LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 30th January 2007 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Declarations of Further Interest.	
2.	Opportunity for Members of the Public to ask Questions.	
3.	Minutes of the Meeting held on 28th November 2006 Part 1 and II	Enclosure 1& 2
4.	Matters arising	
5.	Chairman's remarks	Oral
6.	Report of the Chief Executive	Enclosure 3
7.	Month 9 2006/07 Financial Report.	Enclosure 4
8.	Report of the Medical Director	Enclosure 5
9.	Discuss CAD 2010 Outline Business Case	Enclosure 6
10.	Approve Seven Year Strategic Plan	Enclosure 7 & Presentation
11.	Business Plan 2007/2008	Enclosure 8 & Presentation
12.	Receive progress report on Urgent Care	Presentation
13.	Approve updated Attendance Management Policy	Enclosure 9
14.	Approve revised complaints policy (including Habitual & Vexatious Complainants Policy and SUI Policy)	Enclosure 10
15.	Approve policy in response to 'Being Open'	Enclosure 11
16.	Approve Outline Business Cases for Purley and Battersea	Enclosure 12

For Noting

17.	Draft Minutes of Service Development Committee – 19th December 2006	Enclosure 13
18.	Draft Minutes of the Audit Committee – 4th December 2006	Enclosure 14
19.	Draft Minutes of Clinical Governance Committee – 11th December 2006	Enclosure 15
20.	Annual report regarding the Trust's Risk Register	Enclosure 16
21.	Receive Charitable Funds annual report	Enclosure 17

22.	Audit Commission Annual Audit Letter	Enclosure 18
23.	Report from Trust Secretary on tenders opened & use of the seal since last Board meeting	Enclosure 19
24.	Any Other Business.	
25.	Opportunity for Members of the Public to ask Questions.	
26.	Date and Venue of the Next Trust Board Meeting. 27th March 2007, 10.00am at 220 Waterloo Road, London SE1	

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 28th November 2006

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Barry MacDonald	Non Executive Director
	Roy Griffins	Non Executive Director
	Caroline Silver	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
	Martin Flaherty	Director of Operations
Apologies:		
	Ingrid Prescod	Non Executive Director
	Peter Suter	Director of Information Management & Technology
In Attendance:		
	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development
	Mary Arayo	LAS Patient Forum
	Alex Bass	Communications Officer
	John Wilkins	Head of Governance
	Christine McMahon	Trust Secretary (Minutes)

97/06 **Declarations of Interest**

There were no declarations of interest.

98/06 **Opportunity for Members of the Public to ask Questions**

There were no questions asked of the Board.

99/06 **Minutes of the Meeting held on 26th September 2006**

Agreed: **The minutes of the meeting held on 26th September as a correct record of that meeting with the following corrections:**

1. **Attendance: Caroline Silver was in attendance until 12.00**
2. **Minute 86: EMTs are not legally allowed to supply the drug Diazepam;**

4. **That the Finance Director had received confirmation that funding of £164,000 for the defibrillators in public place scheme would be forthcoming though this had not yet been received.**

100/06 Chairman's remarks

The Chairman congratulated the Director of Operations on an excellent presentation to the GLA. At the meeting on 22nd November the Director of Operations informed the GLA of the actions undertaken by the LAS in response to the lessons learnt following the bombings in London in July 2005.

The Chairman and the Chief Executive attended a meeting with NHS London on 2nd November at which Dr George Greener and Ruth Carnell set out the direction of travel for the NHS in London. The Chairman said he was encouraged as the direction of travel sounded like the right direction. NHS London is still operating with only two permanent Directors, the HR Director and the Director of Nursing.

NHS London has retained McKinsey & Co. to help develop its strategy. Members of the LAS' Senior Management Group are engaging with McKinsey's as to what role the LAS could play.

NOTED The Chairman's report.

101/06 Report of the Chief Executive

The Chief Executive highlighted the following from his report: Category A performance as of 15th November was 75.1% within 8 minutes (target: 75%); Category A within 19 minutes was 97 % (target is 95%); Category B19 was 83% (standard is 95%) and 'Urgents' (at patients within 15 minutes) was 77.7% (standard is 95%).

The Chief Executive anticipated that the next few months will be difficult as the rise in demand associated with winter pressures will coincide with the implementation of rest breaks. A number of mitigating actions have been put in place e.g. the appointment of Richard Webber as Deputy Director of Operations to oversee the Emergency Operations Centre with effect from 11th December. The appointment of Richard Webber will bring additional capacity to the Control Room; the senior management team will be restructured by the end of March 2007. The successful implementation of rest breaks is very important for the Trust, both in terms of performance and financially.

The next three months will be challenging. Nevertheless, it is anticipated that the Trust will break even for 2006/07 and that it will achieve all its performance targets by March 2007.

Emergency planning: the Chief Executive commended the Director of Operations and the Communications Team for the presentation to the GLA on 22nd November, updating the Committee on what progress has been achieved since the initial Assembly report into the response of the emergency services to the July 2005 bombings.

Hazardous Area Response Team (H.A.R.T.): Forty staff from the LAS are participating in a national pilot regarding 'hot zone' working. It is the first time ambulance staff will be trained to treat people inside the 'hot zone' and it is a big development for the Service. If the pilot is successful it will be rolled out across England.

Emergency Planning for London: the LAS has been asked to be responsible for emergency planning for NHS London to which the Board was asked to agree in principle. The details of the Service Level Agreement will be presented to the Trust Board in January. **ACTION: Chief Executive**.

Human Resources: Electronic Staff Resources (ESR) has been successfully implemented; this was a major development for the Service.

Back pay related to Agenda for Change is being addressed as a matter of urgency and appeals against banding decisions are being undertaken as quickly as possible. Work is being undertaken to monitor the impact of introducing rest breaks on the take home pay of front line crews.

As requested by the Remuneration Committee the Trust's car leasing scheme is being reviewed and a report will be presented to the Board in January. **ACTION: HR Director**

A review is also being undertaken of on-call arrangements in line Agenda for Change.

On 7th November the National Ambulance Partnership Forum met; it was attended by representatives of eleven ambulance trusts and staff side representatives. It was a very positive meeting. The Chief Executive was hopeful that progress would be possible on a range of issues as further meetings are held.

Staff absence decreased in November (6.5%). A comparison with other Ambulance Trusts confirms that the LAS has an average level of absences.

The Chief Executive undertook a number of shifts recently and the feedback he received was that front line crews were concerned about the introduction of rest breaks, the potential loss of earnings due to less overtime being offered and a shortage of blankets. The latter is of concern given the amount expended by the LAS each year on blankets.

The LAS Awards ceremony was held on 6th October and the event was very successful. The Chief Executive's report included the details of the categories of the awards and the names of the winners and those staff who were highly commended.

Media: the report highlighted the number of events organised by the LAS.

The tragic death of a 15 year girl who had a fatal epileptic fit received further media coverage that centred around the fact that staff who attended Kayleigh Macilwraith-Christie were all Emergency Medical Technicians (EMTs) who were therefore legally unable to supply the drug Diazepam as part of her treatment. Her family have submitted a petition to Downing Street calling for a paramedic on every ambulance. The Trust has undertaken changes in the Control Room which will enable vehicles that are staffed by paramedics to be easily identifiable so that they can be targeted efficiently to patients with life threatening conditions. The Trust is also in discussion with the Medicines and Healthcare Products Regulatory Agency to change the laws around the use of Diazepam so that in the future this can be provided by Emergency Medical Technicians.

Alexander Litvinenko, the Russian national who is suspected of having being poisoned by the radioactive substance polonum-210 was attended by two crews. The Trust is ensuring that they receive support and there have been no issues identified. Dosimeters which measure radiation will shortly be distributed to all front line staff.

The Chief Executive referred to an incident that had taken place at the weekend which involved eight people being assaulted and one person being murdered. At least one LAS staff member is being recommended for a commendation.

The Chief Executive concluded his report by saying that the main challenges for the Trust over the next few months are: achieve break even; implement rest breaks; implement performance improvements and achieve performance targets; successfully work with NHS London and the Commissioners.

The Director of Operations outlined the progress achieved to date with implementing the Operational Plan previously reported to the Service Development Committee in October 2006. The Operational Plan has been approved by the Department of Health. It is known that some minor changes will be required but the Trust is waiting to be formally informed by NHS London as to what these changes are. The Trust has received £2m capital towards the cost of implementing the step changes which will enable Clock Start to be achieved by March 2008.

A traffic light report will be presented to the Trust Board in January highlighting what progress is being achieved in implementing the Operational Plan. **ACTION: Director of Operations.**

Home responders: for logistical and financial reasons there will only be two sites for the trials.

Overtime: the available overtime hours are being deployed in such a way as to ensure maximum cover of FRU vehicles.

Job cycle: there has been some slippage on achieving the anticipated improvements. Hospitals' A&E departments are being process mapped to ensure that the handover arrangements are as efficient as possible.

Performance at shift change over times, particularly in the evenings, is unsatisfactory. This project is principally about adjusting some shift changeover times to provide a more staggered changeover period – something for which the clinical risk argument is undisputable. Top level agreement in principle has been gained from the Trade Unions and local discussions about implementing changes have commenced. A phased approach is being adopted starting with Fast Responder Unit rosters and aiming to complete the ambulance rosters by end of February 2007.

Individual performance monitoring is being trialled at three complexes and is progressing well. The vast majority of staff have good performance, good response times and good turnaround times at hospitals. There are, however, a small number of outliers and it is their performance that is being addressed. The Clinical Performance Indicators report enables feedback to be given to staff on clinical and operational performances.

Red call volume: changes in AMPDS should permit a reduction by 2.5 percentage points in red call volume by the end of December.

Despatch capacity: this project involves doubling despatch capacity by doubling the number of available dispatchers in EOC and doubling the number of sector desks from seven to 14. This requires changes in technology and the promotion and training of additional staff in the Control Room. Since 18th October there has been a dedicated West sector desk. It has not been possible to split the desks every hour of every day but when they have been split there have been definite improvements. It is planned for the East and South desks to be split before Christmas. Although staffing the desks will be difficult it is anticipated that improvements in despatch will be visible from January.

Fast Response Units (FRUs): the call taking system is being upgraded on 30th November to enable FRUs to be automatically despatched once an appropriate Chief Complaint is established. It is hoped that the trial will demonstrate a decrease in unnecessary multiple dispatches, improve both the activation times for FRUs and their overall utilisation. A pilot is being undertaken in November followed by a full roll out to all FRUs by mid December.

Barry MacDonald commented that the decrease in overtime has been possible without 'catastrophically' impacting on performance. The implementation of ESR is a significant milestone for the Trust. He said he found it encouraging that the graphs for call answering showed a steady improvement over the last three months. He asked that the findings of the individual performance measure be shared with the Board. The Director of Operations undertook to share with the Service Development Committee. **ACTION: Director of Operations.**

Beryl Magrath welcomed the introduction of individual performance data as it had been one of the recommendations of the Governance Review she undertook earlier in the year. In response to her question regarding Clinical Telephone Advisers (CTA) the Director of Operations confirmed that staffing of CTA is an issue. Approximately half the CTA staff is seconded and half are permanent appointments. The Assistant Director of Operations UOC is actively recruiting to ensure that CTA is at full establishment and will be investigating the possibility of recruiting nursing staff.

In reply to a question regarding Patient Report Forms (PRFs) the Director of Operations said that an electronic PRF (ePRF) is due to be introduced in 12-18 months. The Chairman said that British Telecom has approached the LAS about being an early adopter site for trialling ePRFs. A trial on using short form PRFs on FRUs in the East sector is working quite well; it has improved the turnaround time for cars.

The use of standby points are part of on-going discussions with Staff Side that have been extended by the negotiations regarding the introduction of rest breaks. It is anticipated that more flexible ways of working will be introduced from January 2007.

In reply to a question from Beryl Magrath the Director of Finance said that 'cluster working' was being used by PTS to introduce efficiencies into the way PTS vehicles are utilised.

The Chief Executive drew the Board's attention to graph 11 (ambulance hours staffed per day). He said that for the last two weeks' performance has not held up. Since the decrease in the availability of overtime the performance target of 75% for Category A has not been achieved. A&E should be at full establishment from 8th December and attention will be given to the level of abstractions, secondments and sick leave. The good news is that the Trust is on track to deliver a performance of 72% for all the Primary Care Trusts for the year as a whole.

Measures are being taken to ensure that the performance target of 95% is achieved for Category B by March 2007. The Director of Operations recently visited West Midlands Ambulance Trust which is achieving Category B performance targets by using cars to respond to Category B calls. The utilisation of cars is currently 25%. A balance needs to be struck between achieving Category A and Category B calls. The splitting of despatch desks from 7 to 14 will play a significant role in ensuring this objective is achieved. PTS vehicles are being used to transport Doctors' Urgent patients and are now undertaking 300 calls per month for A&E.

Roy Griffins referred to the Chairman's recent email on his outing with an ECP in Croydon. He said it was interesting that staff had thanked the Board for the robust

line it had taken with the Healthcare Commission concerning its assessment of the Trust in October 2006. A small number of staff have written to the Healthcare Commission directly expressing their views on the assessment of the Trust. It was clear that the decrease in overtime and the implementation of rest breaks are of concern to front line crews.

Noted:

1. **The Chairman's report**
2. **That the Board will be asked in January 2007 to agree formally to the LAS taking responsibility for Emergency Planning for London NHS.**
3. **That no staff information was included in the November report due to the recent introduction of the Electronic Staff Records but will be included in the next report to the Board, January 2007.**
4. **That the Trust had received the Healthcare Commission's report in October 2006. It had been discussed at the Service Development Committee held on 31st October 2006.**

102/06 **Month 7 2006/07 Financial Report**

The Finance Director reported that Month 7 had been a difficult month with an unfavourable variance of £890,000. There was an unfavourable variance for Income of £57,000 due to shortfalls in CBRN and Workforce Development Confederation funding. There was an unfavourable variance for Expenditure due to the adjustment to correct the year to date position on A&E vehicle lease charges. In addition a provision was made in the month to take account of staff who have applied for early retirement due to ill health.

The year to date position is £1,291,000 overspent due to income being less than expected (as outlined above) and expenditure being £494,000 higher than budget. The forecast is expected to worsen slightly in December and then recover so that year end is predicted to be a surplus of £266k.

Savings are expected to be achieved in November and December 2006 through a decrease in overtime, reduced subsistence payments and establishment savings. The Trust is under some pressure from Primary Care Trusts in respect of the funding agreed for Emergency Care Practitioners (ECPs).

The Finance Director said that the implementation of rest breaks whilst at the same time having less overtime hours available will be a major challenge for the Trust but it is important that overtime is managed and that the figure continues to decrease.

In response to a question from Sarah Waller the Director of Operations said that the numbers of hours available is being managed across the three areas to ensure an even geographical spread; overtime is being used predominantly in the evening, mid-week and at weekends. The Resource Centre is allotted a number of overtime hours to allocate which it is being held responsible for. An uncontrollable element of overtime is when crews receive calls at the end of their shifts; this accounts for less than 10% of available overtime hours.

An unintended consequence of reducing overtime has been the detrimental impact on Bank Staff due to overtime not being allocated to Bank Staff. The pool of Bank Staff has been built up to 140 staff. As there has been a poor response from permanent staff regarding overtime at Christmas overtime is being offered to Bank Staff to ensure shifts are covered over the Christmas holiday period.

Rest Breaks: the HR Director reported that following negotiations with Staff Side adequate time periods within each shift in which to allocate breaks have been agreed. If a rest break has not been offered during the shift it will be taken at the end of the shift with crews finishing earlier than scheduled. If neither of these actions are possible than compensatory rest will be given in addition to payment. A full report will be presented to the Service Development Committee in December with the Rest Break policy presented to the Trust Board in January 2007. **ACTION: HR Director.**

In response to a question from Barry MacDonald the Director of Finance confirmed that the big movements in the forecast included some reallocations. Barry MacDonald said that another area of concern was the use of third party transport which will be a major challenge for the Trust. Barry MacDonald noted that the report showed large variances in the corporate services cost centres. The Finance Director said he was confident that the variances were due to one-offs (7th July Commemorative event; Corporate Awards Event and the undertaking of the MORI Poll) and for some, the corporate awards, he expected some income to be received to off set the incurred expenditure.

Vehicle Lease: the Finance Director had circulated via email a report to the Board prior to the meeting explaining what had occurred and what remedial action had been undertaken. He said that a salutary lesson had been learnt from the discovery that a lease for vehicles had been incorrectly treated in the management accounts. The impact of this has been a £900,000 reduction in the year end position; the Trust is now forecasting to have a surplus of £266,000.

The error arose initially due to the budget not taking account of either 65 vehicles to be delivered in the current year or any potential pre-lease interest payments. There was no corresponding saving in depreciation costs as the LDV based ambulances, which were replaced, had been fully depreciated before the start of the financial year. The discrepancy in the budget was also missed when a reasonableness check was performed. Principally because the budget matched the forecast and there was an absence of non-financial data.

The invoice control and accrual process should have highlighted the error sooner. In future there will a greater emphasis on analysis and introducing standard procedures. Centrally held funds will be decreased with funds allocated to where the expenditure is being incurred. There will be better links between financial and non-financial departments.

Caroline Silver asked what the implications were with regard to the NHS London's expectation that it would receive £1.3m from the LAS. The Director of Finance said he had reported the finding and the revised forecast at the Senior Finance meeting on 24th November. He is meeting with Jim McAuliffe on 29th November to discuss the matter further.

By statute the Trust is required to break even; if the Trust is able to achieve savings then a contribution will be made, as requested, towards the London health sector's collective deficit. The Board was adamant that patient safety must not suffer in order to deliver that surplus in spite of the new circumstances. Thus, if the Trust is able to achieve a surplus to contribute to NHS London it will be a bonus.

Sarah Waller asked why the error had not been identified earlier; she referred to an earlier error made two years concerning Mobile Data Transmitters (MDTs). The Director of Finance said that it was not similar except that both related to centrally held funds. It had been compounded by staffing issues that are being dealt with.

In response to questions asked by Roy Griffins and Barry MacDonald the Director of Finance said that the budget setting process had been changed; that more focus

will be placed on an analysis of trends. There will be a stronger link between staff and expenditure and asset/expenditure which will improve transparency. He undertook to present a more detailed report to the Audit Committee when it meets on 4th December on how the proposed changes will be implemented and what controls are being put in place. **ACTION: Finance Director.**

In response to a question regarding Internal and External Auditors reviewing the budget setting process, the Director of Finance confirmed that both set of auditors had reviewed the process and had found nothing untoward as the budget setting process itself was correct.

The Chairman said more ownership needed to be taken by non-finance colleagues for their budgets, that there must be a shared responsibility for financial results. The devolution of centrally held funds will go some way to ensuring that non-financial staff have a sounder understanding of what the Trust is going to do. He concluded by saying that, turning to the finance function itself, what had happened underlined the need for attention to detail.

Noted:
1. **The report**
2. **That the £900,000 error concerning the car leases had resulted in the year end forecast being revised to show a predicted surplus of £266,000.**

103/06 **Report of the Medical Director**

The Medical Director highlighted the following from her report:

Update on Serious Untoward Incidents that were of a clinical nature. There are two ongoing investigations; the first involved an investigation into the death of a two year old child who suffered fatal head injuries when an ambulance rolled back in a school yard. The second involved a death in police custody; an investigation is taking place into whether there were delays in crews accessing the patient in the cell and whether essential equipment was taken to the cell.

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

Sixteen alerts were received during the period 13th September-14th November; the Trust has three outstanding alerts:

- A policy is being drafted to meet the requirements of NPSA/2005/10: 'Being Open when Patients are Harmed;
- MDA/2005/069 blood pressure monitors and sphygmomanometers. The MHRA requires sphygmomanometers to be recalibrated annually; investigation has shown that the best value option is for the blood monitors to be replaced on an annual basis.
- DH (2006) 08: Waste Compactor – it has been confirmed that the Trust does have a waste compactor and the Health & Safety Quality Assurance Co-ordinator undertook a risk assessment on 10th November and will be arranging for the provision of information and training to staff as outlined in the alert.

Clinical and cost effectiveness: the National Clinical Practice Guidelines for use in UK Ambulance Services, Version 2006 has been published. The 18 page summary of changes has been issued in advance to members of the Department of Education and Training and to Team Leaders.

Update on Cardiac Care: the Trust's Clinical Audit and Research Unit has provided information on both the number of patients being taken to heart attack centres and those receiving thrombolysis. Between January and March 2006 42% of all patients suffering ST elevation myocardial infarction (STEMIs) were treated with primary angioplasty. In the same period 43% of patients received thrombolysis within 60 minutes of the 999 call; this equated to 91 patients.

In the period between April and June 72% of STEMI patients were conveyed to Heart Attack centres; 41% of patients received Thrombolysis within 60 minutes. This equated to 27 patients. The data on patients taken for angioplasty is gathered from Management Information, while the data on thrombolysis is from MINAP. As previously highlighted we have identified some discrepancies between our data and that provided by MINAP. However, it is clear that the number of patients being managed in centres delivering angioplasty is increasing. With much smaller numbers receiving thrombolysis it will be even more difficult to show a 10% increase over a year.

Cardiac subgroup of JRCALC supports primary angioplasty as a preferred method of managing patients who suffer a myocardial infarction. Work is being undertaken with the Healthcare Commission to suggest they include primary angioplasty as a target.

The LAS Strategy for Stroke Patients was presented as appendix one to the Medical Director's report. The Strategy is aimed at raising awareness of stroke amongst the general public, GPs and providing a pre-alert to hospitals when appropriate. The Trust's priorities will be to identify patients who have suffered a stroke, to transport them to hospital, having identified those who could benefit from thrombolysis and to work with those receiving units which can offer acute stroke care. As of 1st November crews have been advised to place a priority call for any patient with a positive FAST (face, arm speech test) who they can transport to the Emergency Department within three hours of the onset of symptoms. The Trust is endeavouring to identify those units that are able to offer acute stroke are, as many hospitals can only access acute medical beds for these patients.

If the patient tests positive to the FAST test then he/she may be suitable for thrombolysis. For this to be successful the patient needs to receive the appropriate treatment within three hours of the onset of symptoms. Stroke patients (85% of strokes) who have suffered Cerebral Infarction may be suitable for thrombolysis. To date no negative feedback has been received from A&E departments regarding the Trust's Stroke Strategy.

Pain Management: an audit was conducted on pain management for children with fractures. One of the recommendations introduce a pain scoring tool for children – the "Wong-Baker" faces The publisher, Elsevier, has given permission for the LAS to use the pain rating score (appendix 2) which has 5 faces showing different levels of pain, with scores from 0-10. This pictorial tool will be laminated, given to crews to keep in their PRF folder and will be incorporated into the pocket books when they are available.

The paper 'Public perception of myocardial infarction and training in CPR' was published in 'Resuscitation' in March 2006. A copy of the article was included for information (Appendix 3).

Patient Specific Protocols: there has been a rise in specific protocols being requested particularly for patients with respiratory disorder or requiring palliative care. A very valuable piece of work has been undertaken with the Palliative Care Networks. This centres on patients who require treatment which is outside that described in the JCALC Guidelines.

The Paramedics drugs pack now includes amiodrone, epinephrine 1mgin 1ml, chlorphenamine and hydrocortisone. The general drug backs will be updated to include naloxone and hydrocortisone as soon as the redesigned foam inserts are available.

In accordance with the Version 2006 of the National Clinical Practice Guidelines Lidocaine is to be removed from the drugs bag as of 1st December.
A photograph of the revised Paramedic pack layout will be distributed to all stations to ensure that staff are familiar with the new layout of the packs. It is intended to do the same for the Emergency Technical packs when their update takes place.

Pandemic Flu: a Department of Health led group is working to produce guidance for Ambulance Trusts in the event of pandemic flu. A triage tool is being investigated for primary and ambulance care which will give guidance as to which patients can be managed at home.

Beryl Magrath said she was pleased to read of the very positive developments taking place. She recently read an article in the British Medical Journal which was in favour of angioplasty. She was also pleased to learn of the Patient Specific Protocols that are being introduced.

In response to a question regarding whether EMT4s could supply Diazepam the Medical Director said that there was no EMT4 drug pack and Diazepam can only be used by Paramedics. EMT4s use the same drug bag as EMT3s but will have additional skill and knowledge.

In response to a question regarding stroke patients being able to receive scans the Medical Director said that access to a scan in the majority of hospitals was limited to 9am-5pm. Although patients generally receive a scan within 24 hours this is too late for those patients who would benefit from a scan within three hours of the onset of symptoms so as to determine their suitability for Thrombolysis. The only 24/7 treatment centre for stroke patients is the National Hospital for Neurosurgery. In order to increase the provision of scans for patients who suffer a stroke there needs to be public demand for the service to be made available 24/7.

The Director of Service Development said that the Commissioners have not been supportive of the necessity for additional stroke provision in London; they had queried the evidence presented as to the need. The Chairman said that innovation will not come from the provider side but from pressure brought to bear by the public and the professions.

Noted: The Medical Director's report.

104/06 <u>Current issues with NHS London including acute reconfiguration across London</u>

The Director of Service Development gave a presentation on the current issues facing NHS in London: (1) provider/commissioning split and performance management; (2) commissioning, planning framework Department of Health operating framework, (3) NHS London strategy; (4) money (current projected deficit for 2006/07 is £135m); (5) emergency planning; (6) geography (NHS London intends to have three areas – south, east and west.

Reconfiguration: the SHA (NHS London) has given the go ahead for discussion in North Central; North East; South East and for South West to return to its proposal of last year, 'Healthcare Closer to Home'. It is intended that regular updates on the reconfiguration's progress will be produced through the Assistant Director of Operation's weekly meetings.

The Trust is involved in a number of the consultations taking place and a policy has been drafted to state the Service's position. The policy contains the following criteria:

- That the LAS should support proposals that lead to better clinical care for patients with serious illness and injury even if that means longer initial transport;
- That the LAS should represent the importance of major incident resilience – ensuring that there is clarity over responsibilities for emergency preparedness and response. This will include ensuring that an appropriate number of hospitals have responsibility for being in a position to mobilise emergency medical response teams.
- The LAS should encourage PCTs and the SHA to reduce the variability in the types of minor injuries and similar services provided, so that they have a clearly defined range of capabilities that can be easily understood, not least by the public.
- The LAS should support proposals where the PCTs and the SHA are committed to providing a simple set of alternative destinations and services for patients, which cater for all patients with non-life threatening conditions for the majority of the 24 hours and commit themselves to assisting ambulance crews to use such services to the maximum.
- The LAS should support changes that, as well as meeting the above criteria, include a PCT commitment to provide the resources the LAS needs to respond no less quickly to patients who call 999 so that no patient waits longer for an ambulance after the reconfigurations than they would have done before.

In reply to a question from Sarah Waller the Director of Service Development said that the Trust will expect PCTs to reimburse if there is additional cost incurred i.e. if the LAS is required to transport patients greater distances due to the reconfiguration.

Beryl Magrath referred to criterion 2. She said that the under usage of services such as Minor Injuries Units may be explained in part by these Units not having imaging services and crews preferring to transport their patients directly to A&E departments.

Agreed: The five criteria for supporting reconfiguration as listed above.

105/06 <u>Risk management policy and supporting procedures</u>

The Director of Finance presented the Risk Management Policy and supporting procedures for approval. The Policy has been reviewed by the Risk Compliance and Assurance Group and it will be considered by the Audit Committee in December. In addition a teleconference took place on 13th November in which a number of the Non-Executives participated in a discussion of the Policy. The Policy is intended to be a 'live' document. The paper on the Supporting Procedures was circulated by email on Monday 27th November.

Barry MacDonald asked that the Policy be amended to distinguish between the roles of the Risk Compliance & Assurance Group (RCAG) and the Audit Committee and that the RCAG reports to the Audit Committee. The Audit Committee receives the minutes of the RCAG and the Clinical Governance Committee so as to fulfil its role of having an overview of the Trust's clinical and non-clinical risk management.

Roy Griffins said that neither the Policy nor the Procedure was 'reader friendly' which may be a barrier to its dissemination amongst staff. The Director of Communications said that he would ask a member of his department to review the document and liaise with the Head of Governance. **ACTION: Director of Communications.**

Approved: The Risk Management Policy and Supporting Procedure.

106/06 Procurement of additional Fast Response Units

The Director of Finance reminded the Board that the business case for the procurement of additional Fast Response Units (FRU) was originally presented in January 2006. In January the Board had requested that the matter be raised again when ORH had undertaken the necessary modelling which demonstrated the need for additional FRUs. The ORH modelling recommends the Trust using 250 FRUs as part of the operational plan to achieve 'Clock Start'. In 2005/06 the Trust acquired 29 FRUs, in 2006/07 it will acquire 114 and in 2007/08 it will acquire 29; with the existing number of vehicles this will bring the total up to the figure required.

The Board was asked to approve the procurement of 114 additional FRUs which is part of the Trust's plan to achieve 'Clock Start', recently submitted to NHS London and the Department of Health. It is proposed that in 2006/07 114 FRUs will be obtained and in 2007/08 29 in 2007/08. They will be procured using the PASA framework agreement.

In reply to a question from Beryl Magrath the Director of Operations said that the majority were Vauxhall Zafiras with approximately 20 Astras.

The Board had a brief discussion regarding the lease versus buy decision. The Finance Director said this would be reviewed for each asset acquired by the Trust.

Roy Griffins asked that the technicalities surrounding leasing versus buying could be discussed further at the Audit Committee on 4th December. **ACTION: Finance Director.**

Approved: 1. Procurement of 114 Fast Response Units in 2006/07 and 29 in 2007/08.

Noted 2. That the budget for 2006/07 included a capital plan to procure 114 Fast Response Units.

107/06 Disability Equality Scheme

The HR Director presented the Disability Equality Scheme to the Board for approval. The Trust, along with all public authorities, is required to publish a Disability Equality Scheme by 4th December in line with the latest legislative amendments to the Disability Discrimination Act 1995. The Disability Equality Scheme is similar in ethos to the Race Equality Scheme published initially in 2002. The Trust is required to produce a Gender Equality Scheme in April 2007. In due course the different schemes will be amalgamated into one scheme. The Disability Equality Scheme sets out the general requirements on public authorities in terms of their duties to promote disability equality; what the current position is and what the developmental action plan is to address any shortfalls.

The Board was concerned that the Trust had been committed to acceptance of the Social Model of Disability without first gaining the Board's consent. Some Members of the Board were unhappy with the wording in the Disability Equality Scheme where it stated that 'everyone will be treated as they would wish to be treated, with respect and courtesy'. It was proposed that this be changed to

'…would wish to be treated, i.e. with respect and courtesy'. The insertion of 'i.e.' would clarify the Trust's position and be less ambiguous. The Director of Communications said this would mean a change to one of the Trust's values and requested that the matter be discussed by the Senor Management Group.

The HR Director was not able to inform the Board of the number of staff who are disabled as there is no register of disabled people is maintained. The Electronic Staff Records (ESR) does record which staff are disabled but this is on a self-disclosure basis.

The Board considered that the proper processes had not been entered into when the Scheme was drafted nor when the Trust was committed to upholding the Social Model of Disability.

Agreed: 1. In principle to the Disability Equality Scheme but wished the wording to be revised as discussed during the Board meeting.

Noted: 2. That the Senior Management Group will review the Scheme and that the Scheme will be represented to the Board either at its next meeting in January or by email. ACTION: HR Director.

108/06 <u>Annual report on complaints 2005/06</u>

The Chief Executive presented the report on complaints received by the Trust in 2005/06. There was an increase in the number of complaints received 544 in 2005/06 and 444 in 2004/05. Of the 544 complaints received in 2005/06 27 complaints were not related to the LAS. The increase in complaints between 2004/05 and 2005/06 should also be seen in the context of the increasing number of calls that the Trust responded to in 2005/06 compared to 2004/05.

The two main areas for complaints were delays in response and attitude and behaviour. There was a slight increase in the number of complaints received regarding Clinical Telephone Advice and being left at home.

There has been a lot of work undertaken to ensure that crews receive feedback when complaints are received by the Trust; e.g. the Medical Director gives feedback on complaints at the annual consultation meetings with front line staff. Other avenues for giving feedback include the five day Continuing Professional Development course, induction and the Patient Care newsletter. Examples of how complaints have changed practice were included in the report. The Complaints Panel which is meeting on a regular basis reviews complaints and SUIs. Complaints management has been devolved to sectors.

The Healthcare Commission's target for responding to complainants within 25 days will be achieved by March 2007.

Beryl Magrath said that she liked the section on lessons learnt outlined in Section 4 of the report; this will undoubtedly be of interest to the Healthcare Commission when they visit the Trust in February 2007. She said that there was little information available regarding attitude and behaviour and asked that further investigation be undertaken to identify specifics. **ACTION: Head of Complaints.**

In response to a question from Sarah Waller the Head of Complaints said that the Trust was required to meet two targets relating to complaint handling. Firstly to

respond to complainants within two days and secondly to resolve the complaint within 25 days.

Roy Griffins thought the report 'good and succinct' and asked who its intended audience is. The Chief Executive said it had been considered by the Senior Management Group and by each Sector's Management Team. It will be used to try and dispel the fear that exists amongst crews about doing something wrong; of the 544 complaints received only 12 resulted in disciplinary action.

The Chairman asked Mary Arayo attending in place of Malcolm Alexander (Chairman of the LAS Patients' Forum) to report back to Mr Alexander that the Board had considered SUIs in the public part of the meeting. Malcolm Alexander had raised the matter when the Board met in September 2006 (minute 81.06).

Noted: **1. The Annual report on Complaints – 2005/06.**
2. That a revised Complaints policy and procedure will be presented to the Trust Board in January 2007.

109/06 **Emergency Care Practitioner Update**

The Chief Executive presented an update on the Emergency Care Practitioners (ECPs) which he said needed to be seen within a wider context. In January 2007 the Board will receive the Long Term Workforce Plan which will include ECPs, Paramedics etc. The Education and Development department is being reviewed to ensure that it is fit for purpose in particular around delivering training on improving patient assessment. The Medical Director is meeting with trainers and team leaders and discussing the continuing development of clinical leadership. Finally there is the Operational Model which the Board has previously been informed of.

In relation to the ECPs the key issues that have been identified are: mainstreaming; deployment/tasking; education packages; placements; NHS value added; lone working and the future workload. An ECP conference has been arranged for 12th December at which the Chief Executive and other Senior Colleagues will be discussing the Trust's future plans for ECPs. A position paper on ECPs will be presented to the Board in January. **ACTION: Chief Executive**

Work is being undertaken to finalise the Workforce Plan for presentation to the Board in January; to finalise the Training and Education Plan for 2007/08 and to finalise the Clinical and Leadership Model by January/February 2007. **ACTION: HR Director**. The Operational Model will be implemented in 2007 and 2008 **ACTION: Director of Operations.**

In reply to a question from Beryl Magrath it was confirmed that two ECPs have undertaken all the ECP modules with some ECPs who have undertaken the training deciding to withdrawn from the scheme.

A disagreement has arisen with Bromley regarding the ECP Service Level Agreement (SLA). Bromley Primary Care Trust has argued that the ECPs were underperforming as they were not doing 10 jobs per day. The Director of Operations confirmed that the figure of 10 jobs per day is not in the SLA but was mentioned in a presentation given to the PCT by the former ECP Co-ordinator.

The HR Director said that the ECPs will be incorporated into the workforce plan on the basis that they are to be mainstreamed and therefore not reliant on contracts with local PCTs. The Director of Finance said that the decision to mainstream the ECPs had a financial component; it is a £2m decision and required further consideration.

The Chairman said that with hindsight the decision not to mainstream the ECPs from the start but to have them as a separate entity funded by PCTs was a mistake. The initial trial undertaken in Wandsworth demonstrated that the ECPs added value to the NHS system as a whole and that the scheme was clinically safe with fewer

patients being taken to A&E departments. The decision to spread the ECPs around London, with approximately five based in ten PCTs, had not enabled a momentum to be built up and consequently the expected added value has not been realised.

The ECPs need to be seen in the context of the Trust's core business of responding to 999 calls but also to possible developments in the future i.e. out of hours, integrated urgent care.

The Chairman said that it would be useful to raise the matter of ECPs with McKinsey's who are advising NHS London. In terms of demand management the LAS probably impacts on 30-40% of bed days in London and this can be translated into real money for those patients with long term conditions.

The Chief Executive said that the Department of Health was consulting on a national basis what the contents of the ECP curriculum and competency framework should be; to date it had received 100 responses. The findings of the consultation are expected in February or March 2007.

The commercially sensitive aspects of the ECP strategy were discussed in the Board's part II meeting.

Noted: The update on Emergency Care Practitioners.

110/06 <u>Clinical education and development programme 2006/07</u>

The HR Director presented a six month update on the Clinical Education and Development Programme.

Concern was expressed at the poor attendance at some of the courses; e.g. the Continuing Professional Development (CPD) course had 82% attendance and the recent Paramedic recertification course had 72.5% attendance. The Training Department is aware of which paramedic's registration is imminent. Paramedics who fail to re-register are in breach of their contract with the LAS. In the past when this has happened they have dropped a pay grade with the resultant drop in salary until they re-registered as paramedics.

EMT4 training has been introduced and it is anticipated that real value will be realised. As this has just been rolled out it is too early for the training's effectiveness to be ascertained.

The Chief Executive was keen for the Board to know how much training was being undertaken e.g. 741 people have undertaken the five day CPD training.

Beryl Magrath congratulated the management team on the training programme and asked what the reasons for non-attendance were. The HR Director said that the majority of non-attendees gave short notice. The Training Department liaises with individual's manager to ensure that non-attending staff are rebooked onto future courses.

The Medical Director said that the CPD course has continual assessment whereas the EMT4 course is a pass/fail course.

The HR Director said that as part of the Five Year Workforce Plan and Operational Plan the single response vehicle will be staffed by EMT4s and Paramedics.

Sarah Waller said that the list of activity was very good. She asked whether the management had considered recouping the variable cost of running courses from non-attendees so as to ensure staff take attendance at training courses seriously.

Noted: That an update on Higher Education will be presented to the SDC in December. ACTION: HR Director.

111/06 **Draft minutes of Service Development Committee – 31st October 2006**

Noted: **The draft minutes of the Service Development Committee held on 31st October 2006.**

112/06 **Draft minutes of Remuneration Committee – 31st October 2006**

The minutes were not available for the meeting. The Chief Executive reported that the Remuneration Committee met on 31st October to consider the pay packages of the Senior Executive Directors following the publication of the Pay frame Guidance for Very Senior Mangers by the Department of Health.

Noted:
1. **That the Chief Executive's pay is £141,000; that the Director of Finance pay is £100,000; the Director of Operation's pay is £100,000 and the Director of IM&T is £86,000.**
2. **A review is taking place of the car leasing scheme and a report will be presented to the January Trust Board. ACTION: HR Director**

113/06 **Draft minutes of Clinical Governance Committee – 23rd October 2006**

Noted: **The draft minutes of Clinical Governance Committee which met on 23rd October 2006**

114/06 **Draft minutes of Annual General Meeting – 26th September 2006**

Noted:
1. **Draft minutes of Annual General Meeting – 26th September 2006**
2. **That a debrief will be undertaken including consideration of an alternative venue for next year's AGM.**

115/06 **Report from Trust Secretary on tenders opened since the last Board meeting and the use of the Trust Seal.**

Three tenders were opened since the previous Board meeting in September 2006. Their details were as follows:

14/06	Motor Insurance Tender	Zurich Municipal JLT Group Risk Management Partners DAS Legal Expenses Insurance Brian Johnson & Co. Turnamms Claims Adjuster
15/06	Uninsured Loss Recovery	Motor Accident Protection Services Ltd. Turnamms Claims Adjuster DAS Legal Expenses Insurance Jardine Lloyd Thompson corporate risks Ltd Risk Management Partners
16/06	Provision of conversion of Vauxhall Zafiras for RRU & ECP	MacNellie Wilker Papworth

Noted: That three tenders had been opened since the Board met in September 2006.

116/06 Any Other Business

The Chief Executive reported that the Trust will receive new digital hand held radios as part of the national radio programme; they will initially be rolled out as vehicle based equipment. Following an incident a number of years ago when a member of the crew was seriously injured an undertaking was given to staff that radios would be issued to each front line staff member. It is intended that as more radios are received personal issue will be implemented but in the interim radios will be vehicle based; two per vehicle to enable crews to communicate with each other if they are separated and with the Control Room.

In answer to a question from Beryl Magrath as to whether the introduction of the radios would mean the phasing out of Service mobile phones the Finance Director said that this is being reviewed. **ACTION: Finance Director.**

The Chief Executive reported that due to the Thames Gateway and the Olympics it is proposed to site an additional Ambulance Station at Stratford. The business case will be presented to the Trust Board in January 2007. **ACTION: Director of Operations.**

The Chairman invited members of the Board who did not already have copies of the 'Intelligent Ambulance Board' to take a copy. He commended the publication as it was not prescriptive. The publication will be reviewed in due course in light of experience.

Mary Arayo offered to share the work undertaken by the LAS Patients' Forum on stroke treatment with the Medical Director. The Medical Director thanked her for the offer.

That the Part II meeting will be considering commercial sensitive issues relating to the ECP strategy.

The meeting concluded at 1.09pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 26th September 2006
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 26th September 2006 in Part II the Trust Board:

1. Update regarding the first Gateway Review of CAD 2010

The Director of Information Management & Technology shared the findings of the first Gateway Review with the Board. The Review, which is meant to be critical, had made a number of recommendations which the Director of IM&T assured the Board were being taken very seriously. He undertook to share the response to the Gateway Review with the Board at the earliest opportunity.

2. Update regarding Serous Untoward Incidents.

The Board was informed of the unofficial findings of the investigation into the death of a five year old boy who was killed by an ambulance during a school visit. School visits are continuing but without any vehicles.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 30 JANUARY 2007

CHIEF EXECUTIVE'S REPORT

1. ACCIDENT & EMERGENCY SERVICE

1.1 999 Response Performance

The table below sets out the A&E performance against the key standards for the year to date. A detailed position is available in the attached graphs.

New standards with effect from 1 April 2006

	CAT A 8	CAT A 19	CAT B 19	Urgent, at patient within 15 mins
Standard	75%	95%	95%	95%
YTD*	74.3%	97.4%	82.0%	76.5%

*As of 22nd January 2007

Key highlights

i. Category A performance was maintained at target levels through October and November despite an increase in the daily volume of Category A calls.

ii. The Board was advised at the November meeting that the trust did not expect to be able to maintain performance through December given increasing call volumes and the introduction of rest breaks. Overall performance for December is expected to be at 70% once all the final data has been inputted. This was an acceptable outcome given the challenges associated with rest breaks, staffing across the Christmas week and Cat A volumes which rose to 939 per day .

iii. Overall demand for this financial year has increased by 2% when compared to the same period last year.

iv. Rest breaks were introduced on 11th December and as expected we have seen a fall in performance associated with this of circa 3-4%. This is in line with ORH modelling and is now beginning to recover as the system beds down. Further detail on the progress and impact of Rest Breaks is given later in the report.

v. Increasing Category A as a proportion of the total workload is the principle area of concern at the present time and have now risen consistently over the last six months. During the July heatwave the service was dealing with 837 Cat A calls per day and this was exceeded in November (855) rising to

939 per day in December and are currently running at 921per day for the first three weeks of January. In overall terms this means that weekly Cat A volume is now running at circa 39% of total emergency demand and on some individual days this has risen to 42%. This compares with 37% percentage for the same period of January last year.

vi. Analysis of the rising Cat A demand and the particular illness codes affected have shown significant increases in calls for Chest Pain(+ 20%) and Breathing difficulties (+13%). We would expect to see a rise in calls for breathing difficulties at this time of year associated with cold and flu like symptoms but the rise in Chest pain calls is directly associated with the high profile campaign by the British Heart Foundation which encourages patients with chest pain to dial 999 as soon as they experience pain. The service has of course fully supported this campaign but it should be noted that this has added some 50 to 60 additional Cat A calls per day to the overall demand.

vii. The Board will be aware that, for the first time in many years the Trust will be at full operational establishment following some final posting of new recruits during January. Staffing has broadly held up well through November and December despite strict overtime limits and indeed the trust produced more hours than at the same period last year. The exception to this was the Christmas holiday week during which we still had significant staffing shortfalls. It is clear that the current unsocial hours arrangements enshrined in AfC do not provide staff with sufficient incentives to cover bank holidays

viii. The Trust is now at 74.3% ytd performance and the challenge is to recover this position over the coming 10 weeks. The focus will inevitably be on Category A but we will also be attempting to improve Cat B and Urgent performance at the same time. Detailed below are some of the key actions being taken to improve performance over the coming weeks. The position is recoverable but there are two dynamics in play this year namely Rest Breaks and the difficult financial position. This means that we will be relying largely on performance improvements associated with the roll out of the high impact changes in order to do so.

Actions to Recover Performance

1. Improving FRU Performance

- Optimising FRU Auto Dispatch by:
  - Re-defining nearer vehicle 'Look Up' parameters.
  - Amending geographical tasking limits by time of day and geographical area to between 2 and 4 miles
  - Reducing the number of times when the system cancels inappropriately.
  - Adding ECP vehicles and HART responder vehicles to auto dispatch
  - Progressively adding Amber 1 calls to boost B performance.

- Improving the total volumes of Cat A volume being tasked to FRUs from 45-50% to 60-65%
- Increasing overall Utilisation of FRUs from 28% to 50%
- Increasing existing FRU availability to 100%
- Taking delivery of 60 additional FRUs at a rate of 6 per week from mid January.
- Establishing additional FRUs progressively from mid January onwards.
- Utilising Managers to provide additional FRU capacity wherever possible.
- Using Home Response FRUs as much as possible within current financial constraints.

2. Attendance Management

- Maintaining absolute focus on all aspects of attendance management within existing best practice guidelines both on Area and within EOC/UOC.
- Further work with HR to jointly introduce new /temporary processes to improve managers ability to manage attendance.
- Ongoing review of all secondments and abstractions designed to return staff to operational duties wherever possible.

3. Resourcing

- Maintaining maximum effort on resourcing all vehicles.
- Pro-active management of all singles
- Prioritising FRU resourcing

4. EOC Initiatives

- Improving Staffing by general attendance management,
- Adding an additional recruitment course during March to achieve full EMD establishment by end April.
- Continuing to promote additional allocators to ensure increased desk splitting and attain a better skill mix.
- Progressively moving to the new Sector desk configuration on all three operational areas.
- Improving general management of the main control room to achieve more consistent performance across all areas.
- Optimising FRU Desk staffing in terms of quantity and quality of allocators
- Optimising the Operational Command Unit to ensure both effective resolution of real time operational issues and the forward planning of resourcing in conjunction with the Resource Centres.
- Increased focus on lost vehicle hours (VOR)
- Developing Individual Performance Review for EOC staff

- Placing extra emphasis on maintaining performance through the night shift .

5. Reducing Job Cycle Time

- Completing the Handover Process Mapping of priority hospitals
- Clear schedule for completion driven by ADOs with personal AOM responsibility.
- Clarity about definitive management actions required to drive these improvements through. Local responsibility for implementation
- Effective Communication with all staff as to the rationale
- Understanding the synergy with the Individual Performance Review project

6. Service Wide Implementation of Individual Performance Review

- Consolidation of lessons learned from three pilot sites
- Comprehensive briefing of all managers
- Effective communication with staff
- Implementing roll out from mid January
- Local management teams to concentrate principally on mobilisation times and job cycle times for the remainder of the financial year

7. Reducing Performance fall at Shift Changeover

- Pro-active action to secure Trade Union support for roster changes designed to improve shift changeover performance.
- Ownership at AOM level for their complexes, the changes that need to be made and the local negotiations required to deliver against them.
- Detailed action plans by complex to allow delivery against required roster changes.
- Evidence of both clinical and operational performance fall at shift changeover by individual complex.
- Ensure due consideration of the effect of the new Restbreak agreement in terms of additional 1830 and 06.30 finishes.

8. Setting Appropriate Reap Levels

- Weekly review of current REAP levels against normal parameters.
- Consider raising REAP to level 3 ‘Severe pressure’ from third week of January if performance does not recover and workload remains high.
- Take whatever appropriate REAP level actions are indicated.

9. Reviewing Red and Cat A Volumes

- Continue internal work to reduce Cat A volumes by a further 0.5%
- Continue to gather evidence to influence the next national call prioritisation meeting in March 07

- Conduct research to establish any trends in the volume of incoming 999 calls placed in Red Category by EOC watch and by individual call taker.

10. Quality Assurance of Response Times

- Maintain robust quality assurance of all missed CAT A calls .
- Conduct retrospective analysis of all missed Category A calls to the following locations:
    - GP Surgeries
    - Hospitals
    - Fixed sites for public access defibrillators where staff have been trained by LAS
- Ensure that all these calls have response times recorded in line with current department of health guidance.

1.2 Rest Breaks

- The implementation of the rest break policy commenced on the 11th of December the intention of the policy is that all staff will benefit from a rest break during their shift and bring the weekly hours worked down from 39 hours to the AfC requirement of 37.5 hours.

- Prior to these new arrangements 80% of operational ambulance crews did not receive a formal rest break and of the remaining 20% who were allocated a break a large proportion had their break interrupted. The implementation of the rest break policy has reversed this trend with the vast majority of operational staff now being allocated a rest break or receiving a compensatory rest period at the end of their shift.

- In the first three weeks almost 76% of ambulance staff have had a rest period within their shift. The remaining 24% will have received a compensatory payment of £10 or been allowed to finish their shift early.

- Introduction of the policy has been difficult particularly within the control room as staff attempt to place crews on break during a period of the year when workload has been very high. EOC staff have responded very well to this challenge and are to be congratulated for the work they have done to ensure that crews get the rest breaks that they deserve.

- There has of course been some impact on operational performance but early indications are that the performance drop is within the predicted 3-4% fall. As stated earlier performance is slowly recovering as allocation of rest breaks becomes more routine. This is a pattern that has been seen in every ambulance trust on the introduction of rest breaks.

- The implementation should be regarded as successful and whilst there are clearly some difficulties still to overcome, it is pleasing to have reached this point. This is all the more relevant given that there was a fair degree of scepticism on the service's ability to give large numbers of staff adequate rest breaks given our increasing workload.

1.3 Emergency Operations Centre (EOC)

- A decision was taken in early December to appoint a Deputy Director of Operations to oversee the implementation of the Control Services restructure and the overall changes required to attain the new, more stringent, performance targets associated with "clock start". This appointment has initially been made on a temporary basis and has seen Richard Webber, the ADO for East area, seconded to HQ.
- John Hopson continues to lead on the dispatch projects within the Operational Response Improvement Programme. The projects include increasing the numbers of available despatchers by splitting the existing Sector Desks, introducing automatic dispatch of FRUs and reducing multiple deployments to the same incident. To date the milestones laid out in the project plan have been achieved.
- At the last Trust Board it was reported that the West Area despatch desk had been re-configured to provide an increased despatch capacity. This concept of splitting sector desks has now been rolled out to the East and South Areas. Whilst vacancies in the allocator role has hindered the sustained splitting of desks, there have been several occasions where desks across the service have been split. This will continue to increase over the next quarter whilst more staff are promoted to the vacant allocator posts. The benefits realised have been an improvement in activation and a greater ability to effectively manage the resources under that sector; including an increased level of rest break allocation.
- The pilot for Automatic Dispatch of FRUs commenced at the end of November. Following lessons learnt during this phase, it was rolled out to all FRUs service wide in the first week of December. Close collaboration between EOC and IM&T is allowing further enhancements to be implemented during January and February. The early results are very encouraging with the percentage of calls being dispatched automatically rising to 50% of overall FRU activity together with a much higher level of performance than when compared to manually despatched calls.
- The focus on all aspects of attendance management has continued. The levels attained of staffing during December were poorer than anticipated; mainly due to an increase in sickness, a reduced uptake in overtime and the level of vacancies. Steps are in train to ensure that all of these issues are tackled. A more robust approach to the management of sickness has now been implemented and an additional training course has been established for early April. This, coupled with the existing training packages scheduled, will see an additional 39 staff in post by April. If the current staff turnover rates are maintained and all candidates pass the courses, the EOC staffing levels will attain 100% by April.

- Call taking came under pressure during December during the build up to Christmas with increasing activity levels. This has resulted in periods of poor performance, but will improve during the final quarter following the appointment of new staff as described above and further attention to the call taking management process.
- Rest Breaks were implemented in mid December, which has resulted in an increased workload for staff on sector desks. Despite the increase in workload the staff have had some significant achievements, with the FRU desk achieving 98% compliance on some days. Work is now in hand to roll out a rest break agreement for Control Services staff.
- New Years Eve was managed entirely from HQ on this occasion. The event went well from a Control services perspective with 89 control staff on duty. Additional call taking positions were put into UOC and the call taking demand managed appropriately. The Voluntary Aid Societies were managed from the Incident Control Room. This appears to have gone smoothly, with only a few issues identified.

1.4 Urgent Care Service

- Recruitment is now underway for four A&E Support (revised EMT1) training courses, the first of which commences on 29 January and run throughout February and March. Subject to satisfactory recruitment to and successful completion of the course full establishment will be reached this financial year.

- The CTA job description has been revised to open the pool of potential applicants to other registered health professionals, primarily expected to have a nursing background. This revised job description will undergo Agenda for Change assessment shortly and it is hoped that this will improve recruitment towards the target 50wte by year end (currently 28).

- The numbers of calls being dealt with by the Urgent care service continues to represent some 33% of incoming Green, Urgent and non-urgent workload and increasing this is now dependant on improving staffing in coming months. The CTA component of this represents some 4000 calls per month and results in not sending ambulance resources to some 2000 patients per month. The CTA in post figure is now currently 28 wte against an establishment of 50 so there is considerable scope to improve on these figures once new staff are recruited and trained. It should be noted that CTA recruitment has been ongoing throughout the year and some 95 staff have been trained since the role was introduced. The rotational nature of the post has however meant that many staff have tended to undertake it for a period of circa six months and then elected to return to full operational duties which has made increasing the overall in post figures difficult.

1.5 Emergency Planning

Hazardous Area Response Team (HART)

- The Hazardous Area Response Team is now established and operational. A total of 23 staff are seconded to this initiative and provide a response across 16 hours a day, seven days a week.

- This team are providing our first response to any hazardous area, including tunnels, collapsed structures, firearms incidents, hazardous materials situations and CBRN incidents.

- Initial response is in two Fast Response Cars, which are then supported by two mass-equipment vehicles and a sophisticated command vehicle.

- This trial is being led by DH, with a six month evaluation period. It is anticipated that it will be rolled-out across the country at the end of the trial, with London doubling the number of staff involved to provide two 24 hr teams.

- A Ministerial visit to examine the HART operation will take place on 8 March 2007.

Major Incident Exercising

On 7 December 2006 the Service held a significant major incident exercise to test progress against the actions which followed from the 7th July debriefs. The focus of the exercise was largely on the communication arrangements now available.
Three incident sites were established around London and officers were deployed to these sites to run a 'virtual' incident. Other officers were also deployed to hospitals to act as liaison officers.The exercise tested the paging system, the new Airwave tetra radios, the new Incident Control room, the satellite telephone system and the Gold Command Suite.Of particular note was the excellent reception available on the Airwave radios, which will be rolled-out to crew staff later this year.

Crew Safety

- Between now and April, all A&E staff will be issued with a radiation dosimeter, which measures an individual's exposure to radiation. The dosimeter sounds an alarm when unacceptable levels of radiation are detected, allowing the person to exit the contaminated area before significant exposure.These devices are similar to pagers and are worn on the uniform. Each dosimeter is collected in annually and a permanent record is kept of the staff member's exposure level.

- Personal-issue 'escape hoods' will also be provided to each staff member this year. These will provide the staff member with a short period of

filtered air in order to allow a swift exit from a contaminated environment. These are being issued nationally to ambulance staff by DH.

1.6 Response time Data Compliance with DH guidelines

The trust has now received the full guidance document for 2006/7 from the Department of Health. In addition the guidance for 2007/8 is now expected to arrive within the next few weeks. In view of this we will now bring a full paper to the Board in March 07 which demonstrates compliance for 2005/6 and incorporates any changes which will be required in 07/08.

1.8 Update on the 'Improving our Operational Response'programme

- The Board will recall that the Operations Directorate are in the process of implementing a number of High Impact Changes (HICs) to improve performance and provide a stable platform for full implementation of the New Front End Model. These all form part of the 'Improving our Operational Response' Programme which is in turn one strand of our 7yr Strategic Plan.

- Each project is being led by an Assistant Director of Operations (ADO) The HICs have been split into Response Projects and Dispatch Projects and are designed to provide a positive performance impact in the final quarter. A description and brief summary of progress against each project is provided below:

- A more visual summary of progress has been provided in the form of two progress charts at the end of the chief executives report.

- **It should be noted that there will inevitably be some repetition in this section as some aspects of progress against the programme have already been referred to in previous sections of the report under specific functional areas and also within the actions taken to improve performance. It is however important that the Board be able to refer to one dedicated area within the Chief Executives report for a summary of progress against the entire programme.**

Response Projects Summary

Home Responding

- This project involves establishing arrangements for off duty staff to take FRUs home and make themselves available to respond to Category A calls in their vicinity. This project will be of greatest use in outlying areas where the call volumes are low, meaning that we do not place a permanent resource nearby. Home Responding will in theory enable us to reach the low numbers of calls that occur in those areas hence improving our overall performance.

- Limited trials of the scheme commenced before Christmas, and to date five shifts have now taken place with 30 further shifts currently being planned for the Croydon and Bromley complexes respectively. The final challenges to be overcome are closely monitoring the overtime situation to ensure that the initiative remains within budget constraints and making sufficient FRUs available without damaging vehicle availability for the core fleet. The second problem will be eased somewhat in February as delivery of new FRUs commences. Work is currently being undertaken to collate detailed feedback from participating staff coupled with data collection to provide information around A8 performance of the home responder.

Reduce Job Cycle Time

- This project entails reducing overall job cycle time principally by focused management attention on time spent at hospital. Hospitals are being processed mapped to ensure that the handover arrangements are as efficient as possible. This project also links closely to the individual performance monitoring project in so much that staff will be asked to account for their turnaround times where they lie outside of the norms set by their peers.

- There is some slippage on this project in terms of mapping handover processes in hospitals across London but plans are now in hand to commence this with the six hospitals with the longest or most problematical handover processes. This should be completed by the end of this financial year with common themes emerging from this exercise being used to drive discussion and change in other hospitals. Additional project management resource has been allocated to the project and a new project plan and timeline have been produced. Other aspects of the project include setting standards and communicating them and establishing robust plans for management actions designed to address long handover times. The aim is still to reduce the hospital component of the job cycle time from circa 32 minutes to circa 20 minutes by end March 07.

Reduce Performance Fall at Shift Changeover

- The Trust suffers a daily fall in performance around 0700 hrs and 1900 hrs. These times correspond with period where the majority of ambulance and FRU shifts changeover. This project is principally about adjusting some shift changeover times by a small amount to provide a more staggered changeover period– an action for which the clinical risk argument is overpowering.

- Top level agreement in principle has been gained from the Trade Unions and local discussions about implementing changes have now commenced. A phased approach is being adopted, with phase 1, incorporating interim rota and station changes to FRU's, being the element of the project

delivering the most benefit for CAT-A performance. This has been delivered within the designated timescale.

- The remainder of phase 1 (8 complexes), Phases 2 (10 complexes) and phase 3 (7 complexes) are running significantly behind schedule due to a combination of factors. These will involve changing core ambulance rosters and a revised implementation schedule has now been agreed which will aim to have completed all 25 complexes by end March 07. The phased approach to this has now been revised and all AOMs will be concentrating on their individual complexes at the same time. All phases are now expected to be completed by end March 07.

Individual Performance Monitoring

- A trial of this initiative commenced on track at 3 complexes in November. This project involves the production of performance information at an individual level enabling operational managers to address both good and poor performance with staff. The chosen approach is not to set targets for staff to achieve, but rather to hold those with outlying performance to account against complex norms.

- Data is provided by Management Information over a 3 month period in order to ensure that staff are aware of their overall average performance. The aim eventually will be to provide a mix of both operational and clinical performance measures.

- A third version of the monitoring tool in now in use and the scheme is ready to roll out Trust wide within the next two weeks.

Rest Breaks

As per summary in Section 1.2

Dispatch Project Progress

Reducing Red Call Volume

- This project is designed to align LAS 'Red' calls with DH Category 'A' calls as far as is clinically safe. Following this, to align LAS 'Amber' calls with DH Category 'B' calls as far as is clinically safe. A second strand of the project is to influence the DH categorisation of calls into Categories A, B and C.
- The 'reduce red call volume' (release 1) project has now been completed with a further 5 determinants being downgraded from LAS Red to Amber. In total, since commencing this work in July, 38 determinants have been downgraded. Using 2004/5 call volumes, this equates to 13,356 calls per annum which will now receive an amber rather than a red response. This is equal to 4.0% of red call volume over that same period (1.8% of total call volume) and significantly narrows the gap between LAS and DH categorisation.

- The DH work strand is ongoing and on track with meetings chaired by the Chief Executive.

Increased Dispatch Capacity

- This project involves doubling despatch capacity by doubling the number of available dispatchers in EOC and doubling the number of sector desks to 14. This requires changes in technology together with the promotion and training of additional despatch staff in the control room.

- This project has now delivered. The functionality to split sector desks has now been extended to the South and East desks. Analysis of performance since the splitting of the West desk has shown a 5% performance improvement on A8 calls. The West desk has however only been split about for about 50% of the available time to date. Skill mix issues continue to limit the times when the desks can be operated in the new configuration. This situation will improve progressively over the next few weeks and we still aim to be operating in the new configuration across all despatch desks by mid February.

Improved Dispatch of FRUs

- The key objective here is to develop and introduce a system where FRU's (Fast Response Units) are automatically dispatched, once an appropriate Chief Complaint is applied. The system will only despatch vehicles to calls within a limited geographical area and will also check to see whether an ambulance is nearer so reducing the numbers of unnecessary multiple dispatches. This will improve both the activation times for FRUs and also the overall utilisation. Careful attention is being paid to the safety aspects of this process and the system will not be used to despatch any call where there is any indication of a crew safety issue

- This project was fully rolled out in December. Early indications are that the automated method of dispatch gives an additional 14% Cat A performance over and above that attained by manual dispatch. Further extensive work is underway to optimise the benefits associated with auto despatch and this is focussed around progressively increasing the volume of FRU calls receiving an automated despatch from the current level of 37% to circa 60%.

EOC/UOC Restructuring

- The purpose of this project is to define and implement a new senior management tier covering both EOC and UOC ahead of a full restructure in the next financial year.

- This project is currently running behind schedule but a revised project plan has been submitted to ensure delivery by year end. Formal consultation with affected staff is expected to start imminently.

Improve Urgent Performance

- The objective of this project is to increase Urgent calls performance to 95%. The process redesign work to bring about this improvement has been completed, but the anticipated performance gains have yet to be fully realised. This is due in part to reduced ambulance cover during October and November associated with overtime reduction and in part due to patchy compliance with the new operating regime in EOC and UOC.

- Compliance with the new procedures within UOC and EOC will now be monitored at ADO level to ensure that the benefits realisation targets are achieved.

1.9 International Travel

We have received two further requests for speakers to give presentations on the service's response to the terrorist incidents of 7th July 2005.

The first is .a request from the Swiss Medical Rescue Commission (SMEDREC), to send a speaker to Switzerland from 12th to 15th April 2007 to give a presentation on the events of the 7th of July 2005. The Swiss Emergency Medicine Symposium is attended by approximately 400 medical professionals who wish to gain some knowledge of how the LAS dealt with this terrorist event. SMEDREC has confirmed that they will meet the full cost of flights and accommodation. It is proposed that Steve Sale represents the Service at this event.

The second is a request for a speaker to attend a joint UK/USA Fire Services Symposium in Illinois from 27th February to 3rd March 2007. All costs for travel and accommodation will be met by the conference sponsors. It is proposed that Bob Fellows attend this event to represent the service.

The Board is asked to approve these two requests for international travel.

2. PATIENT TRANSPORT SERVICE

Commercial

Bids have been submitted for Camden PCT (existing) and Homerton (new). Results are expected in early February.

Tenders are also underway for existing business with QEH, Hillingdon Hospital and SWL MHS.

New business tenders are currently under review for North Middlesex University Hospital and Darrenth Valley Hospital.

HR

Rest breaks have been introduced as part of the Trust-wide role-out since Dec11, 2006.

Following the loss of the Chase Farm contract in November 2005, most of the staff were retained to specifically carry out PTS suitable journeys for UOC. The decision has been taken to upgrade the skills of these 17 staff. 15 have now been placed on an A&E Support course which commences on 29 January 2007 with the remainder being planned onto a course in early February.

The LAS is taking the opportunity to offer PTS staff to gain a NVQ2 qualification. Other than a 1 day induction course the majority of the evidence required will be achieved through observation by trainers from GAP Training. There is government funding for this and will have no direct costs with indirect costs being limited to a limited number of staff being off the road for the induction course and loss of seat capacity when the observers ride out with the relevant staff. This will be advertised in the RIB in early February.

Performance

Arrival Time and Time on Vehicle have reached a plateau at 88% (% of patients arriving +/- 45 minutes) and 89% (Time on vehicle > 1 hour) respectively. PTS management are continuing to improving local cluster planning to improve performance.

A&E workload completed by PTS dropped to 303 in Dec which was disappointing. However, the valuable resource provided by PTS on the various Alternative Response Vehicles over the holiday period is not yet reflected in these numbers.

Cost per journey continues to be too high. More joint working with A&E will assist in improving productivity.

3. Information Management & Technology

1: Support for High Impact Changes

As part of the Director of Operations High Impact Change Programme there have been two IM&T deliveries worthy of specific noting:

F.R.E.D. Fast REsponse unit Dispatch

The automatic dispatch of Fast Response Units was implemented by the IM&T CTAK team on 30 November 2006. This functionality, known affectionately as F.R.E.D. automatically dispatches FRUs that are mobile and operating within defined parameters. The testing, initial implementation and trialling all went well with minimal inconvenience to EOC users. Current results are very encouraging and are positively contributing towards response time targets.

Individual Performance Monitoring

A new individual web based performance system has been on trial since 6th November in A&E operations. This has proved very successful and it is currently being rolled out to all complexes. Using a combination of information from ProMis (resource allocation database) and the MI performance database, the system developed by Management Information will now give A&E operations the opportunity to look at various performance measures for each member of staff on their station. These measures will include Category A and B performance, job cycle time and times at hospital. Work is currently underway to provide a similar facility for EOC & UOC.

2: IM&T Staff relocation

Historically IM&T staff were distributed across several floors and different offices at Waterloo, Loman Street, Bow, sector offices other temporary local rented offices. This was both inefficient and difficult in terms of providing a coordinated approach to service provision and support. In order to improve the situation a plan was agreed to bring all IM&T functions into two main locations (a single location was not possible).

The first stage was completed during the Summer last year with the move of all of Management Information to the second floor at Bow. The area was specifically designed for the use of MI and includes specialist storage facilities. The second stage was to convert the first floor of Fielden House (by London Bridge Station) for use by IM&T project staff. The work was completed on schedule and staff relocated over the weekend of 16 December. The final stage was the completion of the third floor at Fielden House and the Service Desk and all technical support staff moved in over the weekend of 13 January.

This now completes the re-organisation of IM&T, providing appropriate facilities for the future provision and support of all IM&T services.

3: Failure of Office Automation System – 18 December 2006

At approximately 09:10 on the 18 December 2006 it became apparent that there was a significant problem with the Trust-wide Office Automation System. For the majority of users this prohibited access to network services such as diaries and e-mail. Personal computers could continue working as stand alone devices. 999 call handling and emergency operations were not affected.

The problem was caused by the failure of a disk drive on the central server. In normal circumstances, the system would switch to a back up disk, however this had also failed. IM&T support staff worked through the morning trying a variety of options to quickly restore the system. However, by approximately mid-day it became apparent that none of these approaches would work. Therefore a more fundamental approach had to be adopted to create a new replacement disk. This involved restoring data from the previous day's tape back-up, and then applying changes made that day from a system log file. Given the quantities of data involved, this was a time consuming process. Service was incrementally restored to customers during the late afternoon

and full service was finally restored by 20:00hrs, with no loss of data (that is the system then appeared as it was at 09:10 that morning).

During the day, The IM&T Service Desk undertook a process of informing customers by telephone, tannoy and personal visits of progress with the problem resolution. However, given that it was the Trust's main non-emergency messaging system that had failed, this process was difficult. It is fair to say that some customers may not have been wholly satisfied with this process and consideration is being given to what else could be done in the future.

Equivalent servers are in place at the Trust Disaster Recovery (DR) Fall Back Centre, but the original design did not implement automatic replication of data across the wide area network link. Service was not switched to the DR system at Bow because it was believed that it would take longer to collect backup tapes from the offsite store, take them to Bow and carry out a restore, than was estimated to recover the live system.

The system was implemented some three years ago and reliance on its facilities has continually increased. While it would be incorrect to class this system as 'mission critical', it is evident that its loss does have considerable impact upon the non operational parts of the Trust. In order to reduce the risk of further failures, a fundamental review has been undertaken of the systems configuration. Appropriate hardware upgrades (to further reduce the impact of a hardware failure) have been included within next year's budget planning process.

<u>CTAK performance.</u>

Historically the performance of the CTAK (Computer Aided despatch system) has been based upon perception. This year the SMG set the target for overall availability of 98% as a yearly average, with the last 3 months of the year (Jan, Feb, March 2007) each achieving 99.5% availability (These targets are shown on the graphs by the blue line).

Graph 1 CTAK Uptime (Unplanned outages) and graph 2, CTAK Uptime (Planned & unplanned outages) are derived directly from the CTAK database and map availability against the two different types of outages. The graphs show;

- The August performance problem that was caused by an upgrade to MDT's.
- Downtime caused by planned outages where the system is taken off line for planned maintenance and upgrade work. A high proportion of this has been the implementation of changes to support work on the high impact changes required to support operational performance.

Graph 3, CTAK incidents (d, b records/month) demonstrates the volume of data being recorded and managed by CTAK.

Graph 4 CAD overall service uptime (all outages) builds upon graph 1& 2, but includes any other significant failures that would effect the overall CTAK environment. For example the performance drop in October relates to a network

problem (caused by an upgrade). So whilst CTAK was technically working, it was unusable. This graph therefore best represents a user perspective of the system.

Several conclusions can be drawn;

- Overall the underlying CTAK database is stable
- There are a significant number of changes taking place to support operational requirements.
- Both of the significant failures (August & October) were as a direct result of technical changes and their unintended consequences.

These reporting graphs will continue to be developed. In particular graph 3 will be amended by the removal of planned outages. This will then be the best representation of performance against the agreed targets.

4. HUMAN RESOURCES

Agenda for Change

Considerable progress on AfC Banding Review requests has been made during December 2006 with all but six post holders now having given their verbal submissions (generally in support of previously submitted written submissions) to a banding Review Panel. The banding reviews, subject to Consistency Checking, together with the remaining six reviews, are scheduled for completion by the end of January 2007.

There will remain an on-going maintenance and housekeeping workstream, particularly in respect of the banding of revised and newly introduced roles.

The work of completing arrears payments continues to take a high priority, with dedicated Payroll resource working exclusively on this. Around 70 staff are still awaiting their arrears payment which will be completed within the current financial year.

Electronic Staff Record

The implementation project of ESR has now been completed and formally closed. Work streams have been created however to continue the work to realise the benefits from ESR. This work will be progressed through the Process and Governance Programme stream of the Service Improvement Programme.

Policy Development

The following HR policies/management guidelines documents have been developed / updated in recent months:

- Maternity Policy
- Grievance Policy
- Establishment Control guidelines

- Rest Break Policy
- Responsibilities to inform the Health Professions Council.

Workforce information

Since the implementation of ESR in October 2006, staff continue to work through problems identified with the ESR reporting tool in order to begin to provide regular accurate workforce information.

The graphs provided show current turnover (from ESR) and historical sickness absence from the Trust's legacy system.

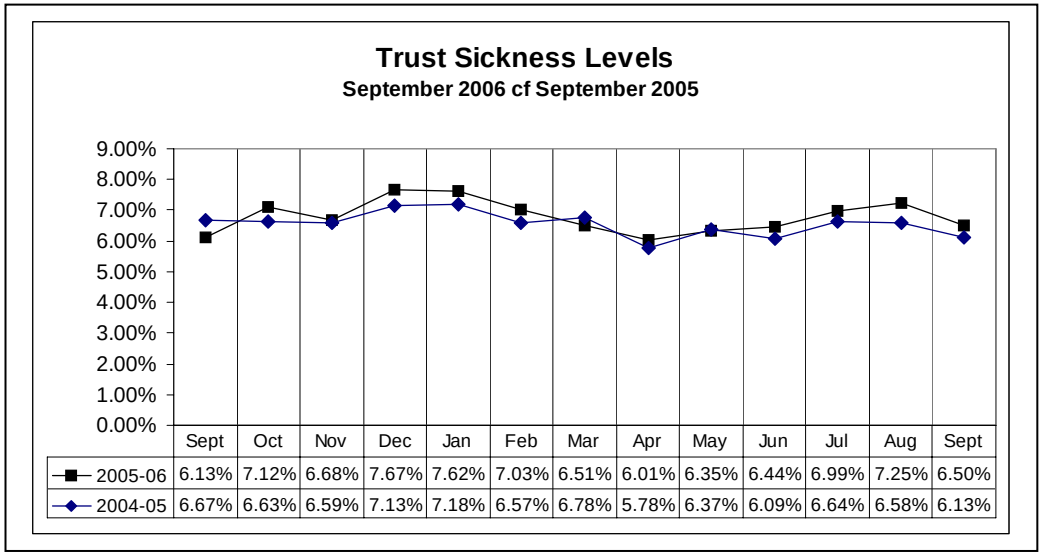
Variation in turnover data reported from ESR is likely to be due to the extensive data cleansing as part of the ESR implementation project.

Reporting on sickness absence will be in line with the national ESR reporting formula in that it measures and calculates absence on the basis of days lost as opposed to the historic LAS model of hours lost. Whilst this has been raised with the national team, as we believe it is not as accurate a measurement, we are not aware of any intentions to change this in the foreseeable future. This formula is the basis against which all NHS Trusts will be compared. Whilst the sickness absence report is still being fully validated, current indications are demonstrating a Trust absence rate of 5.9% using the ESR reporting formula.

It is intended that a fully validated workforce report including sickness absence and workforce numbers will be presented to the Trust Board in March which will serve both as a year end report and benchmark for future monitoring.

WORKFORCE INFORMATION

Sept 06 Absence	
Staff Group	**%**
A & E	6.83%
EOC (Watch Staff)	8.59%
PTS	5.34%
A & C	4.48%
SMP	2.05%
Fleet	4.78%
Total (Trust)	**6.50%**



SUSPENSIONS as 19.01.07		Date of Suspension	Reason	Stage in Investigation	Investigating Officer	Hearing Date
East	2	17.01.07 on return from sickness	Patient care	Complete	Paul Ward	Postponed due to sickness – new date 31.01.07
		27.11.06	Patient Care	Complete	Paul Ward	As above
South	1	20.09.06	Breach of confidentiality.	Complete	Adam Crosby	Postponed due to staff sickness. New date 24.01.07
West	5	24.07.06	Complaints regarding behaviour and patient care.	Investigation almost complete – next steps being considered.	Roger Fox	08.02.07
		27.06.06	Interviewed under caution for handling NHS equipment.	Police not proceeding. LAS to interview 26.01.07.	John Huggins.	
		04.10.06	Allegations of abusive behaviour	All interviews conducted, statements typed and issued, report to be drafted.	Colin Pasey	16.02.07
		05.10.06	Allegations of abusive behaviour.	As above.	Colin Pasey	16.02.07
		22.10.06	Allegation of illegal drug use.	Investigation almost complete.	Paul Gibson	Expected Feb.
EOC	0					
HQ/Fleet/Others	0					

Pre ESR for comparison

Staff Turnover Nov 05 – Oct 06	
Staff Group	**Turnover %**
A & C	8.46%
A & E	4.20%
CTA	0%
Bank Staff	0%
EOC Watch Staff	9.57%
Fleet	3.39%
PTS	8.87%
Resource Staff	2.08%
SMP	6.52%
Total (Trust Turnover)	**5.22%**

Post-ESR Statistics

Staff Turnover Nov 05 – Oct 06	
Staff Group	**Turnover %**
A & C	8.13%
A & E	4.17%
CTA	0.00%
Bank Staff	0.00%
EOC Watch Staff	9.32%
Fleet	3.39%
PTS	8.58%
Resource Staff	2.00%
SMP	6.46%
Total (Trust Turnover)	**5.15%**

Staff Turnover Dec 05 – Nov 06	
Staff Group	**Turnover %**
A & C	9.29%
A & E	4.24%
CTA	0.00%
Bank Staff	0.00%
EOC Watch Staff	10.46%
Fleet	3.17%
PTS	8.39%
Resource Staff	1.96%
SMP	5.60%
Total	**5.24%**

Staff Turnover Jan 06 – Dec 06	
Staff Group	**Turnover %**
A & C	10.59%
A & E	4.59%
CTA	0.00%
Bank Staff	0.00%
EOC Watch Staff	10.82%
Fleet	4.84%
PTS	8.19%
Resource Staff	1.96%
SMP	5.93%
Total	**5.60%**

5. COMMUNICATIONS

Media issues

The Service has received a large amount of media attention on a number of issues over the last couple of months.

Sat nav takes crew to Manchester: At the beginning of December, the national media picked up on the issue of a crew who were misdirected by the faulty mapping information on the satellite navigation system and ended up on the outskirts of Manchester while carrying out the transfer of a patient to a hospital in Brentwood. The story was covered by all but one of the national newspapers, and was also featured in publications in other parts of the world.

Service pressures and alcohol-related calls:

Licensing laws: In late November, the Service issued a proactive statement explaining that alcohol-related incidents had continued to increase despite the introduction of new licensing laws the year before. Interviews followed with LBC radio, BBC London and Tonight with Trevor McDonald where staff took the opportunity to encourage the public to take responsibility for how much they drink and use the ambulance service wisely. Further coverage was achieved in regional and national newspapers (London Lite, Daily Express, Daily Mail, The Independent, The Guardian and the Daily Mirror).

Christmas period: Before the busy Christmas and New Year period, the Communications Department once again worked to generate public messa arour demand caused by alcohol-related calls and the need to use the Service appr iately.

Proactive promotion of messages ahead of the traditional office party night (iday 15 December) and the following Thursday when a mobile treatment centre was set up in the City of London led to significant media attention.

Pre and post office party night coverage was achieved in all key London media (Evening Standard, London Tonight, BBC London - TV, radio and online - Capital and LBC radio. All media ran with messages about how busy the Service would be/was, with many relating the increase in calls to alcohol. Four live interviews with London Tonight, BBC London TV and Radio, and LBC were effective in conveying the messages that it was unacceptable for people to get so drunk that the ambulance service and broader NHS became responsible for their care, and that people should only call 999 for emergencies. On the Monday afterwards the Evening Standard carried this issue as its front page story, with the headline ‘Binge drinking at record high’ and a strap-line ‘Christmas party alarm as 999 calls hit three every minute’. It is estimated that the Service’s messages reached around 15 million people through all of this coverage.

Early the following week, the London Paper – with a readership of one million - published a double-page spread after a reporter spent a Saturday night shift on the Waterloo ‘Booze Bus’. Further opportunities for conveying Service messages came pre and post the running of the mobile treatment centre on 21 December in the City.

As well as London media, this story was picked up by national newspapers including the Daily Mail and The Times. An estimated 19 million people heard or read about this initiative.

New Year: The turn of the year was also busy, with further interviews carried out on BBC News 24 (with an audience of two million), and a ride-out by a Sky News film crew for a firsthand look at demand on the Service's busiest night of the year – this was broadcast through the next morning to an audience of two million. A statement was issued early on New Year's Day to the Press Association highlighting that the previous night had been the busiest since the Millennium – and this angle was picked up by national press (Daily Mail, Daily Mirror, The Sun, The Times, The Guardian, The Independent, The Telegraph) as well as regional press (Metro) and local radio (LBC and Capital radio). The fact that the Service dealt with 1,562 calls (up eight per cent on last year) with over 450 an hour between 2 and 3 am, most of the alcohol-related, was picked up by most media. Messages about the Service's workload over New Year reached an estimated 26 million readers/viewers/listeners across the country.

Rest breaks: In the last few weeks, much of the media focus on the Service has turned to the issue of rest breaks; specifically the deaths of two patients in the Edmonton and Tottenham areas while local ambulance crews were on breaks. On both occasions, staff in cars and ambulances reached the scenes within the Government target times. In its response, the Service has stressed that it is right for hard-working crews to be given a break during long shifts so they can provide a clinically safe service, and everything will be done to ensure these needs are balanced with those of demand on the 999 service.
Coverage of these issues appeared in local newspapers (a front page story in the Enfield Independent), the Evening Standard and London Lite, with additional coverage on regional television and radio stations. The Sunday Express also ran a front page story about incidents involving both the Service and the North East Ambulance Service.

Frequent callers: Following an FOI request to the PALS team about how the Service deals with frequent callers, the Evening Standard published an article about the cost these patients incur for the organisation and highlighted examples of cases where the Service has intervened to ensure patients with complex healthcare needs are better cared for by other parts of the NHS. At the same time an edition of Talk Back, the Service's issues-based newsletter, was published explaining what was being done to address the problems relating to regular 999 callers.

Other stories: Other media coverage that focused on the Service included the assault of a crew who attended a murder victim near Heathrow at the end of November, a tornado in west London following which one person needed hospital treatment in early December, and the freeing of a prisoner by two armed men after he arrived in an ambulance at Hammersmith Hospital.

The Service has also featured in new episodes of the BBC1 City Hospital programme.

Local news stories: Locally, the reunion of a crew and a cardiac arrest patient and his family made the front page of an Islington paper. The same paper also covered the

death of a teenage asthmatic patient; the media statement issued by the Service emphasised that the staff involved did all they could to save the boy's life.

Strategic review of the intranet – *the pulse*: The Communications department has led on a strategic review of the Service's intranet, the *pulse*, to ensure that it is still meeting staff's needs and to inform any future changes to the content, structure and style of the site. The team worked with Precedent, a specialist digital communications agency, to consult a cross-section of Service staff through an online and telephone survey, ten high-level strategic interviews with senior managers and finally, an interactive workshop. The findings and recommendations emerging from this work have been presented to the Senior Manager Group and resources permitting, a first phase of improvements will be made to key elements including the directory of staff contact details and the search facility.

Awards Manager

This Trust Board meeting is the last before the retirement of awards manager Trevor Vaughan after 42 years service with the LAS. It is important to place on record our deep appreciation of the loyalty and commitment shown by Trevor throughout his career which began 'on the road', continued in CAC (now EOC) and has ended in the awards department which he set up and has run for the past five years. Much of his role has been about introducing ways of recognising staff achievement and many of the events he introduced, including passing out ceremonies for new recruits and regular long service and retirement evenings, are now embedded in the Service calendar. We all wish him well and hope he enjoys a well-deserved, long and happy retirement.

Patient and Public Involvement

Recent Patient & Public Involvement (PPI) initiatives across London have included:

- Four members of staff took part in the Junior Citizens Scheme in Croydon. 60 schools (more than 3,000 children) participated in the event over a 6-week period.
- Staff from the Cycle Response Unit worked with Whitechapel Safer Neighbourhood Team, talking with children in the local community and mending their bikes for them, at Bike Safety Day.
- The LAS took part in a multi-agency event for Anti Knife Crime Week at Woodside High School, Edmonton.
- Staff at Barnehurst and from the Community Resuscitation Training team took part in three Bexley Crime and Safety Awareness days, talking about the LAS and teaching children what they should do if they find someone who has collapsed.
- Patients were recorded for a DVD, which was shown at the launch of the Access Programme of SIP 2012, telling their stories about accessing the LAS.

There is continuing concern that the current restrictions on overtime are having a detrimental effect on the Service's ability to participate in PPI events and activities.

Steph Adams, Ambulance Operations Manager (AOM) at Barnehurst, attended the Patients' Forum meeting at Queen Mary's Hospital, Sidcup, to talk about LAS developments, particularly around stroke care. Forum members were impressed with the LAS and were interested in initiatives such as the Alternative Response Vehicle and treatment for cardiac patients.

At the December Patients' Forum meeting, the PPI Manager presented plans for the planned joint project with the NHS Centre for Involvement. This project will focus on the Bangladeshi community in Tower Hamlets, and is likely to include activities around health promotion, access to NHS services, recruitment and relationships between the community and local LAS staff. Other agencies, including Tower Hamlets PCT and the Royal London Hospital, are involved in this project.

At the January Patients' Forum meeting there was a focus on joint work between the LAS and King's College Hospital, particularly around stroke and cardiac care.

Forthcoming events include a health promotion day in Blackfriars, a large multi-agency event in Ealing (in February) focusing on CHD, and a proposed project with young people in the Waterloo area, involving the cycle response unit.

The Public Education Strategy is being taken forward, initially with a workshop event (planned for February) involving all public education staff.

Two new members of staff have joined the team. Abbey Richardson has started a nine-month placement as PPI Project Manager and - amongst other things - will lead on the development of the Patient Care Conference 2007 and the Tower Hamlets project. John O'Keefe, previously a paramedic at Rotherhithe, has been appointed as PALS Officer.

The December PPI Committee meeting focused on current projects, and had a detailed discussion about the other aspect of the project with the NHS Centre for Involvement, which is to carry out a baseline assessment of PPI in the LAS.

The PPI Manager is trying to meet with each of the AOMs, to support them in the development of PPI plans for their complex. She is also encouraging them to make contact with their local Overview and Scrutiny Committees, in preparation for the new PPI arrangements (Local Involvement Networks) when they come into force.

6. Overseas Travel

Three senior managers are undertaking a visit to Cairo between February 2nd and 5th 2007. This follows the signing of a memorandum of understanding by LAS with the Egyptian Health Minister for assistance with developing their pre-hospital care capability. Director of Operations Martin Flaherty has asked Dave Whitmore, Ralph Morris and Steve Irving to undertake a scoping visit with all costs being met by the hosts.

Peter Bradley CBE
CHIEF EXECUTIVE OFFICER
21 January 2007

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th JANUARY 2007

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

Of the three Serious Untoward Incidents of a clinical nature, investigations are complete in two. The final report is on the agenda in one of these, the other is in final draft. A further investigation is underway where a patient who was assessed by an LAS crew, but not conveyed, subsequently suffered a cardiac arrest and died.

Safety Alert Broadcasting System:

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

Seventeen alerts were received during the period of 14th November 2006 – 15th January 2007. In total the trust has seven alerts outstanding as follows:

1) NPSA/2005/10: Being Open when Patients are Harmed

The policy is on the current agenda for noting.

2) MDA/2005/069: Blood Pressure Monitors and Sphygmomanometers

This alert continues to be actioned by the Corporate Logistics Manager. Sphygmomanometers will be now be replaced on an annual basis. A bulletin outlining this to staff is in the process of being drafted.

3) DH (2006) 08: Waste Compactor

This alert was circulated on 19.10.2006. The Trust has a waste compactor at HQ. The Trust's Health and Safety Quality Assurance Co-ordinator undertook a risk assessment on 10.11.2006. Feedback is awaited to confirm that all actions outlined in the alert have been complied with.

4) DH (2006) 09: Electrical Distribution Switchgear, 160A and 2002/250A FCS Switches/Fuse Switches

This alert is being actioned by the Head of Estates. Currently awaiting feedback on progress to date.

5) MDA/2007/003: Ferno Falcon Six and Hawk Six Ambulance Stretcher Trolleys

This alert was received on 15th January 2006 and relates to a weld failure of the above stretcher trolleys. It is outlined in the alert that customer advice notices have been previously issued. This alert has been forwarded to both the Head of Operational Support and Head of Fleet to confirm if further action is necessary.

6) DH (2007) 01: Mandatory Reporting of Defects and Failures and Disseminating DH Estates and Facilities Alerts

Details of this alert have been forwarded to the Head of Estates. Awaiting feedback to confirm if the Trust needs to take further action to comply with the actions outlined in the alert.

7) NPSA/2007/015: Colour Coding Hospital Cleaning Materials and Equipment

This alert relates to the standardisation of colour coding for cleaning materials in NHS organisations, including the colour codes of mops and buckets used for the cleaning of specific areas. It has been confirmed that the trust has a colour code in place but this is not in line with the NPSA recommendations. This alert will be raised and discussed at the forthcoming Infection Control Steering Group meeting in February 2007.

2. Second domain – Clinical and Cost Effectiveness

National Clinical Practice Guidelines for Use in UK Ambulance Services

Version 2006 was distributed to members of the Department of Education and Development in December and issued to crew staff from 8th January. Copies of the pocket book are available but insufficient numbers were printed in the initial run. We anticipate having adequate numbers for distribution by mid February

The new Consent and Recognition of Life Extinct (ROLE) procedures are now in place, along with the associated documentation.

Update on Cardiac Care

The Clinical Audit and Research Unit published the LAS survival figures for out of hospital cardiac arrests for 2005/06 on 22nd January. Survival to hospital discharge as calculated from the Utstein template has increased to **10.9%.** This constitutes a further significant improvement and does not include the period following the

introduction of the 2005 Resuscitation Council Guidelines. The overall cardiac arrest survival (which includes all patients who suffer a cardiac arrest of presumed cardiac origin on whom resuscitation has been attempted) has also increased from 4.3% to 5.3%.

The report includes the figures for ST elevation myocardial infarction for 2005/06. A total of 716 such cases were recorded. 239 (33%) were conveyed to cardiac catheterisation laboratories of whom 120 are known to have received primary angioplasty. 130 patients received thrombolysis during this period. We still await outcome data from both the Myocardial Infarction National Audit programme (MINAP) and the National Infarct Angioplasty Project (NIAP) for this period.

Update on Stroke

The RAPIDS (Rapid Ambulance Protocol for the Identification of Stroke) project, where patients with a positive FAST (Face, arm, speech test) are admitted directly to the 'Brain Attack' Unit at the National Hospital for Neurology and Neurosurgery will go live on 29th January. The Unit has arranged to ring fence a bed and to ensure that a senior clinician is available from 07:00 to 19:00 hrs, 5 days a week. Currently only patients diagnosed by crews from Islington Complex are eligible for direct admission.

We have had a very positive meeting with the Clinical Director of Neurology at St Thomas' Hospital where thrombolysis is considered for any FAST positive patient presenting in the Emergency Department within two and a half hours of onset of symptoms, regardless of whether they are within the catchment area of the hospital or not. Patients presenting from within the local catchment area are also considered for thrombolysis at King's College Hospital Emergency Department.

Other clinical issues of interest

An updated Patient Report Form will be available from March. The major change to note is the replacement of the pink (second) copy with a further white copy to assist those Emergency Departments who are moving to a paperless system and scanning their documents. A box has also been included to enable crews to document the absence of heart sounds, to ensure compliance with the ROLE procedure.

Drugs now available to EMTs (naloxone and hydrocortisone) will be moved from the paramedic bag to the Technician bag by May, freeing up space to allow the inclusion of chlorphenamine (piriton) for paramedics.

We are planning to introduce an oral solution of morphine later this year and to introduce drug stickers, similar to those in routine use in hospitals, initially for use with morphine.

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

A summary of the audit into AMPDS calls categorised by the LAS as Red, over and above those required by the Department of Health is included in Appendix 1. This

includes the criteria used to decide whether a determinant could be safely downgraded. It is hoped that these criteria might be considered by the national Emergency Call Prioritisation Advisory Group (ECPAG) in their ongoing audit of determinants.

In all a total of 5 out of 15 determinants were judged suitable for downgrading from Red to Amber. This, in addition to previous work, has now reduced the overall Red call volume by 4%.

3. Third Domain – Governance

Updates on risk management are covered elsewhere on the agenda.

4. Fourth Domain – Patient Focus

This area is covered in the Report of the Chief Executive

5. Fifth Domain – Accessible and Responsive Care

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

6. Sixth Domain – Care Environment and Amenities

Infection Control

An LAS Infection Control Workshop was held on 10th January attended by members of the Infection Control Steering Group and supported by managers from the DH MRSA and Cleaner Hospitals Team. A self assessment tool applied to our procedures demonstrated 55% compliance and highlighted 7 key challenges. These require urgent work around the implementation of our audit findings, education of staff, best practice design for healthcare environments and cleaning services, and decontamination of reusable medical devices. The risk of infection through insertion and care of peripheral venous access lines was also highlighted.

An action plan to address these areas will be submitted with the Infection Control Annual Report in February and the DH team have offered long term support and advice to assist in implementing this work.

In recognition of the importance of raising the profile of patient safety in general and infection control in particular a business case is being developed to employ a full time Infection Control Co-ordinator.

7. Seventh Domain – Public Health

Pandemic Flu

The Guidelines for Ambulance Services in the event of Pandemic Flu are now being circulated for consultation. An area of particular interest is the development of telephone triage to reduce demand on both primary care and ambulance services. The LAS is involved in developing a face to face assessment tool to enable ambulance staff to decide on the basis of the patient's physiological parameters, their degree of social support and ability to undertake activities of daily living, if they can be managed in the community. This has the potential advantage of incorporating a scoring system which could be linked to the escalating demand on primary and secondary care.

Recommendation

THAT the Board notes the report.

Fionna Moore
Medical Director
19th January 2007

Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board

A summary of the RED call clinical audit report (December 2006)

Author: Dr. Rachael Donohoe & Gurkamal Virdi

Introduction

Earlier this year, the London Ambulance Service NHS Trust (LAS) began a review of the locally upgraded RED calls[1] to explore the possibility of aligning the LAS's call categorisation with the Department of Health's (DH) categorisation. As part of this review, fifteen determinants relating to allergic reactions, back pain, breathing problems, burns, cardiac/ respiratory arrest or death, choking, convulsions, heart problems, stroke and traffic accidents were audited. The aim of this clinical audit was to provide evidence to inform decisions about the clinical safety of downgrading the selected determinants to an AMBER response.

Method

The clinical audit compared the determinant codes and categorisation of the 999 call with information from the Patient Report Form about the patient's condition and survival status. Further information about patient outcomes was derived from the National Strategic Tracing Service. A set of criteria were established by the Medical Director, Assistant Director of Urgent Care & Clinical Development, Head of Clinical Audit & Research and Clinical Audit Co-ordinator, for use in recommending whether or not an audited determinant could be safely downgraded. All criteria needed to be met within the set parameters for a determinant to be recommended for re-categorisation (see Table 1).

Summary of results

Table 1 presents a summary of the results. Five determinants met all of the criteria and were therefore identified as suitable for downgrading to an AMBER response:

- 2B1: Allergic reactions – status of patient unknown
- 5D1: Back pain – not alert

[1] those determinants that are provided a Category A response by the LAS but the DH only require a Category B response

- 6D3: Breathing problems – clammy
- 11D2: Choking – abnormal breathing
- 12B1: Convulsions/ fitting – breathing regularly not verified (under 35 years old).

The remaining 10 determinants did not meet the criteria largely due to the presence of a high number of time critical factors. It is recommended that the remaining 10 determinants continue to receive a RED response and that the evidence produced for these determinants are submitted to the DH for consideration in the national programme of work.

Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD DATE 30 January 2007

CAD 2010 Outline Business Case (Trust Board part 1)

1. Sponsoring Executive Director: Peter Bradley
Sponsoring Director Peter Suter

2. Purpose: For noting

3. Summary

On 22 February 2005 the Service Development Committee (SDC) approved a paper entitled "CAD – The Way Forward". This provided the starting point for a formal project to replace the existing LAS Computer Aided Despatch system.

The result of initial analysis was a business options report that was presented to, and approved by, the Trust Board in November 2005. It identified that the best way forward was by some form of commercial procurement. It was also agreed that the project should proceed on the assumption that there would need to be approval by the Strategic Health Authority (SHA), who require completion of the following three stage business case process:

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

The production and approval of these business cases are inter-linked to a formal procurement process. Ultimately the FBC will define a specific solution and set out the case for the award of contract(s) with named supplier(s) at a defined cost.

The SOC was agreed by the Trust Board in July 2006 and has been passed to the SHA for approval. Work on the Outline Business Case (OBC) has been completed and it is ready to be presented to the SHA. Once approved, a formal procurement process will commence with appropriately placed adverts. Given that the details within the OBC are commercially sensitive, it will be presented to the Trust Board in part 2 of the meeting in order to seek agreement to forward it to the SHA.

4. Recommendation

THAT the Board note the progress of the project to date.

Enclosure 7

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th January 2007

Strategic Plan 2006/07-2012/13

1. **Sponsoring Executive Director**: Peter Bradley
   Sponsoring Director: Kathy Jones

2. **Purpose:** For approval

3. **Summary**

The Strategic Plan 2006-07 was initially reviewed by the Service Development Committee following which additional work was undertaken, in particular workforce planning. Revisions have been made based on this work, further definition of the implementation programme and feedback from Board Members.

The revised draft has been approved by the Senior Management Group and is now enclosed for formal endorsement by the Trust Board. It articulates the long-term direction of the LAS, provides a framework for the service improvement programme (Service Improvement Plan 2012) and annual Service Plans and Budgets over the period.

It is intended that this Plan will be published on the web rather than in hardcopy form and it has been written with this in mind. Consequently it is not assumed that the content will be read in a sequential way but rather interrogated according to the interests of the reader. This necessitates some repetition so that each section is intelligible without the pre-requisite of having read earlier sections. Additionally it is envisaged that hyper-links will take readers from one part of the Plan to another, these are identified in *underlined italics* in the text.

The strategic choice of direction will remain relatively constant over the period of the plan but recognises that the tactical plans to realise the ambition will of necessity need to be flexible to respond to internal developments and external drivers for change. So as to be a living Plan the website will be updated on an ongoing basis to ensure that the content is continually refreshed and up to date. Additionally a short hardcopy document outlining the direction of the Trust to accompany the website will be produced.

4. **Recommendation**

THAT the Trust Board approve the Strategic Plan 2006/07-2012/13

Agenda item 13

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th January 2006

Managing Attendance Policy

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For approval

3. Summary

The attached paper has been produced with the aim of providing the Trust with an improved policy for managing employee attendance issues.

It replaces the 'Irregular Attenders' Procedure' which is predominantly concerned with short-term absence and the management guidance on the 'Process of Managing Long Term Absence' and is aimed at providing a joined-up approach for dealing with these types of absences. Other matters addressed in the document include:

- A statement on the responsibilities of managers and staff;
- Particular considerations for disabled staff, and;
- Advice on occupational health referrals.

The Policy is intended to ensure a consistent approach to addressing employee absence whilst recognising the need to evaluate different situations and act accordingly.

Extensive consultation has taken place with management at all levels (including the Senior Management Group, Human Resources and specialists such as Occupational Health.

The Policy takes account of current legal requirements and recognised good practice guidance such as that provided through Advisory, Conciliation and Arbitration Service (ACAS).

The Trade Unions have also been consulted on the Policy and approved its content at the Staff Council on 12 January 2007.

4. Recommendation

THAT the Trust Board approve the policy for implementation with associated training.

Enclosure 10

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th January 2007

COMPLAINTS POLICY
SERIOUS UNTOWARD INCIDENT POLICY
HABITUAL OR VEXATIOUS COMPLAINANTS POLICY

1. Sponsoring Executive Director: Peter Bradley

2. Purpose:

The following policies are presented to the Board for consideration:

1. Complaints Policy for Approval
2. Serious Untoward Incident Policy for Noting
3. Habitual or Vexatious Complainants Policy for Noting

3. Summary

Complaints Policy

This Policy ensures that the LAS complies with NHS Complaints Regulations 2004 (amended in 2006); Healthcare Commission Core Standard C14; NHSLA Guidance and National Patient Safety Authority (NPSA) 'Being Open'.

The Policy is supported by a Complaints Procedure and Guidance Notes.

The Policy makes it clear that the LAS operates an Open, Transparent and Fair system of complaints handling, aimed at understanding the cause of the complaint, learning lessons and making changes that result in an improved service to the people of London.

This is a new Policy, produced in response to the Review of the Professional Standards Unit, completed and noted by the Board in May 2006.

Serious Untoward Incident Policy

This revised Policy ensures that the Trust complies with relevant parts of the NHS Complaints Regulation; Healthcare Commission Guidance; NPSA Requirements; NHSLA Requirements and guidance issued by NHS London.

Habitual and Vexatious Complainants Policy

This Policy ensures that the Trust is compliant with the Healthcare Commission's requirements regarding the handling of complaints.

The Policy provides guidance on the identification of such complainants, affording protection to LAS staff whilst providing a fair and consistent process to the individual concerned.

4. Recommendations:

THAT the Trust Board:

1. Approve the Complaints Policy
2. Note the Serious Untoward Incident Policy
3. Note the Habitual or Vexatious Complainants Policy

Agenda item 15

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30 January 2006

'Being Open' Policy

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For approval

3. Summary:

This revised Policy ensures that the Trust complies with National Patient Safety Authority requirements, specifically 'Being Open: Communicating Patient Safety Incidents with Patients and their Carers (NPSA 2005)'.

This Policy has been produced to conform to the above regulations and is consistent with NHSLA policy in respect of admitting and apologising for mistakes.

4. Recommendation

THAT the Trust Board approves the 'Being Open' Policy.

Enclosure 12

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD January 2007

Outline Business cases for Battersea Ambulance Station and Purley Ambulance Station

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary

The attached papers provide summaries of the requirements for new ambulance stations to replace the existing Battersea and Purley sites.

Battersea: the report for Battersea provide details of the problems currently encountered at the site and how these affect performance.

Purley: the attached paper provides a summary of the requirements for a new Ambulance station for the Croydon complex to replace the existing facility at the Purley Hospital.

Both papers include details of the facilities required at the new ambulance stations, the short listed options that the outline business cases process explored and the revenue implications for the preferred options.

When suitable sites have been identified full business cases will be presented to the Trust Board for approval

4. Recommendation

THAT the Trust Board approve:

1. The outline business case for Battersea Ambulance Station
2. The outline business case for Purley Ambulance Station

Enclosure 13

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 19th December 2006 at 10:00 a.m.
Held in the Conference Room, LAS HQ

DRAFT Minutes

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Barry MacDonald	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Roy Griffins	Non Executive Director
In attendance:	Caron Hitchen	Director of Human Resources & Organisation Development
	Fionna Moore	Medical Director (until 1.25)
	Mike Dinan	Director of Finance
	Russell Smith	Deputy Director of Operations (for Martin Flaherty)
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Bob Fellows	Education Developmental Manager
	Bill O Neill	Assistant Director of Organisation Development
	Angie Patton	Head of Communications
Apologies:	Caroline Silver	Non Executive Director
	Martin Flaherty	Director of Operations
	Kathy Jones	Director of Service Development

48/06 Minutes of the last meeting of the Service Development Committee, held on 31st October 2006.

The Chairman **signed** the Minutes as a correct record of the meeting held on 31st October 2006.

As yet there has been no decision announced regarding ambulance trusts being allowed to become foundation trusts.

49/06 Chairman's Update

The Chairman said that it was unfortunate that Lord Warner has announced his imminent retirement as he has been very supportive of the LAS.

Although RAB[2] will not be abolished in the immediate future; its future is under review and changes are expected in 2007/08.

Barry MacDonald said that he had recently read articles in the press concerning the NHS funding formulae which argued that London is under funded and not simply in deficit. The Chairman said that Gill Morgan (Chief Executive of the NHS Confederation) is also of this opinion. At a meeting held at the Kings Fund the

[2] RAB (Resource Accounting Budgeting) is a system of accounting and budgeting that was originally applied to government spending departments, to penalise those who exceed their expenditure budget within an accounting period by removing a corresponding amount from their budget for the following period. This has also been applied to NHS Trust, where it is less appropriate.

Chairman of the Commons Health Select Committee (Kevin Barron) said that he was aware that there were distortions in the NHS funding formulae, and added unprompted that there was an underfunding of ambulance services.

The Chairman said he had met with Bamber Postance and they had spoken about the social enterprise Bamber is seeking to set up in Bromley. The Chairman had informed him that the LAS owned the name 'London Urgent Care Ltd.'.

A meeting of Emergency Care Practitioners (ECPs) was held on 12th December 2006 which was attended by 53 of 60 ECPs. At the beginning of the meeting some ECPs expressed concern as they felt they had been let down by the Senior Management. However by the end of the meeting the majority accepted that Senior Management recognised ECPs concerns and that measures will be put in place to move forward. Another meeting with the ECPs will be held in April 2007.

The Chairman referred to the stories in the media regarding the Electronic Patient Record. He had been upset at the approach adopted by the Radio 4 'Today' programme regarding the issue and had sent an email to James Naughtie (the presenter of the item) expressing his concerns. The stories in the print media (and reinforced by the Today Programme) have raised concerns that people would lose privacy and civil liberties whereas the Ministerial Working Party of which he had been a member had recommended that patients should have an explicit and unchallenged right to withhold personal information from the records if they choose to do so.

The Chairman has suggested to Connecting for Health that the Chairman of Bromley PCT be contacted as she may be interested in her PCT becoming a possible Early Adopter (or pilot site) for the Summary Care Record.

PCTs: the Chairman said that the final announcements regarding appointments of Chairmen will be made by the end of January 2007.

The Chief Executive of the Ambulance Service Association (ASA) is to become the Chief Executive of the Federation of Master Builders. It is expected that in due course the Ambulance Services will form an Ambulance Network within the NHS Confederation.

NHS Direct will be appointing a new Chief Executive as well as a Commercial Director.

50/06 Performance update

Russell Smith (Deputy Director of Operations) updated the Committee on performance. Performance in November was 75.02%; the year to date performance is 74.7%.

Overall demand rose by 2% compared to November last year. There has been a recent increase in Category A demand with 963 a day for the first ten days of December (vs. 854 for November. On 11th December the Service received 1010 Category A calls (40% of overall demand). An analysis is being undertaken to understand the underlying causes behind the rise. Category B demand also rose though there was a decrease in the percentage and actual number of Category C calls.

Staffing: Fast Response Units have been staffed 98% of the time during the year to date and Ambulances have been staffed 90% of the time.

Overtime: as A&E is near full establishment (we will be at full establishment by 31st December) the decision was taken to reduce overtime by two/thirds, from 65,000 hours per month to 22,000 hours per month. Overtime will be further reduced in the

final three months of the year. New staff are working Relief B Rota (entails working 7/10 weekends) and this has largely addressed the problem of weekend staffing that was often problematic for the Service.

Performance Targets: Category A 8 Minute will be achieved; Category A 19 minute will be achieved; Category B will be achieved by the final month of the year, following the successful implementation of the High Impact Changes. Further work is needed to ensure that the fourth target, Doctors' Urgents, is achieved.

Rest breaks for operational staff were introduced on 11th December; this was a significant development for front line crews. There has been a mixed reaction from crews; some have welcomed the development while others are concerned at the loss of income due to the cessation of subsistence payment and overtime payment. Currently the implementation of rest breaks is 60-65% with a target of 80%. It is anticipated that as the Watches in the Control Room become more familiar with the system the level of allotted rest breaks will increase.

The Chief Executive said that the drop in performance during the key shift changes (0700 and 1900) has been exacerbated due to the fact that if crews are not allocated a rest break they finish a half an hour early.

He expressed his thanks to Russell Smith, Caron Hitchen, Mike Dinan and Steve Sale who did an excellent job in ensuring that rest breaks were introduced. He also acknowledged the support of the Trade Unions who had worked with Management in the spirit of the Partnership Agreement to implement rest breaks in line with Agenda for Change.

In response to Sarah Waller's question as to possible causes for the rise in Category A demand the Medical Director said it may be linked to the recent poster campaign raising public awareness of chest pain.

The Chief Executive said that the effective take home pay of staff members is being tracked to ascertain the impact of rest breaks on crews' total pay as a result of Agenda for Change. It is unfortunate that rest breaks could not be introduced at the same time as the rest of Agenda for Change (i.e. at the time of the improvements in basic pay and conditions), as some crews have now come to take those for granted, without realising that real rest breaks are part of the package and that subsistence payments in lieu will in future be rare indeed.

The alignment of the definition of LAS 'Red' calls and DH 'Category A' is being reviewed and where the evidence supports recategorisation this is being progressed internally. Further changes are being proposed to the Department of Health for approval in March 2007. It is likely that 2.5% recategorisation will be achieved by the LAS; the impact of the national recategorisation will be to ultimately reduce the percentage of Category A by circa 17% (from 40% to circa 30%).

Ingrid Prescod asked about the rota that new staff are expected to work which requires them to work 8/10 weekends. The Deputy Director of Operations said that recruits are informed at their first interview and during their training of the requirement to work weekends. They are expected to work the rota for two years, after which they will be given the opportunity to change to Relief A rota and thereafter to a core rota on a station which requires 5/10 weekends. As part of the New Front End Model work will be undertaken to review the rotas so as to ensure a fairer system of working for all staff. The HR Director was asked to review the retention rate for recruits who work the Relief B rota and report back to the Committee. **ACTION: HR Director**

The review of rosters will enable the Service to match resources to known periods of demand and to consider where resources might be better situated to respond to demand.

Noted: The update on performance

51/06 Finance report – Month 8

The Finance Director referred the Committee to pages 1 and 11 of the finance report. He said that although the Trust is currently predicting £2.8m deficit he expected to break even with the receipt of the £8m CBRN funding and further internal savings. If the Trust does not receive the £8m funding it will run out of cash in February 2007.

He highlighted the following from the finance report:

- expenditure on overtime has been greater than forecast but it is improving as the level of overtime is decreased;
- further savings will be generated in the final quarter of 2006/07 so as to support the A&E directorate. Work is being undertaken on analysing the Trust's suppliers to identify possible savings.
- the use of third party by A&E and PTS has fallen; with A&E using third party on a minimum basis. Further work will be undertaken to ensure that PTS uses third party on an exceptions basis.

The Trust has not yet received the promised £8m CBRN funding; this is a similar position to last year except that this year the Trust has a letter from the Department of Health which promises recurrent CBRN funding. The Finance Director and the Chief Executive are actively pursuing the matter. £164,000 has been received for the Defibrillators in Public Places scheme.

Following discussion it was recognised that there is a risk that the Trust will not break even and achieve its performance targets. The Trust Board when it meets in January will review whether the Trust is on track to achieve its financial and performance targets. If necessary a 'plan b' to recover performance and achieve break even will be presented to the Board for approval in January.

Noted:
1. **The finance report for Month 8**
2. **That in January 2007 the Trust Board will receive an updated review of the financial outlook to the end of the year in light of progress with the cost reduction initiatives. This will be accompanied, should it prove necessary, by proposals (referred to in the discussion as 'Plan B') spelling out the steps that need to be taken to avoid falling into deficit for the year. (Note 'Plan B' may also have to include a corresponding section on further steps to hit the key performance targets by 31st March if the trajectory shows us as being in danger of missing them.)**

52/06 Gateway Review Process.

The Director of Information Management & Technology (IM&T) gave a brief presentation outlining the Gateway Review Process. The first CAD 2010 Gateway Review (known as Gate 1) took place in June and its report was subsequently shared with the Board. The second CAD 2010 Gateway Review (Gate 2) is scheduled to take place during the week of the 22 January 2007. The outcome will be shared with the Board on the 30 January. This will provide helpful supporting information for the

Board who, at the same meeting, will be asked to agree to the submission to the SHA of the CAD 2010 Outline Business Case for approval.

The Director of IM&T explained that the Gateway Review process is intended to be critical but supportive; he stressed that it is not an audit. Its intended audience is the SRO (Senior Responsible Owner); it is not normal practice to circulate the report widely. It would make a number of recommendations and grade them as: Red: action needed immediately; Amber: action needed during next stage, but prior to the next Gateway Review and Green: action for consideration - advice only

It was important to note that Gateway reviews are not pass or fail and the report as a whole is always graded at the level of the highest (most critical) recommendation. Therefore a report with 1 Red, 4 Ambers & 6 Greens would be graded as Red. The Director of IM&T confirmed that in relation to the Gate 1 report, the one Red recommendation relating to substantiating the recommendations and clarifying the preferred option had been addressed prior to the SOC being submitted to the SHA. He also confirmed that as part of the Gate 2, there would be a review of how the recommendations of the Gate 1 had been implemented.

In response to a specific question, the Director of IM&T confirmed that the Department of Health fund the staff costs of the Review team and the LAS pay the miscellaneous costs of travel, accommodation and subsistence.

Noted: The Gateway Review Process

53/06 <u>Scope of CAD 2010</u>

The Director of IM&T presented the progress to date in scoping CAD 2010. He outlined what would and would not be included in the scope (appendix 1). The Outline Business Case (OBC) will be presented to the Trust Board in January for agreement before being submitted to the Strategic Health Authority for approval. The formal procurement process (commencing with a European advert) can only begin once the SHA has approved the OBC. It was noted that approval of the first stage business case (the SOC) by the SHA was still awaited.

The Director of IM&T reminded the Committee that the second Gateway review (known as Gate 2) would be completed the week immediately prior to the Trust Board's meeting in January 2007. He would provide a verbal update on the outcome of the Gate 2 review when presenting the OBC. However he said that if the Gateway Review produces serious concerns he would inform the Chief Executive and Chairman and possibly withdraw the paper from consideration by the January Trust Board.

The Director of IM&T outlined the approach that is being adopted for the implementation of CAD 2010. For presentation purposes he has adopted a 4 day vision:

Day one, which will be as soon as possible, will see the introduction of a new CAD which will involve minimal business change.

Day two (within six months of the new CAD's introduction) will see a technically stable structure ready to attain the business changes required.

Day three (within six months of the new CAD's introduction) System changes and business changes implemented ready for the Olympics.

Day four is post the Olympics when it is anticipated that there is continuous improvement and a system is in place that can support business change.

The Director of IM&T stated that his immediate priority was to get to Day 1 as soon as possible. In response to specific questions, he clarified the following points:

- the International Olympic Committee will require the Trust to be clear what systems will be in place two years before the Olympics in 2012, with lock down required at twelve months. The Director of IM&T undertook to check with Richard Webber, the Trust's lead on the Olympics, to ensure that his understanding his correct. **ACTION: Director of IM&T**
- it is clear that the reconfigured Ambulance Trusts in England are only now beginning to tackle the issue of changes to their control rooms; any procurement will be on a later timetable. It is therefore unlikely that the LAS will be the able to work with other services on a similar CAD procurement & implementation.
- as part of the OBC process, formal talks have been held with possible suppliers; these have proved encouraging as to what products exist in the market place. It would appear that existing products could meet the key needs of the of the LAS

Noted: The contents of the scope of the CAD 2010.

54/06 <u>Workforce Plan</u>

The HR Director presented the Trust's draft five year A&E workforce plan which has taken into consideration the staffing requirements of the Service Delivery Model. The plan has identified skills and competency levels and mapped levels against the Service Delivery Model. It was made clear that detailed discussions with the Trade Unions will be needed prior to seeking Trust Board approval to proceed with the plan.

The plan presented outlined what the workforce skill mix will look like in 2012/13; with an overall increase in A&E staffing of approximately 800 and the creation of the new Emergency Care Assistant role and an increase in Clinical Telephone Advice staffing. The figures take account of an expected of 3% p.a. increase in demand and reflect expected increases in the population due in part to the effects of the Thames Gateway Development. PTS will be included in the overall LAS workforce plan.

Following discussion it was requested that when the final plan is presented to the Trust Board information is included on the underlying assumptions used in drawing up the plan including job cycle times, productivity and the expected utilisation of crewed vehicles across the 168 hours of the week, and by area. The paper should also make explicit its assumptions about the development and utilisation of alternative (to transport to A&E) pathways. **ACTION: HR Director.**

A&E pay cost per incident is estimated to be £135 in 2012/13. The Finance Director undertook to review the estimated average cost of responding to calls. The Chairman said that he would expect the cost to fall in real terms as a result of the proposed changes. The HR Director said she expected the effect of the changes to be neutral in the long term though initially staffing costs will be higher as additional Paramedics are trained. The Finance Director will review this as part of the financial analysis of the Seven Year Plan. **ACTION: Finance Director.**

In response to a question by Barry MacDonald it was pointed out that the rationale for the workforce plan is to provide better clinical care to patients, reduce clinical risk and to contain the effects of escalating pay levels on the Trust. With the deployment of additional Paramedics alongside the innovations being introduced by the New Front End Model the level of clinical risk for the Trust should be reduced.

At the moment clinical risk is largely managed by crews taking patients to hospitals. With enhanced patient assessment skills and access to alternate clinical pathways crews should have the necessary confidence to leave patients at home when it is appropriate to do so. It is anticipated as a result of the various step changes being introduced transport to hospital will fall to 50% by 2013.

Noted: 1. The report
2. That the Trust Board will be asked to approve the five year workforce plan before 31st March 2007.

55/06 Update on Higher Education Initiatives

Bob Fellows (Education Development Manager) gave a presentation on the higher education initiatives undertaken by the Trust. Since 1995 the Trust has worked in partnership with higher education institutions to produce degree level paramedics. To date the LAS has, and continues to support, 361 part time students; 274 full time BSc students and 106 foundation degree students. To date 374 graduates have been produced (127 diploma/foundation degree and 247 BSc (Hons) degree).

He outlined the costs incurred by the Trust for the different academic routes. There is no cost when students are self-funded; £28,000 when students are funded on a part time course (which includes backfill costs etc). He concluded his presentation by pointing out that the Trust saves money in the long term by undertaking training of paramedics at higher education.

The selection of people for the paramedic science course has included a mixture of those who have a first degree and those who do not have an academic background. The selection procedure takes place in June of each year and is undertaken by HR and Operations.

Quality is monitored through student feedback and QAA reports. Regular meetings are held with the education providers.

Sarah Waller challenged the principle of educating people to degree standard. It was recognised that Ambulance Trusts (unlike Acute Trusts) have to fund staff training costs which is inequitable. The Chairman said that the matter would be raised with the Strategic Health Authority.

The Medical Director said that the content of the course has been changed to reflect feedback from students. Initially the courses run by Hertfordshire University were nursing led and this has been changed; the courses run by St George's Medical School follow the medical model and are better tailored to suit the requirements of ECPs. The theoretical teaching has proved to be of great value in teaching the ECPs. In recent years Paramedics have taken up full or part time teaching posts at the colleges and universities and this has further improved the quality and relevance of the courses.

Noted: The update regarding higher education.

56/06 Update on AOM changes and strengthening of station level leadership.

Bill O Neill (Assistant Director of Organisation Development) outlined the work to date which has been focussed on strengthening station level leadership in the LAS. On taking up his post Bill met with the Senior Management Group and Senior A&E Managers in order to get their input into the programme. The Organisation Development Programme was designed to address the following areas: clinical leadership; developing the senior A&E team; recruitment and development of Ambulance Operations Managers; Leadership Development Programme and Talent Management & Succession Planning.

In 2006 four Area Operations Managers (AOMs) were recruited to substantive posts, four were recruited to acting posts and two were recruited to staff pools for acting up as AOMs. There are three parts of the programme: part one focussed on how high performance complex teams were developed with focus on team building; situational leadership; performance management; role of 'Silver' and Trade Union Partnerships. Part two will be undertaken in January and focus on encouraging innovation, releasing talent, overcoming obstacles to improvement; improvement management toolkit; complaint investigation. Part three will be undertaken in March and focus on the external work undertaken by AOMs in their locality e.g. liaising with the local Scrutiny and Oversight Committees, negotiation skills and commercial awareness. As part of the programme internal mentors and coaches are also being developed to offer support to the AOMs. Action learning sets have also been established where the AOMS can meet and share their learning.

The next steps include evaluation of the course as each stage is completed and included 360' feedback assessment. Work is being undertaken to extend the programme to existing AOMs and developmental work is to be undertaken with the Team Leaders and Duty Station Officers.

Noted: The work being undertaken to strengthen local leadership in the LAS.

57/06 <u>Review of Urgent Operations (including Bromley and Barnet Chase Farm pilot scheme)</u>

Noted: That this item was rescheduled to be presented to the Service Development Committee in February 2007.

58/06 <u>Update on Emergency Planning</u>

The Deputy Director of Operations outlined the different components of the Trust's emergency planning.

Hazardous Area Response Team (H.A.R.T.) is now live; a six month component evaluation will commence in January 2007. 23 staff are involved in the evaluation 16 hours a day/7 days a week. The Department of Health is funding H.A.R.T. though staffing costs are being met by the LAS. They will be tasked to a variety of hazardous incidents not just CBRN incidents.

The equipment includes personal protective equipment; two Zafiras which includes the facility for staff to don breathing apparatus unassisted. Two equipment vehicles which contain amongst other things 50 treatment packs and the facility to delivery oxygen to 50 patients. Five trucks which have a wide range of facilities including relaying pictures to the Incident Control Room, its own independent mobile network and weather station.

Emergency Planning NHS London: the LAS has been asked to take responsibility for co-ordinating emergency planning for NHS London. The key responsibilities will include auditing of major incident planning and preparedness and training for major incidents. A Service Level Agreement is currently being drafted and a formal report will be presented to the Trust Board in January. **ACTION: Chief Executive.**

Flu planning: it is likely that a community based response will be implemented when the flu pandemic occurs. As yet the role of the Ambulance Trusts is unclear; the Medical Director is a member of the Department of Health's Influenza Sub-group which is drafting guidance for ambulance trusts. The Trust's Business Continuity Plan is drafted to include guidance on how the Service will continue to

operate if 40/50% of the staff are unavailable in the event of a flu pandemic. A national flu pandemic exercise (Winter Willow) is planned to take place in January and February 2007.

7th July 2005: the Trust has implemented 118 of the 200 actions identified following the London bombings of 7th July 2005. Most of the remaining actions will be completed when the Major Incident Plan is re-written; it is currently being redrafted. The following are some of the actions implemented: airwave radios; reintroduction of pagers; new Incident Control Room; New Gold Suite; no notice exercise regime in Incident Control Room and the delivery of Major Incident Training to all A&E staff.

Exercises: a recent exercise undertaken by the Incident Control Room verified that the new airwave radios worked well. Individual complexes are undertaking exercise e.g. the Islington complex was recently involved in an exercise that required the evacuation of the new Emirates Stadium.

Noted: The report.

59/06 Update on SMG objectives

The Chief Executive presented an update on the Senior Management Group's collective objectives for 2006/07 which included a forecast for achievement of each objective by March 2007. Some of the objectives were recognised as ambitious e.g. 8 (meet A&E performance targets and prepare for new ones) and 11(develop a standard package of referral pathways in each borough). Clarification was needed for objective 4 (deliver training as per agreed plan) as the acceptable degree of non-attendance had yet to be agreed. The Trust will not meet the BME recruitment target of 15%.

Personal Development Records (PDR): the HR Director said that a progress report is expected in January; informal reports from key areas such as A&E Operations suggest that the Trust will achieve this objective with significant progress made in implementing PDR and Personal Development Plans (PDPs).

Audit of Clinical Performance Indicators (CPI): currently achieving 50% completion, the Chief Executive said that the target of 80% will be achieved by March 2007.

Noted:

1. **The interim update on the SMG objectives.**
2. **That the Senior Management Group's objectives are drawn up by the Group itself**
3. **That the objectives for 2007/08 will be shared with the Board so as to satisfy the Board that the objectives are in line with the agreed strategic direction of the Trust.**
4. **That the Remuneration Committee will also receive an update on the achievement of the objectives when it meets in March 2007.**

60/06 Any Other Business

Sarah Waller asked about the recent trip by an Ambulance to Manchester which was reported in the media; the Chief Executive said that the crew has been spoken to and made aware of how embarrassing such an incident was for the Trust.

In response to a question from the Chairman the Director of IM&T explained that one of the Trust's servers had been down on Monday 18th September due to a significant hard disc failure which meant a number of staff were without email. It did not affect operations. The problem with the server was exacerbated by the

failure of the back up disk drive. A considerable amount of data (50 gigabytes) needed to be recovered and it took eight hours to do so. An investigation is taking place to understand what happened and why the back up failed to work.

Noted: That the Director of IM&T will provide an update on the failure within a future Chief Executive's report. ACTION: Director of IM&T.

61/06 Date of future meetings:

The next meeting of the SDC will be 27th February 2007, Conference room, LAS HQ.

Meeting dates for 2008 were circulated; the Chairman said that the meeting in April 2008 should include the night before which will be a dinner.

Sarah Waller requested that the Committee dates for 2007 be recirculated. **ACTION: Trust Secretary.**

The meeting concluded at 13.35pm

Enclosure 14

LONDON AMBULANCE SERVICE NHS TRUST

Audit Committee - 4th December 2006

1.	**Chairman**	**Barry MacDonald**
2.	**Purpose of the summary:**	**To provide the Trust Board with a summary of the proceedings of the Audit Committee. To highlight items of interest, items agreed and what items require noting by the Trust Board.**

3. **The Committee AGREED:**

1. That it should meet four times a year (March, June, September and December). That the meeting in March will review the Committee's 2007 work plan along with the work plans of the Clinical Governance Committee and RCAG, and the implementation of the governance review. The meeting in June will concentrate on the annual accounts.
2. That the Trust will carry out a mini-tender to ascertain what interest there is in the market to undertake the Internal Audit function and the cost to the Trust. At its March meeting the Committee will consider the merits of internal versus external provision.
3. That the Standing Orders and Financial Regulations should be presented to the Trust Board. The Scheme of Delegation to be circulated for comment by committee members before presentation to the Board.
4. An update on the position with drug control and medical devices would be given to the next meeting, limited assurance only having been given by Internal Audit reports.
5. Improved controls, Finance staff supervision and accruals procedures to be reviewed by Internal Audit after implementation.

   POST MEETING NOTE: the Audit Committee will consider the scheme of delegation at its meeting in March 2007. The Trust Board will receive the Standing Orders etc in March 2007.

The Committee NOTED:

6. That the Language Line Service is being reviewed and the Service will be re-tendered in 2007. A report will be provided to the Audit Committee in March, along with a report on how user feedback is obtained by the trust.
7. The Internal Auditor's reports concerning: Payroll; Fleet & Transport; Drug Control; Clinical Telephone Advice; Medical Devices; Lone Working; Child Protection; Waste Management and Debtors. The Committee asked that future reports include an executive summary highlighting key findings and the associated risks as well as recommendations. A backlog on reports was being cleared.

   (POST MEETING NOTE: an update on the Drug Control and Medical Devices will be presented to the Audit Committee in March.)

The report from the Local Counter Fraud Specialist which highlighted the ongoing investigations taking place.

That controls are being put in place by the Finance Director to ensure that the error of £0.9 million which was uncovered in the 2006/07 management accounts does not recur. The error related to the leasing of vehicles; an error in the budgetary and accruals process with costs being understated.

8. The Annual Audit Letter from the external auditors raised no significant concerns. The implementation of their recommendations will be monitored by the committee.
9. The Risk Management Policy & Procedure is to be revised to include the comments made at the Audit Committee and the Trust Board. RCAG is responsible for the day to day risk while the Audit Committee is responsible for taking a strategic view to the Trust. Future reporting on risk management and Assurance Framework should cover action being undertaken and planned and its effectiveness, as well as the management processes followed to review the subject.
10. The contents of the Assurance Framework report which outlined how the Trust can provide assurance to external bodies (such as the Healthcare Commission and the NHSLA); to give the Board assurance that controls are in place to manage risk; to identify where there are gaps and to give evidence progress has been made in a systematic way with the management of risks.
11. The audited Charitable Funds Annual Accounts which will be presented to the Trust Board in January.
12. That an update on the implementation of the Governance Review will be presented in March 2007.
13. That a representative of the NHSLA will visit the LAS in March 2007 and provide feedback on what Level the Trust should be measured against the new standards in April 2007. The Committee's members said that in order for the Audit Committee to be in a position to give an opinion on the overall working of the risk management processes in the Trust, it should see the work plans of the Clinical Governance Committee and RCAG.
14. That the risks on the Risk Register have been grouped by categories with operations having a number of high/high risks. When the report is presented to the Trust Board in January, more detail will be included about the processes.
15. The three entries in the Director's Hospitality Register and that there had been no waivers of the Standing Orders since the last Audit Committee meeting in July 2006.

The Committee received the following minutes:

Clinical Governance Committee (23rd October 2006) and RCAG (6th November 2006).

4. **Recommendation That the Trust Board NOTE the update regarding the Audit Committee.**

LONDON AMBULANCE SERVICE NHS TRUST

AUDIT COMMITTEE

Monday 4th December 2006

DRAFT MINUTES

Present:	Barry MacDonald	Non-Executive Director (Chair)
	Sarah Waller	Non-Executive Director
	Caroline Silver	Non-Executive Director
	Roy Griffins	Non-Executive Director
In Attendance:	Peter Bradley	Chief Executive
	Mike Dinan	Director of Finance
	Peter Suter	Director of Information Management & Technology (until 4pm)
	John Wilkins	Head of Governance
	Michael John	Financial Controller
	Chris Rising	Bentley Jennison (until 5.20)
	Sue Exton	Audit Commission, District Auditor
	Terry Blackman	Audit Commission
	Keeley Saunders	Audit Commission
	Robert Brooker	Bentley Jennison, Local Counter Fraud Specialist (until 5.20)
	Christine McMahon	Trust Secretary (Minutes)

It was agreed at the Trust Board held on 26th September 2006 that the following Non Executive Directors would be members of the Audit Committee: Barry MacDonald; Sarah Waller, Roy Griffins and Caroline Silver.

The Audit Committee wished to record its thanks to Beryl Magrath who will no longer be attending meetings. Her contribution to the Committee's discussions had been greatly valued.

The Chairman of the Committee requested that the agenda and papers be circulated a week in advance of the meeting, that the papers be accompanied by cover sheets which would state what the agenda item number, the enclosed number and what action the Committee was being asked to take. The papers should make it clear what process had led to their recommendations, e.g. internal consultation, discussion by other groups (RCAG) or committees (CGC). **ACTION: Trust Secretary.**

25/06 Minutes of the last Audit Committee meeting 3rd July 2006

Agreed: The minutes of the last audit committee meeting held on 20th March 2006

26/06 Matters Arising

Minute 14/06: the Head of Governance confirmed that the internal audit reports referred to in the minutes were the reports circulated in the agenda. He apologised that they had not been circulated between meetings.

Minute 16.6: the Director of Finance said that the Language Line service was being reviewed and the Service will be re-tendered in 2007. Feedback has not been sought from users of the Service. The Director of Finance undertook to provide a report on this at the next meeting. **ACTION: Director of Finance.**

Minute 16.6: Chris Rising (Bentley Jennison) confirmed that a credit note had been issued to the Trust following a reconciliation of the actual and billed internal audit days in 2005/06.

27/06 Meeting dates and workplan for 2006/07

Agreed: 1. That the Committee would meet four times in 2007: March, June, September and December.

Noted: 2. That the Committee would review its workplan and that of the RCAG and the Clinical Governance Committee when it meets in March 2007. ACTION: Head of Governance.

3. That the meeting in June would concentrate on the annual accounts

28/06 Internal audit specification

The Director of Finance presented the draft internal audit specification. Since circulating the draft the Trust has obtained specifications for internal audit from three other ambulance trusts which have suggested some changes to the draft specification.

Following discussion the Finance Director was asked to investigate whether it would be feasible for the internal audit function to be performed in-house. He undertook to circulate a discussion paper prior to the next Audit Committee which could be discussed either via email or via telephone conference. **ACTION: Finance Director.**

Sarah Waller suggested that the proposed evaluation criteria be amended to merge some of the categories and make the scoring less mechanistic. **ACTION: Finance Director.**

Agreed: That the Trust should undertake a min-tender to ascertain what interest there is in the market to undertake the internal audit function and what it would cost the Trust. The Committee to consider internal versus external provision.

29/06 Internal Audit

Progress Report 2006/07

Chris Rising highlighted that there were three reports (*Patient Transport Service (PTS); Drug Control and Medical Devices)* which were given limited assurance by the Internal Auditors. The limited assurances were due to staff not complying with the Trust's policies and procedures with the result that there is a risk for the organisation.

The Finance Director said that the internal audit of PTS was undertaken some time ago and he was confident that the areas of concern highlighted by the audit (e.g. bookings processed without proper authorisation and variation of contract not signed by both parties) have been addressed.

The Committee was informed that it has been observed that when the LAS has lost a PTS contract there has been an increase in 999 calls for that area because the new provider phoned 999 when they did not feel able to transport their passengers safely. The Finance Director said that Control Services were monitoring when providers used 999 to transport patients and these journeys would be invoiced by the LAS.

Payroll: Sarah Waller noted that ESR had been implemented. She said that she had been surprised to read that management were not required to verify the names of staff paid on their departmental budget. The Director of Finance said that all Directors received nominal roll with their monthly management accounts. The recommendations lacked an implementation dates and Chris Rising will liaise with the Head of Employee Services to rectify this omission. **ACTION: Chris Rising to liaise with the Head of Employee Services.**

Fleet and Transport: this was the third internal audit of Fleet and Transport and this was the first time that no significant recommendations were made by the Internal Auditors.

Drug Control: the lack of compliance with procedures and policies has been highlighted as a concern, particularly with the risk of an out of date drug bag being used by front line crews. The Chief Executive said that the audit was undertaken in March 2006 and that a lot of work has been undertaken in the interim. The Director of Finance said that the new central storage depot in Deptford has introduced more effective controls of drugs. A report will be presented to the Trust board in January outlining what controls are in place manage drugs in the Trust. **ACTION: Chief Executive.**

Caroline Silver asked whether audits are undertaken without notice i.e. spot checks. She said that this would probably keep people on their toes. The Chief Executive proposed that a report on Drug Control be presented to the Trust Board in January with an in-depth update presented to the next Audit Committee. He said that the introduction of bar code scanning in 2007 would facilitate the use of spot checks.

Clinical Telephone Advice was given a rating of adequate assurance by the Internal Auditors. The Director of Finance said that the CTA function will be included as part of the business continuity plans and major incident planning.

Medical Devices was given a rating of 'limited assurance' by the Internal Auditors due to the number of significant weaknesses found in the management of medical devices within the Trust e.g. maintaining a record of the location of medical devices and inadequate records with regard to service history. The Chief Executive said that the report to the Trust Board and the next Audit Committee would include both drug control and medical devices. **ACTION: Head of Operational Support.**

Lone working was given adequate assurance as was *Records Management.*

Child Protection was given two significant recommendations (there were the same two as when the audit was previously undertaken two years previously). Criminal Record (CRB) checks have been undertaken but Protection of Children Amendment (POCA) has not. The Chief Executive said he would look into the matter. **ACTION: Chief Executive.**

The second issue related to the referrals process; referrals are not referred to appropriate agencies within 24 hours as required by policy.

The Chief Executive said he was disappointed with the findings of the audit as the Trust has done a lot of work around this area and has referred hundreds of individuals but he accepted that improvements could be made. It is probable that there was an underestimation of the numbers of children and vulnerable adults who would need to be referred.

Waste management was audited for the first time and received adequate assurance which the Internal Auditors considered to be very good when benchmarked against other Trusts.

Debtors was audited and received 'substantial assurance'.

Agreed: **1. That the Committee will receive future internal audit reports in a timely manner.**

Noted: **2. That the progress report from the internal auditors will include an executive summary that will highlight key findings and the associated risks as well as the recommendations. The detailed reports will be included as appendices for information. The report will also include comments by RCAG, and show when internal audit reports were produced and when they were given and signed off by managers.**

3. That the following final reports were included in the report: clinical telephone advice, complaints, patient transport service and drugs control. The draft report on urgent care was also included.

4. **That the backlog of internal audit reports was being addressed; the remaining 2005/06 audits are ECPs and Urgent Care and these will be presented to the Committee in March 2006. They will be considered by RCAG beforehand.**

30/06 Audit Commission

Sue Exton presented the following reports to the Committee.

Annual Audit Letter 2005/06 reported on the annual audit conducted in 2006 and summarised the work undertaken by the Audit Commission during the year. The key conclusion summarised on page 5 had been discussed in detail with the Chief Executive and the Director of Finance. The Trust has a good financial standing, it met all its financial targets except capital cost absorption rate. The most important target of breaking even was accomplished. The Annual Audit Letter will be presented to the Trust Board in January 2006. **ACTION: Director of Finance.**

Auditors Local Evaluation 2005/06 was undertaken for the first time in 2005/06 and the Trust achieved a rating of 3(consistently above minimum requirements – performing well) which the Audit Commission considered to be an achievement. A detailed action plan will be drafted that will enable the Trust to achieve a rating of 4 (well above minimum requirements – performing strongly) in 2006/07 which will involve improving financial management arrangements overall. The report contained a detailed explanation as to how the score of 3 was determined.

Final Accounts Audit 2005/06: Keeley Saunders reported that the final accounts had been completed in time and thanked the finance team for their co-operation with the audit. Since the audit was completed in July 2006 there have been some minor adjustments and one significant adjustment.

Noted:
1. **That the Audit Commission gave an unqualified opinion on the 2005/06 accounts.**
2. **That the recommendations contained in the Audit Commission's report should be incorporated into the general recommendations report in order that the Committee can monitor progress.**

31/06 Report of the Local Counter Fraud Specialist

The report of the Local Counter Fraud Specialist (LCFS) highlighted the ongoing investigations taking place; one of which involving the Metropolitan Police was proving to be quite lengthy. This has been due in part to changes in staffing within the Metropolitan Police who have been dealing with the investigation.

Three of the reported investigations have been concluded and the lessons learnt incorporated into practice. With one investigation it was highlighted that the system for checking claimed mileage was not being followed and this has been addressed to ensure reconciliations are undertaken in a timely manner.

On the proactive side the LCFS said that he had spoken with managers, visited stations and spoken with people at ground level. He undertook to report back to the Committee when he had given the presentations regarding fraud to managers and front line crews.
ACTION: Local Counter Fraud Specialist.

Noted: That a summary of the investigative report will be shared with the Committee which will highlight lessons learned and actions taken.
ACTION: Local Counter Fraud Specialist.

32/06 Substantial error in 2006/07 management accounts

The uncovering of a substantial error of £0.9 million in the 2006/07 management accounts had been discussed at the recent Trust Board meeting (28th November 2006).

In reply to Sarah Waller's question as to whether the error with the vehicle lease was the same as two years ago with the MDTs the Director of Finance said the issue was not the same. The issue with the MDTs was that they were mistakenly treated as capital. This is not what happened with the vehicle leases. What happened was that there was an error in the budgetary process and costs had been understated. The secondary issue was that the error was not immediately picked up. Changes have been made in the financial processes to ensure that such an error is not repeated e.g. reconciliations will be undertaken and reasonableness tests will be undertaken by the Financial Controller's team. The level of supervision of finance staff will be reviewed as will the responsibility for production of accruals which should be more for operational management than finance staff.

A further change will be the reduction in centrally held funds. In future budgets will be allocated to departments where activity is taking place. There will be an enhanced involvement of operational departments. There will also be a closer link between the purchasing system and the accounting system with the introduction of Integra in 2007; one problem with the current system (EROS) is that not all purchases go through that system.

The Internal Auditors had undertaken review of the budget setting process and had reconciled reports back to ledger. A detailed analysis of every accounting code was not undertaken. The Trust has generally sound financial control and the Internal Auditor hoped that this error was an exception to the routine effectiveness of the Trust's financial accounting systems.

Caroline Silver said that in her experience organisations undertake a review of the budget half way through the year to ensure that everything was on track for the following year. In her experience audit committees were financially driven and spent time drilling down into the detail of the accounts. The Chairman supported this recommendation but was conscious that the Audit Committee should not trespass on the Board's responsibility for the Trust's financial management.

The Director of Finance said that the new budget format, which is primarily aimed at Foundation Trusts, is very much based around risk, trends and reasonableness. The draft budget will be presented to the Trust Board and SDC and to the next Audit Committee. It will also enable the Trust to undertake comparative work with other Ambulance Trusts and make some progress on reference costs. **ACTION: Finance Director.**

Roy Griffins asked how is the decision made on whether the Trust has an operating lease (which is off balance sheet) or a finance lease. The Director of Finance said that a lease versus buy option is considered and which ever presents the best value for the Trust is undertaken. The decision to have an operating lease or a finance lease is also carefully evaluated and the decision is scrutinised by the Audit Commission. The new budget format will include off balance sheet items. The Trust approached the Audit Commission for their opinion as to whether the lease being agreed was an operating or a finance lease.

The District Auditor said that the National Audit Office is reviewing the question of what items should be off/on balance sheet and it is possible that there will be a revision to the current guidelines.

The Chairman said that given the big system changes being undertaken by the Trust in 2006/07 it is important that the Internal Auditors review the accruals, reconciliations, and budgeting processes after the changes have been implemented. This focus has been incorporated into the annual audit plan.

Noted:

1. **That both the internal and external auditors had given clean opinions on the 2005/06 financial accounts and that there had been no big year end adjustments.**
2. **That controls are being put in place by the Finance Director to ensure that this error is not repeated.**
3. **That the decision to buy/lease or to have an operating lease or a finance lease is based on achieving the best value for the Trust and such decisions are scrutinised by the Audit Commission to ensure Accounting Standards (FRS 5) are adhered to.**

33/06 Risk Management Policy & Procedure

The Committee considered the Risk Management Policy and Procedure which had been considered by the Trust Board in November 2006. It was noted that the Trust Board had requested some changes and a rewrite by the Director of Communications of the section to be issued to all staff. The policy is presented annually to the Board and is amended to ensure that it reflects the internal and external risk management requirements of the Trust. The Risk Compliance and Assurance Group (RCAG) had reviewed the policy prior to its presentation to the Trust Board.

The Chairman said that there needed to be a brief statement making explicit reference to the risk reporting process, actions taken to mitigate risk and monitoring of the effectiveness of actions taken in the first couple of pages.

The RCAG is responsible for day to day risk while the Audit Committee is responsible for taking a strategic view of the risks being managed by the Trust.

The Chairman requested that the Policy include an emphasis on the dynamic part of risk management, how risk is managed in a systematic way, is it tasked and timetabled appropriately and what progress is being achieved. The Head of Governance said that he would make the changes as requested. **ACTION: Head of Governance.**

Procedure: the Head of Governance said that the Risk Reporting and Assessment Procedures document was an amalgamation of what had been two separate procedures and recognised that it was clumsy. It is intended that the Procedure document will be included in staff induction, not necessarily the 2 day course undertaken by all new staff, but as part of the 'day job' induction process. Caroline Silver said that the procedure needed to be abbreviated so that there is a better chance of staff reading it. **ACTION: Head of Governance.**

The Chief Executive said that there was a high level of risk reporting amongst front line staff as judged by the number of LA52 (risk reporting form used by crews) as approximately 5300 were generated by front line crews in 2005. What is currently missing is the feedback loop which would communicate what action has been taken to manage the risk that has been reported.

Caroline Silver said that she would recommend an on-line training tool which would not necessitate taking staff on the road or away from their duties.

Noted:

1. **That the Head of Governance would incorporate the comments of the Audit Committee and of the Board into the policy**
2. **That the Procedure is to be reviewed by the Communications Team so as to make it more 'reader friendly'.**

34/06 Assurance Framework

The Head of Governance presented the Assurance Framework which is considered annually by the Trust Board. It will be presented to the Trust Board in January 2007 with the risks updated following the recent Trust wide risk exercise. The purpose of the Assurance Framework is to outline how the Trust can provide assurance to external bodies such as the Healthcare Commission and the NHSLA and to give the Board assurance that controls are in place to manage risks; to identity where there are gaps; and to give evidence progress has been made in a systematic way with the management of risks. The Trust is required to self-certify that it is managing the risks that might threaten the achievement of the organisation's objectives.

Sarah Waller referred to C5b (regular checking of PRF completion) and was assured that checking is being undertaken, that there is a range of 15-80% completion being achieved between different complexes and the Trust is on track to achieve its target for 2006/07. The Head of Governance said that beneath the Assurance Framework is a body of evidence that demonstrates how the Trust can evidence compliance with core healthcare standards.

It is the responsibility of RCAG to review what progress is being made in achieving the standards and the developmental standards. The RCAG regularly reviews the Risk Register and considers what risks can be deleted or regraded in response to the evidence of mitigating action taken in managing the risk. It also reviews the risks proposed for regrading/deletion by the Clinical Governance Committee.

Noted:

1. **That the risk of insufficient funding is not on the Trust's risk register or part of the Healthcare Commission's healthcare standards although it is a potential risk for the organisation.**
2. **That the Board in January 2007 will receive a report on the Trust's Risk Register.**
3. **That the Trust Wide Risk Assessment is undertaken annually and is an opportunity for staff at all levels of the organisation to consider what risks might affect the Trust achieving its objective and report them so they can be considered as part of the continuing review of the Risk Register.**

35/06 Revision of the Trust's Standing orders and financial regulations

The Committee considered the proposed revisions of the standing orders and financial regulations.

Sarah Waller queried the proposal that the Financial Regulations be amended to include the requirement that a NED be nominated by the Board to be responsible for security management. Though this was something advocated by the Model Rules it is unlikely to be adopted by the Trust Board. Trust Secretary to clarify the requirements for the Trust. **ACTION: Trust Secretary.**

SO 15.1: Roy Griffins queried the proposal for all services to be reviewed. The Chief Executive and the Finance Director said that it is good practice for the Trust to consider whether services should be managed in-house or outsourced.

Agreed:

1. **That the Standing Orders and Financial Regulations should be presented directly to the Trust Board, it was not considered necessary to present the report to the SDC in December as the proposed revisions were not contentious.**

Noted:

2. **That the scheme of delegation will be circulated for comment. ACTION: Trust Secretary.**

3. **The work undertaken by the Trust Secretary in revising the Standing Orders and Financial Regulations.**

36/06 Audited Charitable Funds Annual Accounts

Noted: 1. The audited Charitable Funds Annual Accounts
2. That the accounts would be presented to the Trust Board in January as the members of the Board are trustees of the Charitable Funds.

37/06 Progress report on the implementation of the Governance Review

Noted: 1. That the implementation of the Governance Review would be monitored by the Audit Committee.
2. That the Terms of Reference for the Audit Committee, Clinical Governance Committee and the Risk Assurance & Compliance Group had been agreed.
3. An update will be presented in March 2007. ACTION: Head of Governance.

38/06 Update re. NHSLA including action plan

National Health Service Litigation Authority (NHSLA): the LAS will receive an informal visit from the NHSLA Assessor in March 2007 and receive feedback on what Level the Trust should be measured against the new standards in April 2007. The assessment has three levels that Trusts can be assessed against. The greater the level of risk management demonstrated the greater the discount on annual fees. The LAS, in co-operation with other Ambulance Trusts, has been working with the NHSLA on the revised assessment used by the NHSLA. The work plan for meeting the NHSLA's criteria is being reviewed by the Clinical Governance Committee; the minutes of which are presented to the Trust Board and to the Audit Committee.

The Chairman proposed that in order for the Audit Committee to be in a position to give an opinion on the overall working of risk management processes in the Trust, it should see work plans for the Clinical Governance Committee and the RCAG. **ACTION: Head of Governance.**

Noted: That the Clinical Governance Committee is monitoring the progress of the action plan to prepare for the NHSLA assessment.

39/06 Risk Register Update

The Committee considered the Trust's full Risk Register. The risks have been grouped by categories with operations having a number of high/high risks. The Risk Register was revised to incorporate the findings of the Trust Wide Risk Assessment undertaken in the summer months. The Finance Director said that at the Senior Managers conference held in the Autumn a risk assessment exercise was held and the results incorporated into the Trust Wide Risk Assessment.

The Committee suggested that more detail about the processes should be included when the Risk Register is presented to the Trust Board in January. **ACTION: Head of Governance.** The Chief Executive said that the 28 high level risks will have additional information as to how the risk is being managed and what progress has been made in mitigating risk i.e. what risks have been deleted or regraded. **ACTION: Head of Governance.**

Noted: 1. **The update regarding the Risk Register**
2. **That the Risk Register will be presented to the Trust Board in January 2007 and will include a statement on management controls.**

40/06 Standing Committee items

Noted: 1. **The three entries in the Directors' Hospitality Register:**

- **Peter Suter attended the national IM&T Directors conference; all costs for both accommodation and food were met by the conference organisers. While delegates attended free of charge there was a £1,000 fee for late cancellation; £1,000 was therefore declared as the approximate value of the hospitality received.**
- **Hospitality given by Peter Bradley and Sigurd Reinton to Sir Nigel Crisp on 25th October (£217.40).**
- **Hospitality given by Phil Thompson (UNISON) on 30th October (£221.96).**

2. **That there had been no waivers of the Standing Orders since the Committee last met in July 2006.**

41/06 Audit Recommendations

The Committee considered the report on the audit recommendations.

Noted: That the Committee wished to receive the audit recommendations in the format previously received i.e. July 2006 to include all outstanding internal and external audit recommendations that are "fundamental" or "significant" until reported as fully implemented. ACTION: Head of Governance.

42/06 Draft minutes of the Clinical Governance Committee - 23/10/06

Noted: The draft minutes of the Clinical Governance Committee

43/06 Draft minutes of the Risk Compliance and Assurance Group – 6/11/06.

Noted: The draft minutes of the RCAG

44/06 Any Other Business

Noted: 1. **That Terry Blackman would no longer be the Trust's Audit Manager. It is the Audit Commission's policy to rotate staff after four years. Keeley Saunders, who undertook the Trust's 2005/06 audit, has been appointed the Trust's Audit Manager.**
2. **The Chairman on behalf of the Committee expressed his thanks to Terry for the work he has undertaken during the last four years.**

Meeting finished at 5.30

Enclosure 15

London Ambulance Service NHS TRUST

Clinical Governance Committee - 11th December 2006

1.	**Chairman**	**Beryl Magrath**
2.	**Purpose of the summary:**	**To provide the Trust Board with a summary of the proceedings of the Clinical Governance Committee (CGC). To highlight items of interest, what has been agreed and what needs to be noted by the Trust Board.**

3. **The Committee AGREED:**

1 *That the sending of an EMT staffed ambulance

*Use of hospital beds for inter-hospital transport in A&E ambulance

are both risks for LAS - Propose RCAG include in Risk Register

2. The Assistant Director of Operations, East be commended for an excellent example of clinical governance implementation at shop floor level.

The Committee NOTED:

3. That the National Poisons Information Service (Guys) will continue with free advisory service to ECPs

4. Disposal of single use equipment is a problem for LAS

5. Information held by LAS on high risk addresses is being reviewed.

6. The draft work plan will be considered by a sub-group.

Presentations

7. By CARU: Paediatric Pain Management Audit; Overdose Audit: Reviews of AMPDS audits on behalf of DOH;

Noted that CPI audit revealed patient ethnicity rarely reported on PRF-noted that some illnesses more common in different ethnic groups.

8. By Ergonomics Adviser: outlined extensive trials undertaken regarding different kinds of carry chairs; the risks associated with carrying very heavy patients: the risk of using hospital beds in inter-hospital transport

9. By Head of Governance: KPIs, Healthcare Standards:& NHSLA requirements to be considered by CGC in February 2007. Final declaration on compliance with the Healthcare Standards by May 1st 2007. The NHSLA assessor to visit LAS in March to advise on whether LAS likely to achieve Level 2 & will provide feedback in April 2007.

Noted: It is not certain whether whole Trust Board will require formal training on safety & risk

10. By ADO East; the Clinical Governance Committee Noted that:

*No robust system for 6 monthly driving licence checks

*The need for a system to ensure staff whose training is not up-to-date are not practising

* A database to enable frequent callers to be flagged in EOC

*Uniformity of education & training messages

* Consistency of complaints handling by PIMs in each Sector with round table discussions following incidents

11. By Senior Operations Manager Planning & Risk: Protection of children and vulnerable adults: on actions taken following the audit by LAS Internal Auditors

    Noted Social Services referral very time consuming

12. By PPI Manager: The Public Education Strategy,

13. By PPI Manager: PPI Report Noted Patient Forum review of PTS and Multi-agency "Safe Drive Stay Alive".

14. Annual Health Check highlighted the difficulty that LAS has achieving the Thrombolysis target with small numbers involved. Noted: in recent months DH has accepted the clinical argument in favour of angioplasty for STEMI patients.

15. Safety Alert Bulletins & NICE: Two bulletins to be addressed in 'Being Open' Policy. BP monitors to be replaced annually. No NICE relevant guidelines.

The Committee received the following minutes:

16. *Risk Assurance & Compliance Group – 6th November 2006*

17. *Complaints Panel – 5th December 2006*

    LAS complaints policy and procedure prior to presentation to the Trust Board in January 2007. Comprehensive guidance notes are to be produced to accompany the policy and procedure.

18. *Infection Control Group – 10th November 2006*

    'Flu jabs' were undertaken by ECPs this year. DOH publication 'Essential Steps to Safe Clean Care' framework which to be considered at a workshop in January 2007. An audit is to be undertaken to ensure that the old style cannulas have been taken out of use. PTS and Single Responders to be issued with latex free gloves from April .Personal hand gel containers are being considered for all operational staff.

4. **Recommendation** **That the Trust Board NOTE the update regarding the Clinical Governance Committee.**

LONDON AMBULANCE SERVICE NHS TRUST

DRAFT Minutes of the Clinical Governance Committee
11th December 2006, Committee Room, LAS HQ

Present:

Beryl Magrath (Chair)	Non-Executive Director
Ingrid Prescod	Non-Executive Director
Fionna Moore	Medical Director
David Jervis	Director of Communications
John Wilkins	Head of Governance
Paul Carswell	Diversity Manager
Malcolm Alexander	Chairman, LAS Patients' Forum
Margaret Vander	PPI Manager
Dipak Chauhan	Ergonomics Manager (deputy for Claire Thomas)
Karen Haefeli	Clinical Audit & Research Unit (deputy for Rachael Donohue)
Keith Miller	Acting Head of Education & Development
Chris Vale	Head of Operational Support (until 12.30)
Richard Webber	Assistant Director of Operations, East (from 11am to 12.05pm)
Jasjit Dhaliwal	Compliance Officer
Lyn Sugg	Senior Operations Officer, Planning and Risk (until 12.05pm)
Nicola Foad	Head of Legal Services
Tony Crabtree	Head of Employee Services
Julian Redhead	Consultant in Emergency Medicine, St Mary's, Paddington (until 11.15am)
Ralph Morris	Head of Complaints (from 11.25am)
Christine McMahon	Trust Secretary (minutes)

Apologies

Sarah Waller	Non Executive Director
Kathy Jones	Director of Service Development
Claire Thomas	Health & Safety Adviser
Stephen Moore	Records Manager
Rachael Donohue	Head of Clinical Audit & Research

52 Minutes of the Clinical Governance meeting held on Monday 23rd October 2006

Agreed **The minutes of the Clinical Governance Committee meeting held on 23rd October 2006 with the following correction: Minute 39.3; a quality assurance system for PSIAM (not as stated AMPDS) should be in place by April 2007.**

53 Matters Arising

Minute 39(2): **The National Poisons Information Service (Guys) is continuing to offer a free advisory service to ECPs on acute medical problems. Although the advice has proved extremely useful, the usage of the service does not currently support a joint funding bid to the Department of Health or the Commissioners.**

Minute 40(2): **the Head of Operational Support found that other Trusts do not universally have an Infection Control person in place; that the Clinical Lead or Medical Director takes the lead in the majority of the new Ambulance Trusts. Prior to the reconfiguration only one Ambulance Trust (Kent) had a full time co-ordinator. The picture is not consistent across Ambulance Trusts except at Director lead level with only 2-3 employ a full time infection control co-ordinator.**

Most Ambulance Trusts have representatives that attend the regular meetings of the National Ambulance Infection Control Network which co-ordinates infection control. Pat Billups is the LAS' representative on that Group and he feedbacks to the Trust's Infection Control Group.

The Trust is currently advised by Gladys Xavier (Deputy Director of Public Health, Redbridge & Havering). A business case is being drafted to support the employment of a full time infection control co-ordinator; this is likely to be in line with the guidance being produced by the Department of Health with regard to ambulance trusts and pandemic flu.

Pat Billups is currently updating the Infection Control Guidelines. The Head of Operational Support said that the Trust had undertaken a self-audit and identified a number of areas for improvement which will be the template for future development.

Minute 40 (3): **a bulletin regarding single use equipment has not yet been issued. The LAS is seeking agreement from Acute Hospital Trusts to facilitate the disposal of single use equipment prior to issuing the bulletin. The A&E Consultant undertook to raise the matter at the London A&E Consultants Group so as to enable the LAS to introduce single use equipment. ACTION: A&E Consultant**

Minute 40(11): **in response to the SABs relating to blood pressure monitors / sphygmomanometers will be replaced on an annual basis as this will be more cost effective than having the equipment individually serviced each year.**

Minute 41(11): **Revised terms of reference will be circulated by Trust Secretary. ACTION: Trust Secretary.**

Minute 44(3): **a progress report will be presented to the next meeting regarding actions identified following round table discussions ACTION: Head of Legal Services**

Minute 44(5)**: Complaints policy will be presented to the Trust Board in January for approval. ACTION: Head of Complaints**

Minute 44(7): **Work is being undertaken to review the information kept on addresses deemed to be high risk. ACTION: Senior Operations Officer, Planning & Risk.**

Minute 47(2): **the Director of Communications said that the Trust will continue to use various communication tools to disseminate learning from complaints e.g. articles in the LAS News. David Whitmore (Senior Clinical Adviser to the Medical Director) has written articles on specific clinical issues for inclusion in the LAS News or the RIB. The Head of Governance said that such activity (i.e. learning from complaints) will be audited in 2007/08. The Risk Information Report will contain information on specific outcomes and how practice has been changed as a result of complaints. The Medical Director said that some complaints have resulted from relatively unusual and therefore non-recurring issues so the lessons learnt are relatively specific.**

Minute 50: **(minutes of Infection Control Group): the Annual Report on Infection Control will be presented at the next committee meeting, February 2007.**

54 **Draft work plan for the Clinical Governance Committee**

The draft work plan was discussed and reflected that the Committee will be meeting in 2007 alternatively as either a core or a full meeting.

It is intended that the core meetings will focus on a limited number of agenda items i.e. assurance framework, complaints, clinical audit and risks. There will be reports common to both meetings new risks, risk information report, reports from groups/committees and area governance reports. The full meeting will receive reports regarding PPI, PALS and lessons from complaints.

Malcolm Alexander said that the Committee receives a lot of information but asked whether it should not simply focus on governance issues but ensuring there are proper governance processes in place in the organisation and that clear outcomes can be demonstrated.

Agreed:

1. **That a small working group will meet to discuss further the Committee's 2007 work plan: ACTION: JW, NF, FM, BM and CMc.**

Noted:

2. **The draft work plan which will be revised to incorporate the comments made at the meeting**
3. **That the Committee will receive annual reports from the Clinical Audit & Research Unit, Infection Control and Clinical Steering Committee.**
4. **That there will be regular reports regarding the Healthcare Standards and the NHSLA assessment.**
5. **A representative from Operations will be expected to attend each meeting to update the Committee on clinical governance taking place in their particular area. ADOs to attend in rota.**
6. **The high level risk information report will be considered at the full meeting with a detailed risk information report presented to the core meeting. The Risk Register will be considered by the core meeting.**

55 **Presentation: clinical audit and research unit**

Karen Haefeli, representing the Head of Clinical Audit & Research (CARU) gave an overview of recent developments.

Audit. There have been two clinical audits completed: Paediatric Pain Management Audit & Overdose Clinical Audit. The findings of the audits have been disseminated to members of the Committee. They are also available on the LAS' common server, 'Clinical Audit and Research folder'. The pain management audit has been disseminated to all complexes and is available to others on request.

CARU has completed fourteen AMPDS audits on behalf of the Department of Health's Emergency Allocation Prioritisation Advisory Group (ECPAG). ECPAG has begun reviewing the data with a view to reconsidering the level of response allocated to the audited determinants. CARU is also currently examining a further fifteen LAS RED determinants (that fall under the DH Category B list). All fifteen audits will be completed by 31st December and the evidence will be reviewed by the LAS in the New Year.

Research: an application for research funding has recently been submitted to Diabetes UK. The proposed research will explore the clinical and cost–effectiveness of screening for Type 2 Diabetes and impaired glucose tolerance by the LAS and will be conduced in collaboration with a Health Economist from Brunel University. An application for funding for the project will also be submitted to the National Institute for Health Research (the Department of Heath's new funding stream) in February 2007. CARU is also developing a research proposal into the pre–hospital care of stroke patients, which will be submitted to Stroke UK for funding in early 2007.

There was a brief discussion regarding the recording of ethnicity on the Patient Report Forms (PRFs). The Diversity Manager said that ethnicity should be considered by default unless

there is a reason not to. The ethnicity of patients is not being recorded in every case on every PRF and unless crews understand that there is are clinical reasons-different diseases occur solely or more commonly in different ethnic groups- for wanting the data this will continue to be an issue. He said that only 15% of the PRFs checked (1:100), April to August 2006, recorded ethnicity of patients.

Post Meeting Note–ACTION: all ADOs to note and ensure staff completing PRFs understand why the ethnicity of patients should be recorded on the PRF

The research funding received from the Department of Health is being withdrawn over a three year period with a decrease of £50,000 per year. CARU is making concentrated efforts to identify alternative funding (Diabetes UK, Stroke UK).

Noted:
1. **The report.**
2. **That with the introduction of Version 2006 of the JRCALC guidelines the Trust will be introducing Oramorph so as to provide better pain management for children. The date for the introduction of the drug has yet to be finalised.**

56 Presentation: Ergonomics Adviser

Dipak Chauhan, Ergonomics Adviser, gave a presentation on how applied ergonomics can improve patient care which included the findings of the extensive trials undertaken regarding different types of carry chair. Work was also undertaken in relation to the Paramedic Bag which advised on the optimum layout of drugs in the bags so as to facilitate ease of access.

There was a discussion regarding bariatric patients (in excess of 25 stone). It was reported that a funding bid for 2 vehicles to respond to bariatric patients had been deferred by the Strategic Steering Group. If staff are called to bariatric patients they are expected to undertaken a dynamic risk assessment and if necessary call on the support of other colleagues or the Fire Brigade. The Fire Brigade will not respond to planned transfers but only to emergencies. Although one Ambulance Trust developed a facility for patients with special needs to self-register with the Service, the initiative elicited a poor response. Difficulties often arise with inter-hospital transfer because hospital beds are used and these are not designed for transporting patients. Senior Operations Officer, Planning and Risk said this was an area of potential risk for the Trust. **ACTION: RCAG to note this risk.**

In terms of staff safety the Ergonomics Adviser said that two thirds of all lifting and handling incidents are concerned with heavy and awkward lifts/manoeuvres because of a lack of suitable transportation. Of these incidents the occurrence is approximately 50:50 (ratio of heavy/awkwardly situated patients).

Senior Operations Officer, Planning and Risk said that very large patients are relatively rare, the issue is more around the equipment and vehicles required to transport them. Another issue is that of patients on IAPB[3]. At 85kgs this equipment is only really portable within a hospital and is difficult to secure in the vehicle. There is a low incidence but a significant risk if the patient suffers because of a delay in transport. **ACTION: RCAG to note this risk.**

Noted:
1. **The report**
2. **That the funding application for specialist vehicle was deferred not rejected by the Strategic Steering Group; that the application should be reviewed and re-submitted for the next budgetary round (deadline January 14th).**

57 Presentation: development of KPIs from the NHSLA and Healthcare Standards

The Head of Governance tabled a paper outlining how Key Performance indicators will be developed for the NHSLA and the Healthcare Standards. Work has been done to identify commonality between the two and what evidence is required to satisfy compliance/required level of assessment. The NHSLA has 5 standards, each with 10 criteria; there are three

[3] IAPB: intra aortic balloon pump which is used as a last resort to keep a patient's heart beating.

assessment levels (policy in place, is it working, and whole system is effective). There are 24 healthcare standards with 13 developmental standards.

Following discussion it was agreed that members of the Committee will suggest KPIs to measure the different areas reviewed by the NHSAL/healthcare standards. One approach might be to consider the top risk for a particular department. The deadline for suggestions to be forwarded to Head of Governance is Friday 19th January. The Head of Governance will liaise with individual colleagues as to what might be suitable KPIs for their departments. **ACTION: Head of Governance**

Noted:

1. **The report**
2. **That this will be a significant piece of work and that everybody's contribution will be needed to ensure that the appropriate KPIs are identified to enable the Trust to evidence compliance with the NHSLA and the Healthcare Standards.**
3. **That a small working group (JW, FM, NF, CV, PC, MV) will meet prior to the next Committee meeting to take this work forward. ACTION: Head of Governance.**
4. **That the Trust will be required to make a final declaration on compliance with the Healthcare Standards on May 1st 2007.**
5. **That the NHSLA assessor is visiting the Trust in March and will give feedback on what level the Trust should be aiming for in April 2007.**

58 Protection of children and vulnerable adults

Lyn Sugg, Senior Operations Officer, Planning & Risk, informed the Committee that the protection of children and vulnerable adults has recently been audited as part of the routine bi-annual audit. The Trust's internal auditors, Bentley Jennison, recently completed an audit, the findings of which are contained in the report. The report's executive Summary and action plan is attached to the minutes.

The NHS is required to have measures in place to provide for the protection of children; the LAS has chosen to include vulnerable adults within that service. Since the service was undertaken the workload has increased and there is an argument that it requires a dedicated administrator. An aspect of the service that is proving most time consuming is the referring of children and vulnerable adults to the appropriate social services and following up the referral.

The Senior Operations Officer, Planning & Risk will be submitting a funding bid for 2007/08 to secure funding for an additional post holder to have responsibility for this work. She will also be submitting a risk for inclusion in the Trust's risk register. **ACTION: Senior Operations Officer, Planning & Risk.**

The Medical Director said that there should be close liaison between the Head of PALS and Senior Operations Officer, Planning & Risk to ensure there is no danger of duplication with regard to referrals involving nursing homes and regular callers. The form LA280 is used by the Trust to inform social services, it contains questions that are specific to social services. The Head of PPI said that clear and up to date guidance needs to be produced for staff. Head of Governance undertook to talk to the Head of Records Management about this. **ACTION: Head of Governance.**

Noted: **The report**

59 Public education strategy

The Head of PPI presented the Public Education Strategy which had been considered by the Trust Board in November 2006. The objective of the Public Education Strategy is to bring together the disparate work that is being undertaken across the Trust, to ensure that it is done in a co-ordinated fashion and to identify what resources are necessary to enable public education to be undertaken in professional manner. A number of initiatives are being

undertaken and progress will be reported on in due course. A SPPP[4] was submitted (£145,000 over three years) to support the strategy by ensuring that payment is available to recompense work undertaken by staff in their spare time; this was rejected and a new SPPP will be submitted for 2007/08. It is intended that the staff who undertake public education work are recruited for that role and demonstrate skills and competencies that will enable them to represent the Trust.

A project management approach has been adopted to manage the different streams of work identified. One of the pieces of work that is being undertaken will centre around branding/image e.g. recruitment; Head of PPI, Head of Communications and Diversity Manager are working together on this matter.

Noted: **The report.**

60 Update on PPI activity

The Head of PPI presented an update on the wide ranging PPI activity taking place in the Trust. She highlighted the following: a planned joint project with the NHS Centre for Involvement which will focus on the Bangladeshi and Somali communities in Tower Hamlets and is likely to include activities around health promotion, access to NHS services, recruitment and relationships between the community and local NHS staff.; a PTS event in November at which the Patients' Forum reviewed the provision of patient transport across London and a multi-agency project, 'Safe Drive, Stay Alive' which was reported as a very effective production warning young people of the dangers of dangerous driving.

Noted: **The report**

61 Operational Governance report

The Assistant Director of Operations East joined the meeting to present his report on what clinical governance has taken place in the East area. The Committee's attention was drawn to the minutes of the Clinical Governance meeting (East) held on 24th November which was accompanied by a front sheet that referred matters for the Committee's attention.

The initial trial of the handover form by First Responders has proved successful. There was an issue with Management Information not being able to scan the handover form but this has been resolved. A wider trial will be undertaken in January with the expectation that if it is successful it will be rolled out across the Trust. The advantages of the handover form is that it allows the observations of the First Responder to be included in the PRF which will be handed over by Ambulance crews to the hospital; this is of great importance but of particular significant for asthmatic patients where the initial Peakflow reading would be lost. The cost of introducing the handover forms is expected to be cost-neutral and may even generate savings.

In an effort to reduce paperwork and delays if a crew is cancelled en route by MDT a LA1 form is completed as opposed to a PRF form.

The Trust's Risk Register is reviewed by AOMs and at station level. Work is being undertaken with PALS regarding frequent callers. The Head of Complaints attended the last meeting (24th November) and spoke about the lessons to be learnt from problematic inquests and complaints.

Other items highlighted included the need for: a service wide system to ensure staff driving licence checks are kept up to date; a system to ensure that people whose training is not up to date are not practising; a system to enable frequent callers to be flagged in the control room and the need for follow up action plan following the closure of a complaint

[4] SPPP (strategic planning project profile) this is an internal form used to submit funding bids for projects.

Training: the Acting Head of Education & Development said that information is readily available via the quarterly produced Management Information pack issued to the AOMs. The pack contains information regarding training and recert course. The A/Head of Education & Development to contact all AOMs drawing their attention to where the information can be obtained. **ACTION: A/Head of Education.**

Driving licence: the Head of Employee Services said that the training module on the recently introduced Electronic Staff Records (ESR) will be increasingly used to record such data as driving licence checks and it is important to note that it is not just operational staff that require driving licence check.

Frequent callers: the Head of PPI said that the PALS team is working hard to put in place care plans for frequent callers; the work is often quite time consuming but ultimately it has proved worthwhile. Evidence is being gathered to demonstrate to PCTs that the resources expended on care plans are cost effective in comparison to ambulances being used inappropriately on a frequent basis. The Director of Communications circulated a copy of 'Talkback' which contained an article regarding Frequent Callers.

Assistant Director of Operations, East circulated details of the completion of Clinical Performance Indicators (CPI) for the East area, 1st April-31st August 2006. The data illustrated a significant variation in performance by individual Team Leaders in their review of PRFs and production of CPIs. Discussions will be held with the Team Leaders regarding the disparate performance. The production of CPI data alone is not in itself useful, what is needed is the 1:1 conversation between team leaders and crews to enable learning to take place. To that effect a system of reporting has been put in place to ensure that this process is undertaken on all the complexes.

Agreed:
1. **That the report from East be commended to the Senior Operational team as to how clinical governance can be implemented to ensure there is good governance.**

Noted:
2. **That the Head of Legal Services will raise the issue of driving licence checks at the Motor Risk Group. ACTION: Head of Legal Services**
3. **The operational governance reports from East, South, West and Control Services (EOC & UOC).**
4. **That the ADOs will take turns to attend the Clinical Governance Committee to report on what clinical governance activity has been undertaken in their respective sector.**
5. **That the Committee will receive a regular report from each sector on governance activity in their sector.**

62 Presentation: revised template for the risk information report

The Head of Governance circulated a suggestion for the revised template of the risk information report. The meeting in February will receive a draft risk information report that contains KPI information and data on trends and outcomes.

Noted: The revised template.

63 Clinical risks on the risk register

The clinical risks on the Risk Register were considered; it was suggested that the completion of the CPD course would address some of the risks currently on the register.

Agreed:
1. **That the sending of an ambulance staffed by technicians is a risk for the Trust. The Medical Director to propose adding this to the Risk Register when RCAG meets in March 2007. ACTION: Medical Director**
2. **That the grading of the following risks should remain unchanged until the new complaints policy and guidance is issued: 71, 26, 7, and 138.**
3. **That the grading of the following risks remain unchanged: 202, 64**
4. **That risks 46 and 63 will be considered for regrading at the next meeting**

Noted:

5. **Risk 34 (technicians failing to meet the IHCD requirements). That this risk is unlikely to change until the rotas are changed and time can be ring fenced for training.**
6. **Risk 31(adverse outcome in maternity cases): the Trust is actively seeking to recruit a new midwife. The risk level has not decreased.**
7. **Risk 207 (not being able to download information from defibrillators) evidence to be presented in February for the downgrading of this risk. ACTION: A/Head of Education & Development**
8. **Risk 22 (failure to undertake comprehensive clinical assessments which may result in the inappropriate non-conveyance or treatment of patients) there was still some progress to be achieved as only 85/799 staff have been trained.**
9. **Risk 221 (drug errors and adverse events not being reported) infrequently reported; one of the biggest issues is drug management.**
10. **Risk 194 (risk of patients and to viability of research projects with financial, ethical and reputational impact): work has been undertaken (resus guidelines with input into CPD course, technician course and paramedic recert course) but the risk remains.**
11. **Risk 188 (paramedics failing to qualify for registration): information is disseminated to AOMs.**
12. **Risk 179 (failure to meet responsibility under the Race Relations Act) diversity training has been incorporated within the CPD course and is included in leadership and management development programme**

64 Presentation: standards for better health/annual health check

The Committee considered the Standards for Better Health target that involves Thrombolysis as the Trust will have difficulty demonstrating compliance with this target. April to June 2006, 72% of confirmed ST-elevation Myocardial Infarction (STEMI) patients were transported by the LAS directly to Cardiac Catheter lab. During the same period, so far only one of the STEMI patients taken to A&E was confirmed as receiving thrombolytic treatment and this patient received thrombolysis 56 minutes after calling the LAS (calculated from LAS orcon time).[5]

Discussions have been held with the Healthcare Agency and although sympathetic the Trust's representative was told that the standard was based on DH guidance. It was noted that in recent months the DH has accepted the clinical arguments in favour of angioplasty being undertaken for STEMI patients. The LAS is encouraging a 'call for help to reperfusion time'.

Noted **The update on thrombolysis target.**

65 NHSLA assessment level

The Head of Governance reported that the NSHLA assessor will be visiting the LAS in March 2007 to undertake an informal assessment of the evidence of compliance. He/she will then advise as to what level the Trust should be reviewed when the formal assessment takes place in April 2007.

He said that if the Trust attains Level 2 it will receive 20% discount on its subscription and if it attains Level 3 it will receive 30% discount. The intention is to prepare for assessment at Level 2 when the assessor visits in March.

Work will be undertaken to identify major gaps and an action plan will be presented to the Committee in February the report will be presented using 'traffic lights' to denote achieved,

[5] CARU are still tracing patient outcomes for this period and therefore the calculation of average calls to Thrombolysis is likely to change.

not achieved and partly achieved. This action plan will be presented to the Clinical Governance in February 2006. **ACTION: Head of Governance.**

Board training session on safety and risk: Head of Employee Services said that the Executive Team and Senior Managers received training on safety and risk on 16th May 2006. The Head of Governance was asked to confirm whether the NHSLA will find it acceptable that the Executive Directors have received training on safety and risk or whether NEDs will also be required to receive training. **ACTION: Head of Governance to ask NHSLA assessor.**

Agreed: That the Trust ask to be assessed at Level 2 when the assessor visits in March 2007.

66 Update on safety alert bulletins and NICE

Noted:
1. **That SAB NPSA/2005/10 will be addressed by the 'Being Open' policy being presented to the Trust Board in January 2007;**
2. **That SAB (MDA/2005/069) has been addressed by the decision to replace blood pressure monitors on an annual basis;**
3. **That there were no NICE guidelines issued since the last meeting that were of relevance to ambulance trusts.**

67 Report from groups/committees

Risk Assurance and Compliance Group: 6th November 2006

Noted:
1. **That RCAG had agreed that the following risks be regraded (26, 43, 226, 10 and 181); deleted (192); remain unchanged (182, 173, 35, 267, 71;**
2. **That two new risks were added to the risk register: (1) the delay in fully implementing the action plan devised following the London bombing of July 2005 and (2) the implementation of rest breaks;**
3. **That RCAG considered the risk management policy and procedure prior to them being approved by the Trust Board in November 06;**
4. **That RCAG had reviewed the Annual Complaints Report, which included an update on the implementation of the PSU Review's recommendations. This report was subsequently presented to the Trust Board in November 2006.**

Complaints panel: 5th December 2006

The Head of Complaints reported that the Trust's complaints policy and procedure is being revised and will be presented to the Trust Board in January 2007; they were recently considered by the Complaints Panel which met on 5th December. Comprehensive Guidance notes are to be produced to accompany the policy and procedure. Work is being undertaken to ensure there is consistency across the Trust as to how complaints are investigated and managed; under the new arrangements Performance Improvement Managers (PMPs) are responsible for managing complaints in each of the areas.

As part of the revised policy/procedure there will be a change in how complaints are handled i.e. they will not be handled in an adversarial manner and there will be a greater focus on learning lessons from individual complaints and what themes can be identified.

Infection Control Group – 10th November 2006

Noted:
1. **That 'flu jabs' were undertaken by ECPs this year and a 'walk in' approach adopted. The new arrangements appeared to work better than previous years when the Trust used Occupation Health who insisted on pre-arranged appointments;**

2. **That the Department of Health recently published 'Essential Steps to Safe Clean Care' framework which will be considered at a workshop to be held in early January;**
3. **That an audit is being undertaken of cannulas to ensure that the old style cannulas have been taken out of use. Head of Governance & Head of Clinical Audit & Research are liaising on the design of a new auditing tool to measure this. <u>ACTION: Head of Governance & Head of Clinical Research & Audit Unit;</u>**
4. **That from April 2007 PTS and Single Responders will be issued with latex free gloves;**
5. **That the Group is considering issuing personal hand gel containers to all operational staff.**

Noted: **The report**

68 **<u>Dates of next meeting:</u>**

Core: Monday, 12th February 2006 at 9.30 in the Conference Room, HQ.
Full: Monday, 16th April 2006 at 9.30 in the Conference Room, HQ.

Meeting concluded at 1pm

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 23rd January 2007

Review of the Trust Wide Risk Register and details of progress.

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

This paper updates the Trust Board on the current Risk Register and highlights progress, controls and actions taken.

The Risk Register lists risks, and assesses their impact using the Risk Management Matrix, according to the detailed guidance set out in the Risk Reporting and Assessment Procedure. Risks are ranked and prioritised according to severity and are grouped using the following seven categories:-

1. Clinical –including infection control
3. Operational
2. Health and Safety – including education and development
4. Logistics
5. Finance
6. IM&T
7. Corporate

4. Recommendations

THAT the Trust Board note:

1. The progress which is being made to manage the risks described in the Trust Wide Risk Register Progress Report (First Level).
2. That the top 5 risks from the seven categories will be presented to the Trust Board twice a year to enable the Board to monitor progress.

Enclosure 17

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th January 2006

Charitable Funds Annual Report

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For noting

3. Summary

The London Ambulance Service NHS Trust is the Corporate Trustee of the Charitable Funds. The Board 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.

Attached are the audited accounts for the London Ambulance Service NHS Trust Charitable fund and the Annual Report for the year ending 31st March 2006 which have to be submitted to the Charity Commission.

Key points in the audited accounts are:

- Actual Income for 2005/06 was £17,382; this was £1,382 more than planned.
- Actual Expenditure for 2005/06 was £45,291; this was £3,529 less than planned.
- The value of investments increased by £17,000 during the year.

Also enclosed is the Annual Governance report for the London Ambulance Service NHS Trust Charitable fund for the year-ending 31st March 2006.

4. Recommendation

THAT the Trust Board note the contents of the Charitable Funds Annual Audit Report.

Enclosure 18

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD 30th January 2006

Audit Commission's Annual Audit Letter

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

The purpose of this Annual Letter is to summarise the key issues arising from the work that the Audit Commission has carried out during the year. The key messages are set out on page 5.

The details of the Auditor's Local Evaluation (ALE) are set out on page 8; the Trust received an overall rating of 'Good' for the Trust's use of resources within the Healthcare Commission's Annual Health Check.

4. Recommendation

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

Enclosure 19

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 30th January 2007

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

1. Purpose of Report

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

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

2. Tenders Received

There has been 1 tender received since the last Trust Board meeting.

17/06	Crooked Billet Fixed Satellite Point	Mitie Property Services Russell Crowberry TCL Granby Ltd. Coniston Ltd.

3. Use of the Seal

There have been 5 entries, reference 99, 100, 101, 102 and 103 since the last Trust Board meeting. The entries related to:

No. 99	Assignment of Unite 2 and 3, Falcon Park, Neasden Lane, London.
No. 100	Lease of ground floor, Unit 2, Shacklewell Studios, 18/24 Shacklewell Lane, London E8 2EZ.
No. 101	Lease of land at Crooked Billet Roundabout, Wadham Road Walthamstow.
No. 102	Counterpart lease of Unit 24, Bessemer Park, 250 Milkwood Road, Herne Hill, London SE24 0HG.
No. 103	Deed of release of restrictive covenant noted on leasehold title No. TGL63890 (Unit 24, Bessemer Park)

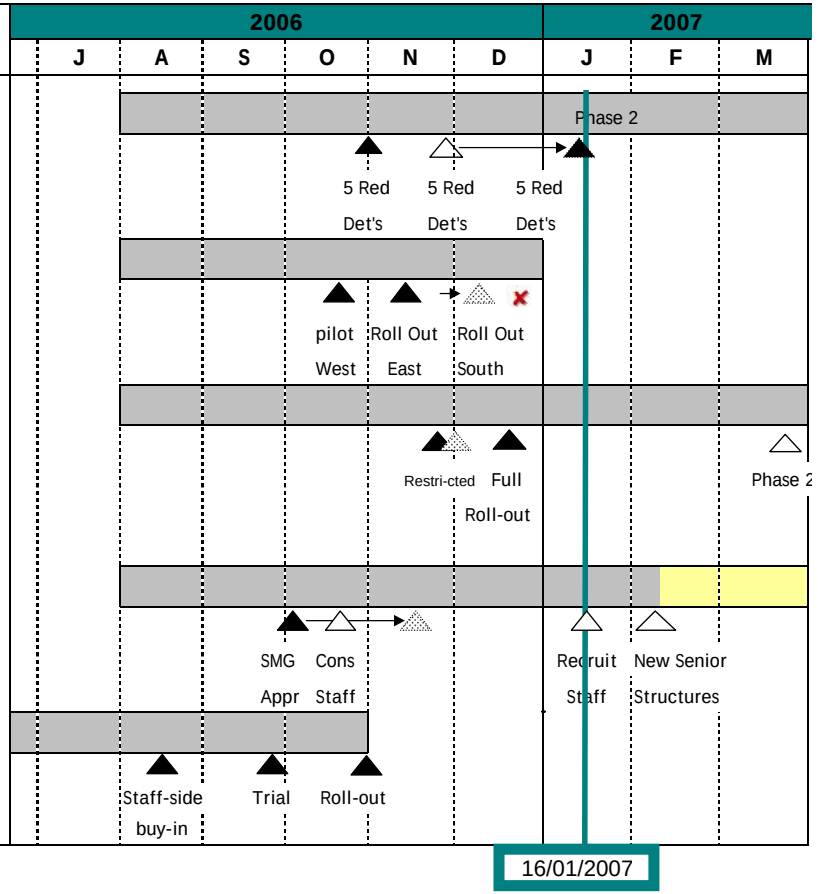
4. Recommendations

THAT the Board note this report regarding the use of the seal.

Christine McMahon
Trust Secretary

Dispatch Project Portfolio - Schedule Summary

Release Name	Change (Project) Manager	Scheduled Start	Scheduled Complete	Progress
Reduce Red Call Volumes	Ian Todd (Ian Todd)	24/8/06	31/12/06	(Delivered)
Increase dispatch capacity	John Hopson (Grenville Gifford)	21/8/06	31/12/06	(Delivered)
Improved dispatch of FRUs	Paul Webster (Paul Webster)	24/8/06	15/12/06	(Delivered)
Restructure EOC & UOC Management	Richard Webber	21/8/06	1/3/07	(-6 weeks)
Improve urgent performance	Richard Webber (Ian Todd)	27/4/06	31/10/06	(Delivered)



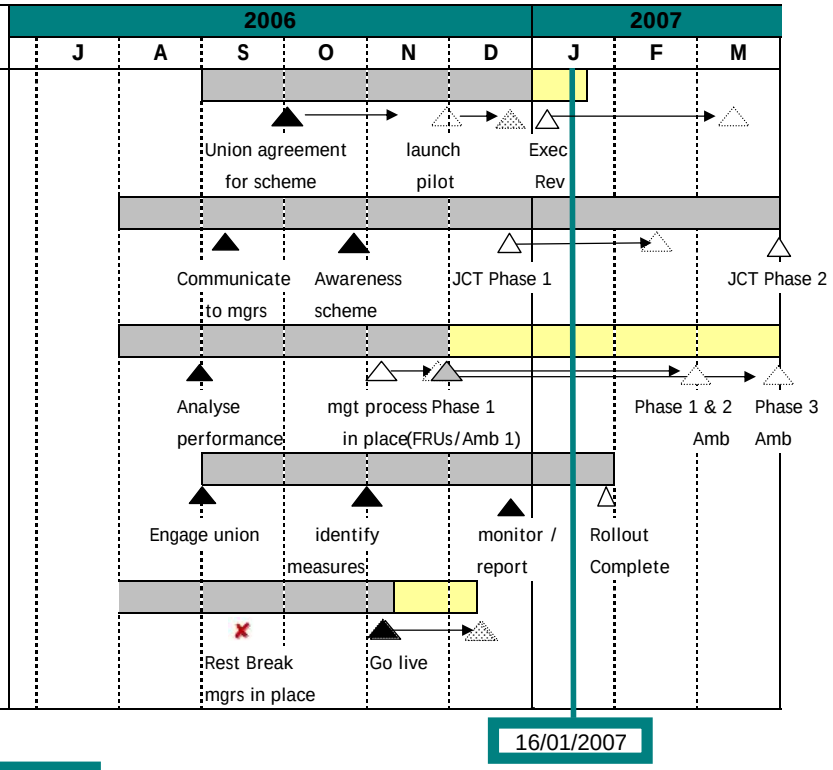
Legend

Schedule
Slippage

Milestone not achieved yet
Milestone achieved
Milestone Slipped
Milestone achieved late
Milestone Cancelled

Response Project Portfolio - Schedule Summary

Release Name					
	Change (project) Manager	**Scheduled Start**	**Scheduled Complete**	**Progress**	
Home responding	Mike Boyne (Philip de Bruyn)	1/9/06	15/12/06	(-4 weeks)	
Reduce job cycle time	Peter Horne (David Court)	1/8/06	31/3/07	(-8 weeks)	
Reduce performance fall at shift c/o	Mike Boyne (Philip de Bruyn)	1/8/06	31/1/07	(12-16 weeks) for AMB phase	
Individual performance monitoring	Russell Smith	1/8/06	31/1/07	(On Track)	
Rest breaks	Steve Sale (Roy Hopkinson)	1/8/06	4/11/06	Delivered	



Legend

- Schedule
- Slippage
- Milestone not achieved yet
- Milestone achieved
- Milestone Slipped
- Milestone achieved late
- Milestone Cancelled

London Ambulance Service
NHS Trust

Information Pack for Trust Board

December 2006

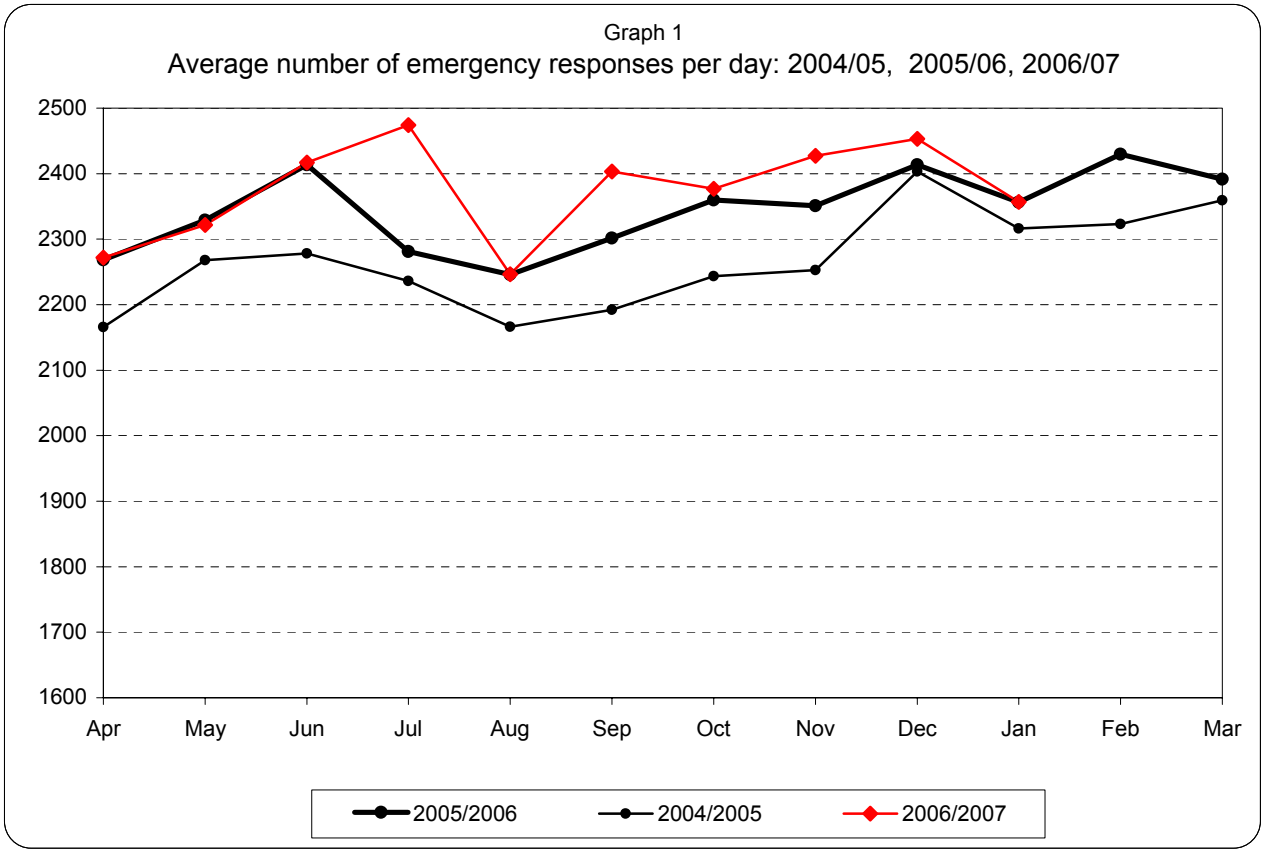
Please note:

PRF data entry is not yet complete for December 06

Data for January has been included, up to the 21st January 07

London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency activity and Urgent activity and performance

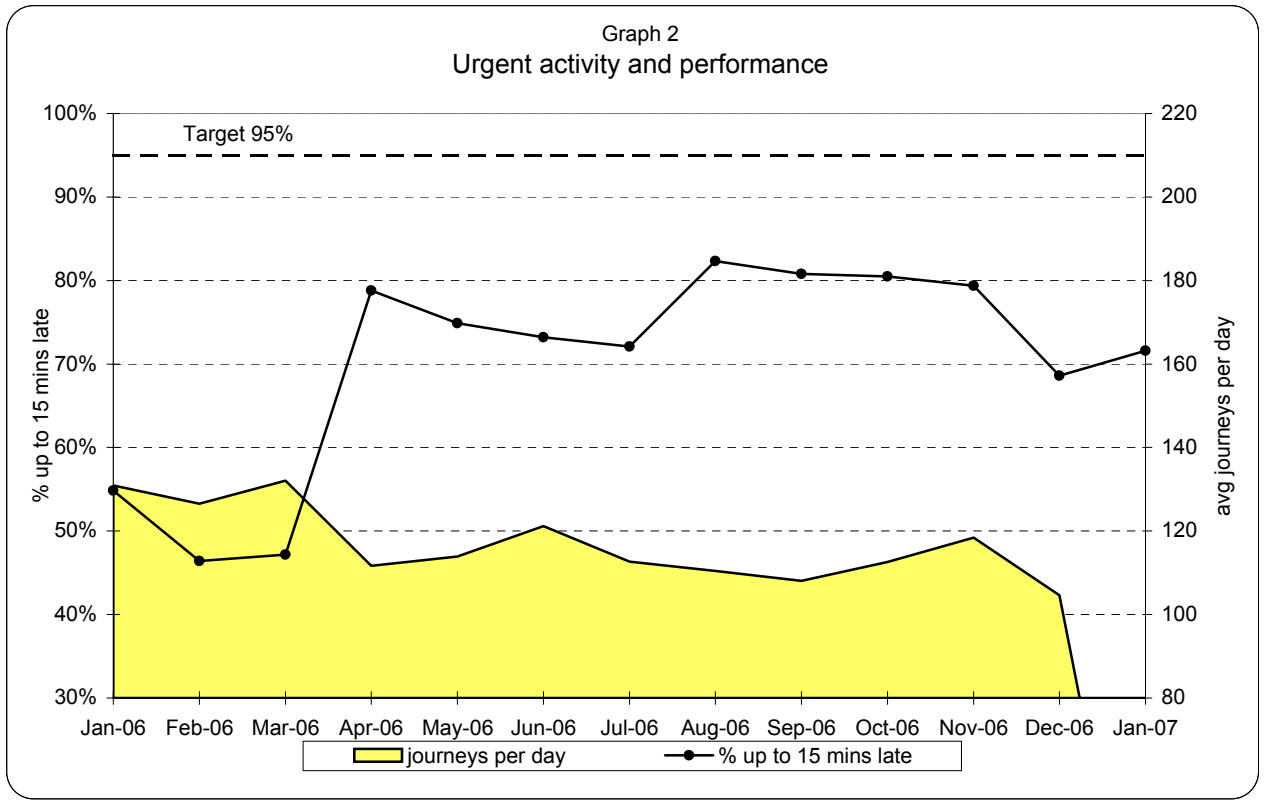
Graph 1



Emergency responses: monthly and year to date comparison

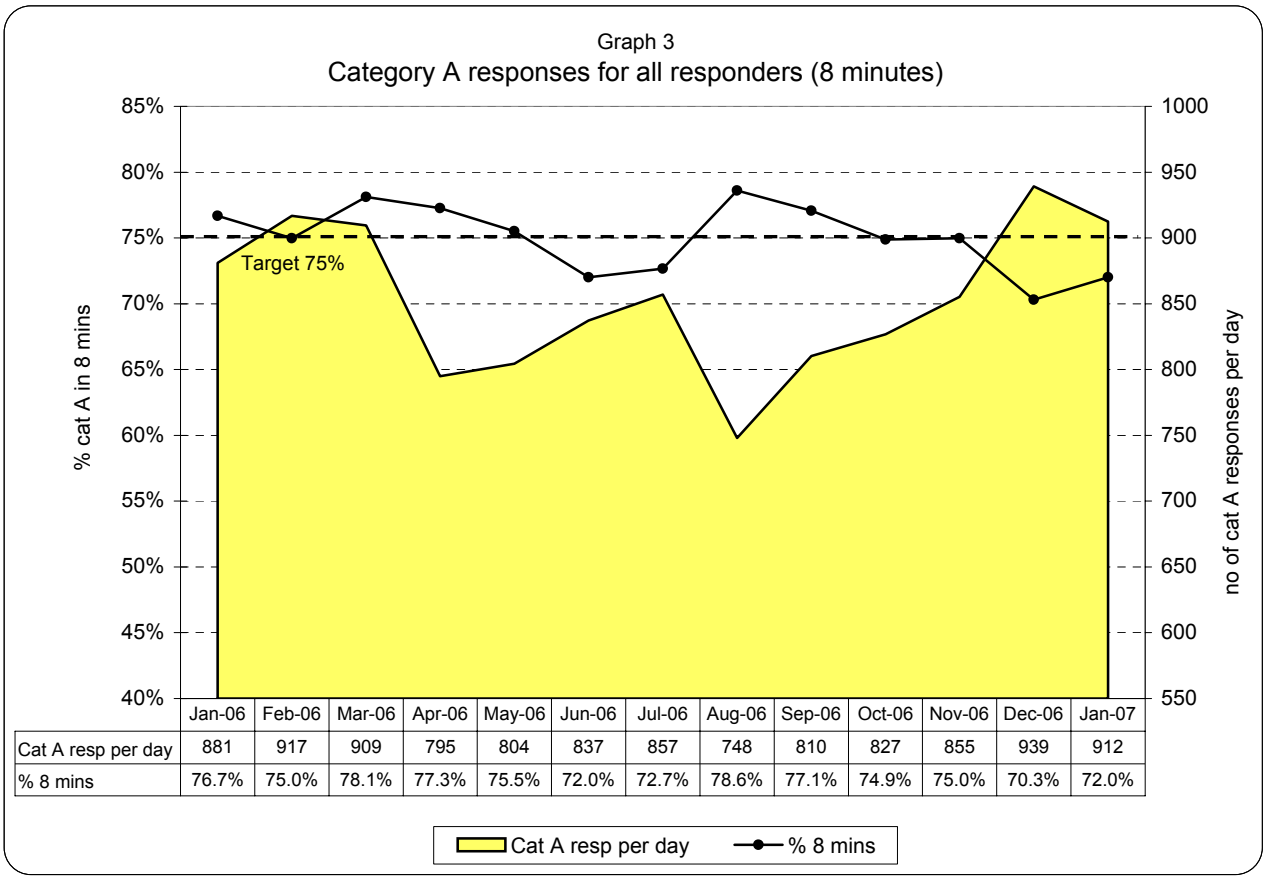
Dec 06 v Dec 05	Apr 06-Dec 06 v Apr 05-Dec 05
+1.6%	+2.0%

Graph 2



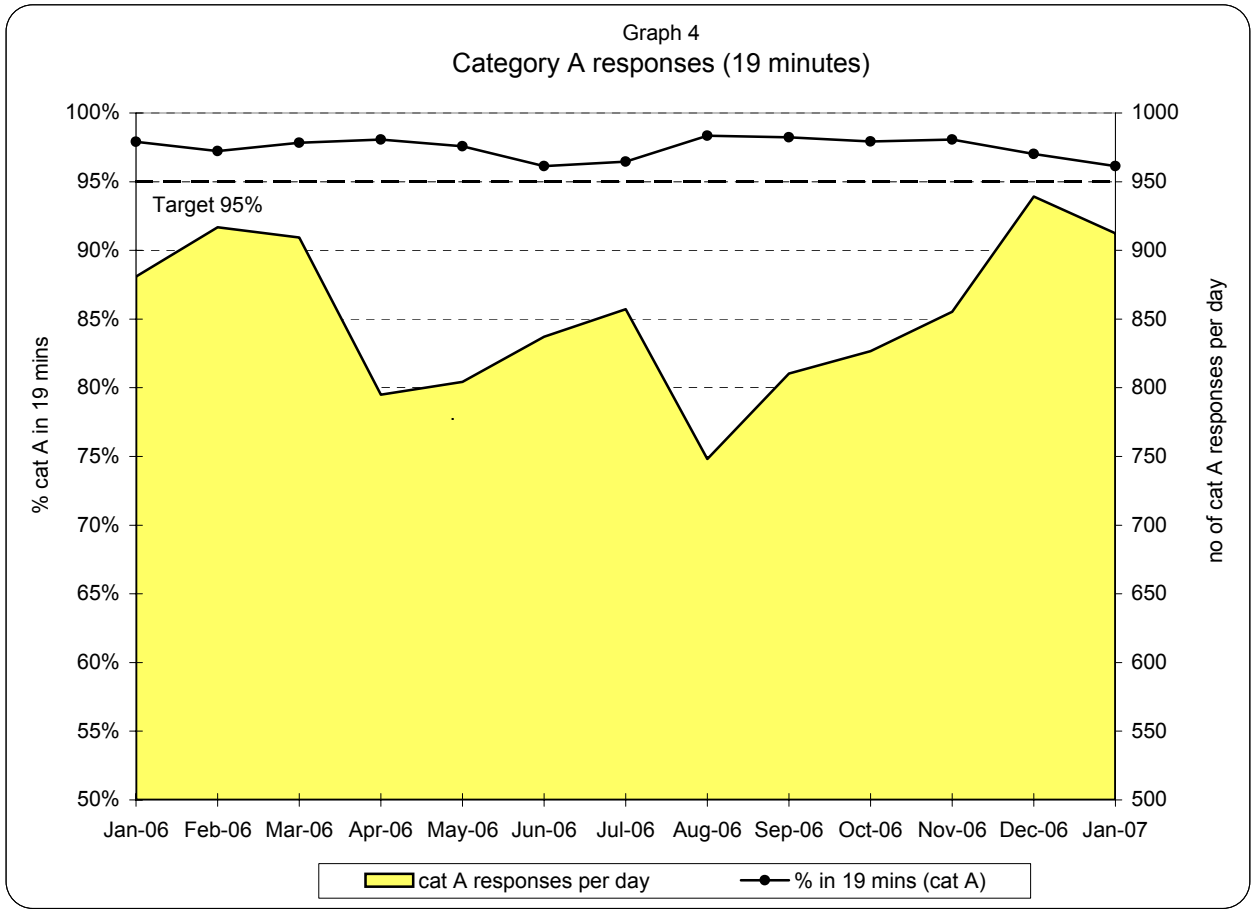
London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency responses: 8 and 19 minute response activity and performance

Graph 3



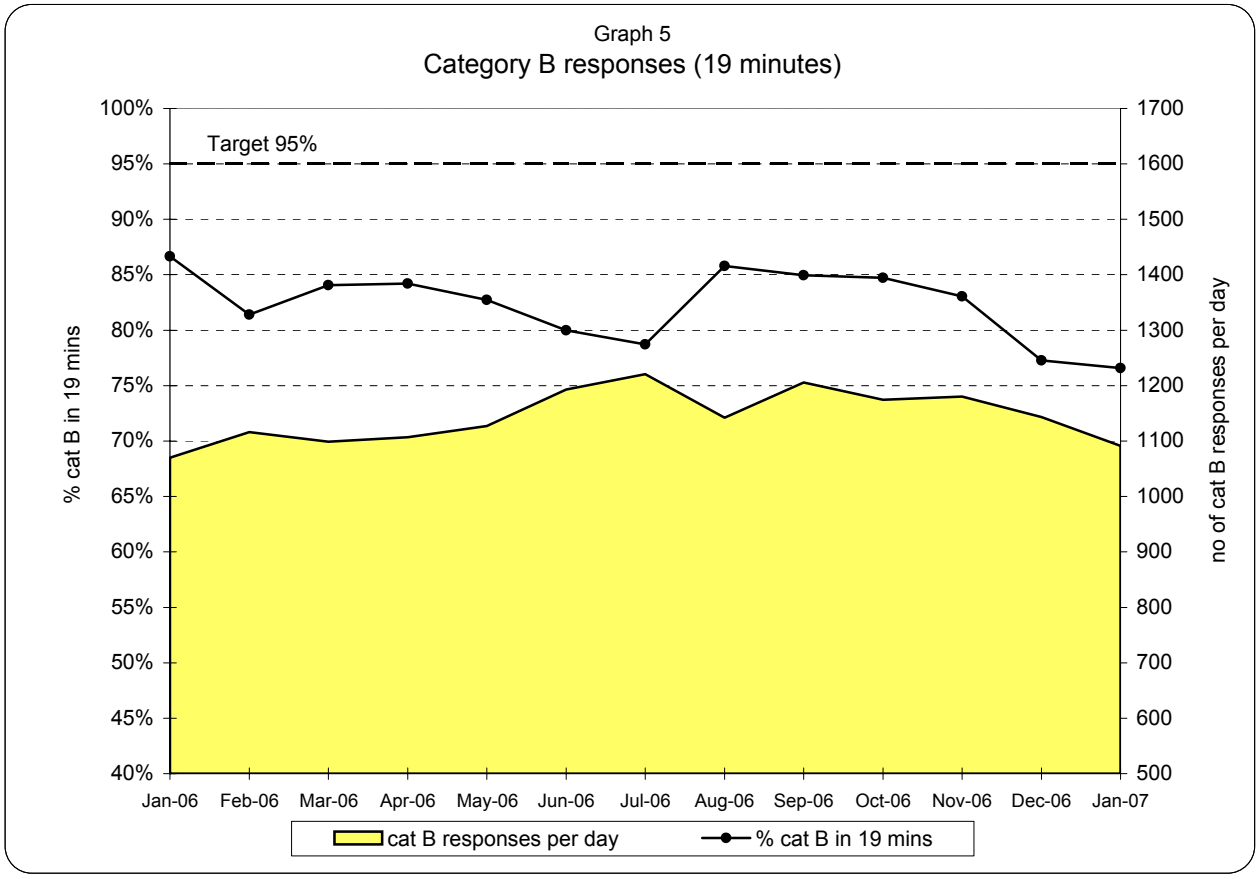
	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07
Cat A resp per day	881	917	909	795	804	837	857	748	810	827	855	939	912
% 8 mins	76.7%	75.0%	78.1%	77.3%	75.5%	72.0%	72.7%	78.6%	77.1%	74.9%	75.0%	70.3%	72.0%

Graph 4

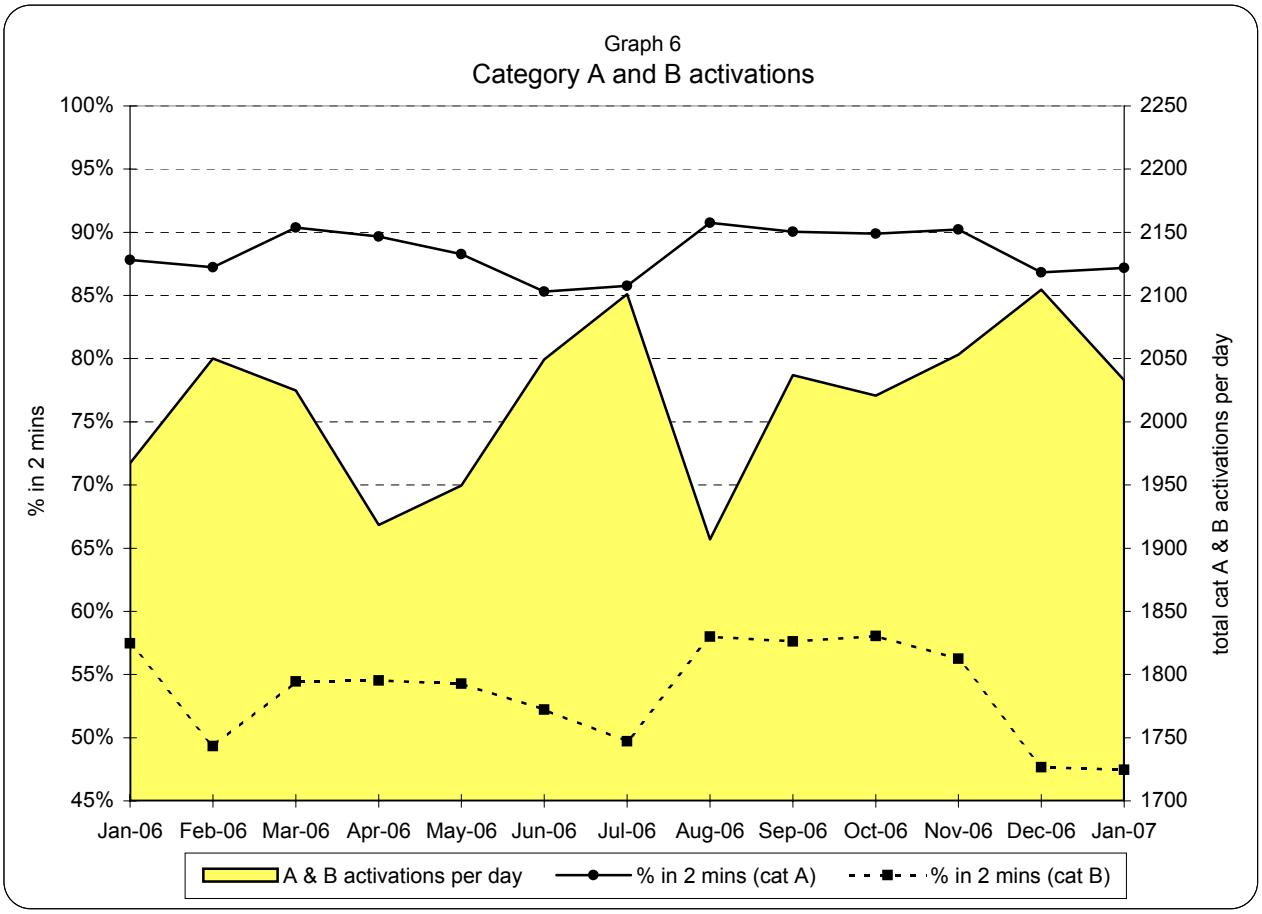


London Ambulance Service NHS Trust
Accident and Emergency Service
19 minute response activity and performance (Cat B) and Cat A and B activations

Graph 5

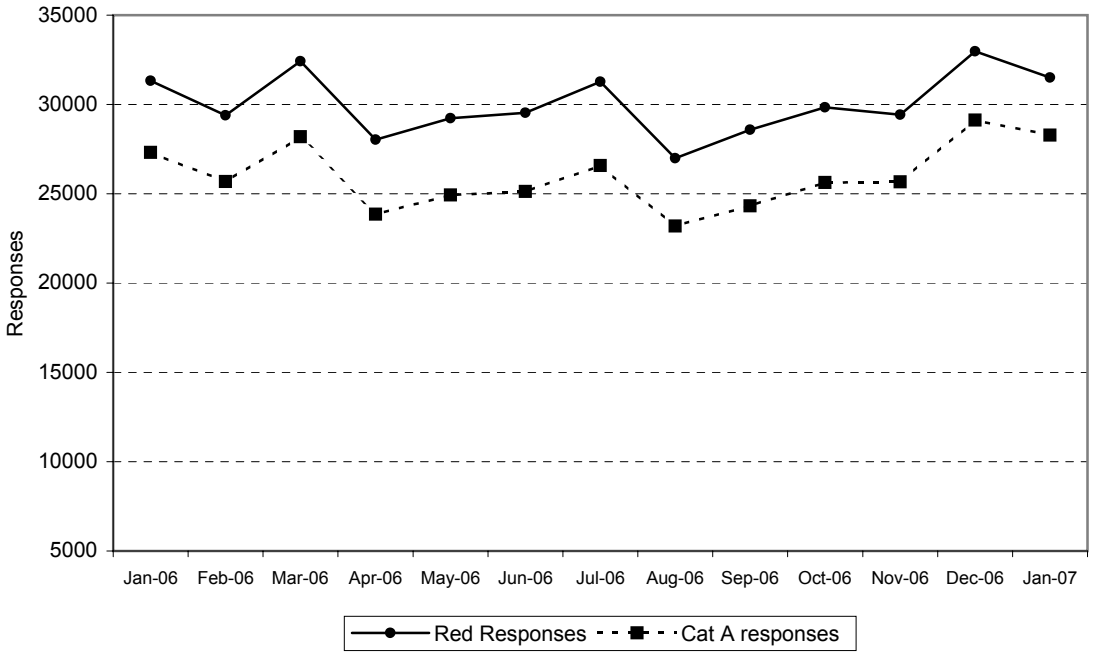


Graph 6

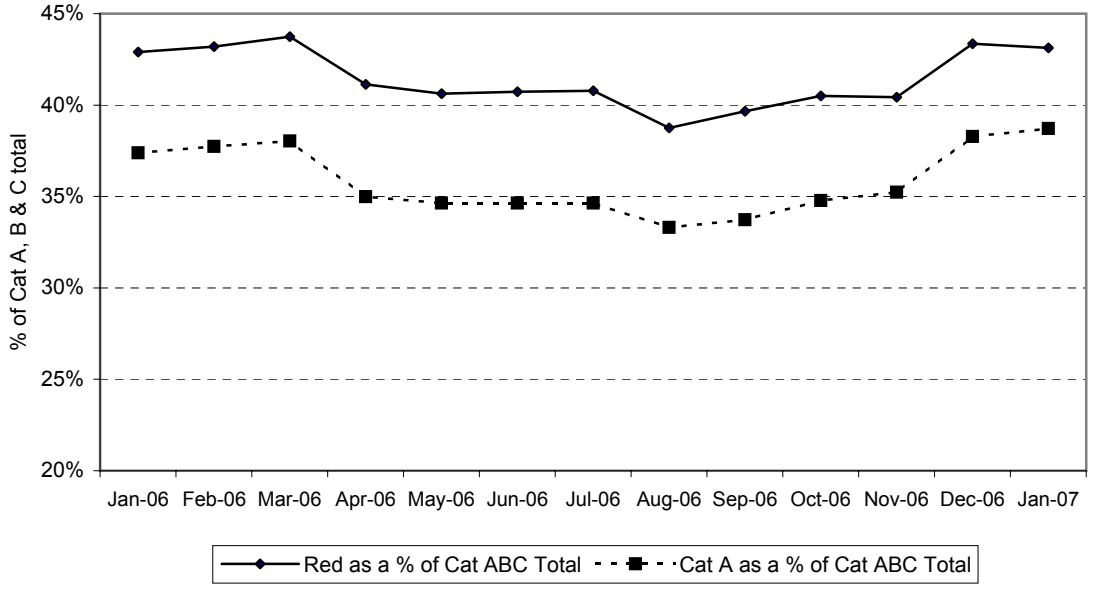


London Ambulance Service NHS Trust
Accident and Emergency Service
Category A and Red Responses

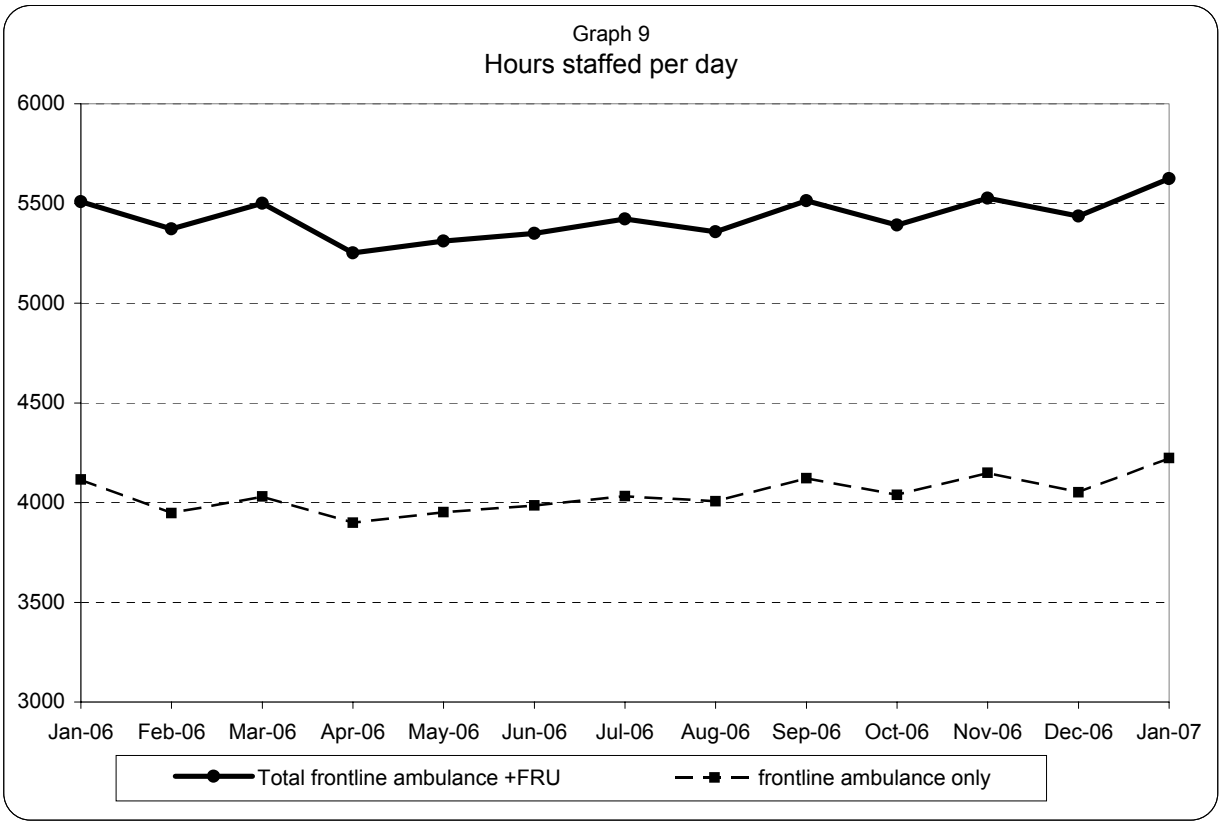
Graph 7
Total Category A and Red Responses

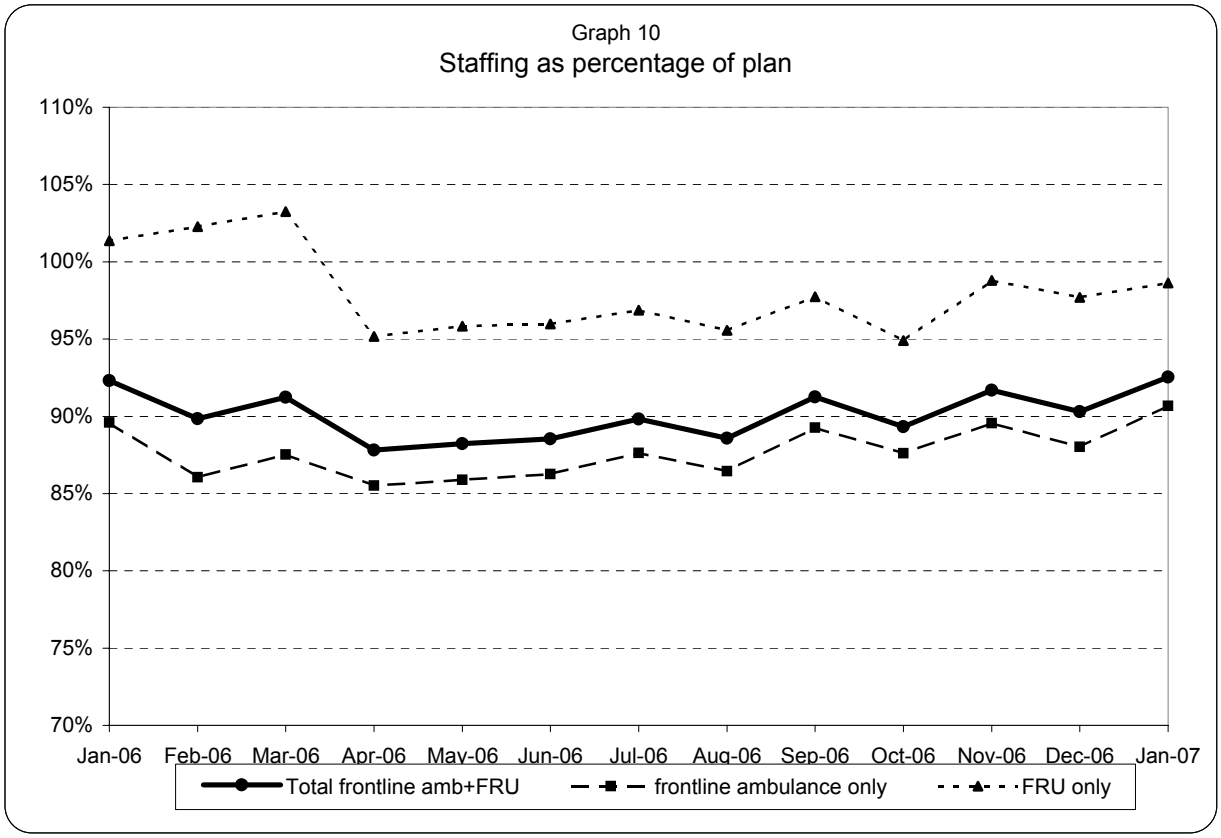


Graph 8
Category A and Red Responses as a percentage of the total Cat A, B & C demand



London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance and FRU staffing

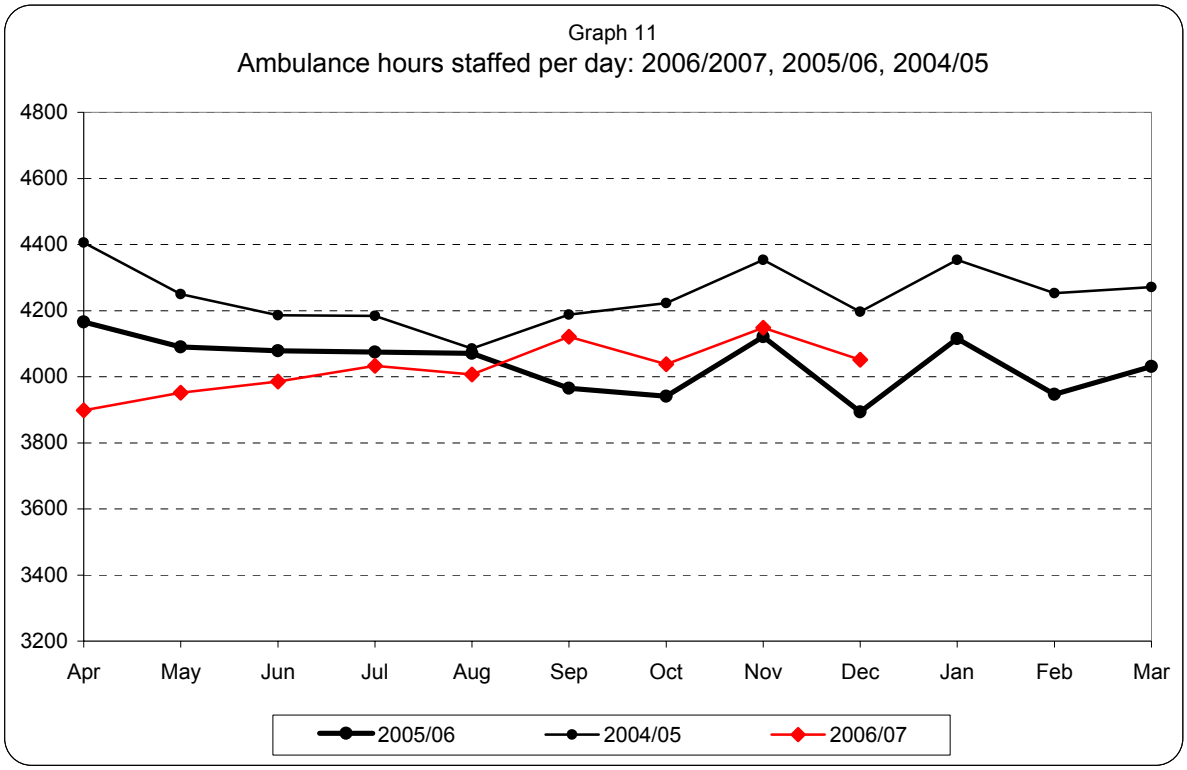




Note: staffed = (plan + additional - unmanned - single)/plan

London Ambulance Service NHS Trust
Accident and Emergency Service
Yearly comparison of ambulance staffing and Average Monthly Utilisation

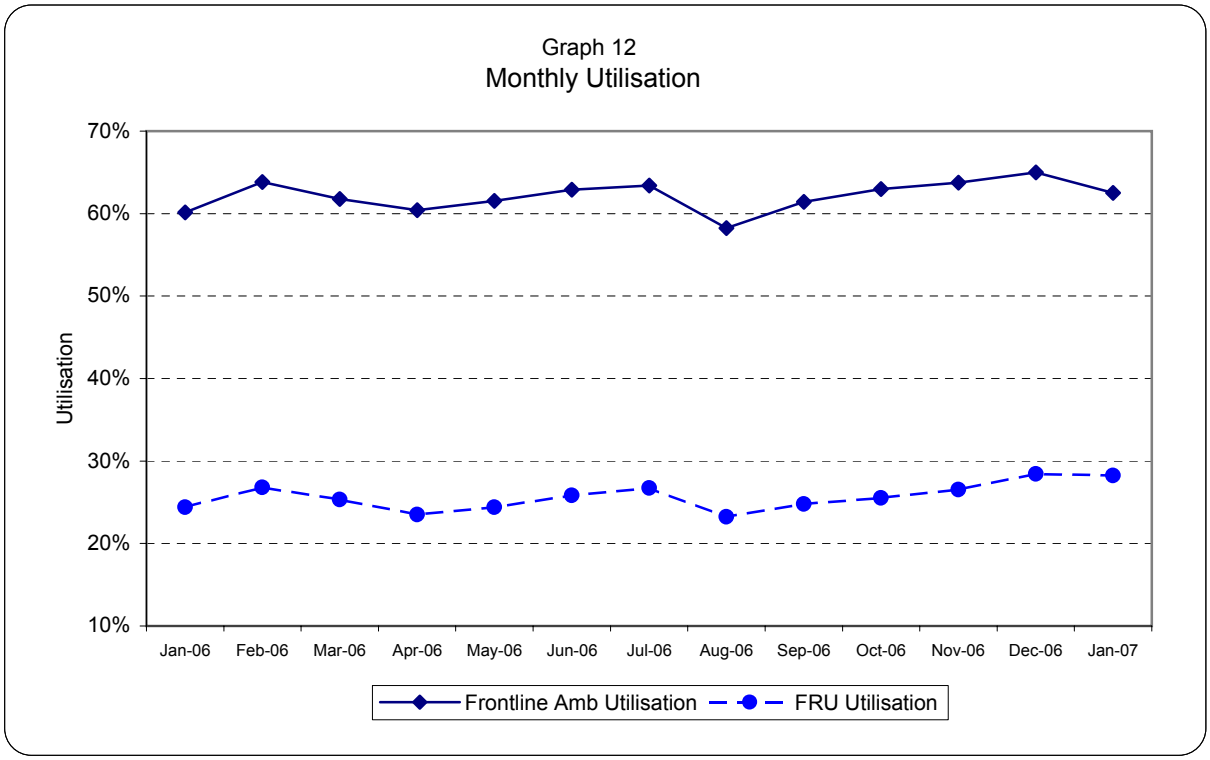
Graph 11



Note: staffed = plan + additional - unmanned - single

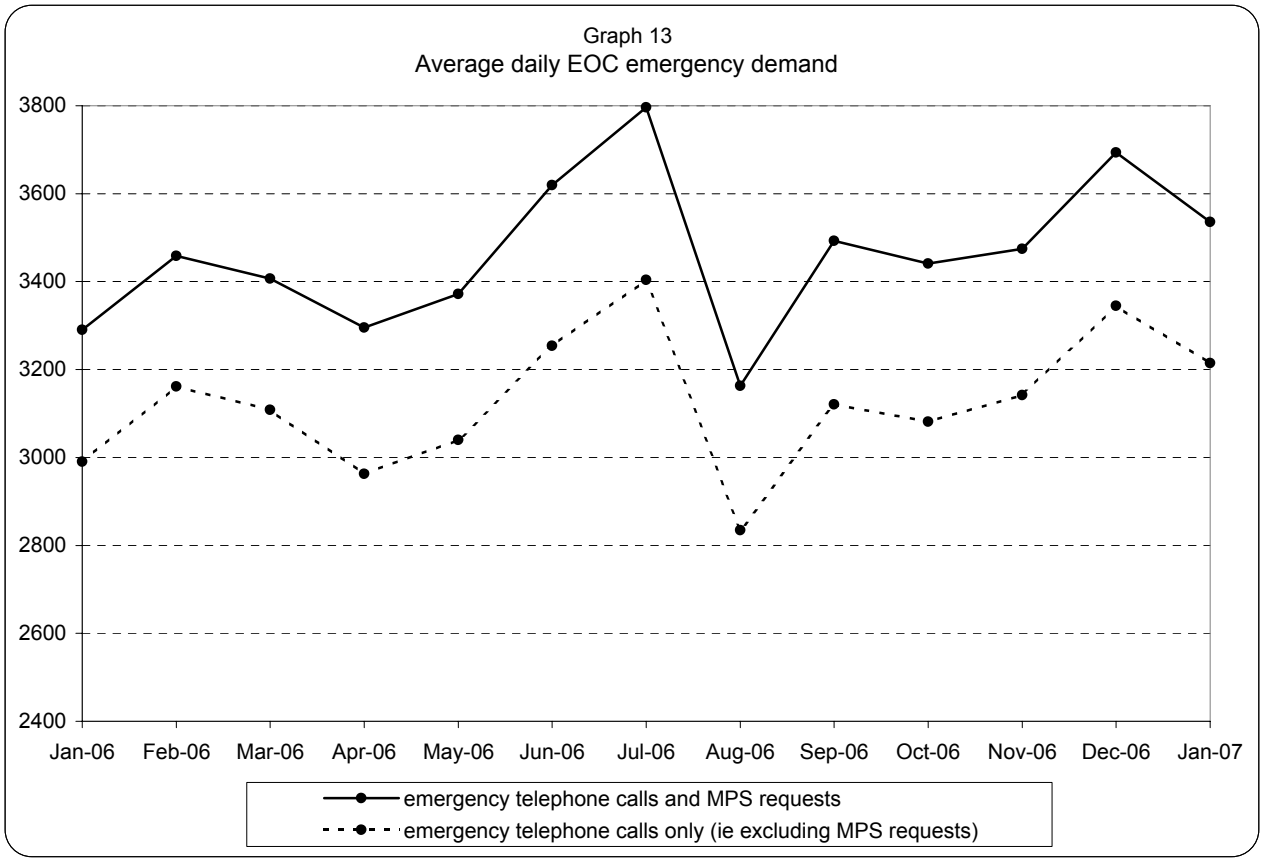
The 04/05 figures are taken from the old manning system. 05/06 figures onwards are from the new system

Graph 12

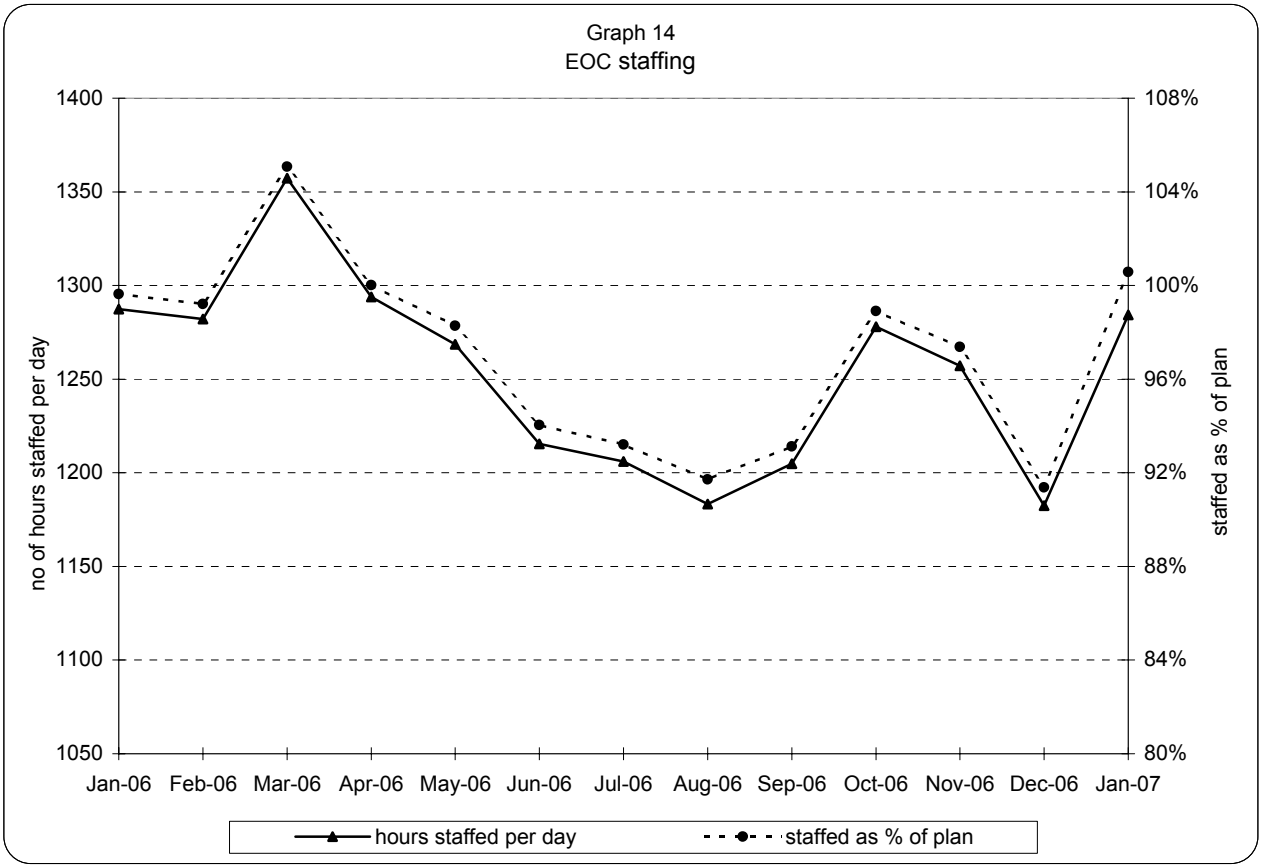


London Ambulance Service NHS Trust
Accident and Emergency Service
EOC activity and staffing

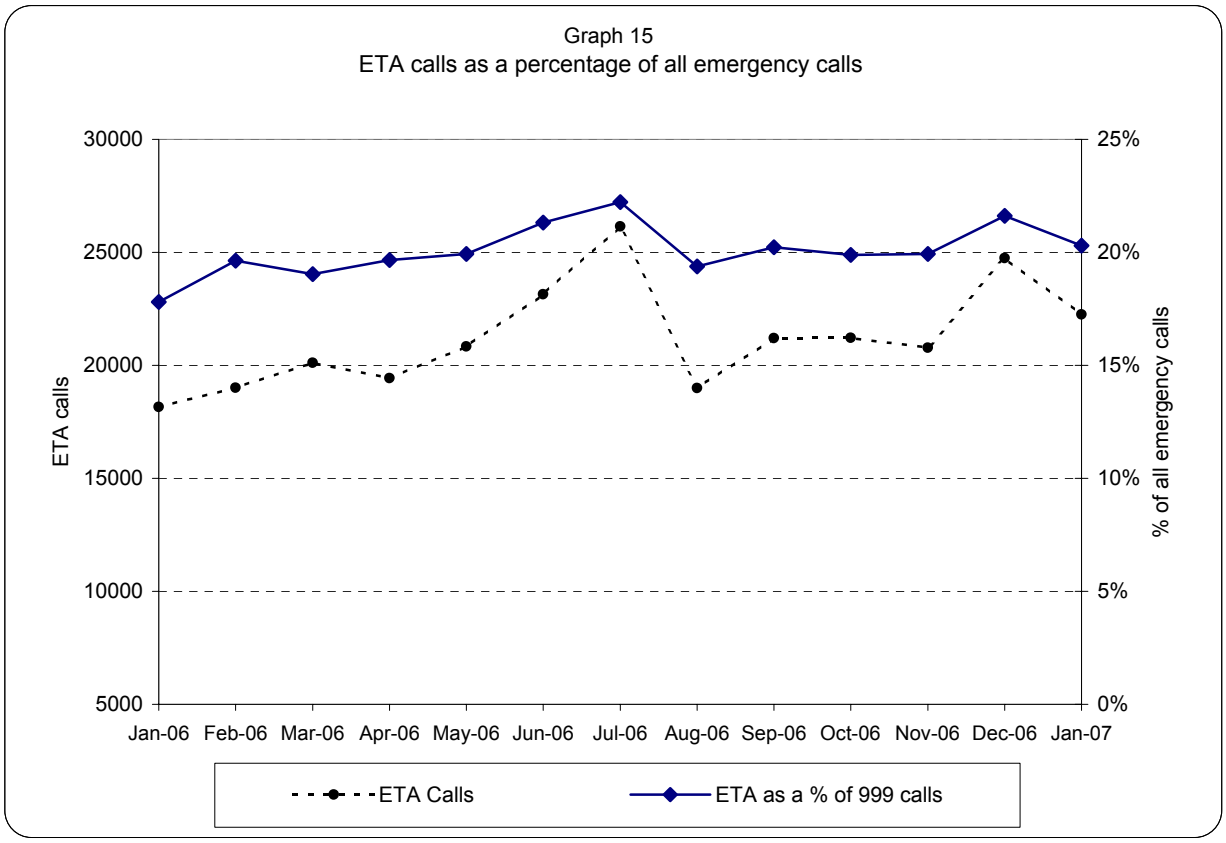
Graph 13
Average daily EOC emergency demand



Graph 14
EOC staffing



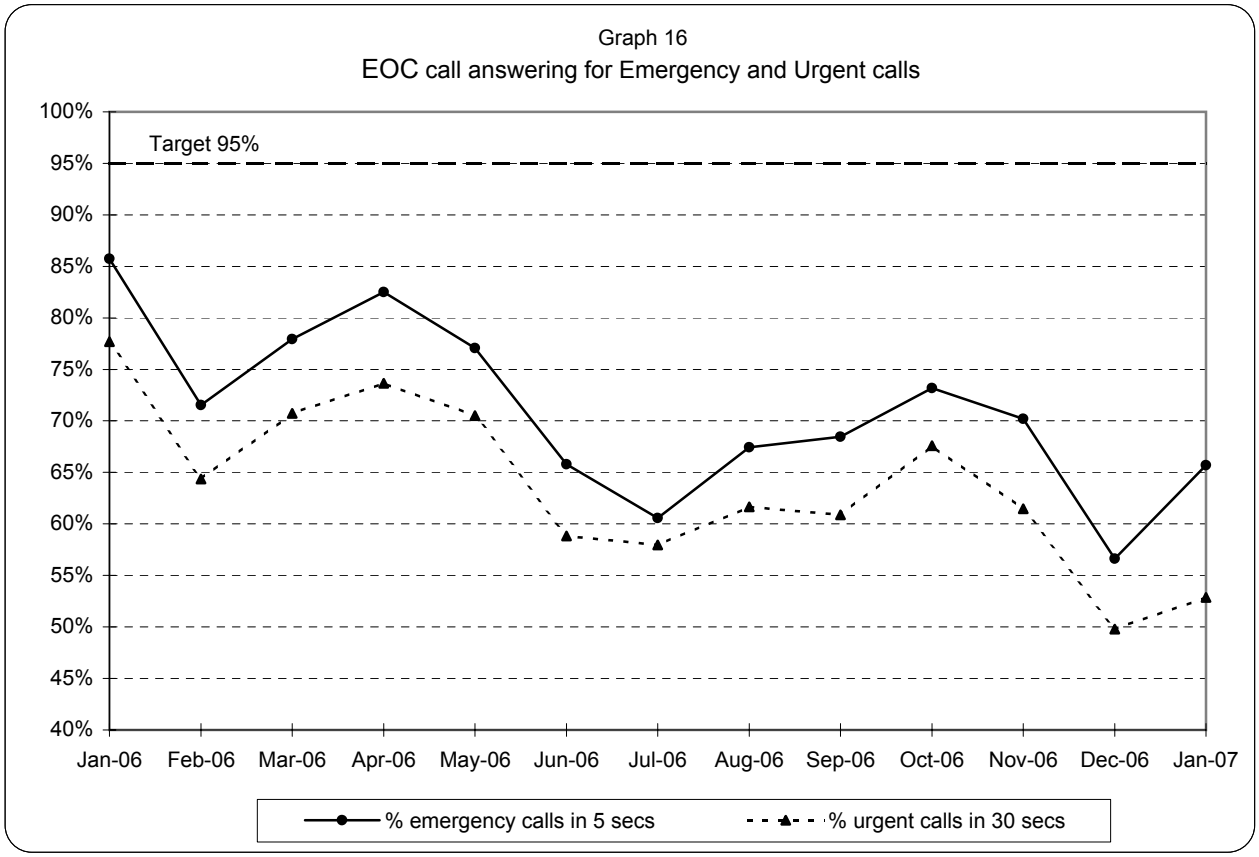
London Ambulance Service NHS Trust
Accident and Emergency Service
ETA calls as a percentage of all emergency calls



London Ambulance Service NHS Trust
Accident and Emergency Service
EOC call answering performance

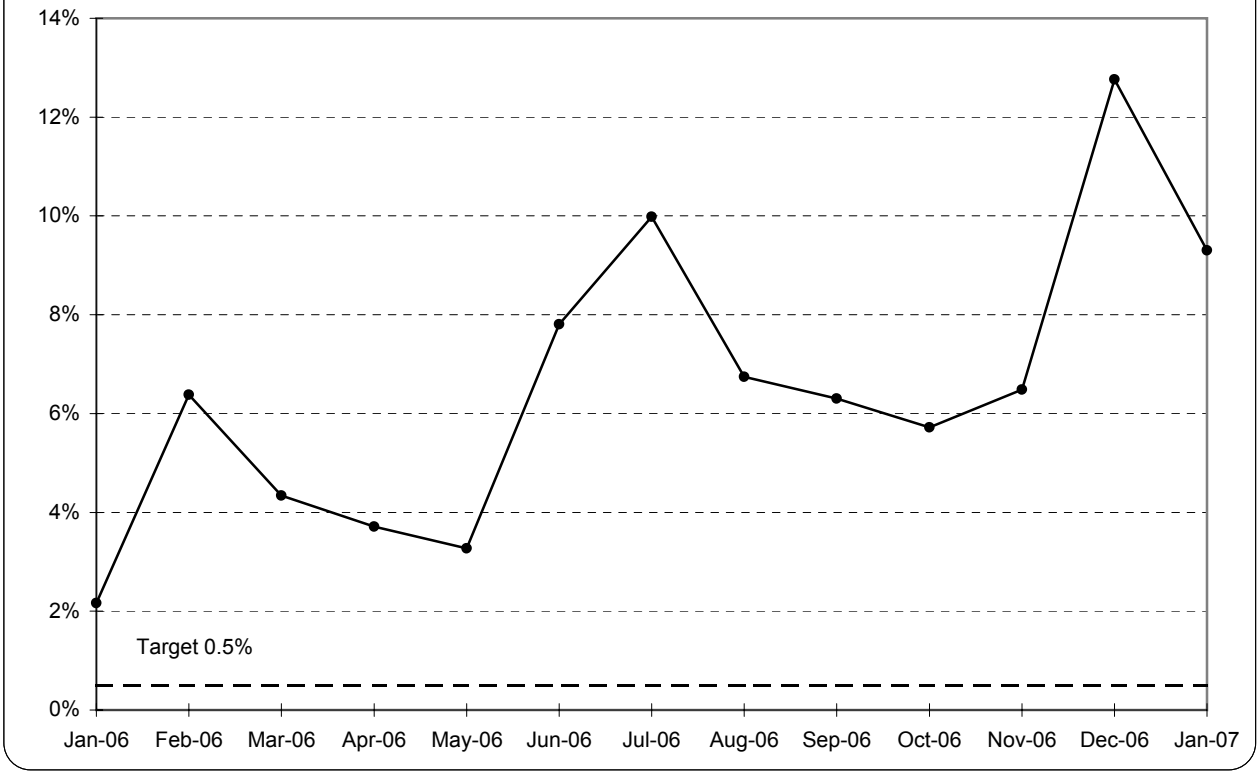
Graph 16

EOC call answering for Emergency and Urgent calls



Graph 17

Percentage of emergency calls answered after 120 seconds



Note: 95% target applies to both Emergency and Urgent call answering

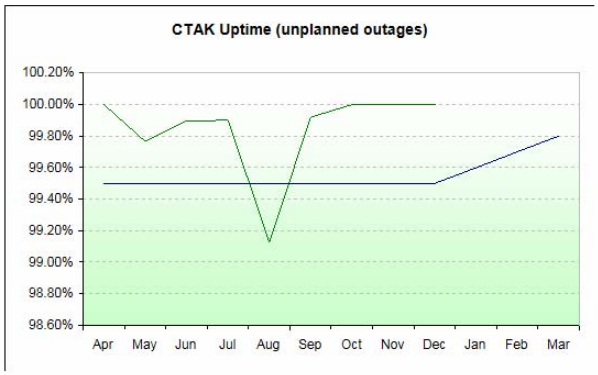
London Ambulance Service NHS Trust
Accident and Emergency Service
Category A activity and performance by Primary Care Trust

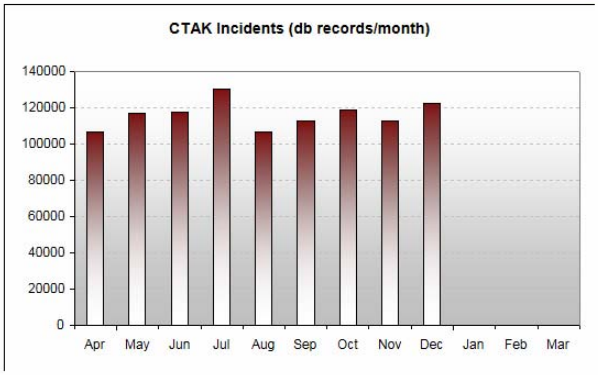
Table 1

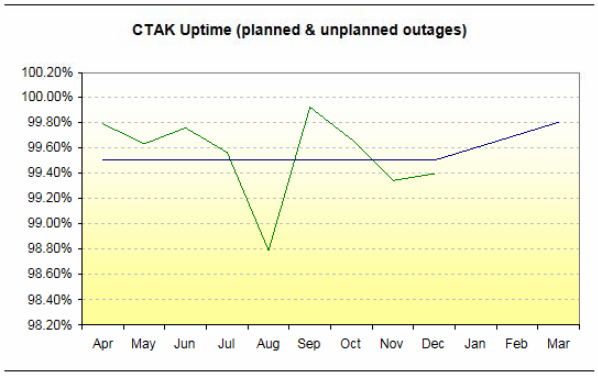
		Oct-06			Nov-06			Dec-06			Year to date		
		Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins
5K5	Brent PCT	946	700	74%	972	737	76%	1,104	751	68%	8,433	6,111	72%
5HX	Ealing PCT	1,028	758	74%	1,032	701	68%	1,162	736	63%	9,213	6,586	71%
5H1	Hammersmith & Fulham PCT	646	491	76%	581	464	80%	719	525	73%	5,498	4,299	78%
5K6	Harrow PCT	577	483	84%	589	463	79%	691	510	74%	5,392	4,317	80%
5AT	Hillingdon PCT	915	678	74%	929	689	74%	1,067	683	64%	8,324	6,099	73%
5HY	Hounslow PCT	771	583	76%	764	541	71%	865	570	66%	6,705	4,973	74%
5LA	Kensington & Chelsea PCT	481	374	78%	466	347	74%	507	351	69%	4,087	3,063	75%
5LC	Westminster PCT	1,143	872	76%	1,159	868	75%	1,296	949	73%	10,335	8,004	77%
North West London Strategic HA		**6,507**	**4,939**	**76%**	**6,492**	**4,810**	**74%**	**7,411**	**5,075**	**68%**	**57,987**	**43,452**	**75%**
5A9	Barnet PCT	911	643	71%	989	733	74%	1,058	733	69%	8,451	5,954	70%
5K7	Camden PCT	918	762	83%	875	723	83%	920	751	82%	7,788	6,560	84%
5C1	Enfield PCT	918	750	82%	916	710	78%	1,080	784	73%	8,139	6,286	77%
5C9	Haringey PCT	878	662	75%	854	652	76%	1,010	688	68%	7,801	5,802	74%
5K8	Islington PCT	822	664	81%	787	632	80%	883	708	80%	7,085	5,741	81%
North Central London Strategic HA		**4,447**	**3,481**	**78%**	**4,421**	**3,450**	**78%**	**4,951**	**3,664**	**74%**	**39,264**	**30,343**	**77%**
5C2	Barking & Dagenham PCT	661	493	75%	689	499	72%	796	499	63%	6,063	4,372	72%
5C3	City & Hackney PCT	962	719	75%	936	707	76%	1,072	729	68%	8,663	6,331	73%
5A4	Havering PCT	612	459	75%	648	434	67%	825	501	61%	5,779	4,030	70%
5C5	Newham PCT	1,016	754	74%	1,016	790	78%	1,122	788	70%	8,968	6,491	72%
5NA	Redbridge PCT	728	539	74%	776	589	76%	855	557	65%	6,539	4,759	73%
5C4	Tower Hamlets PCT	814	568	70%	847	580	68%	988	612	62%	7,705	5,258	68%
5NC	Waltham Forest PCT	770	565	73%	730	551	75%	814	596	73%	6,939	5,171	75%
North East London Strategic HA		**5,563**	**4,097**	**74%**	**5,642**	**4,150**	**74%**	**6,472**	**4,282**	**66%**	**50,656**	**36,412**	**72%**
5AX	Bexley PCT	635	480	76%	586	442	75%	749	512	68%	5,430	4,170	77%
5A7	Bromley PCT	835	587	70%	817	596	73%	943	583	62%	7,321	5,205	71%
5A8	Greenwich PCT	837	599	72%	785	610	78%	896	596	67%	7,310	5,484	75%
5LD	Lambeth PCT	1,082	785	73%	1,052	762	72%	1,146	806	70%	9,522	7,118	75%
5LF	Lewisham PCT	850	651	77%	901	688	76%	984	704	72%	7,702	5,726	74%
5LE	Southwark PCT	1,089	836	77%	1,115	885	79%	1,235	914	74%	9,923	7,593	77%
South East London Strategic HA		**5,328**	**3,938**	**74%**	**5,256**	**3,983**	**76%**	**5,953**	**4,115**	**69%**	**47,208**	**35,296**	**75%**
5K9	Croydon PCT	1,111	786	71%	1,126	814	72%	1,227	788	64%	9,540	6,959	73%
5A5	Kingston PCT	377	282	75%	415	332	80%	530	371	70%	3,655	2,767	76%
5M6	Richmond & Twickenham PCT	446	327	73%	478	332	69%	559	369	66%	3,972	2,816	71%
5M7	Sutton & Merton PCT	968	702	73%	912	684	75%	1,051	719	68%	8,375	6,332	76%
5LG	Wandsworth PCT	819	604	74%	864	664	77%	878	626	71%	7,182	5,436	76%
South West London Strategic HA		**3,721**	**2,701**	**73%**	**3,795**	**2,826**	**74%**	**4,245**	**2,873**	**68%**	**32,724**	**24,310**	**74%**
	Lowest (excl out of London)			70%			67%			61%			68%
	Highest (excl out of London)			84%			83%			82%			84%
	Range			14%			16%			21%			16%

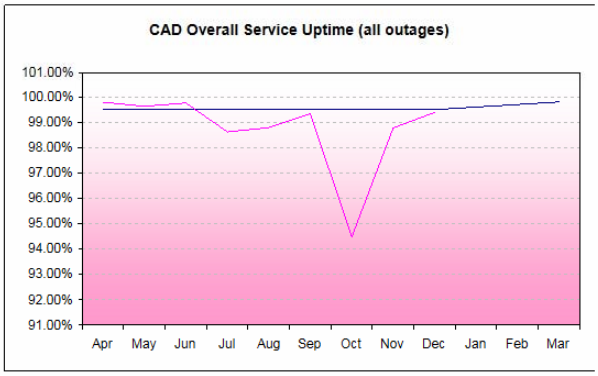
IM&T CAD Service Level Report 2006/7

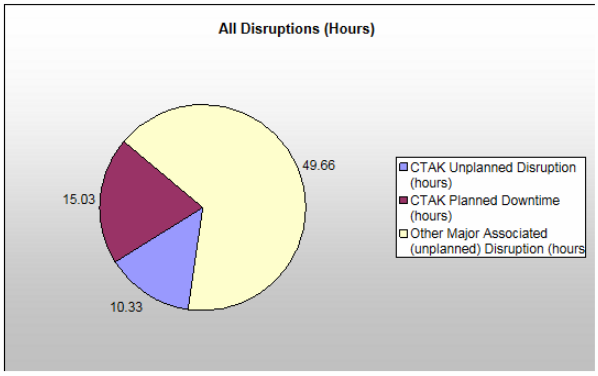
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals YTD
Target Availabilty	99.50%	99.50%	99.50%	99.50%	99.50%	99.50%	99.50%	99.50%	99.50%	99.60%	99.70%	99.80%	
Total hours in month	720	744	720	744	744	720	744	720	744	744	672	744	8760
CTAK Unplanned Disruption (hours)	0.00	1.75	0.75	0.75	6.50	0.58	0.00	0.00	0.00				10.33
CTAK Unplanned Disruption (minutes)	0.00	105.00	45.00	45.00	390.00	34.80	0.00	0.00	0.00				619.80
CTAK Service Uptime (unplanned) %	100.00%	99.76%	99.90%	99.90%	99.13%	99.92%	100.00%	100.00%	100.00%				99.32%
CTAK Planned Downtime (hours)	1.53	1.00	1.00	2.50	2.50	0.00	2.50	4.00	0.00				15.03
CTAK Planned Downtime (minutes)	91.80	60.00	60.00	150.00	150.00	0.00	150.00	240.00	0.00				901.8
CTAK Service Uptime inc plan/unplan disruptions %	99.79%	99.63%	99.76%	99.56%	98.79%	99.92%	99.66%	99.34%	99.40%				99.71%
Other Major Associated (unplanned) Disruption (hours)	0.00	0.00	0.00	7.00	0.00	4.16	38.50	4.75	4.50				49.66
Other Major Associated (unplanned) Disruption (minutes)	0.00	0.00	0.00	420.00	0.00	249.60	2310.00	285.00	270.00				669.60
Total Downtime (all disruptions ~ minutes)	91.80	165.00	105.00	615.00	540.00	284.40	2460.00	525.00	270.00				1801.20
CAD Overall Service Uptime (all disruptions) %	99.79%	99.63%	99.76%	98.62%	98.79%	99.34%	94.49%	98.78%	99.40%				99.14%
CTAK incidents created in period	106803	117096	117672	130824	106624	112888	119089	112943	122765				1046704
Incr/Decr in Inc from previous mth	0.00%	8.79%	0.49%	10.05%	-22.70%	5.55%	5.21%	-5.44%	8.00%				
Call-outs	3	4	2	4	6	13		8	7				44
												Total Disruption (hr)	75.02









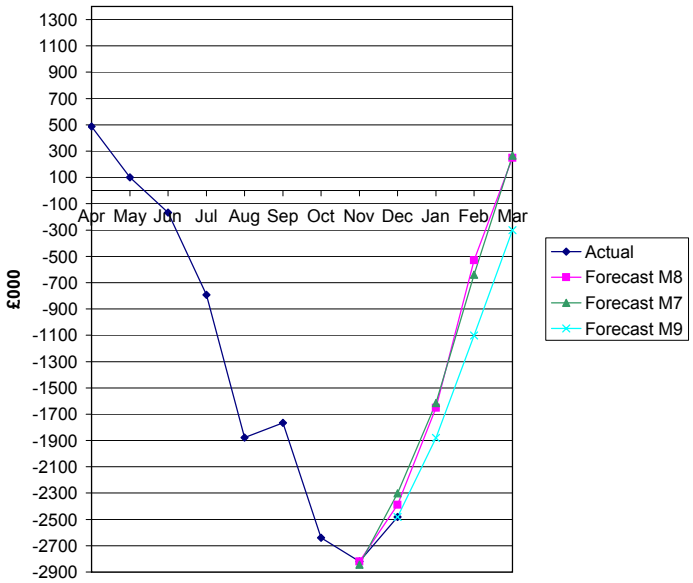


London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending 31st December 2006 (Month 9)

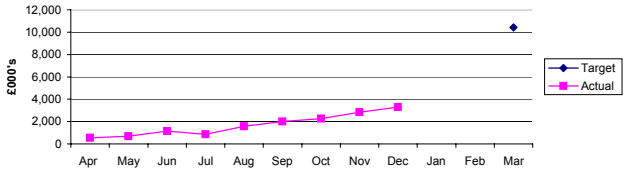
Income and Expenditure

Cumulative Net Financial Position

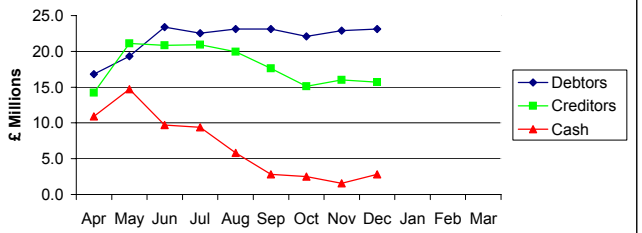


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	Aug	Sept	Oct	Nov	Dec	Risk rating
Asset turnover ratio	1.91	1.92	1.92	1.92	1.92	
Debtors % > 90 days	6%	5%	11%	9%	8%	
A&E Debtor days	17	17	16	15	16	
PTS Debtor days	20	18	27	26	29	
PSPP NHS	69%	69%	70%	95%	75%	
PSPP Non NHS	74%	79%	86%	88%	84%	

Key Financial Drivers

	Sept	Oct	Nov	Dec
A&E Overtime (£000) / Day (Month)	£41	£34	£30	£34
A&E Overtime (% of paybill)	8.53%	9.55%	6.50%	8.36%

note: + is underspent, - is overspent

Subsistence (£000) / Day (Month)	£7	£6	£8	£6
Subsistence per head £	£54	£44	£50	£44

Third Party Transport expenditure / Day (Month)	£6,067	£6,742	£3,264	£0

A&E Cost per incident	£182	£177	£182	£172
A&E Gross Surplus (YTD) (% of Income)	18.8%	18.9%	18.7%	18.8%
A&E Net Margin (YTD) (% of Income)	-2.2%	-2.2%	-2.0%	-1.5%
PTS Gross Margin (YTD) (% of Income)	0.2%	-0.8%	-1.3%	-1.8%

Financial Risks

Overall risk rating	MED	

1	Failure to implement meal breaks on time	MED	
2	Failure to manage A&E overtime within plan	HIGH	
3	AFC arrears paid out are higher than the estimate		
4	ECP Income will be less than forecast	MED	
5	Fuel prices rise in excess of sum helf in budget	MED	
6	Failure to manage and control 3rd party exp	MED	
7	PTS profitability less than forecast	MED	

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report
For the Month Ending 31 December 2006 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	17,869	17,995	(126)U	160,973	162,035	(1,062)U	(0.7%)U	214,337	216,013	(1,676)U
Total Expenditure	17,532	18,191	660F	163,455	163,319	(135)U	(0.1%)U	214,637	216,013	1,376F
Trust Result *Surplus/(Deficit)*	**337**	**(196)**	**534F**	**(2,481)**	**(1,284)**	**(1,198)U**	**(93.3%)U**	**(300)**	**0**	**(300)U**

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report

For the Month Ending 31st December 2006 (Month 09)

1. **Month**

1.1. The position in December is a favourable variance of £534k.

1.2. Income reported an unfavourable variance of £126k. The main reason for the shortfall is back to back income recharged to the strategic health authority for employee retirement costs (£75k); amounts recharged in the year are less than estimated. There are also continuing shortfalls in CBRN, WDC and ECP income, offset by favourable variances on PTS income, BETS elective income and stadia.

1.3. Expenditure reported a favourable variance of £660k. This is primarily due to underspends within Estates and Control Services in the month and an underspend on the Agenda for Change (AFC) provision.

2. **Year to date**

2.1 The year to date position is £1,198k overspent.

2.2 Trust income is £1,062k less than expected. This is as a result of there being lower levels of CBRN, Workforce Development Confederation and ECP income than had been estimated in budgets.

2.3 Trust expenditure is £135k higher than budget. Pay is almost breakeven, this is due to overspends within A&E compensated by an underspend on the AFC provision. Non pay is overspent by £443k due to expenditure on third party transport, vehicle leases, subsistence & legal costs.

3. **Annual**

3.1 The Trust forecast has been revised to an overspend of £300k. A review of AFC monies due identified an understatement of £616k in AFC costs to be paid. This was primarily driven by an error in calculating the correct AFC spine point in several successful appeals. All appeal cases have now been reviewed and prudent assumptions made on the likely cost.

3.2 Additional specific savings of £316k have been identified.

3.3 Further work is underway to recover the forecast overspend.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function
For the Month Ending 31 December 2006 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Income	16,979	17,141	(163)U	152,374	153,803	(1,429)U	(0.9%)U	203,049	205,232	(2,184)U
Sector Services	10,934	10,662	(272)U	98,017	96,298	(1,719)U	(1.8%)U	128,347	126,225	(2,123)U
A&E Operational Support	897	907	10F	8,515	8,401	(114)U	(1.4%)U	11,591	11,463	(127)U
Control Services	1,051	1,133	82F	10,153	10,040	(113)U	(1.1%)U	13,467	13,309	(158)U
Urgent Care Services	770	799	29F	7,089	7,381	292F	4.0%F	9,495	10,014	518F
Total Operations Cost	**13,653**	**13,501**	**(151)U**	**123,773**	**122,119**	**(1,654)U**	**(1.4%)U**	**162,900**	**161,010**	**(1,890)U**
A&E Gross Surplus/(Deficit)	**3,326**	**3,640**	**(314)U**	**28,601**	**31,684**	**(3,083)U**	**(9.7%)U**	**40,148**	**44,222**	**(4,073)U**
Gross Margin	19.6%	21.2%	(1.8%)U	18.8%	20.6%			19.8%	21.5%	2F
Medical Directorate	56	82	26F	670	733	64F	8.7%F	928	978	50F
Service Development	44	51	7F	444	469	26F	5.5%F	600	622	22F
Communications	103	128	25F	1,224	1,188	(36)U	(3.0%)U	1,593	1,572	(21)U
Human Resources	1,046	1,003	(43)U	9,315	9,415	100F	1.1%F	12,452	12,443	(10)U
IM&T	686	721	36F	5,845	5,911	66F	1.1%F	7,828	7,967	139F
Finance	918	1,820	903F	12,420	14,803	2,383F	16.1%F	15,873	19,863	3,989F
Chief Executive	88	84	(4)U	1,012	970	(42)U	(4.3%)U	1,272	1,244	(28)U
Total Corporate	**2,940**	**3,889**	**948F**	**30,929**	**33,490**	**2,561F**	**25.2%F**	**40,547**	**44,689**	**4,141F**
A&E Net Surplus/(Deficit)	**385**	**(249)**	**634F**	**(2,328)**	**(1,806)**	**(522)U**	**(28.9%)U**	**(399)**	**(467)**	**68F**
A&E Net Margin	2.3%	(1.5%)	3.7%F	(1.5%)	(1.2%)	36.5%		(0.2%)	(0.2%)	(0)U
Patient Transport Service	**(49)**	**53**	**(101)U**	**(152)**	**522**	**(675)U**	**(129.2%)U**	**100**	**467**	**(367)U**
PTS Gross Margin	(5.5%)	6.2%	(11.9%)U	(1.8%)	6.2%	(8.2%)U		0.9%	4.3%	(3.4%)U
Trust Result *Surplus/(Deficit)*	**337**	**(196)**	**533F**	**(2,480)**	**(1,284)**	**(1,197)U**	**(93.2%)U**	**(299)**	**0**	**(299)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 31st December (Month 9)

Notes

1. **Income**
   - The main reason for the shortfall in month 9 is back to back income recharged to the strategic health authority for employee retirement costs (£75k); amounts recharged in the year are less than estimated. The year to date adverse variance on income is due largely to shortfalls on CBRN, WDC and ECP income.

2. **A&E Sectors**
   - The overspend in the month is due to rest break slippage, subsistence arrears from November (£154k) and £90k on A&E Lease ambulance costs. Pay is overspent due to additional overtime and a continuing over-establishment of DSO's.

3. **A&E Operational Support**
   - Fleet did not receive overtime due in December causing a favourable variance (20K) this is forecast to be paid in January. Although Vehicle maintenance and BOC continue to overspend this is offset by savings on RAC and contract printing.

4. **Control Services**
   - The underspend in the month is due to vacancies in EOC and Quality Assurance.

5. **Urgent Care**
   - The favourable variance in Urgent care is caused by a reduction in the accrual for third party transport. This was adjusted as use of third party transport was stopped at the beginning of November.

6. **Communications**
   - The underspend in the month stems from a reduction in expenditure on the Corporate Induction and Conference and Ceremonial Expenses budget. The year to date overspend stems from expenditure on the MORI survey "How the public perceives the LAS" and two ceremonies: the 7/7 ceremony and the LAS awards ceremony.

7. **HR**
   - The monthly overspend is due to the number of trainees exceeding the planned budget for the month. In addition there were overspends on the unproductive salaries budget as the number of staff on maternity leave has increased. To date, the underspend is solely down to the Education and Development budget. This underspend is not forecast to continue in the last quarter of the year since expenditure is expected on university course fees and on national clinical guidelines booklets, as well as in house EMT and paramedic training.

8. **IM&T**
   - The underspend in the month is due to vacancies within Management Information and an underspend on the London Ambulance Radio Project (LARP) budget. The year to date position is explained by expenditure on the LARP budget being less than planned.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 31st December (Month 9)

9. Finance

- The underspend in the month stems mainly from the Centrally Held funds budget which reports a favourable position on the AFC provision. In addition the Estates department has underspent in the month, this was due in part to adjustments made to the accruals for two contracts: waste disposal and the cleaning contract, in previous months too much expenditure has been accrued, this was corrected for in month 9. The year to date underspend stems from Centrally held funds due to the underspent AFC provision and the Trust's efficiency savings.

10. PTS

- The monthly overspend is mainly due to a payment of £60K AFC salary arrears which was back dated to 1st December 2005 and the continued payment of about £19K per month subsistence which was budgeted to decrease significantly from October onwards.

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type
For the Month Ending 31 December 2006 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	7,907	7,853	(54)U	70,916	70,720	(196)U	(0.3%)U	94,389	94,773	384F
A&E Overtime	1,117	1,103	(15)U	10,898	10,426	(471)U	(4.5%)U	12,470	11,438	(1,032)U
A&E Management	856	805	(52)U	7,607	7,332	(275)U	(3.7%)U	10,180	9,746	(434)U
EOC Staff	872	949	78F	7,643	7,672	29F	0.4%F	10,252	10,314	63F
PTS Operational Staff	671	577	(93)U	5,709	5,642	(66)U	(1.2%)U	7,677	7,352	(325)U
PTS Management	82	83	1F	774	783	9F	1.1%F	1,022	1,032	10F
Corporate Support	1,158	2,213	1,055F	18,578	19,566	988F	5.0%F	24,379	26,308	1,928F
	12,663	**13,583**	**920F**	**122,124**	**122,141**	**17F**	**0.0%F**	**160,368**	**160,963**	**595**
Non-Pay Expenditure										
Staff Related	444	225	(219)U	3,951	3,415	(536)U	(15.7%)U	4,780	4,129	(652)U
Training	140	171	31F	1,191	1,272	82F	6.4%F	1,469	1,688	218F
Medical Consumables & Equipn	367	371	4F	3,102	3,211	109F	3.4%F	4,305	4,497	193F
Fuel & Oil	317	345	28F	2,818	2,839	21F	0.7%F	3,743	3,771	28F
Third Party Transport	-27	56	83F	1,206	551	(655)U	(118.9%)U	1,240	700	(540)U
Vehicle Costs	827	771	(55)U	7,445	7,178	(267)U	(3.7%)U	9,937	9,558	(379)U
Accommodation & Estates	605	822	217F	6,429	6,573	144F	2.2%F	8,226	8,525	298F
Telecommunications	374	436	63F	3,921	3,942	21F	0.5%F	5,246	5,250	4F
Depreciation	478	529	51F	4,611	4,662	51F	1.1%F	6,169	6,388	219F
Other Expenses	1,026	538	(489)U	3,823	4,432	608F	13.7%F	5,338	6,408	1,071F
Profit/(Loss) on Disposal FA	-2	-2	-0	3	-18	(21)U	115.5%F	-3	-24	(21)U
	4,550	**4,262**	**(288)U**	**38,501**	**38,058**	**(443)U**	**(1.2%)U**	**50,451**	**50,890**	**439F**
Financial Expenditure	**319**	**347**	**28F**	**2,829**	**3,120**	**291F**	**9.3%F**	**3,818**	**4,160**	**342F**
Total Trust Expenditure	**17,532**	**18,191**	**660F**	**163,455**	**163,319**	**(135)U**	**(0.1%)U**	**214,637**	**216,013**	**1,376F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure – Analysis by Expense Type
For the Month Ending 31st December 2006 (Month 09)

1. **A&E Operational staff**
   - The monthly overspend stems from Trainee EMTs. There were a higher number of trainees in December than planned for in the budget. The year to date position is underspent however.
2. **A&E Overtime**
   - Overtime is slightly overspent due to rest break slippage. The overspend in Sectors is offset by a reduced level of overtime in EOC
3. **A&E Management**
   - The overspend is due to the AFC impact on EOC management grades and on sector controllers (£35k). There is also continuing over establishment of DSO's (£25k in the month) although this is lower than previous months due to a re-allocation of budgets from team leader vacancies to DSO's.
4. **EOC Staff**
   - This is favourable in the month due to EMD vacancies.
5. **PTS Operational Staff**
   - The monthly overspend is mainly due to a large payment of AFC salary arrears on a number of PTS contracts which was back dated to 1st December 2005.
6. **Corporate Support Staff**
   - The favourable position stems from the underspend on the AFC provision. In the month an adjustment was made to move the provision into pay from non pay so that the underspend is reflected in the correct category, this has caused the large favourable variance in the month.
7. **Staff Related**
   - The overspend is due to subsistence claims (£177k) from November, before rest breaks were introduced. This should decrease in month 10.
8. **Training**
   - The in month and year to date variance reports an underspend as there are more courses and course fee expenditure scheduled to take place in the last quarter of the year than the previous months.
9. **Medical Consumables & Equipment**
   - This remains favourable year to date due to underspends on medical consumables and medical and ambulance equipment. This is partially offset by overspends on cylinder rental and defibrillator consumables.
10. **Third Party Transport**
    - The favourable variance is caused by a reduction in the accrual for third party transport; this was reduced as all third party transport in A&E was stopped at the beginning of November. In addition PTS taxi costs reduced in December compared to prior months.
11. **Vehicle Costs**
    - The overspend is due to A&E Lease ambulances but is in part compensated for by an underspend on Third Party accident damage.
12. **Accommodation & Estates**
    - The underspend in the month was due in part to adjustments made to the accruals for two contracts: waste disposal and the cleaning contract, in previous months too much expenditure has been accrued, this was corrected for in month 9. In addition furniture was underspent but this is not expected to continue at the current rate as building projects nearer completion.
13. **Telecommunications**

- The underspend stems from a credit to take account of the renegotiation of the data network rental contract by IM&T. The full year saving is £140k. Also expenditure on the LARP radios is yet to show through in the accounts which further contributes to the favourable position.

14. Depreciation

- The year to date and in month underspend reflects an expected underspend on the Trust's depreciation budget.

15. Other Expenses

- This section comprises consultancy fees, legal costs, advertising, catering, hospitality and reserves. The adverse movement on the month stems from an adjustment made to move the AFC provision underspend from non pay to pay so it is reported in the correct category. The year to date underspend stems mostly from an underspend on reserves; this is due to the Trust's efficiency savings budget.

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
As at 31 December 2006 (Month 9)

MONTHLY SPEND

	April	May	June	July	August	September	October	November	December	January	February	March
					Actual						*Forecast*	
Pay Expenditure												
A&E Operational Staff	7,826	7,861	7,917	7,834	7,899	7,883	7,802	7,987	7,907	7,818	7,831	7,823
A&E Overtime	1,320	1,449	1,229	1,245	1,426	1,160	1,064	887	1,117	798	412	362
A&E Management	880	863	789	856	905	825	777	857	856	842	865	865
EOC Staff	767	812	854	789	804	946	855	944	872	859	859	891
PTS Operational Staff	645	640	631	616	624	617	624	642	671	646	659	664
PTS Management	90	96	98	63	92	87	83	82	82	83	83	83
Corporate Support	2,066	2,153	2,126	2,096	2,382	2,086	2,271	2,240	1,158	1,966	1,951	1,885
Sub Total	**13,596**	**13,873**	**13,645**	**13,498**	**14,131**	**13,603**	**13,477**	**13,639**	**12,663**	**13,012**	**12,660**	**12,573**
Average Daily	*453*	*448*	*455*	*435*	*456*	*453*	*435*	*455*	*408*	*420*	*452*	*406*
Non-Pay Expenditure												
Staff Related	420	446	459	425	377	457	455	468	444	334	314	181
Training	9	110	114	122	170	105	151	269	140	93	84	101
Medical Consumables & Equipment	287	292	335	399	328	318	366	410	367	330	450	423
Fuel & Oil	279	386	287	348	306	289	277	329	317	308	308	308
Third Party Transport	197	37	181	130	199	182	209	98	27	11	11	11
Vehicle Costs	731	631	748	774	957	739	1,143	895	827	806	811	876
Accommodation & Estates	570	715	731	766	621	806	810	806	605	483	618	696
Telecommunications	417	463	410	429	598	468	397	365	374	460	399	465
Depreciation	553	554	554	508	508	508	475	475	478	519	519	519
Other Expenses	310	402	434	843	276	59	566	93	1,026	543	488	484
Profit/(Loss) on Disposal FA	0	4	9	0	0	0	0	0	2	2	2	2
Sub Total	**3,773**	**4,030**	**4,264**	**4,744**	**4,339**	**3,931**	**4,851**	**4,020**	**4,550**	**3,886**	**4,001**	**4,063**
Average Daily	*126*	*130*	*142*	*153*	*140*	*131*	*156*	*134*	*147*	*125*	*143*	*131*
Financial Expenditure	**322**	**301**	**283**	**333**	**279**	**317**	**330**	**346**	**319**	**324**	**333**	**333**
Average Daily	*11*	*10*	*9*	*11*	*9*	*11*	*11*	*12*	*10*	*10*	*12*	*11*
Total Monthly	**17,691**	**18,204**	**18,192**	**18,575**	**18,749**	**17,851**	**18,657**	**18,004**	**17,532**	**17,222**	**16,993**	**16,968**
Total Cumulative	**17,691**	**35,895**	**54,086**	**72,662**	**91,411**	**109,262**	**127,919**	**145,923**	**163,455**	**180,676**	**197,669**	**214,637**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31 December 2006 (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	15,713	15,713	0F	141,414	141,414	0F	0.0%F	188,552	188,552	0F
HEMS Funding	2	2	(0)U	22	22	(0)U	(0.0%)U	29	29	(0)U
Other A&E Income	87	87	0F	812	810	2F	0.2%F	1,072	1,070	2F
CBRN Income	724	827	(103)U	6,119	7,042	(923)U	(13.1%)U	8,142	9,373	(1,231)U
ECP Income	94	117	(22)U	865	1,067	(202)U	(18.9%)U	1,195	1,464	(269)U
BETS & SCBU Income	94	61	33F	711	547	164F	29.9%F	970	730	240F
A & E Long Distance Journey	51	40	12F	380	356	24F	6.6%F	484	475	8F
Stadia Attendance	58	29	29F	494	448	46F	10.3%F	631	598	33F
Heathrow BAA Contract	35	34	1F	312	304	8F	2.7%F	416	405	11F
Resus Training Fees	16	55	(39)U	83	330	(247)U	(74.7%)U	133	540	(407)U
	16,874	**16,963**	**(89)U**	**151,212**	**152,340**	**(1,128)U**	**(0.7%)U**	**201,623**	**203,236**	**(1,613)U**
PTS Income	919	854	65F	8,627	8,232	394F	4.8%F	11,316	10,781	535F
Other Income	76	178	(102)U	1,135	1,463	(328)U	(22.4%)U	1,398	1,996	(598)U
Trust Result	**17,869**	**17,995**	**(126)U**	**160,973**	**162,035**	**(1,062)U**	**(0.7%)U**	**214,337**	**216,013**	**(1,676)U**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure – Analysis of Income
For the Month Ending 31st December 2006 (Month 09)

Notes

1. CBRN Income

- CBRN income is £103k under budget in the month and £923k year to date due to a lower than expected level of CBRN income from the Department of Health.

2. ECP Income

- ECP income is £202k below budget year to date due to expected rollouts of schemes in Sutton and Greenwich not taking place.

3. BETS and SCBU Income

- This income is favourable both in the month and year to date due mainly to the elective BETS service, a new service that was launched in the year and therefore not budgeted for.

4. Stadia Attendance

- Stadia attendance was higher in the month than in previous months and compared to budget due to a higher level of activity.

5. Resus Income

- Resus training income is below budget in the month and year to date due to an ambitious income target.

6. PTS Income

- Resus training income is below budget in the month and year to date due to an ambitious income target.

7. Other Income

- Other income includes back to back income that is £75k unfavourable variance in the month and £282k unfavourable year to date. Back to back income represents costs we can recharge to the Strategic Health Authority relating to pre April 2004 medical retirements. The amount recharged this year is less than originally estimated, hence the unfavourable position. Other income also includes a shortfall on WDC income due to a reduction of £350k in funding compared to the prior year. These shortfalls are partly offset by income from secondments outside of the NHS.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Staff Numbers

For the Month Ending 31 December 2006 (Month 09)

	Last Month Actual Paid WTE	This Month Actual Paid WTE	Variance
A&E Operations			
Sector	3,329.00	3,462.73	133.73
Emerg Control Services	376.41	358.60	(17.81)
A&E Operational Support	105.97	85.84	(20.13)
Urgent Care	248.74	253.13	4.39
	4,060.12	4,160.30	100.18
Corporate Support			
Medical Director	11.16	7.80	(3.36)
Service Development	10.00	10.00	0.00
Communications	23.79	24.50	0.71
Human Resources	221.77	264.06	42.29
IM&T	53.45	66.61	13.16
Finance	66.90	64.27	(2.63)
Chief Executive	16.52	16.41	(0.11)
Total Corporate	403.59	453.65	50.06
PTS	340.06	344.82	4.76
Trust Total	4,803.77	4,958.77	155.00

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure – Analysis of Staff Numbers
For the Month Ending 31st December Month 09)

1. **A&E Sectors**
   - The increase in WTE's is due to the payment of the hour and a half that was not paid in November. This was accrued financially but not in WTE's.

2. **Emergency Control Services**
   - The decrease in paid WTE's is due to a significant amount of arrears being paid in Month 8

3. **A&E Operational Support**
   - Fleet only received 3 weeks pay in December. The last week's pay has been accrued but the associated WTE's have not been accrued.

4. **Medical director**
   - The reduction reflects the coding correction and does not represent a real reduction recoding of several months worth of salary out from the directorate.

5. **HR**
   The increase stems from the recoding of staff from departments onto the Unproductive Salaries budget and due to an increase of trainees in the Training School.

6. **IM&T**
   The increase is due to an adjustment to move staff within departments, it does not reflect a real increase in WTE.

7. **PTS**
   The increase in WTE is due to the outstanding AFC back payment made to a number of ambulance persons this month.

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 31 December 2006 (Month 09)

Cost Centre	Cost centre description	Total Project Budget	CURRENT YEAR Annual Budget	YEAR TO DATE Budget	YEAR TO DATE Spend	YEAR TO DATE Variance	Goods Ordered/ Not Received	TOTAL PROJECT Spend	TOTAL PROJECT Variance
S91	**Total Vehicle Projects**								
S933	Minor Fleet Projects	293,200	293,200	0	0	0	41,857	41,857	251,343 F
	Total Vehicle Projects	**293,200**	**293,200**	**0**	**0**	**0**	**41,857**	**41,857**	**251,343 F**
S92	**Total Equipment Projects**								
80300	Lifepak 12 defibs for RRUs	716,500	716,500	0	0	0	637,701	637,701	78,799 F
	Total Equipment Projects	**716,500**	**716,500**	**0**	**0**	**0**	**637,701**	**637,701**	**78,799 F**
S93	**Total Estates Projects**								
80179	Bow Office Changes	1,142,160	333,000	313,762	313,762	0 F	16,081	909,053	233,107 F
80222	New Brixton Ambulance Station	520,000	20,000	0	0	0	0	0	520,000 F
80246	Station Fire Alarms	300,000	150,000	87,386	87,386	0 F	0	149,614	150,386 F
80256	ARRP Accomodation	948,678	465,639	396,750	396,750	0 F	0	469,321	479,357 F
80267	Shoreditch A/S Extension	310,000	155,000	130,779	130,779	0 U	0	130,779	179,221 F
80278	Edmonton extensio	150,000	150,000	143,158	143,158	0 U	0	143,158	6,842 F
80279	Hillingdon A/S refurb SPPP 149	417,125	417,125	238,884	243,820	(4,936)U	2,938	246,758	170,367 F
80280	Fielden Hse Refurb SPPP 071	323,750	323,750	296,507	296,507	0 U	0	296,507	27,243 F
80283	Fr Barnet ext & alt SPPP151	175,620	175,620	161,830	161,831	(1)U	0	161,831	13,789 F
80310	Brixton Ambulance St SPPP146	485,000	485,000	10,000	10,000	0	0	10,000	475,000 F
S932	Minor Estates Projects	1,300,839	714,941	350,102	385,017	(34,915)U	3,299	754,965	545,874 F
	Total Estates Projects	**6,073,172**	**3,390,075**	**2,129,158**	**2,169,010**	**(39,852)U**	**22,318**	**3,271,987**	**2,801,185 F**
S94	**Total IM&T Projects**								
80232	CAD 2010 Capital	711,736	499,000	201,424	198,896	2,528 F	-18,488	326,292	385,444 F
80252	CTAK enhance capital	329,350	200,000	200,000	284,215	(84,215)U	84,919	396,941	(67,591)U
80266	Replacement PC programme 0506	302,952	19,300	15,140	15,100	40 F	61,644	264,077	38,875 F
80281	LARP project (Capital) SPPP 08	0	0	0	0	0	946	946	(946)U
80285	Server replacements SPPP 032	152,000	152,000	58,049	58,160	(111)U	55,167	113,327	38,673 F
80288	Incr Network bandwidth SPPP 10	248,625	248,625	11,700	11,700	0	0	11,700	236,925 F
80289	Remote Access SPPP016	138,750	138,750	8,034	8,034	0 F	9,995	18,029	120,721 F
80290	Interim Command Comm SPPP 193	0	0	0	0	0	19,661	19,661	(19,661)U

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 31 December 2006 (Month 09)

Cost Centre	*Cost centre description*	*Total Project Budget*	*CURRENT YEAR*				*Goods Ordered/ Not Received*	*TOTAL PROJECT*	
			Annual Budget	*YEAR TO DATE*					
				Budget	*Spend*	Variance		*Spend*	*Variance*
80301	PC Replacement programme 0607	369,000	369,000	45,730	45,730	0	0	45,730	323,270 F
S934	Minor Technology Projects	432,739	294,739	105,406	110,944	(5,538)U	507,908	681,243	(248,504)U
	Total IM&T Projects	**2,685,152**	**1,921,414**	**645,483**	**732,780**	**(87,297)U**	**721,753**	**1,877,946**	**807,206 F**
S97	**Approved SPPPs not Committed**								
80045	Buckhurst Hill - Disposal	5,192	0	0	0	0	0	26,111	(20,919)U
80176	Poplar Ambulance Station Rep	0	0	0	0	0	0	0	0 F
80204	Relocation Of Isleworth Ambula	200,000	0	0	0	0	0	0	200,000 F
89998	Approved ISONs not Committed	8,625,338	6,288,045	0	0	0	0	0	8,625,338 F
	Approved SPPPs not Committed	**8,830,530**	**6,288,045**	**0**	**0**	**0**	**0**	**26,111**	**8,804,419 F**
S98	**Total Old Projects**								
	Total Old Projects	**12,148,506**	**388,357**	**390,637**	**393,490**	**(2,853)U**	**40,716,976**	**75,706,053**	**(63,557,547)U**
S99	**Capital Expenditure Reserve**								
S99	Un Allocated Capital Funds	(421,660)	(702,591)	0	0	0	0	0	(421,660)U
	Capital Expenditure Reserve	**(421,660)**	**(702,591)**	**0**	**0**	**0**	**0**	**0**	**(421,660)U**
	Total Programme	**30,325,400**	**12,295,000**	**3,165,278**	**3,295,279**	**(130,001)U**	**42,140,605**	**81,561,654**	**(51,236,254)U**

LONDON AMBULANCE SERVICE NHS Trust

Balance Sheet

For the Month Ending 31 December 2006 (Month 9)

	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets											
Intangible assets	447	431	417	399	381	363	382	414	394	416	
Tangible assets	106,271	112,451	112,054	111,984	111,673	111,896	111,781	111,556	111,627	111,617	
	106,718	112,882	112,471	112,383	112,054	112,259	112,163	111,970	112,021	112,033	
Current Assets											
Stocks & WIP	1,916	1,908	1,914	1,919	1,910	1,910	1,906	1,906	1,906	1,906	
Debtors A&E	8,114	1,996	5,662	10,252	9,646	10,285	9,733	8,484	9,110	8,723	£8,180k > 60 days (84.23%), Nov - £849 > 60 days (8.81%)
Debtors PTS	959	1,957	1,545	1,370	811	449	719	882	793	934	(£60k) > 60 days (-0.62%), Nov - (£52k) > 60 days (-0.54%)
Prepayments, Vat Recoverable, Other Debtors	4,384	3,343	2,561	2,212	2,204	2,512	2,880	2,895	3,257	3,772	
Back to Backed Debtors - PCTs	9,545	9,545	9,545	9,545	9,870	9,870	9,749	9,851	9,787	9,753	
Investments - Short Term Deposits	0	10,000	10,200	9,500	8,300	5,100	2,000	1,700	1,800	2,200	
Cash at Bank and in Hand	667	908	4,512	226	1,114	714	852	817	0	695	
Total Current Assets	25,585	29,657	35,939	35,024	33,855	30,840	27,839	26,535	26,653	27,983	
Creditors: Amounts falling due within one year											
Bank Overdraft	104	53	14	25	39	47	28	0	224	66	
Creditors - NHS	2,077	1,991	2,051	2,047	215	322	229	120	50	90	PSPP - This month (x%), Nov (95%), Ytd (76%)
Creditors - Other	7,019	11,840	18,347	17,713	19,332	17,853	17,365	14,683	15,241	14,573	PSPP - This month (x%), Nov (88%), Ytd (84%)
Dividend Provision	0	345	689	1,034	1,378	1,723	0	344	689	1,034	
Total Current Liabilities	9,200	14,229	21,101	20,819	20,964	19,945	17,622	15,147	16,204	15,763	
Net Current Assets	16,385	15,428	14,838	14,205	12,891	10,895	10,217	11,388	10,449	12,220	
Total Assets less current liabilities	123,103	128,310	127,309	126,588	124,945	123,154	122,380	123,358	122,470	124,253	
Creditors: Amounts falling due after more than one year											
Provisions for Liabilities & Charges	24,539	22,630	22,034	21,607	20,600	19,928	19,063	19,132	18,423	17,907	
Total Net Assets	98,564	105,680	105,275	104,981	104,345	103,226	103,317	104,226	104,047	106,346	
Capital & Reserves											
Donated Assets	508	502	483	455	446	427	407	389	389	351	
Income & Expenditure account	7,592	8,064	7,678	7,481	6,854	5,768	5,894	5,021	4,842	5,186	
Other Reserves	-419	-419	-419	-419	-419	-419	-419	-419	-419	-419	
Public Dividend Capital	49,617	49,617	49,617	49,617	49,617	49,617	49,617	51,417	51,417	53,417	
Revaluation Reserve	41,266	47,916	47,916	47,847	47,847	47,833	47,818	47,818	47,818	47,811	
Total Capital & Reserves	98,564	105,680	105,275	104,981	104,345	103,226	103,317	104,226	104,047	106,346	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement

For the Month Ending 31 December 2006 (Month 9)

	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Opening Cash Balance	563	10,855	14,698	9,701	9,375	5,767	2,824	2,516	1,576
Operating Activities									
Trust I&E	495	-394	-276	-625	-1,085	118	-872	-177	337
Depreciation	553	554	554	508	508	508	475	475	478
Transfer from Donated Asset Reserves	-20	-20	-20	-16	-19	-19	-19	-19	-19
(Increase)/Decrease in Stocks	8	-4	-5	8	0	3	0	0	0
(Increase)/Decrease in Debtors	6,161	-2,472	-4,066	849	4,769	36	968	-834	-234
Increase/(Decrease) in Creditors	5,080	6,872	-306	131	-6,381	-236	-2,448	833	-285
Other	-1,909	-596	-427	-1,008	-672	-865	69	-709	-516
Net Cashflow from operating activities	10,368	3,940	-4,546	-153	-2,880	-455	-1,827	-431	-239
Financial Activities									
Interest received	33	54	72	55	45	39	25	31	26
Interest paid	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0
Net Cashflow from financial activities	33	54	72	55	45	39	25	31	26
Capital Expenditure									
Tangible fixed assets acquired	-109	-151	-523	-228	-773	-460	-306	-540	-534
Tangible fixed assets disposed	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0
Net Cashflow from capital expenditure	-109	-151	-523	-228	-773	-460	-306	-540	-534
PDC Dividends paid	0	0	0	0	0	-2,067	0	0	0
Financing - PDC Capital	0	0	0	0	0	0	1,800	0	2,000
Closing cash balance	10,855	14,698	9,701	9,375	5,767	2,824	2,516	1,576	2,829

LONDON AMBULANCE SERVICE NHS TRUST

Budget Changes Analysed by Function
As at 31 December 2006 (Month 9)

£000s

	ANNUAL			*Comment*
	Initial Budget	Revised Budget	Movement +/(-)	
Income	204,971	205,232	262	
Sector Services	128,618	126,225	-2,393	
A&E Operational Support	11,065	11,463	399	
Control Services	12,122	13,309	1,187	
Urgent Care Services	4,800	10,014	5,213	
Total Operations Cost	**156,605**	**161,010**	**4,406**	
A&E Gross Surplus/(Deficit)	**48,366**	**44,222**	**-4,144**	
Gross Margin	23.6%	21.5%	2.0%	
Medical Directorate	485	978	494	Budget savings less impact of AfC awards and SPPPs.
Service Development	575	622	47	Budget savings less impact of AfC awards and SPPPs.
Communications	1,497	1,572	74	Budget savings less impact of AfC awards and SPPPs.
Human Resources	13,556	12,443	-1,114	Budget savings (£589k) less impact of AfC awards.
IM&T	7,235	7,967	732	Budget savings (£137k) less impact of AfC awards and SPPPs.
Finance	23,764	19,863	-3,902	Budget savings and impact of AfC awards.
Chief Executive	1,520	1,244	-276	Budget savings less impact of AfC awards.
Total Corporate	**48,633**	**44,689**	**-3,944**	
A&E Net Surplus/(Deficit)	**267**	**467**	**-200**	
A&E Net Margin	(0.1%)	(0.2%)	0.1%	
Patient Transport Service	**267**	**467**	**200**	
PTS Gross Margin	2.4%	4.3%	(1.9%)	

Finance Risk Register Items - 2006/07 Risks

	Risk	Priority *(High, Medium or Low)*	Lead Person *(SMG Member)*	Action Plan	Timescale
1	Failure to implement rest breaks on time.	M	SMG	Work up realistic plans.	During 2006/07
2	Failure to manage A&E overtime within plan	H	SMG	Monitor closely and manage in year	During 2006/07
3	AFC arrears paid out are higher than the estimate	M	DOHR/DOF		
4	ECP income will be less than forecast due to pressure on PCT budgets	M	DOF	Monitor closely and manage in year	During 2006/07
5	Fuel prices in excess of the sums held in budgets, and Centrally Held Funds.	M	DOF		
6	Failing to manage and control third party expenditure.	H	DOO	Monitor closely and manage in year	During 2006/07
7	PTS profitability less than forecast	M	DOF	Close control on third party transport exp	During 2006/07

London Ambulance Service NHS Trust

Trust Board Meeting - 30th January 2007

Clinical Reporting to the Board

Clinical Audit & Research Summary Reports for the Trust Board

A summary of the RED call clinical audit report (December 2006)

Author: Dr. Rachael Donohoe & Gurkamal Virdi

Introduction

Earlier this year, the London Ambulance Service NHS Trust (LAS) began a review of the locally upgraded RED calls[1] to explore the possibility of aligning the LAS's call categorisation with the Department of Health's (DH) categorisation. As part of this review, fifteen determinants relating to allergic reactions, back pain, breathing problems, burns, cardiac/ respiratory arrest or death, choking, convulsions, heart problems, stroke and traffic accidents were audited. The aim of this clinical audit was to provide evidence to inform decisions about the clinical safety of downgrading the selected determinants to an AMBER response.

Method

The clinical audit compared the determinant codes and categorisation of the 999 call with information from the Patient Report Form about the patient's condition and survival status. Further information about patient outcomes was derived from the National Strategic Tracing Service. A set of criteria were established by the Medical Director, Assistant Director of Urgent Care & Clinical Development, Head of Clinical Audit & Research and Clinical Audit Co-ordinator, for use in recommending whether or not an audited determinant could be safely downgraded. All criteria needed to be met within the set parameters for a determinant to be recommended for re-categorisation (see Table 1).

Summary of results

Table 1 presents a summary of the results. Five determinants met all of the criteria and were therefore identified as suitable for downgrading to an AMBER response:

- 2B1: Allergic reactions – status of patient unknown
- 5D1: Back pain – not alert
- 6D3: Breathing problems – clammy
- 11D2: Choking – abnormal breathing
- 12B1: Convulsions/ fitting – breathing regularly not verified (under 35 years old).

The remaining 10 determinants did not meet the criteria largely due to the presence of a high number of time critical factors. It is recommended that the remaining 10 determinants continue to receive a RED response and that the evidence produced for these determinants are submitted to the DH for consideration in the national programme of work.

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[1] those determinants that are provided a Category A response by the LAS but the DH only require a Category B response

Table 1: Summary of findings

	Determinant code														
Re-categorisation criteria	**2B1**	**5D1**	**6D3**	**7C2**	**9B1e**	**11D2**	**12B1**	**12C2**	**12C3**	**19C2**	**28C2**	**29B2**	**29B3**	**29D1**	**29D2c**
Total time critical factors <10%	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Cardiac arrest/ ALS & BLS <1%	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	**No**	Yes
Airway and respiratory management <2.5%	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**	**No**	Yes	Yes	Yes	**No**	Yes	Yes
Myocardial Infarction <1%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Decreased consciousness <5% (trauma) or <2.5% (medical)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	**No**	Yes	**No**	Yes	Yes	Yes	**No**
Hypotension <2.5% (trauma only)	N/A	N/A	N/A	Yes	N/A	Yes	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes
Suitable for downgrading to AMBER response?	**Yes**	**Yes**	**Yes**	**No**	**No**	**Yes**	**Yes**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**

Key:

2B1	Allergic reaction – unknown status
5D1	Back pain – not alert
6D3	Breathing problems – clammy
7C2	Burns – difficulty breathing
9B1e	Cardiac/respiratory arrest or death – obvious death (non-recent)
11D2	Choking – abnormal breathing
12B1	Convulsions/fitting – breathing regularly not verified (under 35 years old)
12C2	Convulsions/fitting – diabetic
12C3	Convulsions/fitting – cardiac history
19C2	Heart problems – abnormal breathing
28C2	Stroke – abnormal breathing
29B2	Traffic/transportation accident – multiple patients (one ambulance)
29B3	Traffic/transportation accident – multiple patients (additional ambulances)
29D1	Traffic/transportation accident – multiple response incident
29D2c	Traffic/transportation accident – vehicle vs. pedestrian

London Ambulance Service
NHS Trust

Strategic Plan

2006/07- 2012/13

A World Class Ambulance Service

That Responds Appropriately to All Our Patients

Contents

Strategic Plan 2006/07-2012/13

1. Introduction

1.1 Background

This Strategic Plan 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.

In order to drive forward service improvement and modernisation in the future the plan builds on the achievements of the Service Improvement Programme 2000/01-2005/06 which turned the organisation into a two star Trust achieving national targets in the face of increasing demand. As such it maps the route to achieving the LAS Vision, Purpose and 'CRITICAL' Values (Appendix 1), translating these into tangible outcomes and programmes of work to deliver them:

Vision: *A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.*

Purpose: *The purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and transport to patients requiring our care. These duties will be carried out with integrity, common sense and sound judgement.*

We will be compassionate and courteous at all times and will work hard to maintain the confidence of the public as we strive to build a modern, world class ambulance service for London.

The development of this seven year strategic plan is founded on carrying forward Government policy for the provision of emergency, urgent and out of hours care, specifically building on the NHS core principles documented in the Government's 10 year *NHS Plan* published in 2000, the NHS planning and governance framework "*Standards for Better Health"* published in July 2004, the Department of Health's National Ambulance Review "*Taking Healthcare to the Patient: Transforming NHS Ambulance Services*" published in June 2005, the Health White Paper *"Our Health, Our Care, Our Say"* published in February 2006 and publications in late 2006 on the development of urgent care and accessing emergency care.

The plan is also based on:

- Extensive consultation with eight key stakeholder groups during 2005: patients and public; Primary Care Trusts; NHS partners; police and fire services; LAS staff; Department of Health and Strategic Health Authorities; the Greater London Authority and London Boroughs; and key suppliers. Discussions with patients, unions, commissioners and other stakeholders are ongoing;

- Identification of a number of strategic choices about long-term direction regarding the scope and scale of future LAS activity given developments in the wider NHS and London and what the

implications for the organisation are likely to be. The strategic choice of direction will remain relatively constant over the period of the plan but the tactical plans to realise the ambition will of necessity need to be flexible to respond to internal developments and external drivers for change.

The consultation undertaken and strategic choice made has helped the Trust Board identify the way forward to be:

"A world Class Ambulance Service that Responds Appropriately to All Our patients"

2. Strategic Context

2.1 Baseline: current services and performance

The London Ambulance Service operates in two areas, firstly Accident and Emergency (A&E) care commissioned by the Primary Care Trusts in London for the populations they serve. The second operational area is Patient Transport Services (PTS) where the LAS wins contracts through competitive tendering. These contracts are for the transport of patients to and from locations for medical attention or to hospices when Paramedic or Emergency Medical Technician attendance during transit is not required.

Service Improvement Programme 2000/01- 2005/06

Since the year 2000 the focus for development of both Accident and Emergency and Patient Transport Services has been the Service Improvement Programme. Substantial, quantified progress over the period has been made as follows:

People:

- A substantial shift in staff attitudes and morale (e.g. 60% of respondents in the autumn 2005 feel positive about working for the LAS compared to 42% in autumn 2000);
- Reductions in assaults on staff (153 reported assaults on staff per 1000 staff in 2000 reduced to 87 reported assaults per 1000 staff 2005/06);
- Reductions in staff sickness (reduced from 8% in 2000 to 6.69% in 2005/06).

Patients:

- Cardiac arrest survival rate increased from 2.5% in 1998 and 1999 to 10.9% in 2005/06;
- Increasing proportion of demand diverted to more appropriate care, increasing from 0% in November 2000 to 23.6% in March 2006 and 33% in December 2006;
- A comprehensive cleaning and equipping system (the Make Ready scheme) in place in all complexes by end of March 2006;
- Clinical supervision in place across the Service with the introduction of Team Leaders and Sector Trainers;
- Reductions in complaints in A&E and PTS (e.g. from 5.2 complaints per 10,000 journeys per month in A&E in November 2000 to 1.507 in 2006);
- The development of a PPI strategy and appointment of a PPI manager;
- The roll-out of a drugs management system across the Service.

Performance:

- Category A performance improvement from 40% in 8 minutes in 2000 to 75.1% for the year 2005/06 with a higher absolute number of such calls being responded to in 8 minutes at the end of the period as a consequence of substantial growth in call volume;
- Category A14 up from 83% in 2000 to 95.08% in 2005/06;
- Category A activation time within 2 minutes up from 68% to 86.33%;
- Reductions in vehicle accident rates for both A&E and PTS vehicles (e.g. 5.53 RTAs per 10000 activations in 2005/06 down from 16.16 in 2000 for A&E vehicles) ;
- Internal efficiency savings of £3m pa realised to help fund development activity.

What follows is a review of current services and their performance baseline for this strategic plan, founded on the achievements of the Service Improvement Programme.

Accident and Emergency

Current A&E services can be categorised either in terms of Access or Response with service performance measured primarily but not exclusively in terms of speed in line with national targets, or in the case of Category C calls (see below) local arrangement with Primary Care Trust commissioners .

Access

The only way of accessing LAS services is by telephone. Calls are assessed as either immediately life threatening (Category A), not immediately life threatening but requiring an emergency response because of their seriousness and potential to become life threatening (Category B) or requiring an urgent clinical response but not conditions of sufficient acute seriousness to warrant an immediate emergency response (Category C). Calls are initially handled by the Emergency Operations Centre (EOC) and if assessed as Category C passed to the urgent Operations Centre (UOC). Service performance in relation to these call categorisations is measured against the following targets:

- 95% of 999 calls answered within 5 seconds
- 95% of doctors' "Urgent" calls answered in 30 seconds
- Activation time for a response vehicle for 95% of calls within 2 minutes for Category A and Category B calls;
- A call back by a Clinical Telephone Advisor for Category C (Green) calls within 30 minutes in 100% of cases, (with 60 minutes response if a vehicle is found to be required following CTA).

The achievements arising from *Service Improvement Programme* launched in 2000/01 and performance in 2005/06 outlined in the table below provide the baseline for this strategic plan.

Performance Target	2005/06 Actual
95% of 999 calls answered within 5 seconds	74.1%
95% of doctors calls answered in 30 seconds	66.8%
Activation time for a response vehicle for 95% of calls within 2 minutes for Category A calls	86.33%
Activation times for a response vehicle for 95% of calls within 2 minutes for Category B calls	53.71%
A call back by a Clinical Telephone Advisor for Category C (Green) calls within 30 minutes in 100% of cases. Extended to 60 minutes if a 30 minute ring-back is performed and a second call is warranted	Data not available as calls exceeding this time limit automatically returned to the Emergency Operations Centre but the system is not capable in 2005/06 of separating this group of calls

Response

Once the service has been accessed by telephone a variety of responses may be made depending on the categorisation of the call. Service performance is measured against the following targets:

- Arrival on scene within 8 minutes in 75% of cases for Category A calls (from call connect to the control room as from April 2008 – see below);
- Arrival on scene within 19 minutes in 95% of cases for Category A calls;
- Arrival on scene within 14 minutes (19 minutes from April 06) in 95% of cases for Category B calls;
- Arrival in hospital within 15 minutes of the Stated Time of Arrival in 95% of GP Urgent calls (clock stops on arrival of the ambulance clinician from April 2006 – see below);
- Arrival on scene within 60 minutes of the original call in 100% of appropriate cases for Category C (Green) calls if the Clinical Telephone Advisor decides that attendance by LAS personnel is warranted. These may be Paramedics, Emergency Medical Technicians (EMTs) or Emergency Care Practioners (ECPs).

The achievements arising from the *Service Improvement Programme* 2000 and performance for 2005/06 outlined in the table below forms the baseline for this strategic plan.

Performance Target	2005/06 Actual
Arrival on scene within 8 minutes in 75% of cases for Category A calls	75.1%
Arrival on scene within 14 minutes in 95% of cases for Category A calls	95.08%
Arrival on scene within in 95% of cases for Category B calls in 14 minutes	75.02%
Arrival on scene within 60 minutes of the original call in 100% of appropriate cases for Category C (Green) calls when the Clinical Telephone Advisor decides that attendance by LAS personnel is warranted.	Data not available as calls exceeding this time limit automatically returned to the Emergency Operations Centre but the system is not capable in 2005/06 of separating this group of calls

As a consequence of the National Ambulance Review it has been decided by Government that:

- as from April 2008, for the purposes of measuring 999 Category A and Category B response times the clock should start when the call is connected to the ambulance control room to more closely match the patients' experience and to ensure consistency across the country;
- by April 2009 national performance requirements for Category B response times should be replaced by clinical and outcome indicators against which performance should be managed locally;
- as from April 2007 the performance requirements for responding to patients whose GP calls an ambulance on their behalf (GP Urgents) should be the same as for 999 calls, and as from April 2006, as an interim measure, the clock should stop for this group of patients when an ambulance clinician arrives at the scene.

These changes, on top of the existing national targets, present challenges for the LAS to achieve. It is accepted that the change in clock start time will reduce current reported 8 minute performance by 25-30% (ORH Modelling November 2005).

Workload profile

Like other ambulance services the LAS has traditionally been perceived as an emergency service responding to 999 calls (over 75% of respondents in the 2005 Mori survey gave answers to this effect when asked about what they thought was the most important role of the Service). The Trust has traditionally focused on this activity with a 'Blue Light' response being provided to get patients taken ill or suffering trauma to hospital Emergency Departments (A&E) as quickly as possible:

> *"Training and service provision has been organised around the needs of patients with life threatening emergencies, with severe breathing difficulties, acute coronary syndrome or suffering major trauma. The emphasis has been on life support – stabilising the patient's condition sufficiently for rapid transport to hospital for definitive care. Ambulance technician and paramedic training has focused on trauma, with double – crewed ambulances being the primary method of service delivery."* (Taking Healthcare to the Patient: Transforming NHS Ambulance Services", Department of Health, June 2005)

However only around 10% of the Service's patients are in immediate danger of dying and around another 10% also require an immediate response because, unless attended to quickly, their condition may deteriorate seriously.

Around another 20% of patients are in no danger of dying but nevertheless need the LAS to be there quickly, often because of the pain they are experiencing or complications which might develop if help does not arrive within half an hour. Many of these patients require two people to assist them or they will need to lie down as they are taken to hospital or an urgent care centre, so a double crewed ambulance is required.

The remaining approximate 60% of patients do not need a double crewed ambulance and a variety of responses are possible depending on the assessment in the Urgent Operations Centre as to whether attendance by LAS personnel is appropriate or whether Clinical Telephone Advice is sufficient. The planned development of the Emergency Care Practioner (ECP) programme is a direct response to this.

Patient Transport Service

In PTS operations service provided is defined according to the requirements of each contract won. However there are some generic measures of service performance against the following targets:

- Percentage of PTS patients arriving at destination +/- 45 minutes of agreed time;
- Departure time: Percentage of patients on vehicle within I hour of notification of transport need;
- Patient Survey Results.

The baseline for this strategic plan arising from the *Service Improvement Programme* 2000 and performance in 2005/06 is given in the table below.

Performance Target	2005/06 Actual
Percentage of PTS patients arriving +/- 45 minutes	82.12%
Departure time: Percentage of patients on vehicle within I hour	87.58%
Patient Survey Results (average 2005/06) 95% scoring 5 or 6	90%

2.2 Drivers for change 1: NHS Plan, Standards for Better Health/Clinical Governance, the National Ambulance Review and the Health White Paper

The starting point for framing the Strategic Plan is the need for the Trust to make a demonstrably greater contribution to meeting NHS system-wide objectives in accordance with the Government's 10 year *NHS Plan* published in 2000, the NHS planning and governance framework "*Standards for Better Health"* published in July 2004, the Department of Health's National Ambulance Review "*Taking Healthcare to the Patient: Transforming NHS Ambulance Services*" published in June 2005 and the Health White Paper *"Our Health, Our Care, Our Say"* published in February 2006.

For the NHS as a whole up to 2008 the primary delivery vehicle for these are the three year Strategic Health Authority (SHA) and Primary Care Trust (PCT) Local Delivery Plans, detailing how the NHS targets set out in the NHS planning framework will be achieved. The LAS has a key role to play in supporting the NHS in achieving these targets, many of which depend on taking a whole system approach, with each organisation - including the LAS - playing its part in delivery, with local sharing of performance and financial data and involving front-line staff.

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

- making measurable progress in high priority areas;
- developing capacity by increasing staff efficiency and levels where necessary, facilities and equipment;
- changing the way the whole system works, particularly ensuring greater choice for patients and users.

Every organisation needs to:

- ensure the safety of service users, including developing clinical governance arrangements;
- ensure people are fully informed and involved;
- take into account the working time directive;
- take part in emergency planning;
- continue to modernise service delivery (including sharing good practice);
- provide new skills and competencies;
- introduce new information and communication systems.

The health and social care priorities are:

- improving access to all services through better emergency care, reduced waiting and more choice for patients;
- focusing on improving services and outcomes in cancer, coronary heart disease and stroke, mental health, older people and improving life chances for children;
- improving the overall experience of patients;
- reducing health inequalities;
- contributing to the cross-government drive to reduce drug misuse.

The key national target for LAS remains maintaining response time performance of reaching 75% of patients with conditions prioritised as Category A in eight minutes. Having reached the Category A target, the LAS must concentrate on other national targets (specifically Category B, 19 minutes) and GP Urgent calls as well as improve performance against clinically focused indicators.

The new service improvement programme, and many core activities, need to link to these targets and principles. This plan is designed not only to maintain performance against the Core Standards documented in *Standards for Better Health* but also to make demonstrable progress against the Developmental Standards. These will be used by the Healthcare Commission to determine the Trust's annual performance rating and as such are essential if Ambulance Trusts in due course are expected to move towards Foundation status.

As an ambulance trust the National Ambulance Review is of particular importance as it envisages a reduction of one million in the number of patients taken by ambulance to hospital annually. While the LAS is not affected by the recent consolidation of the thirty one such trusts into twelve larger ones the outcome of the review maps out the future direction of travel. Over the next five years ambulance trusts, working with patients and the public are required to achieve not only operational but also cultural change becoming services which respond appropriately to all patients and which look, feel, behave and deliver differently, building on the principles that there should be:

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

In developing this Strategic Plan the LAS has built on these principles in order to :

- Improve the speed and quality of call handling;
- Provide significantly more clinical advice to callers (hear and treat), and work in a more integrated way with partner organisations to ensure consistent telephone services for patients who need urgent care;
- Provide and co-ordinate an increasing range of mobile healthcare for patients who need urgent care (see and treat);
- Provide an increasing range of other services, e.g. in primary care and diagnostics;
- Continue to improve the speed and quality of service provided to patients with emergency care needs.

The implications for the LAS in doing this is that approximately 200,000 fewer patients per annum will be taken to hospital Accident and Emergency departments. A new approach to patients, callers and the public is necessary, requiring changes in vehicle, skill and workforce mix, training and education, roles, responsibilities and relationships, information management and technology as well as structure and operating arrangements. This Plan identifies the approach the LAS is taking to these challenges in order to realise in London the benefits defined by the National Ambulance Review:

- Patients receive improved care, consistently receiving the right response, first time, in time;
- More patients treated in the community, and fewer unnecessary A&E attendances;
- Greater job satisfaction for staff as they use additional knowledge and skills to care for patients;
- More effective and efficient use of NHS resources;
- Improvements in self care and health promotion.

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

Significant aspects of the White paper potentially are:

- a requirement for Primary Care Trusts to move 5% of acute hospital activity into primary care over the next 10 years;
- a re-think on the closure of community hospitals;
- turnaround teams will become service re-configuration teams in areas with persistent financial deficits;
- a possible duty on local authorities and the NHS to work together to improve the health and well-being of older people to mirror the one improving services for children.

However NHS policy and governance imperatives associated with the Trust making a greater contribution to meeting NHS system-wide objectives only provide some, all be it key, drivers for change. The Strategic Plan has been developed also with cognisance of other developments.

2.3 Drivers for change 2: Environmental scan

In addition to those drivers for change which arise from NHS and Government health policy (section 2.2) a number of emerging themes have been identified from the wider operating environment, some but not all of which are specific to London and to its ambulance service:

1. Stakeholder feedback to the Trust on what they want it to deliver to them over the forthcoming years expressed through Stakeholder Goals and targets. Collectively stakeholders want the LAS to be an accessible service that responds appropriately to patient needs while remaining focussed on delivery. They also want the Trust to more effectively engage with its patients and partners, provide greater options for patients, and have a culture built on the stated CRITICAL values (Appendix 1). This is explored further in section 3.

2. The requirements of Primary Care Trust commissioners that the LAS assist them in preventing unnecessary hospital attendances and admissions through alternative methods of responding to 999 calls and assisting in the management of chronic diseases outside of hospital in a way that is not only clinically safe but demonstrably so. This will help meet the national target that no patient should wait longer than 4 hours in hospital Emergency Departments. Commissioners also want the Service to meet existing and new response time targets in an environment of zero growth in funding through greater efficiency and provide equitable performance across London. They are also keen for the LAS to more effectively integrate with the wider health economy and play a full part in local emergency care networks.

3. The consequences of demand growth, the workload profile mentioned in section 2.1 and the impact of developments in *Out of Hours (OOH)* provision as a consequence of GPs no longer being required to provide OOH cover. The default for the public if they are unable to access healthcare out of hours (or are uncertain how to do so) is to contact the ambulance service even if their need is not an emergency. During 2004/05 call volumes rose at a rate of 7.5% and 2005/06 ended at 3.8% above the level of overall demand for 2004/05 which is in line with the long-term annual growth rate of 3%-4% per annum. Changes in OOH provision will provide a stimulus to organic demand unless carefully managed and further alter the balance between urgent and emergency calls in the workload profile. This will not only stretch the Service but also put pressure on hospital Accident and Emergency departments unless demand can be managed more effectively through alternative responses, for example deployment of Emergency Care Practioners specialised in the management of chronic conditions to treat patients in their homes and thereby reducing hospital attendance.

4. The need to respond to population and visitor growth, particularly in the Thames Gateway area, will have a further impact on demand. The affected boroughs are mainly in NE London – The City, Hackney, Tower Hamlets, Newham, Havering, Redbridge, Barking & Dagenham and Waltham Forest – but almost a third of the developments will be in the boroughs of Lewisham and Greenwich in south east London. Based on the rule of thumb that the 999 ambulance service treats 1 patient per year per 10 people in the population, a further 30,000 calls could be expected in the Thames Gateway area in 2016, compared with 2003/04. Three main issues arise from this:

I. *The impact on relative PCT contributions to the LAS* - as a consequence of the move to Payment By Results (PBR) where PCT contributions are related to actual activity rather than weighted capitation which has been the basis hitherto for the service level agreement which was last re-based in 1991. The last time this was reviewed, in 1999, it became clear that the consequences would have been considerable for PCT allocations, and for this reason, commissioners chose not to pursue it. However, differential population increases of the nature proposed for the Thames Gateway area in the context of PBR make a re-structuring of PCT funding unavoidable;

II. *Resource requirements (with revenue and capital consequences)* - an extra 30,000 calls represents the average yearly workload of three ambulance stations. The costs of this are considerable in capital and revenue terms. Primary Care Trusts in the Thames Gateway area need to be aware of this now and to work with the LAS on modelling the consequences. They should also be considering the LAS when planning any new build (health centres etc.) since costs to the whole health economy may be reduced by including ambulance stand by points, or even stations, within plans (see 5 below);

III. *The potential to develop new models of care* - the LAS worked with the old North East London Strategic Health Authority to develop thinking on how the ambulance service contribution to emergency care should be included in the vision for the Thames Gateway area. As there will be no new hospital for the area, the emphasis will clearly need to be on avoiding A&E attendance if at all possible. This points towards a skewing of investment towards Emergency Care Practitioners (ECPs) over Emergency Medical Technicians (EMTs) or Paramedics.

The opening of Heathrow Terminal 5 will have the effect when working to full capacity of doubling the number of people passing through the airport. This will present additional challenges to service provision in that location.

5. <u>Opportunities for co-location with PCT facilities</u> when they consider new builds. There are considerable service benefits associated with co-location, with the potential for new models of care. There may also be cost benefits. However, the LAS needs ideally to locate its vehicles in areas with easy access to main roads and as close as possible to areas of high demand. Therefore the LAS needs to work more closely with PCTs so they consider the LAS at the earliest possible stage when any new builds are planned, even before decisions have been made about where to locate facilities.

6. <u>The need to further develop and deliver new local Category C measures</u> as an agreed response with PCT commissioners and patient groups to the Government announcement that there is no longer a national response time target for Category C patients, particularly a new focus on outcome measures for specific disease groups. Ambulance services are expected to develop appropriate performance measures and PCTs/SHAs are expected to monitor ambulance services against these targets. Once developed, some of these measures may have investment implications, including, potentially, implications for investment elsewhere in the health economy.

   While some Category C measures may be generic and simple (e.g. the proportion of patients receiving telephone advice within appropriate timescales), others may need to be more sensitive to the needs of specific patient groups. Older people who fall are a good example. The Older People's NSF places an obligation on ambulance services to refer uninjured fallers to falls teams. A measure could be developed for this (numbers, timeliness etc.).This approach should not be confined to Category C patients, however.

There is scope for the development of an appropriate measure in any disease area where there is evidence or guidance for what care is appropriate. Disease/condition groups for whom such an approach could be adopted include: Epileptic patients; Diabetic patients; Asthmatic patients; Patients with Chronic Obstructive Pulmonary Disease (COPD);Mentally ill patients; Older people who fall; Cardiac patients; and Stroke patients.

For seriously ill and injured patients (e.g. myocardial infarctions, stroke and trauma) the most appropriate place of care maybe a specialist unit more distant than the nearest district general hospital. This approach to care is consistent with discussions about how hospital services should be re-configured. However longer distances travelled have resource implications for the ambulance service which need to be factored into discussions.

It is likely that securing appropriate pathways for these patients will require significant investment in additional knowledge and skills for LAS frontline staff including expanding the Emergency Care Practioner (ECP) programme – see section 4.1. ECPs convey around half the patients they attend, whereas normal ambulance crews convey 75 – 80%. The impact on numbers of hospital admissions and lengths of stay is not clear as yet. However, the same principles apply as do within the A&E department: if you increase the skill level at the "front door", you can reduce escalation, hand-offs and delays. All frontline staff will need to be given increased diagnostic and treatment skills as solo responders become a greater percentage of the workforce.

The impact of these investments is highly dependent on the appropriate alternatives to A&E being in place, accessible to frontline staff and resourced to meet the presenting need. This means that, for the full benefits to be achieved of a workforce with higher skill levels, there will need to be investment in the downstream pathways in health and social care.

7. Any possible future requirement by Government for PCTs to divest themselves of their provider functions would present a potential opportunity for the LAS to form closer association with other healthcare professionals such as District Nurses, Community Matrons, GPs and Health Visitors who like ambulance staff and ECPs bring the NHS into people's homes. Greater numbers of autonomous professionals working closely with colleagues in other health and care organisations would have different expectations from their employer. The LAS would need to respond to this, as well as embedding the successful change that has taken place so far. Results of successive staff surveys show that improving delivery has improved the climate at the LAS so that morale is higher than before and people are proud to work for the service. The LAS Organisation Development programme is aimed at making the change sustainable by addressing the organisation's culture. PCT support for this activity will add to the internal drive for change.

8. Demographic changes in the population will present particular challenges to service provision in the future. Not only is the population hyper-diverse with 28.8% of the population classified as being of Black and Minority Ethnic (BME) but also 25% of people were born outside the United Kingdom and no less than 300 languages are spoken in the Capital. Over the next ten years people from BME backgrounds will make up over 80% of the increase in London's working age population. Additionally there will be fewer young people in the population, reducing the pool for recruitment and increasing competition between employers in the labour market. In common with other employers the Trust will have to consider carefully its proposition to the labour market within the parameters set by the NHS pay and conditions framework "*Agenda For Change"*.

9. Emergency preparedness for and response to terrorist threats and conventional major incidents must remain a priority issue in the wake of events on 7 July 2005. The LAS has received additional support from central sources in order to enhance its ability to respond to potential acts of terrorism. Some of this support has been non-recurrent, which needs to be addressed.

10. The Olympic and Paralympic Games coming to London in 2012 present particular challenges to the Service with the influx of an exceptionally large numbers of people into the capital and the need to provide dedicated cover at sporting venues. Resources will need to be allocated to both planning for the Olympics and to provide the additional operational cover required. The impact of the legacy of population growth must also be taken into account alongside the planning for Thames Gateway growth already discussed.

11. NHS funding constraints in the context of the amalgamation of the previous five Strategic Health Authorities in London into one (as from April 2006) may bring about structural change in the pattern of service provision in acute trusts in the Capital. This could have operational implications for the LAS in terms of where it takes patients when they have particular conditions and consequently impact on the achievement of performance targets.

12. Re-configuration of Acute Trust services in London with not all Emergency Departments offering the full range of specialist services will present new challenges to meeting performance targets as ambulances will have longer distances to travel, for example the further development of Cardiac Care and specialist Stroke and Trauma Centres.

3. Strategic Direction and Objectives

3.1 Approach and methodology

This document brings together two strands of work that have been undertaken during 2005 to define the strategic direction of the London Ambulance service from 2006/07 to 2012/13. This section explains how this direction of travel is defined and a graphical representation of the approach is given overleaf.

The core concept behind the approach to development of this Strategic Plan was to base it on delivery of the "*Vision"* for the London Ambulance Service as a "World Class Ambulance Service" as seen from the perspective of eight key groups of stakeholders. This is based on consultation with them.

As a consequence of the stakeholder consultation a short description was developed for each group as to what the Trust would deliver to them by the end of the plan period which would define their experience of interacting with it. This description has been termed a *"Stakeholder Goal"*.

Common underlying themes from these Goals have been identified and termed *"Stakeholder Aspirations"* which have been expressed in tangible terms through measures and targets. This enables progress towards achieving what stakeholders want from the LAS to be tracked, progress managed over time and achievement demonstrated at the end of the plan period. These are "*Lagging (outcome) Measures"* which report outturn performance historically over previous months at year end.

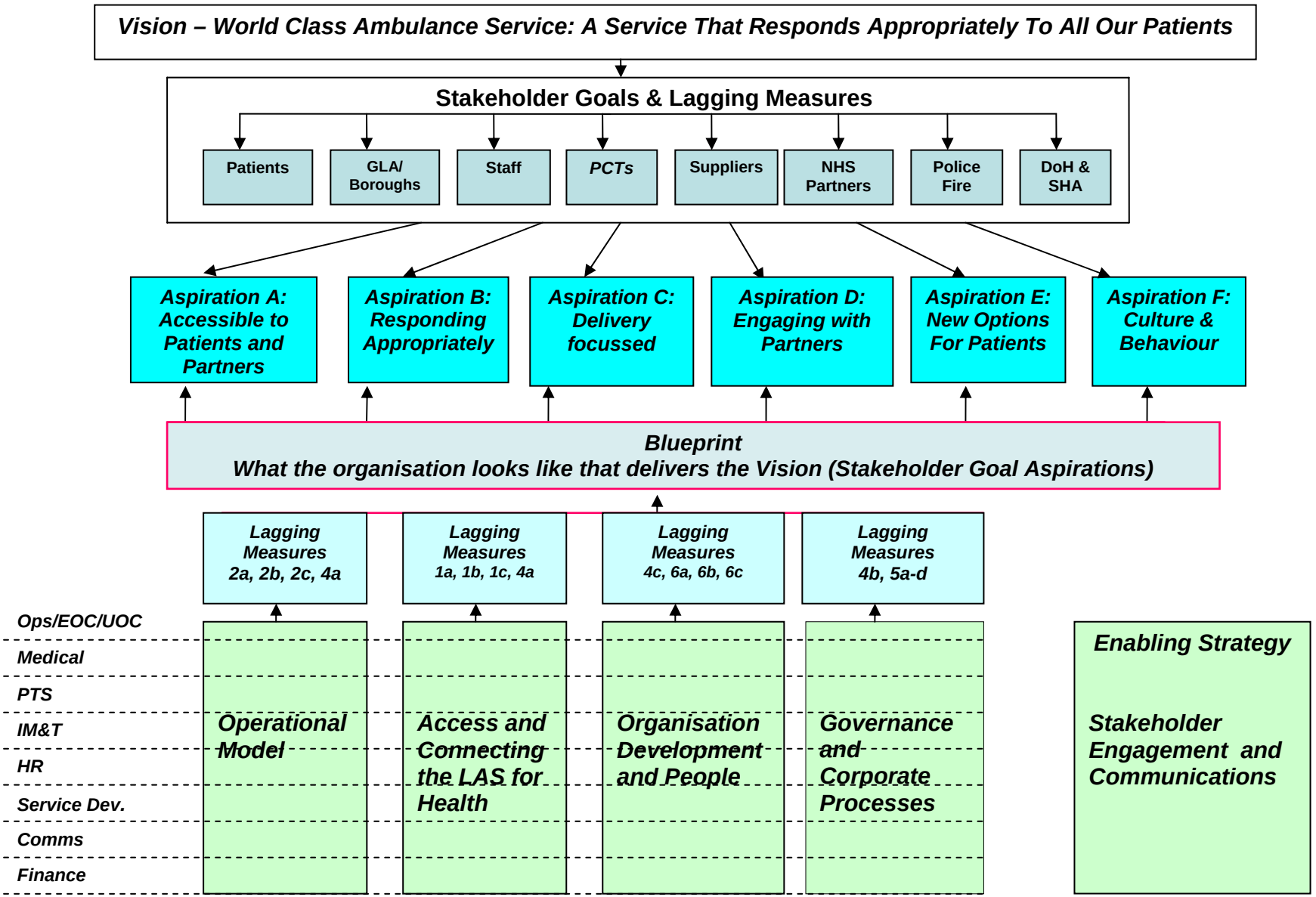
However, given that the organisation does not exist in a vacuum, delivery of the identified *Stakeholder Aspirations* has to take place with cognisance of the drivers for change identified in section 2 of this plan. Concurrently work has been undertaken to envision the scope of LAS activity in the future given developments in the wider NHS and London and what the implications for the organisation are likely to be. This gives rise to a number of strategic choices as to future direction.

These two strands of work, the Stakeholder Goals/Aspirations and the envisioned scope of future operations have been brought together to define a "*Blueprint*" of what the organisation needs to look like in the future.

The delivery mechanism to achieve the Blueprint and Vision is a programme of service improvement and modernisation comprising four cross-functional "*Vital Few Strategic Programmes"* for transformational change and an enabling *Stakeholder Engagement and Communication Strategy*. These have been developed for implementation over the next seven years so that at the end of the period the LAS will "look, feel and behave differently" as described by the Blueprint.

Each strategy has forward looking *"Leading Measures"* associated with it which enable ongoing performance management on a monthly basis. These relate to the activities which determine achievement of the targets set against the lagging (outcome) measures. The new LAS approach to performance management which comprises both the lagging and leading measures brought together in a Balance Scorecard is described in section 7 of this document.

The LAS has had a focus on "*Organisation Development*" (OD) for several years. The required changes to service delivery will not be achieved if the Trust does not pay equal attention to the organisation's structures, capacity and capability, culture, attitudes and behaviour.


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 2a, 2b, 2c, 4a
Lagging Measures 1a, 1b, 1c, 4a
Lagging Measures 4c, 6a, 6b, 6c
Lagging Measures 4b, 5a-d
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
Enabling Strategy
Stakeholder Engagement and Communications

3.2 Organisation Development

The changes described throughout this plan will make Trust services quite different. This means the organisation will need to be different in many ways too.

An organisation built around the idea that every patient is in immediate danger of losing their life has to respond and provide technically expert care quickly. When a patient's life depends on getting things right promptly, tight discipline is needed, and in this context a "command and control" style of management is sometimes necessary too.

But most LAS patients need a caring response more than they need a quick one. They need staff to spend time with them – understanding their situations and resolving their problems. The skills needed are less "technical" – involving skilled communication based on education in assessment and understanding of underlying causes and chronic illnesses and the ability to work with other health professionals in the community to secure the right next step for the patient.

The ambulance professional of the future will have far more independence in decision-making and they will follow guidelines, rather than rules. The emphasis will be on clinical leadership. A command-based or protocol-driven approach will only be right for these professionals on the rare occasions when saving life depends on giving and following instructions.

The above is also reflected in the way the organisation is led and managed. Whilst a transactional, managerial approach is sometimes necessary, and is an important part of the leader's toolkit, it can no longer remain the prevalent or default style. The leadership of the organisation must be approached in the same way that patient care must be approached, with a view to engaging and communicating with individuals to better understand and meet their needs, and motivate and inspire them to develop both themselves and the organisation to enable continual growth, effectiveness and success.

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

To some extent this "cultural change" will just happen by virtue of the fact that the LAS changes its' response regime and increases workforce skills. However, there will need to be an integrated approach across the organisation to changing not only systems, processes and structures, but also how things are done and the way in which staff are engaged and the organisation led if the Service are to be successful in reaching this goal.

To this end the Organisation Development & People programme includes:

- Implementing a workforce plan that supports the operational model and aims for a staff profile that better represents the population of London;

- Establishing a workforce whose personal values, attitudes and behaviours mirror those espoused and promoted by the organisation;

- Providing the workforce with the appropriate skills and resources to enable them to feel confident in delivering optimum patient care;

- Introducing meaningful, ongoing personal development and review whereby all members of staff will have a chance to discuss their progress and their aspirations with their manager;

- Safeguarding the time for training, education and development that is allowed for in our resourcing plans and holding managers to account for releasing staff for training, and staff to account for engaging in it;

- Introduce a process for succession planning, and a programme of talent management, to allow staff the opportunity for further development and career progression;

- Establishing the prevalence of a management style that is supportive of staff, promotes staff involvement and development, and enables the emergence of leadership at all levels;

- Providing development opportunities for managers and teams throughout the organisation by means of an integrated leadership and management development programme;

- Becoming a 'Learning Organisation' that works cross-functionally and in a customer-focused and team-based way with all colleagues and partners, both internally and externally;

- Ensuring systems are in place to make staff able, and feel able, to participate, be heard, and thereby influence organisational decision making;

- Embracing a culture of mutual challenge and personal accountability for behaviour and performance;

- Developing resilient face-to-face, two-way communication processes throughout the organisation and ensuring that information gained and shared enable further organisational improvement;

- Using "service improvement" techniques to involve staff in improving systems and increasing efficiency so that we work smarter instead of just harder and make the working day smoother and less frustrating for everyone.

3.3 Vision: Stakeholder Goals, Aspirations and Outcome Objectives – "A world class ambulance service….."

Vision

The London Ambulance Services aspires as its *Vision* to be "A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care", with the stated purpose "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".

In reality "World Class" looks like different things to different people depending on the nature of their inter-action with the Service and as such is subjective. To be "World Class" requires the organisation to meet the differing stakeholder needs and provide them with an experience of it which at least meets if not exceeds their expectations and leaves them feeling satisfied. Understanding what it is that key stakeholders want is therefore crucial.

LAS Stakeholder Goals, Aspirations and Outcome Objectives

There are eight groups who have been identified as key stakeholders in the London Ambulance Service NHS Trust:

- Patients and the Public, particularly BME groups (including the Patients' Forum);
- Primary Care Trusts;
- Department of Health/ London Strategic Health Authorities.
- LAS staff;
- NHS Partners (General Practioners and other London NHS Trusts);
- Greater London Authority/London Boroughs (particularly Social service Departments);
- Blue Light Emergency Services (Metropolitan Police and London Fire Brigade);
- Strategic Suppliers (mission critical supplies).

Following extensive consultation with them during 2005 and research by Mori in 2006 into public perceptions of the LAS a short description was developed for each group as to what they wanted the Trust to deliver to them by the end of the plan period which would define their experience of interacting with it. These descriptions, the "*Stakeholder Goals*", have been used as one of the key foci in planning for 2006/07-2012/13. These *Stakeholder Goals* are given in the diagram overleaf.

There is commonality of requirements and overlap between the Goals and the underlying themes have been identified and a consolidated list of *"Stakeholder Aspirations"*, things that they collectively are looking for LAS to deliver, has been distilled. It is these core deliverables expressed in the Goals that the organisation has to deliver over the seven years of the Strategic Plan period to achieve its Vision. The organisation needs to develop so it is configured to perform in the desired way.

Vision

A world-class ambulance service for London Staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.

Values

C*linical Excellence* ***R****espect and courtesy* ***I****ntegrity* ***T****eamwork* ***I****nnovation and flexibility* ***C****ommunication* ***A****ccept responsibility* ***L****eadership and direction*

Stakeholder Goals

Patients &Public

An organisation which provides the right response, in the right place, at the right time to satisfy patient's needs, balancing response time targets with what patients really want and need. This requires:
1.The LAS to work collaboratively in partnership with other providers across the health and social care system, thereby creating a shared responsibility for the health and wellbeing of our citizens;
2.Easy and patient centred access routes, responses (be that treatment, conveyance, referral etc.) in and outside of the home based on their diverse needs, conditions and cultural characteristics;
3.Continuous engagement, two way communication and feedback from the many communities of London to ensure that patients and their carers drive continuous service improvement;
4.Staff treating all patients and public according to the LAS Values, sensitively and with awareness of diversity in cultural norms.

GLA/London Boroughs

The LAS will deliver an integrated, responsive and person-centred health and social care system based on frameworks developed with other partners, meeting the varied and diverse needs of individuals, communities and local authorities. This is done through:
(a) Information
-Vulnerable people
-Epidemiology
-Ethnicity
(b) Contributing to each other's planning activities
(c) Identifying gaps in service provision

Staff

'I will make a positive contribution to everyone's well being whilst delivering excellence, supporting and challenging others and myself in the provision of a world leading service'

PCTs

Jointly ensure points of access to pathways that deliver appropriate care relevant to patient needs, through integration with local health and social care providers in the community. A flexible, skilled, confident, empowered and proactive partner service which inspires patient confidence and provides them with high quality outcomes, using shared information and resources to manage demand effectively across the system.

Strategic Suppliers

To achieve world class status as a customer the LAS will be a streamlined, forward thinking, flexible organisation that delivers a quality service through planning ahead, engaging in shared innovation and continuous, long-term collaboration. A partner that engages in trusting relationships focussed on achieving realistic shared objectives with the end goal of improved clinical effectiveness. Providing a consistent network of knowledgeable people to work with and communicating in an open, positive, timely fasion with supply partners. LAS will be clear and unambiguous with requirements, empathise with supplier needs and listen to reason. Not driven by price alone but rather looking for best value and continuous improvement over time.

NHS Partners

A prompt service that we can rely on to be there for our patients when we need it, staffed by skilled professionals who can secure the right care in both emergency and urgent situations. This may include taking fewer patients to hospital and utilising the full range of primary and community health services that are available.

Blue Light Emergency Services

An ambulance service that will prioritise requests from 'Blue light' services. A trusted partner in intelligence led operations. Driven by the overarching need to deliver an effective and timely response to the Capital, recognising local needs and diversity. By:
Joint learning/ training/ risk assessment;
Sharing skills, resources, information;
Jointly supporting public education programme;
Delivering a speedy fast response;
Supporting the overall objectives of the emergency services;
Developing a memorandum of understanding

DoH & SHA

A three star Service which meets national targets for performance and cost efficiency, delivering its part of the NHS Plan, deploying national NHS strategies and achieving high satisfaction scores from patient, public, governmental and NHS partner stakeholders

Stakeholders told the LAS that they wanted it to be an accessible service that responds appropriately, engages the public, its patients and partners, provides greater options for patients, continues to focus on delivery and has a culture built around its CRITICAL values (see appendix 1). The six Aspirations which define the specifics to be delivered over the plan period expressed in both words and tangible, quantified outcome objectives (*Lagging Measures and Targets*) are:

Stakeholder Goal Aspirations	Outcome Objectives	
	Measure	**Target**
1. An accessible service… – ***Accessible to Patients and Partners:*** *E*asy to contact; recognising diversity; responding to partners with right level of authority given to Ambulance Operations Managers	1a **Community engagement and meeting the needs of the population** Systems are in place to ensure that anyone can access our service, regardless of language, disability, age etc.	90% of the population by 2012 (measure to be defined)
	1b **Sharing information externally and promoting best practice** Systems are in place to share data with our partners and stakeholders e.g. Extranet for partners to access	By 2008
	1c **Improved information sharing within the LAS** Provide up to date and accurate information to all staff who need it from a single source, which is re-usable and accessible: input at the most appropriate level to ensure timeliness	By 2008
2. …that responds appropriately… ***- Responding Appropriately:*** *Right response, right place, right time; timely, reliable (for patients and professionals); measured in terms that mean something to patients; appropriate priority to blue light colleagues; responding to major emergencies.*	2a **Appropriate response to advice-suitable calls** Advice-suitable calls are assessed appropriately and effectively	All advice suitable calls CTA assessed at 98% compliance with Quality Assurance systems
	2b **Workforce skilled to match patient need** Workforce skill/type mix re-configured to match demand and provide appropriate patient care to workload profile (Emergency v Urgent)	To be determined following full analysis
	2c **Appropriate referrals to alternative providers** Appropriate referral of patients following face to face assessment	98% of patients referred to appropriate destination by 2013

Stakeholder Goal Aspirations	Outcome Objectives	
	Measure	**Target**
3. … engages the public, its patients and partners… ***– Engaging Patients, Partners and the Public:*** *Collaborative – use of pathways; health & social care (shared information, responsibility, & facilities; joint planning [identifying gaps in provision]; demand management); listens & responds; informed, forward thinking customers.*	3a **Patient, public and partner involvement in all service developments** Service developments are made with the involvement of patients, partners and the Public	100% of service development initiatives
	3b **High patient satisfaction with the service received** Patient satisfaction scores in relation to the service they received from the LAS	95% of patients are satisfied or very satisfied
	3c **Partners satisfied with "how we do business"** Healthcare and other partners (suppliers, emergency services, social services) are satisfied with the experience they have in dealing with the LAS	90% pf partners satisfied or very satisfied
4. … provides greater options for patients… ***– New Outcomes for Patients:*** *Fewer go to A&E; staff skilled & confident to use alternative care pathways; career pathways in place*	4a **Increased number of patients given access to appropriate definitive care first time** Reduction in number of patients transferred or referred on	Target to be determined following further research
	4b **Consistent audit of appropriateness** Develop a suite of measures to monitor this consistently, including CPI checks, clinical audit, clinician feedback and patient surveys	Target to be determined following further research
	4c **Increase and develop staff skills and their confidence in their skills** Embed a robust PDP/PDR process, including use of case reviews, professional portfolios, reflective practice and patient outcome data	All staff have a PDP and appraisals conducted twice a year and carry out their development plans fully

5. …continues to focus on delivery… **– *Delivery Focused:*** *National targets; Government frameworks; Standards & guidance; cost effectiveness.*	5 a-d **Measure what matters** Develop a comprehensive set of indicators to measure performance for: a. Patients, b. People, c. Processes, d. Performance	(see section 7 of this plan)
6. …and has a culture built around our CRITICAL values **– *Culture & Behaviour:*** *Consistent with the values; respecting diversity; taking accountability, challenging each other; empowering; good management; skilled people (technical & inter-personal); consistent.*	6a **Attitude and behaviour** Measurable high standards of attitude and behaviour. All staff behave in ways that reflect the values of the LAS	Target to be determined following further research
	6b **A learning organisation** Evidence of a learning organisation as measured by an validated tool	Target to be determined following further research
	6c **Leadership at all levels** Visible leadership at all levels through identifying the leadership qualities required in all roles and providing a robust structure for supporting the development of leadership skills as part of Continuing Professional Development	Target to be determined following further research

3.4 Scope and scale of future operations – "…….that responds appropriately for all our patients": Strategic Choice

In addition to understanding what stakeholders want from the organisation, a second consideration is the scope and scale of future operations. Given that the organisation does not exist in a vacuum, delivery of the identified *<u>Stakeholder Aspirations</u>* has to take place with cognisance of the drivers for change identified in section 2 of this plan. Therefore work has been undertaken concurrently to envision the scope of LAS activity in the future given developments in the wider NHS and London and what the implications for the organisation are considered likely to be. This gives rise to a number of strategic choices as to future direction.

Five options have been identified as to the potential scope and scale of future LAS operations. These range from scaling back to handling only the minority of calls received which are real emergencies requiring an immediate "Blue Light" response (Category A and B), to seeking to expand to become <u>the</u> *<u>Out of Hours</u>* contact point for the public wanting to access the NHS in

London when not going directly to hospital A&E departments themselves (Category C). The strategic choice as to the direction of travel for the LAS over the plan period is to follow the mid way between these two extremes with the organisation seeking to keep its' current 'market share' of calls to the NHS in London but consolidating the Trust's position, service provision and performance by embracing, promoting and integrating the majority of non-life threatening but urgent calls (Category C) as core LAS work.

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

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

Over the years 2006/07 to 2012/13 the London Ambulance Service has as "*prime objectives"* to:

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

The tactical specifics of the plan to realise the strategic choices made will change over time but this Plan framework is intended to give effect to these objectives over the long–term.

3.5 The Blueprint – "what we want the LAS to be"

To better define "what the LAS wants to be" a *Blueprint* has been developed which describes the organisation which is necessary in order to deliver the *Vision* as expressed through the *Stakeholder Goals*, *Aspirations* and *outcome objectives* detailed in section 3 and the *prime objective* of being and perceived to be as much a provider of urgent care as of emergency care (section 3.4).

The *Blueprint* provides a picture of what the LAS looks like, fells like and how it behaves in 2015, two years after the end of this plan period once the programme of change contained within it has been implemented and bedded down. It is structured around the *Stakeholder Aspirations* explaining in detail what the change requirement is and how this is responded to by the LAS.

The Blueprint has been used to identify what process and other changes are required to move the Trust from where it is in 2006 to where it wants to be in 2015 and to define corporate strategy, change programme benefits, objectives and projects (detailed in section 4).

The Blueprint can be found in appendix 2.

4. Managing Transformational Change – The Implementation Programme *(Part 3)*

4.1 Vital Few Strategic Programmes - what needs to change

The purpose of the corporate *Vital Few Strategic Programmes* and the enabling *Stakeholder Engagement and Communications Strategy* is to implement the *Blueprint* and deliver the targets set against the *Lagging Outcome Measures* identified in section 3.3. These provide the structure for the new service improvement and modernisation change programme to transform the organisation from the way it is in 2006 to the way it aspires to be in 2013. The table below details the *Vital Few Strategic Programmes* and their rationale while the implementation programme structure and initial project portfolio is described in section 4.2. It also outlines the *Stakeholder Engagement and Communications Strategy*.

Description and Scope	Outcome Objective Supported	Rationale
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 disabled people (e.g. deaf) • Connecting for Health • CAD2010 • *Internal IT strategy* • Records and Information Strategy • High Impact changes to EOC/UOC	1a **Community engagement and meeting the needs of the population** 1b **Sharing information externally and promoting best practice** 1c **Improved information sharing within the LAS** 4a (i) **Increased number of patients given access to appropriate definitive care first time**	Patients have told the LAS they want to be able to access the Service quickly and easily. They want it to be equally accessible to disabled people who face communication barriers and to those who do not speak English. Overall they want simplicity: to speak to a helpful human. Others, like General Practioners who ring the Service because they need help in finding beds or providing transport and the Metropolitan Police who need assistance at the scene of incidents, also want quick and easy access to the Service. Partners like Primary Care Trusts (PCTs) and suppliers have said they want to be very clear who to contact to get information, or seek help in making service improvements, and they want local LAS managers to have authority to make decisions about local developments. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients which requires appropriate infrastructure.

Description and Scope	Outcome Objective Supported	Rationale
2. Improving our Response (Operational Model) Scope: Covers service portfolio and the ways of delivering provided to patients/healthcare professionals/public once they have made contact with the LAS: • Develop and 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	2a **Appropriate response to advice-suitable calls** 2b **Workforce skilled to match patient need** 2c **Appropriate referrals to alternative providers** 4a.(ii) **Increased number of patients given access to appropriate definitive care first time**	The LAS has previously provided a "one-size-fits-all" service. Stakeholders have said they want the Service to provide the right response, in the right place, at the right time. They want the Service to be timely and reliable, for patients and professionals. Although they recognise that the major challenge for the Trust is to start to provide appropriate care for patients with lesser emergencies, they also want it to give priority to blue light colleagues and be able to respond even better to major emergencies. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients which requires development of these pathways and appropriate operational models, methods, processes and protocols.
3. Organisation Development And People Scope: Covers Organisation development (section 3.2), 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	4c **Increase and develop staff skills and their confidence in their skills** 6a **Attitude and behaviour** 6b **A learning organisation** 6c **Leadership at all levels**	All stakeholders said that they wanted to see the Service's CRITICAL values (Appendix 1) consistently applied across the Service. Staff and managers are committed to challenge themselves and each other to be accountable for their behaviour as ambassadors for the LAS in everything they do. There is a call for new styles of management – supportive of staff and promoting staff involvement and development. It is clear that most people see this as underpinned by skills – clinical, managerial, leadership and communications. People want to be held accountable, and to hold each other to account, for the highest standards of behaviour and performance. All stakeholders tell us they want us to take fewer patients to A&E. They want our staff to be skilled and confident in using a much wider range of alternative pathways for patients. Staff are clear they want access to extra skills so that they contribute to the well being of all patients.

Description and Scope	Outcome Objective Supported	Rationale
4. ***Governance and Corporate Processes*** <u>Scope</u>: 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 review f. Managing Successful Programmes	4b. **Consistent audit of appropriateness** 5 a-d **Measure what matters**	The Strategic Health Authorities and Primary Care Trusts are clear that they want the Service to continue to focus on national targets, on Government frameworks such as National Service Frameworks and to meet externally set standards. They want the LAS to be cost effective too. Patients want our service to be measured in terms that mean something to them. LAS work with the early patients of Emergency Care Practioners has clarified this. It isn't just about clinical care. It is also about courtesy and respect, about being informed and being reassured. It is about having patients' problem solved. These patients are clear that they do not want to be taken to A&E if they don't need to be there. The Trust itself wants to ensure that internal performance management systems ensure that it delivers on all of its obligations: financial, performance and governance.
Stakeholder Engagement and Communications Strategy <u>Scope</u>: Covers engagement and communications with internal and external stakeholders especially Patients and the Public but also other healthcare professionals, emergency services, social services, key suppliers etc., most particularly PPI: Stakeholder Engagement and Communications projects including: a. patients; b. public; c. NHS partners d. social services e. other emergency services	3a **Patient, public and partner involvement in all service developments** 3b **High patient satisfaction with the service received** 3c **Partners satisfied with "how we do business"**	Government policy places primacy of place on a patient centred NHS with Public and Patient Involvement at all levels from setting strategic direction to the individual patient experience in the care they receive through listening to them, providing information about their treatment etc. All the partner organisations consulted asked the LAS to be collaborative. This means working with them to develop and use different pathways for patients, and work with them in planning, for example, jointly identifying gaps in other services that might be leading people to ring 999 and working with them to set up alternatives. Partner organisations also want us to share more: information about patients in order to ensure they received seamless care; responsibility for the whole package of care received by patients; and also to share premises so that the local health team will be better integrated.

4.2 Programme approach, structure and organisation

Benefits Realisation

The approach being taken to implementation of the new service improvement and modernisation programme is to use the *Managing Successful Programmes* methodology sponsored by the Office of Government Commerce which overarches the PRINCE 2 project management methodology. This approach emphasises clarity and consistency of vision for the programme and a benefits focus, that is realising change benefits for the organisation necessary for achievement of its strategic direction and objectives as the primary focus of the improvement programme rather than just the production of new capability through projects. It emphasises managing benefits from identification through to realisation with frequent review of the intended benefits of the programme so that it remains aligned with its desired outcome.

The following table gives a high level outline of the *initial programme plan*, however this will develop within the overall framework over the plan period as scoping is completed, in response to developments in the environment within which the LAS operates and depending on resource availability and project inter-dependencies.

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 need - 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 Paraolympic 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: • Inventory management • 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	
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

4.3 Delivery of Core and Developmental Standards and the Diversity Agenda

A key requirement of the service improvement and modernisation programme described in this plan is to support the Trust in meeting the requirements of the NHS planning and governance framework "*Standards for Better Health"* published in July 2004. This plan is designed not only to maintain performance against the *Core Standards* but also to make demonstrable progress year on year within resource constraints against the *Developmental Standards* . These will be used by the HealthCare Commission to determine the Trust's annual performance rating, along with delivery against national targets, the Information Governance Toolkit and achieving financial balance. As such achievement against the Standards is essential to move towards Foundation status. Compliance with national targets and performance criteria although supported by development activity remains part of routine operational work and not a separate work stream however.

It is also a legal obligation, as well as a requirement of *Standards For Better Health*, for the Trust to comply with various pieces of legislation concerned with equality of treatment for both patients/the public and staff which forms the framework for the Race Equality and Diversity Implementation Plan. There are six strands of diversity for which legislation exists: race/ethnicity, disability, sex/gender, religion and belief, sexual orientation and age.

The Trust has an established Race Equality and Diversity Implementation Team and in accordance with legislation undertakes *Equality and Diversity Impact Assessment* of relevant functions, policies, procedures and practices to identify actions arising from the assessments for incorporation into the Trust's *Race Equality and Diversity Implementation Plan* and *Race Equality Scheme Action Plan*. While responsibility exists and implementation takes place across the Trust, through all directorates and programmes, responsibility for oversight and driving development and implementation forward rests with the Senior Responsible Owner for *Programme 3, Organisation Development and People* with implementation of the diversity agenda a clearly identified strand of the Programme (project area 15 – see section 4.2).

The Trust is confident that implementation of the change programme will progress the diversity agenda in a way which not only meets legal requirements but positions it to better serve the needs of the hyper-diverse population of London (see section 2.3).

To achieve compliance and keep abreast of changing inspection system requirements year on year the Service will need to adapt and grow resources to serve the increasing inspection criteria from the NHS, Healthcare Commission and NHS Litigation Authority. It will be necessary to maintain flexibility to adapt and adjust so the Service can continue to comply with and act to improve where necessary performance against the assessment criteria defined by the various accreditation bodies. To achieve Foundation Trust status performance will need to be reported with information that secures the highest ratings from these systems of accreditation.

5. Critical Success Factors

5.1 Management of strategic plan delivery

Achievement of the ambitions outlined in this strategic plan will only be possible with the complete buy-in and commitment from all areas of the Service, support from key external players and robust implementation management. In particular there are three areas which will require specific attention which cut across the whole strategic programme:

- Identification and management of Critical Success Factors for plan delivery and benefits realisation;
- Risk management at the plan level;
- Stakeholder engagement in achievement of, and on-going support for, the long-term direction and objectives for the organisation identified in section 3 of this plan.

Each of these is considered in turn.

5.2 Critical success factors

An overarching set of *Critical Success Factors* (*CSFs*) has been produced for the implementation of this plan which capture the assumptions made and the commitment required from all involved. A key *Critical Success Factor* is to robustly manage the *Leading Measures* identified for management control purposes which if correctly identified and performance managed will determine target achievement on the *Lagging (Outcome) Measures*.

Critical Success Factors are categorised into either those which relate specifically to the early part of the plan period when it is necessary to ensure a sound operational model for sustained Service performance or those that relate to longer-term transformational change:

(i) *Shorter term 'High Impact Changes' for sustained performance improvement*: There are a number of critical success factors that apply to all the *High Impact Changes* within project area 18. (New Clock Start Operational Performance – High Impact Changes). This is designed to position the LAS for the challenges presented in maintaining operational performance in the first two years of the plan period (e.g. the change to clock start timing in April 2007 - see section 6.1) so as to provide a sound foundation for the rest of the plan period. These Critical Success Factors for ensuring that the performance improvements intended are fully realised are:

1. Creating a service wide multi-disciplinary approach to performance improvement. This must be driven at Senior Management Group (SMG) level with complete buy-in from all parties and must be firmly rooted in all SMG objectives;

2. Providing capacity for high level professional analysis of current performance together with the formulation of strategic but practical interventions which address the root causes of poor operational performance;

3. Creating a culture of sustained performance improvement which ensures that the initiatives introduced or changes made are the correct ones and that they will be sustainable;

4. Creating absolute clarity on roles and responsibilities both centrally and locally for driving through performance improvement strategies;

5. Developing a comprehensive communications plan for the whole Trust and wider NHS which communicates what we are striving to achieve, why it is important and how we are going to achieve it;

6. Creating a climate in which further change/modernisation can realistically be achieved;

7. Moving the 'emergency service culture' of the organisation to one in which all change which improves patient care is embraced;

8. Achieving a new 'Partnership Agreement' with the Trade Unions to ensure that working practices are modernised quickly and much greater flexibility is secured and utilised to improve patient care;

9. Achieving absolute agreement from all to move progressively towards the response model described in the Department of Health review '*<u>Taking Care to the Patient'</u>*. In this model high level assessment of incoming demand leads to fewer overall responses. When a response is needed it is increasingly a single responder with ambulances reserved in the main for transporting patients with a confirmed need;

10. Acceptance and support from our commissioners that such a radical change in response regimes is the right way to go and acceptance that the scale of change is such that it will take several years to fully achieve.

(ii) *<u>Longer term Benefits Realisation from the four programme areas and supporting stakeholder engagement strategy:</u>* There are a number of critical success factors that apply to realising the benefits intended to be achieved at the end of the seven year Strategic Plan period, these are:

	Critical Success Factor	Managed By Programme/ Strategy
Patients		
	Excellent clinical governance	4
	Audit of non-conveyed calls	4
	Better clinical support/advice/mentorship	3
	Development of relationships with social service departments of the London Boroughs and new care pathways to their services	2
	Valuing diversity	3
	More effective, appropriate patient contact	2
	Convincing staff that the LAS supports them and that they are not automatically in the wrong	3
	A comprehensive public education/ PPI programme with dedicated local teams (three people per complex)	Stakeholder Engagement
	All staff trained and educated to meet the case mix the LAS is attending (i.e. 200,000 fewer A&E attendances)	3
	Employment of 70 full time equivalent CTA staff plus General Practioners to provide clinical oversight.	1
	Employment of up to 300 Emergency Care Practioners	2
	Culture change to a position where continuing patient care improvement is everyone's reason for coming to work	3
	Focus on patient care performance as part of Personal Development Reviews	3
Performance		
	High performing management teams committed to sustained performance Improvement.	3
	Staff and public acceptance of a 'New Front End Model' predicated on a predominantly solo initial response. Staff acceptability of the need for 'Individual Performance Review' linked to PDR which holds them to account for both operational and clinical performance. Staff acceptance of the need for the introduction of a comprehensive 'Distribution Plan' which provides much more flexible resources which are then always placed in the right geographical area to optimise performance across hour of day and day of week. Obsessive commitment to optimising the production of available Ambulance and FRU hours to ensure it is line with anticipated demand.	2/ Stakeholder Engagement 2/3 2 2
	Transformational change with both EOC and UOC including management re-structuring.	2
	Willingness to cause conflict in order to achieve high levels of performance, attitude, behaviour and patient care.	3
	Acceptance that staff need to be more efficient and work smarter and not harder to improve patient care.	2
	Weekly performance management which is balanced and focused and covers all functions	2/4

	Critical Success Factor	Managed By Programme
People		
	Recognition of the significance of key roles that are currently under-rewarded e.g. sector dispatchers	3
	Individual accountability – Personal Development Reviews and valuing, empowering and supporting staff	3
	Provision of training as required in resource planning	3
	24 hour, visible, consistent management support	2
	Development of a more flexible working culture	3
	Effective talent management and use of knowledge in the organisation	3
	Ring fencing of training time for front-line staff	3
	Moving away from the concept of the permanent two man crew with a change to a larger team of ten-fifteen people	2
	Development of greater staff engagement at local level as part of a comprehensive, effective communications strategy	Stakeholder Engagement
Processes		
	Fully automated business processes to support operational/business priorities	4
	Redesign governance structure to ensure agile and speedy decision making and integrate activity	4
	Embed programme and project management methods/processes in departments and ensure all Plan projects are managed appropriately	4
	Maximise resource utilisation to eliminate waste	4
	Involve staff in making improvements	Stakeholder Engagement
	Remove all paper and need for processing from stations	4

Risk management and *Stakeholder engagement* are also *Critical Success Factors* but these are considered separately in sections 5.3 and 5.4 below.

5.3 Risk management (Strategic Plan level)

There are very significant *risks* reflecting the size and scope of the London Ambulance Service (LAS) NHS Trust and the scale of improvement planned. At the same time, NHS organisations have made significant progress over recent years, through the work of *clinical governance*, the implementation of *controls assurance* and the development of governance roles of boards to address risks at an appropriate level and this approach is used in the London Ambulance Service.

Regulatory and inspectorial roles with regard to risk management are carried out by a range of legislative and advisory bodies, including the Healthcare Commission and the NHS Litigation Authority (NHSLA). In addition, independent inspection of controls assurance and finance is provided by internal auditors.

The LAS is accountable for its performance and must create a coherent strategic framework within which service improvement can be delivered. The Assurance Framework brings together strategic

objectives, risks and performance measurement and is used to keep the Board informed of these issues.

It undertakes its performance role through identifying risks which may threaten the achievement of strategic objectives, for example the risk information provided by Datix (the integrated risk management system) or in Trust-wide risk assessment workshops.

Once a risk is identified it is entered onto the Trust-wide Risk Register where it becomes part of the risk reporting structure. Action plans are then put in place to reduce or eliminate these risks.

The following high level risks to the successful implementation of the seven year Strategic Plan have been identified, these will be owned for risk management and monitoring purposes by either the Senior Management Group or by one of the five implementation programmes:

High Level Risks to Successful Implementation of the Strategic Plan	**Managed/ Monitored By Strategy Steering Group (SSG), Programme No. or Stakeholder Engagement Strategy**
Incorrect balance struck between focus on current performance and development for the future – diary pressures prevent SMG devoting sufficient time to personal involvement in managing the development programmes and conveying their importance	SSG
Potential for blame and tension between Operations, Emergency Operations Centre and support departments	SSG
Change of Government policy towards the NHS, particularly as a consequence of any general elections during the Plan period or lack of appetite to see through current policies	SSG
Impact of likely Pandemic Influenza	SSG
Technological fragility – Emergency Operations Centre or Urgent Operations Centre infrastructure failure	1
Failure to learn from major incidents	2
Management and staff capacity and capability/resources insufficient to deliver the Plan	3
Insufficient senior manger training, particularly in the general management training they receive	3
Failure to harness potential of particularly talented staff	3
Failure to manage the "old hands" with consequent negative impact on culture change / modernisation required	3
Failure to challenge inappropriate behaviour and address conflict avoidance	3
Availability of suitable recruits due to demographic change	3
Industrial Relations – a lot of change/modernisation is required early on in the Plan and will make demands on union representatives	3
Risk of fatigue at the second and third tiers of management due to workload pressures	3
Insufficient succession planning to maintain the strength of the Senior Management Group and lack of structure and support for this	3
Insufficient performance management of staff and focus on development of teams including the Senior Management Group	3

High Level Risks to Successful Implementation of the Strategic Plan	**Managed/ Monitored By Strategy Steering Group (SSG), Programme No. or Stakeholder Engagement Strategy**
Risk to reputation from being perceived as arrogant and not sharing information/ consulting i.e. perception of telling people about service provision giving the impression that their views are not really wanted. Stakeholder engagement, pro-active management and more partnership working required rather than a re-active approach.	Stakeholder Engagement
Potential risk to LAS reputation arising from incidents	Stakeholder Engagement
Incorrect balance struck between the centre and local parts of the organisation i.e. level of empowerment and stakeholder engagement	Stakeholder Engagement
Financial losses arising from the activities of Patient Transport Services draining Trust resource	4
Failure to maintain 75% Category A performance necessary to retain "licence to practice"	4
Risk to potential growth arising from financial pressures e.g. reduced annual uplift and increased capital scarcity	4
Cost inefficiency within the Trust in the context of Payment By Results resulting in an imbalance between the costs incurred in service delivery and the income received for it	4
Inability to meet the requirements to become a Foundation Trust	4
Changes as a consequence of "Creating a Patient-Led NHS" and consequent change in the strength of the Trusts' position to argue its position	4
Insufficient productivity in the Urgent Operations Centre (cost per call)	4
More complex and onerous targets and inspection regime	4
Lack of effective project management resource	4
Advent and impact of any litigation against the Trust, particularly in financial terms	4
Financial risk arising for non-recurrent resources for activities the Trust is required to be involved in such as aspects of emergency preparedness	4
Unpredictability of demand increase	4

In order to reduce the level of risk, the LAS prioritises its actions by:

- Being clear about what the risks are, and the ones the LAS can actually do something meaningful about;
- Gaining a focus from staff on the things that really make a difference so that people's efforts are maximised not diffused;
- Making sure that decision making and action is taking place in the specialist risk management groups so that risks are being focussed on by the right people so that progress can be made and reported up to the Board;
- Using the Risk Register to help prioritise the allocation of requests for funding. All Strategic Programme Project Profiles (SPPPs) should reference risk and therefore will form one of the elements of how a decision will be made;

- Getting good quality data and information across the Trust and maintaining an informed view of what is actually happening;
- Actively and appropriately intervening where issues are escalating outside the control of a single group or identified lead;
- Working with other agencies and Trusts where we can to manage risks which cross the boundaries of our organisation;
- Learning from risks and focusing on achieving outcomes that support the improvement of patient care to inform Governance and Corporate Processes strategy.

The risks identified are challenging but the LAS is confident that they are manageable on the basis of its risk management process, allowing the prioritisation of work necessary to manage the risks identified.

5.4 Stakeholder engagement (Strategic Plan level)

The active engagement of all stakeholders in supporting the implementation of the change programme is essential for success and realisation of the intended benefits, especially the eight key groups (see section 3.3):

- Patients and the Public, in particular BME groups (including the Patients' Forum);
- Primary Care Trusts;
- Department of Health/ London Strategic Health Authorities.
- LAS staff;
- NHS Partners (General Practioners and other London NHS Trusts);
- Greater London Authority/London Boroughs (particularly Social service Departments);
- Blue Light Emergency Services (Metropolitan Police and London Fire Brigade);
- Strategic Suppliers (mission critical supplies).

Stakeholder engagement will happen across the Trust at all levels but for the plan as a whole will be overseen by the Senior Responsible Owner for the enabling *Stakeholder Engagement and Communications strategy.* Additionally, in accordance with the *Managing Successful Programmes* approach (see section 4.2) each of the four Programme areas will have its own stakeholder engagement strategy describing how the programme will engage with all stakeholders. These engagement strategies will including mechanisms for encouraging, receiving and responding to feedback from stakeholders, and contain measures to determine how well the communication process is engaging with them.

6. Managing Demand

6.1 Managing Demand and High Impact Change

Primary Care Trust commissioners require the that the LAS assist them in meeting the national target that no patient should wait longer than 4 hours in hospital Accident and Emergency departments through alternative methods of responding to 999 calls, meet existing and new response time targets in an environment of zero growth in funding and hence staff numbers

through greater efficiency and provide equitable performance across London, all in a way that is not only clinically safe but demonstrably so.

In short the LAS is required to manage a growing number of 999 calls in a different way to just attending the patient quickly and transporting them to hospital A&E departments. During 2004/05 call volumes rose at a rate of 7.5% and 2005/06 ended at circa 3.8% above the level of overall demand for 2004/05 which is in line with the long-term annual growth rate of 3%-4% per annum. Only by developing alternative responses can the A&E waiting time target for patients be achieved and LAS response time performance be maintained without significant extra resource at a time when the growth in NHS funding is slowing and Commissioners have zero rated Acute Trust with large deficits to deal with.

The LAS has worked on a number of initiatives to manage demand in a different way such as:

- Development of Clinical Telephone Advice as an alternative to sending a vehicle to suitable Category C calls;
- Implementation of the 'No Send' policy whereby for non-life threatening Category C calls deemed suitable for Clinical Telephone Advice and where deemed clinically safe the Service have and use the power to refuse to send a vehicle even if insisted upon by the caller;
- Development of the Emergency Care Practioner (ECP) programme, with several pilots in London, whereby ECPs treat patients out of hospital rather than convey them unless there is a genuine need.

However in the context of challenges such at capacity constraint in the face of ever increasing demand and changes to clock start timings in April 2007 the Trust has decided that a new operational model is required, both in the short to medium term through making some *High Impact Changes* and in the longer term in the way it responds to the majority of urgent non-emergency Category C calls. Both of these strands are managed through Programme 2 described in section 4.1 and 4.2 however project 18 - New Clock Start Operational Performance - *High Impact Change* is so fundamental to managing and responding to organic demand in the near term that its implementation underlies planning assumptions about operational activity going forward and hence the resource headroom and consequent scheduling for the rest of the service improvement and modernisation programme.

High Impact Change Philosophy

For most NHS organisations the system up to now has been designed to prevent performance failure; to avoid breeches of performance standards or targets and to achieve key targets. The basic aim has been to achieve the performance or quality standard. The current systems tend to focus on particular departments rather than seeking to transform the whole system. Targets are often only achieved by staff working more hours or to a higher level of intensity. The typical performance improvement strategy might have the following components:

- Design the system to prevent performance failure
- Create awareness of targets and performance requirements and raise leadership intent to deliver them.
- Seek to improve the performance of specific departments or areas.
- Make everyone work harder
- Implement measurement systems which monitor compliance with the required performance.

The LAS is currently very much aligned to the above model and has reached a point where following the rationale described previously will fail to deliver the improvements required. The improvement philosophy underpinning the concept of *High Impact Changes* starts from a different mindset. The system needs to be designed not just to avoid performance failure, but also to enable continuous improvement across the whole organisation. Typical components of this type of performance improvement strategy could include:

- Designing the system to continually improve
- Taking a detailed process view of the flow of calls and patients across departmental/organisational boundaries .
- Working smarter not harder
- Focusing on bottlenecks in the system
- Managing and reducing causes of variation in performance
- Segmenting patients according to their specific needs
- Implementing measurement systems for improvement that reveal the true performance of the system and the impact of any changes made in real time.

Performance is improved by mapping patients through the system and removing activities that do not add value or create delays and bottlenecks. Processes must be simplified and speeded up. This often involves both process re-design and role re-design and the two have to be considered in parallel.

The *High Impact Changes* which will be implemented under Programme 2 (and see Appendix 3) are designed to deliver fundamental change across the service in terms of how the LAS organises its processes to deliver on both the challenging new performance targets and high quality patient care. They have been developed by thinking carefully about what needs to be different in A&E Sectors, the Emergency Operations Centre , the Urgent Operations Centre and within Patient Transport Services. In doing so the Service has considered the whole system and have worked to ensure that the changes are complimentary and improve the whole system rather than individual departments.

There will be a need for dedicated high level data analysis support to the A&E Senior Team in order to drive through the changes required and evaluate the impact of these changes in real time. In addition to data analysis there will be a need for significant skills in the whole area of performance improvement across whole systems and additional resource will need to be brought in to assist with this function.

There will need to be stringent performance management arrangements at both local and central levels and the whole process requires complete buy in and commitment from all areas of the service to achieve success.

6.2 Operational activity and resource model of the London Ambulance Service

An operational activity model of the London Ambulance Service has been developed which links call volumes with consequent resource requirements (finance, workforce and assets such as fleet size) to handle a given level of demand based on an understanding of cost drivers in the organisation. The activity model enables scenarios to be developed to inform planning assumptions and for a given level of income an estimate to be made of the level of funding likely to be available for development work each year after providing to meet the expected scenario as to the level of call volumes received. The planned level of development expenditure, along with

project inter-dependencies, is a key determinant of project scheduling within each of the four change programmes described in section 4.2. This plan is based on and informs the planning assumptions made using this model which has been used in developing Sections 8.1 (*Workforce Planning*) and 8.2 (*Financial Planning*) of this Strategic Plan.

6.3 Capacity and Business Continuity Plans

Capacity Plan

For many years the London Ambulance Service has worked at, or near, capacity. There have been occasions, e.g. Winter Pressures, when the LAS has produced a specific plan to deal with anticipated capacity issues. The NHS now accepts that 'over capacity' can occur at any time of the year and has introduced the philosophy of 'Whole System Capacity Planning'. The response by the LAS has been to produce a new *Capacity Plan* which triggers specific measures when the Service is operating at 'over capacity'.

It is the intention of the LAS to maintain a high level of patient care service to the communities of London when experiencing capacity pressures. This is critical to maintain public confidence in the Service and the good reputation of the LAS. During periods of high pressure, the LAS will consider a variety of tactical options that are considered most suitable to deal with the over-capacity situation. The tactical options that may be considered are identified in the *Resourcing Escalatory Action Plan* (REAP) which is designed to increase operational resourcing in line with demand, to cope with periods of high pressure and maintain the quality of patient care.

The REAP plan is in operation at all times. In general it will operate at REAP level one, when the Service is at a steady state. There are varying levels reflecting increasing pressure on the Service, up to level five, where there is the potential of Service failure. Each level is triggered by intelligence from inside the Service or from the external environment. The triggers are detailed in the LAS *Capacity Plan*.

The REAP plan and the REAP levels apply to the whole organisation. The current level will be widely publicised. Every manager has a responsibility to know the current level. Each operational manager and head of department has a responsibility to understand the plan and to have a corresponding implementation plan for their area of operation. All areas of the Service are required to take meaningful action, with the appropriate urgency, as the plan escalates.

There are key triggers which will apply. Each trigger has several parts. Judgement is required to consider whether enough parts have been met to activate the trigger. Each trigger causes an escalating level of the REAP to be activated. Some of the triggers depend on statistical data. The trigger is activated when the data differs considerably from a 'normal' accepted value. As these values are dynamic, the current 'normal' values will vary. In addition to the key triggers, failure of the mission-critical or vital support departments, may trigger any of the REAP levels.

The Deputy Director of Operations will hold responsibility for assessing the key triggers and advising the Director of Operations and the on duty *Gold* officer which trigger has been reached. A weekly return will advise the Director that this task has been carried out. The Director of Operations will declare changes to the REAP level, which will then be advertised widely across the Service, to all departments. Having been made aware of the developing/deteriorating situation,

Gold Control will call an 'over-capacity' meeting at the necessary level, to take action and lead the recovery effort. supported by all departments.

Business Continuity Plan

The Civil Contingencies Act 2004 requires the LAS to have a *Business Continuity Plan* (BCP) to maintain critical services (A & E (Call handling & response) – Emergency Bed Service (EBS) – Patient Transport Service (PTS)) and vital support (elements from – Office of CEO - Finance – Human Resources – Operational Support – Emergency Planning Unit – Information Management and Technology – Communications – Service Development) during an 'Emergency' (Major Incident). The LAS's *Business Continuity Plan* is intended to anticipate, prepare, prevent, respond and recover from an 'Emergency' and maintain patient care as far as is reasonably practicable.

The sources of an 'Emergency' are almost limitless and could be internal (e.g. loss of Trust infrastructure) or external and of a spontaneous nature (e.g. a transportation accident) or slow burn (e.g. influenza pandemic). Sources of an 'Emergency' are, in summary, 'the denial or loss of services or facilities that affects the LAS response to the public of London in terms of A & E, PTS & EBS'.

Plans for some aspects of Business Continuity to support 'call handling & response' exist separately (e.g. the LAS *Capacity Plan* is a specific plan designed to cater with 'pressure & continuity'). In broad terms, these plans deal with the day to day pressures that are placed on the Service and all aspects are practised/invoked on a regular basis. The *Business Continuity Plan* does not supersede those arrangements, but in effect takes the Service into the next stage of Continuity/Recovery on the basis that the incident/event causing concern has passed through the usual and/or anticipated stages into the extraordinary or emanates from another unique, rare or unusual set of circumstances.

The LAS *Business Continuity Plan* is a generic plan that may be implemented totally or, as necessary, in part whilst continuing, as far as is reasonably practicable, to continue to perform its Critical Functions: A & E (call handling and response), PTS & EBS.

The *Business Continuity Plan* will be led by the Director of Finance, but Departments are responsible for maintaining their Business Continuity plans. Once alerted that the Plan is being invoked each of the Directorates will refer to relevant parts of their own Business Continuity plan to provide the required level of support to the LAS in the maintenance of Critical Services.

The decision to invoke the *Business Continuity Plan* rests with the on duty *Gold Control* officer and will be based on any, some, or all of the circumstances described in the *Business Continuity Plan* or as advised by the Chair of the Emergency Business Continuity Group (Director of Finance/Deputy Director of Finance) or nominee. The decision will be confirmed by the *Gold Control* officer declaring an 'Internal Major Incident' and a Gold Group convened supported by the Emergency Business Continuity Group (EBCG).

Once the BCP is invoked the Emergency Business Continuity Group (EBCG) will be convened with appropriate representatives drawn from relevant departments to identify the threat/risk and suggest remedial actions to *Gold Control* for the short, medium and long term. The nature of the continuity/recovery will depend on the nature of the challenge and the EBCG will, in its make-up, reflect the nature of the threat and the departments/personnel required to remediate and return to normality.

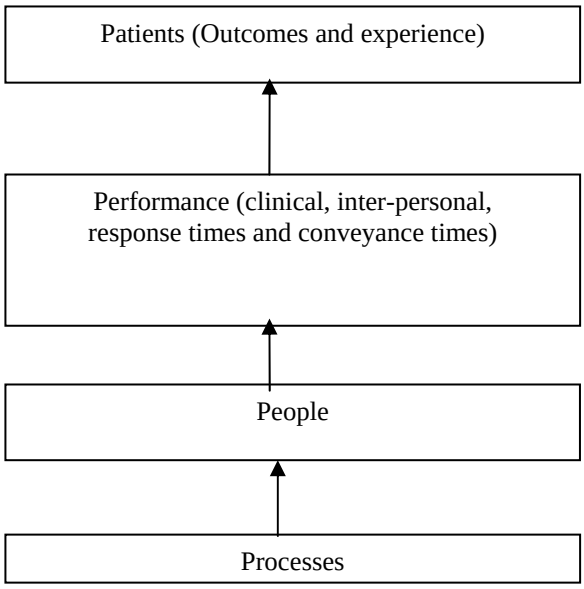
7. Performance Management

7.1 Balanced Scorecard – how the organisation works

Performance management in the LAS has traditionally focused on targets set against '*Lagging Measures'* (or *Outcome Measures*) which define in tangible terms past achievement. These are of restricted use as forward looking control instruments as they detail what has happened and is now beyond influence – the degree to which the organisation has been successful over the previous time period.

Forward looking '*Leading Measures'* which enable ongoing performance management on a monthly basis are the really important control leavers. These relate to the activities which determine achievement of the targets set against the *Lagging (Outcome) Measures*. A *Balanced Scorecard* takes account of both *Leading and Lagging Measures* and this methodology has been adopted by the LAS for future performance management as a smarter, best practice, approach.

The scorecard under development for the Trust is not just a list of separate measures each with a target but rather has coherence as a *theory of how the LAS works*, the same theory that underlies the operational model. In accordance with the scorecard structure used in the wider NHS, the London Ambulance Services is developing a *Balanced Scorecard* using the same four *quadrants or perspectives*: *Patients, Performance, People* and *Processes*. The *theory of how the LAS works* is about the cause and effect relationship between these quadrants as illustrated in the diagram below:



This *theory of how the London Ambulance Service works* which underlies the *Balanced Scorecard* has the rationale that the ultimate objective of optimum patient outcomes and experience is delivered by performance across the board in terms of clinical standards, inter-personal behaviour, speed of response and conveyance to the appropriate location. Performance is determined by front-line people with necessary support service people behind the scenes enabling them to do their job and organisational processes providing the framework with in which both groups operate.

7.2 Balanced Scorecard for the London Ambulance Service NHS Trust

An overview of the long-term Balanced Scorecard under development for used by the London Ambulance Service for performance managing implementation of the strategic plan, both in terms of transformational change and also day to day operations, is given below. The approach is to relate the *Outcome Objectives* for the Strategic Plan identified in sections 3.3 and 4.1 (which if achieved will mean that the Trust has delivered its *Stakeholder Goals)* to the objectives of and benefits arising from the four programmes of work which will deliver these Outcomes.

A Benefits Realisation approach has been taken in defining the programmes. This approach starts with identification of the end objectives of each programme and decomposes these into a series of tangible, measurable benefits from which the required enabling projects and business changes are identified. Tracking delivery of these projects, business changes and the benefits they deliver provide the leading measures to realise the lagging Strategic Plan *Outcome Objectives*. Work to define the benefits in measurable terms is underway.

Balanced Scorecard for the London Ambulance service NHS Trust

For definition of the Lagging Outcome Objectives see section 3.3

Patients (Outcome and Experience**)**

Lagging
1a Community engagement and meeting the needs of the population
3b High patient satisfaction with the service received
4a Increased number of patients given access to appropriate definitive care first time
4b Consistent audit of appropriateness

Leading
- *Access:*
  1. To provide access for all Londoners and visitors to London to the services of the LAS regardless of disability or language (*this must focus on real [evidence backed] not perceived difficulties*).
  2. To provide direct benefit *(e.g. reduced risk)* for patient care through provision of front-line information and tools

- *Corporate Processes and Governance*
  1. Reduced operational and clinical risk (e.g. ability to deal with all types of patient)

- *Operational Model*

Performance

Lagging
2a Appropriate response to advice-suitable calls
2c Appropriate referrals to alternative providers

Plus:
- Access and Response performance targets as per section 2.1 (Call answering, A8, A19, B19, Doctors' Urgents etc.)
- Financial Balance

Leading
- *Access:*
  3. To have a fit for purpose infrastructure to support operations *(call taking, despatch, response control [e.g. MDT] and CTA)*

- *Corporate Processes and Governance*
  2. Maximise the contribution of corporate processes to patient experience and outcomes by supporting the front line (*this includes response time performance*)

- *Operational Model*

People

Lagging
2b Workforce skilled to match patient need
4c Increase and develop staff skills and their confidence in their skills
6a Attitude and behaviour
6b A learning organisation
6c Leadership at all levels

Leading
- *Organisation Development & People:*
  1. Establishment of a workforce profile as described in the Workforce Plan supporting the Operational Model and which is more representative of the population of London
  2. Establishment of an appropriately skilled workforce, confident to use their skills and a much wider range of care pathways
  3. To establish a workforce that lives the CRITICAL values, treating everyone as they would wish to be treated
  4. Establishment of a learning organisation that works cross-functionally in a customer-focused and team based way *(internally and with external partners)*
  5. Embedded culture of mutual challenge and accountability for personal behaviour & performance
  6. Establishment of new styles of management *(supportive of staff & promoting staff involvement & development)* with leadership at all levels underpinned by Skills *(clinical, managerial, leadership & communications)*

Process

Lagging
1b Sharing information externally and promoting best practice
1c Improved information sharing within the LAS
3a Patient, public and partner involvement in all service developments
3c Partners satisfied with "how we do business"
5 a-d Measure what matters

Leading
- *Corporate Processes and Governance:*
  1. Improved process efficiency
  3. Better integration with the whole system (LAS, NHS and London-wide services)
  5. Improved process quality/effectiveness
  6. Reduced process cycle time

- *Access:*
  4. Provision of better integration and management information sharing with our partners and stakeholders *(e.g. PCTs, SHA, emergency services, suppliers)*
  5. Maximisation of the benefits of the national Connecting for Health programme with regard to connecting the LAS with the rest of the NHS (Patient Records and Acutes) for enhanced care pathways, capitalising early on the opportunities presented.
  6. Realisation of 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

- *Operational Model*

8. Resource Plan

8.1 Workforce planning

A skilled, professional workforce configured to future needs and committed to patient care and the Values of the London Ambulance Service are a pre-requisite to achieving the objectives of the Trust. Detailed work has been undertaken to identify the likely front-line clinical workforce requirements based on modelling and planning assumptions made for the plan period, in particular:

- Analysis of anticipated future demand and the categorisation of calls -
  - the number of incidents (all categories) will increase by 3% per annum;
  - the number of emergency transfers will increase by 6% per annum;
  - there will be an additional 30,000 incidents per annum after 2010 resulting from the Thames Gateway developments;
  - the number of Category A calls will reduce to 25% - 30% of all calls by 2010, the balance will be down graded to Category B calls;
  - Olympics impact is ignored as special planning will take place for this one-off event.

- The planned response regime –
  - all Category A and Category B patients will initially receive a response from a Fast Response Unit with a solo responder except for cardiac arrest cases (3% of category A) and other patients who clearly require transport to hospital and will automatically get an ambulance;
  - 10% of Category B calls will be transferred directly to Clinical Telephone Advice (CTA);
  - 85% of Category C calls will be transferred to CTA, the remaining 15% will be responded to by Emergency Care Practitioners (ECPs) to make an assessment of the patient and possible treatment on scene;
  - all emergency transfers and Urgent patient journeys will be undertaken by an ambulance;
  - reduction in patients conveyed to A&E of 200,000 per annum;
  - 50% utilisation;
  - represents c. 2% annual growth in overall productivity

- skill mix – analysis has been undertaken as to the skill mix requirements for each type of response. There will in future be a larger number of single first responders who will require an enhanced level of assessment skills and form a greater proportion of the workforce. We will also move progressively towards a two tier system of ambulance transport with Advanced Life support (ALS) ambulances and Basic Life Support (BLS) ambulances with an appropriate skill mix. Category C patients who cannot be managed appropriately through CTA will receive an assessment visit from an ECP and an increased number of staff trained to this level will also be required.

Overall crew staff numbers are planned to increase over the period from 2,700 in 2006/07 to 3,150 in 2012/13. It is envisaged that there will be a three tier frontline workforce:

Emergency Care Practitioners; Registered Paramedics; and Emergency Care Assistants. This will create a front-line clinical workforce with almost 80% of staff providing direct care to patients being professionally trained together with an increase in those with basic training. Existing Emergency Care Technicians will be up-skilled through professional training to Paramedic status complemented by the recruitment of university trained Paramedics. There will also be growth in the number of CTA staff from 50 in 2006/07 to 120 in 2012/13.

Further work is to be undertaken to identify future requirements for call-taking and despatch staff, Patient Transport Service staff and support department staff.

Consultation with staff side is underway and a full partnership approach will be taken to progressing the workforce plan.

A workforce strategy will be developed ***in partnership*** to support the achievement of this workforce plan. This will include, amongst other things, the approach to training and development, recruitment, retention, career progression and modernisation of working practices.

This workforce plan will be reviewed annually and will take account of any future changes to national or local policy or any new service developments such as provision and expansion of Out of Hours services.

8.2 Financial planning

Assumptions

Outlined below are the financial assumptions for income, costs and assets over the plan period based on implementation of the direction for the Trust outlined in this Strategic Plan and in particular estimated growth in activity and the Workforce Plan:

1. Income Assumptions

    - Over the planning period, average daily activity is forecast to increase by 3.5% p.a. A&E income is assumed to increase by 3.4% p.a. in the same period. This would represent a £38m increase in annual income by 2013;
    - Commercial Income is forecast to grow by 10% p.a.;
    - Income for specific activities such as the Olympics has not been specifically planned at this stage.

2. Cost Assumptions

    - As demand increases by 3.6% p.a., total cost (excluding depreciation) is forecast to grow by 3.3%. A key driver is an increase in overall productivity of 1.9% p.a. to 0.7 incidents per total WTE by 2013;
    - Total Pay is forecast to grow by 4.75% p.a. This is a combination of an increase in staff (1.5%p.a.), pay inflation (2% p.a.) and increasing the skill level of the existing front line workforce;

- Non-Pay excluding depreciation is forecast to decrease by 2.9% p.a. over the period;
- Financial, Depreciation and Other Costs are broadly constant during the planning period.

3. Financial Resource Assumptions

- Total Assets employed grows from a base of £104m to £111m in the planning period. This equates to a 1% annual growth rate;
- Fixed Assets are generally fixed as income grows by 3% as greater efficiencies are achieved from the capital base;
- Likewise, working capital decreases slightly over the period as overall economic activity increases.

Financial Plan

On the basis of the assumptions made the following characterises the Financial Plan for the Trust over the plan period:

- Income increases by 3.2% to £258m in 2013, an increase of £44m in annual income;
- Expenses excluding Financial, Depreciation and Other costs grows by 3.3% p.a. to £248m;
- Earnings before Interest, Taxes, Depreciation and Amortisation (EBITDA) is maintained circa £9.5m on an annual basis in the planning period;
- Financial, depreciation and other costs are broadly constant in the planning period;
- The forecast assumes an annual breakeven position;
- Total cost per A&E incident is forecast to decrease from £221 to £210, a 1% reduction p.a.;
- Total Assets employed grows from a base of £104m to £111m in the planning period. This equates to a 1% annual growth rate.

Appendix 1

London Ambulance Service Values

Clinical excellence

We will demonstrate total commitment to the provision of the highest standard of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to the patients' needs.

Respect and courtesy

We will value all colleagues and the public, treating everyone, as they would wish to be treated, with respect and courtesy.

Integrity

We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.

Teamwork

We will promote teamwork by taking the views of others into account. We will take a genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.

Innovation and flexibility

We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.

Communication

We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

Accept responsibility

We will be responsible for our own decisions and actions as we strive to constantly improve.

Leadership and direction

We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

Appendix 2

Scenario 2015: Blueprint for a service that responds appropriately to all our patients

It is 2015, two years after the end of the 2006/07-2012/13 plan period when the changes made during that time have become embedded. The ambulance service has changed a great deal in the last ten years.

We have responded to the six aspirations that came from our stakeholder consultations in 2005 Our stakeholders said they wanted us to be:

- An accessible service,
- That responds appropriately,
- Is focussed on delivery,
- Engages its patients and partners,
- Provides greater options for patients, and
- Has a culture built on our CRITICAL values

This blueprint describes what that means in more detail.

Accessible to patients and partners

What this meant:

Patients told us they wanted to be able to access us quickly and easily. They wanted us to be equally accessible to disabled people who face communication barriers and to those who did not speak English. Overall they wanted simplicity: to speak to a helpful human.

Others, like GPs who ring us because they need our help in finding beds or providing transport and the Metropolitan Police who need our assistance at the scene of incidents, also wanted quick and easy access to our service.

Partners like Primary Care Trusts (PCTs) and our suppliers said they wanted to be very clear who to contact to get information, or seek our help in making service improvements, and they wanted our local managers to have authority to make decisions about local developments.

How we responded:

Ten years ago pretty much the only way of accessing our service was by telephone.

But the public's use of technology in their everyday lives has continued to change as it did in the previous 10 year period (1995 – 2005). This was the time when mobile phones and the Internet revolutionised the way in which society behaved and set benchmarks in terms of expectations.

In the world of 2015, 2-way data and video communication are now as commonly used as the traditional voice communication by telephone. Indeed, these 3 technologies (voice, data & video) are fully integrated, with on-line video conferencing via mobile communicators (the successors to

mobiles phones) considered as 'normal'. There has also been a convergence of traditional telephone numbers with mobile communicators that means people have a single contact number that is transportable between devices. Improvements in security and satellite technology now enable the identity and location of a caller to be validated to a high degree of accuracy.

Building upon these advances, we have implemented an additional range of options to access our services

1: Direct emergency response: Given the advances in identity validation, members of the public are now able to request the direct sending of an ambulance in an emergency situation. This can be done by direct data input, voice recognition software or the sending of a pre-determined code from a hot key on the mobile communicator. The technology advances automatically locates the location of the caller (and their identity).

2: Self Service: A range of options are available for members of the public to access databases remotely in order to carry out self diagnosis and book appointments. There is also the facility to seek help and interact on-line with a response hub operative.

3: Pooled Resources: The Ambulance services across the country have 'pooled resources in order to meet periods of high demand. While they remain individual services, response hubs are dynamically linked allowing demand to be managed and shared across the county.

4: Single non emergency numbers: 991, 992 & 993 have been nationally implemented as non emergency numbers for the Police, Fire and Ambulance Services. There is full voice & data integration between the 3 services in order that when a multi-agency response is required the first agency taking the call can dynamically request assistance, passing full details of the requirement to the others without the need to re-key data.

Importantly the Ambulance Service has recognised the change in technologies and has adapted its business and working practices to ensure maximum benefit in providing services to members of the public. All of these methods have increased the ability of people to contact us if they have difficulty hearing or speaking and if they do not speak English.

Providing appropriate responses

What this meant:

We were providing a "one-size-fits-all" service. Our stakeholders said they wanted us to provide the right response, in the right place, at the right time. They wanted the service to be timely and reliable, for patients and professionals.

Although they recognised that the major challenge for us was to start to provide appropriate care for patients with lesser emergencies, they also wanted us to give priority to blue light colleagues and be able to respond even better to major emergencies.

How we responded:

When someone contacts us for help we very quickly establish whether the patient needs an immediate response.

Only one in ten 999 patients are in immediate danger of dying. We identify all of them within seconds through our questioning process. But we send an immediate response to another ten percent because we know that if we are not there quickly, their condition may deteriorate seriously.[1]

We send a car **and** an ambulance to this twenty per cent because we know that a patient in cardiac arrest will need the help of three people, and a vehicle that can take them quickly to hospital. One of the three people will have all the extra skills a life-threatened patient may need for their care[2]. The first response will be on scene within five minutes, and the second one will arrive no more than three minutes later. The information gained in the control room is sent electronically to the attending vehicles, so that the staff who attend them have all the information we have about the patient's previous medical history and present circumstances that will help them provide the correct care.

These three people will provide on-scene care that stabilises the patient and diagnoses their condition well enough that we can give the hospital to which we are taking the patient detailed information that will help them prepare for the patient's arrival. Once on the ambulance we will send the information electronically, which avoids the time delays and danger of mis-heard messages that sometimes happened in the past when crews had to ring the control room to ask for the information to be passed on to the hospital.

About another twenty per cent of our patients are in no danger of dying, but nonetheless need us to be there quickly, often because of the pain they are experiencing or complications that might develop if we do not arrive within half an hour. These patients may have experienced a fracture, they may have recovered from a fit or they may be a very elderly person who has fallen and who is in danger of developing pressure sores if left on the floor for too long. We will arrive with these patients within twenty minutes of receiving the 999 call.

Many of these patients will need two people to help them (e.g. to lift them from the floor) or they will need to lie down as we take them to hospital or an urgent care centre, so we will send a double crewed ambulance to these patients. The skills these patients need are excellent assessment of their need, immediate aid for their problem, empathy and an explanation of what is happening. Patients in this group will not need paramedical skills.

The Emergency Medical Technicians who respond will complete an electronic record of the call, which will be added to the patient's electronic record and transmitted back to the ambulance operations centre so that we will be able to review our success.

A lot of what happens for the remaining 60% of patients depends on what happens in the control room, or response hub, as we call it now. Once we know that the patient does not need us there within twenty minutes we switch to a different line of questioning.

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[1] NB – these figures (10% plus 10%) need verifying

[2] In the past these skills were the preserve of the paramedic, who had some extra skills over and above those of an emergency medical technician (EMT). They could intubate patients (place a tube down the throat to help breathing), they could cannulate (insert a needle through which drugs or fluids can be administered) and they were permitted to administer a number of "prescription only" drugs that had been authorised by the Medical Director. But EMTs could always carry out the vast majority of interventions that could save life in the first few crucial minutes. Paramedic skills come into play a few minutes later into the care and, in London, are only used in five per cent of cases. So we had to consider whether the paramedic role was the right one. These days the vast majority of people with paramedic skills are Emergency care Practitioners (see later) and therefore able to provide definitive care for a far greater number of patients.

We have a large team of people, supervised by a doctor, who can spend the time with the caller that is needed to establish exactly what the patient needs next. We started this in the year 2000, after researching it thoroughly, but now we have a much larger team doing it. They have all worked as front-line ambulance people.[3] They can imagine the home circumstances of the patient. They can convey empathy, and understand the combination of clinical and personal circumstances that lead a person to ring 999.

They have received extra training in assessing patients over the telephone, and in the chronic conditions that may have led to them making the call. They have the support of a computer aided diagnostic tool to back up their knowledge. They have access to the patient's prior medical history through the *Connecting for Health* data spine and therefore know the name and contact details of the patient's GP and any others who are involved in the patient's care.

They also understand the limits of the education they have received. The doctors who supervise that service, most of whom are General Practitioners (GPs), are available to advise our clinical telephone advisers (CTAs), or to take over when callers have problems that the CTAs are not qualified to deal with. These GPs also constantly review the decisions being made and every week they run a clinical review session with the CTAs where practice is discussed and CTAs can learn from the GPs' expertise.

As a result of this, we have a robust and safe system that nonetheless means that far fewer ambulances are sent as a matter of course.

In fact we never send an expensive ambulance crewed by paramedics or EMTs if we know we don't need to. Our Patient Transport Service provides cars and larger vehicles to transport patients who will not need care en-route but have no access to transport of their own. Our Urgent Care vehicles are also available for patients who may need a little more in the way of oversight or care when they travel. These vehicles are also controlled by the response hub.

As a result of all these arrangements, we now only send responses to half of the 60% of patients who have a less serious need. In other words only 70% of our 999 patients receive a physical ambulance service response and only 40% receive a traditional double-crewed ambulance response.

But when patients do need a face to face assessment our emergency care practitioners (ECPs) really come into their own. They are trained to paramedic level but they have extra education in patient assessment, physical examination, chronic conditions, care of children and older people, pharmacology and a number of other areas that mean that they can provide a thorough service for this group of patients. However, they can and do attend all types of calls.

Generally they operate singly, in "people carrier" vehicles which are cheaper to buy and equip than a traditional front line ambulance but have all the equipment required for patients and can be used to transport patients who can travel sitting down.

We know from our evaluation of the role as it was being developed more than ten years ago that ECPs are confident to leave more patients at home or refer them elsewhere. Only 30% of the patients they see end up in an A&E department. ECPs can take patients to urgent care centres all over London or they can call on PTS colleagues to provide that transport. They can also refer patients to GPs and other care providers. ECPs can contact their EBS colleagues at the response hub and get information about service availability at the time. At times the ECPs will make

[3] NB – An issue for resolution - should the telephone advisers be separate from the call takers, or should it instead be an all-in-one role, so that patients do not get passed from one person to another.

whatever arrangements are required themselves. At times the EBS team will take over the case, so that the ECP can go on to another call. The case notes that the ECP has taken are added electronically to the patient's care record on the *Connecting for Health* data spine, which means that EBS colleagues can pass full case notes to the next care provider.

As our most skilled staff, ECPs provide clinical supervision and support for EMTs and paramedics. The more experienced of them mentor those still going through their ECP training. At these times they work as part of a double crewed ambulance team and of course this means that they can maintain their skills in the more acute part of ambulance care.

However, ECPs are seen as part of primary care team in their local health area. Urgent Care Networks commission ECP cover so that ECPs work in walk in centres, minor injuries units, urgent care centres and primary care practices as well as ambulance services. They rotate between these centres so that they have the opportunity to gain experience and mentorship in those settings. They also work closely with GPs in delivering out of hours services. As a result, they are fully integrated into the NHS workforce and all professionals involved in urgent care understand each other's role and contribution as never before.

The service has always given access to GPs who wish to arrange transport for their patients and EBS First, begun in 2005, enhanced this service so that GPs only had to make one phone call in order to arrange both a bed and transport. This service is now extended to any health or care professional in the community who needs it, including NHS Direct nurses, mental health professionals and others.

In addition, the response hub can share its detailed, up-to-date information about bed and care availability with any health professional who is registered with the service. These care professionals can access this information electronically, through the *Connecting for Health* data spine. But EBS staff in the response hub are also available when a hard-pressed health worker needs to make complex arrangements for the patient in their care. For example a district nurse who needs to arrange for a patient to be taken into hospital, can ask EBS to arrange that as well as secure a sitting service to look after the patient's housebound spouse and inform all the patient's other support services such as social worker, GP, meals on wheels etc. that they are being admitted to hospital so that arrangements can be made for the patient's return home.

The expansion of the clinical telephone advice service was the main response to the increase. As a result of the reduced rate of dispatch it has been possible to respond to increased demand without increasing the ambulance fleet exponentially.

The LAS intervenes actively for patients who ring regularly, of whom there are around 25 in London at any one time. The service's patient advice and liaison service coordinates case conferences for these patients involving all the relevant care professionals. This results in social service support, re-housing for patients who can no longer manage on their own and referral, for example, to alcohol services.

When patients call for a problem that is likely to recur, the service refers them to appropriate services that can prevent the problem arising again. These include falls prevention teams, specialist chronic conditions nurses and GPs.

But in addition, the service now has a role in preventing emergencies arising in the first place. The service monitors weather patterns that lead to an increase in emergency calls from patients with chronic conditions and ECPs phone or visit these patients to offer advice on how to avoid those

happening. The ECPs work closely with primary care trusts in this work, which hold lists of those patients most likely to be admitted to hospital.

New threats emerged late in the last century and early in the new millennium. Events such as the foot and mouth epidemic and fuel protest of 2001 plus flooding of 2002, heightened our awareness of the need to have robust business continuity arrangements and plans to deal with slowly developing emergencies (known as rising tide incidents). The sarin gas attacks on the Tokyo underground and the terrorist attack on the World Trade Centre in 2001 also introduced a new scale of terrorist threat to prepare for.

10 years ago we were already recognised for our ability both to plan for and to manage typical "big bang" major incidents such as terrorist bombings and rail crashes and we got our first experience of responding to multiple terrorist attacks on July 7th, 2005.

Learning from all of these events we now:

- Not only train, but re-train front-line staff as part of CPD
- Have genuinely seamless arrangements in place with other agencies to deal with CBRN incidents business continuity and major incident plans now equip us to deal with anything from relatively minor disruptions in our 999 service through to truly Catastrophic incidents
- We can implement our plans in a graduated and measured way meaning that the 999 service we offer to the public suffers hardly any disruption
- with the enhanced skills of our staff we are able to discharge some patients at the scene, which reduces our need to take ambulances from 999 services and reduces the number of minor casualties being transported to A&E departments. (With fewer casualties being transported to hospitals and with better information available to them, hospitals now cancel fewer elective procedures and clear fewer beds to deal with incidents than they used to, meaning that other NHS patients do not lose out.)
- are able to transmit casualty data electronically from the scene, which means the hospital has a much better idea of what to expect when casualties arrive
- have formal arrangements to scale down the response to less urgent calls in order to create the capacity to deal with sustained large scale incidents on a national level.

All this is made much easier as we're now using a common, national digital radio system and we have standardised vehicles and equipment. We've also got arrangements with our key suppliers in place so that we can access vast stocks of clinical supplies and equipment if we need it.

Focussed on delivery

What this meant:

The Strategic Health Authorities and PCTs were clear that they wanted the service to continue to focus on national targets, on Government frameworks such as National Service Frameworks and to meet externally set standards. They wanted us to be cost effective too.

Patients wanted our service to be measured in terms that meant something to them. Our work with the early patients of ECPs clarified this for us. It wasn't just about clinical care. It was about courtesy and respect, about being informed and being reassured. It was about having their problem solved. These patients were clear that they did not want to be taken to A&E if they didn't need to be there.

We ourselves identified that we wanted to ensure that our internal performance management systems ensured that we delivered on all of our obligations: financial, performance and governance.

How we responded:

Ten years ago there were few ways of measuring performance except how quickly we got to the patient. This was a fair proxy for outcome, but as many people said, it meant that we could get to a patient within eight minutes and fail to save them and it would go down as a success, yet we could get there in nine minutes and provide excellent care that saved their life, yet it was recorded as a performance failure. Over the years we have added measures of performance that are about the care provided and the outcomes for patients, including the majority of patients for whom the time we take to reach them is completely irrelevant.

The old direct performance measures focused on speed to patient and financial balance with some indirect measures covering clinical outcomes and governance. These measures reflected the emergency nature of essentially an ambulance service. Today, the service is providing a wider range of urgent care services. The service organisation has evolved into a more complex, flexible organisation which is designed to adapt to the changing needs of the Urgent Care Sector while maintaining a relentless focus on basic operating, clinical and financial performance. The service is now funded by a variety of stakeholders, both local and national, using activity & quality based measures. The Performance Measurement system has evolved into a balanced series of metrics that focus on Patients, People, Processes and Performance linked into both national and local Healthcare measurement systems.

The current measures are delivered using credible, transparent information systems that deliver meaningful analysis tools to stakeholders.

Engaging with the public and our partners

What this meant:

All the partner organisations we spoke to asked us to be collaborative. This meant working with them to develop and use different pathways for patients, and work with them in planning. This meant, for example, jointly identifying gaps in other services that might be leading people to ring 999 and working with them to set up alternatives. They also wanted us to share more: information about patients in order to ensure they received seamless care; responsibility for the whole package of care received by patients; and also to share premises so that the local health team would be better integrated.

How we responded:

We pride ourselves on our responsiveness and the quality of that response. We know that our actions can make a very big difference to how the rest of the NHS performs, as well as to outcomes for patients. We meet with colleagues in the NHS on a regular basis so that we understand their objectives. We offer solutions to their problems where we can and cooperate to improve patient care. That is why PCTs see us as their supplier of choice in all emergency and non-emergency care and transport.

Engaging with London's public has never been easy.

What has not changed is:

- **Ethnic diversity:** For example there are people of almost 100 nationalities living in London and over 300 languages are spoken. We need to be constantly adapting to circumstances as new language and ethnic groups join our population mix and as others grow older.
- **Mobility:** A third of Londoners move house every year. It is not surprising that many do not grow roots into the local health and social care networks that could support them instead of the 999 service
- **Tourists and commuters:** the population of London still swells daily by around a million. 2012 was the year of the Olympic and Paralympic games, which saw record tourist numbers
- **Health issues:** London still has high health needs associated with deprivation, higher than national average levels of mental illness and disproportionately high levels of HIV and TB, drug and alcohol dependence and sexually transmitted infections

But some things have changed:

- the population is, on average, older than it was
- New build, particularly in the Thames Gateway area, has increased the population by 11% (800,000) since 2001 – the equivalent of a city the size of Leeds
- By 2016 London's population has grown by around a further 800,000
- There are no more beds in London hospitals than there were a decade ago. Instead there has been massive investment in primary and community health care services, with the emphasis being on treating patients as near as possible to their own homes
- Patient and public expectations have continued to grow, as a consequence both of Government policy and of the fact that people expect more, and more choice, in all aspects of their lives

All of these factors, whether old or new, pose particular challenges to providers of healthcare in London. Communication, information and mutual consultation are key.

Providing greater options for patients

What this meant:

All our stakeholders told us they wanted us to take fewer patients to A&E. They wanted our staff to be skilled and confident in using a much wider range of alternative pathways for patients.

Staff were clear they wanted access to extra skills so that they contribute to the well being of all our patients.

How we responded:

If patients do need to go to a hospital we choose where to take them on the basis of their condition. For example, patients with a Myocardial Infarction (MI) (heart attack) will be taken directly to the unit that can provide the right intervention. We were already starting this ten years ago, but now we can do it for any patient who needs specialist care: for example people who have had strokes and people with complicated traumatic injuries. This will sometimes mean passing a hospital that does not have these facilities, but we will do this when we know that it will improve the patient's

chance of survival and avoid the clinical risk involved in transferring a patient from one unit to another.

When we arrive at the hospital our staff assist the medical team there and as soon as they can they add their notes on the case to the patient's electronic record. They also transmit them back to the operations centre once they return to their vehicles so that the full record can be used to review our success in treating patients.

But if a CTA has concluded that a patient does not need an ambulance response but instead needs to attend a Minor Injuries Unit or Walk in Centre, or see their GP, or be visited by another care provider like a district nurse, mental health specialist, health visitor or social worker for example, they can secure that care for the patient. If the patient needs transport, they can call up an LAS Patient Transport Service vehicle to provide that.

GP practices reserve a number of emergency appointments for patients who have rung 999 and our CTAs can secure those appointments on-line so that the patient knows what slot they have before the phone call ends. They can also make GP appointments for the following day.

Many other health and social care professionals are also available to CTAs. Our Emergency Bed Service (EBS) has extended the services it provides and is now an integrated and crucial part of the response hub. They have real time information, constantly updated, about the availability of emergency and urgent services, ranging from specialist intensive care beds, through emergency hospital beds, to outpatient and rapid access clinic appointments, intermediate care beds and slots in urgent care centres all over London. They have access to health and care workers who can visit patients and they know who is available when. They can also access voluntary sector services such as Red Cross "sitting services", care lines and advice services of various types, such as welfare advice or mental health support.

If the arrangements cannot be made for the patient while the advice call is still going on, our EBS team take over the responsibility for the call. They work to secure the care that is needed and they ring the patient back once they have succeeded so that the patient knows what to expect. As they always did with emergency beds, they maintain oversight of the patient's case until they know that the patient has arrived at the destination or the care provider has visited the patient. The patient's case records are transmitted electronically to the next carer through the NHS's *Connecting for Health* data spine.

We encourage patients to make their own way to their appointment or urgent care centre if they are able to do so. But sometimes, even when we know the patient does not need an ambulance, we nonetheless arrange transport for them. This is because we understand the "social contract" between the public and the NHS, and our role as the last port of call for people who need help, many of whom lack access to transport.

Culture, attitude and behaviour

What this meant:

Everyone said that they wanted to see the service's CRITICAL values consistently applied across the service. Staff and managers were committed to challenge themselves and each other to be accountable for their behaviour as ambassadors for the LAS in everything they did.

There was a call for new styles of management – supportive of staff and promoting staff involvement and development.

It was clear that most people saw this as underpinned by skills – clinical, managerial, leadership, communications. People wanted to be held accountable, and to hold each other to account, for the highest standards of behaviour and performance.

How we responded:

As members of LAS staff, whether we work at the front-line or support those who do, we understand that there is a contract between us and the LAS that goes beyond the simple statement of terms and conditions that we signed when we joined the service.

When we came for interview we needed to demonstrate good communication skills, a caring attitude and a strong motivation to learn and improve. Emotional maturity was also very important. It can be a tough and stressful job, both in the response hub and "on the road". The LAS needs people who have good coping mechanisms and are also able to seek support when things are difficult.

That was the same if we were applying for a job in support services, as an administrator or a professional in finance, human resources, communications, logistics, information technology, research or statistics. The LAS offers excellent training opportunities to all these staff too and, in return, expects them to commit to their personal development and, crucially, a customer service ethic. In the LAS we never hear the words "it's not in my job description". "Yes" is the most common answer to a request for help.

We have always been very lucky in being a part of the NHS that finds it easy to recruit and retain staff. We have not changed our initial entry requirements. It is still possible to join the service after successfully completing post-16 education at A/vocational diploma level. We have not made it necessary to gain a degree in order to join, because we know that there are many intelligent, resourceful and caring people who, for one reason or another, do not go onto higher education straight from school. We also recognise the reduction in the numbers of young people entering the workforce and the need to maintain healthy access routes to professional ambulance careers.

However, you can gain a degree in paramedic science and join the service through that route. Or, having joined with the basic entry requirements, you can go on to gain higher education qualifications at diploma, degree or post-degree level, dependent on your ability and ambitions supported by the service to do so.

Being able to speak a language other than English will increase your chances of getting an interview and we will not employ anyone who is intolerant of the diversity of our community in London. It is very important to us that our staff profile reflects as far as possible the diversity of the Capital city.

The LAS provides the training and experience to do a good job and to progress as far as our ability will take us. In return we are expected to be committed to our learning and development, to take a

self-critical approach to our practice, to seek feedback from our colleagues and managers and take our own opportunities to learn rather than simply wait for the LAS to provide us with learning opportunities.

In the past we were known for a traditional, hierarchical management style that did not always site well with how things were done in the rest of the NHS. We still need that on occasion. For example, at a major incident, our staff will need to carry out orders – for their own safety and for the sake of patient care.

There are also occasional times when staff act negligently. We do not tolerate that. But we do not blame people for mistakes that could not have been avoided. Instead we investigate the faults in the system that led to the mistake, and do whatever we can to stop that occurring again. We expect people to take personal responsibility for their actions, admit to uncertainty and ask for help when they need it.

So, instead of telling people what to do, and asking for compliance based on seniority, managers lead by example and provide leadership and direction and, crucially, support. We encourage staff to question our systems and suggest improvements. We involve them in making these improvements and they get credit for being innovators. Everyone respects each other for the skills and attitudes they bring to the job, regardless of where they are in the organisation.

We expect to work hard, to be efficient, productive and motivated to perform to the highest professional and personal standards. We expect all those things from our colleagues. The LAS is an organisation we are proud to work for.

Appendix 3

Managing Demand –High Impact Changes

High Impact Changes – A &E Service

1. Progressively implement the New Front End Model in ORH LO77 to provide sufficient FRU resources to ensure that main response time targets are achieved by a single responder whilst ambulance resources are held back to provide transport only when it is required. Excludes situations where clearly an ambulance is required as part of the initial response eg. Cardiac arrest.
2. Achieve consistent 97% hour by hour staffing on FRUs and Ambulances against the ideal cover from the ORH LO77 modelling.
3. Eliminate the telephone handshake on station and mobilise crews by alert message to call waiting on MDT
4. Eliminate unnecessary multiple initial tasking to single incidents.
5. Introduce a system to allow available managers to be efficiently tasked to emergency calls .
6. Further modernise working practices to achieve an acceptance that all ambulances and FRUs need to be dynamically deployed in line with the EOC distribution regime. This will include mobilisation from ambulance stations and fixed deployment sites together with the need to actively move around the service to achieve optimum cover.
7. Improve overall ambulance availability by 300hrs per day by actively managing down overall job cycle times . (Reducing from 62minutes on average to 52 minutes).
8. Review and improve the overall attendance management systems within A&E to consistently achieve overall A&E sickness levels of 5.5% or below.

High Impact Changes – Emergency Operations Centre

1. Achieve consistent 97% hour by hour staffing against a revised ideal modelled by ORH
2. Introduce a revised EOC management structure to ensure high levels of visible leadership and personal accountability. Review and refine the EOC Sector controllers role to ensure that only the highest quality individuals are allowed to dispatch vehicles and that they are held to account for their personal performance.
3. Progressively move FRUs back to sector desks to ensure that geographical sectors have all available resources visible to the dispatcher.
4. Introduce Automated dispatch for FRUs ensuring that activation times are then reduced to under one minute.

5. Eliminate unnecessary multiple tasking to single incidents and hold ambulance dispatch until a definite need for transport at that level is identified.

6. As FRU numbers increase against the LO77 New Front End Model plan progressively extend the tasking of FRUs to both Red and Amber Calls.

7. Restrict Urgent workload on the core emergency fleet to those calls which have an STA of 60 minutes or under.

8. As the UOC takes on more of the green workload progressively restrict the dispatch of core emergency resources to only those Green calls which have been upgraded and/or referred back by UOC.

9. Implement and maintain a comprehensive Distribution Regime for both FRUs and Ambulances against a sophisticated plan based on actual and predicted workload.

High Impact Changes – Urgent Operations Centre

1. Introduce a revised and unified UOC management structure to ensure high levels of visible leadership and personal accountability

2. Implement the full technical functionality for UOC to allow the optimal use of all UOC resources.

3. Achieve consistent 97% hour by hour staffing for all Urgent Care Resources against a revised ideal modelled by ORH

4. Progressively increase the numbers of calls being handled by UOC until they are dealing with 80% of all suitable Green Calls and all Doctors Urgents which have an STA of over 60 minutes.

5. Introduce physician support for CTA and ECPs which allows high levels of call resolution over the telephone.

6. Introduce a system whereby large volumes of Green Calls can be handled by an external provider at times when overall demand on available LAS resources causes severe capacity issues.

7. Review the role of EMT1 within the context of overall workforce planning for Urgent care. Introduce revised roles and skill mix arrangements which accurately reflect the patient care needs as defined by the workload.

8. Embed the current PTS central Services function into the UOC operation and optimise the use of PTS staff in management of appropriate A&E workload.

9. Continue to develop and grow the ECP programme in collaboration with local PCTs and Urgent Care Networks. Increase the utilisation of ECPs to achieve maximum impact on both Urgent Care workload and Emergency workload.

High Impact Changes – Patient Transport Service

1. Matching Operational Resources to meet varying demand - this will include looking at Rotas which take operational hours and unusual demand patterns into account making sure that sufficient resources are available to meet demand without recourse to excessive third party involvement.

2. Achieving Excellence in Planning - this will include giving planners the tools to do their job , always planning against appointment time rather than by geographical area and maximising the number of patients conveyed on each trip.

3. Improving the accuracy of recorded journey data - this will include recording appointment times correctly, defining exactly what we mean by arrival and departure times etc.

4. Reducing block bookings at inappropriate times - this will include convincing hospitals not to block–book high numbers of patients at set morning and afternoon times, cooperating with hospitals to help them book long-distance journeys at suitable times etc.

5. Measuring, reporting and monitoring individual productivity - this will include making sure that call-signs are understood and used for all journeys, especially when changing from single crew work to double crew work.

6. Achieving the full staffing of PTS Central Services in line with the ideal modelling work completed by ORH

7. Reviewing how we survey our patients - this will include reviewing the current survey form, how and when patients fill them in, or introducing other methods to gain feedback.

	**London Ambulance Service** **NHS Trust** **Managing Attendance Policy** **For Use By: All Staff**

Date of issue:	Review date:
Approved by:	Reviewer: HR Manager (Policy and Projects)
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1 Introduction

1.1 All employees have a responsibility to attend work and fulfil their contract of employment.

1.2 It is recognised that employees may be unable to attend work from time to time because of illness, it is also in the interests of both staff and patients that sickness absence is managed and minimised. Excessive absence affects the Trust's ability to provide an effective service and also places additional pressures on individuals and teams who continue to provide a service in the absence of colleagues.

2 Scope

2.1 The Policy and procedure applies to all employees and covers absence related to sickness.

3 Aim of policy

3.1 The aim of this policy is to:

- Set out the responsibilities of managers and staff in relation to sickness absence.
- Provide a fair and consistent method of dealing with attendance issues due either to intermittent absence, or ongoing long-term absence.
- Give employees the opportunity to improve their attendance and provide guidance and assistance in accessing appropriate support.
- Provide a means by which employees may be formally advised of the effects of their attendance levels, and the potential consequences for their employment, should their pattern or level of absence not improve significantly.
- Ensure that every attempt is made to investigate employees' ability to perform adequately in their post, taking into account the advice of Occupational Health Department (OHD) and other relevant specialists.
- To help improve employee attendance and therefore the service provided to patients.

4 Responsibilities

Responsibilities in relation to this Policy include:

4.1 Managers' responsibilities

- To ensure that all sickness absence is recorded;
- To promote attendance by setting standards and monitoring and reviewing absence levels;
- To ensure their staff are aware of, and follow, sickness absence reporting procedures.
- To carry out actions in line with the Policy including return to work interviews and attendance reviews;
- When possible to assist and support their staff with ill health problems and/or underlying issues that may affect attendance;
- To facilitate staff attendance at the Occupational Health Department and other meetings/appointments under this Policy, as required;
- To manage absence in a sensitive, fair and timely manner.

4.2 Staff responsibilities

- Report absence and provide medical certificates promptly and in line with this policy and their contract of employment;
- To maintain regular contact with their line manager when absent, to advise on their prognosis and likely return to work date;
- Attend the Occupational Health Department, return to work interviews, attendance review meetings and other meetings under this Policy as instructed;
- To identify to their manager any underlying issues that may have affected their attendance;
- Not to abuse the sickness absence provisions. Any such abuse may result in forfeiture of sick-pay and possible disciplinary action.

4.3 Human Resources' responsibilities

- To advise managers of best practice in the management of sickness absence and to assist them in applying the Managing Attendance Policy
- To advise staff as appropriate in regards to the Policy including the sources of help and support that are available.
- To monitor the consistent application of the Policy.

4.4 Occupational Health Department's responsibilities

- It is the responsibility of OHD, following a referral, to provide advice and support to managers and staff and to liaise with a staffs' GP or medical specialist to provide an informed assessment of employees' fitness for work.

5. Other matters

5.1 The Trust recognises and accepts its duty and responsibility that for matters under the Trust's control, it provides a safe and healthy environment for its staff.

5.2 Whilst both the Trust and individual members of staff have a responsibility to do all they can to reduce risk to themselves and others, it is acknowledged that the nature of some employees' jobs means that there is a possibility of personal injury when carrying out everyday duties.

5.3 When sickness is potentially related to health and safety hazards then these will be investigated, usually by the line manager. Appropriate preventative action will be taken and monitoring carried out to ensure that this is effective. The local Health and Safety representative should be informed and consulted in such circumstances.

5.4 The Trust recognises that it is unlawful to treat a disabled person less favourably because of their disability, unless the disability has a substantial and relevant adverse impact on the person's ability to do their job. The Trust will give due consideration to whether reasonable adjustments can be made which would enable a disabled employee to return to work.

5.5 <u>Policy on alcohol, drug and substance misuse</u>

5.5.1 This Policy sets out the provisions for supporting staff who may have alcohol, drug or substance misuse issues, and managers should be mindful of this Policy. It should be noted that in cases where such misuse may have a direct link with employee's attendance then this should be taken into account when making decisions under the MAP. The aim of the Policy on alcohol, drug and substance misuse is to support the member of staff to overcome their problems. If, however, it becomes clear that staff are not willing to undergo treatment programmes etc then their absence should be addressed accordingly.

5.6 <u>Manual handling policy</u>

5.6.1 When appropriate, managers and staff should refer to the Trust's Manual Handling Policy. The Manual Handling Policy provides information on the available support and assistance that is available to those who have sustained musculo-skeletal injuries.

6 Managing Attendance Procedure

6.1 Reporting absence and maintaining contact

6.2 Employees must report their absence as soon as possible in line with departmental/local requirements. In general, the reason for sickness should be given. It is recognised that staff may not always want to give details of their illness to the person taking the message: in such circumstances the member of staff must subsequently tell the manager the reasons for absence. Employees should, as far as possible, indicate when they are likely to return to work. For any period of absence of between 4 and 7 days inclusive, employees are required to complete a self certification form (LA50).

6.3 On day 8 of any absence employees will provide a medical certificate from their GP or specialist. Employees should also contact their manager to keep them informed of progress unless a certificate has previously been provided.

6.4 Thereafter, employees will contact their manager at least 2 days before their medical certificate is due to expire to update the manager of progress. N.B. Failure to supply medical certificates may result in the absence being considered as unauthorised and will therefore lead to the deduction of pay.

6.5 Depending on the likely length and circumstances of the absence, managers and members of staff should agree additional arrangements for regular contact whilst they are absent from work. Due sensitivity should be given to the employee's medical condition when making such arrangements. The aim is to check on employees' welfare, keep them in touch with developments at work and to enable employees to update their manager regarding their prognosis and likely return to work date.

6.6 Staff have a responsibility to maintain a reasonable level of contact when off sick and will be contacted by managers if necessary. In circumstances when staff fail to maintain contact by other means then a personal visit to the employee's home may be necessary.

7 Recording and monitoring absence

7.1 Managers are responsible for ensuring that all absence is recorded and monitored in order that they are able to respond promptly and appropriately to issues of concern.

7.2 Absence rates

7.2.1 For the sake of clarity, absence triggers in this procedure are stated in duty days. Triggers should be pro-rated, as appropriate, for part-time staff and should be adjusted to take account of different shift patterns.

7.2.2 It is often most effective to monitor and manage absence in terms of absence rates. These may be calculated as follows:

$$\frac{\text{Working days lost (during a specific period)}}{\text{Available working days (during the same period)}} \times 100 = \%\ \text{absence rate}$$

7.2.3 Bradford Scores

Bradford scores may also be used as a means of monitoring absence (see Appendix 7).

8 Employee absence – points to consider

8.1 When the level or pattern of absence gives rise to concern, then consideration will be given to addressing the absence in line with this Policy. A key aim of the Policy is providing a 'fair and consistent method' of addressing absence. This does not necessarily mean treating everyone the same way, but recognising that in addressing employees' absence, there needs to be consideration of differing health problems and circumstances affecting members of staff, including consideration of their past absence record. Particular consideration should be given to employees who have a serious underlying medical condition or who are disabled under the terms of the Disability Discrimination Act 1995 (see paragraph 14.6). Note that staff with an underlying medical condition or disability will be subject to this Policy.

8.2.1 Any consideration of an employee's absence record should include an assessment of whether it:

- Indicates the likelihood of future absence, for example an apparent general debility with a variety of ailments;
- Indicates a disabling health problem;
- Is attributable to an accident or condition requiring hospital treatment
- Indicates a discernable pattern

8.3 Meetings under this procedure should take place in private with the employee's absence record available for discussion. The meeting should explore any issues; whether medical, work-based or domestic that may be preventing the employee from attending work regularly.

8.4 Consideration should be given to the individual's past attendance record and any management action that may have been taken.

8.5 With due consideration to the context of the job and service requirements, practical assistance and advice should be given on such issues as work environment and shift patterns. Managers should take all reasonable and practical steps to ensure that improvements in these factors are made when they are having an adverse effect on work performance and/or attendance. Managers should, when necessary, seek the advice of OHD on this issue.

8.6 Managers should consider ways of enabling the member of staff to attend work and overcome difficulties caused by the illness. Changes such as a phased return to full duties, amendments to shift patterns, or redeployment to alternative duties (on a short or long-term basis), may be considered at any stage. Discussion should take place with the member of staff regarding such options and the advice of OHD may be sought when appropriate.

8.7 Managers may wish to seek advice from HR whenever an individual's absence gives cause for concern. Human Resources staff should attend meetings under the Procedure as indicated.

8.8 Members of staff are able to be accompanied by a trade union representative or work colleague at all meetings under the procedure other than the Return to work (section 9) and the General absence discussion (section 10), as both of these are intended as an initial one-to-one meetings.

8.9 Advice from Occupational Health may be sought at any stage. See Appendix 2 for further information.

9 Return to work interviews

9.1.1.1 All managers/supervisors will carry out return to work interviews with their staff following any period of absence. The purpose of the meeting is to welcome staff back and to ensure that they are fully fit for work. The nature and detail of the discussion will depend on circumstances, including the employee's past absence record, but the manager/supervisor may wish to address the following matters:

- The reasons for absence
- Is there any specific medical advice?
- Is the employee taking any medication and is this likely to affect their ability to carry out their duties?
- Is there likely to be a re-occurrence of the illness?
- Is there any help that the Trust can provide in supporting the member of staff to attend work.

9.2 The employee should be notified of all available support in-line with that detailed in Section 15.

9.3 The return to work interview should be carried out as promptly as possible on the employee's return. To this end, and if the line manager/supervisor is unavailable, the responsibility for carrying out the interview may be delegated to another manager or supervisor. The manager/supervisor should outline, as appropriate, the support available to the member of staff.

9.4 The return to work interview is also an opportunity to update the member of staff on any changes whilst they have been away. The return to work form should be completed (Appendix 5).

10 General absence discussion

10.1 At an early stage - following a period of absence and in addition to the return to work interview, it may be appropriate for the manager to meet with the member of staff. This will be an opportunity to discuss the absence, and, if appropriate, to warn the member of staff that he or she is approaching absence trigger points. Consideration should be given to any underlying causes for absence – the application of trigger points may not always be appropriate. A brief record of this meeting should be made.

11 Intermittent absence

11.1 Informal Stage - interview and targets for improvement

11.1.1 The triggers for addressing an employee's absence under the intermittent section of this Procedure is when the employee has had:

- three periods of absence in a rolling 12 month period,
- or, two periods of absence resulting in eight or more days being lost, in a rolling twelve month period.

The manager may also meet with the member of staff when their pattern of absence gives rise for concern e.g. he or she is regularly absent on a particular day of the week, following payday etc.

11.1.2 It is recommended that a letter is sent or given to the employee confirming the details of the meeting. Any meeting should take place as soon as possible, and in normal circumstances a maximum of four weeks, after the period of absence. It is the responsibility of all involved to help to achieve this. The member of staff may be

accompanied by a trade union representative or work colleague at the meeting.

11.1.3 The purpose of the meeting with the member of staff is to advise them that their sickness record is of concern and to discuss the reasons for absence. This will give the member of staff the opportunity to discuss any health, work based, domestic, or other problems that may be affecting attendance.

11.1.4 The member of staff should be advised of the willingness of the Service to help. A range of services, including OHD, is available (see Section 15). The member of staff may also be encouraged to seek help via their GP.

11.1.5 The manager and member of staff may jointly consider options to help improve the member of staff's attendance levels.

11.1.6 Consideration must be given to any serious underlying causes of absence and the prognosis of any condition, prior to deciding on whether targets for improvement are set at this time and what these targets might be.

11.2 Targets for improvement

11.2.1 If targets for improvement are set, then the manager should clearly inform the member of staff of the expected improvements in attendance and the period during which these improvements are expected.

11.2.2 An improvement period will generally be set of up to 12 months. Any targets set should be with the aim of achieving a significant improvement in levels of attendance. Generally a further two periods of absence or one period of four or more days during the improvement period should trigger consideration of action under the formal stage of the procedure.

11.2.3 The manager will also inform the member of staff that should his or her attendance level not improve, then the next stage of the Managing Attendance Procedure will be initiated. The member of staff should be informed that this in turn may lead to dismissal from the service.

11.2.4.1 Every effort should be made to give the member of staff time, opportunity, encouragement and assistance to improve.

11.2.5 A record should be made of this discussion which may be on the sickness/lateness record card or the Meeting record (Appendix 6). This should be signed by the member of staff. A letter should

subsequently be sent to the employee to confirm the outcome of the discussion.

11.2.6 The member of staff should be reminded of his/her right to approach his Union or other representative for advice.

11.3 Ongoing review

11.3.1 It is recommended that the manager carries out review meetings with the member of staff on a regular basis (e.g. 3 monthly) during the improvement period. Meetings may occur sooner should the employee's absence give rise to concern. A record must be made of these meetings.

11.4 Referral to the Occupational Health Department

11.4.1 A referral to OHD may be made at any time, but it should always be done before moving into the formal part of the procedure.

11.4.2 The referral may include a request for OHD's opinion on:

- Whether an improvement in attendance can be reasonably expected.
- Whether there is a significant underlying medical cause that has had an impact on the member of staff's attendance
- Future prognosis of any health issues affecting the member of staff.

11.4.3 If the advice received from OHD is that improvement is envisaged, the case may be kept under review. If, after a reasonable period, no improvement is achieved, a formal interview takes place.

11.4.4 Other information from OHD may be considered together with other relevant specialist advice.

11.4.5 The OHD or other advisers can only provide advice on their own area of expertise. It is the manager's responsibility to take account of the advice provided and to decide the appropriate action to take as regards the member of staff. For further information on OHD please refer to Appendix 2.

11.5 Formal Stage - Interview and targets for improvement

11.5.1 The formal part of the procedure will be initiated when a target for improvement has been issued at the Informal Stage and there has been no improvement or no significant improvement in the member of staff's overall attendance.

11.5.2 Triggers for initiating the Formal Stage of the procedure will generally be a further two periods of absence or one period of four or more days during the improvement period. The formal procedure may also be initiated when a member of staff's absence has hit an alternative absence trigger that was set at Informal Stage e.g. that may have been set to take account of a underlying medical condition or past absence record.

11.5.3 The member of staff should be written to inviting them to interview under the Formal Stage of the procedure. The interview at Formal Stage will generally be carried out by the next-in-line manager together with a representative of the Human Resources Directorate. The member of staff may be accompanied by a TU or other representative. Any meeting should take place as soon as possible, and in normal circumstances a maximum of four weeks, after the period of absence. It is the responsibility of all involved to help to achieve this.

11.5.4 The interview should take account of OHD and other relevant advice. Particular consideration should be given to any underlying medical conditions.

11.5.5 The interview will cover:

- reference to previous absence discussions and warnings
- a review of the member of staff's attendance including a discussion of the reasons for absence.
- The member of staff should be encouraged to seek advice or support from any expert sources including those detailed in Section 15 of this procedure.

11.5.6 The manager, depending on the member of staff's circumstances, and including the advice provided by OHD, may or may not decide that an improvement in the member of staff's absence can be expected at this time.

11.5.7 If it is decided that an improvement in attendance is necessary, then the the member of staff should be clearly advised that unless a significant improvement becomes apparent within a stated period (up to 12 months), it may be necessary to initiate the procedure to terminate their employment. Any targets for improvement at the Formal Stage must be confirmed in writing and should clearly set out the points discussed at the interview.

11.6 <u>Ongoing review</u>

11.6.1 It is recommended that the manager carries out review meetings with the member of staff on a regular basis (e.g. 3 monthly) during the

improvement period. Meetings may occur sooner should the employee's absence give rise to concern. A record must be made of these meetings

.

11.6.2 If there is no, or inadequate, improvement in attendance, during or after the stipulated period following the formal warning, then the matter should be referred to the OHD for the specific attention of the Occupational Health Physician. Further advice may be sought from any other relevant sources.

11.6.3 The manager, taking into account advice, including that of OHD, may decide that a further period of review is appropriate. Alternatively the manager may decide to refer the matter for consideration of dismissal (see Section 13).

11.7 Further high levels of absence following successful completion of improvement periods

11.7.1 In the event of a period of improvement, resulting in the manager removing or not extending targets for improvement, followed by a return to similar patterns of high levels of absence, then, taking into account the previous management action, the appropriate part of the procedure relating to intermittent absence, or ongoing long-term absence may be invoked.

12 Ongoing long-term absence

12.1 Long-term absence for the purposes of this Procedure, is defined as four weeks or more. This generally will be a continuous period of absence but may be long periods of absence broken by a few days.

12.2 Contact

12.2.1 A reasonable level of two-way contact should be maintained between the manager and member of staff for the duration of the absence. The manager should document this contact.

11.2.2. This procedure will not usually be applied in circumstances when the absence is planned and the likely outcome is clear to all concerned e.g. a member of staff is being referred to hospital for an operation.

12.2.3 It would be unreasonable to give warnings to an employee when a chronic health problem, or deteriorating health has been identified, to improve their attendance. In circumstances when there is a reasonable expectation that a member of staff will not return to work then it may be appropriate to go immediately to Consideration of Dismissal (see Section 13). Ill-health retirement may apply in some circumstances (see paragraph 14.3).

12.2.4 There are four potential outcomes to managing ongoing long-term absence:

- A return to work
- Redeployment
- Ill-health retirement
- Dismissal on the grounds of capability.

12.3 Referral to the Occupational Health Department

12.3.1 At four weeks, or at the point that it appears likely that the member of staff will be absent for four weeks or more, he or she should be referred to the OHD. OHD should be asked to advise on the member of staff's state of health and how this is likely to affect future employment.

12.4 Meeting following the OHD report

12.4.1 The manager should arrange a meeting with the member of staff.

12.4.2 Staff should be given 7 days' notice of this meeting and may request a representative to be present. An HR Adviser may accompany the manager to this meeting.

12.4.3 The purpose of the meeting is to discuss the member of staff's condition and his or her prognosis, and find out whether there are any ways that the Trust can help. It is also an opportunity to discuss the OHD report, including any recommendations and how these might be implemented.

12.5 The subsequent management response to the sickness absence will take account of the circumstances of the case and may include the need to seek further specialist advice, redeployment to alternative duties on a temporary or permanent basis or an application for ill-health retirement.

12.6 However, when there is little likelihood of the member of staff being able to return to work in any capacity within the Trust and other options have been exhausted, he or she should be referred for possible dismissal on the grounds of capability.

12.7 Ongoing review meetings

12.7.1 If there is a likelihood of an improvement in the employee's condition then further meetings with the employee should be arranged. The frequency of these review meetings should reflect the individual circumstances. Throughout the employee's absence, and in addition to these review meetings, regular contact with the member of staff should be maintained.

12.7.2 The review meetings will follow a similar format to the earlier meeting and discussion relating to any outcomes of that meeting. The meeting should be held with the member of staff, their manager and HR Adviser. The member of staff should be given 7 days' notice of the meeting and may have a representative present.

12.7.3 Advice may be sought from the OHD at any stage. If the employee's absence is likely to be protracted then the manager must make a referral to OH for further advice regarding the employee's prognosis. Depending on the likely prognosis then a referral may be made for possible dismissal.

12.8 Further high levels of absence

12.8.1 In the event of an employee returning to work resulting in the manager removing or not extending targets for improvement, followed by a return to similar high levels of absence, then, taking into account the previous management action, the appropriate part of the procedure relating to intermittent absence, or ongoing long-term absence may be invoked.

13 Hearing to consider possible termination of employment

13.1 A referral may be made for a possible termination of employment. This may follow high levels of absence being recorded and addressed under the intermittent absence and/or the ongoing long-term absence parts of this procedure (see sections 11 and 12).

13.2 Dismissal is the extreme sanction that can be used by the employer against an employee. Proper application of the Managing Attendance Procedure should prevent the need for dismissal in most cases by encouraging and helping staff to attend work on a regular basis.

13.3 A letter should be sent to the employee. This should be sent at least 7 days in advance of the hearing together with copies of all paperwork due to be considered at the hearing. In all cases when dismissal is a potential consideration, this will be made clear in the letter.

13.4 Managers' right to dismiss will be in line with the Trust's Disciplinary Policy.

13.5 The hearing should take into account all medical and other advice, representations from management and from the member of staff or their representative.

13.6 In considering dismissal, the Chair should take into account: the member of staff's length of service; past performance; likelihood of a change in attendance; the availability of suitable alternative work and the effect of past and future absences on the organisation. If the eventual decision is to dismiss, then the Chair should first satisfy her/himself that the Trust has acted reasonably and that the member of staff has been given sufficient opportunity to improve their attendance or in the case of ongoing long term absence, to return to work. For guidelines regarding carrying out the hearing see Appendix 4.

13.7 Reasons for dismissal

13.7.1 Reasons for dismissal will be classified as:

- Capability – in cases when the employee because of their illness and level of absence are incapable of fulfilling the requirements of the job (this will be predominantly applicable in cases of longer-term absence)
- Some other substantial reason – in cases when, whilst the employee may be fit for work at the point of dismissal, their absence record is such that the Trust cannot continue to employ them. The dismissal letter should state that the absence is on the grounds of 'some other substantial reason' and specifically for the 'failure to attend work regularly'.

13.9 Dismissal with notice

13.9.1 Unless the employee is being dismissed for reasons of gross misconduct, he or she should receive the appropriate period of notice or payment in lieu of notice. If the employee appeals against dismissal then every effort should be made to hear the appeal during the notice period.

13.10.1 Appeals

13.10.2 The employee or his/her representative must notify in writing they wish to appeal the decision to dismiss and to state the reasons for appeal, within 14 days of receiving written confirmation of the decision to dismiss

13.10.3 The appeal letter should be submitted to the Director of Human Resources. The appeal panel will consist of an external advisor (agreed by management and staff-side) a Non-Executive member of the Trust Board and the Director of Human Resources or other nominated senior HR manager.

13.10.4 The employee should be contacted within 14 days of receipt of the appeal letter with an appeal date.

13.10.5 Appeals will not normally involve a re-hearing of the case but should focus on the grounds of appeal.

13.10.6 Appeals will generally follow a similar order to that for the Hearing to consider possible termination of employment as set out in Appendix 4.

13.10.7 If the appeal is successful then pay will be re-instated and backdated to the end of the notice period.

14 Other matters

14.1 Ill-health redeployment

14.1.1 If it is established that a member of staff is unable to carry out their job on either a temporary or permanent basis, then the Trust will endeavour to offer redeployment to suitable alternative duties. Priority will be given to considering ill-health redeployees for posts prior to them being advertised (see appendix 3).

14.2 Ill-health retirement

14.2.1 Employees will be advised of the option for ill-health retirement in circumstances when it appears that they are permanently incapable of carrying out their duties and redeployment is unlikely to be successful. Ill-health retirement will be subject to the advice of OHD and other specialists.

14.2.2 Approval for ill-health retirement rests solely with the NHS Pension Scheme Medical Advisers.

14.3 Disability

14.3.1 A disabled person in terms of the Disability Discrimination Act 1995 (as amended), is someone who has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day to day activities.

14.3.2 It is unlawful to treat a person with a disability less favourably for a reason that relates to their disability, in any area of employment, unless the disability will have a substantial and relevant adverse impact on their ability to do the job.

14.3.3 The manager should consider whether any reasonable adjustments could be made to help the member of staff. This may be as simple as an additional piece of equipment. A reasonable adjustment can also mean redeployment to a different kind of work if necessary.

14.3.4 If a member of staff's absence appears to be related to their disability then OHD and HR advice should be sought. Whilst consideration should be taken of a member of staff's disability, it should not preclude reasonable management action to address absence.

14.4 Musculo-skeletal injuries

14.4.1 Specific advice regarding musculo-skeletal injuries are included in the Trust's Manual handling policy.

14.5 Confidentiality

14.5.1 It is essential that confidentiality is respected in relation to reasons for any absence. Particular care should be taken to ensure that correspondence between OHD and the manager/HR is kept secure.

14.6 Conduct issues

14.6.1 In cases when it is suspected that sick leave and pay is being abused, then this would be a potential conduct issue that should be investigated as appropriate, and, if necessary, addressed using the Trust's Disciplinary Procedure. This may include circumstances such as an employee being employed elsewhere when on sick leave, engaging in activities that are inconsistent with the alleged illness, or failing to provide or falsifying medical certificates.

14.7 Lateness/unauthorised absence

14.7.1 Whilst cases of lateness or unauthorised absence may be recorded alongside sickness absence, it will generally be an issue of conduct, and as such should be addressed, as appropriate, which may include use of the Disciplinary Procedure.

14.8 Risk assessments

14.8.1 After a period of long term absence it may be beneficial that a general risk assessment for the member of staff who is returning to work. This will help determine if there are any limitations on his or her ability to resume full duties. It may be useful to refer the employee to OHD in such circumstances.

14.9 Visiting employees during their absence

14.9.1 During periods of absence line managers may arrange to visit the employee at home, or at a mutually agreed venue, by prior arrangement with the employee. In exceptional circumstances when staff fail to maintain contact with the Trust by phone, post etc. then an unannounced visit to the employee's home may be necessary.

14.10 Annual leave during periods of sickness absence

14.10.1 Employees are not expected to go away on holiday during a period of sickness absence. However, when a member of staff wishes to honour a pre-booked holiday they must seek permission from their line manager in advance. The line manager may request information from the GP or Occupational Health Department about the fitness of the employee before giving their permission. Annual leave will be taken for the period that the employee is away on holiday.

14.11 Fitness to return to work

14.11.1 In cases of long-term illness or injury, managers must refer the employee to the Occupational Health Department in order to ensure that they are fit to undertake full duties.

14.11.2 In cases of long-term absence, staff may be helped back into work through a phased return e.g. working fewer hours, carrying out alternative duties or by working amended shift patterns for a short period. This will be with the aim of the employee returning to full duties within a reasonable time-span. Staffs' previous full rates of pay will initially be provided for a four-week period. In the exceptional circumstance that the member of staff has not returned to full duties by the end of four weeks, then a review will be carried out (with OHD input as necessary) to determine whether the arrangements for the phased return need to be amended. Discussions with the employee at this stage will also include, at the employee's request, his or her TU representative.

14.12 Terminal illness

14.12.1 In situations when an employee is terminally ill then the Trust would aim, as far as possible, to accommodate the employee's wishes and would advise on the most beneficial package available.

14.12.2 In such cases the employee should contact an HR adviser who will seek advice from the Trust's Pensions' Officer regarding the options for the employee and/or their next-of-kin.

15 Sources of help and support

15.1 The Trust has a number of staff support initiatives that may be of assistance these include: LINC, the (Listening, Informal, Non-judgemental, Confidential) peer support scheme; a range of services through Occupational Health including counselling; and the Employee Assistance Programme (EAP) a 24/7 service, independent of the Trust, that allows staff to talk through and obtain help with personal or work related matters. Staff may also consult their Trade Union representative at any time.

15.2 Appropriate time should be given for the employee to consult with their representative in advance of any meetings under the procedure which the representative is expected to attend.

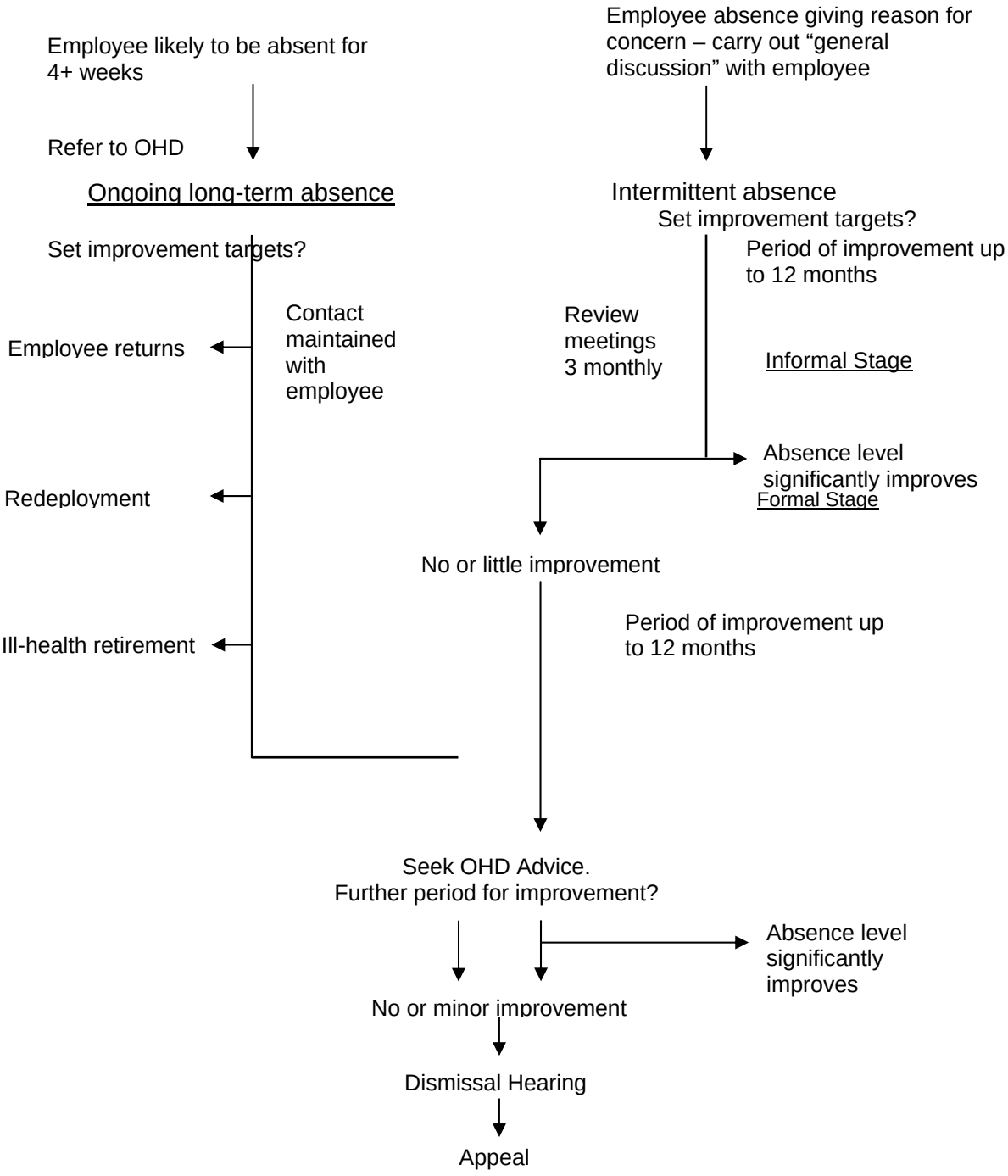
15.3 Further information on the above and other support services are included on the Trust's intranet site, the Pulse, under *Home>About Me>My Support*.

15. 4 Human Resources

15. 4.1 Human Resources staff are available to provide advice and guidance at any stage.

MANAGING ATTENDANCE PROCEDURE – FLOWCHART Appendix 1

Ongoing management of all employees' attendance
(carry out return-to-work interviews for all staff)



The Occupational Health Department **Appendix 2**

1 Introduction

A manager can refer an employee to the Occupational Health Department (OHD) at any stage within the process. The employee may also refer themselves to OHD.

The role of the OHD in relation to sickness absence is to offer advice on an individual's health and ability to work. The manager will take this advice into consideration when addressing the member of staff's absence.

Attendance at an OHD appointment is a reasonable management request and the member of staff is obliged to attend.

2 Referrals to the Occupational Health Department

Managers, in making a referral to OHD, should be as specific as possible in terms of the questions being asked and the opinions sought of OHD. The questions should relate directly to the employee's health and how this is affecting, or is likely to affect, the employee's ability to carry out his or her job.

Specific questions could include:

- When is the employee likely to return to work?
- Is there an underlying medical condition?
- Is the sickness likely to continue and for how long?
- Is the medical condition likely to improve with treatment and over what time period?
- What is the possibility of recurrence?
- Is there any particular support that would be useful to the employee to facilitate a return to work.

It is useful to provide information such as job descriptions, information about the working environment etc as well as any information about the employee themselves such as their level of absence, pattern of absence etc.

3 Failure to attend an Occupational Health appointment

The Service will do everything reasonable to facilitate an employee's attendance at OHD. The OHD will inform the manager if an employee has failed to attend an appointment. The manager may contact the employee to check the reasons for non-attendance.

In the event of an employee's continuing avoidance of attending OHD, a management decision will be taken on how to proceed on the basis of the limited information available.

4 Refusal to give consent

In cases when a member of staff fails to give consent to approach their own doctor then the employee must be advised that in the absence of additional medical information and advice, any decision regarding their future employment will be taken on the basis of the limited information available.

5 Other services

The OHD, in consultation with the Trust, may refer onto other services e.g. physiotherapy in order to aid staff with their recovery.

6 Managing attendance is a managerial issue

OHD will provide medical advice and it is the manager's responsibility to consider this when making their decision.

OHD advice will be based on a range of factors including the following:

- Medical reports;
- Employee role and responsibility;
- Underlying medical conditions;
- Current state of health;
- Working environment.

OHD may also provide advice regarding possible redeployment or alternative duties. Again it is the manager's responsibility to consider this advice, alongside all other available information in deciding on how to proceed with any given matter.

All decisions made under this procedure, including the decision to dismiss, are for managers to make.

Redeployment **Appendix 3**

1 Introduction

The Trust will endeavour to support employees to return to work following long-term sickness absence by offering temporary or permanent employment wherever possible.

2 Temporary redeployment

Temporary redeployment would be suitable for employees who are fit to return to work in some capacity but need a period of transition before resuming the full duties of their substantive post. Temporary redeployment of this kind will generally be agreed for periods of up to 3 months but may be extended at the manager's discretion. Employees should be written to outlining the terms of the secondment, including the end date.

3 Permanent redeployment

Permanent redeployment is appropriate when it is clear that the employee will not be able to return to their substantive post. In such circumstances consideration of the employee for any appropriate posts will be made prior to advertisement. Redeployment may be arranged on a trial basis of up to 3 months if necessary;

The following will apply:

- individuals will be considered for any vacancy for which they have the necessary skills;
- the individual will be kept informed of all vacancies as they are advertised;
- reasonable training will be given to enable staff to meet post requirements;
- Consideration will be given to any reasonable adaptations that may be necessary to enable staff to undertake posts;
- If alternative employment is accepted, it will be under the terms and conditions (including salary and grade) for that post;
- OHD will be asked to confirm that the post is suitable for the individual on health grounds;
- If there are no suitable vacancies after this period, or when a member of staff does not accept alternative employment then termination of the contract with the Trust will be considered.

Hearing to consider possible termination of employment Appendix 4

1. Before the hearing

1.1 Any employee who is the subject of a hearing to consider potential dismissal will receive a letter from the Chair setting out the reason(s) for the hearing. It should be clearly stated that dismissal is a potential consideration.

1.2 The letter will include the date, time and venue of the hearing.

1.3 The letter will advise the individual of the right to representation and the employee will be given the opportunity to consult with her/his representative before the hearing.

1.4 At least seven calendar days' notice of the hearing will be given.

1.5 If circumstances necessitate, the employee can request one postponement of up to seven calendar days, or more by mutual agreement. Hearings should be held as soon as practicably possible and should not be unreasonably delayed due to the non-availability of a specific representative.

1.6 The individual or representative should formally respond by accepting the date of the hearing or giving a reason for a requested postponement. This response should also include details of copies of any documents to be presented. It is the responsibility of the employee to approach her/his own witnesses.

1.7 All parties reserve the right to investigate new information of relevance prior to the completion of the hearing. Where the hearing has already begun, this may require an adjournment.

2 Conducting a hearing to consider possible termination of employment

2.1 Panel will comprise a manager of appropriate seniority, who will chair the hearing, supported and accompanied by an HR advisor/manager.

2.2 The presenting manager will generally be the manager who has been most involved in managing the employee's absence.

2.3 The Chair will ensure that the hearing takes place in a fair and orderly way and with due sensitivity regarding the member of staff's illness.

2.4 The Chair should open the Hearing by confirming those present and their respective roles.

2.5 The manager will make their presentation. They will present the employee's absence record, measures that have been taken to reduce the absence and any outcomes.

2.6 The employee, or the representative on behalf of the employee, will then make their presentation including any mitigating factors regarding their absence.

2.7 The panel members may question the presenting manager, witnesses and/or employee at any time.

2.8 The presenting manager will be invited to make a final submission – this should summarise the key points and not raise any new matters.

2.9 The employee and/or representative will be invited to make a final submission – this should summarise the key points and not raise any new matters.

2.10 The employee, representative and the presenting manager will be asked to withdraw to allow the Chair time for reflection and proper consideration. If new facts have emerged during the hearing it may be appropriate to reconvene.

2.11 In considering dismissal, the Chair should take into account: the member of staff's length of service; past performance; likelihood of a change in attendance; the availability of suitable alternative work and the effect of past and future absences on the organisation. If the eventual decision is to dismiss, then the Chair should first satisfy her/himself that the Trust has acted reasonably and that the member of staff has been given sufficient opportunity to improve their attendance or in the case of ongoing long term absence, to return to work. The Chair should also consider, if applicable, whether the redeployment would have been appropriate. The HR advisor will provide guidance as necessary.

2.12 The employee, representative and the presenting manager will be recalled and advised of the decision of the Chair, along with the right of appeal if necessary.

LONDON AMBULANCE SERVICE NHS TRUST

POST SICKNESS INTERVIEW REPORT

NAME: **UNIT**

CAUSE OF ABSENCE:

DATE OF ABSENCE:

FIRST DAY	**LAST DAY**

TOTAL CALENDAR DAYS	**TOTAL DUTY DAYS**
(confirm with staff member)	(confirm with staff member

CERTIFICATION (where appropriate)

SELF CERTIFICATION, L A 50 4-7 DAYS	**YES**	**NO**
MEDICAL CERTIFICATE (8 DAYS+)	**YES**	**NO**

ACCIDENT

	N/A	**OFF DUTY**	**ON DUTY**
ACCIDENT REPORT FORM COMPLETED (LA52)		**YES**	**NO**

ASSISTANCE NEEDED

WELFARE	**YES**	**NO**
OCC. HEALTH	**YES**	**NO**

COMMENTS(full details of reason for absence and current health. Continue overleaf if necessary)

SIGNED _____ (Staff member) **DATE** _____

SIGNED _____ (Supervisor/Manager) **DATE** _____

FOR OFFICE USE ONLY

Recorded on sick card (please tick) Initials

Cross checked in DCB Initials

Attendance Procedure (informal stage) – Meeting Record Appendix 6

Employee……..

Representative……..

Reason for meeting

……
……
……

Absence Record

Illness/Injury	Dates	Total Days
	Total periods:	**Total days:**

Improvement period set……..

Targets…….

Review date……....

Record of Reviews

Review ( ) date _____
_____
_____
Review ( ) date _____
_____
_____
Review ( ) date _____
_____
_____

Off IAP/ To formal IAP (circle as appropriate)
Date and comments _____
_____

Extra Notes

Bradford Scores — Appendix 7

Using Bradford scores, an employee's irregularity of attendance can be assessed by combining measures of absence frequency and duration. The scores show whether an individual's sickness absence record is made up of a few or many spells of short or long duration. They can be used to monitor trends in sickness absence, to provide trigger points for further action, and to provide comparisons with absence rates for the organisation as a whole.

The basic formula for calculating a Bradford score is S x S x D.

- S = the number of spells of absence in a specified period.
- D = the number of days (or hours) of absence in that period.

The following example illustrates the Bradford scores for three employees with the same annual absence for 12 days.

- One absence of 12 days, Bradford score = 1 x 1 x 12 = 12 points
- Six absences of 2 days each, Bradford score = 6 x 6 x 12 = 432 points
- 12 absences of 1 day each, Bradford score =12 x 12 x 12 = 1728 points

The following example shows how the Bradford scores have been used by one trust.

South Devon Healthcare NHS Trust produces quarterly manpower reports for each clinical directorate, locality and staff group. In each case the report shows:

- Percentage of staff with less than 300 points
- Percentage of staff with 300 – 499 points
- Percentage of staff with 500 or more points
- Percentage of staff with five or more spells of sickness absence in a rolling 52 week period.

Sickness absence rates and average Bradford scores can be compared and can help to target action. For instance, the contrasting position of speech therapists and physiotherapists in the trust can be identified.

A high absence rate and a low Bradford score indicate a small number of staff with long absences. Low absence and a high Bradford score show a small number of staff with frequent short absences.

It is important to stress that any absence measure must be used with discretion. Best practice is to use a variety of absence indices providing information on different aspects.

Further information can be found in *Managing Sickness Absence in the NHS* published by the Health Education Authority as part of the Health at Work in the NHS project.

London Ambulance Service
NHS Trust

Complaints Policy

Circulated To: LAS Departments, All Stations, EOC and PTS, Training and Resource Centres.

For Use By: All Staff

1. INTRODUCTION

1.1 The London Ambulance Service NHS Trust (LAS) is committed to an open, transparent, fair and non-judgmental approach to complaints received from users of the service, their family and friends or members of the public and stakeholders. The objective is to resolve the complaint to the satisfaction of the complainant and to learn lessons from complaints that lead to improvements in service. The ethos of the management of complaints within the LAS is set out in the Being Open Policy (also see 1.4 below).

1.2 The NHS publication "Organisation with a Memory (2000)" highlighted the need to identify organisational and systemic weaknesses that cause complaints, rather than focusing on blaming individuals. The LAS endorses this approach to complaints handling and is committed to the identification of the cause of complaints and making any changes that may be necessary to prevent reoccurrence.

1.3 The intention is that investigation of a complaint will not involve disciplinary action against a member of staff as its primary focus. However, an allegation of serious misconduct will require investigation and further action will be taken as appropriate. The disciplinary investigation and any action resulting from it will be conducted according to the LAS Disciplinary Procedure and not be investigated by staff from the Complaints Department.

1.4 A fundamental requirement of the complaints handling arrangements of the LAS is the development of an open and just culture that is receptive to adopting new practices and learning from complaints, by involving both complainants and staff (see Being Open Policy).

1.5 The Trust acknowledges the importance of an effective and efficient complaints policy and procedure. It also recognises that complaints provide useful management information about service quality, image and staffing issues etc. from the perspective of service users, their families, friends and the public.

1.6 The key aims of the policy are to ensure that:

1.6.1 complainants will be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following these options

1.6.2 complainants shall receive any assistance necessary to enable them to complain if they wish and that no form of discrimination will arise following a complaint

1.6.3 complaints are investigated and the cause of the complaint is established.

1.6.4 appropriate responses are provided within required timeframes

1.6.5 corrective actions are undertaken

1.6.6 lessons are learned

1.6.7 staff are supported throughout.

1.7 To ensure that lessons are learnt and to minimise the likelihood of future occurrences, the cause of complaints needs to be established. All staff should assist in the process of establishing the underlying cause of each complaint.

1.8 The Trust will, whenever appropriate, use the management information resulting from complaints to effect improvements to work processes or systems to prevent recurrences.

1.9 Effective management of complaints will:

1.9.1 Assist in identifying pressures on the Trust's procedures and protocols.

1.9.2 Ensure complainants are heard and their dissatisfaction is appropriately responded to.

1.9.3 Act as a key tool in re-establishing the reputation of the Trust in the eyes of the complainant and those associated with the complaint.

1.9.4 Identify trends in poor performance of the Trust in meeting expectations of patients, carers and users of Trust services in addition to the general public.

1.9.5 Assist in ensuring that the Trust is an open, honest and transparent organisation and perceived as such by both the public and members of staff.

1.9.6 Identify how the service can be improved which may provide potential benefits to all patients.

1.10 The LAS Complaints Policy, Procedure and Management Guidance on complaints handling are intended to provide clear guidance to all staff on how complaints are to be managed. This is intended to ensure a consistent, fair and just approach to both complainants and any staff who may be involved in the complaint investigation.

1.11 The LAS will provide opportunities for patients, relatives, carers and staff to give feedback on the quality of service provided when dealing with complaints.

1.12 The LAS Complaints Policy and Procedure have been compiled with reference to the contents of the NHS publication "Guidance to support implementation of the National Health Service (Complaints) Regulations (2004). These also comply with the requirements of the National Health Service (Complaints) Regulations (2004) and The National Health Service (Complaints) Amendment Regulations (2006). In addition, the Healthcare Commission publication "Guidance for Trusts on Good Complaints Handling (2005)", the NHS National Patients Safety Agency publication "Being Open – communicating patient safety incidents with patients and their carers 2005" and the NHS Litigation Authority requirements on complaints handling have all been taken into account, in producing this policy.

1.13 This policy is not intended to duplicate issues which are clearly set out in the above regulations and guidance, but adapts and supplements these to meet local needs and recent developments within the NHS.

2. DEFINITIONS

2.1. For the purpose of this document a complaint is defined as:

"An expression of dissatisfaction from a patient or any person who is affected by, or likely to be affected by, the action, omission or decision of any member of the London Ambulance Service NHS Trust, whether justified or not".

3. POLICY STATEMENT

From section 8 and 9 of the National Health Service (Complaints) Regulations 2004

Persons who may make complaints

(1) A complaint may be made by -

(a) a patient; or

(b) any person who is affected by or likely to be affected by the action, omission or decision of the NHS body which is the subject of the complaint.

(2) A complaint may be made by a person (in these Regulations referred to as a representative) acting on behalf of a person mentioned in paragraph (1) in any case where that person -

(a) has died;

(b) is a child;

(c) is unable by reason of physical or mental incapacity to make the complaint himself; or

(d) has requested the representative to act on his behalf.

(3) in the case of a patient or person affected who has died or who is incapable, the representative must be a relative or other person who, in the opinion of the complaints

manager, had or has a sufficient interest in his welfare and is a suitable person to act as representative.

(4) If in any case the complaints manager is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, he must notify that person in writing, stating his reasons.

(5) In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child and where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

(6) In these Regulations any reference to a complainant includes a reference to his representative.

Making a complaint

(1) Where a person wishes to make a complaint under these Regulations, he may make the complaint to the complaints manager or any other member of the staff of the LAS which is the subject of the complaint.

(2) A complaint may be made orally or in writing (including electronically) and -

(a) where it is made orally, the complaints manager must make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made; and

(b) where it is made in writing, the complaints manager must make a written record of the date on which it was received.

(3) For the purposes of these Regulations where the complaint is made in writing it is treated as being made on the date on which it is received by the complaints manager or as the case may be, other member of the staff of the LAS.

This policy is intended to be used by all staff so that the trust is compliant with all requirements of the NHS Complaints Regulations 2004, and will be reviewed routinely to ensure its details remain correct.

3.1 It is the Trust's policy that complaints from patients, or their representatives, will be dealt with as quickly as possible, with due regard to the respect and dignity of the complainant. The Trust will ensure they are dealt with thoroughly and honestly with the aim of satisfying the complainant and enabling learning outcomes to be shared with them.

3.2 This policy is based on the key principle that patients and service users shall express their views about the treatment and services they receive in the knowledge that:

3.2.1 no discrimination will occur as a result of making a complaint

3.2.2 the complainant will be treated with courtesy and respect

3.2.3 the complainant will be taken seriously

3.2.4 an acceptable level of investigation, adhering to an action plan that has preferably been established and agreed, with input from the complainant, will take place

3.2.5 the cause of the complaint will be established

3.2.6 the complainant will receive a response within defined time-frames

3.2.7 the response will address the complainants concerns and state what action is to be taken as a result of the complaint

3.2.8 the complainant will receive an appropriate apology

3.2.9 the complainants views will inform learning and improvements in service delivery, and

3.2.10 there is a system for taking action to address the full range of problems that have been identified as the cause of the complaint with the intention of preventing further occurrences.

3.3 All members of staff involved in a complaint will be treated fairly, openly and with dignity throughout the investigation process.

3.4 The NHS Complaints Regulations 2004, amended in September 2006, determine three stages to the complaints process. The first stage is concerned with local resolution. This means that the complaint is dealt with by the LAS to the satisfaction of the complainant. In the event that the complainant remains dissatisfied with the first stage resolution, he or she may request the Healthcare Commission to review the way that the complaint was handled or the outcome. This is known as the second stage of the above regulations. In the event that the complainant remains dissatisfied with the result of the Healthcare Commission review they are entitled to approach the Health Service Ombudsman and request his intervention (stage three).

3.5 The regulations make it clear that all NHS Trusts should endeavour to resolve complaints through local resolution and this document is produced with the aim of achieving a satisfactory resolution at local level.

3.6 This document details how effective and prompt management of complaints is key in improving patient care. The Complaints Department deals with formal complaints and the LAS Patient Advice and Liaison Service (PALS) handles enquiries or concerns about the LAS. Both departments work closely in resolving all issues raised by patients, their family and friends and members of the public.

3.7 The LAS Patient Advice and Liaison Service (PALS) operates to advise and support service users, their families or carers, the general public and health / social care professionals in their respective care, journeys and contacts with the LAS.

3.8 The LAS affords equal importance to PALS and the Complaints Department as mechanisms for achieving organisational change and improving patient care by creating learning opportunities arising from concerns brought to the Trust.

3.9 It is the choice of the individual whether to use the PALS or the formal NHS complaints procedure. Enquirers maintain the right to pursue a complaint at any stage – most usually if they remain dissatisfied at the conclusion of PALS enquiries. However, complainants should not use PALS to pursue a concern where the NHS Complaints Procedure has been exhausted. PALS may refer matters to the Complaints Department where it is appropriate to do so and ensure complainants know how to access the NHS complaints procedure and relevant advocacy services e.g. the Independent Complaints Advocacy Services (ICAS).

3.10 Close collaboration between PALS and the Complaints Department works to ensure a coherent and seamless approach to resolving concerns expressed by service users, members of the public, professional colleagues, etc.

3.11 This policy relates specifically to formal complaints received from patients, patient representatives and the public regarding LAS services.

3.12 This does not cover:

3.12.1 A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services. (for more information please refer to the Department of Health website How to Complain - www.dh.gov.uk.)

3.12.2 Complaints from members of staff; LAS staff should be encouraged to use the Trust's Grievance Procedure to raise issues of concern about Trust policies, or the result of decisions by managers or other staff.

3.12.3 A complaint made by an employee of the LAS about any matter relating to their contract of employment

3.12.4 A complaint which is being or has been investigated by the Health Service Ombudsman.

3.12.5 A complaint arising out of an alleged LAS failure to comply with a data subject request under the Data Protection Act 1998 (LAS Data Protection Policy TP/012) or a request for information under the Freedom of Information Act 2000 (implemented on 1st January 2005).

3.12.6 A complaint about which the complainant has stated in writing clearly that they will be taking legal proceedings.

3.12.7 A complaint about which the LAS is taking or proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint

3.13 It should be recognised that often people coming into contact with the LAS have personal concerns and anxieties through which they feel vulnerable. If properly addressed and answered, concerns will often not develop into complaints.

3.14 All staff are empowered to resolve issues and concerns at a local level whenever possible or appropriate. Prompt action may prevent the issue from escalating to a formal complaint by the provision of explanations and apologies when appropriate.

3.15 We will work collaboratively with Independent Complaints Advocacy Service (ICAS) and value their contribution to the continuous improvement of our complaints procedure.

3.16 Effective completion and early evaluation of information provided on the Patient Report Form and Investigation Report is an essential part of complaints management as this may allow staff to identify any necessary improvements in patient care or service delivery before a complaint arises.

3.17 A complaint may be made in person, by telephone, fax or in writing (including email). Where a complaint is made orally a written record must be completed by staff (LA23). A complaint may be made by a third party with the consent of the complainant or in cases where the complainant lacks capacity.

3.18 The final written response to a complaint must be authorised and signed by the Chief Executive Officer of the LAS except in cases where for good reasons the Chief Executive Officer is not able to sign it, in which case it may be signed by a person designated to act on his behalf.

3.19 This policy is primarily concerned with improving the quality of services to patients; it is not concerned with disciplining our staff. However, on occasion a complaint investigation may reveal that there has been a serious or wilful act or omission by a member of staff. In such circumstances this procedure will be set aside to allow a full investigation to take place and this will be conducted according to the LAS Disciplinary Procedure. The complaints investigation will be completed separately to the disciplinary investigation.

3.20 Complaints handling within the LAS will be monitored through the Complaints Panel and Clinical Governance Committee (see governance arrangements below).

4. SPECIFIC RESPONSIBILITIES for COMPLAINTS MANAGEMENT

4.1 Board Appointee

4.1.1 The Board should appoint a complaints "champion(s)" who should be an executive or non-executive Board member. The role of the "champion" is to ensure that action is taken as a result of complaints and to monitor the effectiveness of complaints handling arrangements in the LAS and their compliance with NHS requirements.

4.1.2 The action plans produced as a result of complaints will form the basis for monitoring service improvements by the Board's complaints "champion".

4.2 Chief Executive Officer

4.2.1 The Chief Executive Officer has overall responsibility for the management of complaints.

4.2.2 The Chief Executive Officer or Deputy during absence will sign all final resolution letters.

4.3 Complaints Manager

The Complaints manager is responsible for

4.3.1 Developing Trust wide policies, procedures and strategies for the management and investigation of complaints, and develops outcomes for improving patient care as evidence of lessons learnt and action taken to prevent a recurrence.

4.3.2 The overall management of complaints throughout the Trust.

4.3.3 Ensuring that Complaints Officers follow the principles and practice for complaints handling within the Service as set out in this policy and the Complaints Procedure although the line management of Complaints Officers rests with the ADO/PIM in the operational areas.

4.3.4 Ensuring that all complaints are acknowledged within two days.

4.3.5 Ensuring that holding letters are sent out where necessary i.e. if a complaint cannot be completed within 25 days and that contact is maintained with the complainant in protracted investigations.

4.3.6 Ensuring that consent to disclose information has been received in appropriate cases.

4.3.7 Ensuring that complaints are handled in a timely and effective manner, to the satisfaction of the complainant and in accordance with legislation and Trust policy and procedure and provide ongoing support and advice to staff dealing with the complaint where appropriate.

4.3.8 Attending meetings with the complainant on behalf of the Trust to help resolve the complainants concerns when appropriate.

4.3.9 Maintaining a database of all formal complaints received by the LAS.

4.3.10 Producing information on the LAS Complaints Policy and Procedure and making it accessible to the public, via the Trust website and other communications media.

4.3.11 Ensuring that any person that requests complaints information in larger fonts, Braille or other languages etc. is assisted in every way possible.

4.3.12 Ensuring that all relevant information and assistance is provided to the Healthcare Commission as part of the independent review process.

4.3.13 Liaising with complaints managers at other NHS Trusts in cases when a complaint involves more than one Trust. Agree the most appropriate way to investigate the complaint and ensure that the complainant is advised.

4.3.14 Ensuring that the views of complainants in relation to the manner that their complaints were handled are audited with input and feedback from complainants.

4.3.15 Ensuring that complaints officers receive training appropriate to their role.

4.3.16 Reporting complaints information to the Complaints Panel and participate fully as a member of the Panel (see terms of Reference for Complaints Panel in the section below headed Governance arrangements).

4.3.17 Ensuring that the service is able to comply with the requirements of the Healthcare Commission in respect of complaints handling (currently core standard c14).

4.3.18 Producing reports on all aspects of complaints handling to meet internal and external requirements on a quarterly and annual basis to the Complaints Panel, Clinical Governance Committee and ultimately the Trust Board.

4.3.19 Monitor the progress of action plans, completion of recommendations and implementation of service wide changes arising from complaints.

4.4 **Assistant Directors of Operations.**

All Assistant Directors of Operations are ultimately accountable for the local complaints handling arrangements across the Trust within their areas of responsibility. The ADO responsible for the Emergency Operations Centre, the Urgent Operations Centre and the Head of Patient Transport Services are accountable for their areas of responsibility.

4.4.1 Responsible for the standard and timeliness of complaints handling within their operational area.

4.4.2 ADO's are ultimately accountable for the management of Complaints Officers and Investigation Officers in their respective areas. Day to day management will be the responsibility of Performance Improvement Managers.

4.4.3 Responsible for the quality and content of all draft responses sent to the Chief Executive (via the Complaints Manager) for signature and for ensuring that all concerns raised have been addressed.

4.4.4 Responsible for ensuring that complaint handling arrangements are applied consistently across the service and are in accordance with the latest LAS Policies, Procedures and Guidance Notes.

4.4.5 Ensure that arrangements are in place to allocated complaints to an appropriate officer dependent on the grading of each complaint using the Risk Management Matrix (see Risk Reporting and Assessment Procedure). In some cases the ADO may be the investigating officer.

4.4.6 Consider the value of meeting with the complainant, in appropriate cases, to respond directly to the complainants concerns.

4.4.7 Ensure that all available methods for resolving the complaint, including the use of mediation services, have been considered.

4.4.8 Ensure that arrangements are in place for all staff mentioned in a complaint to be informed and receive appropriate support.

4.4.9 Ensure that arrangements are in place for staff who are involved in the handling of complaints produce an action plan to achieve time-limited recommendations.

4.4.10 Ensure that arrangements are in place to monitor complaint outcomes and action plans and that these are implemented by a named individual within a specified time-frame.

4.4.11 Ensure that arrangements are in place to obtain a report on the progress of action plans on a regular basis.

4.4.12 The issues raised in individual complaints should be considered and, where applicable, initiate service improvements. Issues arising from complaints, problems and other user feedback should be standard items for discussion at team meetings.

4.4.13 Ensure that, when service-wide changes have been identified as a result of a complaint investigation, these are referred to an appropriate service wide forum so that they may be implemented in an appropriate and timely manner.

4.4.14 Responsible for ensuring that arrangements are in place for recommendations made by the Healthcare Commission, as a result of second stage review of complaints, are dealt with in an appropriate and timely manner.

4.4.15 Ensure that arrangements are in place for the complaints manager to be provided with regular updates/reports on all aspects of complaints management within the operational areas.

4.5 **Performance Improvement Managers.**

4.5.1 Responsible to the Assistant Directors of Operations for performance relating to complaints handling within operational area and compliance with all NHS complaints standards, set out in the LAS Complaints Policy and Procedure, including the acknowledgement of a written complaint within 48 hours and completion of a complaints investigation within 25 working days (unless otherwise agreed with complainant).

4.5.2 Responsible for the line management of Complaints Officers and other staff who may be dealing with a complaint in their respective areas.

4.5.3 Responsible for ensuring that staff who are the subject of complaints are fully informed and supported throughout the investigation process.

4.5.4 Ensure that arrangements are in place to allocated complaints to an appropriate officer dependent on the grading of each complaint using the Risk Management Matrix (see Risk Reporting and Assessment Procedure). In some cases the ADO may be the investigating officer or the PIM.

4.5.5 Consider the value of meeting with the complainant, in appropriate cases, to respond directly to the complainants concerns.

4.5.6 Responsible for ensuring that letters, particularly final response letters, comply with all aspects of complaints regulations, are compatible with good practice, written to the highest standard of quality and answer all concerns raised by the complainant.

4.5.7 Responsible for analysing the cause of complaints, to identify the cause aiming to use Root Cause Analysis as appropriate to the complexity and severity of the concerns detailed by the complainant, Identify emerging trends that may indicate underlying systemic problems.

4.5.8 Responsible for monitoring the production of action plans, assisting when necessary, ensuring that they are completed within specified time-frames and that lessons learnt from complaints are shared across the service.

4.5.9 Responsible for the production of reports on the progress of the action plan when delays in implementation are encountered.

4.5.10 Responsible for ensuring that staff who have been named in a complaint receive feedback on how the complaint was handled and resolved.

4.6 **Complaints Officers**

4.6.1 Responsible for the day to day handling of complaints by area under the direction of the PIM.

4.6.1 Accountable to the Performance Improvement Manager and responsible for managing complaints that they are allocated to investigate.

4.6.2 Responsible for meeting with the complainant as soon as possible, when appropriate.

4.6.3 Responsible for the investigation of complaints to an acceptable standard. Ideally, the complainant will be involved in the decision on how the complaint will be investigated or dealt with and agree the process that will be followed.

4.6.4 Responsible, at an early stage of the investigation, for determining the need to access specialist advice e.g. from the Medical Director, Senior Medical Adviser or Head of Education and Development. In some cases the benefit of external specialist advice may also be considered.

4.6.5 Responsible for ascertaining the full extent and origin of all complaints aiming to apply the Root Cause Methodology of Analysis when appropriate.

4.6.6 Responsible for ensuring that staff who are the subject of a complaint are informed and well supported at all stages in the investigation.

4.6.7 Responsible for ensuring that complaints are answered fully, and that letters are clear, well written and comply with regulations and procedures.

4.6.8 Ensure that all complaints are closed within specified time-frames.

4.6.9 Report any instances where a delay in completing the complaint is encountered or expected and ensure that the complainant is advised of the delay, and agreeing to an extension.

4.6.10 Ensure that the LAS Risk Register is continuously updated and complete with up to date progress reports related to risks concerning complaints.

4.6.11 Ensure that each complaint has an outcome which is recorded and held by the Complaints Manager.

4.6.12 Produce ‘Action Plans’ when appropriate and ensure that these are monitored and completed.

4.6.13 Ensure that ‘Lessons Learnt’ as a result of complaints are reported to the PIM and Complaints Manager.

4.6.14 Ensure that all ‘working copies’ of complaints files are kept in a secure location and sent to the central complaints department for storage once the complaint has been resolved.

5. OBJECTIVES

5.1 To ensure that people who complain are treated with respect, without fear of discrimination, listened to sympathetically and assisted in every way possible through the complaints process.

5.2 To treat every complainant as an individual with differing needs thereby requiring a personalised approach to the management of the complaint. This may involve the use of patients' advocates or interpreters. Other ways to achieve an acceptable outcome, including mediation, will be considered at an early stage.

5.3 To ensure that the complainant and all LAS staff are treated fairly throughout the complaints process and that staff receive all available support.

5.4 To ensure that all complaints are investigated promptly, to the degree necessary, honestly and openly.

5.5 To ensure that complainants are kept informed of the progress and outcome of the investigation with explanations or apologies, as appropriate, being given.

5.6 To ensure that action to rectify the cause of the complaint is identified, implemented and evaluated, thereby improving the quality of service. Where necessary this may involve revising procedures.

5.7 To ensure that any resultant change in practice or procedure resulting from a complaint is fed back to the complainant and others as appropriate. Feedback to others in the LAS will take place where appropriate as a means of ensuring consistency and best practice across the service.

5.8 To provide feedback to staff named in a complaint to advise how the complaint was handled and resolved.

5.9 To ensure that complaints are managed within the context of the LAS clinical governance and training programmes.

5.10 To ensure that data collated on complaints is utilised effectively within the LAS to assist in improving patient care. This will include such data as ethnicity, gender, disability. The Trust has a duty to ensure that we deliver an equitable service to all.

5.11 To ensure the service identifies and responds appropriately to incidents where there is a perception of racism, homophobia, sexism and/or victimisation of disabled people etc. as described in 4.9 above.

6. GOVERNANCE ARRANGEMENTS

Complaints monitoring is undertaken by the Complaints Panel and the business of the panel is reported as described in the terms of reference for the Clinical Governance Committee and the Complaints Panel which are included immediately below.

6.1 The Clinical Governance Committee

Terms of Reference for Clinical Governance Committee

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 six times a year with three 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 and one executive director.

- The committee's minutes will be reported to, and considered by, the Trust Board.

- The functions of the Clinical Governance Committee

Functions and how these will be achieved

The committee's prime purpose is to ensure 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 (Note: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee).

- Require evidence 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 Strategy and the Clinical Governance Development Plan.

The Committee will establish and monitor 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 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

- Receive and review regular reports from feeder Groups, in particular Standards for Better Health Group, the Risk Information Report (which combines data from risks complaints, claims and clinical incidents), the Complaints Group, 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 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:

- Work with 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 aggregated data from the Risk information Report and other sources as it sees fit to ensure that clinical risk reduction programmes of a high standard are in place.

- Monitor the implementation of risk reduction programmes to ensure that identified risks are reduced, and that adverse events are detected early, investigated speedily and openly and that the lessons learned are promptly applied.

The Committee will ensure that quality improvement processes (e.g. clinical audit) are in place and integrated with the quality programme for the organisation as a whole. It will do this, inter alia, by requesting reports from the Clinical Audit and Research Steering Group in, for example, the extent to which 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, inter alia:

- Requesting the relevant information from The Training Services Group and the Area Governance Groups, and other feeder Groups as appropriate

- Monitoring the Trust wide Training Needs Assessment.

The Committee will define and develop Key Performance Indicators which provide quantitative and qualitative information to be collated in the form of an annual clinical governance report to the Board. These will be changed annually and will contribute to a Trust-wide scoring system.

The Committee may recommend policy, as appropriate, to the Trust Board for formal approval. They may also commend further training or clinical service development as a result of evidence produce to the Committee.

The Committee is responsible for providing the Audit Committee with evidence 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.

Membership (*deputies to be proposed unless already stated)*
*1 Non Executive Director (chair)
*2 NED

*Medical Director (vice chair)
*Director of Communications
Head of Education and Development
Head of Clinical Audit & Research
*Head of Legal Services
*Head of Governance
Safety & Risk Advisor
*Deputy Director Operations
PPI Manager
*Head of Records Management
Diversity Manager
*Head of Complaints
Head of Operational Support
*Assistant Director of Operations EOC (deputy -Senior Operations Officer – Planning & Risk)
*Director of Communications (deputy -Head of Communications)
Area Governance representative
*User Representative(s)/
A&E Consultant
Head of Employment Services

*Indicates member of core committee

6.2 The Complaints Panel

Terms of Reference for Complaints Panel

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 Health Care Standards.

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 Management Committee.

- 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 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 Head of Education and Development		EOC Manager responsible for complaints Complaints Manager Staff Representative Frontline staff (A&E, EOC,PTS) PPI Manager Head of Urgent Care Head of Legal Services

7. COMPLAINTS HANDLING PROCEDURE AND RELATED GUIDANCE.

The detailed arrangements for local handling of complaints are set out in the Complaints procedure. This procedure is supplemented by the guidance included in the Complaints Management Information for managers.

References:

The National Patient Safety Agency "Being Open"
Communicating Patient Safety Incidents with Patients and their Carers 2005
The Health Service (Complaints) Regulations 2004
The National Health Service (Complaints) Amendment Regulations 2006
Assurance Framework
Incident Reporting Procedure
Claims Policy
Complaints Procedure
Being Open Policy

Whistle blowing Policy
SUI Policy
Driving and care of Service Vehicles
Risk Reporting and Assessment Procedure
Health and Safety Policy
Disciplinary Procedure
Trust's Strategic Plan 2006/07 – 2012/13
Trust Service Plan 2006/07
Standards for Better Health (Department of Health July 21 2004)
The Annual health check in 2006/7 Assessing and rating the NHS (Healthcare Commission September 2006)
Risk Management Policy

Signature: 

Peter Bradley
Chief Executive / Chief Ambulance Officer

London Ambulance Service
NHS Trust

Habitual (or Vexatious) Complainants

Circulated To: LAS Departments, All Stations, EOC, PTS, Training and Resource Centres.

For Use By: All Staff

1. Introduction

1.1 Habitual or vexatious complainants are becoming an increasing problem for NHS staff. The difficulty in handling such complaints is placing a strain on time and resources and is causing undue stress for staff who may need support in difficult situations.

1.2 NHS staff are trained to respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

1.3 It is also recognised that a persistent complainant should be protected by ensuring that they receive a response to all genuine grievances and are provided with details of independent advocacy.

1.4 Therefore, in determining arrangements for handling such complaints, staff are presented with the following key considerations:

1.4.1 To ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed.

1.4.2 To appreciate that even habitual complainants may have grievances which contain some genuine substance.

1.4.3 To ensure an equitable approach.

1.4.4 To be able to identify the stage at which a complainant has become habitual.

2. PURPOSE OF THIS GUIDANCE

2.1 All complaints handled by the London Ambulance Service NHS Trust are processed in accordance with NHS complaints procedures.

2.2 During this process LAS Trust staff inevitably have contact with a small number of

complainants who absorb a disproportionate amount of NHS resources in dealing with their complaints.

2.3 The aim of this guidance is to identify situations where the complainant might be considered to be habitual and to suggest ways of responding to these situations which are fair to both staff and complainant.

2.4 **It is emphasised that this policy should only be used as a last resort and after all reasonable measures have been taken to try to resolve complaints following the NHS complaints procedures,** for example through local resolution, conciliation, and involvement of independent advocacy as appropriate.

2.5 Judgement and discretion must be used in applying the criteria to identify potential habitual complainants and in deciding the action to be taken in specific cases.

2.6 **This policy should only be implemented in relation to a specific complainant, following careful consideration by, and with the authorisation of the Chief Executive Officer or nominated deputy in the case of absence.**

3. DEFINITION OF A HABITUAL COMPLAINANT

3.1 Complainants (and/or anyone acting on their behalf) may be deemed to be habitual where previous or current contact with them shows that they meet at least TWO of the following criteria:

Where complainants:

a) Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.

b) Seek to prolong contact by changing the substance of a complaint or continually raising new issues and questions whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).

c) Are unwilling to accept documented evidence of treatment given as being factual eg drug records, ECG print out etc.

d) Deny receipt of an adequate response despite evidence of correspondence specifically answering their questions.

e) Do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

f) Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of LAS Trust staff and, where appropriate,

independent advocacy, to help them specify their concerns, and/or where the concerns identified are not within the remit of the LAS to investigate.

g) Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a 'trivial' matter can be subjective and careful judgement must be used in applying this criterion).

h) Have, in the course of addressing a registered complaint, had an excessive number of contacts with London Ambulance Service NHS Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, E-mail or fax). Discretion must be used in determining the precise number of "excessive contacts" applicable under this section using judgement based on the specific circumstances of each individual case).

i) Are known to have recorded meetings or face to face/telephone conversations without the prior knowledge and consent of the other parties involved.

j) Display unreasonable demands or expectations and fail to accept that these may be unreasonable (eg insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

k) Have threatened or used actual physical violence towards staff or their families or associates at any time - this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidents should be documented in line with the Zero Tolerance Procedures).

l) Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this.) Staff should document all incidents of harassment in line with the Zero Tolerance Procedures, completing an incident form (LA52).

4. PROCEDURE FOR DEALING WITH HABITUAL COMPLAINANTS

4.1 Check to see if the complainant meets sufficient criteria to be classified as an habitual complainant.

Where there is an ongoing investigation

4.2 The Complaints Manager should write to the complainant setting parameters for a code of behaviour and the lines of communication. If these terms are contravened consideration will then be given to implementing other action.

It would be inappropriate for the Chief Executive to set these parameters at this stage as s/he will be involved in the ongoing complaints process.

Where the investigation is complete

4.3 At an appropriate stage, the Chief Executive or Complaints Manager should write a letter informing the complainant that:

a. the Chief Executive has responded fully to the points raised, and
b. has tried to resolve the complaint, and
c. there is nothing more that can be added,

therefore, the correspondence is now at an end.

4.4 The Trust may wish to state that future letters will be acknowledged but not answered.

4.5 In extreme cases the London Ambulance Service NHS Trust should reserve the right to take legal action against the complainant.

5. WITHDRAWING 'HABITUAL' STATUS

5.1 Once complainants have been determined as 'habitual' there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

5.2 Staff should previously have used discretion in recommending 'habitual' status and discretion should similarly be used in recommending that this status be withdrawn.

London Ambulance Service
NHS Trust

Serious Untoward Incidents Policy

For Use By: All Staff

Introduction

For the purpose of this procedure, a Serious Untoward Incident (SUI) is defined as:

- an event during which the actions or omissions of London Ambulance Service NHS Trust (LAS) personnel may have contributed to the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS.

- an event involving the LAS which may produce significant legal, media or other interest which, if not properly managed, may result in loss of the Trust's reputation or assets.

- an event during which the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS may have resulted from a delay in dispatching appropriate LAS resources, or where a delay may have been a contributory factor in those outcomes.

- When a potential SUI is reported the recipient must dispatch all information to the Complaints Manager/ Director of Operations/ Medical Director

- The above group review the information and conduct a risk assessment of the incident (using the Risk Reporting and Assessment Procedure)

- A decision is then made on whether to recommend that the incident be classified and dealt with as an SUI or not.

- A record must be kept of all the factors considered in determining whether or not an incident is classified as an SUI. This record must be maintained by the Complaints Manager.

This policy applies to all LAS staff and it requires them to report any potential serious untoward incident according to the guidance set out below.

The LAS is committed to cooperating fully with external agencies when they are reviewing any adverse incident and will share information with them, providing that relevant statutory responsibilities (Data Protection, Freedom of Information Acts etc.) are met. The LAS will also

involve and include other agencies in SUI investigations as appropriate. e.g. if an LAS employee reports a criminal offence has occurred during the incident then the Police will be contacted immediately.

Objectives

The purpose of this document is to describe a procedure that, when followed, will allow the LAS and its staff to:

1. Understand what constitutes an SUI and be provided with guidance on how to deal with these potentially stressful events.

2. Respond quickly and positively to an incident, mitigating the consequences and provide evidence that its main concern is for the wellbeing and best interests of patients, staff and those working on behalf of the LAS.

3. Take a consistent approach to the management of such incidents.

4. An SUI investigation should not be confused with an investigation conducted under the LAS Disciplinary Procedure. If, as a consequence of the SUI investigation, a disciplinary issue is discovered, a separate investigation, conducted in accordance with the LAS Disciplinary Procedure, will take place. In the event of a disciplinary investigation, all due care will be taken to avoid unnecessarily approaching patients, carers or members of the public for information relating to the incident which has already been obtained previously by the LAS.

5. Apply this procedure in an open and transparent way.

6. Involve and fully inform stakeholders, staff, other organisations/professionals, patients and their families, in line with Department of Health guidance on best practice.

7. Deal with cases where poor practice is identified as a contributory factor in a sensitive and fair manner in accordance with the Trust's workforce policies.

8. Consider the individual needs of staff, patients, their relatives and carers within the wider system, particularly regarding their cultural and/or religious needs.

9. Learn from all incidents and prevent recurrence as far as possible.

10. Address the lessons to be learnt from such incidents from both operational and organisational perspectives, recognising that the majority of incidents in health care occur because of failure in systems rather than individual practice alone.

Audit

The Trust will know that this procedure has been effectively implemented when:

- Full compliance with policy has been achieved and has been evidenced through use of the audit tool and audit standards in **Appendix 1.**
- It is demonstrated that contributory factors in an SUI are identified, action taken and recommendations are communicated, implemented and reviewed in accordance with the Trust's Risk Management Policy
- In those cases where disciplinary action is used it is apparent that gross negligence has been found -
- There is evidence of patient / public involvement
- There is evidence that the support offered reasonably met everyone's needs including cultural and religious requirements.

The LAS commits to monitor full compliance with this procedure and the routine achievement of the above objectives to ensure that the audit cycle is completed every time an SUI is declared. The methodology and standards for the audit are included in **Appendix 1**. The purpose of the audit is to ensure that lessons have been learned and patient care has been improved as a direct outcome of a SUI investigation.

Procedure

Following declaration of an SUI all identified personnel will be informed within 24 hours of the incident occurring, where contactable; the matter will be followed up by a full incident review.

The LAS is committed to being open with patients who have been unintentionally harmed. Being open involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and reassuring patients/carers that lessons learned will help prevent a similar incident recurring.

The LAS policy of Being Open has been developed in line with the National Patient Safety Agency's national 'Being Open' Policy that was launched in September 2005. The LAS Policy of Being Open must be read in conjunction with the LAS SUI Policy..

1.0 Reporting of Incidents Identified by Operational Staff

1.1 It is vital that in the event of an adverse incident that meets the above criteria, an appropriate Senior Manager is alerted accordingly. Crucial to the effective management of an adverse incident is speed of communication.

1.2 The decision to declare an SUI and apply the procedure to an incident will be made by the Chief Executive Officer (CEO) or another Executive Director and/or the Director of Operations and/or the Medical Director within 24 hours of it being reported. The

requirements of the SUI guidance issued by the Strategic NHS Authority for London must be met during the process of every SUI – see **Appendix 2**. The Director of Communications will be informed if the procedure is invoked.

2.0 Reporting of Incidents by Other Means

2.1 Information regarding incidents may come from various sources. When the SUI criteria applies to an incident that is reported through an internal source such as an enquiry made to the Patient Advice & Liaison Service (PALS), a complaint to the Complaints Manager, or notification of a 'problematic' coroner's inquest to Legal Services, the CEO and /or Director of Operations and / or the Medical Director must be notified accordingly.

2.2 The Communications Directorate, Legal Services, PALS & Complaints should all be simultaneously informed when an SUI is declared to enable a consistency of approach to enquiries from interested parties and avoid any duplication of investigation.

2.3 In the case of the Emergency Operations Centre (EOC), if an incident becomes apparent as it occurs, EOC must record all relevant details of the incident on the Call Receipt Form (AS1), using the electronic call log. If there is no pre-existing CAD log for the incident, one should be created. All decisions and records of who is informed about the incident and by whom must be recorded in the log. The Senior Operations Officer should inform the duty 'Silver' (Site managers) of any incident that they believe may constitute an SUI and a decision made whether to inform the duty 'Gold' (senior manager responsible).

3.0 Management of the Incident

3.1 The CEO/Director of Operations delegates the authority to the Complaints Manager to ensure the SUI investigation is conducted in a manner that is fully compliant with the SUI Policy.

3.2 The CEO/Director of operations will delegate the appointment of a Case Manager as appropriate.

3.3 As soon as possible a SUI Group consisting of the CEO and / or the Director of Operations, the Director of Communications, the Medical Director or their representatives and any other persons invited by the Group must be organised. The group will meet and be facilitated by the Case Manager. It will monitor developments, maintain a strategic overview and enable the specific management of the review and dissemination of the outcome(s).

3.4 The Complaints Manager has the role of overseeing the work of the appointed SUI group, including the Case Manager, and the conduct of the investigation.

3.5 The case manager is responsible for the timely production of interim and final reports which must always include time-limited recommendations. The CEO, Director of

Operations and Medical Director will be kept informed of developments, as will other appropriate managers

4.0 Responsibilities of Case Manager

The responsibilities of the Case manager are;

4.1 To monitor the progress of the investigation and ensure the procedure is followed correctly.

4.2 To immediately appoint a Family Liaison Officer (FLO) to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives and the SUI Group. The role of the FLO is defined in **Appendix 3**. **Any information given to staff, patient(s), relatives and the public must be documented**. Every effort will be made to ensure that patient(s) and/or relative(s), staff and other persons potentially affected by the incident are informed at the earliest opportunity and in advance of any public announcement. This will be facilitated by the FLO.

4.3 To immediately appoint a Staff Liaison Officer (SLO) to provide regular feedback and support, as appropriate for staff. All staff involved should be informed when this procedure has been invoked.

4.4 To ensure the immediate appointment of an appropriate Investigation Officer to coordinate the enquiry. The investigation officer must produce the report of the investigation in accordance with the timescale set by the SUI group appointed. The quality assurance of the report will be undertaken by the case manager. The case manager will be expected to ensure that the cause of the incident has been understood and set out in the report.

4.5 To ensure that full details of the incident are relayed to the Strategic Health Authority for NHS London (or its successor) and other NHS organisations as appropriate. The Communications Directorate will be responsible for informing and updating the Department of Health, which may include the Chief Medical Officer. The Case Manager must ensure that the SUI process and reporting of it complies with strategic health authority requirements. SUI Information must be provided so that it enters at the top of the flow chart set out in **Appendix 2**. If subsequent changes are made to the process by any strategic authority level NHS body, then this procedure will need to be amended and the amendment agreed by the Trust Board.

4.6 To ensure that a comprehensive record of the incident is maintained (see **Appendix 4**) as part of the FLO's role. Included in this record should be a note describing all information that is given by the LAS to the patients, carers, relatives and families of those involved in the SUI during the SUI investigation and afterwards. Any information given to those potentially affected directly by the incident and/or the public must also be documented.

4.7 The Head of Legal Services is responsible for informing the National Health Service Litigation Authority (NHSLA). The HR department will be responsible for advising the Health & Safety Executive in appropriate cases, and keeping them informed and updated during the progress of the SUI management.

4.8 Ensure the appropriate debriefing and support for all staff involved in the Incident is provided.

4.9 Ensure timely and effective dissemination of the final SUI report is made, internally and externally. This report must routinely contain recommendations and an action plan including a time scale for their implementation.

4.10 See **Appendix 4** for SUI Check list.

5.0 Reporting requirements

5.1 The interim, draft and final SUI reports must be produced to the deadline set by the Director of Operations or (through his delegated authority) by the Complaints Manager. The Complaints Manager will check that the scope of the recommendations reflect accurately and appropriately the scope and conclusions from the investigation of the incident. The Complaints Manager will then complete the preparation process within the deadline set by giving the report to the Director of Operations (or through delegation) to an appropriate Executive Director to confirm the report and recommendations will be considered by the Senior Management Group for immediate implementation. The Datix file on the incident must be opened within 24 hours of the incidents.

5.2 The Case Manager will convene a meeting of those contributing to the SUI management process in order to prepare a final report for the Chairman, CEO, Director of Operations, Medical Director and the Trust Board. SUIs will be reported to the Trust Board as part of the CEO's report. Every report must include a root cause analysis or similar methodology that identifies what factors contributed to the incident occurring:

- All SUI reports must be dated (on every page) so that the time elapsed between the incident and the production of the report is clear.
- Making time –limited recommendations for further action to be taken / lessons to be learnt to prevent recurrence.
- SUI reports should be placed in the S Drive and SMG informed accordingly.
- In the event of a delay in completing the investigation (e.g. due to information awaited from an external organisation) an interim report must be produced in accordance with deadlines originally determined. The interim report must be constructed using the same process as the final report (see 5.1 above) and must clearly set out the caveat that further recommendations or actions may be produced on receipt of the information outstanding.

- Implementing agreed action measures.

- Ensuring feedback to the patient(s) and/or relatives and/or staff and/or member(s) of the public of the outcome of the investigation and the action taken/proposed. In respect of clinical incidents, in addition to the formal written response to the patient/relatives outlining the investigation findings, consideration should also be given to offering a meeting with the senior staff involved in the investigation process

  Note: In the event that, following a SUI, concurrent related internal investigations are ongoing (e.g. disciplinary investigation involving staff), such investigations will not delay the resolution of clinical issues including the final response to patient/relatives or agreeing with relevant parties any additional media notification as necessary and appropriate.

- Ensuring that arrangements are in place for the relevant external stakeholders including the SHA and National Patient Safety Agency (NPSA) to be notified of the outcome of the investigation and the actions taken or proposed.

- The CEO and/or relevant Director will be responsible for advising the Chairman and the Trust Board of the outcome of the investigation and the action taken or proposed

- Monitoring of agreed action measures will be undertaken as part of the wider Incident Reporting System arrangements via the Risk Compliance and Assurance Group and/or Clinical Governance Committee and Complaints Panel in order to keep these committees advised of progress against agreed action plans.

The focus of SUI reports will be on delivering outcomes aimed at preventing recurrence and improving patient care. This focus will be monitored by the Complaints Panel to ensure these benefits occur. The SUI Group should also include a review reflecting on how it managed the incident, in order to continuously improve the quality and effectiveness of this procedure

6.0 Responsibilities of CEO and Trust Board

6.1 There may be instances when it is appropriate to establish a serious incident team independent of the Trust. This decision should be made by the CEO and Trust Board.

7.0 Communications with the LAS Trust Board

7.1 The CEO / Director of Operations will ensure that other Executive Trust Board Directors are informed of the incident and updated on developments.

7.2 The CEO / Director of Operations will inform and liaise with the Trust Chairman who will inform Non Executive Trust Directors.

7.3 The resulting Report and Action Plan will be disseminated internally and externally as appropriate

7.4 The Report and Action Plan will be made available to the LAS Complaints Review Panel to ensure outcomes have been achieved, lessons learned and prevention of recurrence noted.

7.5 The Case Manager will be responsible for informing and liaising with relevant Health Authority(s) and provider(s).

7.6 The SUI Group will decide on any other organisations to be informed and how and when that will occur.

8.0 Patient and Public Involvement

"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately. This open approach minimises the trauma they feel." (Seven Steps to Patient Safety NPSA 2003)

8.1 All areas of health care are moving towards greater public involvement.
It is recognised that this can be a complex matter so the Trust supports this approach in supporting the patient and public involvement by :-

- The FLO visiting the patient/relatives to explain the process to them and to ascertain any questions/issues raised.
- Making available the final report and action plan and offering any advice about the options available in respect of pursuing matters. This should involve a further meeting to explain the report.
- Inviting patients /relatives to be a part of any ongoing development and/or audit

8.2 If a patient /relative does attend a meeting it is suggested that they bring along a 'friend' for support. This person does not need to be actively involved in the review and need not be a legal representative.

9.0 Media Relations

9.1 The Director or Head of Communications will be responsible for media relations, and liaising with those responsible for media relations in other organisations. The Medical Director will be responsible for and involved with clinical issues.

9.2 If the LAS takes a proactive stance on the incident – i.e. the LAS plans to inform the media of the incident before the media is aware, the Director of Communications will ensure that patient(s) and relative(s) are aware of any LAS statement to the media. This will be done through the appointed FLO.

9.3 Relatives and patients will be notified before any statement is made by the Trust to the media. Similarly, if the LAS is reacting to media inquiries, the Director of Communications will ensure that patient(s) and relative(s), staff and other persons potentially affected by the incident are aware of media interest and the content of any LAS statement. These functions will usually be facilitated by the appointed FLO.

9.4 No member of staff will provide statements independently of this process.

9.5 For serial incidents and dealing with multiple enquiries the following arrangements will be made:-

A 'hot-line' will be set up by the Communications Directorate in accordance with the *CHI/Healthcare Commission's "Guidance for the NHS in Establishing and Running Rapid Response (Telephone) Help Lines" 2003* to deal with all calls coming in from the media and public about the incident. PSU, PALS and Legal Services teams will also be briefed accordingly. The Director of Communications will delegate these arrangements within his directorate so that there is a process to ensure staff are available and skilled to assist. The designated room will be the Communications Directorate Office and will mirror arrangements in the Trust's Major Incident Plan, when SUIs occur that may potentially affect large numbers of people or where serial incidents may occur e.g. exposure/screening problems, terrorist attacks.

9.6 The Director of Communications in liaison with the Chief Executive or Director of Operations will appoint a senior representative of the Trust to act as spokesperson for the LAS in the event of a Press conference, radio or TV interviews.

References:

The London Ambulance Service NHS Trust Major Incident Plan
Safer Practice Notice 10 National Patients Safety Agency 15 September 2005[1]
Serious Untoward Incident Guidance (South West London SHA).
Incident Reporting Procedure
Complaints Procedure TP/004
The Protocol for the Investigations & Analysis of Clinical Incidents (Prepared by University College Hospital)
C.N.S.T. Standards 2002
NHSLA Standards
Building a Safer NHS for Patients (An Organisation with Memory). April 2001, DoH 23720 1P 2K
Strategic Health Authority SUI policy.
Seven Steps to Patient Safety (NPSA 2003)
Criteria for Assessing Core Standards (Healthcare Commission 2005).
Being Open Policy (2006)
Whistle Blowing Policy

Signature: 

Peter Bradley CBE
Chief Executive Officer

Appendix 1

1.0 Standards and Audit Instructions

This audit should be routinely undertaken at the conclusion of an SUI investigation and reviewed by the LAS Complaints Panel.

Standard 1
There will be an up-to-date SUI policy available on Pulse and the LAS website; general instruction publicised in RIB and LAS News; specific memoranda to AOMs and DSOs.
Audit instruction:
Has the above been completed? Check SUI file.

Standard 2
In the event of a SUI being declared, the policy will be adhered to and the checklist completed.
Audit instruction:
Check SUI checklist

Standard 3
Following a SUI a full incident review will take place within 28 working days and a report completed within 45 working days
Audit instruction:
Did a clinical incident review take place? When was the report finalised?. If the incident is non clinical an incident review should still occur. This standard assumes that a root cause analysis would be undertaken routinely as part of every incident review.

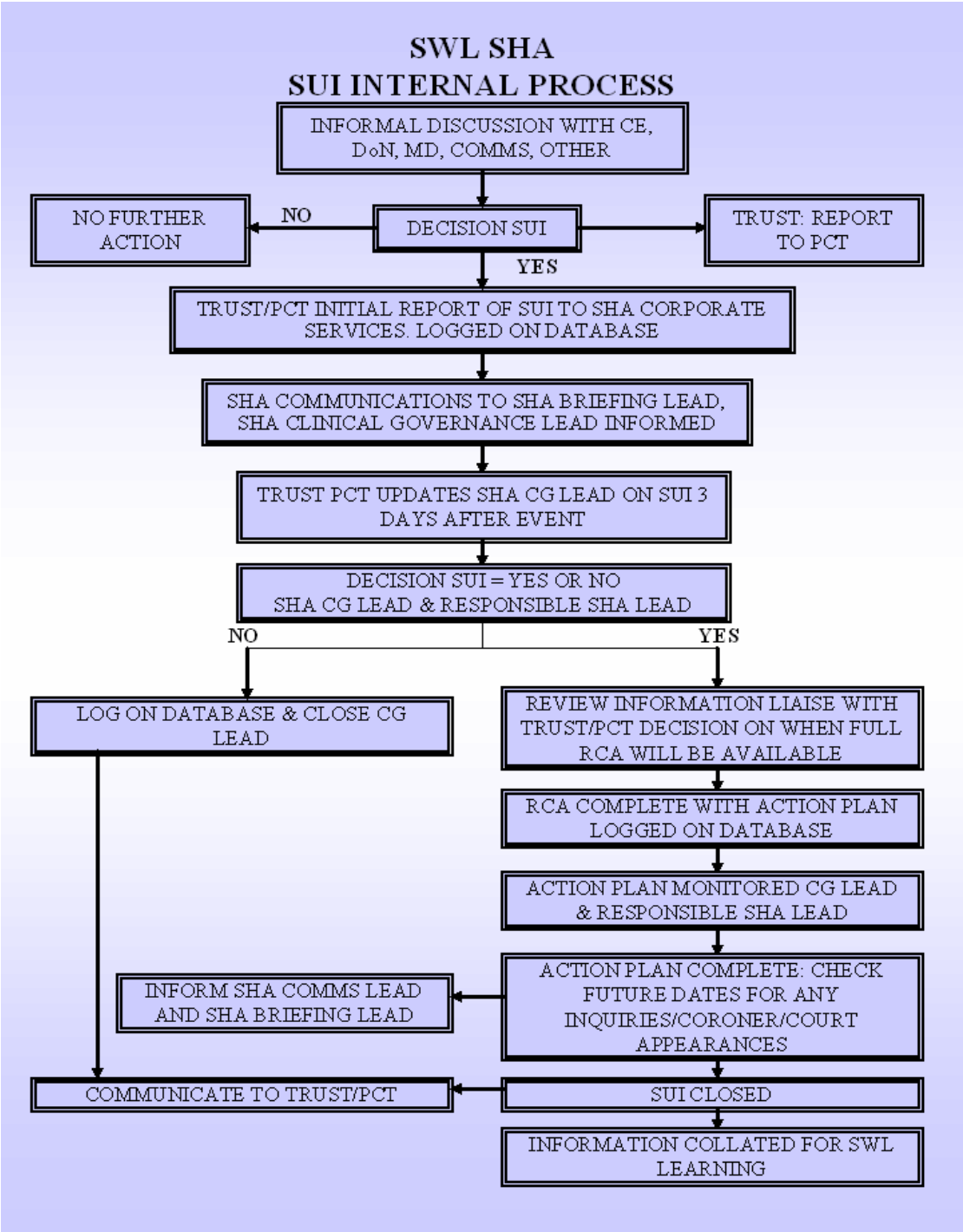
Standard 4
The support needs of those involved (patient, relatives, staff) will be considered immediately and the need for ongoing support reviewed at the point of declaring an SUI
Audit instruction:
Was support offered? Check SUI file; consider employing feedback mechanisms.

Standard 5
Carers/relatives will be offered a named contact for support and information.
Audit instruction:
Were relatives offered a named contact? Check SUI file

Standard 6
The risk management service will notify the Strategic Health Authority of any SUI which meets their criteria within 72 hours*
Audit instruction
Was the SHA informed? Check SUI file

**In extreme cases the Trust will notify the SHA immediately*

Appendix 2


SWL SHA
SUI INTERNAL PROCESS
INFORMAL DISCUSSION WITH CE, DoN, MD, COMMS, OTHER
NO FURTHER ACTION
NO
DECISION SUI
TRUST: REPORT TO PCT
YES
TRUST/PCT INITIAL REPORT OF SUI TO SHA CORPORATE SERVICES. LOGGED ON DATABASE
SHA COMMUNICATIONS TO SHA BRIEFING LEAD, SHA CLINICAL GOVERNANCE LEAD INFORMED
TRUST PCT UPDATES SHA CG LEAD ON SUI 3 DAYS AFTER EVENT
DECISION SUI = YES OR NO
SHA CG LEAD & RESPONSIBLE SHA LEAD
NO
YES
LOG ON DATABASE & CLOSE CG LEAD
REVIEW INFORMATION LIAISE WITH TRUST/PCT DECISION ON WHEN FULL RCA WILL BE AVAILABLE
RCA COMPLETE WITH ACTION PLAN LOGGED ON DATABASE
ACTION PLAN MONITORED CG LEAD & RESPONSIBLE SHA LEAD
INFORM SHA COMMS LEAD AND SHA BRIEFING LEAD
ACTION PLAN COMPLETE: CHECK FUTURE DATES FOR ANY INQUIRIES/CORONER/COURT APPEARANCES
COMMUNICATE TO TRUST/PCT
SUI CLOSED
INFORMATION COLLATED FOR SWL LEARNING

Appendix 3

Family Liaison Officer – role description

Introduction

The primary focus of the Family Liaison Officer (FLO) is to act as a conduit to convey information to and receive queries from relatives and others concerning an event, which has been declared a Serious Untoward Incident (SUI) by the London Ambulance Service NHS Trust. (LAS). The FLO must always keep a record of any information given to staff, patient(s) and/or relative(s) and the public to comply with the requirements set out in sections 9.3 and 4.2 of the SUI Policy.

- The main purpose of the FLO is to keep the service user, relatives ,carers and others with a direct responsibility for their welfare, fully briefed about the progress of the investigation process, how the incident is being managed, and to provide advice relating to the implementation of LAS policy and procedures. The FLO may also offer information about other agencies such as the Healthcare Commission and the Independent Complaints Advocacy Service (ICAS) who can provide advice about the NHS Complaints Procedure.

- The FLO does not have an active role in the investigation of the incident, although the FLO may facilitate communication channels between LAS NHS Trust investigations so that the relationship between them is connected to the chronology of the investigation.

- The FLO must always maintain a contemporaneous summary log of the progress of the incident inquiry including a record of all contacts by LAS NHS Trust staff with the Service User, family, relatives and carers. This record will also be routinely available to LAS NHS Trust staff, complainants, Investigators and representatives of those involved in the incident.

- In the event of a request for information about the SUI from the media, the FLO should immediately refer the enquirer to the Communications Directorate.

- The FLO has no role in advising on or defending the position of the London Ambulance Service NHS Trust (LAS NHS Trust) regarding the Serious Untoward Incident (SUI) in which their staff have been indirectly or directly involved. The FLO is a source of accurate information for the service user, relatives, carers and others with a direct interest in/responsibility for the welfare of those involved in the SUI.

- The FLO should not offer opinion or comment on matters related to the incident or the inquiry into it, to the Service User/complainant/Relative/Carer/ Representative other than to explain the implementation and progress of the application of the LAS NHS Trust SUI Policy process to the incident or the relationship of it to NHS complaints procedures.

- The FLO must always connect and respond in a timely manner with those seeking information, and be able to demonstrate that the parties with a direct interest (as described above) in the welfare of the service user have good access to all appropriate information about the incident. To facilitate this, the FLO will hold a minimum of at least one initial meeting with them.

- The FLO must liaise with all departments of the LAS NHS Trust to ensure the information requirements from the incident are addressed and complied with.

Appendix 4

SUI Checklist

The following points must be part of every SUI process undertaken by the LAS. It is by no means exhaustive:

Being Open – This advice reflects the approach to "Being Open" issued by the NPSA

1.0 Preliminary meeting with the patient and/or their carers

1.1 Who should attend?

A lead member of staff with appropriate experience will attend the preliminary meeting with the patient and/or carers.

It is important to ensure that those staff who attend the meetings can continue to do so to aid continuity.

The person taking the lead should be supported by at least one other appropriate member of staff,

Ask the patient and/or their carers who they would like to be present

Consider the communication skills of each team member; they need to be able to communicate clearly, sympathetically and effectively.

Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting.

1.2 When should it be held?

As soon after the incident as possible.

Consider the patients and/or their carer's home and social circumstances.

Check they are happy with the timing.

Offer them a choice of times and confirm the chosen date in writing.

Do not cancel the meeting unless absolutely necessary.

1.3 Where should it be held?

Use a quiet room where you will not be distracted by work or interrupted.

Do not host the meeting near to the place where the incident occurred if this may be difficult for the patient and/or their carers.

1.4 How should you approach the patient and/or their carers?

Speak to the patient and / or their carers as you would want someone in the same situation to communicate with a member of your family.

Do not use jargon or acronyms: use clear, straightforward language.

Consider the needs of patients with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities.

1.5 What should be discussed?

Introduce and explain the role of everyone present to the patient and/or their carer and ask them if they are happy with those present.

Acknowledge what happened and apologise on behalf of the team and the organisation. Expressing regret is not an admission of liability.

Stick to the facts that are known at the time and assure them that if more information becomes available it will be shared with them.

Do not speculate or attribute blame.

Suggest sources of support and counselling.

Check they have understood what you have told them and offer to answer any questions.

Provide a named contact who they can speak to again.

1.6 Follow – up

Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines.

The patients notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the patient and/or their carers have been told, and a summary of agreed action points.

Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counselling, as appropriate.

2.0 Quick reference guide to *Being Open (NPSA 2005)*

- Obtaining a full set of the contemporaneous records.
- Producing a chronology of events.
- Seeking internal or external clinical advice.
- Using management information data.
- Identifying the key staff involved in the incident.
- Deciding who needs to be interviewed and the order in which the interviews will take place.
- Ascertaining the final outcome.
- Ascertaining the key problems and when they arose.

- Produce a draft report for the SUI Review Manager to sign off following consultation with the SUI Review Group.

Interviews will be undertaken by members of the SUI Review Group following consultation with the Investigation Officer to:

- Establish the chronology and role played by the member(s) of staff and asking each interviewee to identify the main problems without apportioning blame.

- Establish to what extent action was guided by National Clinical Guidelines and, if not, how reasonable it was to depart from those guidelines and protocols.

- Identify the contributory factors e.g. work load, availability of equipment, training and distinguishing the specific and general contributory factors.

An analysis of an SUI using 'root cause' methodology must always be done as stated in the policy to establish at least the minimum facts below:-

- What happened?
- How did it happen?
- Why did it happen?
- What can be done to change things and prevent it happening again?
- Where and when can the LAS monitor that actions and recommendations from the report have been implemented and improved patient care?

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
265	Inability to match resources to demand. Rosters do not match current demand. Weak at weekends.	**OPER**	**31-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**R.S**	Sector support' rotas have been introduced for staff to work solely at night or during weekends. Over time at 'double time' has been made available to staff between 11pm and 3am on Fri., Sat. and Sun. All new staff now join a relief rota where they work 7 out of 10 weekends.
248	EOC not checking logs of Cat.C calls. This allows them to conf. whether call can be handled by UOC.	**OPER**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**J.HOP**	Deputy Director of Operations recommends that this risk is now removed, as an automatic process is now in place to refer all Cat C calls to UOC. Proposal for deletion to go to RCAG on 28/02/07.
246	Existing rosters do not provide the cover to match demand	**OPER**	**25-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	Deputy Director of Operations recommends that this risk be deleted, as issues have now been written in to risk 265. Proposal to go to the RCAG on 28/02/07.
70	Delays are occurring in responding to urgent calls resulting in these calls becoming emergency calls	**OPER**	**14-Jan-2003**	**20**	**16**	**HIGH**	**HIGH**	**J.HOP**	Recommend that this risk be reduced to 'Significant 12'. New process in place which treats Urgent Calls 'within one hour' as emergency calls, and refer Urgent Calls 'within three hours' to UOC for dispatch.
25	Delay in activating vehicles due to inability to answer calls promptly before the recorded message is played.	**OPER**	**14-Nov-2002**	**20**	**16**	**HIGH**	**HIGH**	**J.HOP**	Dispatch staff have been given the facility to also answer calls when demand is high. Additional call takers are being recruited.
17	Lack of crewed ambulances on Fri, Sat.&Sun nights.	**OPER**	**14-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	250 staff now in place. Proposal to go to the RCAG on 28/02/2007 to accept this risk is rolled into 265 and deleted.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
9	Risk of injury to staff, patient or third party travelling in an LAS vehicle or involved in an RTA with an LAS vehicle.	**OPER**	**13-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'Significant 12'. FRU staff are receiving individual driver training. 'Black box' accident data recorders are on trial to identify causes of accidents. Monitoring and adjudication of accidents is to be reinstated. Child patient safety under review. Protocols in place for safety of other patients and travellers. All new A & E ambulances fitted with recessed child harness in head and attendants seats, and all new PTS ambulances are fitted with all age (above 4 years old) adjustable harnesses.
254	Assessment of Manual Handling and Training	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**DCH**	Meeting took place with the Practice Development Manager of the South Area to explore effective ways of developing, delivering train the trainer/assessor course and also to plug the immediate shortfall in having competent persons to deliver patient handling training. Proposal to go to the RCAG on 28/02/2007 to accept this risk is rolled into 8 under H&S and deleted.
251	Reduced ambulance management cover due to fixed responses. Managers are tied up supporting police and fire calls.	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	The HART team will be addressing many of these calls from Jan '07. Proposal to go to RCAG to downgrade this risk to 6.
249	Loss of FRU cover due to inappropriate tasking.	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'Significant 12'. Both desks can now see each others resources.

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221	No effective backup in place for EBS	OPER	13-Jun-2006	15	15	HIGH	HIGH	SM	It has been agreed that EBS fallback will be located in the large meeting room at Loman Street. This risk should be deleted after MS has arranged for the necessary technical requirements to be completed.
268	Delay in fully implementing the action plan devised following the London bombings on 7/7/05.	OPER	09-Nov-2006	12	12	SIG	SIG	J.P	Traffic lighted action plan. Overseen by designated senior manager. Most serious actions colour coded and reviewed by the Head of Emergency Preparedness. Monthly performance review with designated department leads. 3 monthly monitoring report presented to SMG by the Head of Emergency Preparedness.
257	Capability to deal with day to day situation of the Development and Operations of Wembley Complex	OPER	25-Jul-2006	12	12	SIG	SIG	PS	Assessment of risk will be undertaken when stadium is near completion.
235	EOC lack info. at time of disp. and co-ord. between sect. & FRU desks. Sect. desks lack full info., as call is still underway.	OPER	24-May-2006	12	12	SIG	SIG	J.HOP	There are plans to consider moving the FRU's to the new split sector desks in 2007/8"
232	Staff have not had training to use the newly configured equipment on the Amb's. Staff won't be able to use new equipment.	OPER	24-May-2006	12	12	SIG	SIG	KM	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'moderate 4'. CPD courses had previously been put on hold, due to performance pressures. Staff were therefore not receiving training in manual handling devices. These courses have now been re-instated.
231	Lack of qualified RTA investigators. Leads to delayed RTA reporting and exposes the Trust to higher motor risk claims.	OPER	24-May-2006	12	12	SIG	SIG	MD	Training needs analysis to be updated to enable training of RTA investigators to be undertaken. Review of training needs analysis to be undertaken including progress monitoring at next RCAG meeting on 28.02.07

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229	Low levels of measurable utilisation of ECPs is likely to result in withdrawal of stakeholder funding	**OPER**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**I.TODD**	Proposal to go to RCAG on 28/02/2007 to increase this risk to 'high 15' due to recent PCT funding being withdrawn in some areas. A new tasking strategy has been implemented and has improved situation. Weekly utilisation report produced. Proposal to SMG on 17/1/07 to fund ECPS as part of workforce plan
228	Single responders being sent on incomplete calls.	**OPER**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	Driver is updated once the call is complete. Until then, a dynamic risk assessment is carried out. Proposal to go to RCAG on 28/02/2007 to downgrade to 6 due to increased controls.
223	No ability to hold regular team meetings/briefings	**OPER**	**12-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	Face to face communication still lacking but Comms department are addressing this issue. New rosters in 2007 should address this. Proposal to go to RCAG on 28/02/2007 to downgrade to 6.
222	Lack of frontline management staff at weekend. Risk to staff welfare and staff support who require advice , could lead to SUI.	**OPER**	**13-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	New rostering and leave arrangements for DSOs underway. Proposal to go to RCAG on 28/02/2007 to downgrade to 8.
215	Risk of having impractical ratios of CTCs to EMDs	**OPER**	**13-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**J.HOP**	Proposal for deletion of risk to go to RCAG on 28/02/2007 as supervisors in place.
163	Not being able to instigate an effective response in the event of either an internal or external incident that affected the service due to a lack of comprehensive Contingency Plan.	**OPER**	**21-Jul-2004**	**15**	**12**	**HIGH**	**SIG**	**SRM**	Business Continuity Plan in place and is currently being reviewed. Proposal to go to RCAG on 28/02/2007 to downgrade to 6.

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21	Delay in activating vehicles due to human error in EOC	OPER	14-Nov-2002	15	12	HIGH	SIG	J.HOP	Officer appointed to assist call taking supervisor. Superintendent also given specific responsibility for call taking. Proposal to go to RCAG on 28/02/2007 to downgrade to moderate 6.
266	Cancellation of Update Training, which could lead to inappropriate treatment of patient.	OPER	31-Jul-2006	9	9	SIG	SIG	R.S	Recommend that this risk be removed, as covered in risk 232. Proposal to go to the RCAG on 28/02/2007.
236	Risk of new work practices being introduced for EMT's as a result of AFC before relevant training packages have been provided	OPER	24-May-2006	9	9	SIG	SIG	KM	Recommend that this risk be removed due to training package now being provided and staff being instructed not to practice until trained. Proposal to go to RCAG on 28/02/2007.
218	EOC does not call back abandoned calls from mobile phones.	OPER	12-Jun-2006	9	9	SIG	SIG	J.HOP	Protocol in place to advise CTs to follow up calls. Proposal to go to RCAG on 28/02/2007 for removal of risk from register
151	Trust may not manage crew overtime down	OPER	19-Dec-2003	9	9	SIG	SIG	R.S	Proposal to go to RCAG on 28/02/2007 for risk to be removed.Overtime successfully reduced by two thirds.
176	Formal arrangements are not in place to run a Payroll, and pay staff salaries if HQ was inaccessible or shortage of power supply	OPER	17-Jan-2005	16	8	HIGH	SIG	TC	Proposal to go to RCAG on 28/02/2007 for risk to be removed. As advised by the Director of Finance. Payroll is now part of new ESR roll out.
217	Not being able to contact resource in a "Black Spot" area.	OPER	12-Jul-2006	6	6	MOD	MOD	R.S	Rarely experienced with MDTs. New radios in '07 will significantly reduce the frequency of this issue.
26	Delay in activating vehicles due to difficulties in obtaining address from caller.	OPER	14-Nov-2002	16	6	HIGH	MOD	R.S	Risk has been mitigated by the recent uploading of the new Gazeteer, as it contains updated information on new buildings and new addresses in London. Arrangements are in place to ensure quarterly updates are undertaken.

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30	Long journey times due to distance travelled and traffic	**OPER**	**14-Nov-2002**	**20**	**4**	**HIGH**	**MOD**	**R.S**	RCAG are asked to accept this risk as part of risk 265.
193	Carry chairs are not being presented with A&E vehicles for servicing	**OPER**	**01-Jan-2003**	**12**	**3**	**SIG**	**LOW**	**C.V.**	Proposal to go to RCAG on 28/02/2007 to remove this risk, as there is continued ongoing assessment of Carry Chairs every 6 weeks.
239	Failure of Ferno Pegasus Trolley Bed	**LOG**	**24-Jul-2006**	**25**	**25**	**HIGH**	**HIGH**	**C.V.**	Reinforcement of trolley beds complete. All trolley beds checked for deformation. Each trolley bed checked by Fleet at 6 weekly intervals. Any trolley beds outside tolerances removed from the service and replaced by spare Ferno Falcon Six trolley bed.
250	Inability to treat Paediatrics due to equipment out of date	**LOG**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**C.V.**	Roll out plan in place to replace out of date drugs. Some stations withholding bags preventing replacement.
206	Unavailability or the non-functioning of critical patient care equipment on vehicles.	**LOG**	**02-Mar-2006**	**20**	**20**	**HIGH**	**HIGH**	**C.V.**	Make Ready implemented service wide. Equipment checked each night on every vehicle made available.
35	Risk of loss of Patient Report Forms or inappropriate access to patient related information, due to lack of security.	**LOG**	**01-Jun-2002**	**20**	**16**	**HIGH**	**HIGH**	**C.V.**	Secure post boxes installed on each station 2003. COMPLETE- Proposal was made to the RCAG to delete this risk. RCAG decided on the 7/11/2006 that the risk should remain on the register and considered for deletion in February. Although the risk has been addressed there has been a recent incident involving PFI forms being stolen from North Kensington Ambulance Station.
186	Management of Medical Devices not consistent throughout the organisation.	**LOG**	**10-Feb-2004**	**12**	**9**	**SIG**	**SIG**	**C.V.**	Asset database due to go live NOV 06. All equipment will be checked against planned servicing date.

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172	Not meeting operational targets and unnecessary pressure on fleet due to unavailability of vehicles because of poor local care.	LOG	05-Jan-2005	15	9	HIGH	SIG	C.J	Fleet Status reporting in place. Asset Tracking Tool will also monitor the vehicle location. Flexible Fleet Management Project being extended to further station complexes.
170	Vehicle Defect Reporting Forms not used/ used inappropriately	LOG	05-Jan-2005	12	9	SIG	SIG	CV	A new fault reporting book is close to agreement at VEWG. Orders will be placed for new books by Jan'07.
72	Inconsistent action relating to the maintenance and repair of trolley beds due to inadequate record keeping.	LOG	17-Mar-2003	16	9	HIGH	SIG	C.J	Transferred records to electronic database. Asset Tracking tool will also assist in locating trolley's. Fleet Dept. considering replacement of Fleet Plan Computer Record System.
184	Failure to meet Fleet Support requirements to service vehicle without putting staff at addit.risk of injury working excess O/T.	LOG	10-Feb-2006	12	8	SIG	SIG	C.J	Fleet have additional funding for winter pressures. Also, more mobile workshops to cope with the demand. Fleet status reports have identified that there are spare vehicles which can be utilised.
187	Not having fully equipped vehicles, due to equipment lost or left at hosp. and not recorded. As most hospitals have 1:1 swaps.	LOG		15	6	HIGH	MOD	C.V.	We are addressing this as part of the Logistics Restructure. Implementation Dec '06/Jan '07
43	Oxygen cylinders are not all stored safely and appropriately on vehicles and in stations	LOG	14-Nov-2002	8	3	SIG	LOW	C.V.	Make Ready has been implemented service wide and ensure that all vehicles have a designated oxygen storage. Additional oxygen cabinets have also been purchased. RCAG agreed on 7/11/2006 to downgrade this risk from 12 to 3.
66	Risk to patients and staff due to contamination of equip.and vehicle	LOG	14-Nov-2002	15	2	HIGH	LOW	C.V.	Make Ready currently rolled out to A& E vehicles. Future plans to also roll out to RRU vehicles and planning to extend to PTS in next financial year.

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56	Risk of cross infection and injury to staff,patients and public due to inadequate disposal of products other than needles.	**LOG**	**14-Nov-2002**	**12**	**2**	**SIG**	**LOW**	**C.V.**	Service will be in negotiations in the near future with Hospitals, in getting an agreement to allow crews to dispose of clinical waste.
214	Inability to send time critical SMS messages due to lack of network coverage	**IMT**	**17-May-2006**	**25**	**25**	**HIGH**	**HIGH**	**PS**	SMS should not be used to send time critical messages. It is totally unsuitable and hence unreliable for this purpose. In terms of sending critical messages, the Trust's preferred approach is voice or data via MDT's. A separate pager over-lay has also been installed for the transmission of urgent messages. It is recommend by the Director of Information Management & Technology that this risk is removed from the risk register. Proposal to go to the RCAG on 28/02/07.
237	Staff being paid incorrectly,or not at all if the pay data does not migrate successfully and accurately into the new database	**IMT**	**24-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**TC**	Payroll system is now functioning to standard required. Recommendation for this risk to be deleted. Proposal to go to the RCAG on 28/02/07.

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238	Inability to dispatch to MDTs from FALL back Centre at Bow	**IMT**	**24-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**JD**	The underlying ExpressQ infrastructure has been upgraded at Fall Back Control in line with the live configuration at HQ and a number of remedial activities have been carried out to test individual technical elements of the overall facility. A plan to fully test Fall Back operation is being developed to be implemented February 2007. The risk rating should be reduced from 15 High to 12. Proposal to go to the RCAG on 28/02/07 to reduce the risk rating.
242	No back up if PSIAM software fails. So CTAK would be without support aid.	**IMT**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**JD**	PSIAM operates on servers based at HQ, the architecture provides resilience to individual component failure. Data backup procedures are carried out at HQ to secure data and allow for recovery in the event of a total hardware failure. Disaster recovery servers are similarly configured at the Bow Fall Back Control, however there are no workstations at this location allocated for CTA (or general UOC) operations. This is a matter for UOC Command and Estates to resolve therefore the primary risk owner is Assistant Dir UOC, IM&T can procure install and configure client PCs & associated telephony equipment once specific location of fall back users is agreed.

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168	Exposed of support for the CAD system if Dep. Dir. of IMT was unavailable, due to knowledge of software d'vpmt. & M'tnce.	**IMT**	**05-Jan-2005**	**16**	**9**	**HIGH**	**SIG**	**JD**	The Deputy Director of IM&T has now left the Trust. 2 consultants are providing support and a full time position is being advertised. In terms of this specific risk, this risk should be closed. However in terms of CTAK there remains (and always will) a risk regarding it's proprietary nature. Head of Software Development & Support will raise a separate risk in relation to this issue and will be the nominated senior responsible manager. He will provide you with a separate update for this. Proposal for deletion and new risk to go to RCAG on 28/02/2007.
178	Risk that business critical data (with the exception of cental systems i.e. CTAK, finance etc.) could be lost.	**IMT**	**30-Mar-2005**	**9**	**2**	**SIG**	**LOW**	**AO**	Information will no longer be kept on hardrives it will be migrated across to network drives and will be backed up daily. The aim is to complete this work during 2007.
244	Lack of protected time for staff professional and career development	**HS**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**CH**	Awaiting update.
262	Lack of training for Investigation Officer's.	**HS**	**26-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.M.M**	Awaiting update.

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173	Risks to staff, patients and organisation of staff working excessive overtime/ hours	**HS**	**05-Jan-2005**	**16**	**16**	**HIGH**	**HIGH**	**RA**	A&E Resources Group has responsibility for monitoring hours worked. A quarterly review would be undertaken and progress monitored. A proposal was put to the RCAG that the risk be downgraded to SIGNIFICANT LEVEL = 9 or MODERATE LEVEL= 6. The RCAG decided on the 7/11/06 that this risk should remain the same. To be reviewed in February'07 when evidence from PROMIS should support regrading.
7	Failure to reduce reported incident risks through incident information not being shared with all relevant depts & committees	**HS**	**13-Nov-2002**	**20**	**9**	**HIGH**	**SIG**	**JS**	Awaiting update.
243	AFC - difficulty in recruiting staff levels to organisation	**HS**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**CH**	Awaiting update.
240	Lack of quality of training which could result in new recruits not meeting the req. standard.	**HS**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**CH**	Awaiting update.
174	Staff expectations not met due to inability to sustain implementation of PDR service-wide.	**HS**	**05-Jan-2005**	**16**	**9**	**HIGH**	**SIG**	**S.S**	Awaiting update.
8	Risk of injury to operational staff and/or patient through issues relating to manual handling.	**HS**	**13-Nov-2002**	**20**	**9**	**HIGH**	**SIG**	**CH**	Meeting has taken place to explore effective ways of developing , deliver train the trainer/assessor course and also to plug the immediate shortfall in having competent persons to deliver patient handling training. The LAS Ergonomics Advisor offered to develop and deliver training to A&C staff, fleet, estates, IM&T and other office staff based on risk assessment.

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10	Risk of LAS staff being physically assaulted	**HS**	**13-Nov-2002**	**20**	**6**	**HIGH**	**MOD**	**RA**	MOU between the NHS and the Police signed off in September 2006 to increase prosecutions resulting from assaults on NHS staff. Review of the High Risk Address Register to commence on the 23rd November 2006. Proposal was put to the RCAG that the risk be downgraded from a SIGNIFICANT LEVEL = to a MODERATE LEVEL = 6. RCAG agreed on the regrading on the 7/11/2006.
252	Clinical Assessment and support when returning to work after extending periods away.	**HS**	**25-Jul-2006**	**6**	**6**	**MOD**	**MOD**	**CH**	Return to work interview. Whilst staff are away from work they are offered and sent information to keep them up-to-date.
226	Lone worker Policy not fully implemented	**HS**	**12-Jul-2006**	**15**	**6**	**HIGH**	**MOD**	**J.S**	Recommend that this risk be removed, as covered in risk 232. Received positive feedback from Bentley Jennison's audit on Lone Worker Policy. Their recommendation is to review the High Risk Address Register, which will commence on the 23rd November 2006. RCAG decided on the 7/11/2006 that this be regraded from 15/high to 6/moderate, as it was accepted that the Internal Audit review of lone working had not proposed any significant recommendations and there has been training delivered on lone working.
164	Policies and Procedures not adhered to due to lack of staff awareness and robust implementation plans	**FINAN**	**04-Jan-2005**	**12**	**5**	**SIG**	**MOD**	**SRM**	Policies and Procedures Working Group developing an Implementation Working Plan template.

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182	Not being able to escape from an LAS building in the case of fire or other emergencies.	**HS**	**09-Feb-2004**	**9**	**4**	**SIG**	**MOD**	**J.S**	Fire evacuation drills undertaken twice yearly. Fire alarm testing undertaken weekly. Proposal was put to the RCAG that the risk be downgraded to a LOW LEVEL = 2. RCAG decided on 7/11/2006 that the risk should remain as 4/moderate and be reviewed again in February' 07 at RCAG.
181	Risk of injury to staff from slips, trips and falls on LAS premises. H&S Inspections & Incident Reports not implemented.	**HS**	**09-Feb-2003**	**9**	**4**	**SIG**	**MOD**	**J.S**	Premises inspections of all LAS properties undertaken on 3 monthly basis. 2 day Health & Safety Awareness course module covers premises inspections. Premises inspections of all LAS properties undertaken on 3 monthly basis. 2 day Health & Safety Awareness course module covers premises inspections. Proposal was put to the RCAG on 28/02/2007 that the risk be downgraded from a MODERATE LEVEL = 6 to a MODERATE LEVEL = 4. RCAG agreed on the 7/11/2006 to downgrade to MODERATE LEVEL = 4
27	Risk of cross infection due to inability to replace supplies on a 24 hr. basis.	**HS**	**14-Nov-2002**	**16**	**3**	**HIGH**	**LOW**	**J.S**	Stores moved to Deptford, and second store manager employed. Make Ready is now live on all 25 complexes.
210	Staff drinking, eating, smoking and using mobile phones whilst driving	**HS**	**04-May-2006**	**9**	**2**	**SIG**	**LOW**	**J.S**	All Operational staff undergo comprehensive driver training. All Operational staff comply with Road Traffic Act/Highway Code. Team leaders monitor crew staff implementation of policy and procedures.

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208	Risk of staff not knowing their accountabilities for internal control and principles of Code of Conduct	**HS**	**11-Apr-2006**	**3**	**2**	**LOW**	**LOW**	**C.MC'M**	Standing Orders revised and Code of Conduct included in induction for Non-Executive and Executive Directors.
205	Not being able to identify staff training due to incomplete training records.	**HS**	**01-Jun-2005**	**16**	**2**	**HIGH**	**LOW**	**KM**	Complex Team Leaders report to Training and Education on a weekly basis of staff that have been trained. Data is entered in PROMIS Live, which links into PROMIS database.
200	Fires may become uncontainable due to the inability to extinguish	**HS**	**01-Jan-2002**	**15**	**2**	**HIGH**	**LOW**	**J.S**	To remain as low risk. Awaiting update.
199	Risk to staff safety / vandalism/theft due to inability to adequately secure premises	**HS**	**01-Jan-2003**	**9**	**2**	**SIG**	**LOW**	**M.N.**	Quarterly Health and Safety Premises inspections. Bulletin reminding staff to secure premises when leaving unattended. Periodic change simplex lock combination. To remain as a low risk.
198	Risk of injury/electric shock arising from inadequate lighting, loose wiring and faulty plugs.	**HS**	**01-Jan-2003**	**20**	**2**	**HIGH**	**LOW**	**M.N.**	Quarterly visual inspection by Estates Department Surveyors. 5 yearly IEE/Electricity at Work Act Statutory Inspection. HSE Inspection following electric shock incident. To remain as a low risk.
197	Risk of injury due to workshop equipment	**HS**	**13-Feb-2006**	**16**	**2**	**HIGH**	**LOW**	**C.J**	Specific H&S awareness training for Workshop staff. To remain as a low risk.
196	LAS staff are subject to verbal assault	**HS**	**01-Jan-2002**	**12**	**2**	**SIG**	**LOW**	**RA**	High Risk Address Register is to be reviewed in November 2006. Post Violence Support procedure recently updated.
83	Not having suitable facilities to service PTS contracts for vehicles and staff.	**FINAN**	**17-Mar-2003**	**12**	**12**	**SIG**	**SIG**	**MD**	PTS management currently reviewing practical alternatives using external facilities.
256	Failure to jointly agree rest breaks for all crew staff.	**FINAN**	**25-Jul-2006**	**12**	**12**	**SIG**	**SIG**	**M D**	Agreed rest break agreement
253	Full CBRN income not received.	**FINAN**	**25-Jul-2006**	**12**	**12**	**SIG**	**SIG**	**V.C**	CBRN funding awaited. Invoice sent.

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255	Non compliance with EU Procurement legislation	FINAN	25-Jul-2006	9	9	SIG	SIG	P.CAND	Review of Top 200 suppliers underway
158	Until tenders for each project are received, there is the possibility that costs will increase.	FINAN	01-Jun-2004	9	9	SIG	SIG	P.CAND	Proposal to go to RCAG for deletion on 28/02/2007
157	The demanding income levels within the central services budget may not be achieved	FINAN	27-May-2004	9	9	SIG	SIG	N.D	Integration with Urgent Care underway. Budget levels will be adjsuted accordingly.
153	Fuel prices in excess of sums held in budgets.	FINAN	06-Jan-2004	16	9	HIGH	SIG	M.S	For 2006/7, holding reserve that cover expenditure up to £1 per litre.
152	Any new or unforseen cost pressures	FINAN	06-Jan-2004	9	9	SIG	SIG	M.S	Prompt monthly reports at Management Level (Budget Holders).
150	Savings to be achieved to both balance the budget and fund SIP initiatives.	FINAN	19-Dec-2003	9	9	SIG	SIG	M.S	Achieved savings in both balancing budget and funding SIP initiatives. Continuing exercise to achieve same in 2006/07
148	Employers' Superannuation Contributions is not sufficient to cover the additional costs the Trust will incur.	FINAN	19-Dec-2003	16	9	HIGH	SIG	M.S	Received sufficient funding.
147	Funding for the increase for Agenda for Change	FINAN	19-Dec-2003	9	9	SIG	SIG	M.S	Received enough funding for 2006/7.
145	Recurrent effect of CBRN funding needs to be secured as this has been used to fund recurrent staffing.	FINAN	19-Dec-2003	9	6	SIG	MOD	M.S	Finance Director emailed the SHA on the 26/09/2006, requesting release of funds. Awaiting final confirmation of funding (11/1/07)
213	Loss of computer data / information caused by unannounced or pre-warned electrical power cut	FINAN	16-May-2006	3	3	LOW	LOW	SMG	U.P.S systems in place.
212	Power-brake switches activated in Resource Centre, affecting adjacent workstns in MI, during testing of emerg. power generator.	FINAN	16-May-2006	3	3	LOW	LOW	M.N.	CTS Engineer / Electrician on call to reset switches.
191	Not having data sharing protocols enabling patient identifiable information (without permission from the patient)	FINAN	01-Jan-2003	12	3	SIG	LOW	SRM	Head of Records Managent is negotiating with other NHS bodies to set up a possible PAN London Information Sharing Agreement for NHS Trust's.

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ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
247	Risk of not delivering benefits of the programme through non-delivery of project outcomes.	**CORP**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**M.B**	Senior Managers are being trained through MSP and practice courses. Launch workshops held for all major programme strands. Only the Operational Model programme is live during 2006/07 and programme and project management methodologies are being used to deliver project outputs and realise programme benefits.
269	At shift changeover times, LAS performance falls as we take longer to reach patients.	**CLIN**	**08-Dec-2006**	**20**	**20**	**HIGH**	**HIGH**	**R.S**	Shift changeover times under review.
71	Risk of not learning and changing practice, as appropriate, as a result of complaints	**CLIN**	**17-Jul-2002**	**16**	**20**	**HIGH**	**HIGH**	**R.M.M**	Significant review of complaints handling been undertaken by service. Complaints now dealt with at local level. New complaints procdeure being produced. Monitoring to be undertaken by RCAG and Complaints Panel.
267	Delay in activating vehicles due to the unavailability of vehicles	**CLIN**	**12-Oct-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	There have been a number of PALS enquiries, 13 complaints received and 3 notifications regarding inquests. It was proposed that this risk be re-graded from a High/16 to High/20 to reflect the increased risk to the Trust. RCAG decided on the 7/11/06 that risk grading should remain the same. To be reviewed at the next RCAG when there is more data regarding complaints received by the Trust (28.02.07).

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138	Failing to appreciate the significance and urgency of psychiatric illnesses.	**CLIN**	**12-Nov-2003**	**12**	**16**	**SIG**	**HIGH**	**KM**	Mental Health strategy key points received by the Trust Board for further decisions still to be made regarding training for all frontline staff. Significant training on mental health issues on 5 day CPD Course (roll out ongoing from April 05 to 2yrs) Highlighted at Chief Executive Consultation Meetings.
34	Risk of technicians failing to meet the IHCD requirements	**CLIN**	**14-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**KM**	In addition, a 5-day course will be delivered to operational staff over the next two years, covering clinical refresher and many areas of best practice. A one day module entitled "Promoting Best Practice in the Workplace" forms a key part of this CPD course. Training Officers have received bespoke training to enable them to effectively deliver and role model in this respect.
31	Adverse outcome in maternity cases	**CLIN**	**14-Nov-2002**	**20**	**16**	**HIGH**	**HIGH**	**KM**	Appointed midwife leftt; a replacement is being sought. In the meantime the Trust has access to a number of midwives for advice re. problematic maternity cases.
207	Risk of not being able to download information from Defribillators	**CLIN**	**04-Apr-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	To trial the downloading information from data cards. Trial will begin in January which will then go service-wide, IT support permitting.
22	Failure to u/take comprehensive clinical assessments which may result in the inappropriate non-conveyance or t/ment of patients	**CLIN**	**14-Nov-2002**	**20**	**15**	**HIGH**	**HIGH**	**KM**	The EMT4 Course which is scheduled to be delivered over a two year programme will go some way to reduce this risk, currently in the region of approximately 400 people have successfully completed the course.

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20	Failure to fully complete the Patient Report Form.	**CLIN**	**14-Nov-2002**	**20**	**15**	**HIGH**	**HIGH**	**R.S**	Proposed that this be regraded to 15 as failure to complete PRF was moderate/certain rather than none/rare. It was suggested that the forms need to be re-designed to include CAD number and date, a full trial needs to be undertaken. If successful, approval should be sought from the CGC.(May'06) PRFs are still not fully completed. Ethnic box on the form has not been filled in for 94.5% of the PRF documentation audited
211	Drug errors and adverse events not being reported.	**CLIN**	**08-May-2006**	**16**	**9**	**HIGH**	**SIG**	**R.S**	Produce article for the Patient Care News on any reported drug administration errors.
194	Risk of patients and to viability of research projects with financial ethical and reputational impacts.	**CLIN**	**01-Sep-2004**	**9**	**9**	**SIG**	**SIG**	**R.D**	Include the principles, importance and processes for Research in all LAS training courses (incl. Corporate Induction and the current CPD course), to be discussed at the Clinical Education Development Group.
188	Paramedics failing to qualify for registration.	**CLIN**	**01-Jan-2002**	**20**	**9**	**HIGH**	**SIG**	**R.S**	Ensure all staff attend recertification courses. Attendance to be monitored through regular audits.
179	Failure to meet responsibilities under the Race Relations Act	**CLIN**	**09-Feb-2006**	**9**	**9**	**SIG**	**SIG**	**P.C**	A report, together with a revised Racial Equality Scheme, and workforce data will be added to the LAS website so that it can be accessed by the public. Versions will be available in other languages and formats on request. To implement Diversity Training for all staff.Race Equality and Diversity Implementation Plan (READIP) have been incorporated into the Trust's Service Plan and the Service Improvement Plan.

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165	Delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones	**CLIN**	**04-Jan-2005**	**12**	**9**	**SIG**	**SIG**	**KJ**	Older People Strategy currently being revisited and revised. Results of "Fit To Be Left" research project on older fallers to be presented to SMG shortly with recommendation for action.
133	Risk of potential legal action/negative publicity due to staff being unaware of how to report suspected abuse of children	**CLIN**	**18-Jul-2003**	**12**	**9**	**SIG**	**SIG**	**L.S**	Protection of Children and Vulnerable Adults Working Party - monitor compliance with LAS policies and procedures relating to this group. Internal audit recommendations being reviewed.
46	Risk of infection to staff due to needlestick injury	**CLIN**	**14-Nov-2002**	**3**	**9**	**LOW**	**SIG**	**R.S**	The new cannulas are now in use which should hopefully reduce the number of injuries.
63	The risk of incurring liability through the re-use of single use devices	**CLIN**	**14-Nov-2002**	**8**	**8**	**SIG**	**SIG**	**F M**	Poster distributed to all stations. Arising from recent Infection Control Group discussion.
202	Risk of Cross Infection from uniforms	**CLIN**	**01-Jan-2002**	**16**	**2**	**HIGH**	**LOW**	**C.V.**	New Uniform is industrial launderable, and trousers will be treated with an anit-bacterial treatment, which will greatly reduce the chance of cross infection.

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265	Inability to match resources to demand. Rosters do not match current demand. Weak at weekends.	**OPER**	**31-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**R.S**	Sector support' rotas have been introduced for staff to work solely at night or during weekends. Over time at 'double time' has been made available to staff between 11pm and 3am on Fri., Sat. and Sun. All new staff now join a relief rota where they work 7 out of 10 weekends.
248	EOC not checking logs of Cat.C calls. This allows them to conf. whether call can be handled by UOC.	**OPER**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**J.HOP**	Deputy Director of Operations recommends that this risk is now removed, as an automatic process is now in place to refer all Cat C calls to UOC. Proposal for deletion to go to RCAG on 28/02/07.
246	Existing rosters do not provide the cover to match demand	**OPER**	**25-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	Deputy Director of Operations recommends that this risk be deleted, as issues have now been written in to risk 265. Proposal to go to the RCAG on 28/02/07.
70	Delays are occurring in responding to urgent calls resulting in these calls becoming emergency calls	**OPER**	**14-Jan-2003**	**20**	**16**	**HIGH**	**HIGH**	**J.HOP**	Recommend that this risk be reduced to 'Significant 12'. New process in place which treats Urgent Calls 'within one hour' as emergency calls, and refer Urgent Calls 'within three hours' to UOC for dispatch.
25	Delay in activating vehicles due to inability to answer calls promptly before the recorded message is played.	**OPER**	**14-Nov-2002**	**20**	**16**	**HIGH**	**HIGH**	**J.HOP**	Dispatch staff have been given the facility to also answer calls when demand is high. Additional call takers are being recruited.
17	Lack of crewed ambulances on Fri, Sat.&Sun nights.	**OPER**	**14-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	250 staff now in place. Proposal to go to the RCAG on 28/02/2007 to accept this risk is rolled into 265 and deleted.

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9	Risk of injury to staff, patient or third party travelling in an LAS vehicle or involved in an RTA with an LAS vehicle.	**OPER**	**13-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'Significant 12'. FRU staff are receiving individual driver training. 'Black box' accident data recorders are on trial to identify causes of accidents. Monitoring and adjudication of accidents is to be reinstated. Child patient safety under review. Protocols in place for safety of other patients and travellers. All new A & E ambulances fitted with recessed child harness in head and attendants seats, and all new PTS ambulances are fitted with all age (above 4 years old) adjustable harnesses.
254	Assessment of Manual Handling and Training	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**DCH**	Meeting took place with the Practice Development Manager of the South Area to explore effective ways of developing, delivering train the trainer/assessor course and also to plug the immediate shortfall in having competent persons to deliver patient handling training. Proposal to go to the RCAG on 28/02/2007 to accept this risk is rolled into 8 under H&S and deleted.
251	Reduced ambulance management cover due to fixed responses. Managers are tied up supporting police and fire calls.	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	The HART team will be addressing many of these calls from Jan '07. Proposal to go to RCAG to downgrade this risk to 6.
249	Loss of FRU cover due to inappropriate tasking.	**OPER**	**25-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'Significant 12'. Both desks can now see each others resources.

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221	No effective backup in place for EBS	OPER	13-Jun-2006	15	15	HIGH	HIGH	SM	It has been agreed that EBS fallback will be located in the large meeting room at Loman Street. This risk should be deleted after MS has arranged for the necessary technical requirements to be completed.
268	Delay in fully implementing the action plan devised following the London bombings on 7/7/05.	OPER	09-Nov-2006	12	12	SIG	SIG	J.P	Traffic lighted action plan. Overseen by designated senior manager. Most serious actions colour coded and reviewed by the Head of Emergency Preparedness. Monthly performance review with designated department leads. 3 monthly monitoring report presented to SMG by the Head of Emergency Preparedness.
257	Capability to deal with day to day situation of the Development and Operations of Wembley Complex	OPER	25-Jul-2006	12	12	SIG	SIG	PS	Assessment of risk will be undertaken when stadium is near completion.
235	EOC lack info. at time of disp. and co-ord. between sect. & FRU desks. Sect. desks lack full info., as call is still underway.	OPER	24-May-2006	12	12	SIG	SIG	J.HOP	There are plans to consider moving the FRU's to the new split sector desks in 2007/8"
232	Staff have not had training to use the newly configured equipment on the Amb's. Staff won't be able to use new equipment.	OPER	24-May-2006	12	12	SIG	SIG	KM	Proposal to go to RCAG on 28/02/2007 to downgrade this risk to 'moderate 4'. CPD courses had previously been put on hold, due to performance pressures. Staff were therefore not receiving training in manual handling devices. These courses have now been re-instated.
231	Lack of qualified RTA investigators. Leads to delayed RTA reporting and exposes the Trust to higher motor risk claims.	OPER	24-May-2006	12	12	SIG	SIG	MD	Training needs analysis to be updated to enable training of RTA investigators to be undertaken. Review of training needs analysis to be undertaken including progress monitoring at next RCAG meeting on 28.02.07

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229	Low levels of measurable utilisation of ECPs is likely to result in withdrawal of stakeholder funding	**OPER**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**I.TODD**	Proposal to go to RCAG on 28/02/2007 to increase this risk to 'high 15' due to recent PCT funding being withdrawn in some areas. A new tasking strategy has been implemented and has improved situation. Weekly utilisation report produced. Proposal to SMG on 17/1/07 to fund ECPS as part of workforce plan
228	Single responders being sent on incomplete calls.	**OPER**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	Driver is updated once the call is complete. Until then, a dynamic risk assessment is carried out. Proposal to go to RCAG on 28/02/2007 to downgrade to 6 due to increased controls.
223	No ability to hold regular team meetings/briefings	**OPER**	**12-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	Face to face communication still lacking but Comms department are addressing this issue. New rosters in 2007 should address this. Proposal to go to RCAG on 28/02/2007 to downgrade to 6.
222	Lack of frontline management staff at weekend. Risk to staff welfare and staff support who require advice , could lead to SUI.	**OPER**	**13-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**R.S**	New rostering and leave arrangements for DSOs underway. Proposal to go to RCAG on 28/02/2007 to downgrade to 8.
215	Risk of having impractical ratios of CTCs to EMDs	**OPER**	**13-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**J.HOP**	Proposal for deletion of risk to go to RCAG on 28/02/2007 as supervisors in place.
163	Not being able to instigate an effective response in the event of either an internal or external incident that affected the service due to a lack of comprehensive Contingency Plan.	**OPER**	**21-Jul-2004**	**15**	**12**	**HIGH**	**SIG**	**SRM**	Business Continuity Plan in place and is currently being reviewed. Proposal to go to RCAG on 28/02/2007 to downgrade to 6.

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21	Delay in activating vehicles due to human error in EOC	OPER	14-Nov-2002	15	12	HIGH	SIG	J.HOP	Officer appointed to assist call taking supervisor. Superintendent also given specific responsibility for call taking. Proposal to go to RCAG on 28/02/2007 to downgrade to moderate 6.
266	Cancellation of Update Training, which could lead to inappropriate treatment of patient.	OPER	31-Jul-2006	9	9	SIG	SIG	R.S	Recommend that this risk be removed, as covered in risk 232. Proposal to go to the RCAG on 28/02/2007.
236	Risk of new work practices being introduced for EMT's as a result of AFC before relevant training packages have been provided	OPER	24-May-2006	9	9	SIG	SIG	KM	Recommend that this risk be removed due to training package now being provided and staff being instructed not to practice until trained. Proposal to go to RCAG on 28/02/2007.
218	EOC does not call back abandoned calls from mobile phones.	OPER	12-Jun-2006	9	9	SIG	SIG	J.HOP	Protocol in place to advise CTs to follow up calls. Proposal to go to RCAG on 28/02/2007 for removal of risk from register
151	Trust may not manage crew overtime down	OPER	19-Dec-2003	9	9	SIG	SIG	R.S	Proposal to go to RCAG on 28/02/2007 for risk to be removed.Overtime successfully reduced by two thirds.
176	Formal arrangements are not in place to run a Payroll, and pay staff salaries if HQ was inaccessible or shortage of power supply	OPER	17-Jan-2005	16	8	HIGH	SIG	TC	Proposal to go to RCAG on 28/02/2007 for risk to be removed. As advised by the Director of Finance. Payroll is now part of new ESR roll out.
217	Not being able to contact resource in a "Black Spot" area.	OPER	12-Jul-2006	6	6	MOD	MOD	R.S	Rarely experienced with MDTs. New radios in '07 will significantly reduce the frequency of this issue.
26	Delay in activating vehicles due to difficulties in obtaining address from caller.	OPER	14-Nov-2002	16	6	HIGH	MOD	R.S	Risk has been mitigated by the recent uploading of the new Gazeteer, as it contains updated information on new buildings and new addresses in London. Arrangements are in place to ensure quarterly updates are undertaken.

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30	Long journey times due to distance travelled and traffic	**OPER**	**14-Nov-2002**	**20**	**4**	**HIGH**	**MOD**	**R.S**	RCAG are asked to accept this risk as part of risk 265.
193	Carry chairs are not being presented with A&E vehicles for servicing	**OPER**	**01-Jan-2003**	**12**	**3**	**SIG**	**LOW**	**C.V.**	Proposal to go to RCAG on 28/02/2007 to remove this risk, as there is continued ongoing assessment of Carry Chairs every 6 weeks.
239	Failure of Ferno Pegasus Trolley Bed	**LOG**	**24-Jul-2006**	**25**	**25**	**HIGH**	**HIGH**	**C.V.**	Reinforcement of trolley beds complete. All trolley beds checked for deformation. Each trolley bed checked by Fleet at 6 weekly intervals. Any trolley beds outside tolerances removed from the service and replaced by spare Ferno Falcon Six trolley bed.
250	Inability to treat Paediatrics due to equipment out of date	**LOG**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**C.V.**	Roll out plan in place to replace out of date drugs. Some stations withholding bags preventing replacement.
206	Unavailability or the non-functioning of critical patient care equipment on vehicles.	**LOG**	**02-Mar-2006**	**20**	**20**	**HIGH**	**HIGH**	**C.V.**	Make Ready implemented service wide. Equipment checked each night on every vehicle made available.
35	Risk of loss of Patient Report Forms or inappropriate access to patient related information, due to lack of security.	**LOG**	**01-Jun-2002**	**20**	**16**	**HIGH**	**HIGH**	**C.V.**	Secure post boxes installed on each station 2003. COMPLETE- Proposal was made to the RCAG to delete this risk. RCAG decided on the 7/11/2006 that the risk should remain on the register and considered for deletion in February. Although the risk has been addressed there has been a recent incident involving PFI forms being stolen from North Kensington Ambulance Station.
186	Management of Medical Devices not consistent throughout the organisation.	**LOG**	**10-Feb-2004**	**12**	**9**	**SIG**	**SIG**	**C.V.**	Asset database due to go live NOV 06. All equipment will be checked against planned servicing date.

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172	Not meeting operational targets and unnecessary pressure on fleet due to unavailability of vehicles because of poor local care.	LOG	05-Jan-2005	15	9	HIGH	SIG	C.J	Fleet Status reporting in place. Asset Tracking Tool will also monitor the vehicle location. Flexible Fleet Management Project being extended to further station complexes.
170	Vehicle Defect Reporting Forms not used/ used inappropriately	LOG	05-Jan-2005	12	9	SIG	SIG	CV	A new fault reporting book is close to agreement at VEWG. Orders will be placed for new books by Jan'07.
72	Inconsistent action relating to the maintenance and repair of trolley beds due to inadequate record keeping.	LOG	17-Mar-2003	16	9	HIGH	SIG	C.J	Transferred records to electronic database. Asset Tracking tool will also assist in locating trolley's. Fleet Dept. considering replacement of Fleet Plan Computer Record System.
184	Failure to meet Fleet Support requirements to service vehicle without putting staff at addit.risk of injury working excess O/T.	LOG	10-Feb-2006	12	8	SIG	SIG	C.J	Fleet have additional funding for winter pressures. Also, more mobile workshops to cope with the demand. Fleet status reports have identified that there are spare vehicles which can be utilised.
187	Not having fully equipped vehicles, due to equipment lost or left at hosp. and not recorded. As most hospitals have 1:1 swaps.	LOG		15	6	HIGH	MOD	C.V.	We are addressing this as part of the Logistics Restructure. Implementation Dec '06/Jan '07
43	Oxygen cylinders are not all stored safely and appropriately on vehicles and in stations	LOG	14-Nov-2002	8	3	SIG	LOW	C.V.	Make Ready has been implemented service wide and ensure that all vehicles have a designated oxygen storage. Additional oxygen cabinets have also been purchased. RCAG agreed on 7/11/2006 to downgrade this risk from 12 to 3.
66	Risk to patients and staff due to contamination of equip.and vehicle	LOG	14-Nov-2002	15	2	HIGH	LOW	C.V.	Make Ready currently rolled out to A& E vehicles. Future plans to also roll out to RRU vehicles and planning to extend to PTS in next financial year.

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56	Risk of cross infection and injury to staff,patients and public due to inadequate disposal of products other than needles.	**LOG**	**14-Nov-2002**	**12**	**2**	**SIG**	**LOW**	**C.V.**	Service will be in negotiations in the near future with Hospitals, in getting an agreement to allow crews to dispose of clinical waste.
214	Inability to send time critical SMS messages due to lack of network coverage	**IMT**	**17-May-2006**	**25**	**25**	**HIGH**	**HIGH**	**PS**	SMS should not be used to send time critical messages. It is totally unsuitable and hence unreliable for this purpose. In terms of sending critical messages, the Trust's preferred approach is voice or data via MDT's. A separate pager over-lay has also been installed for the transmission of urgent messages. It is recommend by the Director of Information Management & Technology that this risk is removed from the risk register. Proposal to go to the RCAG on 28/02/07.
237	Staff being paid incorrectly,or not at all if the pay data does not migrate successfully and accurately into the new database	**IMT**	**24-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**TC**	Payroll system is now functioning to standard required. Recommendation for this risk to be deleted. Proposal to go to the RCAG on 28/02/07.

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238	Inability to dispatch to MDTs from FALL back Centre at Bow	**IMT**	**24-Jul-2006**	**15**	**15**	**HIGH**	**HIGH**	**JD**	The underlying ExpressQ infrastructure has been upgraded at Fall Back Control in line with the live configuration at HQ and a number of remedial activities have been carried out to test individual technical elements of the overall facility. A plan to fully test Fall Back operation is being developed to be implemented February 2007. The risk rating should be reduced from 15 High to 12. Proposal to go to the RCAG on 28/02/07 to reduce the risk rating.
242	No back up if PSIAM software fails. So CTAK would be without support aid.	**IMT**	**02-Jun-2006**	**12**	**12**	**SIG**	**SIG**	**JD**	PSIAM operates on servers based at HQ, the architecture provides resilience to individual component failure. Data backup procedures are carried out at HQ to secure data and allow for recovery in the event of a total hardware failure. Disaster recovery servers are similarly configured at the Bow Fall Back Control, however there are no workstations at this location allocated for CTA (or general UOC) operations. This is a matter for UOC Command and Estates to resolve therefore the primary risk owner is Assistant Dir UOC, IM&T can procure install and configure client PCs & associated telephony equipment once specific location of fall back users is agreed.

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168	Exposed of support for the CAD system if Dep. Dir. of IMT was unavailable, due to knowledge of software d'vpmt. & M'tnce.	**IMT**	**05-Jan-2005**	**16**	**9**	**HIGH**	**SIG**	**JD**	The Deputy Director of IM&T has now left the Trust. 2 consultants are providing support and a full time position is being advertised. In terms of this specific risk, this risk should be closed. However in terms of CTAK there remains (and always will) a risk regarding it's proprietary nature. Head of Software Development & Support will raise a separate risk in relation to this issue and will be the nominated senior responsible manager. He will provide you with a separate update for this. Proposal for deletion and new risk to go to RCAG on 28/02/2007.
178	Risk that business critical data (with the exception of cental systems i.e. CTAK, finance etc.) could be lost.	**IMT**	**30-Mar-2005**	**9**	**2**	**SIG**	**LOW**	**AO**	Information will no longer be kept on hardrives it will be migrated across to network drives and will be backed up daily. The aim is to complete this work during 2007.
244	Lack of protected time for staff professional and career development	**HS**	**25-Jul-2006**	**20**	**20**	**HIGH**	**HIGH**	**CH**	Awaiting update.
262	Lack of training for Investigation Officer's.	**HS**	**26-Jul-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.M.M**	Awaiting update.

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173	Risks to staff, patients and organisation of staff working excessive overtime/ hours	**HS**	**05-Jan-2005**	**16**	**16**	**HIGH**	**HIGH**	**RA**	A&E Resources Group has responsibility for monitoring hours worked. A quarterly review would be undertaken and progress monitored. A proposal was put to the RCAG that the risk be downgraded to SIGNIFICANT LEVEL = 9 or MODERATE LEVEL= 6. The RCAG decided on the 7/11/06 that this risk should remain the same. To be reviewed in February'07 when evidence from PROMIS should support regrading.
7	Failure to reduce reported incident risks through incident information not being shared with all relevant depts & committees	**HS**	**13-Nov-2002**	**20**	**9**	**HIGH**	**SIG**	**JS**	Awaiting update.
243	AFC - difficulty in recruiting staff levels to organisation	**HS**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**CH**	Awaiting update.
240	Lack of quality of training which could result in new recruits not meeting the req. standard.	**HS**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**CH**	Awaiting update.
174	Staff expectations not met due to inability to sustain implementation of PDR service-wide.	**HS**	**05-Jan-2005**	**16**	**9**	**HIGH**	**SIG**	**S.S**	Awaiting update.
8	Risk of injury to operational staff and/or patient through issues relating to manual handling.	**HS**	**13-Nov-2002**	**20**	**9**	**HIGH**	**SIG**	**CH**	Meeting has taken place to explore effective ways of developing , deliver train the trainer/assessor course and also to plug the immediate shortfall in having competent persons to deliver patient handling training. The LAS Ergonomics Advisor offered to develop and deliver training to A&C staff, fleet, estates, IM&T and other office staff based on risk assessment.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
10	Risk of LAS staff being physically assaulted	**HS**	**13-Nov-2002**	**20**	**6**	**HIGH**	**MOD**	**RA**	MOU between the NHS and the Police signed off in September 2006 to increase prosecutions resulting from assaults on NHS staff. Review of the High Risk Address Register to commence on the 23rd November 2006. Proposal was put to the RCAG that the risk be downgraded from a SIGNIFICANT LEVEL = to a MODERATE LEVEL = 6. RCAG agreed on the regrading on the 7/11/2006.
252	Clinical Assessment and support when returning to work after extending periods away.	**HS**	**25-Jul-2006**	**6**	**6**	**MOD**	**MOD**	**CH**	Return to work interview. Whilst staff are away from work they are offered and sent information to keep them up-to-date.
226	Lone worker Policy not fully implemented	**HS**	**12-Jul-2006**	**15**	**6**	**HIGH**	**MOD**	**J.S**	Recommend that this risk be removed, as covered in risk 232. Received positive feedback from Bentley Jennison's audit on Lone Worker Policy. Their recommendation is to review the High Risk Address Register, which will commence on the 23rd November 2006. RCAG decided on the 7/11/2006 that this be regraded from 15/high to 6/moderate, as it was accepted that the Internal Audit review of lone working had not proposed any significant recommendations and there has been training delivered on lone working.
164	Policies and Procedures not adhered to due to lack of staff awareness and robust implementation plans	**FINAN**	**04-Jan-2005**	**12**	**5**	**SIG**	**MOD**	**SRM**	Policies and Procedures Working Group developing an Implementation Working Plan template.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
182	Not being able to escape from an LAS building in the case of fire or other emergencies.	**HS**	**09-Feb-2004**	**9**	**4**	**SIG**	**MOD**	**J.S**	Fire evacuation drills undertaken twice yearly. Fire alarm testing undertaken weekly. Proposal was put to the RCAG that the risk be downgraded to a LOW LEVEL = 2. RCAG decided on 7/11/2006 that the risk should remain as 4/moderate and be reviewed again in February' 07 at RCAG.
181	Risk of injury to staff from slips, trips and falls on LAS premises. H&S Inspections & Incident Reports not implemented.	**HS**	**09-Feb-2003**	**9**	**4**	**SIG**	**MOD**	**J.S**	Premises inspections of all LAS properties undertaken on 3 monthly basis. 2 day Health & Safety Awareness course module covers premises inspections. Premises inspections of all LAS properties undertaken on 3 monthly basis. 2 day Health & Safety Awareness course module covers premises inspections. Proposal was put to the RCAG on 28/02/2007 that the risk be downgraded from a MODERATE LEVEL = 6 to a MODERATE LEVEL = 4. RCAG agreed on the 7/11/2006 to downgrade to MODERATE LEVEL = 4
27	Risk of cross infection due to inability to replace supplies on a 24 hr. basis.	**HS**	**14-Nov-2002**	**16**	**3**	**HIGH**	**LOW**	**J.S**	Stores moved to Deptford, and second store manager employed. Make Ready is now live on all 25 complexes.
210	Staff drinking, eating, smoking and using mobile phones whilst driving	**HS**	**04-May-2006**	**9**	**2**	**SIG**	**LOW**	**J.S**	All Operational staff undergo comprehensive driver training. All Operational staff comply with Road Traffic Act/Highway Code. Team leaders monitor crew staff implementation of policy and procedures.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
208	Risk of staff not knowing their accountabilities for internal control and principles of Code of Conduct	**HS**	**11-Apr-2006**	**3**	**2**	**LOW**	**LOW**	**C.MC'M**	Standing Orders revised and Code of Conduct included in induction for Non-Executive and Executive Directors.
205	Not being able to identify staff training due to incomplete training records.	**HS**	**01-Jun-2005**	**16**	**2**	**HIGH**	**LOW**	**KM**	Complex Team Leaders report to Training and Education on a weekly basis of staff that have been trained. Data is entered in PROMIS Live, which links into PROMIS database.
200	Fires may become uncontainable due to the inability to extinguish	**HS**	**01-Jan-2002**	**15**	**2**	**HIGH**	**LOW**	**J.S**	To remain as low risk. Awaiting update.
199	Risk to staff safety / vandalism/theft due to inability to adequately secure premises	**HS**	**01-Jan-2003**	**9**	**2**	**SIG**	**LOW**	**M.N.**	Quarterly Health and Safety Premises inspections. Bulletin reminding staff to secure premises when leaving unattended. Periodic change simplex lock combination. To remain as a low risk.
198	Risk of injury/electric shock arising from inadequate lighting, loose wiring and faulty plugs.	**HS**	**01-Jan-2003**	**20**	**2**	**HIGH**	**LOW**	**M.N.**	Quarterly visual inspection by Estates Department Surveyors. 5 yearly IEE/Electricity at Work Act Statutory Inspection. HSE Inspection following electric shock incident. To remain as a low risk.
197	Risk of injury due to workshop equipment	**HS**	**13-Feb-2006**	**16**	**2**	**HIGH**	**LOW**	**C.J**	Specific H&S awareness training for Workshop staff. To remain as a low risk.
196	LAS staff are subject to verbal assault	**HS**	**01-Jan-2002**	**12**	**2**	**SIG**	**LOW**	**RA**	High Risk Address Register is to be reviewed in November 2006. Post Violence Support procedure recently updated.
83	Not having suitable facilities to service PTS contracts for vehicles and staff.	**FINAN**	**17-Mar-2003**	**12**	**12**	**SIG**	**SIG**	**MD**	PTS management currently reviewing practical alternatives using external facilities.
256	Failure to jointly agree rest breaks for all crew staff.	**FINAN**	**25-Jul-2006**	**12**	**12**	**SIG**	**SIG**	**M D**	Agreed rest break agreement
253	Full CBRN income not received.	**FINAN**	**25-Jul-2006**	**12**	**12**	**SIG**	**SIG**	**V.C**	CBRN funding awaited. Invoice sent.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
255	Non compliance with EU Procurement legislation	FINAN	25-Jul-2006	9	9	SIG	SIG	P.CAND	Review of Top 200 suppliers underway
158	Until tenders for each project are received, there is the possibility that costs will increase.	FINAN	01-Jun-2004	9	9	SIG	SIG	P.CAND	Proposal to go to RCAG for deletion on 28/02/2007
157	The demanding income levels within the central services budget may not be achieved	FINAN	27-May-2004	9	9	SIG	SIG	N.D	Integration with Urgent Care underway. Budget levels will be adjsuted accordingly.
153	Fuel prices in excess of sums held in budgets.	FINAN	06-Jan-2004	16	9	HIGH	SIG	M.S	For 2006/7, holding reserve that cover expenditure up to £1 per litre.
152	Any new or unforseen cost pressures	FINAN	06-Jan-2004	9	9	SIG	SIG	M.S	Prompt monthly reports at Management Level (Budget Holders).
150	Savings to be achieved to both balance the budget and fund SIP initiatives.	FINAN	19-Dec-2003	9	9	SIG	SIG	M.S	Achieved savings in both balancing budget and funding SIP initiatives. Continuing exercise to achieve same in 2006/07
148	Employers' Superannuation Contributions is not sufficient to cover the additional costs the Trust will incur.	FINAN	19-Dec-2003	16	9	HIGH	SIG	M.S	Received sufficient funding.
147	Funding for the increase for Agenda for Change	FINAN	19-Dec-2003	9	9	SIG	SIG	M.S	Received enough funding for 2006/7.
145	Recurrent effect of CBRN funding needs to be secured as this has been used to fund recurrent staffing.	FINAN	19-Dec-2003	9	6	SIG	MOD	M.S	Finance Director emailed the SHA on the 26/09/2006, requesting release of funds. Awaiting final confirmation of funding (11/1/07)
213	Loss of computer data / information caused by unannounced or pre-warned electrical power cut	FINAN	16-May-2006	3	3	LOW	LOW	SMG	U.P.S systems in place.
212	Power-brake switches activated in Resource Centre, affecting adjacent workstns in MI, during testing of emerg. power generator.	FINAN	16-May-2006	3	3	LOW	LOW	M.N.	CTS Engineer / Electrician on call to reset switches.
191	Not having data sharing protocols enabling patient identifiable information (without permission from the patient)	FINAN	01-Jan-2003	12	3	SIG	LOW	SRM	Head of Records Managent is negotiating with other NHS bodies to set up a possible PAN London Information Sharing Agreement for NHS Trust's.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
247	Risk of not delivering benefits of the programme through non-delivery of project outcomes.	**CORP**	**25-Jul-2006**	**9**	**9**	**SIG**	**SIG**	**M.B**	Senior Managers are being trained through MSP and practice courses. Launch workshops held for all major programme strands. Only the Operational Model programme is live during 2006/07 and programme and project management methodologies are being used to deliver project outputs and realise programme benefits.
269	At shift changeover times, LAS performance falls as we take longer to reach patients.	**CLIN**	**08-Dec-2006**	**20**	**20**	**HIGH**	**HIGH**	**R.S**	Shift changeover times under review.
71	Risk of not learning and changing practice, as appropriate, as a result of complaints	**CLIN**	**17-Jul-2002**	**16**	**20**	**HIGH**	**HIGH**	**R.M.M**	Significant review of complaints handling been undertaken by service. Complaints now dealt with at local level. New complaints procdeure being produced. Monitoring to be undertaken by RCAG and Complaints Panel.
267	Delay in activating vehicles due to the unavailability of vehicles	**CLIN**	**12-Oct-2006**	**16**	**16**	**HIGH**	**HIGH**	**R.S**	There have been a number of PALS enquiries, 13 complaints received and 3 notifications regarding inquests. It was proposed that this risk be re-graded from a High/16 to High/20 to reflect the increased risk to the Trust. RCAG decided on the 7/11/06 that risk grading should remain the same. To be reviewed at the next RCAG when there is more data regarding complaints received by the Trust (28.02.07).

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
138	Failing to appreciate the significance and urgency of psychiatric illnesses.	**CLIN**	**12-Nov-2003**	**12**	**16**	**SIG**	**HIGH**	**KM**	Mental Health strategy key points received by the Trust Board for further decisions still to be made regarding training for all frontline staff. Significant training on mental health issues on 5 day CPD Course (roll out ongoing from April 05 to 2yrs) Highlighted at Chief Executive Consultation Meetings.
34	Risk of technicians failing to meet the IHCD requirements	**CLIN**	**14-Nov-2002**	**16**	**16**	**HIGH**	**HIGH**	**KM**	In addition, a 5-day course will be delivered to operational staff over the next two years, covering clinical refresher and many areas of best practice. A one day module entitled "Promoting Best Practice in the Workplace" forms a key part of this CPD course. Training Officers have received bespoke training to enable them to effectively deliver and role model in this respect.
31	Adverse outcome in maternity cases	**CLIN**	**14-Nov-2002**	**20**	**16**	**HIGH**	**HIGH**	**KM**	Appointed midwife leftt; a replacement is being sought. In the meantime the Trust has access to a number of midwives for advice re. problematic maternity cases.
207	Risk of not being able to download information from Defribillators	**CLIN**	**04-Apr-2006**	**15**	**15**	**HIGH**	**HIGH**	**R.S**	To trial the downloading information from data cards. Trial will begin in January which will then go service-wide, IT support permitting.
22	Failure to u/take comprehensive clinical assessments which may result in the inappropriate non-conveyance or t/ment of patients	**CLIN**	**14-Nov-2002**	**20**	**15**	**HIGH**	**HIGH**	**KM**	The EMT4 Course which is scheduled to be delivered over a two year programme will go some way to reduce this risk, currently in the region of approximately 400 people have successfully completed the course.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
20	Failure to fully complete the Patient Report Form.	**CLIN**	**14-Nov-2002**	**20**	**15**	**HIGH**	**HIGH**	**R.S**	Proposed that this be regraded to 15 as failure to complete PRF was moderate/certain rather than none/rare. It was suggested that the forms need to be re-designed to include CAD number and date, a full trial needs to be undertaken. If successful, approval should be sought from the CGC.(May'06) PRFs are still not fully completed. Ethnic box on the form has not been filled in for 94.5% of the PRF documentation audited
211	Drug errors and adverse events not being reported.	**CLIN**	**08-May-2006**	**16**	**9**	**HIGH**	**SIG**	**R.S**	Produce article for the Patient Care News on any reported drug administration errors.
194	Risk of patients and to viability of research projects with financial ethical and reputational impacts.	**CLIN**	**01-Sep-2004**	**9**	**9**	**SIG**	**SIG**	**R.D**	Include the principles, importance and processes for Research in all LAS training courses (incl. Corporate Induction and the current CPD course), to be discussed at the Clinical Education Development Group.
188	Paramedics failing to qualify for registration.	**CLIN**	**01-Jan-2002**	**20**	**9**	**HIGH**	**SIG**	**R.S**	Ensure all staff attend recertification courses. Attendance to be monitored through regular audits.
179	Failure to meet responsibilities under the Race Relations Act	**CLIN**	**09-Feb-2006**	**9**	**9**	**SIG**	**SIG**	**P.C**	A report, together with a revised Racial Equality Scheme, and workforce data will be added to the LAS website so that it can be accessed by the public. Versions will be available in other languages and formats on request. To implement Diversity Training for all staff.Race Equality and Diversity Implementation Plan (READIP) have been incorporated into the Trust's Service Plan and the Service Improvement Plan.

London Ambulance Service NHS Trust
Risk Register

First Level Progress Report:
As at 22nd January 2007

ID	Risk	Risk Type	Date Opened	Rating (initial)	Rating (current)	Risk level (initial)	Risk level (current)	Senior Manager	Summary of Progress
165	Delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones	**CLIN**	**04-Jan-2005**	**12**	**9**	**SIG**	**SIG**	**KJ**	Older People Strategy currently being revisited and revised. Results of "Fit To Be Left" research project on older fallers to be presented to SMG shortly with recommendation for action.
133	Risk of potential legal action/negative publicity due to staff being unaware of how to report suspected abuse of children	**CLIN**	**18-Jul-2003**	**12**	**9**	**SIG**	**SIG**	**L.S**	Protection of Children and Vulnerable Adults Working Party - monitor compliance with LAS policies and procedures relating to this group. Internal audit recommendations being reviewed.
46	Risk of infection to staff due to needlestick injury	**CLIN**	**14-Nov-2002**	**3**	**9**	**LOW**	**SIG**	**R.S**	The new cannulas are now in use which should hopefully reduce the number of injuries.
63	The risk of incurring liability through the re-use of single use devices	**CLIN**	**14-Nov-2002**	**8**	**8**	**SIG**	**SIG**	**F M**	Poster distributed to all stations. Arising from recent Infection Control Group discussion.
202	Risk of Cross Infection from uniforms	**CLIN**	**01-Jan-2002**	**16**	**2**	**HIGH**	**LOW**	**C.V.**	New Uniform is industrial launderable, and trousers will be treated with an anit-bacterial treatment, which will greatly reduce the chance of cross infection.

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 2006 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 with 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 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 statements 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 misstatemetns 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 2006 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 Floor
Millbank Tower
Millbank
London
SW1P 4HQ

audit commission

Annual governance report

London Ambulance Service Charitable Fund

Audit 2005/06

External audit is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services.

Audit in the public sector is underpinned by three fundamental principles:

- auditors are appointed independently from the bodies being audited;
- the scope of auditors' work is extended to cover not only the audit of financial statements but also value for money and the conduct of public business; and
- auditors may report aspects of their work widely to the public and other key stakeholders.

The duties and powers of auditors appointed by the Audit Commission are set out in the Audit Commission Act 1998 and the Commission's statutory Code of Audit Practice. Under the Code of Audit Practice, appointed auditors are also required to comply with the current professional standards issued by the independent Auditing Practices Board.

Appointed auditors act quite separately from the Commission and in meeting their statutory responsibilities are required to exercise their professional judgement independently of both the Commission and the audited body.

Status of our reports to the Charity

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to Trustees or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any Trustee or officer in their individual capacity; or
- any third party.

Copies of this report

If you require further copies of this report, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0845 056 0566.

For further information on the work of the Commission please contact:
Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
Tel: 020 7828 1212 Fax: 020 7976 6187 Textphone (minicom): 020 7630 0421
www.audit-commission.gov.uk

Contents

Purpose of this report

1 We are required by the International Standards on Auditing (UK and Ireland) to issue a report to those charged with governance summarising the conclusions from our audit work. For the purposes of this report, the Trust Board (which serves as Trustees to the Charity) is considered to fulfil the role of those charged with governance and references to the Board should be read as such.

2 We are also required to report to the Board certain matters before we give our opinion on the financial statements. The section of this report covering the financial statements fulfils this requirement.

3 This is our annual governance report covering the audit of the Charity for the year ended 31 March 2006 and is presented by the District Auditor.

4 The principle purposes of the report are: to reach a mutual understanding of the scope of the audit and the respective responsibilities of the auditor and the Board; to share information to assist both the auditor and the Board to fulfil their respective responsibilities; and to provide the Board with recommendations for improvement arising from the audit process.

Scope of the report

5 In undertaking our audit, we comply with the statutory requirements of the Charities Act 1993, the Charity Commission SORP 2005; and the International Standards on Auditing (UK and Ireland). Auditors' responsibilities are to review and report on, to the extent required by the relevant legislation the Charity's financial statements.

6 Our risk assessment and planned response to the key audit risks was summarised in our audit plan. This annual governance report summarises the significant findings, conclusions and recommendations arising from our work.

7 We have issued separate reports during the year following completion of specific aspects of our programme, which are listed in Appendix 1. Appendix 2 provides information about the fee charged for our audit and in Appendix 3 we confirm that we have met professional requirements in respect of integrity, objectivity and independence.

Financial statements

8 We are required to give an opinion whether:

- the financial statements give a true and fair view, in accordance with the Charities Act 1993, of the state of affairs of the Charity as at 31 March 2006 and of its income and expenditure for the year then ended; and
- the Trustees' Annual Report is consistent with the financial statements.

Status of the audit

9 Our work on the financial statements is now complete.

Matters to be reported to the Board

10 We have the following matters to draw to the Audit Board's attention.

Expected modifications to the auditor's report

11 On the basis of our audit work, we currently propose to issue an unqualified audit opinion. A draft audit report is attached at Appendix 4.

Uncorrected misstatements

12 Management have adjusted all misstatements notified to them. There are therefore no unadjusted misstatements to report.

Adjusted misstatements

13 To assist you in fulfilling your governance responsibilities, we are required to consider reporting adjusted misstatements to you where these are material. There was one such amendment:

- £2,346 within debtors balance in respect of LAS Award Vouchers reclassified as stock.

Qualitative aspects of accounting practices and financial reporting

14 Our audit includes consideration of the qualitative aspects of the financial reporting process, including matters that have a significant impact on the relevance, reliability, comparability, comprehensibility and materiality of the information provided by the financial statements. We have no such matters to report to you.

Material weaknesses in internal control identified during the audit

15 Our audit identified no material weaknesses in systems of accounting and financial control.

16 We have not provided a comprehensive statement of all weaknesses which may exist in internal control or of all improvements which may be made, but have addressed only those matters which have come to our attention as a result of the audit procedures we have performed.

Matters specifically required by other auditing standards

17 Other auditing standards require us to communicate with you in other specific circumstances, including:

- where we suspect or detect fraud;
- where there is an inconsistency between the financial statements and other information in documents containing the financial statements; and,
- non-compliance with legislative or regulatory requirements and related authorities.

18 We have no issues to bring to your attention in relation to the above.

Any other matters of governance interest

19 Finally, we are required to report any other matters that we believe to be of governance interest. We report these matters in Table 3 below.

Table 1 Other matters of governance interest

Area	Auditor responsibility	Findings
Annual report	The auditor reviews the annual report for material consistency with the statutory financial statements.	We are satisfied that the annual report is consistent with the financial statements on which we have issued an unqualified opinion.

Letter of representation

20 We have obtained written representations from management as an acknowledgement of its responsibility for the fair presentation of the financial statements and as audit evidence on matters material to the financial statements.

Next steps

21 We are drawing these matters to the Audit Board's attention so that you can consider them before the financial statements are approved and certified.

Closing remarks

22 This report has been discussed and agreed with Michael Dinan (Director of Finance). A copy of the report will be presented at the Board on [date] 2006.

23 The Charity has taken a positive and constructive approach to our audit and I would like to take this opportunity to express my appreciation for the Charity's assistance and co-operation.

Susan M Exton
District Auditor

October 2006

Appendix 1 – Audit reports issued

Table 2

Planned output	Planned date of issue	Actual date of issue	Addressee
Audit plan	May 2005	June 2005	Trust Audit Board
Annual governance report	July 2006	21 September 2006	The Trustees
Opinion on financial statements	July 2006	21 September 2006	The Trustees

Appendix 2 – Fee information

Table 3

Fee estimate	Plan 2005/06	Actual 2005/06
Accounts	£3,000	£3,000

Appendix 3 –Integrity, objectivity and independence

24 We are required by ISA (UK and Ireland) 260 and the Auditing Practices Board Ethical Standard 1 to communicate following matters to the Audit Board:

- the principal threats, if any to objectivity and independence identified by the auditor, including consideration of all relationships between the Charity, directors and the auditor;
- any safeguards adopted and the reasons why they are considered to be effective;
- any independent partner review;
- the overall assessment of threats and safeguards; and
- information about the general policies and processes for maintaining objectivity and independence.

25 We are not aware of any relationships that may affect the independence and objectivity of the team, and which are required to be disclosed under auditing and ethical standards.

Appendix 4 – Independent auditor's report to the Trustees of London Ambulance Service Charitable Fund

Opinion on the financial statements

I have audited the financial statements of London Ambulance Service Charitable Funds for the year ended 31 March 2006 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 the trustees and auditors

As set out in the Statement of Trustee's Responsibilities, the Trustees are responsible for preparing the financial statements 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 judgments 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 2006 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.

Signed: Date:

Susan M Exton

Audit Commission

First Floor

Millbank Tower

Millbank

London

SW1P 4HQ

London Ambulance Service NHS Trust

Annual Audit Letter

Audit 2005-2006

November 2006

External audit is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services.

Audit in the public sector is underpinned by three fundamental principles:

- auditors are appointed independently from the bodies being audited;
- the scope of auditors' work is extended to cover not only the audit of financial statements but also value for money and the conduct of public business; and
- auditors may report aspects of their work widely to the public and other key stakeholders.

The duties and powers of auditors appointed by the Audit Commission are set out in the Audit Commission Act 1998 and the Commission's statutory Code of Audit Practice. Under the Code of Audit Practice, appointed auditors are also required to comply with the current professional standards issued by the independent Auditing Practices Board.

Appointed auditors act quite separately from the Commission and in meeting their statutory responsibilities are required to exercise their professional judgement independently of both the Commission and the audited body.

Status of our reports to the Trust

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director or officer in their individual capacity; or
- any third party.

Copies of this letter

If you require further copies of this letter, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0845 056 0566.

For further information on the work of the Commission please contact:
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www.audit-commission.gov.uk

Contents

Purpose, responsibilities and scope

The purpose of this letter

1 The purpose of this Annual Audit Letter (letter) is to summarise the key issues arising from the work that we have carried out during the year. Although this letter is addressed to the directors of the Trust, it is also intended to communicate the significant issues we have identified, in an accessible style, to key external stakeholders, including members of the public. The letter will be published on the Audit Commission website at www.audit-commission.gov.uk and also on the Trust website.

2 This letter has been prepared in the context of the Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission. This is available from www.audit-commission.gov.uk.

The responsibilities of the auditor and the Trust

3 We have been appointed as the Trust's independent external auditors by the Audit Commission, the body responsible for appointing auditors to local public sector bodies in England, including NHS trusts.

4 As the Trust's external auditors, we have a broad remit covering financial and governance matters. We target our work on areas which involve significant amounts of public money and on the basis of our assessment of the key risks to the Trust achieving its objectives. It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

The scope of our work

5 We plan and carry out an audit that meets the requirements of the Audit Commission's Code of Audit Practice (the Code). Under the Code, we are required to review and report on:

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

6 In addition to this, we use our assessments to provide scored judgements for the Healthcare Commission to use as part of its Annual Healthcheck.

7 This letter summarises the significant issues arising from both these areas of work and highlights the key recommendations that we consider should be addressed by the Trust. A list of all reports issued to the Trust in relation to the 2005/06 audit is provided in the closing remarks section at the end of this letter.

Key messages

8 The following matters should be considered by the Trust Board.

Table 1 Key conclusions and required actions

Area	Issue/conclusion	Recommended action
Accounting issues	There were no material matters to draw to the attention of the Audit Committee before giving the audit opinion. The Trust's draft annual report was not available for review at the time of our accounts audit.	The Trust should aim to prepare its annual report prior to the deadline for the audit opinion on the accounts, to enable it to be covered by the opinion.
Financial standing	The Trust achieved a surplus of £1.3m, continuing its record of sound financial management. All financial targets were met except the Capital Cost Absorption Rate, which was above the target range.	Ensure that the Capital Cost Absorption Rate is within the target range of 3-4 per cent.
Value for money	We concluded that the Trust had proper arrangements in place to secure value for money in the use of resources.	None required.
Auditor's local evaluation	The Trust achieved a score of 3 (above minimum requirements) in 4 of the 5 areas.	The Board should monitor progress and outcomes against the various plans in place to further improve the Trust's performance under the Auditor's Local Evaluation.

The audit of the accounts

9 We were able to issue an unqualified opinion on the Trust's accounts on 6 July 2006, in advance of the deadline set by the Department of Health. In our opinion, the accounts give a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust during the year.

10 Before we give our opinion on the accounts, we are required to report to those charged with governance, in this case the Trust's audit committee, significant matters arising from the audit. A detailed report was issued on 28 June 2006 and only the key issues are summarised here.

Accounting issues

11 The accounts were produced on time and complete and the Trust responded well to our requests for further information during the audit. There were no material matters to draw to the attention of the Audit Committee before giving the audit opinion. However, the Trust's draft annual report was not available for review at the time of our accounts audit, so we were unable to cover the annual report in our audit opinion.

Recommendation
R1 The Trust should aim to prepare its annual report prior to the deadline for the audit opinion on the accounts, to enable it to be covered by the opinion.

Financial standing

12 Table 2 shows the Trust's performance against its key financial targets for 2005/06.

Table 2 Financial performance

Target	Achieved?	Performance
Statutory breakeven duty	✓	The Trust's in-year surplus was £1.26 million and its cumulative surplus was £1.33m.
Capital Resource Limit	✓	The Trust undershot its limit of £6.69m by £1.25m.
External Financing Limit	✓	The Trust met its limit of £9.64m.
Capital Cost Absorption Rate	✗	The Trust's rate of 4.1 per cent was outside the target range of 3 to 4 per cent.

13 The Trust made a surplus in 2005/06 of £1.26m. Within this overall position, expenditure on the Accident and Emergency (A&E) service was overspent against budget by £2.54m, reflecting the additional burden of dealing with the terrorist incidents of 7 July 2005. The Trust obtained extra funding from the Department of Health for this, resulting in a surplus for A&E of £1.18m. The Patient Transport Service made a deficit of £0.16 million.

14 For 2006/07, the Trust is forecasting a surplus of £1.3m. The Trust has achieved in-year surpluses since 2000/01, providing a sound financial platform which has underpinned a period of successful service improvement. However, the pressures within the London health economy as a whole may impact upon the Trust's ability to benefit from any surplus for 2006/07 - NHS London's economy-wide financial plan requires the Trust to contribute its surplus into a 'pool' to offset deficits expected to be made by other NH organisations in London.

The Trust's use of resources

15 We are required to issue a conclusion on whether we are satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the value for money conclusion.

16 We are also required to assess how well NHS organisations manage and use their financial resources by providing scored judgements on the Trust's arrangements in five specific areas. This is known as the Auditor's Local Evaluation.

Value for money conclusion

17 We concluded that the Trust had proper arrangements in place to secure value for money in the use of resources.

Auditor's Local Evaluation

18 We assessed the PCT/Trust's arrangements in five areas. Each area was scored from 1 to 4 (1 = below minimum requirements - inadequate performance, 2 = only at minimum requirements - adequate performance, 3 = consistently above minimum requirements - performing well and 4 = well above minimum requirements - performing strongly). The individual scores as shown in Table 3 resulted in an overall rating of 'Good' for the Trust's use of resources within the Healthcare Commission's Annual Health Check.

Table 3 ALE scores

Area	Score	Recommended action
Financial reporting	3	Covered under 'Accounting issues' above.
Financial management	3	Formalise the Trust's medium term financial strategy and perform benchmarking exercises on the use of the Trust's assets.
Financial standing	3	Ensure that the Capital Cost Absorption Rate is within the target range of 3-4 per cent.
Internal control	2	Review standing orders, standing financial instructions and the scheme of delegation at least annually. Formal agreements need to cover all the Trust's significant partnership arrangements. Provide regular ethical conduct training for both board members and employees.
Value for money	3	Provide further evidence of progress in the Trusts' drive for improvement.

19 The Trust has performed well, with just one area - internal control - being only at minimum requirements rather than above them. A detailed report supporting our assessment and highlighting areas for improvement was issued to the Trust on 14 September 2006.

Recommendation
R2 The Board should monitor progress and outcomes against the various plans in place to further improve the Trust's performance under the Auditor's Local Evaluation.

Specific risk-based work

20 Our audit plan also included specific pieces of work as follows.

- Managing Resources for Improvement.
- Computer Aided Despatch (CAD) system implementation review.

Managing Resources for Improvement

21 Our review assessed the contribution the Trust is making to strategic service improvement within the wider context of its key role in delivering urgent care services. The Trust has made significant progress in recent years in improving its services, although the Healthcare Commission's Annual Health Check rating of the Trust's quality of care as 'Weak' - due to not meeting national targets for Category B calls and provision of thrombolysis - indicates a need for continuing advances.

22 The audit assesses arrangements that support improvement against five key improvement themes:

- strategic fit;
- service redesign and modernisation;
- financial management;
- realising patient benefits; and
- value for money.

23 Our review found that the Trust faces a number of challenges in securing strategic service improvement, in particular:

- urgent Care Networks in London have had limited impact to date, making service redesign across the whole health economy problematic; and
- whilst the Trust's financial management is good, a clear basis is needed on which to share benefits and risks with other trusts and PCTs in the service redesign process.

24 Our review found evidence of progress by the Trust.

- The Trust's strategy from 2000 to 2005, as realised through the Service Improvement Programme, was effective at securing improvement and the Trust has built on this to develop a new strategy aimed at delivering transformational change, closely aligned with national priorities.
- The Trust has already made progress in modernising its services through initiatives such as fast response units and emergency care practitioners.
- The Trust is making good progress in developing performance measures, and should aim to maximise the benefits from using more comparative data now that other ambulance trusts in England are organised on a regional basis.

25 However, improvements are needed in realising patient benefits, and the Trust's efforts to improve the patient experience would benefit from more input from public health experts.

CAD implementation review

26 This review has been postponed at the request of Trust management pending full implementation of the new system.

Closing remarks

27 This letter has been discussed and agreed with the Chief Executive and Director of Finance. A copy of the letter will be presented at the Audit Committee on 4 December 2006 and copies will be provided to all Board members.

28 Further detailed findings, conclusions and recommendations on the areas covered by our audit are included in the reports issued to the Trust during the year. These are listed in the following table.

Table 4 Reports issued in relation to the 2005/06 audit

Planned output	Actual date of issue
Audit Plan	March 2005
Annual Governance Report	June 2006
Opinion on Financial Statements	July 2006
Value for Money Conclusion	July 2006
Final Accounts Memorandum	August 2006
Auditors' Local Evaluation	September 2006
Annual Audit Letter	November 2006

29 This has been a challenging year for the Trust. Management and staff have taken a positive and constructive approach to our audit and I would like to take this opportunity to express my appreciation for the Trust's assistance and co-operation.

Susan M Exton

Engagement Lead

November 2006