and technical training, the apprentice will hold a recognised qualification, and will be capable of holding a junior IM&T support or development position.

5. Information Governance and Security

5.1 Background

Information Governance and Security ensures necessary safeguards for, and appropriate use of, patient, personal and organisational information. Health records are confidential and they should be shared only on a need-to-know basis. Therefore the principles of information security must require that all reasonable care is taken to prevent inappropriate access, modification or manipulation of data from taking place. In the case of the LAS, the most sensitive of data is patient record information.

In practice, Information Governance and Security is applied through three requirements - **confidentiality, integrity and availability.**

- Information must be secured against unauthorised access – **confidentiality**.
- Information must be safeguarded against unauthorised modification – **integrity**.
- Information must be accessible to authorised users at times when they require it – **availability.**

Information Governance and Security is there to ensure these requirements are upheld by setting clear guidelines (policy) for all LAS users.

5.2 Compliance

Information Governance and Security compliance is mandated, rather than optional. Each year there is a requirement for each HNS Trust to complete the Information Governance Toolkit. This is a detailed assessment tool resulting in an overall evaluation against set criteria (listed at Appendix 3). The data is required by the Healthcare Commission and the National Information Governance Board, who will assess the LAS against the set standards. This yearly return will be the benchmark against which the LAS will be assessed in terms of Information Governance and Security.

5.3 Governance

An Information Governance Group will oversee all aspects of Information Governance and Security on behalf of the LAS. It will be jointly chaired by the Medical Director (Caldecott Guardian) and the Director of IM&T, and report either directly or indirectly to the Trust Board. The LAS will also maintain certain expert posts, such as Information Security Manager and Head of Records Management in order to deal with implementing and supporting local policies.

5.4 Data Transfer

Any data stored on a PC or other removable device in a non-secure area or on a portable device such as a laptop, PDA or mobile phone will be encrypted. This is now a requirement across all public sector organisations set by the Cabinet Secretary. In brief summary, the NHS IG data encryption algorithms currently applicable are:

- **3DES (168bit)**
- **AES 256** (recommended to be used for Internet or by removable media transferred**)**
- **Blowfish**

These algorithms should be used with a recommended minimum key length of 256 bits where available. The strategy is to adopt these standards and remain within NHS IG guidelines.

5.5 ISO 17799 & Security Controls

Within the context of this Strategy, Information Security should be considered as an 'umbrella' term that encompasses all aspects of accessing information securely. In order to implement robust and secure processes, the internationally recognised ISO17799 framework will be used as a guide, in order to avoid reinventing the wheel. However, given the considerable documentation requirement, full certification is not the goal at this stage.

Information security controls will be considered from the outset of new projects and initiatives, this will ensure that there are defined responsibilities and procedures for software development and procurement and products will be 'fit for purpose' and assured. This will then enable Confidentiality, Integrity and Availability (CIA) to be maintained within agreed parameters.

Dedicated incident response teams, with defined responsibilities, will be tasked to manage individual security incidents. For reasons of expediency, the option of remote diagnostics and resolution will be the normal approach, rather than personal visits to each PC. Acknowledging that ISO17799 establishes many of the necessary controls, below are two specific areas of activity;

5.6 Single Sign-On

It is a standard approach for each software application to require a password. Within the LAS environment, it is common for users to access multiple applications, hence making the requirement to remember different passwords difficult. It also increases the temptation to write passwords down, hence negating the security controls.

In order to mitigate this problem, automated Single Sign-On (SSO) will be implemented. This will allow staff to access defined and required services (from any LAS terminal) without the need to logon to individual applications. This will also provide centralised accountability and auditing of all network access.

5.7 Business Continuity

IM&T business continuity planning initiatives will be implemented, tested and a formal risk based approach will be used during the requirements stage of all projects. This will ensure that IM&T systems are appropriately resilient and tested regularly. This work will form part of the Trust's overall business continuity planning arrangements.

6. Information

Over the course of the Strategic Plan (2006/07-2012/13), the approach to how information is captured and used will change. The information vision is to:

- Maximise the use of all the data held within the Trust.
- Where possible, ensure that data is collected automatically.
- Input data as close to where it is originally captured as possible and make it available to other applications (within defined parameters) without the need for re-keying.
- Promote effective information sharing, analysis and informed decision making.
- Ensure that all relevant information about patients and their environment is appropriately available.
- Provide tools and techniques to support the provision and analysis of information.

In the context of this strategy, data can be defined as “numbers, words or pictures without context, which exist and have no significance, and which can be useful or not”. Information can be defined as “a collection of numbers, words or pictures which have meaning”. Information is data that that has been put into a framework or structure that provides context.

6.1 Data Map

The first priority will be to map out all of the data that is held by the Trust to provide a clear understanding of what is available and how it is created and stored. Baseline requirements can then be established that in turn would allow a gap analysis to be undertaken. This would allow the Trust the opportunity to plan the capture of additional information to support the LAS strategy and delivery of services.

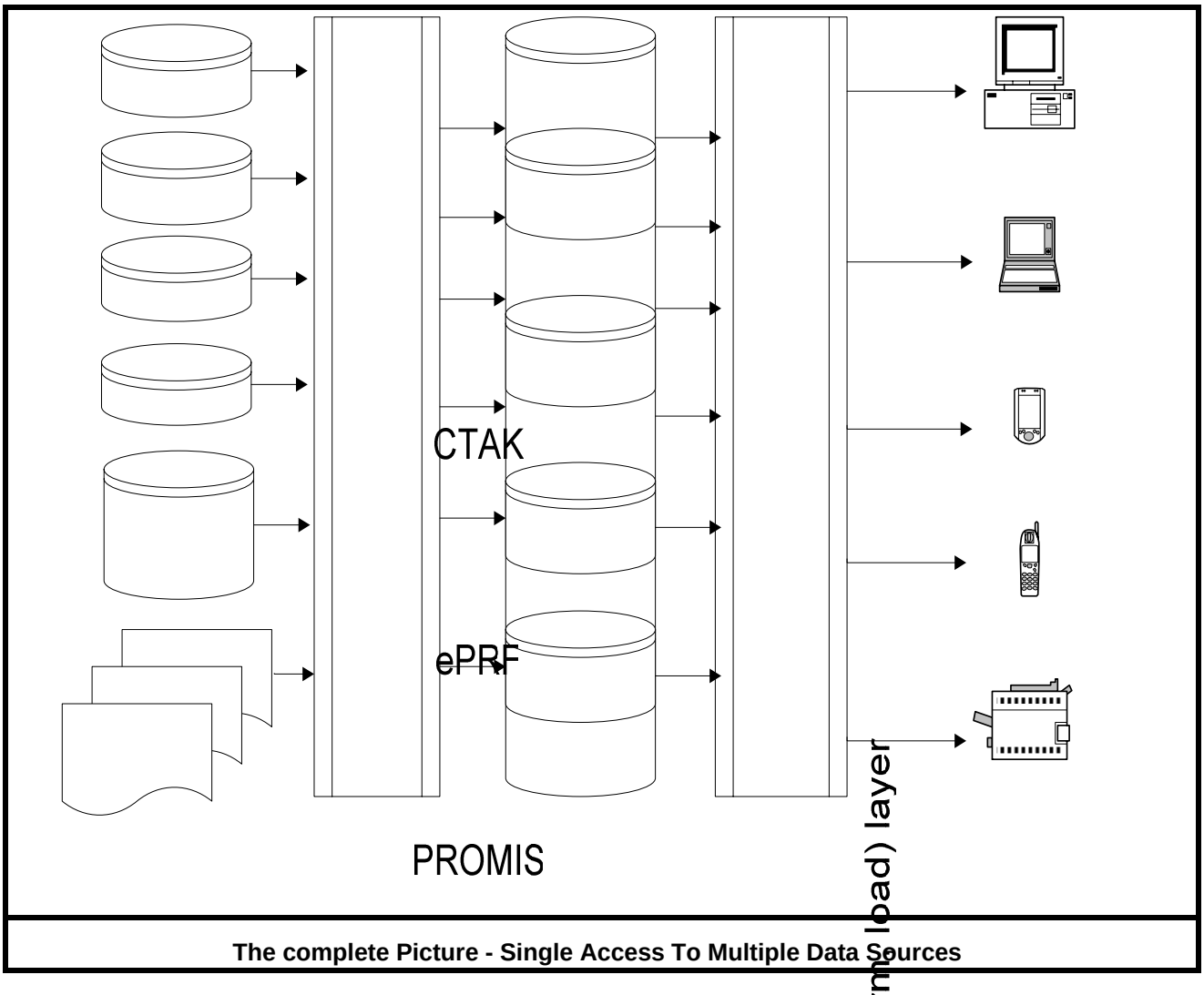
6.2 Information Architecture

To support the information vision, a technical architecture will be designed and delivered to ensure that all data is held in a centralised information repository. This will enable data from the various systems throughout the Trust to be accessible and turned into information where appropriate. This will remove the requirement to access different systems in various formats to combine datasets.

Through the provision of appropriate tools and techniques, decision makers will be provided with direct desktop access to their required information. Routine/standard reports will be instantly accessible with the opportunity for managers to create their own reports using various tools. This will allow Trust staff access to information that they require to support decision making at all levels and will include appropriate access control for personal data.

6.3 National Initiatives

The LAS is committed to national initiatives such as Connecting for Health, ESR and ePRF via the Spine. It is recognised that take-up of these services as they mature will enable improved and efficient data capture and a range of clinical and operational benefits.



The complete Picture - Single Access To Multiple Data Sources

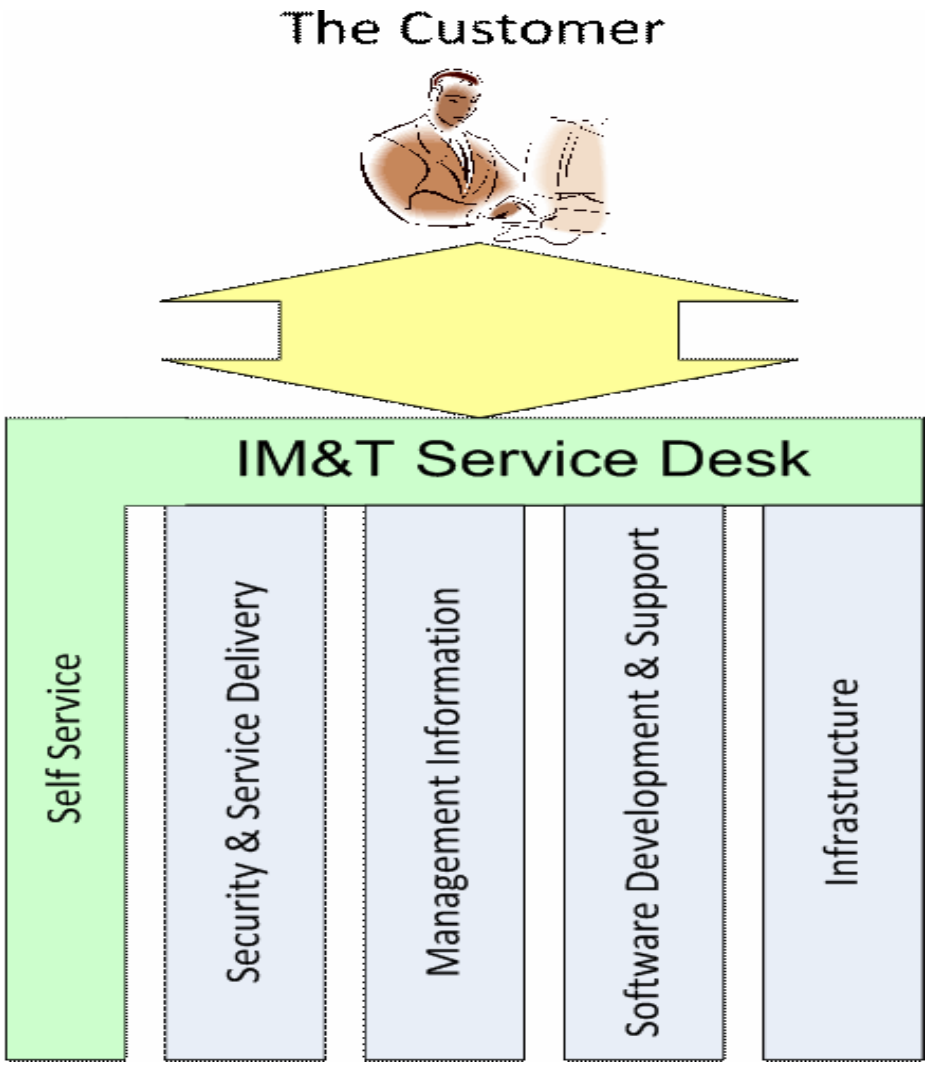
7. Customer Driven Service Provision

Customer service will underpin every activity of IM&T support and delivery. There will be a clear focus to ensure consistency and seamless working between IM&T Departments to deliver an effective and co-ordinated service. There will be a simple underlying approach to which the answer to the following question should always be clearly positive:

If the IM&T Directorate were a commercial company, would it be the LAS supplier of choice?

7.1 Information Technology Infrastructure Library

In order to realise the vision of providing excellent customer services, the IT Infrastructure Library (ITIL) best practice framework (in compliance with ISO 20000) will be adopted as a standard. This will ensure that services are underpinned by tried and trusted procedures and processes. The heart of which will be a central Service Desk that will act as a focal point for all service co-ordination.



Service Desk 'Single Point of Contact'

7.2 Super User Programme

Integral to the customer service approach will be the empowerment of customers through the creation of an IM&T Super Users Programme. This will provide recognition for IT literate LAS staff who provide local support to their colleagues. The key benefits of this will be to improve communication, provide faster response to simple queries, develop IT literacy throughout the LAS and reduce demand on the IM&T Service Desk.

7.3 European Computer Driving Licence

In order to ensure the effective use of IM&T driven solutions, training and education will become a core part of all provision. This will improve levels of satisfaction and also reduce the level of support required. The approach will be to utilise training delivered by the IM&T Directorate, Learning & Development department, E-learning and external training providers. The European Computer Driving Licence (ECDL) will be available as a base-line standard.

7.4 File Management

In order to provide a solution for file management, a range of applications will be implemented such as a document management and an effective e-mail archiving system. There will be numerous beneficial outcomes from this work, but the key advantages will be to avoid the duplication of data and support the compliance with the Freedom of Information Act.

8. Infrastructure

The term 'Infrastructure' refers to the technology and connections that in the broadest terms, link servers to desktops and provides the complete sphere of telephony and radio communications. The infrastructure underpins the delivery of all IM&T services and has the target of providing the right information services, in the right place, at the right time.

In terms of overall performance, the aim is to enable any user to access core services with consistent performance from any LAS workplace.

8.1 Converged Networks

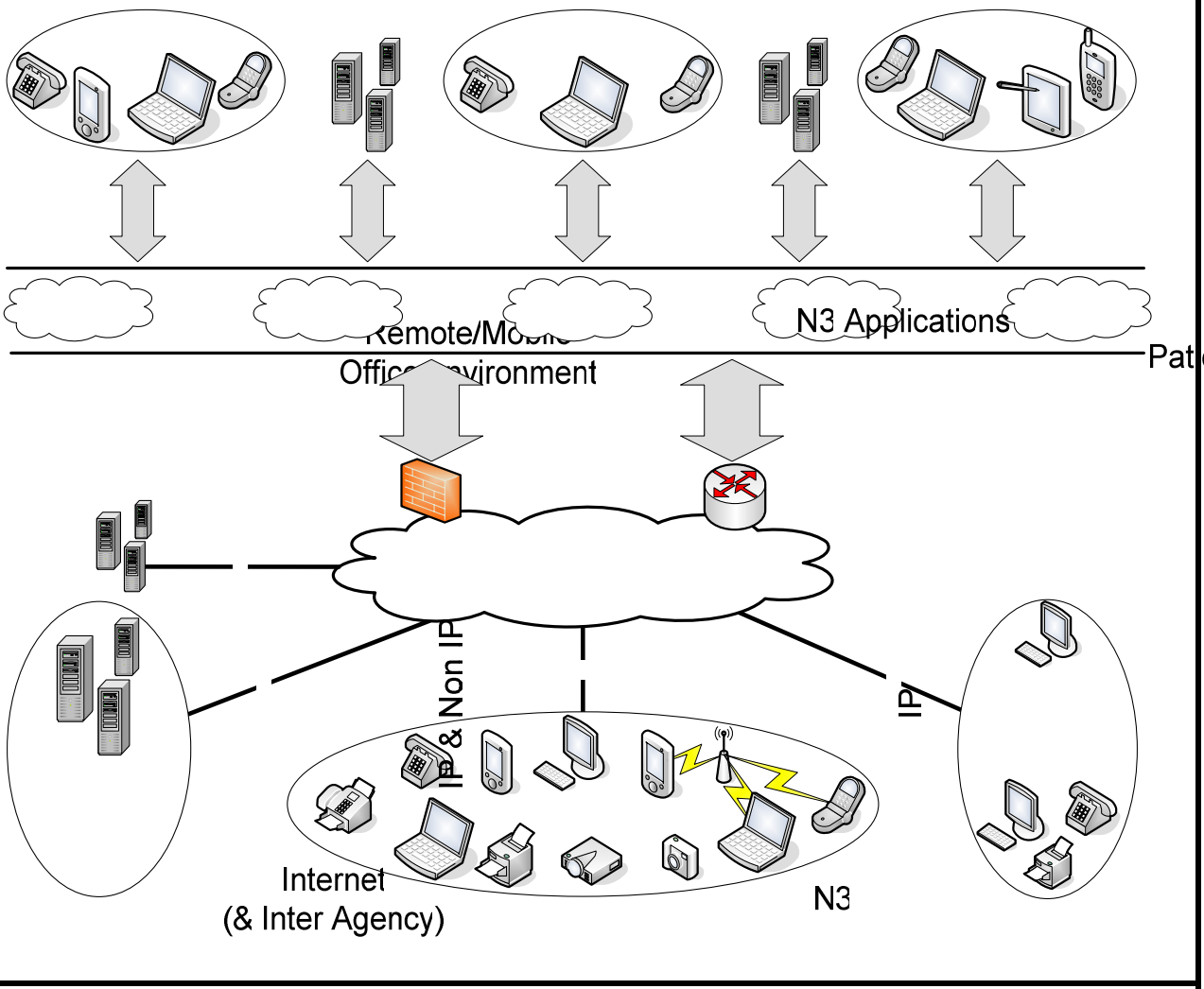
The vision of the IM&T infrastructure is to facilitate the movement of digital information irrespective of use. This entails a complete merger of voice/data/video traffic, utilising technologies such as 'IP Telephony (IPT)' where voice information is managed in the same way as traditional data traffic. It is therefore the stated intention to move away from proprietary equipment (e.g. PABXs) and manage the corporate infrastructure on common multi-purpose hardware and software platforms.

To support the converged vision, a new technical architecture will be designed and delivered. The following diagram illustrates how the concepts of a converged network may be applied within the Trust's infrastructure.

In order to realise this vision, a programme of work will be undertaken to:

- Redesign the Trust's networks to provide a high availability, scalable and robust IP network, supporting voice, video and data convergence, across all LAS sites, with secure interconnection with other organisations and mobile and public networks.
- Implement voice services across the Trust using IPT, Airwave, and mobile telephony.
- Implement secure remote access to the network and wireless connectivity at Trust premises to facilitate flexible working.
- Support standardised applications to maximise re-use and minimise client footprint. Include solutions for managing remote working devices.
- Review mobile phone and radio services with the aim of providing closer integration with the LAS voice networks and improved equipment support services to customers.

With an increased reliance on a single, albeit resilient, infrastructure platform for all voice, data and video traffic, it is essential that real time network management is implemented. This will include capacity and availability management processes and the remote management of all network component and system devices. Where necessary, specific measures will be implemented and maintained to provide enhanced levels of resilience and availability so as to underpin the continuity of Trust's critical operations.



Integrated IP Infrastructure

IP Multiple separ

Multiple site
Secure
Firewalls

Multi site real
time network
management

IP

Trust c
IP Wide Area
Networks

IP

Multi site

8.2 The London Ambulance Radio Projects (LARP) and the Implementation of Airwave

In July 2005, the Department of Health awarded a contract to O2 Airwave for the provision of a new digital radio service for all Ambulance Trusts in England. The replacement will be a centrally provided managed service, delivering a digital radio network for voice and data services. This will include the supply of mobile and hand portable radios, control room dispatcher equipment connected to the network and the integration of existing CAD services.

The new network will deliver direct improvements in terms of coverage, capacity, functionality, improved flexibility and inter-operability with other emergency services. It will also enable a reduction in the operational reliance on public telephone networks. The success of this initiative is dependant on more than technical resources and implementation; engagement with internal customers will be vital to fully realise business benefits.

The managed service arrangement is a significant change in direction from the existing approach where the Trust owns, and is in direct control of, the radio infrastructure. Significant internal support will be required to manage the relationship with O2 Airwave and the DH Contract. Support will be co-ordinated through the IM&T Service Desk.

The introduction of the new Airwave service will provide a number of enhancements that will offer significant additional operational benefit. The LAS will develop a specific project to ensure that these additional benefits are fully realised.

9. Software Provision and Support

9.1 Approach to software provision

In terms of new software provision, the starting point will be to gather initial requirements and undertake a feasibility study. Where necessary, customers will be assisted in this process and the resulting requirements list will be prioritised and agreed with the requesting customer. This documentation will also form the basis of ensuring that what is delivered is what was required, and for inputting into the business benefits plan. This approach will influence the decision as to whether to proceed with one or a combination of the following:

- Amend an existing system.
- Implement a third party product.
- Provide an interface between existing systems.
- Develop in-house (web services and a browser interface will be the standard).

There will also be a drive toward working collaboratively with the wider emergency services family to produce joined-up solutions.

9.2 Software Quality

Software quality relates to the product being functionally correct (i.e. it does what is expected), operationally correct (it works in the correct sequence) and technically stable.

There will be a focus to continually improve the quality of the products by following a regime of rigorous testing of both functional and non-functional aspects of systems and software applications.

Where it is beneficial, comparison will be undertaken with models and best practice such as the Capability Maturity Model, ISO/IEC 15504 (SPICE - Software Process Improvement and Capability Determination), ISO12207 (Software Life Cycle) and agile software development methods.

9.3 Command & Control System

The computer aided dispatch system (CAD) is the centre of a complex integration of applications critical to both the Emergency and Urgent Operation Centres (EOC and UOC). The current CAD System is known as CTAK (Call TAKing system). Its core function is the recording of 999 calls and the despatching of appropriate resources.

CTAK was developed in-house, has evolved incrementally and is now over 10 years old. The system is not fault tolerant, is unable to predict or warn of potential failures and is unable to support the level of availability and agility required by a modern ambulance service. It will be replaced by the CAD 2010 project. This project will thoroughly explore current and future business requirements, investigate procurement options and ultimately contract with supplier(s) to provide a system that will meet the current and future needs of the LAS.

However, given the projected CAD 2010 timetable, CTAK will continue to be enhanced in line with business driven requirements during the intervening period. This will include changes to allow more flexible operations and integration with the Airwave radio system under the auspices of the LARP.

9.4 Web Development

The first tranche of simple web applications was delivered on the 31st March 2006. The next series of enhancements and new solutions will be designed and implemented during 2006/7. An ongoing programme of further solutions will be managed over the lifetime of this strategy, looking to deliver at least five applications each year. A Net Services Management Group (with key customer involvement), will act as a steering group overseeing the evolution of Intranet/Internet developments. The web development team will receive work requests from, and report progress to, this group.

A suitable standardised method for software development, to be known as the London Ambulance Software Development Method (LASDM), will be evolved. It is anticipated that this will be based on a contemporary agile method with emphasis on requirements, prototyping and incremental delivery.

9.5 Systems Support

Recognising the increasing organisational reliance on information systems and the adoption of ITIL best practice, a range of proactive measures will be introduced:

- Performance matrices will be developed for all core systems. Monthly reports will be produced and shared with key customers.
- Named system administrators will take responsibility for individual system performance.
- Where appropriate, consolidation of server hardware and the use of 'virtualisation' will be implemented to allow multiple systems to be deployed on single hardware platforms.
- The business continuity requirement will be analysed as a part of the initial business justification and implemented accordingly. Service levels will then be managed against this requirement.

The objective will be to ensure that internal customers have a clearly defined level of service and that systems performance is measured and provided against this standard.

Appendix 1: Strategic Plan Programme Portfolio

Programme	Project Portfolio
1. Access and Connecting (the LAS) For Health	**1. Provide access for all Londoners and visitors to London to the services of the LAS regardless of disability or language.** • Investigate other (non-telephone) access channels, particularly those that are more user friendly to disabled people and those who don't speak English. • Explore possible technological and other solutions to improve translation. • Exploit solutions to aid access addressing information barriers, physical barriers, policy and procedural barriers.
	2. Maximise the benefits of the national Connecting for Health programme with regard to connecting the LAS with the rest of the NHS (Patient Records and Acute Trusts) for enhanced care pathways, capitalising early on the opportunities presented. • Progress the evaluation and deployment of electronic patient records in partnership with the London cluster and Connecting for Health local provider. • Establish access to the NHS data Spine. • Develop expertise in using the data and maximising the value of the information for the Trust.
	3. Provide better integration and management information sharing with our partners and stakeholders (e.g. PCTs, SHA, emergency services, suppliers). • Identify scope for access to LAS data with NHS partners and commence pilot. • Develop Extranet and connectivity with stakeholder Extranets. • Develop information sharing protocols. • Develop information data warehouse.
	4. Fit for purpose infrastructure to support operations (call taking, despatch, response control and CTA). • Support High Impact Changes developed under Portfolio 2 (Improving our Response [Operational Model]) – continue existing CTAK enhancements. • Progress CAD 2010 project for future CAD system. • Progress implementation of Airwave and begin exploitation of the Airwave network for additional benefits. • Review MDT infrastructure and commence upgrade where appropriate. • Review the need for improvements to PSIAM in line with the Operational Model. • Move towards office automation in accordance with best practice. • Implement Internet Protocol Telephony (single network for voice and data convergence). • 24/7 infrastructure monitoring and back-up servers.
	5. Provide direct benefit (e.g. reduced risk) for patient care through provision of front-line information and tools. • Exploit opportunities presented by Electronic Patient Record and CAD2010. • Investigate distributed call management. • Investigate Automatic Estimated Time of Arrival update to callers. • Investigate "MDT Lite" – a reduced mobile data facility in a hand-portable format.
	6. Realise real-time management information reporting and communication for staff, providing up to date data and accurate information to all who need it from a single source. • Identify and scope projects to implement Records and Information Management Strategy. • Implement projects to give effect to Records and Information Management Strategy. • Develop policy and implement procedures for minimising use of paper and maximising use of electronic media.

Programme	Project Portfolio
2. Improving our Response (Operational Model)	**1. Develop an operational model for tasking the right resources to the right jobs which describes what resources will be deployed, and how, in order to meet patient need, and how this will be managed - includes:** • Identify nature of patient needs. • Identify skills required to meet patient need (inc. phone assessment [possible GP involvement] and face to face). • Identify qualifications/job roles required to meet patient need. • Identify vehicle types and equipment required. • Identify staff numbers required to meet patient need and meet performance targets. • Identify vehicle numbers required.
	2. Develop implementation plan for new operational model • Cost the implementation of the model. • Create implementation plan for the model (including identifying practical constraints [such as availability of training places or the skill types required] and alternatives) and taking into account the outcome of the access strategy project(s). • Decide (on basis of affordability) the timescales for roll-out of the new model. • Develop education and development strategy to support operational model (covering all staff).
	3. Implement new operational model • (as per implementation plan).
	4. CTA Projects • Pilot CTA on remote sites. • Implement remote-site CTA if pilot successful.
	5. Care Pathway development projects • Develop full possible range of referral pathways. • Secure access to all pathways from CTA.
	6. New Clock Start Operational Performance – High Impact Changes not covered by 1-5 above supported by Portfolio 1 and Portfolio 3): • Develop and implement an operational plan to successfully achieve new targets with effect from new clock start. • Develop and implement IM&T support plan to deliver the operational plan to successfully achieve new targets with effect from new clock start. • (NB. Identifies requirements for changes in Emergency Operations Centre and Urgent Control Centre but these are implemented through Programme 1 (Access Strategy and Connecting (the LAS) for Health) and requirements for Workforce but these are implemented through Portfolio 3 (Organisation Development and People).
	7. Olympic and Paralympic Games • Operational planning to manage additional demand arising and provide coverage at sporting venues.
	8. Development of the Thames gateway • Operational planning for the increase in population in the Thames gateway area.
	9. Major incident resilience • Planning and implementation of major incident resilience preparedness.

Programme	Project Portfolio
3. Organisation Development And People	**1. Establish a workforce profile as described in the Workforce Plan supporting the Operational Model and which is more representative of the population of London.** • Analyse how the public and staff see the service as an employer. • Consult with stakeholders. • Review and re-design recruitment strategy. • Progress the recruitment dimension of Workforce Plan Phase 1 (response staff). • Create, consult on and implement Workforce Plan Phase 2 (call taking and support functions).
	2. Establish an appropriately skilled workforce, confident to use their skills and a much wider range of care pathways. • Progress the induction, training and education requirement aspects of the Workforce Plan Phase 1 (e.g. Enhance trainer development). • Workforce modernisation and skill mix delivery. • Individual performance management and progressing effective use of Personal Development Reviews (PDR) and Personal Development Plans (PDP). • Prepare increased numbers of staff for lone working on Fast Response Units.
	3. Establish a workforce that lives the CRITICAL values, treating everyone as they would wish to be treated. • Review Operational Model roles and link all roles to the strategic direction. • Appropriate training given to staff roles that support how to challenge (including clinical practice). • Values aspect of recruitment. • Leadership Development programme.
	4. Establish a learning organisation that works cross-functionally in a customer-focused and team based way (internally and externally with partners). • Protected learning time and time out for e.g. PDR/PDP. • Training needs analysis and development of a robust training programme. • Adopt new ways of working to deliver the training programme. • Personal awareness training. • Staff engagement (e.g. staff led projects).
	5. Embed a culture of mutual challenge and accountability for personal behaviour and performance. • Process for clinical supervision. • Staff briefings. • Reward and Recognition. • Devolve Board/SMG decision making. • Formal process and training for performance management with a Performance Management Framework in place for all staff (encompassing appropriate consequences e.g. reward and recognition).
	6. Establish new styles of management (supportive of staff and promoting staff involvement and development) with leadership at all levels underpinned by skills (clinical, managerial, leadership and communications). • Agreed performance objectives for all staff and implementation of performance management system for all staff. • Recognising and celebrating achievements. • Leadership and management development for all managers. • Design and implement a succession planning system. • Coaching and mentoring. • Development time built into all rotas. • Union partnership agreement.

Programme	Project Portfolio
4. Governance and Corporate Processes	**1. Improve process efficiency.** • Process improvement for reduction of LAS costs to closer align with national reference costs for ambulance trusts. • Fleet strategy and workshop review. • Flexible fleet management. • Real-time fleet management information. • Development of local Key Performance Indicators to support performance management. • Implement other process improvements following process mapping to increase efficiency.
	2. Ensure corporate processes contribute to patient experience and outcomes by supporting the front line (this includes response time performance). • Mapping all processes and identify improvements. • Implement process improvements as appropriate to optimise contribution to patient experience and outcomes.
	3. Provide better integration with the whole system (LAS, NHS and London-wide). • Development of the Intelligent Trust (stakeholder intelligence). • Trust development (Foundation Trust status evaluation if Ambulance Trusts are required to do so, evaluation of other development opportunities). • Agreed delegation of authorisation for improved partner interface.
	4. Reduce operational and clinical risk (e.g. ability to deal with all types of patient). • Review fitness for purpose of abstraction management. • Software system to facilitate risk management and the risk register. • Map processes to ensure optimisation of risk management opportunities presented by Electronic Patient Record. • Enhance Quality Assurance of clinical practice. • Optimise use of individual performance management tools and their availability to operational managers.
	5. Improve process quality/effectiveness • Electronic Staff Record Phase 2. • Supply Chain Review: o Inventory management. o Asset tracking for equipment. • Electronic data capture (web based). • Enhance management of confidential information.
	6. Reduce process cycle time • New ordering/financial system - procurement (FISC) to replace EROS. • Regular supplier reviews. • Development of faster establishment control and recruitment process. • Improve information reporting time (e.g. Resource Centre to get information on staff availability).

Enabling Strategy	
5. Stakeholder Engagement and Communications	**1. Communications projects, including patient, public and partner involvement.** • Develop a stakeholder engagement and communications strategy for the programme and each portfolio. • Build on experience of Patient Care Conferences to create year-round programme designed to cement ongoing patient involvement and public education. • Expand community involvement opportunities (LAS attendance and involvement at events). • Build partner relationships (NHS, social services etc.). • Devise and conduct regular surveys of our partners and act on outcomes. • Devise and conduct patient surveys and act on outcomes. • Specifically address issues identified with black and ethnic minority patient satisfaction. • Carry out baseline assessments of current partnership projects. • Identify all service developments (in order to then ensure patient involvement). • Develop systems to record patient involvement. • Identify benefits to patient / public of getting involved in LAS (in order to maximise involvement). • Communicate PPI strategy to staff / training and education. • Give patients choices about involvement and build relationships with them. • Ask for participant feedback on whether they felt involvement was genuine. • Identify staff with partnership working interest and skills.

Appendix 2: How the future may look for the LAS with the delivery of the IM&T Strategy

Key components

A new suite of services will be available for people who do not speak English, and/or who cannot use the telephone as an able bodied person would. This includes direct internet services, and text messaging via translator services that then interact with the control room. New national targets have been agreed for these types of calls, as 8 minutes from initial call answer, is recognised as being not realistically achievable.

Electronic PRFs are fully installed in all response vehicles. Details of the call automatically populates the ePRF 'tablet' (hand portable PC device) and where patient details are known, appropriate medical information is downloaded from the Spine. Mandatory fields ensure 100% data compliance. If the patient is to be transported then all recorded details are downloaded to the receiving centre (hospital or urgent care centre of some type), e.t.a. is automatically calculated, hence reception staff know what to expect and when.

The ePRF tablet also acts as information centre for the Paramedic. It has access to various clinical guidelines and provides basic translation software for deaf people and commonly used languages. It is in continuous development as a vital Paramedic aid.

Staff training and education has evolved. All employees are required to have a basic level of IM&T literacy, irrespective of their role (e.g. e-mail, basic word processing). Many training modules are now delivered by web-based e-learning packages, including many clinical modules. Traditional classroom based training is still delivered, but it is more of an exception rather than normal practice. Importantly, staff accept that they are responsible for their ongoing training – this is not something 'done to them' by managers.

The LAS has fully implemented Airwave. Every crew member carries a digital radio that provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies. Data is now routinely passed across this system alerting staff to calls, and in the case of non MDT vehicles, passing the actual call details.

ESR is the single repository for all staff data, including records of personal issue equipment. Application forms are now all electronic and from moment of initial enquiry, the entire employee process is automated. Extraction routines take data from ESR and populate other systems that need data about people (e.g. telephone directory). This includes setting the access level that each member of staff has for information systems. Self service is fully implemented allowing staff to self-manage certain personal attributes (e.g. Bank details, address, telephone extension).

All staff book on/off duty, time recording will therefore automatically satisfy the requirements of the working time directive. Additionally, when booking on duty, all clinically qualified staff will be issued with an Airwave radio, that in turn will show their availability to the CAD system. All clinically qualified staff will be expected to be available to respond to local calls to perform physically local BLS duties, irrespective of their other duties.

All managers who have a justified business requirements will have a laptop computer equipped will full remote access, allowing 24 X 7 access to all corporate services. All staff will have access to basic e-mail (known as web mail) from any internet terminal – essentially giving free access to Trust e-mail from home computers or internet cafés. Vitally, a new culture will have emerged where staff use this technology to work smarter, not harder – this access will not simply be work added to the 'day job'.

The concept of IM&T Super User is now well established. This role is a recognised responsibility undertaken by appropriate staff at each main LAS location. The person provides local user support and has a direct liaison with the IM&T Customer Services Department, who provide ongoing support and training.

There is a 24X7 IM&T Support desk that acts as a single focal point for ALL IM&T support. Utilising interactive tools, the support technician is able to remotely access the faulty equipment or service. 70% of the calls receive a 'fix' at the point of the call being received. That is, the technician is able to restore at least a basic service to the customer, and where necessary, complete fault resolution to be undertaken in slow time. Increasingly customers will use 'self service'. Through a web browser they will be able to log on to the service desk and report their problem. They will also be able to access a series of tools and help scripts to assist in 'self fix' and also monitor progress of their fault.

'IP' communications has enabled the LAS to implement a fully integrated digital network. Voice, data, video are seamlessly passed between LAS locations, and four digit dialling connects any voice device (not necessarily a traditional telephone). 'Hot desking' is common place, with staff having a transportable telephone number (can by moved to any fixed or mobile handset) and are able to log onto their user accounts and files from any LAS PC.

There is a new, fully integrated CAD system supporting two control rooms (each with 100% spare capacity for resilience). Reliability is 99.9%+ with complete system failures now unheard of. New functionality is released twice a year through upgrades provided by the commercial provider of the CAD software.

All data is input once, as close to the original collection point as possible, normally via a web browser. Hence, through streamlined business processes and work flow applications, paper forms are no longer sent to data input functions. Once entered, data is then re-used by a defined suite of systems, thus removing the need for duplicate data entry.

Management Information is provided by a suite of reporting tools that reside on all desktop and remote access computers. There are different levels of tools, and staff are able to generate reports as and when they require them, according to their access rights. The central Management Department provides expert analysis for the most complex queries, reports on overall trends, provides predictions, continually develops the tools and acts as guardian of data standards.

Software provision is split between in-house developments (normally under six months from concept to delivery) and commercial packages. Large scale bespoke software development is not undertaken and where necessary, business processes are adjusted in order to implement package solutions.

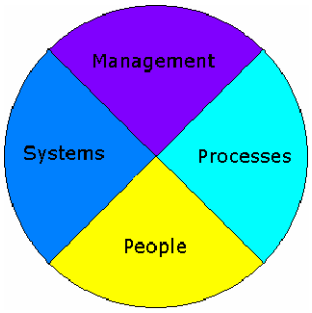
'The future is here – it just isn't connected yet'

Appendix 3: Information Governance Standards on which assurance is sought

Information Governance Toolkit version 5: Control listing

The toolkit is grouped by requirements and also by initiatives.

Requirements



1. Initiatives

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Corporate Information Assurance

2. Full control listing

101
Does the AMT have adequate governance in place to support the current and evolving Information Governance agenda?

102
How would you assess your AMT's ability to access expertise across the Confidentiality and Data Protection Assurance agenda?

103
How would you assess your AMT's ability to access expertise across the Information Security agenda?

104
How would you assess your AMT's ability to access expertise across the Information Quality and Records Management Agenda?

105
Does the AMT have in place comprehensive IG Policy and associated Strategy and Improvement Plans all signed off by the Board?

106
Does the AMT have up to date and tested business continuity plans for all critical infrastructure components and core information systems?

107
Does the AMT have a comprehensive Board endorsed Information Lifecycle Management Policy/Strategy and implementation plan?

108
Has the AMT implemented its Information Governance management arrangements to ensure the NHS CFH Statement of Compliance (SoC) is satisfied?

109
Does the AMT ensure that staff and those working on behalf of the AMT comply with the terms and conditions set out on the RA01 form?

110
Does the AMT ensure that it has formal contractual arrangements that include compliance with information governance requirements, with all contractors and support organisations?

111
Does the AMT ensure that all individuals carrying out work on behalf of the AMT have employment contracts which require compliance with information governance standards?

112
Does the AMT's staff induction procedure effectively raise the awareness of Information Governance?

113
Does the AMT assess staff training needs and ensure job/role specific information governance training is provided to all staff?

201
Does the AMT have a confidentiality code of conduct that provides staff with clear guidance on the disclosure of patient personal information?

202
Does the AMT ensure that patients are generally asked before their personal information is used in ways that do not directly contribute to, or support the delivery of, their care and that patients' decisions to restrict the disclosure of their personal information are appropriately respected?

203
Does the AMT ensure that patients are informed about the proposed uses of their personal information and the importance of providing accurate information to NHS staff?

204
Does the AMT have effective procedures for ensuring that detailed questions, raised by patients about how their information may be used, can be answered?

205
Does the AMT have appropriate procedures for recognising and responding to patient requests for access to their health records?

206
Has the AMT established appropriate confidentiality audit procedures to monitor access to confidential patient information?

208
Has the AMT put in place safe-haven procedures for all routine flows of patient personal information to the organisation?

209
Does the AMT comply with data protection requirements in respect of transfers of personal data about patients or staff to countries outside of the EEA?

210
Does the AMT ensure that all new processes, software and hardware, comply with confidentiality and data protection requirements?

301
Does the AMT have a formal information security risk assessment and management programme that is implemented and regularly reviewed?

302
Does the AMT have documented and accessible information security event reporting and management procedures in place that are explained to all staff?

303
Has the AMT established business processes that ensure all staff smartcards and access profiles issued are appropriate and satisfy their obligations as Registration Authorities?

305
Does the AMT ensure that operating and application information systems under its control support appropriate access control functionality?

306
Are there defined, documented and agreed access rights for all users of AMT based information systems and services?

307
Has the AMT established a register of all its major information assets and assigned responsibility or ‘ownership’ for each?

308
Does the AMT ensure that digital information shared with other organisations is secured in transit?

309
Does the AMT have adequate procedures in place to ensure the availability of information processing facilities, communications services and data?

310
Does the AMT have procedures in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error?

311
Does the AMT ensure that its information systems are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code?

312
Does the AMT have in place appropriate procedures for ensuring that the development and introduction of any new local information systems, software, IT projects and, more generally, IT support activities are conducted in a secure and structured manner?

313
Does the AMT have appropriate procedures in place to ensure that communication networks under the AMT's control operate in a secure manner?

314
Does the AMT have appropriate procedures for ensuring that mobile computing and teleworking are conducted in a secure manner?

315
Does the AMT satisfy its security management requirements to protect the Airwave communications service?

401
Does the AMT have a strategy to ensure the correct NHS Number is recorded for each active patient and ensure that it is used routinely in clinical communications?

403
Does the AMT have an organisation-wide, multi-professional audit of clinical record keeping standards, including accuracy for all professional groups in all specialities?

405
Does the AMT have robust procedures and processes for monitoring all data collection activities across the AMT?

408
Does the AMT have procedures in place to ensure that when new services are provided, or where changes within the system are made, that these do not adversely impact on information quality?

601
Does the AMT have documented and implemented procedures for the creation and filing of electronic corporate records to enable efficient retrieval and effective records management?

602
Does the AMT have documented and implemented procedures for the creation, filing and tracking/tracing of paper corporate records to enable efficient retrieval and effective records management?

603
Does the AMT have publicly available, documented and implemented procedures to ensure compliance with the Freedom of Information Act 2000?

604
Has the AMT carried out an audit of its corporate records and information as part of the information lifecycle management?

London Ambulance Service NHS
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

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 TofR.
28/08/08	2.3	Head of Governance(MB)	Include new TofR 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
20/10/08	3.1	Head of Governance(MB) – all chairs of risk management groups/cttees Trust Chairman	Amendments to TofR for all New TofR for SMG
21/10/08	3.1	Amendments to Risk Management Structure and details of Committee Membership and Frequency of attendance	For approval by Trust Board on 25th November 08.

***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**
Trust Board	Next meeting 25/11/08	3.1
Ratified by:		

Published on:	Date	By	Dept
The Pulse			
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	
TP/44	Organisational Learning & Improvement through Feedback, Complaints, Incidents & Claims	
	Standards for Better Health (DH July 21 2004)	
	NHSLA Risk Management Standards for Ambulance Trusts	

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.

Purpose

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. In addition, clinical risks will be reported to the Clinical Governance Committee, where specific analysis, learning and decisions regarding action required will be reported to the RCAG and subsequently the Trust Board. 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 high 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 completion CPIs	CGC
The timeliness in which	CGC, HSG, Motor Risk Group

incidents/accidents/RTAs are reported and investigated.	and RCAG
Demonstrate organisational learning, actions taken to prevent recurrence from SUIs, Complaints, claims and incidents	Feedback, Learning & Improvement Group (previously 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.

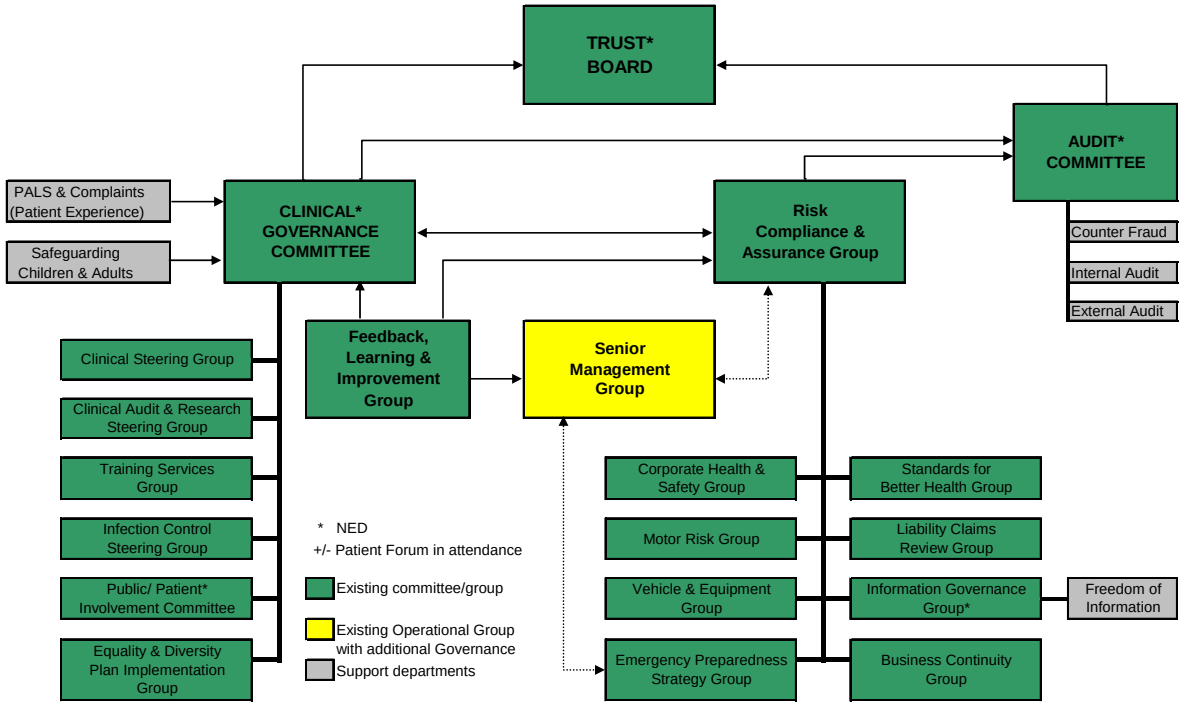


Figure 1 – Risk Management Structure

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.

- Head of Patient Experience (PALS & 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 Feedback, Learning & Improvement Group (FLIG – previously 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 to the public 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. KPI on page 15/16 used as measures by the RCAG.

Appendix 1

Membership and terms of reference of the Risk Management Committees and Groups

		Chair / Vice Chair	Meetings per year	Minimum annual attendance for each member
1	Risk Compliance & Assurance Group	CEO	4	50%
2	Clinical Governance Committee	NED / Medical Director	4	50%**
3	The Audit Committee	NED	4	50%
4	Corporate Health & Safety Group	HR & OD Director / AD Employee Support Serv.	6	50%
5	Senior Management Group	CEO	12	75%
6	Feedback Learning & Improvement Group	Executive Director	4	50%
7	Liability Claims Review Group	Head of Legal Serv. & AD Employee Support Serv.	2	50%
8	Standards for Better Health Group	Finance Director	4	50%
9	Vehicle & Equipment Working Group	Head of Operational Support	4	50%
10	Motor Risk Group	Finance Director	4	50%
11	Training Services Group	HR & OD Director	6	50%
12	Infection Control Steering Group	Head of Operational Support/Infection Control Co-ordinator	4	50%
13	Patient and Public Involvement Committee	Communications Director	4	50%
14	Clinical Audit & Research Steering Group	Medical Director	2	50% **
15	Information Governance Group	IM&T Director & Medical Director	4	50%
16	Business Continuity Steering Group	Finance Director	12 (conf.calls)	50%
17	Emergency Preparedness Strategy Group	Deputy Director of Operations	4	50%
18	Clinical Steering Group	Medical Director	2	50% **
19	Equality & Diversity Plan Implementation Group	Diversity Manager	2	50%
** Attendance by external members may be virtual; email / telephone call / conference call				

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 Standards for Ambulance Trusts.
- 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 Standards for Ambulance Trusts (monitored by the NHSLA) and the standards within the Annual Healthcheck (monitored by the Healthcare Commission and in future the Care Quality 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.

Frequency

Meetings will be held at intervals appropriate to Board sub-committee meetings, no fewer than 4 a year. The minutes of the committee will be formally recorded and submitted to the relevant committees. Whist each member should make every effort to attend all of the meetings, they should each attend no fewer than 2 meetings a year without due cause and reason.

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 reports from the following groups: (when a meeting has occurred in the period leading up to the RCAG meeting)

- (corporate) Health and Safety Group
- Standards for Better Health Group
- Feedback, Learning & Improvement Group (previously 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

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 NHSLA Risk Management Standards for Ambulance Trusts. To this end, the Committee will work with the Risk Compliance and Assurance Group

[1] NB: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee (JRCALC)

- 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 Patient Experience (PALS & Complaints Manager)
Senior Safety & Risk Advisor
Head of Operational Support
PPI Manager
Head of Clinical Audit & Research

Frequency

Whist each member should make every effort to attend all of the meetings, they should each attend no fewer than 2 meetings a year without due cause and reason.

Attending full committee meetings but not core meetings
Director of Service Development
Director of Communications
Assistant Director of Operations Control Services (deputy -Senior Ambulance Operations Manager – control services)
User Representative(s)
Emergency Medicine Consultant
Diversity Manager

Special attendance/reports – once a year
Patient Transport Services (LAS)
HEMS
BASICS
Voluntary Aid Societies/ Private Contractors
Community First Responders Scheme

4. Regular Reports will be received from:
- Standards for Better Health Group
- Feedback, Learning & Improvement Group (previously Complaints Group)
- Clinical Audit and Research Steering Group

- Risk Compliance and Assurance Group
- Area Governance Groups
- PPI Committee
- Equality and Diversity Plan Implementation Group
- Infection Control Group
- Training Services Group
- Lead for Safeguarding Children and Vulnerable Adults
- Six month update on NICE Guidance applicable to LAS
- Clinical Steering Group

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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. Whist each member should make every effort to attend all of the meetings, they should each attend no fewer than 2 meetings a year without due cause and reason.

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.

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5. Senior Management Group (SMG)

1. Purpose

The purpose of the Senior Management Group (SMG) will be to manage the performance of the Trust within the strategic framework established by the Trust Board. This arrangement forms part of the overall Board Assurance Framework. The SMG will advise the Trust Board on key policy and service issues and recommend policy proposals for Trust Board decision. The SMG will be accountable to the Trust Board through the Chief Executive. The SMG is an Executive Team meeting and will work within the parameters of the direction set through this team and the Trust Board.

2. Objectives

The Senior Management Group (SMG) will provide an opportunity for wider engagement and to influence the Executive Team. This will be achieved by;

1. Recommending the Trusts Business Plan to the Trust Board, and manage its' implementation and delivery.
2. Managing the performance of the Trust against its targets and other key deliverables.
3. Overseeing the financial performance of the Trust and agree any actions to improve the Trust's position and mitigate risks of delivery.
4. Managing the delivery of actions to prevent and mitigate risk, focussing on high risk issues and those with immediate service quality or operational implications.
5. Directing robustly and visibly, using the infrastructure of Governance , Clinical & Operational Groups.
6. Monitoring delivery compliance of suppliers contract content and for their services.
7. Recommending to the Trust Board policy direction and implementation plans, which enable the Trust Board to fulfil its corporate responsibilities.

8. Establishing working groups to take forward the business of the Trust.
9. Approving & ratifying Trust appointments, policies and procedures.
10. Developing a participative approach to developing Foundation Trust application and other similar programmes.
11. Overseeing and contribute to other committees across the Trust.
12. Receiving reports and support the Trust's Groups/Committees.
13. Overseeing and contributing to fuller communications across the Trust.
14. Support and advise the Chief Executive in his role as accountable officer.

3. Reporting Groups/Committees

The SMG will ensure recognition of operational pressures and unplanned changes in the environment within a system of corporate accountability. The aim will be to have appropriate reporting arrangements and clarity about how decisions are to be transacted.

There are a number of groups and committees which will need to inform the Senior Management Group in order for it to transact its business, including;

- Trust Board
- Audit Committee
- Risk Compliance and Assurance Group
- Feedback Learning and Improvement Group (previously Complaints Committee)
- Clinical Governance Committee
- Trust wide communication to staff
- External Communications and Press Releases

4. Membership

Chief Executive (chair)
Finance Director
Director of Human Resources and Organisation Development
Director of Operations
Medical Director
Director of Information Management and Technology
Director of Communications
Director of Service Development

Additional Trust Managers and Heads of Department will report to the SMG and may be called to attend the Senior Management Group according to the agenda.

5. Frequency & Structure of Meetings

The Senior Management Group will meet on a monthly basis, with a weekly diary meeting to complete outstanding work and additional business.

The SMG quorum will be 5 members of those entitled to attend (or deputy), a nominated director will chair in the absence of the CEO.

Agenda setting will take place at least one week before the Senior Management Group meeting. It will be set by the Chief Executive based on a process that allows all members to contribute and through a managed forward programme.

Minutes and notes from diary meetings will be circulated by the Trust Secretary or The Executive Officer.

The terms of reference will be reviewed annually.

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6. Feedback, Learning & Improvement Group (previously 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
Head of Patient Experience (PALS & 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.

7. 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.

8. 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).

9. 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

10. 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

11. 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

12. 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.

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13. 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.

14. 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

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15. 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.

16. 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

17. Emergency Preparedness Strategy Group

1. The London Ambulance Service (LAS) National Health Service (NHS) Trust Emergency Preparedness Strategy Group (EPSG) 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 his nominated delegate.

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; Assistant Director of Employee Services; Head of Communications; Head of Records & Business Continuity; LRT LAS representative; Director or SMT member of IM&T and the LAS CBRN Co-ordinator. When approved by the chair, members of the group may invite other representatives to attend as and when required.

5. The quorum for the group will be Deputy Director of Operations or delegate, Head of Emergency Preparedness or delegate, and three others. Specified post-holder members of the Group may delegate their authority through a representative.

6. The Group will meet quarterly, or more frequently if required.

7. The Group will:

a. Consider and Approve for adoption by the Chief Executive the contents of the Major Incident Plan & the Catastrophic Plan plus necessary appendices;

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. This training will be in line with current DOH guidance relevant at the time;

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; and

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 by a full meeting of the group as outlined above.

18. 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 telephone 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.

19. 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 Organisation 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

STANDING ORDERS OF THE LONDON AMBULANCE SERVICE NHS TRUST

CONTENTS PARAGRAPH

APPENDIX I: NOTICES OF MOTION AND OF QUESTIONS

APPENDIX II: TENDERING AND CONTRACT PROCEDURE

APPENDIX III: TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

APPENDIX IV: TERMS OF REFERENCE FOR THE REMUNERATION AND TERMS OF SERVICE COMMITTEE

APPENDIX V: TERMS OF REFERENCE FOR CHARITABLE FUNDS COMMITTEE

APPENDIX VI: STANDARDS OF BUSINESS CONDUCT FOR LONDON AMBULANCE SERVICE NHS TRUST

DEFINITIONS AND INTERPRETATION

Board	Shall mean the Chairman and non-executive Directors appointed by the Secretary of State for Health and the executive Directors appointed by the relevant committee of the Trust.
Board Director	Shall mean one of those comprising the Board and appointed in accordance with the Membership and Procedure Regulations and includes the Chairman.
Chairman	Means the person appointed by the Secretary of State for Health to lead the Board and to ensure it successfully discharges its overall responsibility for the Trust as a whole. The expression "Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.
Chief Executive	Shall mean the chief officer of the Trust
Committee	Shall mean a committee appointed by the Trust.
Committee Members	Shall be persons formally appointed by the Trust to sit on or to chair specific committees.
Director	Shall mean a Director whether they are a Board Director or a non Board Director.
Director of Finance	Shall include in its meaning the Chief Financial Officer of the Trust.
Executive Director	Shall mean Board Director
Membership and Procedure Regulations	Shall mean the National Health Service Trust (Membership and Procedure) Regulations 1990(SI(1990)2024).
Observer	Shall mean a nominated person that the Trust Board has agreed and accepted by way of a resolution who may sit with the Trust Board and participate in Trust Board discussions at its public meetings as set out in these Standing Orders.
Officer	Shall mean an employee of the Trust.
Secretary	Means a person appointed by the Trust to act

	independently of the Board and monitor the Trust's compliance with the law, SOs and observance of NHS Executive guidance.
SFIs	Means the Standing Financial Instructions of the Trust.
SOs	Means the Standing Orders of the Trust.
Trust	Means the London Ambulance Service National Health Service Trust as established by The London Ambulance Service National Health Service Trust (Establishment) Order 1996 (as amended).
Trust Board	Means the Board
Trust Secretary	Means Secretary.
Vice-Chairman	Means the non-executive director appointed by the Trust to take on the Chairman's duties if the Chairman is absent for any reason.

PART I: MEETINGS

1. ORDINARY MEETINGS

1.1. The regular ordinary meetings of the Board shall be held as the Board may determine and at such places as the Board may from time to time appoint.

1.2. In addition to a public meeting, held annually at a venue to be decided by the Board, to present the Financial Accounts and Annual Report of the Trust, all other formal meetings of the Board will be held in public. The formal notice of the annual public meeting will be issued 14 days in advance of that meeting.

2. ADMISSION OF THE PUBLIC TO TRUST MEETINGS

2.1. As required by the Public Bodies (Admission to Meetings) Act 1960, at the annual public meeting of the Trust, and any other meeting to which the press and public are invited, the Trust may resolve to exclude the press and public from part of a meeting "whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business or of proceedings".

2.2. The Trust will provide an opportunity for questions from the public to be put to the Board at its regular meetings. Questions may receive an oral response at the meeting or a written response afterwards at the Chairman's discretion. The Trust Board reserves the right not to answer questions which would be in breach of the NHS Code of Openness, such as areas concerning personal information about patients, information about legal matters and proceedings, and information given in confidence etc. The agendas for Board meetings shall have an item placed both at the beginning and the end of the public part of the agenda which invites questions from the public.

2.3. The Trust will normally exclude the press and public where discussing, for example:

2.3.1. matters relating to individual patients or members of staff;

2.3.2. information relating to consultations or negotiations with regard to labour relations matters;

2.3.3. detailed matters relating to proposals for the placing of contracts; and

2.3.4. instructions with regard to legal action by the Trust.

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

2.4. Nothing in these Standing Orders shall require the Trust (Board) to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

3. EXTRA-ORDINARY MEETINGS

3.1. The Chairman may call a meeting of the Board at any time and if he/she refuses to call a meeting after a requisition for that purpose, signed by at least four of the whole number of Board Directors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him/her, such four or more Board Directors may forthwith call a meeting.

4. VICE-CHAIRMAN

4.1. The Directors of the Board may select one of the non-executive Directors other than the Chairman to be Vice-Chairman for a period of one year or where the period of his/her membership of the Board during which he/she is elected has less than a year to run, for the remainder of such period.

4.2. Provided that any non-executive Director so elected may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman, and the Board Directors shall thereupon elect another Vice-Chairman in accordance with the provisions of this Standing Order.

4.3. Where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Vice-Chairman.

5. CHAIRMAN OF MEETING

5.1. At any meeting of the Board the Chairman, if present, shall preside.

5.2. If the Chairman is absent from the meeting, the Vice-Chairman, if present, shall preside.

5.3. If the Chairman and Vice-Chairman are absent, such non-executive Director as those present shall choose, shall preside.

6. NOTICE OF MEETINGS

6.1. Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted thereat, shall be delivered to all Board Directors, or sent by post to the usual place of residence of all such Directors, so as to be available to them at least three clear days before the meeting.

6.2. Provided that a meeting of the Board shall remain valid if any Board Director does not receive such notice.

6.3. Provided also that, in the case of a meeting called by four or more Board Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

6.4. Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting. (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a).)

6.5. VOTING

Every question at a meeting, which the Board agrees should be put to the vote, shall be determined by a majority of the votes of Board Directors present and voting on the question and, in the case of equality of votes, the person presiding shall have a second and casting vote.

7. RECORD OF ATTENDANCE

7.1. The names of Board Directors present at the meeting shall be recorded.

8. QUORUM

8.1. No business shall be transacted at a meeting unless at least four of the whole number of Board Directors are present, two of whom shall be Executive and two Non-Executive Directors.

8.2. An officer in attendance on behalf of an executive Board Director but without formal acting up status agreed by the Board's Remuneration Committee may not count towards the quorum.

8.3. If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

8.4. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

9. MINUTES

9.1. The minutes of the proceedings of a meeting shall be drawn up and entered in a book kept for that purpose and shall be signed at the next ensuing meeting by the person presiding thereat.

9.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

9.3. Draft minutes will be circulated with the agenda and papers for the next meeting of the Board.

9.4. Where providing a record of a public meeting the minutes shall be made available to the public as required by the Code of Practice on Openness in the NHS.

9.5. An action sheet indicating action to be taken, by whom and by what date, shall be sent to Board Directors, following each Board meeting within two weeks and should be included in the Board's agenda.

10. **CHAIRMAN'S RULING**

10.1. The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his/her interpretation of the Standing Orders shall be final.

11. **MANNER OF VOTING**

11.1. All questions put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by show of hands provided that, upon any question the Chairman may direct, or it may be proposed, seconded and carried that a vote be taken by paper ballot.

11.2. If at least three Board Directors so request, the voting on any questions may be recorded so as to show how each Board Director present and voting gave his/her vote.

11.3. If a Board Director so requests, his/her vote shall be recorded by name.

11.4. In no circumstances may an absent Board Director vote by proxy. Absence is defined as being absent at the time of the vote.

11.5. An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity, absence or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of that Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of that Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

12. AMENDMENTS

12.1. Whenever an amendment is made to an original motion no second amendment shall be made until the first amendment is disposed of. Any subsequent amendment shall not be inconsistent with any amendments to the original motion that have been carried.

13. TENDERING AND CONTRACTING PROCEDURE

13.1. The tendering and contracting procedure to be employed by the Trust is set out in Appendix II.

14. DECLARATION OF INTEREST IN CONTRACTS AND OTHER MATTERS APPLICABLE TO DIRECTORS AND OFFICERS

14.1. Subject to the following provisions of this Standing Order, if a Board Director, or anyone with whom that Director has a familiar relationship, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it - see paragraph 14.6.

14.2. Board Directors and Officers present will be invited to declare any new or undeclared interests at the commencement of all meetings of the Trust Board.

14.3. Notwithstanding the provisions of 14.1 and 14.2 above, Board Directors are required to register, on being appointed, any significant pecuniary or other interest material and relevant to the business of the Trust. This information is to be updated as may be necessary and recorded in the Minutes of the Board. The declaration should include:

14.3.1. Directorships, including non-executive Directorships held in private companies or Plcs.;

14.3.2. Ownership or partnership of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust;

14.3.3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust;

14.3.4. A position of authority in a charity or voluntary body in the field of healthcare or social services; and

14.3.5. Any material connections with a voluntary or other body contracting for services with NHS organisations.

14.3.6. Any other commercial interest in a decision before a meeting of the Trust Board.

14.4. The Secretary of State may, subject to Regulations, terminate the appointment of any Non-Executive Director who fails, as required, to declare a pecuniary or other interest. In the case of Board Director who fails to declare an interest or is found to have used his/her position or knowledge for private advantage, the Board may take disciplinary action leading to his/her dismissal.

14.5. The Secretary of State may, subject to conditions as he may think fit to impose, remove any disqualification in any case in which it appears to him

in the interest of the National Health Service that the disqualification should be removed.

14.6. The Board may exclude a Board Director from a meeting of the Board at which any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

14.7. Any remuneration, compensation or allowance payable to a Chairman or other Board Director under the provisions of paragraph 9 of Schedule 2, chapter 19 to the NHS and Community Care Act 1990 as amended shall not be treated as a pecuniary interest for the purpose of this regulation.

14.8. A Board Director shall be treated, subject to Standing Order 14.5. and the next following paragraphs, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if -

14.8.1. he/she or a nominee of his/her is a Director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

14.8.2. he/she is a partner, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration and in the case of persons living together the interest of one partner shall, if known to the other, be deemed to be also the interest of the other.

14.9. A Board Director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only -

14.9.1. of his/her Directorship of a company or other body if he/she has no beneficial interest in any securities of that company or other body; or

14.9.2. of an interest of his/her or of any company, body or person with which he/she is connected as mentioned in Standing Order 14.8 which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Board Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

14.10. Where a Board Director has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £10,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issues share capital of that class, this shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any

questions with respect to it, without prejudice however to his/her duty to disclose his/her interest.

14.11. The provisions of this Section 15 shall apply to all those present at a meeting of the Board irrespective of whether they are Board Directors or not.

14.12. This Standing Order (15) applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he is also a member of the Trust) as it applies to a member of the Trust.

14.13. Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

14.14. If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

14.15. Register of Interests - The Trust Secretary will ensure that a Register of Interests is established to record formal declarations of interests of Board members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board members, as defined in Standing Orders.

14.16. These details will be kept up to date by means of an annual review of the Register by the Audit Committee in which any changes to interests declared during the preceding twelve months will be incorporated.

14.17. The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

PART II: COMMITTEES

15. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

15.1. Subject to any directions by the Secretary of State, the Board may, and if directed as aforesaid shall, appoint committees of the Board, or together with one or more Health Authorities or other National Health Service Trusts appoint joint committees, consisting in either case wholly or partly of persons who are not Directors of the Board or other body, except that Board Directors may not be appointed to any committee set up to carry out the functions of Managers under the Mental Health Act 1983.

15.2. A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Secretary of State or the appointing authority or authorities, appoint sub-committees consisting wholly or partly of persons who are not members of the committee or joint committee, subject to the provisions set out in the Standing Order 15.1 above.

15.3. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

15.4. The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Executive or Non Executive Directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

15.5. Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

15.6. Such committees appointed in accordance with Sections. 15.1 and 15.2 shall continue until such time as the Board agrees to their disbandment.

15.7. The quorum requirements for each Committee so established by the Board will be set out in the Committee's Terms of Reference. Those Terms of Reference shall ensure that the quorum for a Committee must include at least one Non Executive Director of the Board.

16 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS

16.1 Subject to any directions by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 15, hereof, by any officer appointed by the Board, or by any other body as defined by Standing Order 17.2 below, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State may direct and subject to the provision that the Standing Orders of the Board shall apply mutatis mutandis to committee and sub-committee meetings.

16.2 S16B of the NHS Act 1977 allows for regulations to provide for the functions of Trusts to be carried out for the Trust by third parties.

16.3 Overriding Standing Orders – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to both the Chief Executive and the Trust Secretary as soon as possible.

17 AUDIT COMMITTEE

17.1 In accordance with guidance issued by the NHSD Executive under EL(94)40, the Board shall establish an Audit Committee to provide an independent and objective view of internal control - see paragraph two of Standing Financial Instructions.

17.2 The Committee shall comprise of three non-executive Directors, other than the Board Chairman (with a quorum of two). The Chief Executive and Director of Finance will attend this Committee as appropriate and it will be serviced by the Trust Secretary. It will report to the Trust Board. Membership of the Committee together with its Terms of Reference, delegated powers and reporting arrangements shall be formally established and approved by Resolution of the Board. Terms of Reference for the Committee are at Appendix III.

18 REMUNERATION AND TERMS OF SERVICE COMMITTEE

18.1 In accordance with the guidance issued by the NHS Executive under EL(94)40, the Board shall establish a Remuneration ~~and Terms of Service~~ Committee. The Committee shall comprise of Non-Executive Directors (with a quorum of three), be chaired by the Board Chairman, the Chief Executive and Director of Human Resources & Organisation Development will attend this Committee as appropriate and it will be serviced by the Trust Secretary. It will report to the Trust Board. Membership of the Committee,

together with its Terms of Reference (which should also specify which posts fall within the Committee's area of responsibility) shall be formally established by Resolution of the Board. Terms of Reference for the Committee are at Appendix IV.

19 CHARITABLE FUNDS COMMITTEE

19.1 The Board shall establish a Charitable Funds Committee to determine the policy for the management of the LAS' charitable funds and to implement that policy. The Committee will be chaired by a Non-Executive Director, and will include the Director of Human Resources & Organisation Development (or his/her representative) and the Director of Finance's (or his/her representative) and representatives of the staff. It will report to the Trust Board. The Trust Board shall formally agree membership of the Committee together with its terms of reference as detailed in Appendix V.

20 SERVICE DEVELOPMENT COMMITTEE

20.1 The Board shall establish a Service Development Committee to provide a discussion forum for future service developments and opportunities. The Committee shall be a non-decision making Committee which will be Chaired by the Trust Chairman. Members shall comprise Non-Executive Directors and the Chief Executive. Other Board Directors, Non-Board Directors and Officers shall attend by the invitation of the Committee's Chairman. The proceedings of the Committee will be recorded in writing and presented to the next scheduled meeting of the Trust Board. The Terms of Reference of the Committee are as detailed in Appendix IX.

21 CLINICAL GOVERNANCE COMMITTEE

22.2 The Board shall establish a Clinical Governance Committee to monitor clinical standards and provide a means of ensuring matters relating to achieving high standards of patient care come under consideration and scrutiny. The Committee will be chaired by a non-Executive Director of the Board. The Committee will report to the Trust Board and its Terms of Reference shall be established by the Board. Terms of Reference for the Committee are at Appendix X.

22 RISK MANAGEMENT

The Risk Compliance and Assurance Group has been established to manage the Trust's risks. The Group will report to the Audit Committee.

23 APPEALS PANELS

23.1 The Chief Executive will nominate a panel to hear staff appeals in disciplinary matters. Such panels will exclude any Director who has been involved in the decision(s) at issue and will normally include an Independent Chairman, a Non-Executive Director and the Director of Human Resources & Organisation Development or her/his nominee who will act as an advisor to the Panel.

24 COMPOSITION OF COMMITTEES

24.1 With the exception of the Audit Committee, the Chairman of the Board shall be an ex-officio member of all Trust Committees and Sub Committees.

25 PROCEEDINGS IN COMMITTEES TO BE CONFIDENTIAL

25.1 A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without the permission of the Committee's Chairman until the Committee shall have reported to the Board or shall otherwise have concluded action on that matter.

25.2 Provided that a Director of the Board or a member of a Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee notwithstanding that the matter has been reported or action has been concluded, if the Chairman of the Board or Committee has resolved that it is confidential.

26 APPOINTMENT OF CHAIRMEN OF COMMITTEES

26.1 The Chairman of the Trust Board shall appoint the Chairman of Trust Committees at the first meeting of the Trust Board for the following year and, if desired, a Vice Chairman of the Committee. Appointments will continue from one year to the next unless the Chairman decides otherwise.

26.2 Appointment of members of Committees shall be made by the Chairman of the Trust Board in consultation with the Chairman of the Committee.

27 SPECIAL MEETINGS OF COMMITTEES

27.1 The Chief Executive shall summon any Committee at the request of its Chairman, or on the requisition in writing or any two Committee members.

28 **QUORUM**

28.1 Except where approved by the Board, business shall not be transacted at any meeting of any Committee of the Board unless at least half of the whole number of the Committee is present, provided that in no case shall the quorum of the Committee be less than two members.

PART III: CUSTODY OF SEAL AND SEALING OF DOCUMENTS

29 CUSTODY OF SEAL

29.1 The common seal of the Trust shall be kept by the Trust Secretary in a secure place in accordance with arrangements approved by the Trust.

30 SEALING OF DOCUMENTS

30.1 The fixing of the seal of a NHS Trust shall be authenticated by the signature of the Chairman or some other such person authorised generally or specifically by the Trust for that purpose and one other director.

30.2 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive and an Executive Director.

31 REGISTER OF SEALINGS

31.1 The Trust Secretary shall keep a register in which shall be entered a record of the sealing of every document and every such entry shall be signed by those present when the document is sealed. The entries in the register shall be consecutively numbered and any additions reported at the next regular Board meeting.

PART IV: APPOINTMENT OF OFFICERS, ETC.

32 CANVASSING OF, AND RECOMMENDATIONS BY, DIRECTORS

32.1 Canvassing of Directors of the Board or any Committee of the Board directly or indirectly for any appointment within the Trust shall disqualify the candidate for such appointment. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

32.2 A Director of the Trust shall not solicit for any person, any appointment within the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving a written testimonial of the candidate's ability, experience or character for submission to the Chief Executive.

32.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

33 RELATIVES OF BOARD DIRECTORS OR OTHER MEMBERS OF STAFF

33.1 Candidates for any appointment under the Trust shall when making application, disclose in writing to the Trust any relationship to or with any Board Director of the Trust or any other employee of the Trust. A candidate who purposely and deliberately conceals such information shall be disqualified for such appointment and, if appointed, shall be liable to dismissal with notice. Every Board Director of the Trust or the holder of any post reporting directly to a Director of the Trust, shall disclose to the Board any relationship known to him/her to exist between himself/herself and a candidate for an appointment of which he/she is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

33.2 Where a relationship to a Board Director of the Trust is disclosed the Standing Order headed "Declaration of Interest in Contracts and Other Matters" (SO No.14) shall apply.

33.3 Two persons shall be deemed to be related if they are husband and wife or living together as husband and wife or as partners or if they are the son or daughter; nephew or niece; grandson or granddaughter; or brother or sister of either of them or in-laws as applicable.

34 INTERESTS OF MEMBERS OF STAFF

34.1 If it comes to the knowledge of any member of the staff of the Trust that a contract in which he/she has any pecuniary or other interest, whether direct or indirect, not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall at once give notice in writing to the Board of the fact that he/she is interested therein. In the case of persons living together, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

PART V: MISCELLANEOUS

35 SUSPENSION OF STANDING ORDERS

35.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one Member who is not) and that at least two-thirds of those members present signify their agreement to such suspension.

35.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

35.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Board.

35.4 No formal business may be transacted while Standing Orders are suspended.

35.5 The Audit Committee shall review every decision to suspend Standing Orders.

36 VARIATION AND AMENDMENT OF STANDING ORDERS

36.1 These Standing Orders shall not be varied except upon notice of motion under Paragraph 1 of Appendix I and unless there are at least eight Directors of the Board present and provided that any variation does not contravene a statutory provision or direction made by the Secretary of State.

37 STANDING ORDERS TO BE GIVEN TO DIRECTORS

37.1 The Trust Secretary shall ensure that a copy of the Standing Orders is given to each Director of the Board and to appropriate members of staff.

38 SIGNATURE OF DOCUMENTS

38.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, or the Board has given the necessary authority to some other

person for the purpose of such proceedings, be signed by the Chief Executive or the Trust Secretary.

38.2 The Executive Directors of the Board shall be authorised to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been necessarily approved by the Board or any committee or sub-committee with delegated authority.

39 STANDING FINANCIAL INSTRUCTIONS

39.1 Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

40 URGENT DECISIONS

40.1 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.

40.2 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.

41 CODES OF CONDUCT AND ACCOUNTABILITY

41.1 Codes of Conduct and Accountability issued by the Department of Health shall apply to the Board and its Directors. Standards of Business Conduct for the Trust are as set out in Appendix VI.

41.2 Staff should comply with the national guidance contained in Health Service Guidelines 1993/5 “Standards of Business Conduct for NHS Staff”.

42 CODES OF PRACTICE

42.1 Codes of Practice approved by the Trust Board shall have effect as if they were part of these Standing Orders. The Trust Secretary will maintain a list and copies of such Codes of Practice. The Trust Board shall approve the manner in which Codes of Practice are maintained and varied as each Code of Practice is approved by the Board.

43 OVERSEAS BUSINESS TRAVEL OUTSIDE THE UNITED KINGDOM BY TRUST EMPLOYEES

43.1 From time to time it will be necessary and appropriate for Trust staff to travel outside the UK for business purposes. This may include the opportunity to observe and research new systems in operation, attendance at conferences with an international perspective, and income generating advice and consultancy projects.

43.2 In order to ensure probity and public confidence in their appropriateness, all such journeys outside of the European Union area will be reported to the Trust Board on an annual basis. The Audit Committee will receive an annual ~~regular~~ report on travel undertaken by Trust staff.

43.3 There will be an internal process for approving overseas travel outside the UK which will consider the following criteria/requirements:

43.3.1 Clear Trust benefits are expected and specified
43.3.2 A personal presence is required
43.3.3 There is a major role to be played at any conference attended
43.3.4 Part funding by conference organisers should be considered
43.3.5 The appropriateness of Business Class travel
43.3.6 Written report to the Trust Board on outcomes achieved

43.4 Irrespective of the reason for travel the Trust will pay all travel and subsistence costs unless the Trust Board has approved other arrangements in advance.

44 DOCUMENTS HAVING THE STANDING OF STANDING ORDERS

44.1 Standing Financial Instructions, Decisions Reserved for the Board and the Scheme of Delegation shall have effect as if incorporated into Standing Orders.

45 REVIEW OF STANDING ORDERS

45.1 Standing Orders shall be reviewed as required by the Board, and not less frequently than every two years.

46 PART VI: DECISIONS RESERVED FOR THE BOARD

46.1 The Board has reserved to itself decisions on the items shown in the Schedule of Decisions Reserved for the Board at Appendix VIII.

47 PART VII: SCHEME OF DELEGATION

The Board has agreed a Scheme of Delegation to show the approved officers who have been delegated responsibility for deciding particular matters and those who may act in their absence. The scheme is shown in Appendix XIII.

PART VIII: INTERPRETATION OF STANDING ORDERS

The Chairman of the Board shall be the final authority in the interpretation of Standing Orders on which he/she shall be advised by the Chief Executive or the Trust Secretary, or, in the case of Standing Financial Instructions, by the Director of Finance.

APPENDIX 1 NOTICES OF MOTION AND OF QUESTIONS

1. NOTICES OF MOTION

1.1 Subject to the provisions of paragraph 3 of this Appendix, a Director of the Board desiring to move a motion shall send a notice thereof at least seven clear days before the meeting to the Chairman or Trust Secretary, who shall insert in the agenda for the meeting, all notices so received subject to the same being in order. Requests made between the third day and the seventh day before a meeting may be included on the agenda at the discretion of the Chairman. This paragraph shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meetings (see paragraph 4 of this Appendix).

2. RIGHT OF REPLY

2.1 The mover of a motion shall have a right to reply at the close of any discussion on a motion or any amendment thereto.

3. MOTION TO RESCIND A RESOLUTION

3.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Board Director who gives it and also the signature of two other Board Directors. When any such motion has been disposed of by the Trust it shall not be competent for any Board Director, other than the Chairman, to propose a motion to the same effect within six months.

4. MOTIONS WHICH MAY BE MOVED DURING DEBATE

4.1 When a motion is under debate no other motions shall be moved except the following:

4.2 to amend the motion

4.3 to adjourn the meeting

4.4 to adjourn the debate

4.5 to proceed to the next business

4.6 to appoint an ad hoc committee to deal with a specific item of business

4.7 that the question be now put

4.8 a motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act, 1960 to exclude the public.

No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

5. NOTICES OF QUESTIONS

5.1 A Board Director may lay a notice of question before the Chairman of the Board, Chairman of a Committee or Sub-Committee or Trust Secretary. Provided reasonable notice is given, such questions will be answered by written or oral reply at the next appropriate meeting of the Board.

5.2 Questions to be put on behalf of the public must be received by the Trust Secretary 24 hours before the appropriate meeting of the Trust Board

APPENDIX II TENDERING AND CONTRACT PROCEDURE

1. DUTY TO COMPLY WITH STANDING ORDERS

1.1 The Trust shall ensure that competitive tenders are invited for

- the supply of goods, materials and manufactured articles;
- The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens); for disposals.

Every contract, whether made by the Trust, or by a committee of the Trust or by a nominated officer to whom the power of making contracts shall have been delegated, shall comply with these Standing Orders and, unless the Board has resolved to do otherwise in advance and on a per project/procurement basis, with any extant Departmental guidance. Where the Board makes such a resolution then it shall take precedence over any provisions to the contrary in these Standing Orders. Copies of such guidance documents can be obtained for reference purposes from either the Director of Finance. No exception from any of the following provisions of these Standing Orders shall be made other than by direction of the Board or, in an emergency, as detailed in paragraph 1.2 of this Appendix.

1.2 An exception from any of the following provisions of these Standing Orders may be made by direction of the Board. In an emergency an exception may be made by direction of the Chief Executive, or in his/her absence, the Director of Finance and Business Planning, or in his/her absence, an Executive Trust Director other than the Director directly involved in the issue. In such emergency circumstances, the exception shall only be made after consulting with the Chairman of the Board or, in his/her absence, the Vice-Chairman, in accordance with Standing Order 40.

1.3 The Trust shall comply as far as is practical wit the requirements of the Department of Health “Capital Investment Manual” and “Estate Code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance. “The Procurement and Management of Consultants within the NHS”.

2. EU DIRECTIVES

2.1 Directives by the Council of the European Union (EU) prescribing procedures for awarding contracts for services, building and engineering works and for the supply of goods, materials and manufactured articles

(hereafter referred to as goods and services) shall have effect as if incorporated in these Standing Orders and shall apply throughout.

2.2 The EU public procurement thresholds represent contractual value levels above which public authorities must follow EU procedural rules with regard to the issuing of contracts.

2.3 Value is defined as the total consideration excluding VAT that is to be paid over the lifetime of the contract (e.g. a three-year supplies contract with an anticipated annual expenditure of £500,000 has a value of £150,000). Where the contract includes options, the value of these options must be taken into account in determining whether the threshold as been reached. In the case of contracts for lease, rental or hire purchase the relevant figure is the aggregate of the consideration that will be paid throughout the duration of the contract. Where the term exceeds 12 months the estimated residual value must also be included. Where the duration is indefinite or uncertain the relevant figure is the monthly contract value multiplied by 48. In the case of regular or renewable contracts the relevant figure is either the aggregate of the consideration to be paid during the anticipated duration of the contract (or over the first 12 months if the duration is indefinite) or the consideration paid by the buyer under similar contracts for goods of the same type during the preceding 12 months (adjusted for any expected changes), whichever is the more appropriate. A single contract providing for a regular supply over a period of time and a series of separate contracts concluded over a period of time for the same type of goods are both regarded as 'regular' contracts for these purposes.

2.4 The thresholds are set bi-annually and with effect from January 1st 2008 are as follows:

2.2.1	Services (Part A)	~~£99,695~~	£90,319
2.2.2	Services (Part B)	~~£93,738~~	£90,319
2.2.3	Works	~~£3,611,319~~	£3,497,313
2.2.4	Supplies	~~£93,738~~	£90,319

3. PROCUREMENT FRAMEWORK

3.1 Standard Procurement Method

The Trust's standard method of procurement shall be by competitive tendering. However, as detailed below, the Trust's standard method of procurement shall be affected by the monetary value of the goods and services being purchased.

3.2 Purchases below £3,000

3.2.1 Standard LAS purchasing procedures shall be followed without the requirement for either competitive tendering to be implemented or competing quotations to be sought. Refer to paragraph 6 of this Appendix.

3.2.2 Wherever possible the goods and services being purchased shall be joined together so that the value shall exceed £3,000.

3.3 **Non-Estates Purchases between £3,000 and £25,000**

3.3.1 Competing quotations shall be sought, unless the purchase is made through the Trust's supplies agent. Refer to paragraph 5 of this appendix

3.3.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

3.4 **Estates Purchases between £3,000 and £100,000**

3.4.1 Competing quotations shall be sought. Refer to paragraph 5 of this Appendix.

3.4.2 Estates purchases relate to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

3.5 **Non-Estates Purchases above £25,000**

3.5.1 Competitive tendering shall be implemented. Refer to paragraph 4 of this Appendix.

3.5.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

3.6 **Estates Purchases above £100,000**

3.6.1 Competitive tendering shall be implemented. Refer to paragraph 4 of this Appendix.

3.6.2 Estates purchases relate to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

4. COMPETITIVE TENDERING

4.1 The Board shall ensure that competitive tenders are invited for:

4.1.1 the supply of goods with a monetary value in excess of £25,000;

4.1.2 the supply of materials and manufactured articles with a monetary value in excess of £25,000;

4.1.3 the rendering of services, including consultancy costs, with a monetary value in excess of £25,000;

4.1.4 building and engineering works of construction and maintenance, (including construction and maintenance of grounds and gardens) and for professional design services on works projects, with a monetary value in excess of £100,000, or such other figure as the Department of Health may from time to time determine;

4.1.5 for fee bids which take price into consideration for disposals and for all other projects.

4.2 Competitive tendering may be waived under the following circumstances:

4.2.1 where the goods or services are ordered under existing contracts;

4.2.2 as provided for under paragraphs 4.4, 4.6 and 14 of this Appendix;

4.2.3 where so provided in the NHSE Capital Investment Manual - copies of which are held within the Finance and Estates departments for reference purposes as appropriate;

4.2.4 The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender.

4.2.5 the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

4.2.6 there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

4.2.7 where in the opinion of the Chief Executive and the Director of Finance, the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be

practicable taking into account all the circumstances (as detailed in paragraph 5.2 of this Appendix).

4.3 In the event of any of the above referenced circumstances where competitive tendering is waived, the reasons shall be set down in a permanent and signed record. A copy of the signed record shall be retained with the associated project working papers and the original signed record shall be retained by the Director of Finance or the Chief Executive.

4.4 The provisions of this paragraph apply where EU procurement regulations have been satisfied. Where it is proposed that competitive tendering shall be waived and single tender action is being proposed, the relevant Director shall provide detailed information in writing regarding:

(i) the justification for single tender action;

(ii) compliance with public procurement regulations (EU Directives);

(iii) the possible effects of not seeking competitive tenders; and

(iv) value for money.

4.5 Where it is proposed that competitive tendering shall be waived, the information (as detailed in paragraph 4.4 of this Appendix) shall be presented to the Director of Finance, the Chief Executive or the Trust Board as appropriate (as detailed in paragraphs 4.5.1, 4.5.2 and 4.5.3 below). Where the Director of Finance, the Chief Executive or the Trust Board approve the waiving of competitive tendering, the relevant record (as detailed in paragraph 4.3 of this Appendix) shall be authorised. Where the approval to waive competitive tendering is authorised, such decisions shall be reported by the Director of Finance to the Trust's Audit Committee.

4.5.1 Where the proposal to waive competitive tendering relates to goods or services valued at less than £150,000, the authorisation shall be given by the Director of Finance.

4.5.2 Where the proposal to waive competitive tendering relates to goods or services valued at more than £150,000 and less than £400,000, the authorisation shall be given by the Chief Executive.

4.5.3 Where the proposal to waive competitive tendering relates to goods or services valued at more than £400,000, the authorisation shall be given by the Trust's Board.

4.6 Competitive tendering is not required where:

4.6.1 The goods or services can be obtained through a pre-tested competitive framework or catalogue arrangement to which the Trust has legitimate access and meets the requirements of public procurement regulations.

4.7 Formal tendering procedures may be waived, under the authority of one of the Trust's Executive Directors, without reference to the Chief Executive and the Director of Finance where:

4.7.1 the estimated expenditure is not in relation to building and engineering works, does not exceed £25,000 and is within budget allocation;

4.7.2 the estimated expenditure is in relation to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix), does not exceed £100,000 and is within budget allocation.

4.7.3 Under these circumstances competing quotations are to be sought (as detailed in paragraph 5 of this Appendix).

4.8 The Board shall ensure that invitations to tender are sent to a sufficient number of comparable firms to provide fair and adequate competition - taking into account the capacity of the firms to supply the goods or materials or to undertake the services or works required.

Normally, a minimum of three comparable firms shall be invited to tender unless procurement is routed through the Trust's supplies agent. In circumstances where the Trust's supplies agent are being used to secure tenders or quotations, the procurer shall not be specified. In circumstances where at least three tenders are being sought without the use of the Trust's supplies agent, the Trust's supplies agent could also be one of the organisations invited to produce a tender or quotation.

4.9 Where approved lists are maintained, the Board shall normally ensure that the firms invited to tender are among those on such approved lists. Such lists, where compiled, will include approved firms which have been subject to appropriate financial vetting (as detailed in paragraph 7 of this Appendix) as well as the separate maintenance list or record for minor works in accordance with ESTMANCODE guidance. Where maintained, the Director of Finance shall keep the list of financially approved firms and the Director of Finance/Head of Estates shall keep the maintenance list and minor works record.

5. COMPETING QUOTATIONS

5.1 Where formal competitive tendering is dispensed with under paragraph 4 of this Appendix, competing quotations shall be obtained in writing wherever possible, unless procurement is routed through the Trust's supplies agent. In circumstances where procurement is routed through

the Trust's supplies agent, the Trust's supplies agent shall abide by LAS Standing Orders at all times. In circumstances where it is not possible to obtain three competing quotations in writing, a file note of three competing quotations secured via telephone shall be maintained as a minimum. The value of contracts allocated without formal competitive tendering shall not exceed £25,000 in the case of non-estates goods or services or £100,000 in the case of building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

5.2 Competing quotations may also be invited directly from any firm, including the Trust's supplies agent, without regard to the provisions of paragraph 5.1 of this Appendix (i.e., where the value of the procurement exceeds £25,000 or £100,000 as appropriate) for the following purposes:

5.2.1 the supply of proprietary or other goods and the rendering of services where such goods or services are of a special or unique character, for which, in the opinion of the Chief Executive and the Director of Finance it is neither possible nor desirable to purchase through competitive tendering;

5.2.2 the supply of goods or manufactured articles of any kind which, in the opinion of the Chief Executive and the Director of Finance are required quickly for the continuance of the provision of the service provided by the Trust and are not obtainable under existing contracts.

5.2.3 In such circumstances, the firms invited to provide competing quotations shall only be those which are deemed suitable in the opinion of the Chief Executive and the Director of Finance.

5.3 Unless the Trust's supplies agent is used, a minimum of three competing quotations shall be invited in writing from comparable firms. Where this is not possible the Director of Finance shall be informed, in writing, of the reasons for and the outcome of the limited quotations. A copy of the written record shall also be retained with the associated project working papers.

5.4 Similar arrangements to those described in paragraph 5.2 above may be made for specialist services works in connection with building and engineering maintenance, provided that the Director of Information Management & Technology and Director of Finance certifies that the provisions of paragraph 5.2.1 and 5.2.2 above are applicable. The reasons for the decision shall be passed by the Director of Technology to the Chief Executive and Director of Finance in writing. The record shall be counter-signed by the Chief Executive and Director of Finance to show their acceptance of the reasons for the decision. A copy of the signed and authorised record outlining the reasons for this decision shall be retained with the associated project working papers.

6. STANDARD PROCUREMENT

6.1 Where the value of the goods and services to be purchased are less than £3,000, they shall be joined together wherever possible so that the total value exceeds the £3,000 minimum required for purchasing through competing quotations.

6.2 Where the provisions of paragraph 6.1 of this Appendix are not possible, the requirement for procurement through either competing quotations or competitive tendering shall be waived, and the goods and services shall be purchased through standard LAS procurement channels in accordance with standard LAS procurement procedures. It should be noted that, in order to maintain procedures of best practice and value for money, it is recommended that at least three telephone quotations shall be sought for expenditure of less than £3,000.

7. LIST OF APPROVED FIRMS

7.1 The Trust shall maintain, wherever possible, lists of approved firms from whom tenders and quotations may be invited, ensuring that the establishment and maintenance of such lists allows for sufficient competition. Such lists shall be maintained as detailed in paragraph 4.8 of this Appendix.

7.2 The lists, where maintained, shall be subject to periodic review and re-establishment, where appropriate, by advertising. It is to be noted that Department of Health guidance in CONCODE provides for the list to be re-established by advertisement every five years.

7.3 The lists, where maintained, shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Director of Finance is satisfied.

7.4 Where the Director of Finance is not satisfied with the technical and financial competence of the firms, the firms are to be removed from the list of approved suppliers, where maintained, and no tenders or quotations are to be accepted or invited from such firms.

7.5 Where no lists are maintained by the Trust, the Director of Finance is to be informed of all firms who have been invited to provide tenders or quotations by the Trust and subsequent to the opening of the tenders, shall determine whether such tenders or quotations received are to be accepted by the Trust by reference to their technical and financial competence (as detailed in paragraph 12.5 of this Appendix).

8. INVITATIONS TO TENDER

8.1 All invitations to tender on a competitive basis shall be in accordance with the Board's agreed procedures and be submitted in either :

a) hard copy (as used by the Estates Department)
b) electronically using the Bravosolution e-tendering portal (as used by the Procurement Department.

8.1.1. For hard copy tender returns it will be stated that no tender shall be accepted unless it is submitted in either the special envelope/package provided by the Trust or a plain, sealed envelope/package bearing the word "Tender" followed by the subject to which it relates and the latest date and time for receipt of such tender.

8.1.2 For electronic returns the 'Sealed' option for viewing responses shall be used.

8.2 Every tender for goods, materials, services or disposals shall embody the Contract Conditions that the tender shall be awarded under. However, in the case of tenders for the purchase of computer equipment and associated maintenance contracts, the facilities and conditions of contract of the NHS Central responsibility (as detailed in paragraph 4.2.4 of this Appendix) shall be used in accordance with relevant Departmental policy and guidance.

8.3 Every tender for building and engineering work, except any tender for maintenance work only (where Capital Investment Manual guidance shall be followed) shall be in the terms of the current editions of the Appropriate Standard Forms of Contract. Where appropriate, these base documents shall be modified and amplified to accord with extant Departmental guidance and other instructions and, in minor respects, to cover special features of individual projects.

8.4 All invitations to tender shall state in the invitation to tender that no tender shall be accepted unless it includes details of at least three recent referees who can be contacted to provide information on the technical and organisational competence of the tenderer, and the latest set of published financial statements of the tenderer.

8.5 All invitations to tender shall require tenderers to submit prices exclusive of VAT. Tenderers shall state the applicable VAT separately.

9. RECEIPT AND SAFE CUSTODY OF TENDERS

9.1 The Trust Secretary shall be responsible for the receipt, endorsement and recording of competitive tenders in the competitive tendering register and, for hard copy tender returns, for the safe custody of tenders received until the time appointed for their opening.

9.2 The competitive tendering register shall be in the form of a bound book with pre-numbered pages. For reference purposes, an example of the type of information held within the competitive tendering register has been included as Appendix B of this Appendix.

9.3 The date and time of receipt of each tender by the Trust Secretary shall be endorsed on the unopened tender envelope/package and recorded in the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.4 For electronic tender returns, tenders may not be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

10. OPENING TENDERS

10.1 For hard copy tender returns, as soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers officers designated by the Chief Executive and not from the originating department. The originating department will be taken to mean the Department sponsoring or commissioning the tender.

10.2 All Executive Directors/Members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

For any tenders with a value greater than £1 million, the tenders must be opened in the additional presence of an Executive Director.

10.3 All eligible tenders received shall be opened on one and the same occasion.

10.4 Every tender received shall be endorsed with the date of opening and initialled by at least two of those present at the opening, at least one of whom shall be a Director in circumstances outlined in paragraph 10.2 of this Appendix.

10.5 A record of the opening of the tenders shall be maintained in the appropriate register (as detailed in paragraph 9.2 of this Appendix). The record is to be signed by at least two persons present at the opening of the tenders, in accordance with paragraph 10.5 of this Appendix as appropriate. The record shall show for each set of competitive tenders:

(i) the name of all firms invited to tender, details of which shall not be supplied to those designated officers responsible for receipt and opening until after the date of return;

(ii) the names of firms from which tenders have been received;

(iii) the date the tenders were opened;

(iv) the price tendered (excluding VAT).

10.6 Except as in paragraph 10.8 below, a record shall be retained within the appropriate register (as detailed in paragraph 9.2 of this Appendix) of apparent price alterations within the tender. The record shall take the form of an addendum to the appropriate register and shall be initialled by at least two of those present at the opening, signed in accordance with paragraph 10.5 of this Appendix as appropriate. The addendum shall detail:

(i) all price alterations on the tender;

(ii) the final price shown on the tender;

(iii) any letter, document or material enclosed with or accompanying the tender.

10.7 A record shall be made in the addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix), if the price alterations are so numerous on any one tender as to render the procedure outlined in paragraph 10.7 of this Appendix unreasonable in the opinion of the Chief Executive or the Trust Secretary.

10.8 All records required to be maintained, as outlined within this Appendix, shall be held in the custody of the Trust Secretary.

11. ADMISSIBILITY OF TENDERS

11.1 Late tenders shall not be considered where other tenders received have already been opened, except in the circumstances described in paragraphs 11.2 and 11.3 below.

11.2 Technically late tenders are those despatched in good time but delayed beyond the due time for the receipt of tenders through no fault of the tenderers. Such tenders may be regarded as having arrived in due time by the Chief Executive or the Trust Secretary and a permanent signed record kept of the reasons, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

11.3 Late tenders shall only be considered in circumstances, to be determined by the Chief Executive or the Director of Finance, which would be of advantage to the Trust. Such circumstances may be where significant financial, technical or delivery advantages would accrue to the Trust and

the Chief Executive and the Director of Finance are satisfied that there is no reason to doubt the bona-fides of the tenderers concerned. In such circumstances, the tender may be considered and a permanent signed record shall be kept of the reasons, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

11.4 Incomplete tenders are those from which information necessary for the adjudication of the tender is missing. These shall be dealt with in accordance with paragraph 11.6 below.

11.5 Amended or re-submitted tenders shall not be considered after the due time for receipt.

11.6 If it is considered necessary by the Chief Executive or his/her nominated officer to discuss with a tenderer the contents of his/her tender in order to elucidate technical points before the award of a contract, the tender need not be excluded from the adjudication. A signed record of the nature of the discussion and its outcome shall be kept, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

11.7 Where the examination of tenders reveals errors which, in the opinion of the Chief Executive or his/her nominated officer, would affect the tender figures, the tenderer is to be given details of such errors and given the opportunity of confirming or withdrawing their offer. In such circumstances, the tender need not be excluded from the adjudication and a signed record of the nature of the discussions and their outcomes shall be kept. In these circumstances, the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

11.8 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration and while negotiations are in progress or re-tenders are being sought, the tender documents shall be kept strictly confidential and held in safe custody by the Chief Executive or the Trust Secretary.

12. ACCEPTANCE OF TENDERS

12.1 Non-Competitive Tenders

12.1.1 Where only one tender is sought and/or received the Chief Executive or his/her nominated officers shall, as far as is practicable, determine that the price to be paid is fair and reasonable and keep a signed record of the reasons for this decision. In such circumstances, the signed record is to be

retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

12.1.2 In circumstances where either no tender is received by the Trust or the Chief Executive or his/her nominated officer determine that the price to be paid is not fair and reasonable, the Chief Executive shall empower the Director responsible for the originating department to approach firms which the Director is aware can provide the relevant goods or services to the Trust. the Director shall report, in writing:

(i) the content and outcome of their discussions with the approached firms;

(ii) the agreed prices for the provision of the specified goods or services;

(iii) their recommendations as to which firms shall provide the goods or services to the Trust.

12.1.3 The Director shall forward the record (as detailed in paragraph 12.1.2 of this Appendix) to the Director of Finance, the Chief Executive or the Trust Board for approval of their recommendations as per the financial limits detailed in paragraphs 4.5.1, 4.5.2 and 4.5.3 of this Appendix.

12.1.4 Where this procedure is adopted, the Director of Finance shall maintain the duly authorised record, and report the decisions made to the Trust's Audit Committee.

12.2 **Building, Engineering and Maintenance Works**

12.2.1 If the number of tenders received is insufficient to provide adequate competition, or tenders are late, amended, incomplete, qualified, or otherwise not strictly competitive, in the opinion of the Chief Executive or his/her nominated officer, they shall be dealt with in accordance with Department of Health guidance extant or guidance obtained for the purpose of the particular case. Such guidance can be found, for example, in CONCODE - which can be obtained for reference purposes from the Director of Finance. Competitive tendering cannot be waived for building and engineering construction works, maintenance (other than in accordance with CONCODE) without the Department of Health's approval.

12.3 **Basis for Acceptance of a Tender**

12.3.1 The basis for the acceptance of a tender shall be that which is the most economical advantageous to the Trust and this may be, but

is not necessarily, that with the lowest price where payment is made by the Trust. If the lowest price is not accepted then the good and sufficient reasons shall be set out in either the contract file or other appropriate record.

12.3.2 The possible criteria for acceptance of the tender shall be:-

(i) price
(ii) quality
(iii) delivery date
(iv) capital expenditure implications
(v) revenue expenditure implications
(vi) cost effectiveness
(vii) aesthetic characteristics
(viii) functional characteristics
(viii) technical merit
(ix) after sales merit
(x) technical assistance
(xi) any other relevant criteria.

12.3.3 The basis for the acceptance of a tender shall be kept in a signed record, signed in accordance with paragraph 10.5 of this Appendix. The signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

12.4 **Tender Other than the Lowest**

12.4.1 Any tender accepted shall be the most advantageous to the Trust, have the lowest price where payment is made by the Trust or have the highest income where payment is received by the Trust.

12.4.2 A tender, other than the lowest where payment is to be made by the Trust or the highest where payment is to be received by the Trust, shall only be accepted for good and demonstrable reasons if the Chief Executive or his/her nominated officer so decide and keep a signed record of that decision. This decision shall then be reported to the Trust Board. The original signed record shall be retained with the Trust Board's relevant working documents and a copy shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

12.5 **Financial Competence**

12.5.1 Any tender or quotation shall only be accepted by the Trust where the Director of Finance is satisfied with the financial competence of the firms involved. Such assurance shall be sought by the use of financial criteria, to be determined as appropriate by the Director of Finance or his/her nominated

officer, to analyse the financial information received with the tender documentation, and any other documentation the Director of Finance or his/her nominated officer consider appropriate. In circumstances where the Director of Finance is not satisfied with the financial competence of the firms, the position shall be discussed by the Director of Finance or his/her nominated officer with the firms in an attempt to be satisfied with the tenderer's financial competence on behalf of the Trust. Only where the Director of Finance is satisfied with the financial competence of the firms shall the tender or quotation be assigned to those firms. A permanent, signed record of the discussions and outcomes shall be retained with the appropriate working papers used to analyse financial competence and retained within the Finance department - where the records can be viewed by appropriate officers of the Trust as appropriate.

12.6 **Technical & Organisational Competence**

12.6.1. Any tender or quotation shall only be accepted by the Trust where the Director responsible for the originating department is satisfied with the technical and organisational competence of the firms involved.

12.6.2 At least one recent reference shall be taken up from the selection of three provided with the tender documentation of the chosen tenderer. Any tender shall only be accepted where the references taken up are satisfactory, in the opinion of the relevant Director (as detailed in paragraph 12.6.1 of this Appendix).

13. POST-TENDER NEGOTIATIONS

Post tender negotiations with the successful tenderer shall only be carried out with the agreement of the Chief Executive or the Director of Finance and a signed record shall be kept of the reasons for the negotiations and the outcome of the discussions, with the signed record being retained with the associated tender working papers.

14. DISPOSALS

14.1 Paragraph 4 of this Appendix shall not apply to the disposal of:

14.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer.

14.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

14.1.3 items arising from works of construction, demolition or site clearance, which shall be dealt with in accordance with the relevant contract;

14.1.4 land or building concerning which Department of Health guidance has been issued, but subject to compliance with such guidance.

14.1.5 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

I5 IN HOUSE SERVICES

15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

16. FORMS OF CONTRACT

Every contract for building and engineering works, except contracts for maintenance work only, where Departmental Capital Investment Manual guidance shall be followed, shall embody as much of the JCT as are applicable (as detailed in paragraph 8.2 of this Appendix). In the case of contracts for building and engineering works costing more than £100,000 (or such other amount as the Department of Health may from time to time determine), the contract shall be embodied in a formal document executed under seal.

Cancellation of Contracts - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS and in accordance with Standing Orders, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 an other appropriate legislation.

Determination of Contracts for Failure to Deliver Goods or Material – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods

or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

Contracts involving Funds Held on Trust – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

17. ADVANCED/PHASED PAYMENTS

Advance/phased payments, except those made for capital building projects as laid down conditions of contract, are only to be made in exceptional circumstances and shall only be made following the agreement of the Chief Executive and the Director of Finance. A signed record shall be kept of the reasons for this method of payment, with the signed record being retained with the associated tender working papers.

18. APPLICATION OF LIQUIDATED AND ASCERTAINED DAMAGES ON CONSTRUCTION CONTRACTS

The Chief Executive or his/her nominated officer shall normally enforce the application of liquidated and ascertained damages on construction contracts, except where the Chief Executive or his/her nominated officer determine that they should be waived. In circumstances where such damages are waived the Chief Executive shall note the reasons in a signed record, which will be passed to the Director of Finance and presented to the Audit Committee as appropriate.

19 REPORTING OF TENDER ACTIVITY

20.1 The Trust Secretary shall report to the Board any tenders received and the names of those organisations tendering.

20.2 After the analysis of tenders by the senior manager responsible has completed then the Trust Secretary shall report to the Board for noting in its non-public session:

19.2.1 what was being tendered,
19.2.2 the names of those tendering and
19.2.3 the amounts of each tender.

This report is to be presented as soon as practicable after tenders have been opened.

The senior manager responsible for the procurement shall provide the Trust Secretary with sufficient information to enable the reporting required at paragraph 18.2

20 PRIVATE FINANCE INITIATIVE

20.1 Where appropriate the Trust will test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

20.2 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

20.3 Where the sum exceeds delegated limits set by the Department of Health, a business case must be referred to the organisation designated by the DoH for approval.

20.4 The proposal must be specifically agreed by the Board.

20.5 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

London Ambulance Service NHS Trust
Competitive Tendering Register
Record of Invitations to Tender

Record of offers for: **Offer ref:**

Latest date & time for receipt:
Amended date & time (if appropriate):

Offer procedure being used: Open/Restricted/Negotiated *
(***** Delete as appropriate)

EU/Non-EU *

Number of suppliers invited to offer:

Number of responses to offer notice:

Invitation to offer Date	Supplier	Offer received date

Prepared by: **Signature:**

Name: **Date:**

APPENDIX III: TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

Terms of Reference

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.

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.

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.

~~The Chief Executive and~~ 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.

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.

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

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

APPENDIX IV: TERMS OF REFERENCE FOR THE REMUNERATION ~~AND TERMS OF SERVICE~~ COMMITTEE

1. Constitution and Function

1.1. The Committee shall be formally established by the Board and its terms of service, membership, delegated powers and area of responsibility formally minuted.

1.2. The following posts will fall within the Committee's area of responsibility:

- The Chief Executive and
- Board Directors,

1.3. The Committee will comprise the Board Chairman and non-executive Directors. Its composition is to be given in the Annual Report. The Chief Executive and the Human Resources Director will normally be in attendance at meetings but will not be present for discussions about their own remuneration and terms of service.

1.4. The Board should decide in advance its general policy on Directors' remuneration and terms of service and look to the committee to ensure that its policy is applied consistently.

1.5. The Committee will meet as directed by the Board. Its proceedings will be formally minuted and it will be serviced by the Trust Secretary.

1.6. The Committee is to be authorised by the Board to obtain legal or other professional advice it deems to be necessary.

1.7. The Committee shall be made aware of the Terms and Conditions applied to both Non Trust Board Directors, and such senior managers as it determines, and any amendments thereto from time to time.

1.8. The Committee is to report in writing to the Board specifying the basis for its recommendations. The Board will use the Committee's report as the basis for its discussions on the remuneration and terms of service for those staff falling with its area of responsibility. The minutes of the relevant Board meetings are formally to record decisions taken.

2. **Overall Purpose**

2.1. To make such recommendations to the Board on the remuneration and terms of service of the Chief Executive, other Board Directors and such senior managers as the Board may have decided should fall within the Committee's remit, as to ensure that they are fairly rewarded for their individual and corporate contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangement for such staff where appropriate.

2.2. To advise on and oversee appropriate contractual arrangements for the staff covered by paragraph ~~8~~ 1.2 above, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

3. **Procedure**

3.1. In developing recommendations for remuneration packages, the Committee will wish to ensure that they have:

3.1.1. a clear statement of the responsibilities of the individual posts and their accountabilities for meeting objectives of the organisation;

3.1.2. means of assessing the comparative size of the job by job evaluation; and

3.1.3 comparative salary information from the NHS, other public sector organisations including Trusts, and other industrial and service organisations.

APPENDIX V: TERMS OF REFERENCE FOR THE CHARITABLE FUNDS COMMITTEE

1. Constitution and Function

1.1. The Trust Board members shall act as the Trustees of the LAS' Charitable Funds. The Trustees shall hold the Trust Funds upon trust to apply for any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by the LAS NHS Trust.

1.2. The Committee shall be formally established by the Board and its terms of reference, membership delegated powers and reporting arrangements formally minuted. The Committee shall normally meet once a year. The Committee's minutes will be presented to the Board.

1.3. The Panel will be chaired by a Non-Executive Director, and will include the Human Resources Director (or his/her representative), the Financial Controller (on behalf of the Director of Finance), and representatives of the staff. It will report to the Trust Board.

2. Overall Purpose

2.1. The overall purpose of the Fund is to oversee the gradual dispersion of capital in accordance with the objectives of the Fund.

~~2.2. The Committee is to recommend to the Trust Board a long term expenditure policy, examining the balance between expenditure from income and capital and the need to establish a minimum balance of capital to be held.~~

~~2.3. Adopt the criteria existing during 1997/98 for drawing Charitable Funds and propose to the Trustees any revisions as part of the future long term expenditure policy~~

2.4. Funds would be invested to achieve consistent investment returns with low levels of risk with possible reference to an ethical investment policy.

2.5. To monitor investment performance and the use of the fund's resources.

3. Functionality

3.1 A sub-group, composed of representatives of the Director Human Resources and Organisation Development, the Financial Controller and staff side, will meet on a quarterly basis to consider applications to the Charitable Funds.

3.2 Applications will be approved or rejected on their basis of their compliance with the Charitable Fund's terms of reference.

3.3 An annual report will be presented to the Charitable Funds Committee, detailing the items approved by the sub-group during the year.

APPENDIX VI STANDARDS OF BUSINESS CONDUCT FOR LONDON AMBULANCE SERVICE NHS TRUST

1. INTRODUCTION

1.1. These guidelines are produced in the light of the challenges that staff face in the new and more commercially oriented environment of Trust status, and are intended by the Trust to reinforce the guiding principles set out in the Codes of Conduct and Accountability in the NHS published by the Appointments Commission April 2004 for NHS Boards. Should there by any conflict between these principles and EL (94) 40 the latter will take precedence.

1.2. In promoting and safeguarding the reputation and standing of the London Ambulance Service NHS Trust (the Trust)) with local communities, with customers and suppliers, with patients and with the media, it is Trust policy that the professional and social conduct of staff should reflect the highest possible standard of personal integrity and that the business affairs of the Trust are conducted in a moral, honest manner and in full compliance with all the applicable laws and Trust Standing Orders.

2. RESPONSIBILITY OF THE TRUST BOARD

2.1. The Trust Board is responsible for bringing these guidelines to the attention of all LAS staff and for introducing procedures to ensure that they are implemented.

3. RESPONSIBILITY OF LAS DIRECTORS

3.1. All LAS Directors have a responsibility to uphold these guidelines and to act primarily at all times, in the interest of the Trust as a whole.

4. RESPONSIBILITY OF LAS STAFF

4.1. It is the responsibility of Trust staff to ensure that they do not place themselves in a position where their private interests and the Trust duties conflict. This primary responsibility applies to all Trust staff.

5. GUIDING PRINCIPLE IN CONDUCT OF PUBLIC BUSINESS

5.1. It is important that the Trust, along with all public sector bodies, must be seen to be impartial and honest in the conduct of its business and that its staff should remain above suspicion. It is an offence under the Prevention of Corruption Acts 1906 and 1916 for a member of staff corruptly to accept any inducement or reward for doing, or refraining from doing, anything in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts.

5.2. Note: Staff should be aware that a breach of the provisions of the Prevention of Corruption Acts renders them liable to prosecution and may lead to loss of their employment and superannuation rights in the Trust. Failure to adhere to the Business Conduct Policy may result in disciplinary action if it is proved that the employee has failed to declare a relevant interest, or has abused his/her official position or knowledge, for the purpose of self-benefit or the benefit of family, friends or those others with whom the employee has a relationship as defined in paragraph 32.3 of these Standing Orders.

6. PRINCIPLES OF CONDUCT WITHIN THE TRUST

6.1. Trust staff are expected to give the highest possible standard of service to the public and to provide appropriate advice to Directors of the Trust and to fellow employees. In particular Trust staff are required to:

6.1.1. ensure that the interest of patients remain paramount at all times;

6.1.2. be impartial and honest in their conduct of official business; and

6.1.3. use the public monies entrusted to them in a responsible and lawful manner to the best of advantage of the Trust, always ensuring value for money and avoiding legal challenge to the authority.

6.1.4. It is also the responsibility of Trust staff to ensure that they do not:

6.1.4.1. abuse their official position for personal gain or to benefit their family or friends; and

6.1.4.2. seek to advantage or further their private business or other interests in the course of their official duties.

6.2. Wherever Trust staff have private or personal interests in any matter they have to deal with at work, they must not let these interests influence how they act on behalf of the Trust. Interest may be financial interests but non-financial interest can be just as important. Kinship; friendship; membership of an association, society or trusteeship and any other kinds of relationships can sometimes influence the judgement of Directors and employees of the Trust, or may be thought to do so. A good test is for staff to ask themselves whether others could possibly think the interest be close enough or of such a nature as to give rise to any suspicion. In such cases the member of staff must disclose the interest to the Chief Executive through his or her Director.

7. DECLARATION OF INTEREST

7.1. The Trust Board must be advised of all cases where a member of staff or his/her close relative, partner or associate has a controlling, or

significant, or financial interest in a business, or any other activity, which may compete for a contract to supply goods or services to the Trust.

7.2. All Trust staff are required to declare such interests either when they are appointed or on acquisition of the interest, in order that it may be known to the Trust and in no way promoted to the detriment of the Trust or to the patients served by the Trust.

7.3. A Register of Interests shall be maintained by the Trust Secretary to whom all declarations must be submitted in writing. This Register shall be made available for inspection by all Trust Directors and by contractors.

7.4. In determining what needs to be declared all Trust staff should:

7.4.1. ensure that they understand these guidelines and consult their line managers if further clarification is required;

7.4.2. ensure that they are not in a position where their private interest and their Trust duties conflict;

7.4.3. declare to the Trust Board any relevant interests; if in doubt they should ask themselves:

7.4.3.1. am I, or might I be, in a position where I or my family or associates might gain from the connection between my private interests and my employment with the Trust?

7.4.3.2. do I have access to information which could influence purchasing decisions?

7.4.3.3. could my outside interest be in any way detrimental to the Trust or to patients' interests?

7.4.3.4. do I have any reason to think that I may be risking a conflict of interest?

7.4.4. If still unsure - **declare it!**

8. PREFERENTIAL TREATMENT IN PRIVATE TRANSACTIONS

8.1. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. (This does not apply to any arrangements negotiated with companies on behalf of the Trust, or by recognised staff organisations, on behalf of all staff - for example LAS staff benefit schemes).

9. OTHER EMPLOYMENT

9.1. It is a condition of employment that Trust staff do not undertake any other employment, paid or unpaid, which conflicts with the requirements of their Trust post or be detrimental to it. Staff wishing to take up any employment must provide full details and seek prior written authority from the Human Resources Director. The Trust will be responsible for judging whether the interests of patients or of the Trust could be harmed e.g.:

9.1.1. full-time ambulance staff who undertake driving duties outside their employment;

9.1.2. employees associated with or working for private transport organisations; or

9.1.3. employees undertaking alternative employment.

9.2. If written approval is given to a member of staff to undertake any other employment the Human Resources Director will ensure that this is recorded in the Register of Staff Engaged on Other Employment held in his/her department.

10. ACCEPTANCE OF GIFTS AND HOSPITALITY

10.1. National Health Service regulations prohibit staff from soliciting gifts or hospitality from organisations, suppliers or individuals with whom they are brought into contact in the course of their work.

10.2. **Gifts**

10.3. As a general rule all offers of gifts and hospitality should be refused except where such a refusal would cause offence but acceptance must be limited to items similar to those set out below:

10.4. Casual gifts offered by contractors and others, for example:

10.4.1.1. at Christmas time (articles of low intrinsic value (up to £20) such as pens, calendars, diaries etc.) **or**

10.4.1.2. small items of low value (up to £20) such as desk furniture and tankards received at the conclusion of an official visit or conference or seminar.

these items may not be connected with the performance of duties so as to constitute an offence under the Prevention of Corruption Acts. Items of this nature do not need to be declared.

10.4.1.3. Staff must not, however, accept any money gifts or consideration where such acceptance could be deemed to influence or to have influenced their business conduct. Any member of staff who is unsure whether or not to accept a gift must consult their line manager or the appropriate Director. The Chief Executive will consult the Chairman in respect of gifts offered to him.

10.5. Tokens of gratitude from patients or their relatives must be politely but firmly declined. If, however, patients insist on crews accepting such gratuities, these must be reported to their line manager who will make arrangements for charity allocation.

10.6. Registers of Gifts Offered and Accepted shall be maintained by the Trust Secretary and all details of gifts offered and accepted must be submitted to him/her on a monthly basis. This will be reported to the Audit Committee.

10.7. **Hospitality**

10.7.1. Employees should only accept offers of hospitality if there is a genuine need to impart information or represent the Trust and that the Trust will benefit from such hospitality.

10.7.2. Modest hospitality may be accepted provided that it is normal and reasonable in the circumstances, for example, lunches in the course of working visits. In accepting hospitality, however, staff must not place themselves in a position where acceptance might be deemed by others to have influenced them in making a business decision. Offers to attend purely social or sporting functions should be accepted only when these are part of the life of the community served by the Trust or it is in the Trust's interest to attend for the execution of its business or its operational activity or where the Trust should be seen to be represented. Attendance at such events must be approved in advance by the relevant Director or by the Chief Executive for Directors and by the Chairman for such requests made by the Chief Executive. They should be properly authorised and then recorded by the Trust Secretary.

10.7.3. The frequency and type of hospitality accepted must not be significantly greater than the Trust would be likely to provide in return.

10.7.4. Offers of hospitality involving the provision of transport or overnight accommodation must only be accepted after approval from the appropriate Director or Chief Executive. If in doubt about the acceptance of hospitality, staff must seek advice from their line manager or appropriate Director, or in the case of the Chief Executive, the Chairman.

10.7.5. Registers of Hospitality Offered and Accepted shall be maintained by the Trust Secretary.

10.7.6. On an annual basis the Trust Secretary will remind all staff of the Trust's policy regarding the acceptance of gifts and hospitality.

11. COMMERCIAL SPONSORSHIP OR ATTENDANCE AT COURSES AND CONFERENCES

11.1. Acceptance by employees of hospitality through attendance at relevant conferences and courses is acceptable, but only where it is clear that the hospitality is corporate rather than personal and where the employee seeks permission in advance and the Trust is satisfied that acceptance will not compromise purchasing decisions in any way. On occasions where it is considered necessary for staff advising on the purchase of equipment in operation in other parts of the country, or, exceptionally, overseas, to attend courses and conferences the Trust may consider meeting the costs so as to avoid jeopardising the integrity of subsequent purchasing decisions.

12. COMMERCIAL SPONSORSHIP OF POSTS - LINKED DEALS

12.1. If a company offers to sponsor a post for the Trust either wholly or partially, it should be made clear that the sponsorship can have no effect on purchasing decisions within the Trust. Where such sponsorship is accepted, purchasing decisions must be monitored by the Trust Secretary to ensure that they are not being influenced by the sponsorship arrangement.

12.2. Under no circumstances should the Trust agree to Linked Deals whereby sponsorship is linked to the purchase of particular products or to supply from a particular source.

13. "COMMERCIAL IN-CONFIDENCE"

13.1. Staff must not make public internal information of a "commercial in-confidence" nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain. The term "commercial in-confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit, for example, the exchange of data for medical purposes subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interest of patients.

14. COMPLAINTS ABOUT BREACHES OF THE CODE

14.1. Any staff complaints about breaches of the guidelines on Standards of Business Conduct, maladministration or other concerns of an ethical nature, should be taken up initially, through line management. Should that be inappropriate or non-productive then the matter should be referred up to Director and, if necessary, to Board level.

APPENDIX VII SCHEDULE OF DECISIONS RESERVED FOR THE TRUST BOARD

1. **Standing Orders** - for the effective conduct and operation of the Board in the fulfilment of its responsibilities. The decision to suspend standing orders or to vary and amend standing orders.

2. **Standing Financial Instructions -** for the regulation of the conduct of the Trust, its Directors, staff and agents in relation to all financial matters and the security of its assets.

3. **Scheme of Delegation -** to show the approved officers who have been delegated responsibility for deciding particular matters, and those who may act in their place during their absence.

4. **The Strategic Direction -** the strategic policy of the Trust and the selection of its key objectives.

5. **Service Plans -** the consideration and endorsement of the annual service plan and associated budgets to facilitate of the Board's function of exercising financial supervision and control.

6. **Committees/Sub-Committees -** the establishment, terms of reference and reporting arrangements for the Audit Committee, and Remuneration and Terms of Service Committee and all other committees and sub-committees acting on behalf of the Board as laid down in Part II of these Standing Orders. Confirm the recommendations of the Trust's committees where the committee's do not have executive power.

7. **Capital Schemes~~,~~ and assets and large contracts** - the acquisition of capital assets in accordance with the Scheme of Delegation; any capital scheme or acquisition or disposal of assets with a value of £1,000,000 or more; or any lease or contract with substantial recurring financial implications.

8. **Financial and performance objectives for the Trust -** the establishment of financial and performance targets and the regular provision of information against those targets - to facilitate proper monitoring and control.

9. **Non-Exchequer Funds -** the formulation of policy for the management of non-exchequer funds.

10. **Treasury Policy -** the formulation of policy for the investment of both exchequer and non-exchequer funds.

11. **External Consultants -** the endorsement of the selection of any external consultants involving fees in excess of £100,000.

12. **Human Resources Policies** - the endorsement of Human Resources policies affecting pay, redundancy, retirement, equal opportunities, grievance and disciplinary procedures.

13. **Appointments -** the appointment, appraisal, disciplining and dismissal of the Chief Executive, other executive Board Directors and the Trust Secretary.

14. **Declaration of Interests** - Requiring and receiving the declaration of interests from Board Directors and Officers which may conflict with those of the Trust as per Standing Order No. 15.

15. **Organisational Structures** - Adoption of organisational structures, processes and procedures to facilitate the discharge of business or duties by the Trust and agree modifications thereto.

16. **Ratification of Urgent Decisions** - The ratification of urgent decisions taken in accordance with Standing Order No. 37.

17. **Corporate Trustee** - Approval of arrangements relating to the discharge of the Trust's responsibilities and duties as a corporate trustee for funds held on trust as set out in Standing Order No. 21.

18. **Bailee's Property** - Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

19. **Trust Representatives** - The approval of any Trust representative on outside bodies.

20. **Management of Risk** - The approval and monitoring of the Trust's policies and procedures for the management of risk.

21. **Significant Activity or operation** - The approval of the introduction or cessation of any significant activity or operation.

22. **Contracts** - Approval of individual contracts (other than NHS contracts) of a capital or revenue nature in accordance with the Trust's Tendering and Contracting Procedure as set out in these Standing Orders.

23. **Litigation** - The agreement to action on matters relating to litigation against or on behalf of the Trust as defined in the approved Scheme of Delegation.

24. **Statement of Internal Control Evaluation** - Controls Assurance statement is a responsibility of the Board to sign as part of the financial statements.

25. **Approve arrangements for the dealing with complaints**

26. **Approve proposals of the Remuneration Committee regarding Directors and Senior Employees and those of the Chief Executive for staff not covered by the Remuneration Committee.**

APPENDIX VIII:

SCHEME OF DELEGATION

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
1.	STANDING ORDERS & STANDING FINANCIAL INSTRUCTIONS	Approves Standing Orders and Standing Financial Instructions Approves suspension of Standing Orders. Audit Committee to monitor compliance with Standing Orders and Standing Financial Instructions. Audit Committee to review every decision to suspend Standing Orders.	Final authority in the interpretation of Standing Orders The powers which the Board has retained in itself within these Standing Orders may in emergency be exercised by the Chairman and Chief Executive having consulted at least two NEDs.	Responsible for the creation/submission of Standing Orders and necessary changes	Director of Finance is responsible for the creation/submission of Standing Financial Instructions and necessary changes	
2.	AUDIT ARRANGEMENTS	Approves Audit arrangements through the Audit Committee Decides on action in response to the external auditors' management letter Receives the minutes of the Audit Committee Audit Committee to advise the		Submits the External Auditors management letter to the Trust Board. To follow though the implementation of all recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office.	Director of Finance - to manage the arrangements for the provision of internal and external audit. - to involve the Audit Committee in the selection processes when/if an internal service plan is changed. - to monitor and ensure	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		Board on Internal and External Audit Services.			compliance with SOFs Directions on fraud and corruption including the appointing of the Local Counter Fraud Service.	
3.	APPOINTMENTS	Appointment of the Chief Executive and the Executive Trust Board Directors	The Chairman shall liaise with the NHS Appointments Commission over the appointment of NEDs and once appointed shall take responsibility, either directly or indirectly, for their induction, their portfolios of interest and assignment and performance.	Appointment of all other Directors	Appointments within their Directorates within approved establishment Human Resources Director authorises variations in establishment within approved resources Human Resources Director issues contracts of employment	
4.	DISMISSALS	Approve the arrangements for the discipline and dismissal of staff Nomination of a panel to hear appeals against dismissal brought by the Chief Executive or Executive Trust Board Directors	Dismissal of the Chief Executive and Executive Trust Board Directors Nomination of a panel to hear appeals against dismissal brought by Directors who are not members of the Board.	Dismissal of any non Trust Board Director Nomination of a panel of Directors to hear appeals against dismissal by staff below Director level	Dismissalof staff.	Human Resources Director or a nominee to advise panels dealing with dismissals and appeals
5.	REMUNERATION	Decides the Directors'	Recommends	Decides performance	Directors recommend	Human Resources

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
	AND TERMS OF SERVICE FOR THE CHIEF EXECUTIVE, DIRECTORS AND OTHER SENIOR OFFICERS	remuneration and terms of service on the recommendation of the Remuneration Committee. Decides performance related payments to the Chief Executive. The Remuneration Committee shall report in writing to the Board the basis of its recommendations.	performance related payments for the Chief Executive	related pay awards for Directors and all staff on performance related pay	performance related payments to their staff to the Chief Executive	Director advises the Remuneration Committee
6.	HUMAN RESOURCES POLICY, DISPUTES/ ARBITRATION/ DISCIPLINARY MATTERS	Approves all Human Resources policies Approves premature retirement for the Chief Executive and all Directors	Initiates action on disciplinary matters relating to the Chief Executive and/or Directors	Determines submissions to the Trust Board Approves premature retirement for staff up to Director level Settle disputes in line with the agreed disputes procedure	Human Resources Director to prepare options and draft policy in liaison with Directors	Human Resources Director to advise the Chief Executive and Trust Board
7.	SERVICE PLAN, BUDGET, ANNUAL REPORT AND ACCOUNTS	Receives and decides on reports submitted by the Chief Executive and/or Director of Finance Approve Service Plan and		Compiles and submits an annual service plan to the Trust Board. Approves financial	Director of Finance – to prepare and submit budgets and financial reports to the Trust Board. - to devise and maintains	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		budget before commencement of financial year Approve annual report and accounts. Audit Committee to review the annual financial statement prior to submission to the Board.		reports for submission to the Trust Board. Compiles and submits an annual report for the Trust to the Trust Board. Approves budget for submission.	systems of budgetary controls. - to monitor financial performance and reports to the Board. - to submit financial accounts to the Trust Board.	
8.	Making Ex-Gratia Payments in respect of liability claims where legal advice has indicated a case can be made for LAS liability which would need to be contested in court or tribunal.	Notes delegated action taken. Approves all payments in excess of £500,000.	Approves all payments above £250,000 and up to £500,000, subject to a report from the Chief Executive.	Chief Executive to approve all payments up to £250,000.	Director of Finance to ensure that document procedures cover management of claims and payments below the deductible.	Director of Finance reports all ex-gratia payments to the Audit Committee as a Standard Report. Under legal obligation the Trust is authorised to pay the full amount. Ex-gratia payments following legal opinion over £1m must be referred to DoH Ex-gratia payments

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
						without legal opinion over £500,000 must be referred to the DoH.
	b. Payment resulting from tribunal.	As above	As above	Approves payments above £50,000 and up to £250,000, subject to a report from the Directors of Finance and Human Resources.	Human Resources Director approves payments up to £50,000	Under legal obligation the Trust is authorised to pay the full amount. Ex-gratia payments following legal opinion over £1m must be referred to DoH Ex-gratia payments without legal opinion over £500,000 must be referred to the DoH.
	c. Payment Resulting from Claims relating to the Property Expenses Scheme.	As above	As above		Director of Finance to approve payments up to £20,000	Payments in excess of £20,000 are covered by the NHSLA Property Expenses Scheme.
	d. All other Public and Employer Liability Claims including personal Injury	As above	As above	Approves payments above £50,000 and up to £250,000, subject to a report from the Director of Finance (for claims not admitted to the NHSLA Indemnity Scheme).	Director of Finance and Head of Legal Services to be responsible for payments up to £50,000, and approves payments above £10,000.	Payments in excess of £10,000 are covered by the NHSLA Liability to Third Parties Scheme Human Resource Director to be advised on all payments to staff

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
						in settlement of Employer Liability.
	e. Making Ex-Gratia Payments in circumstances other than those above (including where legal advice has not been obtained).	Approves Delegated action taken. Approves all payments in excess of £500,000.	Approves all payments above £250,000 and up to £500,000, subject to a report from the Chief Executive.	Approves ex-gratia payments up to DoH Limit (Currently £50,000) where no legal advice is available. Approves payments up to £250,000 where legal advice is available, subject to a report from the Finance Director.	Relevant Director to approve payment up to £1,000.	Director of Finance reports all ex-gratia payments to the Board.
9.	INSURANCE ARRANGEMENTS	Approves insurance arrangements.		Reports to Board on potential insurable risks and associated costs	Director of Finance - to obtain quotations for insurance cover. - to present an annual report to the Audit Committee	
10.	MANAGEMENT OF LAND AND BUILDINGS	Approves the general policy in respect of acquisition, sale, exchange or reservation of land and buildings Authorises the sale and purchase	Approves arrangements in conjunction with the Chief Executive, for granting/taking a lease of property up to £1m over the period of the	Approves arrangements in conjunction with the Chairman, for granting/taking a lease of property in excess £100,000 up to £250,000 over the period of the	Director of Finance, in conjunction with the Chief Executive and/or Director of Operations, is authorised to grant or take up a lease of property up to £100,000	Must obtain advice of District Valuer on all property transactions In accordance with o

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		of land within delegated limits by the Secretary of State Approves acquisition or disposal of land or the granting or taking of a lease with payments over the life of the lease over £1m	lease.	lease Ensures that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans Responsible for the management of capital schemes and for ensuring that they are delivered on time and within costs. Ensure that capital investment is not undertaken without available of resources to finance all revenue consequences. Ensure that a business case is produced for each proposal. Maintenance of asset register (on advice from the Director of Finance) Overall responsibility for fixed assets.	over the period of the lease. The Strategic Services Group (SSG) to approve business cases up to £1m. Director of Finance - to advise the Board through the submission of reports. -to be responsible for the day to day management of all land and buildings. - to prepare reports on the purchase/sale of land - to approve procedure for reconciling balance on fixed asset accounts in ledgers against balance on fixed asset registers. - to calculate and pay capital charges in accordance with Dept. of Health requirements. - to approve of fixed asset control procedure. The Director of Finance is responsible for the day to day management of	SHA's delegated limits and procedures approval of SOC, OBC and FBC to be obtained.

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					Waterloo and Devons Road sites.	
11	CAPITAL EXPENDITURE (other than land and buildings) a Acquisitions	Approval of capital expenditure in excess of £1m on high risk projects or complex transactions following consideration of the Outline Business Case, Full Business Case and Strategic Outline Case.		Approves arrangements, in conjunction with the Chairman, of an acquisition in excess £100,000 up to £250,000	Strategic Services Group to approve the acquisitions of up to £1m following consideration of business cases.	Acquisitions must comply with the Secretary of State delegated limits and procedures that may be in force from time to time. In accordance with o SHA's delegated limits and procedures approval of SOC, OBC and FBC to be obtained.
	b Disposals (with the exception of land and buildings)	Approve of disposals with an Open Market Value (OMV) of more than £1 million following consideration of the submitted Outline Business Case (OBC) and Full Business Case (FBC). Approve of disposals on high risk projects or complex		Approves disposals, along with 1 Executive Director and the Director of Finance (not being the same person), with an OMV of between £250,000 and £1 million, following consideration of the submitted	One Executive Director and the Director of Finance may approve disposals with an OMV of up to £250,000 following consideration of the submitted AFA.	Disposals must comply with the Secretary of State delegated limits and procedures that may be in force from time to time, including a maximum value for freely disposable assets of £1 million.

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		transactions following consideration of the OBC, FBC and Strategic Outline Case.		Combined Business Case.		
12.	BANKING	Approves the Banking arrangements			Director of Finance - is responsible for managing the LAS's banking arrangements and advising on the provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. - will review banking arrangements at regular intervals.	
13.	MANAGEMENT OF CHARITABLE FUNDS	Approves the composition and terms of reference of the Charitable Funds Committee Receipts and approves the annual report and accounts for funds held on trust. The Charitable Funds Committee sets overall policy on investment. The Charitable Funds Committee presents annual progress reports on the			Director of Finance - is responsible for monitoring the effective administration of charitable funds, including management and accounting arrangements. -to approve the appointment of the Financial Adviser to the Charitable Funds Committee.	An annual return is submitted to the Charity Commissions.

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		update of the Trust's charitable funds				
14.	MANAGEMENT AND CONTROL OF STOCKS				The Directors Operations is responsible for the control of all medical /pharmaceutical stocks, and supplies held by NHS Supplies including uniform. The Director of Operations is responsible for all fuel and vehicle stocks. The Director of Finance: - to approve stocktaking arrangements - to ensure that there is a system to review slow moving & obsolete items and for the condemnation, disposal and replacement of all unserviceable items.	The discovery or suspicion of loss of any kind must be reported immediately to either the Head of Department or the nominated officer. The Head of Department or nominated officer should then inform the Chief Executive and Director of Finance.
15.	RECORDING AND MONITORING OF PAYMENTS UNDER THE LOSSES AND COMPENSATION	Approves the writing off of losses within the limits delegated to it by the DoH on the recommendation of the Audit Committee			Director of Finance : - is authorised to make write offs and special payments up to £50,000 subject to the requirements of FDL(95)27	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
	REGISTER				- will notify the Chief Executive of items of a material nature without delay.	
16.	SIGNING TENDERS SUBMITTED BY THE TRUST	Approves arrangements for submission of tenders Approves PTS tenders with an annual value of over £1m .		To sign tenders with an annual value of over £500,000 in conjunction with the Director of Finance. For PTS tenders only with an annual value of up to £1m to be signed by the CE and Finance Director.	Director of Finance signs all tenders up to £500,000. Head of PTS and Director of Finance to sign PTS tenders with an annual value of up to £750,000	
17.	TENDERING PROCEDURES a General	Agrees Standing Orders regarding tendering Approves exceptions to Standing Orders regarding Competitive Tendering May waive the requirement for competitive tendering for goods and services valued at over		Ensures compliance with Standing Orders. May authorise exceptions to Standing Orders in an urgent situation following consultation with the Chairman or Vice Chairman under Standing	Must ensure that at least 3 competing quotations from comparable firms are received for appropriate contracts unless NHS Supplies is used. The appropriate Directors may waive formal tendering	No tender shall be accepted by the Trust unless the Director of Finance is satisfied with the financial competence of the tendering organisations. EU Public procurement

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
		£200,000 except where subject to EU procurement regulations. All waiving of the competitive tendering must be reported to the Audit Committee.		Order 42. The provisions of the following paragraph apply where EU procurement regulations have been satisfied. May waive the requirement for competitive tendering for goods and services up to £200,000 in conjunction with the Finance Director May, where insufficient tenders are received, authorise the originating Directors to approach known firms with a view to procuring the goods or services required.	requirements for contracts up to £50,000 Director of Finance must be satisfied with the financial competence of all tendering organisations	thresholds apply to contracts with a value in excess of £93,738 (for supplies & services) and £3,611,319 (for works) (w.e.f. Jan. 06.)
18.	TENDERING PROCEDURES b Limits	Ensures that proper tendering arrangements are in place.		Ensures that competitive tenders are received for non-estate purchases above £25,000 and estate purchases over £100,000	To ensure that competing quotations are received for non-estates purchases between £3,000 and £25,000 and for Estates	EU Public procurement thresholds apply to contracts with a value in excess of £93,738 (for supplies &

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					purchases between £3,000 and £100,000 except where ordered through NHS Supplies	services) and £3,611,319 (for works) (w.e.f. Jan.06.)
	TENDERING PROCEDURES c Receipt on Opening			Chief Executive shall nominate officers, including the Trust Secretary to open tenders. May accept late tenders, despatched in good time but delayed through no fault of the tenderers. May, in conjunction with the Director of Finance accept tenders which otherwise are received other than by the due date.	The Senior Manager responsible for the procurement and the Trust Secretary will be present at the opening of submitted tenders. For any tenders with a value greater than £1 million, the tenders must be opened in the additional presence of the Executive Director responsible for the originating department.	Trust Secretary is responsible for the safe receipt, endorsement and recording of competitive tenders. The Trust Secretary will advise the Board by way of a report on both tenders invited and received and, in due course, tender amounts after their analysis is complete.
	TENDERING PROCEDURES					

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
	d Post Tendering			May authorise post tender negotiations.	Director of Finance may authorise post tender negotiations. Directors may request in writing to the Chief Executive or Director of Finance that post tender negotiations take place. Directors must keep a record of the reasons for post tender negotiations and their outcome.	
	TENDERING PROCEDURES e Approvals			Decides where a tender, other than the lowest, if payment is to be made by the Trust, or other than the highest, where payment is to be received by the Trust, shall be accepted. Approves all non-competitive tenders subject to report to the Board.		A report to the Board is required where any tender other than the lowest, where payment is made by the Trust. Report to the Board is required for all single tender action.
19.	APPOINTMENT OF CONSULTANTS	Approves appointment of consultants contracts in excess of £100,000	Approves appointments to contracts £75,000-100,000and all cases where competition is	Approves appointments to contracts between £50,000-75,000 and all cases where competition	Approve appointment of consultants, following competition, up to £50,000	EU Public procurement thresholds apply to contracts with a value in excess of £93,738

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
			considered inappropriate	is considered inappropriate.	Recommend the appointment of consultants to contracts up to £10,000 where there has been no competition to the Chief Executive.	(for supplies & services) and £3,611,319 (for works) (w.e.f. Jan. 06.)
20.	COMPLAINTS AGAINST THE TRUST	Approves the Trust's Complaints Procedure. Receive reports regarding complaints about any aspect of service.		Is responsible for the management of complaints within the Trust and personally signs responses to all written complaints.		
21.	PAYMENT UNDER LEGAL OBLIGATIONS	Considers action in respect of claims and legal proceedings where the cost exceeds £100,000.		Determines action in respect of claims and legal proceedings where the cost is less than £100,000. Approves compensation payments made under legal obligation subject to consultation with the Finance Director		Quarterly report to the Trust Board by the Chief Executive on payments made.
22.	OPERATION OF ALL DETAILED FINANCIAL MATTERS INCLUDING BANK	Sets overall policy and strategy for the financial performance of the Trust within the requirements of the Secretary of State.		Overall responsibility for the performance of the Trust, subject to accountability to the Trust Board.	The Director of Finance - is responsible for overall financial control and the implementation of Trust Policies.	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
	ACCOUNTS AND BANKING PROCEDURES			Delegation of responsibility for Budgets to Executive Directors and agreement to virement.	- to advise the Chief Executive and Directors on budgets allocated and spending against budgets.	
23.	RAISING ORDERS & PURCHASING BY OTHER MEANS.	Defines policy on the raising of orders for goods, supplies and services			Director of Finance to recommend to the Chief Executive the policy for the raising of orders. Directors are able to raise orders as defined in the LAS Budget Manual.	
24.	DELEGATION OF BUDGETS	Agrees financial plans and approves budget before ~~at~~ the start of the financial year. Approves requests from the Chief Executive for virement in excess of £1 million. Approves all revenue contracts over £1million	Approves requests from the Chief Executive for virement up to £1m	Can authorise virement from non-pay to pay budgets. Can authorise virement between headings up to £500,000 No permanent employees are to be appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.	Directors have delegated to them budgets for: • staffing; and • non staffing items as indicated in the budget. They are authorised to expend these budgets in line with the Trust's Service Plan and Standing Financial Instructions. Directors may delegate parts of their overall budgets to individual budget holders within their directorate. Directors can authorise	Director of Finance to produce annual budget manual. Director of Finance to ensure adequate training is delivered on an on-going basis to budget holders.

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					virements within their budget headings in accordance with the Budget Holders Manual as revised from time to time up to £100,000. Director of Finance to report budget virements of over £100,000 to the Trust Board.	
26.	SEALING AND SIGNING OF DOCUMENTS	Trust Board receives a report of all sealings.	Seal to be affixed by the Chairman and the Chief Executive or another Executive Director in accordance with standing orders. Chairman, Chief Executive and an Executive Director to approve and sign all documents which will be used in legal procedures.	Seal to be affixed by the Chief Executive in accordance with standing orders. Chief Executive and an Executive Director to approve and sign all documents which will be used in legal procedures.	Common seal of the Trust shall be kept by the Trust Secretary in a secure place in accordance with arrangements approved by the Trust. Trust Secretary to keep a register of sealings.	
27.	MANAGEMENT AND CONTROL OF COMPUTER SYSTEMS AND FACILITIES	Approves the overall corporate IT Policy on procurement and control of systems and facilities on the recommendation of the Director of Information Management & Technology.			Director of Information Management &Technology to co-ordinates IT Policy on behalf of the Trust and be the responsible officer for control and security of hardware, software and	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					data. All Directors are responsible for compliance with the Data Protection Act, Use of Computers Act and other legislation in their Directorate. Director of Information Management & Technology - is responsible for the operation and compliance with legislation for all telecommunications and radio systems. - to ensure that risks to the Trust from IT are identified and considered and that disaster recovery plans are in place. The Director of Finance should ensure that he/she is satisfied that where computer systems have an impact on corporate financial systems:	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					• System acquisition, development and maintenance are in line with corporate polices, • Data assembled for processing by finance system is adequate, accurate, complete and timely and that a management trail exists • That the Finance Director and staff have access to such data • That such computer reviews are being carried out as are considered necessary.	
28.	HEALTH AND SAFETY ARRANGEMENTS	Approves overall policy on Health and Safety at work.		Responsible for an effective overall Health and Safety system within the Trust and compliance with legislative requirements.	~~*Director of*~~ Human Resources Director to ensure the effective implementation of the Human Resources aspects of Trust policy and advises the Chief Executive of requirements. The Director of Operations ensures the effective implementation of clinical	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					aspects of Health and Safety and advises the Chief Executive of requirements Individual Directors are responsible for arrangements within their Directorates/Divisions.	
29.	EDUCATION AND TRAINING	Approves the policy on education and training		Submits policy to the Trust Board	Human Resources Director - is responsible for education policy in liaison with Directors. - is responsible for the development of vocational/technical training in conjunction with Directors.	
30.	NON-EXECUTIVE, EXECUTIVE DIRECTORS ISSUES (VISITS, HOSPITALITY, ETC)	Approves overall policy on hospitality and visits.	The Chairman to advise the Appointments Commission on the performance of Non-Executive board members	Brings guidelines to the attention of all Directors.	Uphold the guidelines Director of Finance to develops policies and guidelines on behalf of the Chief Executive.	
31.	DATA PROTECTION	Approves policy on Data Protection			Director of Information Management & Technology - is responsible for notification under the Data	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					Protection Act and the implementation of the Board's Data Protection Policy. - advise the Board on Data notification. All Directors are responsible for ensuring compliance with the Data Protection Act and the Board's Data Protection Policy in their Directorate.	
32.	FREEDOM OF INFORMATION	Approves Freedom of Information Policy. Receives an annual report on the implementation of the policy.			Director of Information Management and Technology - is responsible for ensuring the Trust is compliant with the requirements of the 2005 FOI Act. -to publish and main a FOI scheme.	
33.	FRAUD				Where a criminal offence is suspected the Director of Finance must inform the Police if theft or arson is involved. In cases of fraud and corruption the Director of	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					Finance must inform the relevant LCFS and CFSMS Regional team in line with SOS Direction. The Director of Finance should notify CFSMS and External Audit of all fraud.	
34.	RISK MANAGEMENT	Approve and monitor risk management programme The Audit 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 activity both clinical and non-clinical that support the achievement of the organisation's objectives. Decide whether the Trust will use risk pooling scheme administered by the NHS Litigation Authority or self insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.			Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procures cover these arrangements. Where the Board decides not to use the pool risking scheme administered by the NHSLA for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that	

	DESCRIPTION	ROLE OF TRUST BOARD	DELEGATION OF AUTHORITY TO			REPORT/ADVICE REQUIRED
			Chairman	Chief Executive	Directors	
					the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal document procedures for the management of any claims arising from 3rd parties and payments in respect of losses that will not be reimbursed.	

APPENDIX IX: TERMS OF REFERENCE FOR THE SERVICE DEVELOPMENT COMMITTEE

1. Constitution and Function

1.1. The Committee will comprise the Chairman of the Trust, the Non-Executive Directors and the Chief Executive.

1.2. The Committee will be chaired by the Chairman of the Trust.

1.3. Board Directors, Non-Board Directors, Officers and others may be invited to attend when their presence is considered necessary.

1.4. The Committee will not be a decision making Committee.

1.5. The Committee shall produce a written record which will be reported to and considered by the next scheduled Trust Board.

2. Terms of Reference

2.1. To consider future developments that may be of interest to the Trust.

2.2. To consider NHS wide developments and encourage discussion on how, if at all, the Trust could be affected.

2.3. To establish areas of interest where further consideration by the Trust Board would be of benefit to patient care.

2.4. To identify opportunities for long term growth and strategic planning and recommend such to the Trust Board.

APPENDIX X: TERMS OF REFERENCE FOR 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) and the standards within the NHSLA Risk Management Standard 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

[1] NB: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee (JRCALC)

- 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 Patients Experience (Head of Complaints/PALS)
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)
Emergency Medical ~~A&E~~ Consultant
Diversity Manager

Special attendance/reports – once a year
HEMS
BASICS
Voluntary Aid Societies/ Private Contractors
Community First Responders Scheme
PTS

4. Regular Reports will be received from:

- Standards for Better Health Group
- Feedback Learning and Improvement Group (previously Complaints Group)
- Clinical Audit and Research Steering Group
- Risk Compliance and Assurance Group
- Area Governance Groups
- PPI Committee
- Equality & Diversity Plan Improvement Group ~~Race Equality and Diversity Group~~
- Infection Control Group
- Lead for Safeguarding Children and Vulnerable Adults
- Training Services Group
- Clinical Steering Committee
- Six month update on NICE Guidance applicable to LAS

APPENDIX XI: APPLICATION OF STANDING ORDERS TO TRUST BOARD OBSERVER AND PROCEDURES ETC RELATING TO OBSERVER APPOINTMENT AND PARTICIPATION.

1. Appointment

1.1. The Trust Board may appoint an Observer to participate in the public agenda part of its public meetings to the extent and within the Participation terms and conditions set out below.

1.2. The Board does not restrict itself in any way by making arrangements to have an Observer present at its meetings.

1.3. The Observer can only be appointed by way of a resolution of the Trust Board. The Board may consider a nomination for an Observer from such body as the Trust Board deems fit. The Board may, after consideration, agree to accept or reject the nomination.

1.4. The Observer's tenure shall be for 12 months from the Trust Board's resolution to accept a nomination. The nominating body shall make arrangements three calendar months prior to the end of the Observer's tenure to either renew an existing nomination or make a new nomination. This must be passed to the Trust Board's Secretary to ensure proposed arrangements can be both presented to, and considered by, the Trust Board.

1.5. The nomination of an Observer shall include the nomination of a named substitute Observer and the Trust Board shall consider these together and at the same meeting.

1.6. The substitute Observer may take the place of the Observer at the Trust Board's public meetings. No other person or body may substitute for the substitute Observer.

1.7. The provisions of this Appendix XI shall apply equally to the substitute Observer as applicable.

1.8. The Observer shall not be nor construed to be a member of the Board nor an Officer or employee of the Trust

2. Participation

2.1. The Observer shall take a full and active part in the proceedings of the Board at its public meetings. Such participation will be for the purpose of reflecting and contributing the views of the public across London in order to assist the Trust Board in its decision making processes. Standing Orders shall apply to the Observer as set out below:

2.1.1. The Observer is not a member of the Trust Board nor an Officer of the Trust and may not represent the Trust in any capacity unless this has been approved in advance by way of a resolution of the Board.

2.1.2. The Observer shall be included in the record of attendance as per Standing Order 8.

2.1.3. The minutes of the meetings shall reflect any contributions made by the Observer in the normal manner and style of the Board's minutes. Standing Order 10 (Minutes) shall apply.

2.1.4. Standing Order 11 (Chairman's Ruling) shall apply.

2.1.5. The Observer is required to declare any interests at the commencement of a Trust Board meeting or during the course of any item on the agenda of the meeting. This shall include all the declarations or reasons for declaration set out in Standing Order 15.

2.1.6. The Trust Board may appoint the Observer to one or more of the Board's Committees. The relevant Standing Orders relating to Committees shall apply to the Observer where such an appointment takes place.

2.1.7. Standing Order 46 (Interpretation of Standing Orders) shall apply.

2.1.8. Where a motion to exclude the public from a meeting or part of a meeting is heard and the Board resolves to exclude the public then the Observer, being a member of the public, shall also be excluded.

2.1.9. The Observer shall ensure that the following are kept as strictly confidential in the event the Observer learns of or gleans or has such disclosed to them:

2.1.9.i. patient identifiable information or

2.1.9.ii. staff member/employee identifiable information or

2.1.9.iii. "commercial in confidence" information or

2.1.9.iv. information covered by the Information Management and Technology Security Policy or policies emanating from the activities of the Trust's Caldicott Guardian or

2.1.9.v. information that becomes restricted in the future and is so advised

2.1.10. The Observer shall not use their association with the Trust to gain any advantage or preference or benefit in their own private dealings or transactions

2.1.11. No other requirements of Standing Orders are binding upon the Observer. The Trust Board reserves its right to amend its own Standing Orders which includes this Appendix XI from time to time and such an amendment or amendments may be binding upon the Observer in the future.

London Ambulance Service

Standing Financial Instructions

21/11/2008

PRE-AMBLE

1. The "Directions on Financial Management in England" issued under HC (91)25 in 1991 state that each Board must adopt Standing Financial instructions (SFIs) setting out the responsibilities of individuals.

2. Each Board operates within the statutory framework within which it is also required to adopt Standing Orders. In addition to the Standing Orders, there is a Scheme of Delegation, Financial Procedural Notes and locally generated rules and instructions. Collectively these must comprehensively cover all aspects of financial management and control. They set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

Mike Dinan
Director of Finance
November 2008

CONTENTS

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of Sections 99(3), 97(A)(4) and (7) of the National Health Service Act 1977; National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts for the regulation of the conduct of the LAS in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders of the LAS.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the London Ambulance Service NHS Trust (LAS). They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LAS. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before action is taken.

1.1.5 Failure to comply with SFIs is a disciplinary matter that could result in dismissal.

1.1.6 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Trust" means the London Ambulance Service NHS Trust;

(b) "Board" means the Board of the LAS;

(c) "Budget" means a resource, expressed in financial terms, proposed by the LAS for the purpose of carrying out, for a specific period, any or all of the functions of the LAS;

(d) "Chief Executive" means the chief officer of the LAS;

(e) "Director of Finance" means the chief financial officer of the LAS;

(f) "Budget Holder" means the director or employee with delegated authority to manage finances and resources for a specific area of the organisation; and

(g) "Legal Adviser" means the properly qualified person appointed by the LAS to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them subject to the Scheme of Delegation.

1.2.3 Wherever the term "employee" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within overall income before the commencement of the financial year;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation Document (EL(94)40 refers)

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the LAS.

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LAS' activities and is responsible to the Board for ensuring that its financial obligations and targets are met.

1.3.4 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these instructions.

1.3.6 **The Director of Finance** is responsible for:

(a) implementing the LAS' financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) ensuring that detailed procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the LAS' transactions, in order to disclose, with reasonable accuracy, the financial position of the LAS at any time;

and, without prejudice to any other functions of directors and employees to the LAS, the duties of the Director of Finance include:

(d) the provision of financial advice to the LAS, its directors and employees;

(e) the design, implementation and supervision of systems of financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LAS may require for the purpose of carrying out its statutory duties.

1.3.7 **All directors and employees,** severally and collectively, are responsible for:

(a) the security of the property of the LAS;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 **Any contractor or employee of a contractor** who is empowered by the LAS to commit the LAS to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

1.3.9 For any and all directors and employees who carry out financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Order, following the guidelines set out in the NHS Audit Committee Handbook 2005. The Board shall establish an Audit Committee which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit service;

(b) reviewing financial systems and monitoring the integrity of the financial status and reviewing significant financial judgements;

(c) ensuring compliance with Standing Orders and Standing Financial Instructions;

(d) Reviewing schedules of losses and compensations and making recommendations to the Board.

(e) 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.

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Director of Finance in the first instance.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities.

(d) ensuring that an annual audit report is prepared for consideration by the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control measures in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) progress against plan over the previous year;
(iii) major internal financial control weaknesses discovered;
(iv) progress in the implementation of internal audit recommendations;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the LAS;

(c) the production of any cash, stores or other property of the LAS under an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established accounting and financial policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the LAS' assets and interests are accounted for and safeguarded from loss of any kind, arising from;

(i) fraud and other offences
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Statement on Internal Control in accordance with guidance from the Department of Health.

2.3.2 The plan of work for Internal Audit should be reviewed and approved by the Audit Committee at the beginning of each financial year. This plan should be drawn up with full consideration of all risks as detailed within the risk register.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the LAS.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director

of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.4 FRAUD AND CORRUPTION

2.4.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Secretary of State (SofS) Directions on fraud and corruption.

Fraud - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Appendix B is a summary of the Fraud Act 2006.

Corruption - where someone is influenced by bribery, payment or benefit-in-kind to unreasonably use their position to give some advantage to another

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the Department of Health Fraud and Corruption Manual and guidance.

The contact details for the LCFS are

Name: David Foley
Telephone: 07721 977523
Office: 020 7920 3200
Email: david.foley@rsmbentleyjennison.com
Address: RSM Bentley Jennison, 45 Moorfields, London, EC2Y 9AE

2.4.3 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.4.4 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the Directorate of Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.4.5 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary for Health guidance on NHS security management.

2.4.6. The Trust has a Anti-Fraud and Corruption Policy which is available on the intranet site, the Pulse.

2.5 EXTERNAL AUDIT

2.5.1 The external auditor is appointed by the Audit Commission and paid for by the LAS. The Audit Committee must ensure a cost-efficient external audit service. Should there appear to be a problem, then this should be raised with the external auditor and referred to the Audit Commission if the issue cannot be resolved.

3 SERVICE PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and approval of service plans and budgets

3.1.1 The Board must ensure that there is an approved annual service plan before the commencement of the each financial year. The Chief Executive will compile and submit to the Board an annual service plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) aims and objectives.

(b) a statement of the significant assumptions on which the plan is based;

(c) details of major changes in workload, delivery of services or resources required to achieve the plan.

(d) the individual and collective responsibilities of directors.

3.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Service Plan;

(b) accord with workload and staffing plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income; and

(e) identify potential risks.

3.1.3 The Director of Finance shall monitor financial performance against budget and service plan and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing, in the Scheme of Delegation, and be accompanied by clear definitions of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virements limits set by the board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) data correlating financial, establishment and activity trends;
(iii) movements in working capital:
(iv) capital project spend, including commitments, and projected outturn against plan;
(v) explanation of any material variances from plan;
(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the consent of the Board;

(b) any potential underspend is highlighted to the Director of Finance (for virement if necessary)

(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(d) no permanent employees are appointed without the approval of the Director of Human Resources other than those provided for in the budgeted establishment as approved by the Board. Permanent employees must be appointed against recurrent income.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.5 **MONITORING RETURNS**

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the relevant monitoring organisation.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance will:

(a) prepare financial returns for the LAS, in accordance with the guidance given by the Department of Health and the Treasury, the LAS' accounting policies, and generally accepted accounting principles;

(b) prepare, certify and submit annual financial reports to the Secretary of State for each financial year in accordance with current guidelines; and

(c) submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Department of Health.

4.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's Audited Annual Accounts must be presented to a public meeting and made available to the public.

4.3 The LAS will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts. The document will include inter alia:

(a) the Annual Accounts of the LAS;

(b) details of relevant directorships and other significant interests held by Board members, as defined in Standing Orders;

(c) composition of the Remuneration and Terms of Service Committee;

(d) remuneration of the chairman, highest paid Director, and other Directors and highly paid employees, in accordance with guidance relating to the NHS.

5. BANK AND PGO ACCOUNTS

5.1 GENERAL

5.1.1 The Director of Finance is responsible for managing the LAS' banking arrangements and for advising the LAS on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the NHS and the Department of Health. In line with 'Cash management in the NHS' Trust should minimise the use of commercial banks accounts and consider using Office of the Paymaster General (OPG) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK AND PGO ACCOUNTS

5.2.1 The Director of Finance is responsible for:

(a) bank accounts and Paymaster General Office (PGO) accounts;

(b) establishing separate bank accounts for the LAS' non-exchequer funds;

(c) ensuring payments made from bank or PGO accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the LAS' bankers for overdraft facilities.

(e) monitoring compliance with DH guidance on the level of cleared funds.

5.3 BANKING PROCEDURES

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and PGO accounts which must include:

(a) the conditions under which each bank and PGO account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the LAS' accounts.

5.3.2 The Director or Finance must advise the LAS' bankers in writing of the conditions under which each account will be operated.

5.4 TENDERING AND REVIEW

5.4.1 The Director of Finance will review the banking arrangements of the LAS at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the LAS' banking business. Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for OPG accounts.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The LAS shall follow Department of Health's advice in the 'costing' manual in setting prices for NHS service agreements.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards for the NHS (2000) shall be followed.

6.2.4 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated. Overpayments will be reviewed in order that procedures are introduced to prevent recurrence.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreements forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the LAS.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless, exceptionally, such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LAS is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LAS from responsibility for any loss.

7. CONTRACTING FOR PROVISION OF SERVICES

7.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Service Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) costing and pricing of services;

(b) payments terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

7.2 Contracts should be devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with "Costing for Contracting" guidelines as applicable to Ambulance Services.

7.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

7.4 Any pricing of contract at marginal cost must be undertaken by the Director of Finance and reported to the Board.

8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

8.1 REMUNERATION ~~AND TERMS OF SERVICE~~

8.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration ~~and Terms of Service~~ Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (The constitution of this committee is covered in Standing Orders.)

8.1.5 The LAS will remunerate the Chairman and Non-executive Directors in accordance with instructions issued by the Secretary of State.

8.2 FUNDED ESTABLISHMENT

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Director of Human Resources and the Director of Finance. Any change must comply with paragraph 3.3.2(d).

8.3 STAFF APPOINTMENTS

8.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive Officer; and

(b) within the limit of their approved budget and funded establishment.

8.3.2 The Board will receive proposals by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

8.4 PROCESSING OF PAYROLL

8.4.1 The Director of Human Resources & Organisation Development is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notification;

(b) the final determination of pay remitted and allowances;

(c) making payment on agreed dates.

8.4.2 The Director of Human Resources & Organisation Development will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

8.4.3 The Director of Finance will issue instructions regarding:

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque, bank credit to employees;

(i) procedure for the recall of cheques and bank credits

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records and handling cash; and

(l) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Human Resources & Organisation Development's instructions and in the form prescribed by the Director of Human Resources & Organisation Development;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Human Resources & Organisation Development must be informed immediately.

8.4.4 Regardless of the arrangements for providing service, the HR Director & Organisation Development shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 CONTRACT OF EMPLOYMENT

8.5.1 The Board shall delegate responsibility to the Director of Human Resources & Organisation Development for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

(c) the authorised signatories policy; a list of authorised signatories will be held by the Finance Department.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LAS. In so doing, the advice of the LAS' adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

Requisitions are not to be split or otherwise raised in a manner devised so as to avoid the financial thresholds. No requisition is to be raised which would cause a budget, year to date, to become overspent.

9.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) a list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and that charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined.
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payments.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Pre-payments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) the appropriate Director must provide, in the form of a written report to the Director of Finance, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LAS if the supplier is at some time during the course of the prepayment agreement unable to make his commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a pre-payment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the LAS' terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as provided in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU on public procurement

(c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by the Department of Health.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than;

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

The Standing Orders includes guidance, set out in Appendix VI, the Standards of Business Conduct for London Ambulance Service NHS Trust.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the LAS to a future un-competitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type or purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

(m) purchases using purchasing cards are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.

(n) Purchasing card records are maintained in a form as determined by the Director of Finance.

9.2.7 The Chief Executive must ensure that the LAS' Standing Orders are compatible with the requirements issued by the NHS in respect of building and engineering contracts (CONCODE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the Director managing those areas. The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

10 EXTERNAL BORROWING AND INVESTMENTS

10.1 EXTERNAL BORROWING

10.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the NHS. The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

10.1.2 The Board will agree the list of employees (including specimen of their signatures) who are authorised to make short term borrowing on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

10.1.3 Any application for a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by him and the Board will be informed of this at the following meeting.

10.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

10.1.5 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirements must be authorised by the Director of Finance.

10.1.6 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

10.2 INVESTMENTS

10.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board via the Treasury policy.

10.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

10.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1.1 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for ensuring that there is a system in place to ensure the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchasers support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal above the limits set in the Scheme of Delegation the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest possible ratio of benefits to costs; and

(ii) appropriate project management and control arrangement; and

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

11.1.4 The Director of Finance shall assess on an annual basis the requirements for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.5 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "ESTATECODE".

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitments against authorised expenditure.

11.1.6 The approval of a capital programme shall not constitute approval for expenditure on any individual scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "ESTATECODE" guidance and the LAS' Standing Orders.

11.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. ~~These procedures shall fully into account the delegated limits for capital scheme included Annex C of HSC (1999) 246.~~ This procedure shall take fully into account the delegated limits

for capital scheme included in DH publication "Delegated limits for capital investment'.

11.2 PRIVATE FINANCE

11.2.1 When the LAS proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum involved exceeds delegated limits the business case must be referred to the Department of Health or in line with current guidelines.

(c) The proposal must be specifically agreed by the Board where it exceeds the threshold set for capital schemes for Board approval.

11.3 ASSET REGISTERS

11.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and, inter alia, the Director responsible for fleet and facilities concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.3.2 The LAS shall maintain an asset register recording fixed assets. ~~The minimum data set to be held within these registers shall be as specified in the NHS Capital Accounting Manual as issued by the Department of Health~~. The minimum data set to be held within these registers shall be designed so as to generate the standard accounting figures to enable the annual accounts to be produced, as set out in the NHS Trust Finance Manual. [http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance]

11.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

11.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the Department of Health.

11.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting manual issued by the Department of Health.

11.3.8 The Director of Finance of the Authority shall calculate and pay capital charges as specified in the Capital Accounting manual issued by the Department of Health.

11.4 SECURITY OF ASSETS

11.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

11.4.4 Whilst each employee has a responsibility for the security of property of the LAS, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

11.4.5 Any damage to the LAS' premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.4.6 Where practical, assets should be marked as LAS property.

12 STORES AND RECEIPT OF GOODS

General position

12.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stocktake;

(c) valued at the lower of cost and net realisable value.

12.2 Subject to the responsibility of the Director of Finance for the system of control, overall responsibility for the control of stores shall be delegated to the Director of Operations by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of the Directors of Operations; the control of fuel and oil of the Fleet Manager.

Comment [S1]: Requires amendment

12.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Directors of Operations. Wherever practicable, stocks should be marked as health service property.

12.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

12.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

12.7 There will be a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The Director~~s~~ of Operations shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 15, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a LAS asset, the Director or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

13.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments. These will be authorised by the Audit Committee.

13.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the particular circumstances of the case will determine the stage at which the police are notified.

13.2.3 In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Director of Finance must inform the relevant CFOS regional team in accordance with SofS Directions.

13.2.4 The Director of Finance must notify the Department of Health Directorate of Counter Fraud Services and the External Auditor of all frauds.

13.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board, and

(b) the External Auditor.

13.2.6 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

13.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LAS' interests in bankruptcies and company liquidations.

13.2.8 For any loss, the Director of Finance should consider whether any insurance claim can be made against insurers.

13.2.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

13.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

13.2.11 All losses and special payments must be reported to the Audit Committee ate very meeting.

14 INFORMATION TECHNOLOGY

14.1 The Director of Finance, and the Director of Information Management and Technology, who are responsible for the accuracy and security of the computerised financial data of the LAS, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LAS' financial data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that adequate management (audit) trails exists through the computerised system and that such computer audit reviews as are considered necessary are being carried out.

14.2 The Director of Finance shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 The Director of Information Management & Technology shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

14.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency

shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

14.5 Where computer systems have an impact on corporate financial systems the Directors of Information Management and Technology and Finance shall be satisfied that:

(a) systems acquisitions, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Directorate of Finance staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

14.6 In the case of computer systems which are proposed General applications (i.e. normally those applications which the majority of Trusts in an NHS area wish to sponsor jointly) all responsible directors and employees will send to the Director of Information Management and Technology:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15 **PATIENTS' PROPERTY**

15.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") of patients not able to physically safeguard their property or in the possession of unconscious, confused, or deceased patients.

15.2 The Director of Finance must provide detailed written instructions on the collection, custody, and safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients

and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

15.3 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16 CHARITABLE FUNDS

16.1 INTRODUCTION

16.1.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

16.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

16.1.3 The Director of Finance will have primary responsibility to the Board for ensuring that these SFIs are applied to charitable funds.

16.2 EXISTING FUNDS

16.2.1 The Director of Finance shall arrange for the administration of all existing charitable funds, in conjunction with the Legal Adviser. They shall ensure that a governing instrument exists for every trust fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identity the restricted nature of certain funds.

16.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Director of Finance may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific stations or departments.

16.2.4 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity

Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

16.2.5 The Scheme of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion rearing the disposal and use of the funds are to be taken by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

16.2.6 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.3 NEW FUNDS

16.3.1 The Director of Finance shall, in conjunction with the Legal Adviser, arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

16.3.2 The Director of Finance shall present the governing document to the Board for adoption as required in Standing Orders for each new trust. Such document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Trust to delegate powers to manage and the power to assign the residue of the trust to another fund contingent upon certain conditions, e.g. Discharge of original objects.

16.4 SOURCES OF NEW FUNDS

16.4.1 In respect of Donations, the Director of Finance shall:

(a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:

(i) the identification of the donors intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the LAS' charitable funds and that the donor's intentions have been noted and accepted.

16.4.2 In respect of **Legacies and Bequests,** the Director of Finance shall, with appropriate legal advice:

(a) provide guidelines to officers of the Trust covering any approach regarding:
   (i) the wording of wills;
   (ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the LAS is the beneficiary;

(c) be empowered, on behalf of the LAS, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

16.4.3 In respect of **Fund-raising,** the Director of Finance shall:

(a) after consultation with the Legal Adviser, deal with all arrangements for fund-raising by and/or on behalf of the LAS and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for the LAS and provide them with an adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible, along with the Legal Advisers, for alerting the Board to any irregularities regarding the use of the LAS' name or its registration numbers; and

(d) be responsible, after due consultation with the Legal adviser, for the appropriate treatment of all funds received from this source.

16.4.4 In respect of **Trading Income,** the Director of Finance shall:

(a) be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by the LAS as corporate trustee; and

(b) be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

16.5 **INVESTMENT MANAGEMENT**

16.5.1 The Director of Finance shall be responsible for all aspects of the management of the investment of income and funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) in conjunction with the Legal Adviser, the formulation of investment policy within the powers of this Body under Statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and where appropriate, fund managers and:

(i) the Director of Finance shall agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of NHS Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

16.6 **DISPOSITION MANAGEMENT**

16.6.1 The exercise of the LAS' dispositive discretion shall be managed by the Director of Finance in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each charitable fund;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the LAS; and

(f) the definitions of "charitable purposes" as agreed by the NHS and the Charity Commission.

16.7 **BANKING SERVICES**

16.7.1 The Director of Finance shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the LAS as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 **ASSET MANAGEMENT**

16.8.1 Charitable fund assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure:

(a) in conjunction with the Legal Adviser, that appropriate records of all assets owned by the LAS as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the charitable funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the LAS NHS Trust.

16.9 **REPORTING**

16.9.1 The Director of Finance shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

16.9.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

16.9.3 The Director of Finance, in conjunction with the Head of Legal Services, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the NHS and to the Charity Commission for adoption by the Board.

16.10 **ACCOUNTING AND AUDIT**

16.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year.

He will liaise with external audit and provide them with all necessary information.

Comment [S2]: Is this reference to both internal and external audit in the same sub-clause correct? Should there be separate sub-clauses here?

Comment [S3]: As above

16.10.3 The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

16.11 **ADMINISTRATION COSTS**

16.11.1 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

16.12 **TAXATION AND EXCISE DUTY**

16.12.1 The Director of Finance shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17 ACCEPTANCE OF GIFTS BY STAFF

17.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines, currently the Records Management: NHS Code of Practice.

18.2 The documents held in archives shall be capable of retrieval by authorised persons

18.3 Documents held in accordance with the Records Management: NHS Code of Practice shall only be destroyed at the express instigation of the Head of Records Management within the authority delegated by the Chief Executive. Records shall be maintained of documents so destroyed.

19 RISK MANAGEMENT

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health controls assurance requirements, which must be approved and monitored by the Board.

19.2 The programme of risk management shall include:

1) a process for identifying and quantifying risks and potential liabilities;

2) engendering among all levels of staff a positive attitude towards the control of risk;

3) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

4) contingency plans to offset the impact of adverse events;

5) audit arrangements including; internal audit, clinical audit, health and safety review;

6) a clear indication of which risks shall be insured.

7) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

19.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.4 With three exceptions Trusts may not enter into insurance arrangements with commercial insurers. The exceptions are:

1) Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
2) Where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
3) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the NHS Litigation Authority.

19.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

19.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

All the risk-pooling schemes require members to make some contributions to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

LONDON AMBULANCE SERVICE CHARITABLE FUND

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2008

FOREWARD

The Charity's annual report and accounts for the year ended 31 March 2008 have been prepared by the Corporate Trustee in accordance with the Statement of Recommended Practise by Charities (SORP 2005) issued in March 2005 and applicable UK Accounting Standards and the Charities Act 1993.

The Charity has a Corporate Trustee, the London Ambulance Service NHS Trust. The members of the Trust Board who served during the financial year were as follows:

Board Member	Designation within the Trust
Sigurd Reinton	Chairman
Peter Bradley	Chief Executive
Barry MacDonald	Non Executive Director (resigned 30/11/07)
Sarah Waller	Non Executive Director
Beryl McGrath	Non Executive Director
Roy Griffiths	Non Executive Director
Ingrid Prescod	Non Executive Director
Caroline Silver	Non Executive Director
Brian Huckett	Non Executive Director (appointed 01/02/08)
Fionna Moore	Medical Director
Michael Dinan	Director of Finance
Martin Flaherty	Director of Operations
Caron Hitchen	Director of Human Resources

The Charity is registered (No 1061191) in accordance with the Charities Act 1993.

Reference and Administrative Details

The London Ambulance Service Charitable Fund (No 1061191) was entered on the Central Register of Charities on 7 March 1997. It is an NHS Special Purpose Charity.

Charitable funds received by the Charity are accepted and held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

Trustee

The London Ambulance Service NHS Trust is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and also the law applicable to Charities which is governed by the Charities Act 1993.

The Board has devolved responsibility for the on going management of the funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

This committee was formed on 7 March 1997 and the names of the people who served during the year as agent for the Corporate Trustee as permitted under regulation 16 of the NHS Trust (Membership and Procedures) Regulations 1990 and reports to the Board Members, were as follows:

Caroline Silver (Non Executive Director)
Caron Hitchen (Director of Human Resources)
Michael John (Financial Controller)
Eric Roberts (UNISON representative)
Tony Crabtree (Head of Employee Services)
Christine McMahon (Trust Secretary)

The Charitable Funds Committee normally meets once a year and the minutes of the meeting are received by the Trust Board in the public agenda. In addition a sub group of the Charitable Funds Committee meets on a quarterly basis to review grant applications for the quarter and financial performance of the fund.

Principle Charitable Fund Adviser to the Board

Caron Hitchen, Director of Human Resources is the budget holder, who under a scheme of delegated authority approved by the corporate trustee, has day to day responsibility for the management of the Charitable Fund, and must personally approve, on behalf of the corporate trustee, all expenditure over £1,000 with an upper limit of £5,000 using her delegated authority.

Michael John, Financial Controller acted as the principal officer overseeing the day to day financial management and accounting for the charitable funds during the year.

Principal Office

The principal office for the charity is:

Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Principal Professional Advisers

Bankers

Lloyds Bank plc
South Bank Branch
2 York Road
London SE1 7lZ

Auditors

Audit Commission
1st Floor
Millbank Tower
Millbank
London
SW1P 4HQ

Investment Managers

Investec Investment Management Limited
2 Gresham Street
London
EC2V 7QP

Structure, Governance and Management

The majority of the charity's funds are held in an unrestricted fund, which was established using the model declaration of trust and all the funds held on trust as at the date of registration were part of this fund. Almost all of the subsequent donations and gifts received by the charity have all been attributable to that fund and have been added to the existing balance.

At the start of the year the charity had one restricted fund relating to support and training of staff in the cycle response unit. This was spent in full during the year.

Members of the Trust Board and The Charitable Funds Committee are not individual trustees under Charity Law but act as agents on behalf of the corporate trustee. Non Executive members of the Trust Board are appointed by the NHS Appointments Commission and Executive members of the Board are subject to recruitment by the NHS Trust Board. The NHS Trust as corporate trustee appoints a Charitable Funds Committee to manage the charitable funds under delegated authority.

Newly appointed Trustees receive copies of the standing orders which include the terms of reference for the Charitable Funds Committee terms of reference.

Acting for the Corporate Trustee the Charitable Funds Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

- Control, manage and monitor the use of the fund's resources;
- Manage and monitor the receipt of income and support/ guide any fundraising activities;

- Ensure that best practice is followed in the conduct of its affairs fulfilling all of its legal responsibilities;
- Ensure that the Investment Policy approved by the NHS Trust Board as Corporate Trustee is adhered to and performance is continually reviewed whilst being aware of ethical considerations;
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The financial record and day to day administration of the funds are dealt with by the Finance Department whose address is given above.

Risk Management

The major risks to which the charity is exposed have been identified and considered. They have been reviewed and systems established to mitigate those risks. The most significant risk identified was possible losses from the fall in the value of investments and the level of reserves available to mitigate the impact of such losses. This has been carefully considered and there are procedures in place to review the investment policy and also to ensure that both spending and firm financial commitments remain in line with income.

Partnership working and networks

London Ambulance Service NHS Trust and its staff are the main beneficiaries of the charity and is a related party by virtue of it being a corporate trustee of the charity. By working in partnership with the Trust, the charitable funds are used to best effect and so when deciding on the most beneficial way to use charitable funds; the corporate trustee has regard to the main activities & plans of the Trust. The corporate trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of the fund.

Objectives and strategy

The Charity has the following objective:

"the trustee shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service"

The Charitable Funds Committee have agreed that the main purpose of the fund is to fund projects for the benefit of all employees.

Annual review

The majority of donations received by the fund in the past and currently are specifically given to thank ambulance staff. Hence, the main charitable activities undertaken by the fund are those which will benefit staff by providing goods and services that the NHS is unable to provide. Typical examples are grants towards improved facilities for staff at ambulance stations, long service awards and contributions towards retirement and Christmas parties.

Grant Making policy

Each year applications are invited from any member of the London Ambulance Service. Based on their knowledge of the service, the Charitable Funds Committee agrees funding priorities and reviews the applications for quality and value for money.

Reserves Policy

Reserves are needed to provide funds, which can be designated to specific projects to enable these projects to be undertaken at short notice.

The policy of the Trustees is to maintain expenditure at its current level for as long as possible. The level of expenditure has exceeded income in recent periods. The strategy of the Trustee is to continue to utilise reserves to fund the level and type of expenditure experienced in the current and recent periods.

The level of reserves are monitored and reviewed by the Trustee, usually once every 5 years.

Our future plans

The future plans for the Charity are to continue to fund projects for the benefit of staff in line with the current level of funding.

A Review of Finances, Achievements and Performance

The net assets of the Charity as at 31st March 2008 were £327,000 (2006 £421,000). Overall net assets decreased by £94,000 due to the net expenditure of £36,000 and a loss on the value of investments of £58,000.

The main sources of income of the charity are donations and investment income. Total incoming resources for the year were £21,000.

Expenditure totalled £57,000 during the year, with the largest items of expenditure being Christmas grants of £24,474 and £24,088 on other amenities.

The charity has no employees so relies on the London Ambulance Service NHS Trust to review the appropriateness of grant applications. Each year the Charity Funds Committee sets a budget and reviews income and expenditure against this budget on a quarterly basis. In addition, the Charity Funds Committee, reviews and manages the performance of the Charity's investments in accordance with the investment policy.

Investments

The Corporate Trustee invests the charitable funds with Investec Investment Management.

The funds are managed in accordance with an investment policy which is set by the Charity Funds Committee. Currently the investments are split approximately 83%/ 17% by value between pooled funds and interest bearing bonds and cash. The performance of the pooled funds are monitored against the performance of similar funds.

The Trustees operate an ethical investment policy. Investments are not made in companies dealing predominantly in the tobacco trade or in the manufacture and sale of arms.

Signed:……..

Peter Bradley, Chief Executive of the Trust Board on behalf of the Corporate Trustee

Date:……

Organisation

LONDON AMBULANCE SERVICE CHARITABLE FUND			
Data entered below will be used throughout the workbook:			
This year	2007-08		
Last year	2006-07		
This year ended	2008		
Last year ended	2007		
This year beginning	1 April 2007		
This year name	31 March 2008		
Last year name	31 March 2007		

LONDON AMBULANCE SERVICE

CHARITABLE FUND ACCOUNTS

YEAR ENDED 31 MARCH 2008

Statement of trustees' responsibilities

The trustees are responsible for:

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 1993 and those outlined in the directions issued by the Secretary of State;

- establishing and monitoring a system of internal control; and

- establishing arrangements for the prevention and detection of fraud and corruption.

The trustees are required under the Charities Act 1993 and the National Health Service Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with the Charities Act 1993. In preparing those accounts, the trustees are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 3 to 9 attached have been compiled from and are in accordance with the financial records maintained by the trustees.

By Order of the Trustees
Signed:

Chief Executive*..... Date..... 2008

Trustee ..... Date..... 2008

*the Board may authorise another trustee to sign in place of the Chairman.

Independent Auditors' Report to the Corporate Trustee of the London Ambulance Service NHS Trust Funds Held on Trust

I have audited the financial statements of London Ambulance Service Charitable Funds for the year ended 31 March 2008 which comprise the Statement of Financial Activities, the Balance Sheet and the related notes. These financial statements have been prepared under the accounting policies set out within them.

This report is made solely to the trustees of London Ambulance Service Charitable Funds in accordance with section 43A of the Charities Act 1993. My audit work has been undertaken so that I might state to the trustees those matters I am required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the trustees of London Ambulance Service Charitable Funds for my audit work, for this report, or for the opinion I have formed

Respective Responsibilities of Trustees and Auditors

As set out in the Statement of Trustee's Responsibilities, the Trustees are responsible for preparing the financial statement in accordance with applicable law and United Kingdom accounting standards (United Kingdom Generally Accepted Accounting Practice).

I have been appointed as auditor under section 43A of the Charities Act 1993 and report in accordance with regulations made under section 44 of that Act.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board

I report to you my opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the Charities Act 1993. I also report to you if, in my opinion, the Trustees Annual Report is not consistent with the financial statements, if the charity has not kept proper accounting records, or if I have not received all the information and explanations I require for my audit

I read other information contained in the Trustee's Annual Report, and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information

Basis of audit opinion

I conducted my audit in accordance with the Charities Act 1993 and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the trustees in the preparation of the financial statements, and of whether the accounting policies are appropriate to the charity's circumstances, consistently applied and adequately disclosed

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements

Opinion

In my opinion the financial statements give a true and fair view of the state of the charity's affairs as at 31 March 2008 and of its incoming resources and application of resources for the year then ended and have been properly prepared in accordance with the Charities Act 1993.

Signature:…….. Date:…….

Name: Susan M Exton Address: Audit Commission
1st Floo
Millbank Towe
Millbank
Londor
SW1P 4HQ

Statement of Financial Activities for the year ended 31 March 2008

	Note	2007-08 Unrestricted Funds £000	2007-08 Restricted Funds £000	**2007-08 Total Funds £000**	2006-07 Total Funds £000
Incoming resources					
Incoming resources from generated funds					
Donations from individuals		9	0	**9**	3
Legacies		0	0	**0**	0
Sub total voluntary income		9	0	**9**	3
Investment income		12	0	**12**	12
Total incoming resources		**21**	**0**	**21**	**15**
Resources expended					
Costs of generating funds					
Investment management costs		2	0	**2**	2
Charitable activities					
Staff education and welfare - grants payable	3	49	0	**49**	45
Governance costs	4	5	0	**5**	5
Total resources expended		**56**	**0**	**56**	**52**
Net incoming/ (outgoing) resources		**(35)**	**0**	**(35)**	**(37)**
Other recognised gains and losses					
(Loss) /Gains on revaluation and disposal of investment assets		(58)	0	**(58)**	32
Net movement in funds		**(93)**	**0**	**(93)**	**(5)**
Reconciliation of Funds					
Fund balances brought forward at 31 March 2007		421	0	**421**	426
Fund balances carried forward at 31 March 2008		**328**	**0**	**328**	**421**

The notes at pages 5 to 9 form part of these accounts

Balance Sheet as at 31 March 2008

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2008 £000**	Total at 31 March 2007 £000
Fixed Assets					
Investments	5	318	0	**318**	416
Total Fixed Assets		318	0	**318**	416
Current Assets					
Stocks	6	3	0	**3**	2
Debtors	7	0	0	**0**	1
Cash at bank and in hand		10	0	**10**	4
Total Current Assets		13	0	**13**	7
Creditors: Amounts falling due within one year	8	3	0	**3**	2
Net Current Assets/(Liabilities)		10	0	10	5
Total Assets less Current Liabilities		328	0	328	421
Total Net Assets		**328**	**0**	**328**	**421**
Funds of the Charity					
Income Funds:					
Restricted - Cycle Response Unit		0	0	**0**	0
Unrestricted - general purposes fund		328	0	**328**	421
Total Funds		**328**	**0**	**328**	421

The notes at pages 5 to 9 form part of these accounts.

Signed:

Date:

Notes to the Account

1 Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with the Statement of Recommended Practice by Charities (SORP 2005) issued in March 2005 and applicable UK Accounting Standards and the Charities Act 1993.

1.2 Incoming Resources

a) All incoming resources are included in full in the Statement of Financial Activities as soon as the following three conditions can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii) certainty - when there is reasonable certainty that the incoming resource will be received;

iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

1.3 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is reasonably certain; this will be once confirmation has been received from the representative of the estate that the payment of the legacy will be made or properly transferred and once all the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimated amount receivable.

1.4 Resources Expended

Liabilities are recognised as resources expended as soon as there is a legal or constructive obligation committing the charity to the expenditure. A liability is recognised where the charity is under a constructive obligation to make a transfer of value to a third party as a result of past transactions or events. All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

a) Cost of generating funds

These are the costs associated with generating income for the charity. They comprise fees paid to the charity's investment managers.

b) Charitable activities

Costs of charitable activities comprise all costs identified as wholly or mainly incurred in the pursuit of the charitable objectives of the charity.

c) Grants payable

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the charity's charitable objectives.
They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.
Provisions are made where approval has been given by the trustee due to the approval representing a firm intention which is communicated to the recipient.

d) Governance costs
These comprise all costs identifiable as wholly or mainly attributable to ensuring the public accountability of the charity and its compliance with regulation and good practice.
These costs include costs related to statutory audit together with an recharge of overhead & support costs from London Ambulance Service NHS Trust.

e) Allocation of overhead and support costs

All overhead and support costs are included in Governance costs.

1.5 Structure of funds

Where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose & has created a legal restriction on use of the funds the fund is classified as a restricted income fund.

The remaining funds held by the charity are classified as unrestricted funds.
The expenditure of these funds is wholly at the trustee's unfettered discretion.

The major funds held under these categories are disclosed at note 9.

1.6 Investment Fixed Assets

Investment fixed assets are shown at market value at the balance sheet date.
Quoted stocks and shares are included in the balance sheet at mid-market price, ex-div.
Common Investment Fund Units are included in the balance sheet at the closing dealing price at the balance sheet date.

1.7 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as the arise.
Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

2 Allocation of support costs and overheads

All support costs and overheads are allocated to governance costs.

The total value of support costs and overheads was £5,000 (2007: £5,000)

3 Analysis of charitable expenditure

	Unrestricted Funds	Restricted Funds	**Total 2008 Funds**	Total 2007 Funds
Staff welfare and amenities	£000	£000	**£000**	£000
Grants payable to individuals	49	0	**49**	48
	49	**0**	**49**	48

All grant applications are considered and approved by a sub group of the Charity Funds Committee on behalf of the Corporate Trustee.

4 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2008 Funds**	Total 2007 Funds
	£000	£000	**£000**	£000
Audit fee	3	0	**3**	3
Apportioned overheads	2	0	**2**	2
	5	0	**5**	5

The auditors remuneration of £3,000 (2007 £3,000) related solely to the audit with no other work undertaken (2007 £0)

5	**Analysis of Fixed Asset Investments**	**2008**	2007
5.1	**Movement in fixed asset investments**	**£000**	£000
	Market value at 31 March	**416**	411
	Less: Disposals at carrying value	**(48)**	(4)
	Add: Acquisitions at cost	**0**	0
	Net (Loss) / gain on revaluation	**(50)**	9
	Market value at 31 March	**318**	416
	Historic cost at 31 March	**314**	344

5.2	**Market value at 31 March 2008**	Held in UK £000	Held outside UK £000	**2008 Total £000**	2007 Total £000
	Investments listed on Stock Exchange				
	- Bonds	68	0	**68**	66
	Investments in a Common Deposit Fund or Common Investment Fund	237	0	**237**	345
	Cash held as part of the investment portfolio	13	0	**13**	5
		318	0	**318**	416

Included in the investments above are 93,200 units in the Investec Fund Managers UK Value Fund, valued at £237,045, which is considered material to the total investments.

5.3	**Analysis of gross income from investments**	Held in UK £000	Held outside UK £000	**2007-08 Total £000**	2006-07 Total £000
	Investments listed on Stock Exchange	3	0	**3**	3
	Investments in a Common Deposit Fund or Common Investment Fund	9	0	**9**	9
		12	0	**12**	12

6	**Analysis of Stocks**	31 March 2008	31 March 2007
	Award Vouchers	3	2
	Total Stocks	**3**	2

7	**Analysis of Debtors**	31 March 2008	31 March 2007
	Amounts falling due within one year:	**£000**	£000
	Other debtors	**0**	1
	Total debtors	**0**	1

8	**Analysis of creditors**	31 March 2008	31 March 2007
	Amounts falling due within one year:	**£000**	£000
	Other creditors	**3**	2
	Total creditors	**3**	2

9 Analysis of charitable funds

The charity has one unrestricted general purposes fund. The unrestricted fund is available for any charitable purposes relating to the NHS at the absolute discretion of the trustees.

10 Material legacies

There were no material legacies during the year. (2007 - NIL)

11 Related party transactions

The London Ambulance NHS Trust is the corporate trustee of the charity.

During the year none of the members of the Trust Board, senior NHS Trust staff or parties related to them were beneficiaries of the charity. Neither the corporate trustee nor any member of the NHS Trust Board has received honoraria, emoluments or expenses in the year and the Trustee has not purchased trustee indemnity insurance.

The charity paid an administration fee of £2,500 to the London Ambulance Service NHS Trust.