LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 27th March 2007 at 10am

First Floor 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 30th January 2007 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 11 2006/07 Financial Report.	Enclosure 4
8.	Report of the Medical Director	Enclosure 5
9.	Approve 2007-10 Budget	Enclosure 6
10	Approve Long Term Workforce Plan	Enclosure 7
11.	Approve Assurance Framework	Enclosure 8
12.	Approve Revised Standing Orders	Enclosure 9
13.	Approve Gender Equality Scheme	Enclosure 10
14.	Note the Emergency Planning SLA; approval of which will be sought in Part II.	Enclosure 11
15.	Note the Introduction of Individual Performance Monitoring and Reviews	Enclosure 12
16.	Receive Annual Report re. Infection Control.	Enclosure 13
17.	Draft Minutes of Clinical Governance Committee – 12th February 2007	Enclosure 14
18.	Draft Minutes of Service Development Committee – 27th February 2007	Enclosure 15
19.	Draft Minutes of Audit Committee – 12th March 2007	Enclosure 16
20.	Report from Trust Secretary on tenders opened since last Board meeting	Enclosure 17
21.	Any Other Business.	
22.	Opportunity for Members of the Public to ask Questions.	
23.	Date and Venue of the Next Trust Board Meeting. 22nd May 2007, 10.00am at 220 Waterloo Road, London SE1	

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 30th January 2007

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
	Ingrid Prescod	Non Executive Director
	Roy Griffins	Non Executive Director
	Sarah Waller	Non Executive Director (from 10.25)
	Beryl Magrath	Non Executive Director
	Caroline Silver	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
Apologies		
	Martin Flaherty	Director of Operations
In Attendance:		
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development
	Angie Patton	Head of Communications (deputising for David Jervis, Director of Communications)
	Ian Todd	Assistant Director of Operations, Urgent Care and Clinical Development (deputising for Martin Flaherty, Director of Operations)
	Martin Brand	Head of Planning & Programme Management
	Malcolm Alexander	LAS Patients' Forum Representative (from 10.20 until 11.35)
	John Wilkins	Head of Governance (from 11.35)
	Ralph Morris	Head of Complaints (from 11.35 to 12.40)
	Martin Nelhams	Head of Estates (from 12.30 to 12.40)
	Christine McMahon	Trust Secretary (Minutes)

01/07 Declarations of Further Interest

There were no declarations of further interest.

02/07 Opportunity for Members of the Public to ask Questions

There were no questions.

03/07 **Minutes of the Meeting held on 28th November 2006**

Agreed: **The minutes of the meeting held on 28th November 2006 as a correct record of that meeting with the correction (minute 101/6) that a report regarding the Trust's car leasing scheme will be presented to the Remuneration Committee in March 2007.**

04/07 **Synopsis of the Trust Board's Part II minutes held on 28th November 2006**

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

05/07 **Matters Arising from the minutes of the meeting held on 28th November 2006**

Noted:

1. **That at a recent Patients' Forum meeting attended by Beryl Magrath a representative of King's College Hospital stated that the hospital operated the only 24/7 stroke unit in London. St Thomas' also claim to offer 24/7 care. The Medical Director said that St Thomas' Head of Acute Stroke Care has agreed that the Stroke Unit will take patients if they can arrive within two and a half hours of the onset of symptoms. The Medical Director said that the information is being disseminated to staff.**
2. **Minute 101/06: the Service Level Agreement with NHS London regarding the LAS taking responsibility for emergency planning in London has not been finalised. It will be presented to the Trust Board in draft when the details of the Agreement have been finalised. ACTION: Chief Executive**
3. **Minute 102/06: the Rest Break Policy had been posted on the Pulse. The HR Director circulated a copy of the Policy to the Board for information.**
4. **Minute 116/06: the Finance Director said that mobile phones were being reviewed as part of the 2007/08 business planning.**

06/07 **Chairman's remarks**

The Chairman said that 26 of the 31 London Primary Care Trusts' Chairmen have been reappointed following the Fit for Purpose review undertaken by the Department of Health.

NHS London is forecasting a London wide deficit of £120 million. The Chairman said it is likely that London Trusts' income will be top sliced by 3.5% in 2007/08; which may benefit the LAS if this funding is subsequently used to fund strategic initiatives for London, such as integrated emergency care hubs.

A number of London Trusts' Chief Executive Officers have recently resigned due primarily to individual trust's financial deficit. The Chairman said that there is

clearly a strong link between delivering on performance and financial balance, and remaining independent from external pressures.

Following Lord Warner's resignation, it has been decided to split his ministerial portfolio in three. Andy Burham has been appointed Minister responsible for Urgent and Emergency Care; Rosie Winterton has been given responsibility for Emergency Planning and Lord (Philip) Hunt of Kings Heath has been given responsibility for Health in London.

Negotiations are continuing regarding the merger of the Ambulance Service Association and the NHS Confederation and should be concluded by the summer of 2007. Following the resignation of the ASA's Chief Executive Officer to become the Chief Executive of the Confederation of Master Builders, Hayden Newton has been appointed as the Acting Chief Executive Officer. The Chairman said that following the merger the NHS Confederation will probably establish an Ambulance Services Network, similar to the Foundation Trust Network and the Primary Care Network.

The NHS Confederation is seeking to amend its Articles of Association to enable private sector organisations, if they are accredited to supply the NHS, to become full members of the Confederation

The Chairman reported that Transport for London is carrying out work in front of Headquarters to install traffic lights to enable buses to control traffic in order that they can turn in the road. The Chairman was concerned at the lack of consultation and a protest has been registered with Transport for London. It was feared that the introduction of traffic lights will impede access for ambulances.

Noted: The Chairman's remarks.

07/07 <u>The Chief Executive's report</u>

The Chief Executive reported that Category A8 minute performance year to date is 74.3%. The Category A8 performance in December was 70% and in January it was 72.2%. Performance has been effected by a rise in Category A8 demand following the National Heart Foundation's poster campaign (there had been a 2.5% increase in demand compared to January 2006) and the introduction of rest breaks from the 11th December 2006.

Rest Breaks: Approximately 75% of front line staff currently receive uninterrupted rest breaks. The modelling undertaken by ORH, regarding the impact on performance of introducing rest breaks, estimated that it would be 3-4% but the actual impact had been circa 5%. Measures were being taken to support staffing levels at 6-8am, 11-4pm and 6-8pm when performance falls due to rest breaks being allocated or staff finishing 30 minutes early if they have not been allocated a rest break. Managers were being deployed to cover these periods. The Service instigated REAP Level 3 as of 29th January 2007[1].

Category B 14 performance has fallen due to the increased pressure the Service has been under due to the increase in Category A8 demand.

The Chief Executive's report outlined a number of initiatives being introduced to manage the situation and ensure that the performance targets for Category A8 (75%) and Category B (80%) are achieved.

[1] Resourcing Escalation Action Plan (REAP) is used to identify the level of pressure the Service is under at any given time, and provides a range of tactical options to deal with the over capacity situation. The current status is REAP Level 3 – severe pressure.

CAD: The Chief Executive drew the Board's attention to the Information Management and Technology report which included a graph illustrating CAD's performance in January 2007.

Agenda for Change: there were approximately 70 AfC arrears outstanding and six appeals awaiting review. The information provided on the workforce will improve as Electronic Staff Records is bedded down.

Emergency Planning: the Hazardous Area Response Team (HART) is now established and operational. A Ministerial visit to examine the HART operation is expected in March 2007.

Personnel: The Chief Executive paid tribute to Trevor Vaughan, Awards Manager, who recently retired after 42 years of service. On a sad note he also paid tribute to John O'Grady, Senior Resource Manager, who died recently at the age of 51.

Healthcare Commission: the Chief Executive said that in addition to meeting performance targets, it is important that the Trust receive the best possible assessment from the Healthcare Commission with regard to use of resources and quality of service.

The Chief Executive said he will be briefing the Minster, Andrew Burnham, on 'Clock Start' in March 2007. A substantial funding gap of £100 million at national level has been identified which will hamper the introduction of clock start if not filled.

Barry MacDonald said that the introduction of rest breaks had been a fantastic achievement. In reply to a question about the relationship between the Control Room and front line staff, the Assistant Director of Operations (UCCD) said that there will always be tension between the two. The introduction of rest breaks had been challenging given the continuing challenge for the Control Room to allocate and hold calls. The Rest Break Policy is scheduled to be reviewed in February in order to address any issues that have arisen with its implementation.

Malcolm Alexander asked about the impact of the stories in the media of twelve people dying as a result of the introduction of rest breaks. The Chief Executive said that the figure of twelve is an estimate of the detrimental impact of introducing rest breaks nationally; the North East of England and rural areas have been adversely affected by the introduction of rest breaks. The Chief Executive said that the LAS investigates each allegation that is received concerning delays in responding to calls.

Barry MacDonald said the report that Clinical Telephone Advice had saved 2,000 ambulance journeys a month was very good news.

In reply to a question about Electronic Patient Records (ePRFs) the Director of Information Management and Technology (IM&T) said that a review had been undertaken in December to consider whether the LAS could be an early adopter for ePRF. The review concluded that it was not something the Trust wished to do now. The Trust will continue to work closely with BT and Connecting for Health with the intention that a pilot is undertaken later in 2007. By this time the ePRF software will have been upgraded and it will be able to deliver the expected benefits immediately. The Chairman said he had recently been talking to Fujitsu; and it was a matter of when ePRFs would be introduced, not if.

Beryl Magrath asked whether it was worth while for PTS to tender for patient transport contracts when it is known that the tendering Trusts were in deficit. The Director of Finance said that each tender was reviewed on its own merits as to whether it was viable for PTS to tender for the patient transport contract. He said Acute Trusts continue to have responsibility for providing patient transport,

regardless of their deficit. PTS is seeking to be more efficient and effective e.g. through the introduction of cluster planning.

Malcolm Alexander, Chairman of the Patients' Forum, said that the Forum was contacting Acute Hospitals when they were tendering patient transport contracts, reminding them that they are required to consult local partners regarding quality of the service. The Forum had drawn up ten quality standards that it shares with the Acute Trusts. He undertook to keep the Board informed of progress.

In reply to a question from Sarah Waller, the HR Director said that it was only Ambulance Trust staff who have been affected by the AfC unsocial hours' payment. Staff working in Acute Hospitals have continued on their pre Agenda for Change unsocial hours' arrangements. A national review of unsocial hours' payment is taking place and its findings are expected in October 2007.

Sarah Waller asked about the pilots being undertaken with regard to individual performance reviews; while there may be potential for confusion due to terminology, the HR Director said that there is a clear distinction made between individual performance monitoring and the Personal Development Reviews. A presentation regarding individual performance monitoring and reviews will be given to the Board in March 2007. **ACTION: Director of Operations.**

Agreed: **1. To grant permission for overseas travel by three senior managers to Egypt to assist with the development of pre-hospital care in Cairo.**

Noted **2. That the Trust is committed to breaking even and to achieving 75% for Category A8 minute.**

3. That the Director of Communications had prepared a pack related to the media coverage received by the Trust during the Christmas period.

08/07 **<u>Month 9 2006/07 Financial Report</u>**

The Finance Director presented Month 9 Finance Report and highlighted the following:

Month 9 had an actual surplus of £337,000. A surplus of £436,000 had been forecast; the difference was due to the late introduction of rest breaks and an increase in overtime in December 2006.

An overspend of £3000k was forecast for year end. The actual expenditure for the month was £17.5m as opposed to the forecast £17.4m; this was due to increase in pay from the forecasted £12.7m to an actual of £12.8m.

- The accrual for AfC required a £400,000 adjustment.
- There was an increase in overtime to offset vacancies in A&E.
- PTS had an increased, non-recurrent, expenditure of £60,000 due to AfC arrears.
- There had been a delay in implementing rest breaks as they had not been introduced until 11th December. Overtime and rest breaks were being closely tracked so as to understand the financial implications for the Trust.
- The use of Third Party transport had decreased and was being stringently managed by EOC, UOC and PTS.

The Trust paid a large amount of AfC arrears in December and January; a substantial amount of arrears was paid due to a successful appeal which resulted in one group of staff moving from the top of Band 4 to the top of Band 5.

Work is being undertaken to ensure that the Trust breaks even; any surplus funding will be used to pay for overtime to support A&E.

The Finance Director said that there was daily control on non-pay expenditure which the Finance Team sign off. He undertook a review of the outstanding AfC appeals and was reasonably confident that the accrual that was in place is sufficient.

In reply to a question from Sarah Waller regarding overtime the Finance Director said that he and the Director of Operations meet on a twice monthly basis to consider the resources available to pay for overtime. He said that overtime needed to be seen in the context of A&E being at full establishment.

CBRN: the Finance Director had been informed that the CBRN funding is being held by NHS London and he expects the money to be passed to the LAS in early February. Discussions are being held as to whether the LAS will receive the full £8m or £7.3m. He said that he will endeavour to ensure that the recurrent CBRN funding is received in a timely fashion in 2007/08.

The Chairman said that he was content that management has demonstrated its ability to control expenditure on overtime but was concerned on the impact on performance. He also expressed concern that centralising control (which was probably the only way to cut spending on overtime fast enough) will have an impact on Ambulance Operation Managers and their sense of ownership as it will take away some of the levers that give them freedom of action in their areas.

The Chief Executive said that Ambulance Operational Mangers are focussed on achieving the performance targets and breaking even. Although A&E is at full establishment, there are financial pressures this year coinciding with an increased Category A8 demand. The increase in Category A8 demand has been, in part, due to heightened awareness amongst the public following the recent Heart Foundation poster campaign. A number of Ambulance Trusts across the country have reported a rise in Category A8 demand.

Agreed:

1. **That the Trust should ensure that the Category A8 performance targets is achieved – even if it means going into deficit.**
2. **That in the event that the Trust does not break even in 2006/07 it would be in good measure due to the number of unforeseen financial impositions from the SHA during the year.**

Noted:

3. **That the Trust would receive a weak rating for the use of resources if it is overspent by a single £; unlike the Department of Health (which judges the duty to break even on the basis of a rolling three year average) the Healthcare Commission looks narrowly at each year in isolation.**

09/07 **Report of the Medical Director**

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

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 on the Utstein template had 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) had 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. Outcome data is still awaited from both the Myocardial Infarction National Audit programme (MINAP) and the National Infarct Angioplasty Project (NIAP) for this period. The full report will be presented to the Trust Board in March. **ACTION: Medical Director.**

Serious Untoward Incident: investigations into two clinical Serious Untoward Incidents have been completed. The first had been finalised, the details were contained in the Chief Executive's report and the report released to the Coroner. The second is in final draft. A further investigation was downgraded from being a SUI though an investigation into the circumstances of the incident is continuing.

Safety Alert: discussions are taking place with the publishers following the discovery that the pocket books relating to the 2006 National Clinical Guidance contain errors. The altered pages will be reprinted and reissued.

I*mprovements in Stroke care in London*: 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 went live on 29th January. The Unit had agreed to ring fence a bed and 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.

A very positive meeting was held 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.

Patient Report Form: to assist Emergency Medicine departments the form has been amended so that the pink copy is now white which will enable the information to be scanned.

Drugs: the Trust hopes to introduce oral solution of morphine later this year. It is also planned to introduce Drug stickers as used in hospitals to improve clinical safety by enabling crews to label syringes.

Audit: A study is being carried out to align red calls requiring an 8 minute response and the Department of Health category A calls, to which the Trust is required to respond within 8 minutes. The Board's attention was drawn to Appendix 1 which outlined the downgraded 5 determinants. The Medical Director approved the decision that 10 red determinants should remain unchanged. The evidence-based criteria used to determine regrading of red calls have been shared with ECPAG[2] to assist that body when it is considering regrading Category A calls.

Infection Control: the Department of Health's MRSA and Cleaner Hospital team was working closely with the Trust's Infection Control steering group who have used the

[2] ECPAG: Department of Health's national Emergency Call Prioritisation Advisory Group responsible for auditing determinants.

self-assessment tool 'implementing control of infection' which identified 55% compliance and highlighted 7 key challenges.

A business case is being written to support the employment of a full time Infection Control Co-ordinator in 2007/08.

Pandemic Flu: guidance had been written for ambulance staff but consultation on the document had been delayed until the Department of Health's exercise 'Winter Willow' had been completed. A triage tool had been developed by South Manchester AS to facilitate face to face triage in the event of Pandemic Flu.

Beryl Magrath said that the infection control workshop had highlighted key challenges for the Trust. In reply to a question regarding the Continuing Professional Development course it was confirmed that infection control was not part of the programme. The Medical Director said that there was constant dissemination to staff regarding infection control. The Make Ready scheme had proved very successful with regard to improving infection control.

Noted: The Medical Director's report.

10/07 <u>CAD 2010 Outline Business Plan</u>

The Director of Information Management & Technology (IM&T) reported that the CAD 2010 Outline Business Case had been completed on schedule, and was ready to go to the SHA for approval. Also during the past week the project had been subject to a Gateway, Gate 2 review, which supported the project moving forward to the next stage.

Due to the commercially sensitive nature of the Outline Business Plan, the actual document would be considered by Board in the confidential Part II meeting.

In reply to a question from Malcolm Alexander, the Director of IM&T confirmed that CAD 2010, as part of the Access Programme, will facilitate improved access to the Service for people with disabilities or people who do not speak English.

Noted: The report.

11/07 <u>Seven Year Strategic Plan</u>

The Director of Service Development presented the Seven Year Strategic Plan to the Board for approval. Earlier drafts of the Plan had been shared with the Board and with the Service Development Committee to ensure that Board Members were fully informed of the direction of travel and could comment on what was being proposed.

The Director of Service Development visited a number of Primary Care Trusts in London to meet with colleagues, explain the future plans of the LAS and receive their feedback on the Plan. As part of her presentation to the Primary Care Trust she had referred to what was achieved under the first Service Improvement Programme 2000-2006 which saw performance improvements and improvements in staff satisfaction. When undertaking these visits the Director of Service Development had usually been accompanied by the local Assistant Director of Operations and Ambulance Operation Managers who were able to talk about local operational issues.

The Chairman said that the purpose as outlined in 1.1 should be amended to read: "the purpose of the London Ambulance Service NHS Trust is to provide the highest standards of telephone-answering, triage, treatment and referral *or* transport to patients requiring our care". The Chief Executive suggested the Director of Communications should be asked his views prior to any changes to the statement. **ACTION: Director of Communications**

SIP 2012 will be overseen by individual Programme Boards which will report to the Strategic Steering Group which in turn will report to the Trust Board. The next step is to identify what resources will be available to fund the projects associated with the four Programmes. The projects will be prioritised and a judgement made about which ones are essential to undertake in 2007/08. It is likely that given its size and complexity the Olympics Project will become a Programme in its own right. External funding is being sought to fund the Olympic Programme.

In reply to a question from Malcolm Alexander the Director of Service Development confirmed that there would be continuous public and patient involvement during the duration of SIP 2012. It had been suggested that one way of promoting public involvement would be for the Trust's web site to contain a message board to allow interaction between members of the public and the Trust. Updates on the SIP's progress will be posted on the web site.

The Director of Service Development outlined the key positive and negative messages she received during the course of her meeting with representatives of the PCTs. The key positives included: some appetite for commissioning Urgent Care differently and a desire to work with other Urgent Care providers. One of the key negatives concerned the treatment of stroke patients. Some hospitals had expressed concern about stroke repatriation which is the expensive part of the treatment needed by stroke patients. Under the present tariff system it is the Trusts that undertake the initial intervention who receive funding. There needs to be an 'unbundling' of the acute and rehabilitation phases. The Chairman said that it was clear that discussions needed to be held at Chief Executive and Finance Director level as to how this can be addressed as it is a real concern for a number of hospitals. **ACTION: Director of Service Development**

Amongst the other key negative feedback from the Primary Care Trusts was the need to ensure there was a closer relationship between local LAS managers and the PCTs and concern was expressed about the utilisation levels of Emergency Care Practitioners.

One of the action points that arose from the meeting with Tower Hamlets PCT was the suggestion that a copy of the PRF be forwarded to a patient's GP. This is being considered. **ACTION: Director of Service Development?**

Beryl Magrath said that the presentation had been very helpful but suggested that it was important that the message was heard by the Boards of the various PCTs. She said that it was important that the LAS is seen as integral to any healthcare plan as 25-30% of people who become ill in London dial 999. She supported the objective of increasing the number of the Emergency Care Practitioners.

Barry MacDonald said that the Organisation Development section was a good addition to the Plan; he suggested that the options considered but discounted should be included as part of the introduction to the Plan. **ACTION: Director of Service Development.**

Barry MacDonald said he recognised that one purpose of the SIP 2012 is to provide the Trust with some 'headroom and slack' in order that it can respond to an ever increasing volume of work whilst working under financial constraint. Sarah Waller asked whether the planning assumption of an increased workforce of 400 with 2% annual growth in productivity was realistic and whether it should be greater than 2%. The HR Director said that the Plan was supported by the Strategic Workforce Plan which set out the direction of travel. Staff Side Representatives have been consulted about the Seven Year Strategic Plan. The assumptions in the Plan had been made on the basis of what is currently known about future demand, future resources and how

the Trust wishes to respond in future to its increasing workload. These assumptions will continue to be reviewed throughout the life of the Plan.

Sarah Waller asked whether another title for the Programme could be identified as there was a danger of the title being over-used given the SIP 2000-2006.

Roy Griffins said that the Plan was inspirational; he asked that the referral to Heathrow's Terminal 5 be amended to state that the expected increase in passengers had been capped at 480,000. **ACTION: Director of Service Development**

The Finance Director said that the 2% improvement in productivity was across the Trust and was based on incidents handled per person and substantial sustainable change.

Forecast revenue was expected to grow at 3.4% per annum in the planning period. This will be updated as the Government Comprehensive Spend review is published. Early indicators are that Health spending will grow at between 3-4%.

The Finance Director said that there is a national discussion taking place regarding Payment By Results which should ideally focus on outcomes rather than activity, and be in line with positive outcomes for patients and decreasing the NHS's overall costs. He said that the latest information regarding reference costs show that the LAS is close to other Ambulance Trusts allowing for the cost impact of road speed in London.

Barry MacDonald asked whether or not the 3.4% included inflation. The Director of Finance said that it did. Pay inflation of 2% was assumed in the analysis. The danger for the LAS is if inflation is more than 2%. Barry MacDonald said that the annualised rate of growth in the current Retail Price Index was 4-5% and it should not be forgotten that London is a high cost housing area. The Finance Director said that AfC has an allowance for London Weighting which is annually included in the inflation uplift.

The Chairman said that there is a growing recognition that the NHS in London is under-funded and is penalised by the current allocation formula. Both the Health Select Committee and the Conservative Party are sympathetic to this argument. The NHS Confederation is currently undertaking a review into the question. The Chairman said that the allocation formula is based on crude proxies rather than real health need.

Caroline Silver said that it was difficult to fully understand the figures without seeing further sensitivity analysis; she said it was very comprehensive piece of work. She said she would like to see which parts of the programme would fall off should funding be cut, which projects would be retained and which deferred. The Director of Finance offered to share with the Non-Executives the sensitivity analysis that has been undertaken. **ACTION: Finance Director.**

Agreed: 1. The Seven Year Strategic Plan

Noted: 2. The work undertaken by Martin Brand, Head of Planning and Programme Management, who has been leading the work on drafting the plan.

12/07 <u>Business Plan 2007/08</u>

The Finance Director presented the draft budget for 2007/08-2009/10. NHS London has requested all London Trusts provide three year financial plans. The stated intention is that there will be a lighter regulatory touch based on risk analysis. It is unfortunate that the deadline issued by NHS London for the submission of the draft budget had not coincided with the Board's scheduled meetings. NHS London's deadline for the business plan was 29th January; it was informed that this was not

possible as the Trust Board was not meeting until 30th January. NHS London's deadline for receiving the final draft of the business plan is the 16th March 2007. The Trust's Assurance Framework (which will be presented to the Trust Board in March) will be used to support the risk management aspects of the Business Plan. With the production of the business plan there will be no need to produce the traditional Annual Service Plan.

The draft presented to the Board is a top down budget based on the known level of funding; during February work will be undertaken to produce a bottom up plan. A revised plan will be presented to the Service Development Committee on 28th February 2007.

Income & Expenditure Summary: the Finance Director outlined what progress had been made in the negotiations with the Commissioners. There was currently a significant gap between what the LAS has said is needed and what the Commissioners were offering. The requirement to implement the new and earlier 'Clock Start' with effect from April 2008 has important resource consequences for the LAS. The Chief Executive said that the LAS will not agree to achieving a 75% Category A8 performance target under the new 'clock start' rules if it is not properly funded to do so.

Barry MacDonald said that with reference to the £1.5m that was brokered in 2005/06, which should be returned in FY 2007-08, the Trust would be advised to use this one off funding to finance non-revenue spending, thereby reducing cost basis rather than supporting the break-even objective.

In reply to a question from Beryl Magrath it was confirmed that front line staff comprised circa 75% of the Trust's workforce; she also queried the forecast increase in productivity of 2%.

Barry MacDonald said that the ratios were very helpful as they set the context for the proposed improvements outlined in SIP 2012.

Agreed: **1. That the draft three year business plan be submitted to NHS London**

2. To authorise the Service Development Committee in February 2007 to approve the business plan on behalf of the Trust Board in order to meet NHS London's deadline of 16th March 2007.

Noted: **3. That funding has not been agreed by the Commissioners for 2007/08.**

13/07 **Progress report on Urgent Care**

Ian Todd, Assistant Director of Operations, Urgent Care and Clinical Development (ADO, UCCD) gave a presentation outlining what progress has been made on improving Urgent Care. The Urgent Care Control room opened on 30th November 2005 and brought together the Emergency Bed Service, PTS Central Services, Clinical Telephone Advice and Urgent Care Despatch, Ambulance-Train-Ambulance (ATA) and Third Party, plus Emergency Care Practitioner programme development. UOC's target is to manage 80% of green calls, GP Urgents with STA 1 hour and non urgents in a more appropriate, cost effective manner. Urgent Care successfully manages 90,000 patient episodes per year, which is circa 33% of the identified potential workload. This is above expectations based on current staffing levels and future requirements modelled by ORH.

Emergency Care Practitioners: a conference was held on 12th December at which Senior Managers and the majority of Emergency Care Practitioners discussed the

future of the ECP role. David Whitmore, Senior Clinical Adviser to the Medical Director, is undertaking a review of the ECP curriculum with the aim that it will be more structured with clearer entry and exit points. It is intended that ECPs will focus primarily on 'green' calls (since these are often more complex) but act as First Responders when required and when necessary support Fast Response Units or Clinical Telephone Advisers with complex decision-making, additional drugs etc. It is planned to expand the number of ECPs to circa 250 and for them to be part of the core workforce with line management at complex level. The utilisation of the ECPs will be improved through improved scheduling of their workload.

PTS Central Services: Urgent Care had increased the workload passed to PTS, nearly 400 calls per month for the first time, though this had not been proportionate to the increase in staffing at Chase Farm and Bromley. It is planned that A&E will pay for PTS services on a 'pay as you go' basis. PTS Central Services is investigating how it can up-skill in the new financial year.

Urgent Care: five staff have been trained to the new A&E Support role and a further four courses were planned for this financial year (2006/07). This will mean an additional 40 new staff, comprising 20 external and 20 internal candidates who have chosen to regrade.

All Urgent Care vehicles now have Mobile Data Transmission functionality and utilisation had improved. Achieving full establishment remains a major obstacle with 40 vacancies in an establishment of 114.

The EMT1 course had been redesigned and banded at Level 3 and was compatible with the Emergency Care Assistant role.

Clinical Telephone Advice (CTA): CTA deals with 50,000 calls per annum and saves a frontline ambulance response in 50% of cases. The establishment was increased from 35 to 50 but there have been difficulties with recruitment. There were a number of reasons for the high vacancy rate: Waterloo is unattractive to many staff; Band 5 gives no additional incentive for increased clinical risk taking and it is often a transitional role for staff. There is an active recruitment drive which brings in 4-5 new staff each month and over 100 staff have rotated through CTA since inception. A competency based Job Description and Person Specification have been drawn up in order to open recruitment to nurses and Allied Health Professionals; this requires reassessment under AfC and it is possible that it may be viewed as Band 6 role. Alternative locations were also being investigated e.g. Wimbledon, Bow.

Emergency Bed Service moved to Waterloo in November 2005 and there had been good progress to modernise and expand its services to better fit the LAS portfolio. An internal audit review was recently undertaken and feedback is awaited. CTAK had been introduced to enable EBS to input bookings directly onto the system.

In partnership with First Response at West Midlands Ambulance Service EBS introduced a National Cot Locater Service; this had been commissioned by the Department of Health.

The next steps for Urgent Care were: to agree Emergency Bed Service and Emergency Care Practitioner strategies for implementation from April 2007; contribute to Workforce Plan to ensure appropriate growth for 2007/08 and deliver full Clinical Telephone integration.

Ingrid Prescod requested that a copy of the presentation be circulated via email **ACTION: Trust Secretary.**

In reply to a question from Sarah Waller regarding the curriculum for ECPs the ADO UCCD said that the Trust is awaiting publication of the curriculum framework from the Department of Health's Skills for Health team.

Noted: The update on Urgent Care

14/07 Attendance Management Policy

The HR Director presented the Attendance Management Policy to the Board for approval. The Policy had been revised to amalgamate two policies (Sickness Absence and Irregular Attendance) to ensure there was a more effective mechanism in place to manage attendance. There had been extensive consultation on the contents of the Policy and it had been agreed at the recent Staff Council.

Sarah Waller said that the reference to a chairman in Section 13.6 should be clarified to refer to the chair *of the panel considering possible termination of employment*. In response to a question the HR Director confirmed that there is the discretion under the AfC framework to extend sick pay although it is not explicitly stated in the policy. The requirement that managers interview members of staff who are returning to work after a period of sickness will be audited at a local level.

Beryl Magrath said that it was a very comprehensive document and she was pleased to see that the services required from Occupational Health had been reviewed. The HR Director said that the Trust was about to commence a tender exercise for these services.

Ingrid Prescod said that she was relieved to see one document that can be referred to when dismissal appeals are being heard as the existence of two different policies had been a source of confusion.

In response to a question from Malcolm Alexander the HR Director confirmed that the policy contained guidance regarding the phased return to work for members of staff who had had a long term absence.

Agreed: 1. The Attendance Management Policy
Noted: 2. That the Trust will be re-tendering the Occupation Health Service

15/07 Complaints Policy, Habitual & Vexatious Complainants Policy and SUI Policy

Ralph Morris, Head of Complaints, presented the above policies to the Trust Board. Following the review undertaken in 2006 of the Professional Standards Unit, work was undertaken to revise the Trust's Complaints Policy. In addition to a revised Complaints Policy it was considered necessary that the Trust had policies regarding Habitual & Vexatious Complainants and Serious Untoward Incidents. The policies have been drafted in accordance with guidance issued by NHS Complaints Regulations 2004 (amended in 2006); Healthcare Commission Core Standard C14; NHSLA Guidance and National Patient Safety Authority 'Being Open'. Comprehensive guidance notes have been issued to Managers on how the Complaints Policy should be implemented.

Complaints Policy: the Trust's Complaints Policy had been reviewed and amended in accordance with the guidance from the external bodies listed above.

Beryl Magrath said that section 4.6.13 should be amended to read that ensure "that lessons learnt as a result of complaints are reported to the PIM and Complaints Manager and *shared as appropriate."* The Head of Complaints confirmed that if a member of staff wishes to complain about another member of staff it is covered by

the Whistle Blowing Policy. In the event that a complaint is received whilst there is a disciplinary investigation taking place, the two would be treated as separate entities. When the disciplinary process is concluded, the Complainant would be informed of the outcome of that investigation; the six month period in which complainants have the right to take their complaint to the Healthcare Commission would commence from the date of that letter.

The Chairman said that he would like the following amendment to be done: section 3.2.8 apology *where that is appropriate.* He said that in due course he would like the three policies to be consolidated into one policy that is truly owned by the Trust and meets the requirements of external regulators – rather than separate bits imposed by regulators.

Serious Untoward Incident Policy: this policy was revised and updated to provide greater clarity in managing Serious Untoward Incidents e.g. setting out reporting arrangements to NHS London and the Patient Safety Agency.

Habitual & Vexatious Complainants Policy: this policy was written to ensure that the Trust is compliant with the Healthcare Commission's requirements regarding the handling of habitual & vexatious complaints. It provides guidance on the identification of such complainants, affording protection to LAS staff whilst providing a fair and consistent process to the individual concerned.

Agreed: **1. To approve the Complaints Policy.**
Noted: **2. The Habitual & Vexatious Complainants Policy.**
3. The Serious Untoward Incident Policy.
4. That the Board has yet to formally appoint a Champion for Complaints.

16/07 **'Being Open' Policy**

The Head of Complaints presented the 'Being Open' Policy to the Trust Board. The adoption of the Policy ensures that the Trust is compliant with the National Patient Safety Authority's requirements, specifically 'Being Open: Communicating Patient Safety Incidents with Patients and their Carers' (NPSA 2005). It is also consistent with the NHS Litigation Authority's policy in respect of admitting and apologising for mistakes.

The Head of Complaints said that following enquiries from colleagues about the 'Being Open' policy he had confirmed with the NHSLA that saying sorry is not an admission of guilt and is seen as good practice.

Roy Griffins said that section 3.4 should be amended to read 'proactive approach *in dealing* with clinical negligence'. The Chairman said that there were two terms used in the policy which needed to be clarified: Patient Safety Incidents (PSIs) and Serious Clinical Incidents (SCIs). **ACTION: Head of Complaints.**

Agreed: **1. The 'Being Open' Policy**
Noted: **2. The work of the Head of Complaints in reviewing the various policies presented to the Trust Board.**

17/07 **Outline Business Cases for Purley and Battersea Ambulance Stations**

The Director of Finance presented the outline business cases for Purley and Battersea Ambulance Stations. Following Board approval, work will be undertaken to identify replacement sites for the two ambulance stations. When alternative sites have been identified, full business cases will be presented for approval to the Trust Board.

Agreed: **The outline business case for Purley and Battersea Ambulance Stations.**

18/07 **Draft Minutes of Service Development Committee – 19th December 2006**

Minute 50/06: the HR Director confirmed that although dissatisfaction had been expressed with the B Relief rota, there had not been a significant turnover of staff. To date, 20% of those staff who were initially working the B Relief Rota (seven weekends in ten) were now working the A Relief Rota (5 weekends in ten). Staff are not expected to work the B Relief Rota on a permanent basis but are expected to move to either the A Relief Rota or a Core Rota within approximately a year of joining the Service.

Noted: **The draft minutes of the Service Development Committee, 19th December 2006.**

19/07 **Draft Minutes of the Audit Committee – 4th December 2006**

Noted: **The draft minutes of the Audit Committee, 4th December 2006.**

20/07 **Draft Minutes of the Clinical Governance Committee – 11th December 2006**

Beryl Magrath, Chairman of the Clinical Governance Committee, said that the ADO East's clinical governance report had highlighted the disparity that exists in the auditing of Clinical Performance Indicators by Team Leaders. She said that in terms of improving clinical standards in the Trust, it is essential that following the review of Patient Report Forms, one-to-one conversations take place between front line crews and their Team Leaders. This is not happening sufficiently often at the moment.

Noted: **The draft minutes of the Clinical Governance Committee, 11th December 2006.**

21/07 **Annual Report regarding the Trust's Risk Register**

The Director of Finance presented the Risk Register to the Trust Board; it is a work in progress and it is proposed to present a further report later in the year on the top five risks for each of the categories included in the register.

Barry MacDonald said that the Service Development Committee in February or April should consider the Risk Register in detail. The Committee will review the Trust's Risk Management Framework in February. It was proposed that a further discussion concerning the strategic issues associated with how the Trust manages risk and the role of the Audit Committee take place at the Away Day in April **ACTION: Director of Finance**

Noted: **The Risk Register**

22/07 **Charitable Funds annual report**

Noted:
1. **The Charitable Funds annual report**
2. **The Audit Commission Governance report**

23/07 **Audit Commission Annual Audit Letter**

Noted: **The Audit Commission's Annual Audit Letter**

24/07 **Report from Trust Secretary on tenders opened since the last Board meeting**

One tender had been opened since the last Trust Board meeting:

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

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

There have been five occasions when the Trust Seal has been used since the last Trust Board meeting. The references in the Seal Book are 99-103.

Noted: The report of the Trust Secretary on tenders received

25/07 **Any Other Business**

The Director of Finance said that the Make Ready contractor, LRS went into administration on 8th January 2007. In the interim, a related company, Lightbridge, was providing the Trust with a Make Ready service. Discussions were scheduled to be held on 31st January with Lightbridge; there is currently no contract in place between the LAS and Lightbridge. The Director of Finance will ensure that the Chief Executive and the Chairman are kept fully informed of developments.

26/07 **Date of next meeting**

Tuesday, 27th March 2007, 10.00, Conference room, LAS headquarters, Waterloo Road.

Meeting finished at 13.38

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 30th January 2007
held in the Conference Room, LAS HQ, London SE1

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

On the 30th January 2007 in Part II the Trust Board discussed:

Out of Hours Service, Bromley

A meeting took place between the Chairman and Mr Bamber Postance regarding the possibility of working in partnership to provide an Out of Hours Service in Bromley. Following the meeting Mr Postance said he wished to purse his individual application for Social Enterprise Funding from the Department of Health to fund his proposed project in Bromley.

CAD 2010 Outline Business Case

The Director of Information Management & Technology presented the Outline Business Case for CAD 2010. The Board considered the document which defined the reason for change, why action is necessary and the proposal to procure a commercially off the shelf product.

The Board agreed to approve the Outline Business Case and authorised its presentation to the Strategic Health Authority, NHS London, for approval.

The Director of Information Management & Technology was authorised to continue with as much work as possible leading to the Full Business Case on the assumption of SHA approval. A waiver would be sought from the SHA to enable progress to be made with regard to the tendering process. This was on the understanding that any work undertaken will not commit the Trust contractually or financially beyond the continuation of existing project costs.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 27 MARCH2007

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*	74.9%	98%	80.9%	74.9%

*As of 21st March 2007

Key highlights

i. I am pleased to report to the Board that the service remains on track to achieve the 75% Category A target for 06/07 once all the final data has been inputted for March. This is a tremendous achievement given the challenges of increasing Cat A volumes during the final months of this year coupled with the accompanying challenge of Rest Breaks and the extremely tight financial position.

ii. Category A volumes have remained at a very high level high during the last few weeks rising from 909 per day in January to 948 per day in February . This level exceeded the December 06 figures of 944 per day. March has seen a welcome fall in Category A numbers to circa 863per day for the first 12 days of the month.

iii. Overall demand for this financial year has increased by 1.5% when compared to the same period last year.

iv. There was some recovery during January despite the high Category A volumes and final performance for the month was 73.1% .This fell back during February as Cat A volumes rose again and further overtime restrictions were introduced. These restrictions were relieved during the final week of February following an injection of additional overtime funds and performance began to recover coming in at 71.4% for the month overall.

v. The first three weeks of February were especially challenging for all the reasons outlined above and during this period there were some excessive waiting times predominantly for small numbers of less seriously ill patients. Two new graphs have been added to the pack to show the response time distribution for both Category B and for Category C patients. The graphs in this pack show the

responses made over the first six months of the year. In the case of Category B it shows the vast majority of all calls receiving a response within 30 minutes and in the case of Category C calls within 60 minutes. More work is in hand to understand the detail surrounding the small number of responses which fall outside these timeframes. We are aware that these need to be minimised.

vi. A reduction in overall workload and in Cat A volumes for the first 14 days of March coupled with all the actions put in place due to the Trust being in full performance recovery mode has led to a significant improvement in performance. March is currently running at circa 77% at time of writing.

vii. We are continuing to bed down the Rest Break agreement and have introduced further initiatives to mitigate against the performance fall across the main rest break window during the day. These have included rostering additional ambulances across this period and also significantly increasing the numbers of calls which are being attended by managers. There is still further work to do but it is encouraging to note a return to target performance whilst still managing to ensure that the majority of staff receive a rest break. Further detail on the progress and impact of Rest Breaks is given later in the report.

viii. Further analysis of the rising Cat A demand and the particular illness codes affected has continued to show shown significant increases in calls for Chest Pain and Breathing difficulties. In addition we have seen an overall rise in the numbers of calls being received for patients in the 0-10 age group and in the 0-40 age group coupled with a fall in the numbers of calls for patients aged 65 and over.

ix. The Trust is still in full performance recovery mode and remains at Reap Level 3 'Severe Pressure'. The focus has inevitably been on Category A and we have had to accept a small fall in the performance for B and C calls in order to do so. It is anticipated that we will remain in recovery through April in order to ensure a good start to 07/08.

Actions to Recover and maintain performance

The Board has been given significant detail associated with the recovery plan in the previous two Board reports and it was not felt necessary to repeat the actions in the same level of detail for this report. By way of summary the following areas continue to be addressed as part of the ongoing recovery plan:

1. Maintaining 24/7 Gold responsibility for performance recovery
2. Improving FRU Performance
3. Improving Attendance Management
4. Optimising Resourcing
5. Progressing the EOC initiatives described in previous reports.
6. Reducing Job Cycle Time
7. Service Wide Implementation of Individual Performance Review
8. Reducing Performance fall at Shift Changeover
9. Setting Appropriate REAP Levels and acting on associated actions.
10. Ongoing Review of both Red and Cat A Volumes
11. Ongoing Quality Assurance of Response Times

1.2 Rest Breaks

- The implementation of the rest break policy commenced on the 11th of December and is continuing to bed down. Over 32,000 breaks have now been given and the overall level of breaks being allocated across this 12 week period is 72%. A new Graph (Graph 9) has been added to the Board information pack to provide ongoing data regarding rest break allocation.

- Fluctuations in workload and staffing clearly affect our ability to place crews on breaks and during the first part of February the numbers of allocated breaks fell back to 68% before recovering again in early March as staffing improved and workload lessened.

- We still need to improve on these figures and anticipate that we will move to a more consistent position of circa 80% of staff receiving meal breaks within the next three months. The position is also different for staff on cars, 90% of whom regularly receive a break. This is due to the lower utilisation rate for cars when compared with ambulances which in turn creates more opportunity to place them on break.

- It is clear that the section of the agreement which allows crews to finish their shift 30 minutes early if they have not had a break has increased the performance fall at shift changeover. A temporary solution to this has been found for the last six weeks of the year and this and other areas of the agreement are now currently being reviewed in partnership with the trade unions.

- The implementation should continue 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)

- The EOC/UOC restructure is continuing. Following a period of formal consultation the First Phase of the restructure has commenced. The existing Senior Operations Officer post is being replaced by an AOM level post, with an advert already placed both internally and externally in order to attract appropriately experienced managers for the future. The next phase of the restructure will take place following the filling of the newly created posts.

- The dispatch projects within the Operational Response Improvement Programme are continuing within the previously identified time lines. The projects include increasing the numbers of available despatchers in order to split the existing Sector Desks routinely and introducing automatic dispatch of FRUs. To date the milestones laid out in the project plan have been achieved.

- The dispatch desks are now being more routinely split across the service. Whilst vacancies in the allocator role has hindered the sustained splitting of desks, the on

going recruitment to this is improving this situation. The anticipated benefits are starting to be realised and include improvement in activation times, improved ability to effectively manage the resources and an increased level of rest break allocation.

- The Automatic Dispatching of FRUs has continued to be embedded into everyday practise. The percentage of calls now being dispatched in this manner accounts for over 80% of FRU activity with an average reduction in allocation time of over 2 minutes. This has also contributed towards the increased volume and resultant performance in terms of Category A work undertaken by FRUs. We are now aiming for the FRUs to deal with 60% of total Cat A volume and achieve 90% within 8 minutes.

- The focus on all aspects of attendance management has continued. The effects of lower sickness and abstractions have been an general increase in staffing levels within EOC. The additional training course established for early April, coupled with the existing training packages scheduled, will see an increase in in-post staff numbers to full establishment by end April 07.

- Call taking has again come under pressure during the last couple of months as the volumes increased. However we have seen an upward trend during the last quarter. These improvements will be stabilised by the recruitment to the vacant posts described above together with increased focus on the management arrangements for call taking.

- As previously reported, the Rest Breaks for Vehicle Crew Staff were implemented in mid December, which had resulted in an increased workload for staff on sector desks. This is starting to stabilise as the practice becomes mainstreamed as every day practise and will be further enhanced following the administration of an IT based solution which is due to be trialled in early April. Consultation is now in hand to roll out a rest break agreement for Control Services staff.

- Additional focus is being placed on complaints as the numbers have risen during February and particular attention is being placed AMPDS compliance within call taking.

1.4 Urgent Care Service

- 21 A&E Support staff are currently in training with a further course due to commence towards the end of March. These courses have seen a regrading of PTS Central Services staff to enhance the breadth of call types suitable for them to attend. These courses will deliver full establishment within the Urgent Care operational fleet by end May.

- The CTA job description has been revised to include a clinical reviewer role and has completed the Agenda for Change process. This revised job description and associated banding increase should enhance our ability to recruit both internally and externally. Adverts are due to run imminently to ensure that the full establishment of 50 staff is reached as soon as possible.

- 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. A new table (Table 1) has been added to the Board Information pack which gives greater detail around the workload being dealt with by the Urgent Care Service.

- The final integration work of the PSIAM decision support software and CTAK is due to take place during late April or early May and this should enhance CTA efficiency further.

- Discussions are underway with NHS London to gain support for a London wide Capacity Management System which could, subject to further consultation, be operated by EBS. This would put the Trust at the forefront of capacity management pan London as well as giving the Trust the ability to offer a single point of access for referral pathways initially internally but potentially externally across health and social care pan London.

1.5 Resourcing

- There has been a significant improvement in resourcing following the identification of additional funds in late February . This has allowed overtime hours to be increased to the levels seen during the Autumn. These are approximately one third of the levels used during the early part of 06/07 and reflect an improvement in our in post staffing.

- Although the Service is close to full establishment in employment terms, there are approximately 60 staff still to complete their training and be posted to stations. In addition, abstractions for HART, additional FRUs and various other activities still require cover through overtime.

- In addition, sickness absence remains high at circa 7.5%, but is being tackled in part by a new initiative from the HR Directorate to immediately call back every person who reports sick to ensure that they are being fully supported and to understand the likely length of absence which we should expect. They are then maintaining appropriate regular contact with the member of staff until they return to work. Whilst this should of course be part and parcel of normal management activity on station we have recognised that with managers spending more time providing operational cover during the last six weeks of the year some additional assistance in this area was required.

- Due to the increased overtime allocation in late February there has been a step change in the number of hours of ambulance provision from approximately 26,000 hours per week, to 29,000 hours. This improvement in cover, coupled with the declaration of REAP pressure level 3 (and its associated actions, including the opening of Gold Suite) has ‘kick-started’ the process of performance recovery and we have reported performance significantly above target for the past three weeks.

- Overtime is also being targeted wherever possible to the areas of London where we 'miss' the highest numbers of Category A calls. This is mainly Central and East Central sectors, due to the volume of calls in this area.

1.6 Emergency Planning

HART

- The Hazardous Area Response Team (HART) was officially launched by the Health Minister, Rt. Hon. Rosie Winterton MP, at Waterloo H.Q on 8 March 2007.

- The Minister examined the HART vehicles and equipment and was given a tour of the Incident Control Room. During a televised interview with the BBC she described the LAS HART provisions as "reassuring".

FLU Planning

- The Service played a full part in the recent 'Winter Willow' influenza preparedness exercise. The national exercise (the largest emergency planning exercise ever held in the UK), was played out over two weeks, to test the response to an influenza pandemic by the Cabinet Office, SHAs, PCTs and local government.

- The LAS, as a Category One responder, participated at each of the five London Influenza Pandemic Committees during the exercise, ensuring a partnership approach to tackling a pandemic. The Service was also represented at the strategic Gold group, of the Regional Civil Contingencies Committee.

Emergency Planning for London

- Discussions are underway between LAS and London SHA towards the Service contracting to undertake emergency planning for London. A draft service level agreement has been written and we are currently establishing the employment arrangements of those carrying out the core roles.

- Subject to agreement, it is anticipated that LAS will take over the service with effect from 1 July 07.

1.7 Response time Data Compliance with DH guidelines

- The trust has now received the full guidance document for 2007/8 from the Department of Health. In addition the national Directors of Operations forum is designing a best practice document regarding data management which will be adopted by all ambulance trusts to ensure uniformity in terms of response time data management.

- SMG has now agreed that a comprehensive paper be provided for the Board each year at its meeting in May which demonstrates compliance with the latest DH guidance for the current year. In view of this we will now bring a full paper to the Board in May 07 which demonstrates compliance for 2007/8 guidance.

- Work has also been ongoing in terms of retrospective data analysis of the 06/07 data to ensure full compliance with the DH guidance for this financial year which was also issued in recent weeks. This has allowed the trust to bring its reporting arrangements fully in line with other trusts particularly around reporting on calls to static defib sites and where other healthcare professionals are already on scene.

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

The following projects contained in the response portfolio have now been delivered:

- Individual performance monitoring
- Rest breaks

The following provides an update on progress for those projects still outstanding as part of the release 1 response portfolio:

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.

- To date seven shifts have now taken place in Croydon. A further five shifts have been planned between 6th March and 2nd April. We are in the process of trying to plan further shifts for both the Croydon and Bromley complexes however due to limited funding for this project coupled with lack of available vehicles, it is now likely that there will be insufficient data to undertake a thorough review of this initiative by the planned delivery date of 31st March 2007. The project will therefore be extended into April and May to allow for a thorough review of the benefits and take a decision on whether this initiative should be part of a permanent contribution to performance targets.

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. The main aim is to ensure that the common themes emerging from this exercise will be used to drive discussion and change in other hospitals. 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.

- A revised plan is now focussing on the five hospitals with the longest / most problematical handover processes. Mapping is now complete. The output of the process mapping is a schedule of short, medium and long term process changes for each hospital. These should be agreed and implemented with the Trust where possible. Andrew Castle (the consultant engaged to undertake this exercise), has produced a report summarising common themes and possible next steps / actions that might arise out of the mapping exercises. This is being forwarded to the relevant AOMs for feedback. The AOMs are being tasked with providing an action plan and scheduling a meeting in April, with the appropriate A&E department to discuss how to implement these actions. The objective is still to reduce the hospital component of the job cycle time from circa 32 minutes to circa 20 minutes.

- This initiative remains a key component of our overall improvement strategy and whilst it is proving difficult to realise the benefits it is one which needs to be rigorously pursued. The main issue will be one of culture change and as discussed before it will be a combination of process re-design coupled with individual performance review for front line staff which finally delivers the benefits.

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 are ongoing. A phased approach is being

adopted, with phase 1, incorporating rota and station changes to FRU's, being the element of the project delivering the most benefit for CAT-A performance. This element 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 phases 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 May 07. . It is fair to say that the degree of progress being made differs significantly from complex to complex and further action needs to be taken by local AOMs to get this project back on track ADOs will be taking personal responsibility for ensuring that the plans for each of their complexes are delivered to allow this revised schedule to be met.

Rest Breaks

- As per summary in Section 1.2

Dispatch Project Progress

The following projects contained in the dispatch portfolio have now been delivered:

- Reduce red call volumes
- Improve dispatch of FRUs

The following provides an update on progress for those projects still outstanding as part of the release 1 dispatch portfolio:

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 from a technical perspective however further work is ongoing to provide sufficient allocators to be able to staff the desks in the new configuration on a permanent basis. It is now envisaged that we should be able to staff a permanent reconfiguration by end April 07.

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 one month behind schedule. The consultation stage was initiated on the 29th January and dates for the assessment centres are

now set. The Trust will be in a position to make offers to successful candidates the w/c 4th May.

Staff and Union engagement

- This project is approximately six weeks behind schedule. It was hoped that a new partnership agreement, coupled with the implementation of a new constitution would be in place by April 1st 2007, but currently focus on operational performance has slowed activity. A revised delivery date is being agreed with the Trade Unions.

Improve Urgent Performance

- The objective of this project was 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 and limited UOC resources and in part due to patchy compliance with the new operating regime in EOC and UOC.

- New national guidelines for the management of Urgent calls are now due to come into place on May 1st 2007 which will take all of them through an AMPDS process and will assign a Category A category to those patients who the requesting clinician decides need an immediate response. The majority of other urgent patients will then receive a response within four hours unless the clinician specifically requests a shorter time frame.

- John Hopson is taking forward the work to introduce the new arrangements from 1st May 2007.

2. PATIENT TRANSPORT SERVICE

Commercial

The bid to retain the Hillingdon Hospital PTS has been unsuccessful. The award has been made to a company called "Door to Door" who have won on price and have undercut the LAS by £100,000.

North Middlesex University Hospital (new business) has also announced the results of their tendering process and again the LAS have not been successful in winning this business. As yet we have not been advised who the successful company is.

In both cases detailed feedback is being sought to understand where we can improve our bids although in both cases it would appear that cost is the motivating factor.

News on tenders submitted for Camden PCT (existing), Queen Elizabeth Hospital, Greenwich (existing) and Homerton (new) have all been delayed.

Work has started on putting a tender submission together for Kingston Hospital (existing) who has now issued their tender specification. The closing date for bids is 10 April 2007.

Expressions of interest have also been made in respect of The Mayday Hospital (new) and Darrenth Valley Hospital (new).

South West London and St George's Mental Health trust have signed up to a further year of provision with the LAS and Queen Mary's in Sidcup have also indicated that they wish to extend their contract subject to further negotiations.

The loss of Hillingdon will affect 12 staff. The LAS will look at possibilities for redeployment for these staff, however, these are likely to be limited. Consequently the majority of staff will transfer under TUPE to the new provider with effect from 1 July 2007. The first consultation meeting with affected staff has been held and they have been advised that transferring across to the new provider is likely.

PTS Central Services will transfer across to UOC with effect from 1 April 2007. Staff currently working in this area are either undertaking the A&E Support course which started at the end of February or will join the course arranged for the end of April. This will impact on PTS' ability to carry out work for UOC, however, UOC will have better control of this resource and fills the vacancies that remained at A&E Support level.

Performance

This remains almost static within arrival time at 88.1% (within +/- 45 minutes) and 94% (less than 60 min) for time on vehicle. With changes to the Central Services structure we expect to see a slight drop in these figures. However, these should pick up with the planned changes to come through on staff rostering.

Cost per journey fell and this should continue to fall once Central Service staff pass across to UOC.

3. HUMAN RESOURCES

Agenda for Change

The process of banding reviews is now complete, with all details of any resulting changes with Payroll. A final project board will be convened to close the implementation project of Agenda for Change.

The Audit Commission visited the Trust in early March to conduct an audit on the impact of AfC, with a particular interest in workforce redesign and alignment with the Trust's strategic plans. The visit was seen as positive and we await the report from the Audit Commission.

Equality and Human Rights in the NHS

The above document, produced by the DH and specifically aimed at Trust Boards, has been circulated with the agenda for the attention of all Trust Board members.

Policy and procedure update

The Trust Board are advised that the following HR policies/management guidelines documents have been drafted/ updated, consulted upon, and subsequently published recently:

- Responsibilities of managers providing work experience
- Adoption leave
- Agency Staff Booking Procedure

Staff survey

Initial results from the Staff Survey, which was carried out in October and November of last year, show few significant changes in results with the previous year, with the exception of significant improvement in responses relating to appraisal. The response rate of 38% was also in line with the previous year. The detailed results are embargoed, on a national basis, until March 21.

Personal Development Review

The first full year of the Personal Development Review (PDR) process will be completed by the end of March. The figures below are based on current reporting and it should be noted that there are still a small number of outstanding reports which will improve further the percentages for PDR and PDP completed.

Trust wide completion:

- 99% of staff have a KSF outline (either approved or in final draft)
- 86% have been through a PDR process
- 85% have a PDP.

The above figures can be broken down further:

A&E Operations:

99% have a KSF outline
85% have been through a PDR process
83% have a PDP

Support Directorates:

91% have a KSF outline
92% have been through a PDR process
92% have a PDP

Staff employed on fixed term contracts or external contract staff will not have a KSF outline and may not be included in the PDR / appraisal process if employed for a term of less than 12 months.

A formal review of the PDR process will be scheduled for April of this year. The review will include;

- PDR training arrangements
- PDR Audit and monitoring (including e-KSF / ESR potential link)
- Staff Side feedback
- Staff experience
- Future Team Leader involvement
- Learning and development data base
- Ongoing responsibilities for PDR
- Ongoing responsibilities for KSF
- Quality assurance of PDR
- PDR implementation programme closure.

The first full year of PDR has been completed with 99% of posts within the Trust having a KSF outline and over 85% of all staff having an appraisal / PDR interview. Given that the overwhelming majority of staff are operational and work varying shift patterns combined with the recent performance pressures within A&E operations, these figures should be considered a success for the Trust.

Workforce information

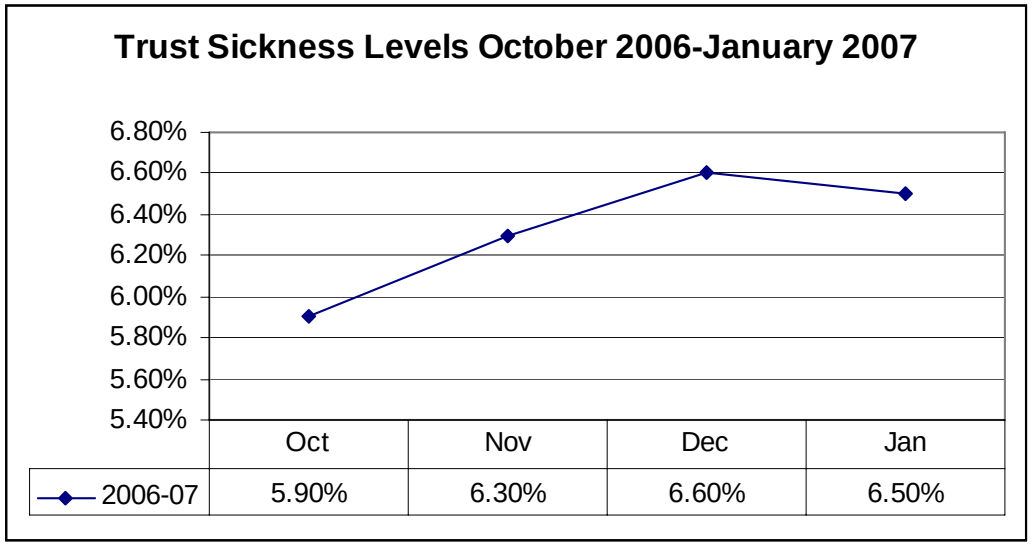
Sickness absence is now reported through ESR and calculates absence on the basis of days lost. There is no comparative data provided therefore as previous reports have been based on hours. Managing sickness absence remains a key priority for the Trust. The provision of additional support to Operations has recently contributed to a reduction in levels of absence which will be seen in future reports.

The numbers and period of staff suspensions has also improved. Our aim will be to continue to ensure that the time period of suspensions is kept to a minimum.

INTERIM WORKFORCE INFORMATION

Jan 07 Absence	%
A & E Ops East	7.9%
A&E Ops South	7.1%
A&E Ops West	6.8%
Control Services	7.3%
PTS	5.3%
Total (Trust)	**6.50%**

Staff Turnover March 2006 -February 2007	
Staff Group	**Turnover %**
A & C	11.76%
A & E	4.72%
CTA	0.00%
Bank Staff	0.00%
EOC Watch Staff	11.00%
Fleet	3.39%
PTS	8.19%
Resource Staff	1.96%
SMP	7.04%
Grand Total	**5.84%**



SUSPENSIONS as 14.03.07		Date of Suspension	Allegation:	Stage in Investigation	Investigating Officer	Hearing Date
East	1	06.02.07 Suspension reviewed 19.02.07 & 07.03.07	Inappropriate behaviour towards patients and staff.	Commenced	Martin McTigue	
South	2	19.02.07	Neglect of patient and poor care	Report Complete.	Richard Lee	26.03.07
		09.01.07	Bullying & harassment	On-going	John Boyaram	
West	1	22.10.06	Illegal drug use	Investigation complete. Staff member now an in-patient. Awaiting OHD advice.	Paul Gibson	
EOC	0					
HQ/Fleet/Others	0					

4. COMMUNICATIONS

Media issues

Launch of Hazardous Area Response Team (HART): At the beginning of March, the Communications Department worked with the Department of Health to coordinate media interest in the official launch of the Hazardous Area Response Team (HART) by Health Minister Rosie Winterton. Broadcast journalists from BBC London and Sky News were given full access to the Minister's tour at the Service's headquarters. It was emphasised that HART is not exclusively a chemical, biological, radioactive or nuclear response but a general one sent to a range of incidents at which, it is predicted, there could be large number of casualties. John Pooley, Head of Emergency Preparedness, gave interviews and demonstrated the equipment available on the HART vehicles. A tour was also conducted around the Service's Incident Control Room. The launch was subsequently covered by BBC London television, radio and online.

Strategic plan: The Service's new workforce plan, discussed at the last Trust Board meeting, was picked up by the Evening Standard. The Health Correspondent met with Director of Service Development Kathy Jones and Assistant Director of Operations Ian Todd to discuss the implications of the plan; this resulted in an article focusing on the move for more paramedics in cars to assess patients. Unfortunately a headline 'Ambulances will only go to 10% of 999 calls' was misleading. To clarify, this figure relates to the most serious calls that would receive an ambulance and a car as part of an initial response (more recent estimates are 10-20 per cent). In terms of other calls, paramedics in cars would assess what treatment a patient needed and would request an ambulance if appropriate.

Operational pressures: A number of pressure-related stories have appeared in the media recently.

The Evening Standard ran an article in February about operational pressures on the Service as a result of the high volume of Category A calls and sickness levels.

Related to this, a number of stories about delays in attending 999 calls were published in national and local papers.

The Mail on Sunday ran an article about a patient who was taken to hospital in south east London on a bus because no ambulances were immediately available to attend. The story, which was published the day after the incident, was subsequently covered by local press in the area.

The following week, a columnist on The Times wrote about a delay in attending a call to one of his elderly relatives. This was followed up by another journalist on the same newspaper, but a response was provided which outlined that all crews in the area had been attending other patients at the time of the call. This incident, and a story in the Health Service Journal about ambulance response times across the country, prompted another article in The Times focussing on national demand and performance issues.

The Service has also since received a Freedom of Information enquiry from The Sunday Times about response times; it is understood that this request has also been made to other ambulance services.

Other negative local stories included those about a woman who was mugged in Crouch End and was taken to hospital by Police after it took more than an hour for an ambulance to arrive; a 35-minute response to a man in Romford after he fell unwell; and a three-hour response to a woman who fell over and injured herself at home in the same area. The paper which covered the latter two incidents also ran a negative article about the local Patient Transport Service contract. The Communications Department worked with the local Ambulance Operations Manager to write a letter to counter allegations in this story, and this was published the following week.

Other stories: Other incidents that attracted media interest included a rush hour road traffic collision on Regent Street which left six people injured, two accidents involving ambulance vehicles on the way to emergency calls, and a building collapse in east London. Problems with a supplier that affected the mobile data terminal system for a few days were also picked up by BBC News online.

An enquiry was received from ITV London Tonight news who interviewed a former patient's father, Mohammed El-Bhanasawy, who maintains that the Service's response to his son's fatal asthma attack in December was inadequate. The story, which was previously covered in the Islington Gazette, focused on the father's main point of contention that the first responder wasn't carrying oxygen. From the start the Service issued a statement outlining that the first responder *was* carrying oxygen and did everything she could to save the patient's life. Colleagues at the Whittington Hospital, where the patient was initially treated, advised that this case is now pending a coroner's inquest. Therefore, it was decided not to put a spokesperson up for interview until the inquest reaches its conclusion so as not to prejudice the investigation.

The Communications Directorate has also been coordinating the Service's involvement in ITV's Tonight with Trevor McDonald programme, which is due to be broadcast in April and is expected to feature the case of teenage epileptic patient Kayleigh Macilwraith-Christie, who died last July. A Freedom of Information request for information relating to this tragic case was received from ITV last month.

Evidence given at London Assembly's investigation into emergency life support skills training

Having submitted a formal response in February, the Service was among a number of agencies to give evidence at a meeting of the London Assembly's Health and Public Services Review Committee on 6 March. Medical Director Fionna Moore was accompanied by Clinical Practice Manager Mark Whitbread as she answered questions as part of a scrutiny investigation into how emergency life support (ELS) skills training is delivered in London.

The meeting also heard from representatives from St John Ambulance, the British Heart Foundation, the Resuscitation Council UK and the Saving Londoners Lives project. Key issues discussed included how training is regulated, available sources of funding, the benefits of making ELS training a mandatory part of the school curriculum, how other emergency services could be involved in delivery and what target London should be aiming for in comparison to Seattle, which is recognised as leading the way.

The Service played a key role in the investigation and now awaits the Committee's recommendations which are expected to be published in June, outlining how the number of

Londoners trained in basic life support could be increased. It was noted that if funding was available, there is a great deal of potential for the Service to lead the way in delivering more training, working in conjunction with other partners across the capital.

Visit to 10 Downing Street to celebrate NHS successes in tackling coronary heart disease

The department coordinated the Service's attendance at an event held on Wednesday 14 March at 10 Downing Street to celebrate the successes of the NHS in tackling coronary heart disease. The event was hosted by Professor Roger Boyle, National Director for Heart Disease & Stroke Department of Health, to mark the seven year anniversary of the NHS Coronary Heart Disease National Service Framework. Clinical Practice Manager Mark Whitbread and Community Defibrillation Officer Jo Smith accompanied former patient Kevin Jolly who they took to the London Chest Hospital for primary angioplasty after he suffered a heart attack in December 2005. They joined other NHS staff and cardiac patients as they shared their stories with the Prime Minister and highlighted the Service's work to improve emergency cardiac care in London. Interviews were held after the event with BBC regional media.

Patient and Public Involvement

Although the current pressures have severely limited operational staff involvement in Patient & Public Involvement (PPI) activities, staff from Wimbledon complex were able to take part in the Junior Citizens Scheme in Wandsworth. St. Helier and Edmonton complexes are planning open days for the summer, and the Ambulance Operations Manager at Edmonton is meeting with local communities to discuss the possibility of developing community responder schemes in the area. Staff at Edmonton are also developing links with a local school.

The LAS had stands at a health promotion day in Blackfriars and a coronary heart disease event in Ealing. Although these were less well-attended by the public than the organisers had hoped, both events provided a good opportunity for LAS staff to meet partners from other local organisations, as well as the patients who did attend. On the evening of the Ealing event, the Community Defibrillation Officer (Joanne Smith) gave an excellent presentation to members of the local community about the Service's cardiac care developments.

These events have led to plans for a 'resource pack' to be developed, for use by any member of LAS staff wishing to have a stand at an event. This includes a checklist for the planning stage, an event plan and risk assessment, as well as other resources that may be required, depending on the theme of the event and the visitors expected.

A trial of the Medical Visual Language Translator is underway with the Cycle Response Unit at Heathrow Airport. So far, the cards have not been used many times, although staff report that they have been useful on occasions. When the trial is completed, consideration will need to be given as to whether the LAS invests in a larger number of these cards, or whether other ways need to be developed to aid communication with deaf, speech-impaired and non-English speaking patients.

The Public Education Strategy has been agreed and a development day is being planned for the new financial year. In the meantime, the Public Education Strategy Steering Group is doing an audit of all public education work carried out by operational staff.

At the February Patients' Forum meeting the PPI Manager provided an update about the Tower Hamlets (Bangladeshi) project. Three sub-groups have now been formed for this project, and will focus on women and maternity services, children and young people, and joint work between LAS staff and the local 'health guides', who speak local languages and work as volunteers with members of the community. Activities are likely to include work shadowing, CPR training, careers information and health promotion.

The March Patients' Forum meeting focused on mental health, and the Head of Policy, Evaluation and Development (Nick Lawrance) attended to update Forum members on the implementation of the Mental Health Strategy and the action plan arising from the Serious Untoward Incident involving Andrew Jordan.

Towards the end of March the LAS has been asked to attend a careers event for young unemployed women in Tottenham. A member of staff (Charlotte Elliot) will give a talk about her career in the LAS, from joining PTS to becoming a Team Leader. Also in March the Diversity Officer will attend a careers event in Camden, in partnership with Communities into Training and Employment (CITE).

A Patient Transport Service (PTS) conference is to be held on 21st May at the Oval Conference Centre. This will be an opportunity for the LAS to hear about the views and experiences of PTS users, and for patients to influence future developments. It is planned that, although patients and carers will make up most of the audience, others will be invited to participate, such as commissioners of PTS services and regulators.

Other forthcoming events over the summer include a health day organised by Sutton & Merton PCT (June), the annual Pride celebrations (July) and a multi-agency event in Newham which aims to use the anniversary of the London bombings to build cohesion amongst all faith communities in the capital. The LAS annual Patient Care Conference will be held at the end of July.

5. Overseas Travel

The LAS lead for CBRN Marc Rainey, has been invited to assist the Thai government at a four day symposium in Bangkok. The Foreign and Commonwealth Office will meet all costs and have assembled a panel of experts to advise on all aspects of anti terrorism preparation.

6. Recommendation

THAT the Trust Board note and approve overseas travel

Peter Bradley CBE
CHIEF EXECUTIVE OFFICER
20 March 2007

Enclosure 5

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 27th March 2007

Report of the Medical Director

Standards for Better Health

1. First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

A Serious Untoward Incident was declared on 7th March following the death of a 7 month old child from presumed meningococcal septicaemia where the initial call handling may have failed to identify the serious nature of the child's condition, thus leading to a delayed response. This is the only outstanding incident where investigations are incomplete.

NHSLA informal visit on 7 March

The NHSLA assessor visited the Trust and provided an overview of the new assessment system that the NHSLA is considering for implementation. The more detailed requirements for the assessment will be made available after the new provider of risk management services for the NHSLA, Det Norske Veritas Ltd, take up their role on April 1st this year (the previous provider, Willis, having unsuccessfully tendered for the contract). The Ambulance Service Association has asked the NHSLA to clarify what impact the change of provider will have on the development of the new ambulance standard.

The proposed piloting of the new standard will include a visit in June-September 2007 to help trusts self assess their compliance with the 10 criteria of the 5 new standards at assessment level one. This level is concerned with ensuring that policies and procedures are in place.

The proposals also include a requirement that the two ambulance trusts which currently have level two status under the outgoing system (LAS and one other) will be visited in October 2007. This visit will be to review the Trust's compliance at the new level two with evidence of implementation of the policies and procedures demonstrated at level one.

The new system transfers the responsibility of monitoring the Risk Register and the Assurance Framework to the Audit Commission under the ALE (Auditors' Local Evaluation assessment), if approved. The latter informs the rating of the Use of Resources component of the Annual Health Check.

Once the approach to piloting the new standard is clarified in April a project plan incorporating a gap analysis will be put in place, co-ordinated by the Head of Governance with support from senior managers.

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.

Eighteen alerts were received during the period of 16th January 2007 – 08th March 2007. In total the Trust has six alerts outstanding as follows:

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

This alert continues to be actioned by the Corporate Logistics Manager. It has been agreed that sphygmomanometers will be replaced on an annual basis. A bulletin outlining this to staff is in the process of being drafted.

2) DH (2006) 08: Waste Compactor

This alert was circulated on 19.10.2006. Currently waiting for feedback to confirm that all the actions outlined in the alert have been completed.

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

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

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

This alert was received on 15th January 2007 and relates to a weld failure of the above stretcher trolleys. This alert remains on-going as modifications outlined in the alert are being made.

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

Details of this alert have been forwarded to relevant departments. Awaiting feedback to confirm if the trust complies with the actions outlined in the alert.

6) 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. The Trust has confirmed that though a colour code is in place this is not in line with the NPSA recommendations. This alert was discussed at the Infection Control Steering Group meeting in February 2007, where it was agreed that colour codes will be reviewed in line with the recommendations.

2. Second domain – Clinical and Cost Effectiveness

National Clinical Practice Guidelines for Use in UK Ambulance Services

Version 2006 is now in use across the Service with manuals distributed to front line staff. Copies of the pocket book were distributed in mid February. Unfortunately some errors were identified in the section on drug dosages leading to reprinting of the affected pages. The corrected pages have now been circulated to staff for insertion. Some concern has been expressed about the quality of this edition of the pocket book, as the print has shown a tendency to smudge when wet. The publishers have agreed to replace any pocket books where pages have become illegible.

As with the previous edition of the Guidelines there are a small number of areas where the LAS is not fully compliant with the advice given. The most significant issue is around the concentration of oxygen administered to patients with medical conditions, including acute myocardial infarction and stroke, where provided there is no evidence of hypoxia, as evidenced by normal oxygen saturation levels, LAS policy is to give medium rather than high flow oxygen. The LAS plan to implement the advice contained in the British Thoracic Society Guidelines on Oxygen Therapy which are due for publication later this year.

The Trust Board is asked to note this variation in practice and to approve the use of the 2006 version of the Guidelines for staff working within the LAS.

Update on Cardiac Care

For the year 2005/06 the LAS received a ‘weak’ rating for patient care, based on the joint indicator of achieving a call to thrombolysis time of within 60 minutes in only 42 % cases. As since April 2006 the majority of STEMI patients in London are now taken for primary angioplasty, Professor Roger Boyle (the National Director of Cardiac and Stroke Care) was approached to suggest that the measurement against thrombolysis did not adequately reflect the quality of care received by this group of patients. The LAS asked that a ‘time to reperfusion’, which could cover both those patients having angioplasty and thrombolysis, might be a more accurate reflection of the standard of care.

Some clarification has recently been received from the Health Care Commission (HCC) regarding the thrombolysis indicator.

1. **Low numbers rule**. If the LAS demonstrates low numbers of patients taken for thrombolysis in either Oct 06 - Mar 07 or Apr 06 - Mar 07, then it would be excluded from the indicator. The HCC have not yet confirmed what is classified as 'low numbers', but last year it was 20 patients.

So far, only 4 patients have been entered onto the MINAP database for Oct 06 - Mar 07. This suggests that the low numbers rule may well be applied however, hospitals are still entering data onto the MINAP database so this position could change Hospitals will ratify their data in April 2007.

2. **Primary angioplasty rule.** If the LAS does not meet the low numbers rule, then the Trust may be eligible for the PCI rule. In which case the LAS needs to meet or exceed in April 06 - March 07 our April 05 - March 06 figure of 52.201%.patients taken for PCI. The figure is

currently 41.7%, but this is changing on a daily basis as hospitals enter more data. (As an example, a few days ago the figure was 33%).

The HCC has not yet decided what the PCI threshold will be.

3. **Existing target.** If the LAS does not meet either the low numbers or PCI rule the Service needs to achieve a thrombolysis target of:

* 65.589% or higher in Oct 06 to Mar 07; a 10% point increase on our figure from Oct 04 to Mar 06 (55.589%) and

* 52.201% or higher for Apr 06 to Mar 07; greater than or equal to our figure from Apr 05 to Mar 06 (52.201%).

Greater London Authority Committee investigation into emergency life support skills training (6th March 2007)

Background

The Service was among a number of agencies to give evidence today (Tuesday 6 March) at a meeting of the London Assembly's Health and Public Services Review Committee chaired by Joanne McCartney. The Committee wanted to investigate how emergency life support training is delivered in London and how the number of Londoners trained could best be increased.

The meeting, held at City Hall, also heard from representatives from other organisations as follows:

- Alan Powell, Head of Training and Development, St John Ambulance
- Colin Elding, Heartstart UK Manager, British Heart Foundation
- Dr Mike Colquhoun, Vice Chairman Resuscitation Council UK (also Welsh Ambulance Service Medical Director)
- Dr Gillian Schiller, Project Manager, Saving Londoners Lives

The LAS had previously provided evidence about its involvement in the training of Londoners in emergency life support, public awareness campaigns and the National Defibrillator Project. The meeting focused on additional schemes and initiatives which might improve survival in out of hospital cardiac arrest. We anticipate being asked to comment on the Committee's draft report when published in the late spring.

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 has now started. The Unit has extended its admission criteria to all local complexes, having previously only accepted patients brought by crews from Islington.

Other clinical issues of interest

Clinical Leadership meetings:

Members of the Medical Directorate and the Department of Education and Development have now participated in over 20 meetings with the Complex clinical teams, focusing on local issues such as rates of return of spontaneous circulation, time to first shock, rates of successful endotracheal intubation, end tidal carbon dioxide monitoring, pain management and completion of clinical performance indicators. We have sought feedback on complex based training, selection for paramedic training and alternative methods of delivering the education agenda.

Airway management

JRCALC is hosting a debate on the optimal method of advanced airway management in pre hospital care. Hitherto endotracheal intubation has been accepted as the gold standard. However, the evidence largely gathered in the United States, suggests an unacceptable complication rate. In addition many ambulance trusts are having difficulty in accessing training slots in operating theatres. With the increasing popularity of the laryngeal mask airway (LMA), available to both paramedics, and EMT4s (in London), there is an increasing move towards the LMA being the standard advanced airway. While the subcommittee gathers evidence around UK practice the LAS will undertake an audit to determine the average number of intubations undertaken by paramedics each year and produce good practice guidelines for the verification of endotracheal tube placement and skill retention.

Drug identification

Drug stickers, similar to those in routine use in hospitals, initially for use with morphine have been introduced across the Service.

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

A summary of the cardiac arrest report 2005/2006 and the report of ST elevation myocardial infarction for the same period is included in Appendix 1.

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

The annual report of the Infection Control Steering Committee is presented as a separate agenda item.

7. Seventh Domain – Public Health

Pandemic Flu

The LAS took part in 'Winter Willow', one of the most comprehensive pandemic flu exercises undertaken so far, involving 18 Government Offices, all the SHAs and the Devolved Administrations, as well as some PCTs, acute and ambulance Trusts. Five LAS AOMs were involved at each of the Influenza Pandemic Committees (IPCs) in London. The AOMs fed back on a local basis to an intelligence cell set up on the days of play in the Incident Control Room (ICR). The information was then funnelled up to gold and reported at the Regional Resilience Committee (RCCC).

NHS London described the exercise as 'ambitious and successful'. The debrief is currently being written up with dissemination over the next two weeks. This will influence the draft national ambulance guidance which will in turn influence local ambulance plans.

Recommendation

THAT the Board:

1. Notes the report
2. Approves the adoption of Version 2006 of the National Clinical Practice Guidelines for Use in UK Ambulance Services, accepting the major area of non compliance.

Fionna Moore
Medical Director
15th March 2007

Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board

Summary of Cardiac Arrest Annual Report 2005/06

Authors: Dr Rachael Donohoe and Karen Haefeli

The following information relates to 3022 patients who were resuscitated following an out-of-hospital cardiac arrest of presumed cardiac aetiology, during 1st April 2005 to 31st March 2006.

Patient Profile

The average age of the cardiac arrest patient was 68 (0 - 109) years and the majority of patients were male (66%).

Time and Location of Arrest

Emergency calls requesting help for a cardiac arrest were most frequently received between 8am and 12 noon (24%). Most occurred on a Friday (15%), with one in ten occurring in November (10%). The majority of cardiac arrests (72%) occurred in a private, residential location.

Bystander Witness and CPR rates

Nearly half (46%) of all cardiac arrests were witnessed (seen or heard) by a bystander. A further 12% cases were witnessed by LAS crews. Bystander CPR was initiated in over a third (39%) of cases.

Community Defibrillation

Twenty-four (<0.8%) patients were defibrillated by someone trained as part of the LAS's Community Defibrillation Programme. Nine of these 24 patients (38%) were discharged alive from hospital.

Response Intervals

Interval	Average (range) in minutes
999 call* – arrival on scene	7 (0 – 133)
999 call* – 1st LAS defibrillation**	9 (1 – 51)
Arrival at scene – 1st LAS defibrillation**	3 (0 – 31)
Total job cycle (999 call – green)	39 (0 – 153)

** Time when the incident location and patient's chief complaint were obtained (ORCON time)*

***Includes only patients with a non-crew witnessed arrest and an initial rhythm of VF/VT*

Initial Arrest Rhythm

Almost half of all patients (43%) were in Asystole on arrival of the ambulance crew. Just over a quarter (27%) had an initial presenting rhythm of VF/VT.

Return of Spontaneous Circulation

Just under one fifth (19%) of patients had a return of spontaneous circulation (ROSC) at some point during their treatment by the LAS.

Survival Calculations

The Utstein survival rate (patients in VF/VT who also had a bystander witnessed arrest) was 10.9% (54/495), representing an increase of 6.7% since 1998/1999. The overall survival rate (regardless of rhythm and witnessed status) was 5.3% (152/2884), representing an increase of 2.1% from 2003/2004.

Points for Action

- Efforts must continue to ensure complete, accurate and legible PRF documentation through the Team Leader CPI audit and feedback process.
- Team Leaders must encourage crews to hand in FR2 data cards and downloaded them on a regular basis.
- The LAS should continue to support its programmes of community defibrillation and community resuscitation.
- The LAS must continue to support its programme of cardiac research and audit to enable further cardiac care developments to be made and measured in the coming years.

Summary of ST Elevation Myocardial Infarction Report 2005/06

Authors: Dr Rachael Donohoe and Debbie Evans

The following information relates to 716 patients who, between 1st April 2005 and 31st March 2006, were diagnosed by LAS crews using 12-Lead ECGs as suffering from an ST-elevation myocardial infarction (STEMI).

Patient Information and Type of Infarct

The average age of the STEMI patient was 64 (19 - 100) years and the majority of patients were male (73%). Anterior (45%) and Inferior (40%) were the most common types of infarct documented.

Time of call for help

The majority (19%) of emergency calls requesting help for the STEMI patient were received between the hours 10am and 1pm.

Aspirin Administration

83% of STEMI patients were administered aspirin by LAS crews. 4.5% had taken aspirin before the arrival of the LAS and for 8% aspirin administration was contraindicated.

Pain Assessment

An initial pain assessment was documented on 97% of PRFs. A numerical pain score was used for 66% of patients and a qualitative form of pain assessment was utilised for 31% of patients. Documentation of a subsequent pain score was not as high at 84%, although this does represent an improvement on previous years.

Response Intervals

Interval	Average (range) in minutes
999 call* – arrival on scene	7 (0 – 64)
Arrival on Scene – arrive patient	1 (0 – 18)
Arrival on scene – leave scene	27 (8 – 75)

** Time when the incident location and patient's chief complaint were obtained (ORCON time)*

Conveyance Location

One-third (33%) of STEMI patients were taken directly to a Cardiac Catheter Laboratory during this reporting period. (Please note that direct access to Cardiac Catheter Laboratories was still in the pilot phase and the number of STEMI patients transported to these facilities has increased since then).

In-hospital Treatment

120 (17%) STEMI patients were confirmed as receiving primary angioplasty treatment. Nearly three-quarters (73%; n=88) of these patients were admitted directly to a Cardiac Catheter Laboratory by LAS crews.

130 (18%) STEMI patients were confirmed as receiving thrombolytic treatment; 55% received this treatment within the 60 minute call-to-needle target.

Patient Outcome

Of the 286 patients with outcome data available, 249 (87%) were discharged from hospital alive.

Action points

- Crews must ensure that they record both initial and final numerical pain scores on the PRF.

- Reasons for delays to hospital must be clearly documented as are recorded on MINAP and may result in such incidents being excluded from the Healthcare Commission's thrombolysis target.

- Crews must clearly document the destination hospital name, code and ward to allow accurate identification of patients directly transported to a Cardiac Catheter Laboratory.

Illness code 87 must be used for all patients with an MI confirmed by 12-Lead ECG

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 27th March 2007

2007-10 Budget

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

The attached power point presentation sets out the business plan for 2002/08 and the outline plans for the two following years.

Details of changes from earlier discussions will be outlined by the Director of Finance at the Trust Board meeting

4. Recommendation

THAT the Trust Board approve the 2007/10 budget.

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD 27 March 2007

Long Term Workforce Plan 2007 -2013

5. Sponsoring Executive Director: Caron Hitchen

6. Purpose: For approval

7. Summary

The long term workforce plan presented to the Trust Board is the culmination of work which commenced early last year and has involved the:

1. development and agreement of an operational response model
2. identifying and refinement of a number of future assumptions
3. associated workforce skill mix modelling
4. financial planning and modelling

Details of these assumptions together with the overarching vision of the future workforce are contained in the attached excerpt from the Trust's Strategic Plan which was agreed at the Trust Board in January 2007 (appendix 1).

It should be noted that this workforce plan will continue to be reviewed to take account of changing circumstances which may affect current assumptions. The plan as presented assumes no additional funding for the introduction of revised national response time measurements (Call Connect). If this situation were to change, the plan would need to be revised accordingly.

A description of the future plan is provided with a breakdown of the workforce planning numbers contained in appendix 2.

8. Recommendation

THAT the Trust Board approve the long term workforce plan and support the next steps.

London Ambulance Service NHS Trust

Long Term Workforce Plan

2007 – 2013

Introduction

The long term workforce plan presented to the Trust Board is the culmination of work which commenced early last year and has involved the:

5. development and agreement of an operational response model
6. identifying and refinement of a number of future assumptions
7. associated workforce skill mix modelling
8. financial planning and modelling

Details of these assumptions together with the overarching vision of the future workforce are contained in the attached excerpt from the Trust's Strategic Plan which was agreed at the Trust Board in January 2007 (appendix 1).

It should be noted that this workforce plan will continue to be reviewed to take account of changing circumstances which may affect current assumptions.

A breakdown of the workforce planning numbers is contained in appendix 2.

Workforce plan 2007/08

In the context of next years budget the Trust aims to consolidate the existing expanded workforce and begin to introduce the desired change to skill mix in order to meet the needs of the new service delivery model including the "New Front End Model" (NFEM). These plans currently assume no additional funding to support the changes in response time measurement (Call Connect) to be introduced in April 2008. The plan will therefore change should the Trust be successful in its bid for additional funding in this respect.

The main focus therefore will be to begin the process of enhancing the skills of those staff currently in post rather than recruiting additional staff and the overall staffing numbers will therefore remain unchanged.

The costs of existing Emergency Care Practitioners (ECPs) will be absorbed into the Trust's baseline budgets so as not to be reliant on annual funding negotiations with individual PCTs. This will give the stability required to continue to develop the individuals in these roles and give the Trust the confidence to role out the ECP model further throughout the organisation in future years.

The number of Paramedics is expected to increase from 815 to 936. This will be achieved through a combination of recruitment of university trained Paramedics and internal

paramedic training of Emergency Medical Technicians (of which the majority will be EMT4).

Staff employed in the new A&E support role (title of Emergency Care Assistant is under review), will increase from 99 to 126.

External recruitment within this year will therefore concentrate on the Paramedic role together with some anticipated recruitment to the new A&E support role and the filling of existing vacancies for Clinical Telephone Advisors.

Workforce plan to 2013

From 2008 onwards the Trust will continue the process of enhancing the skills of its existing workforce and will also begin to increase its numbers in response to the assumptions on demand and change in service delivery. Over the period of the plan the Trust intends to:

- Increase the numbers of ECPs by 130 in order that this role can be used appropriately, responding to the patients who require their level of knowledge and skill.

- Maintain the number of Team Leaders (based on existing organisational size and structure).

- Continue the programme of university recruitment and internal training and thereby increase the number of Paramedics to 1,911 (from 815 in 2007).

- Continue to develop existing Technicians through the career progression route with paramedic training. This will be supported by an HR framework agreed through a joint partnership working group. Staffing numbers in both the EMT3 and EMT 4 roles will reduce over time and these roles will ultimately disappear. It is anticipated that by 2013 the majority of EMT3 staff will have progressed to EMT4 or paramedic roles and approximately 120 EMT4s will remain.

- The numbers of A&E support staff will increase by 345 to 444.

- Clinical Telephone Advice will expand with double the numbers of Clinical Telephone Advisors (100 by 2013).

Next steps

The Trust Board to approve the long term workforce plan.

Work will continue with staff side colleagues to agree the HR framework to support the implementation of this workforce plan and provide appropriate protection to existing staff. The next meeting is scheduled for 19 April 2007.

The Training Services Group are is working to finalise agreement of the training plan to support the intentions within this workforce plan.

The vision of the future workforce has been published in LAS News in February 2007. Future communication will include the planned range of staff and managers conferences scheduled to commence in April 2007 together with specific communication of outcomes from the discussions with staff side.

The Trust continues to be fully involved in the national work developing the A&E support role (Emergency Care Assistant).

8.1 Workforce Plan

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 hospital 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 Medical 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 Medical 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.

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 27th March 2007

Assurance Framework

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: To review the Assurance Framework as evidence of compliance with all twenty four core standards for the 2006/7 Annual Healthcheck

3. Summary

This Framework records the assurance and controls we have in place that evidence compliance with the twenty four Core Standards of the Seven Domains that comprise the requirements of the Annual Healthcheck. Non compliance with these standards is treated as risk that threatens our achievement of objectives.

This Framework is the document that provides the Trust Board with assurance that the organisation is fully compliant with the standards for the period from 1st April 2006 to 31st March 2007. When the Final Declaration is submitted to the Healthcare Commission in accordance with their deadlines in April 2007 it will record our full compliance.

The Final Declaration is required to include commentary from the Overview and Scrutiny Committees of the London boroughs. The Framework will be used as the basis for presentations on our compliance to them as requested.

Objectives used for the purpose of the Framework are updated annually and are consistent with the Board and annual service plan's objectives.

The key controls are taken from the Risk Register and other reports prepared and presented to the Board and the Trust's senior committee. Updates are routinely sought to evidence progress and compliance with standards is maintained.

4. Recommendation

THAT the Board agree:

1. That the Assurance Framework contains sufficient controls to evidence full compliance with the Twenty Four Core Standards that comprise the Annual Healthcheck.

2. That the Final Declaration of the Annual Healthcheck be submitted stating that the Trust is fully compliant with the Twenty Four Core Standards and that there have been no significant lapses during the period covered by the Declaration.

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 27th March 2007

Standing Orders, Financial Instructions And the Scheme of Delegation

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary

The Standing Orders, Financial Instructions and Scheme of Delegation have been reviewed and updated in line with the NHS Model Rules published in March 2006. They have been circulated separately to the main agenda (appendix 1)

The Audit Committee considered the proposed amendments to the Standing Orders and Financial Instructions in December 2006 and the Scheme of Delegation in March 2007.

4. Recommendation

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

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

The Standing Orders and Financial Instructions have been reviewed in collaboration with colleagues and a comparison undertaken against the NHS Model Rules published in March 2006.

The following are the proposed amendments to the Standing Orders, the Financial Instructions and the Scheme of Delegation. Please note that in the attached paper 'strike through' denotes a proposed deletion and underlining indicates an addition or amendment.

1. Standing Orders

The main changes to the Standing Orders are:

Admission of the public to Trust meeting

Page 11: 2.4 has been amended in line with the NHS Model Standing Orders. Appendix X1 sets out the Trust's current policy towards Observers.

Minutes

Page 14: 10.5 has been amended and it is proposed that an action sheet be included in the Board's papers and be circulated within 2 weeks of the Trust Board's meeting.

Risk Management Committee

Page 20: the reference to the Risk Management Committee has been deleted and replaced by reference to the Risk Compliance and Assurance Group.

Page 20: following the proposed review of the Trust's Freedom for Information Policy the Standing Orders will include a reference to FOI Appeal panels.

Custody of Seal and Sealing of Documents

Page 23: following the receipt of legal advice the procedure for the use of the Trust Seal has been amended so that two signatures are required for documents executed as deeds.

Suspension of Standing Orders

Page 26: the paragraph relating to the suspension of standing orders has been amended in line with the NHS Model Standing Orders

Codes of Conduct & Accountability

Page 27: this has been amended with reference made to the Department of Health rather than NHS Executive

Overseas Business Travel outside the United Kingdom by Trust Employees

Page 28: the section relating to overseas travel has been amended. It is proposed that this is managed internally, with regular reports to the Audit Committee and an annual report to the Trust Board.

Tendering and Contract Procedure

Page 33- 48 various paragraphs have been amended in line with the NHS Model Standing Orders

Page 49: a paragraph has been added requiring the Chief Executive to demonstrate that best value for money can be demonstrated for all services provided on an in-house basis.

Terms of Reference for the Remuneration & Terms of Service Committee

Page 58: It is proposed that the minutes of the Remuneration Committee be presented to the Trust Board as soon as is practical.

Terms of Reference for the Charitable Funds Committee

Page 60: paragraph 1.3 has been amended to reflect that it is the Trust Board that should determine the policy for the management of the charitable funds

Standards of Business Conduct for London Ambulance Service NHS Trust

Page 62: the changes reflect the issuing of the revised code of conduct and accountability in April 2004 by the Appointments Commission.

Acceptance of Gifts & Hospitality

Page 64: it is proposed that the reporting of hospitality to the Audit Committee is stated within the Standing Orders.

Page 65: this reflects the practice of reminding staff in December of the Trust's policy re. gifts and hospitality.

NB: the recently revised terms of reference of the Board's committees (the clinical governance committee and the audit committee) have been included.

2. Financial Instructions

General

Page 3 Any waivers of Financial Instructions must be reported to the Audit Committee.

Audit

Page 6
- Reference to 2005 Audit handbook has been added
- Annual audit report contents slightly revised to reflect the guidance in the handbook

	Director of Finance
Page 7	Annual Audit report to contain a clear opinion as to the effectiveness of internal control.
	Fraud & Corruption
Page 9	Local Counter Fraud Specialist to be appointed and a written presented to the Audit Committee on counter fraud work undertaken.
	Service Planning, Budgets, Budgetary Control and monitoring
Page 10	States that all budget holders sign up to their allocated budgets at the start of the financial year.
	Annual Accounts and reports
Page 13	Addition to annual accounts being made available to the public (via web site) or on request.
	Bank and Paymaster General Office accounts
Page 13	- Addition of requirement in Model for OPG to be considered for banking services. - Addition of requirement of monitoring compliance with DH guidance on the level of cleared funds
	Income, Fees and Charges and Security of Cash, Cheques and other negotiable Instruments
Page 15	Reference to the DH's 'costing' manual in setting prices for NHS service agreements.
	Choice, requisitioning, orders, receipt and payment for goods and services.
Page 20	requisitions are not to be slip or otherwise raised in a manner so as to avoid the financial thresholds. No requisition to be raised which would cause a budget (year to date) to be overspent.
Page 24	use of purchase cards are mandated by the Director of Finance.
	Stores and receipt of goods.
Page 30	deletion of 12.8 is recommended as purchases from NHS Logistics are no different from any other supplier.
	Information Technology
Page 32	The Director of Technology to publish and maintain FOI

Publication Scheme.

Charitable Funds

Page 34 Trustees responsible must be discharged separately and full recognition give to the Trust's dual accountability to the Charity Commission for Charitable funds held on Trust and to the Secretary of State for all funds held on trust.

Retention of Documents

Page 40 The Chief Executive is responsible for maintaining archives for all documents required to be retained with DH guidance currently the Risk Management: NHS Code of Practice.

Risk Management

Page 41 If the Board decides not to use the risk pooling scheme for any of the risk areas this decision should be reviewed annually.

3. Scheme of Delegation

The Scheme of Delegation has been updated and revised in accordance with the NHS Model Rules. The Audit Committee considered the Scheme and made further amendments which have been incorporated.

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 27 March 2007

Gender Equality Scheme

1. Sponsoring Executive Director: Caron Hitchen

2. Purpose: For approval

3. Summary

The Trust, in common with all public authorities, is required to publish a Gender Equality Scheme.

The Gender Equality Scheme sets out, in broad terms, how the Trust intends to promote gender equality as well as tackle any issues of discrimination or harassment. An action plan is being developed to set out the practical application of the Scheme.

The document is similar in style and structure to previous Schemes published in regards to both Race and Disability. It is intended, subject to agreement of this Scheme, that we combine these schemes in one overall document for ease of use and to demonstrate where commonalities exist.

It is intended that regular reports on the Gender Equality Scheme and its application are taken to the Clinical Governance Committee as with other similar schemes.

4. Recommendation

THAT the Trust Board approve this scheme and support the concept of developing a single Equality Scheme.

Gender Equality Scheme

(April 2007)

This document is also available in other languages, large print, and audio format upon request.

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Αυτό το έγγραφο διατίθεται επίσης σε άλλες γλώσσες, τυπωμένο με μεγάλους χαρακτήρες και σε κασέτα κατόπιν αιτήματος.

ئەم بەلگەیە هەروەها بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەویت

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Este documento encontra-se também disponível noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਰਾਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Настоящий документ по отдельному запросу можно получить в переводе на другие языки, напечатанным крупным шрифтом или на аудиокассете.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio.

Hati hii vile vile inapatikana katika lugha nyingine, kwa maandishi makubwa na katika sauti kwa maombi.

நீங்கள் கேட்டுக்கொண்டால், இந்த ஆவணம் வேறு மொழிகளிலும், பெரிய எழுத்து அச்சிலும் அல்லது ஒலிநாடா வடிவிலும் அளிக்கப்படும்.

Bu belge çeşitli dillere çevrilmiş olup, isterseniz iri harflerle basılmış şeklini ve kasetini de size gönderebiliriz.

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

Tài liệu này cũng có sẵn bằng các ngôn ngữ khác, bản in chữ to, và băng ghi âm khi được yêu cầu.

020 7921 5100

London Ambulance Service Gender Equality Scheme

Introduction
From April 2007 public authorities, including the London Ambulance Service NHS Trust (LAS), are required to produce and publish a Gender Equality Scheme setting out how we will promote gender equality and eliminate discrimination and harassment in the workplace as well as in the delivery of our services.

This Gender Equality Scheme sets out how the Trust will meet its duties set out in the Sex Discrimination Act 1975, as amended by the Equality Act 2006.

Background
It is acknowledged that women can experience disadvantage in the workplace. Across the economy as a whole, the pay gap between men and women stands at 18.3% for full time workers and 43.2% for part time workers. 11% of women work as senior managers or officials compared with 18% of men (Annual Survey of Hours and Earnings 2004 ONS).

The average life expectancy at birth of females born in 2004 in the UK was 81.07 years, compared with 76.82 years for males. Whilst women can expect to live longer than men they are also more likely to spend more years in poor health or experiencing a disability (Health Statistics Quarterly – Winter 2006 ONS).

About the London Ambulance Service
The London Ambulance Service is in the frontline of the NHS in the Capital and provides healthcare to around one and a half million emergency and non-emergency patients throughout Greater London area each year. Demand on our service in growing – during 2005/06, we handled just over 1.2 million emergency calls from across London and attended over 850,000 emergency incidents – up from 827,000 in 2004/05

The core functions of the Trust are to respond to 999 calls, providing the most appropriate response to patients - this may include: sending an emergency response vehicle; providing telephone advice or referring elsewhere; working with GPs and acute trusts in allocating hospital beds; and, providing patient transport services to acute, mental health and primary care trusts across London. The Trust also works closely with the fire and police services and local authorities in matters of emergency planning and major incidents.

The London Ambulance Service is managed by a Trust Board comprising a non-executive chairperson, five executive directors (including the chief executive) and six non-executive directors. A representative from the Patients' Forum has observer status on the Trust Board.

LAS Vision and Values

The London Ambulance Service has a vision statement and a set of values that set out the organisation's approach to its staff, to the communities it serves, and to all of its stakeholders.

The LAS Vision is:

> ***"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."***

The LAS Values are:

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 patient's needs

Respect and Courtesy - We will value diversity and will treat 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.

Equality and Diversity Policy Statement

The Trusts' vision and values are supported by the following Policy Statement:

'The London Ambulance Service is committed to equality and diversity. One of our values states:

> ***'We will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy.***'

In practical terms this means:

> • Everyone, including patients, colleagues and health and social care partners, will be treated as they would wish to be treated, with respect and courtesy.
>
> • At recruitment and throughout their employment we will treat all individuals fairly. This will include ensuring staff receive equal treatment regardless of ethnic origin, gender, disability, sexual orientation, age, religion or belief.
>
> • We recognise that the diversity of our staff benefits the organisation – we aim to have a workforce that is reflective of, and knowledgeable about the communities in which we work.
>
> • We will seek to treat patients to the highest possible standards and according to their individual need.

It is the responsibility of all staff to support this commitment in all aspects of their work.'

Public Authority Duties

General Duty
From 6th April 2007 all public authorities are subject to the General Duty under the Sex Discrimination Act, when carrying out their functions, to have due regard to the need to:

- eliminate unlawful discrimination and harassment that is unlawful under the Sex Discrimination Act 1975(SDA) and in relation to employment and vocational training (including further and higher education), eliminate discrimination and harassment against transsexual individuals
- eliminate discrimination that is unlawful under the Equal Pay Act 1970, and
- to promote equality of opportunity between men and women.

Specific Duties
In addition, the Government set out a number of Specific Duties designed to enable organisations to comply with the General Duty:

- prepare and publish a Gender Equality Scheme by 30 April 2007 showing how a public authority intends to fulfill the general and specific duties and setting out its gender equality objectives;

- In preparing a scheme to:
  - consult employees, service users and others (including trade unions);

    - take into account any information it has gathered or considers relevant as to how its policies and practices affect gender equality in the workplace and in the delivery of its services;
    - in formulating its overall gender equality objectives, consider the need to have objectives to address the causes of any gender pay gap.

- ensure that the scheme sets out the actions the authority has taken or intends to take to:
    - gather information on the effect of its policies and practices on men and women, in employment, services and performance of its functions;
    - use the information to review the implementation of the scheme objectives;
    - assess the impact of its current and future policies and practices on gender equality;
    - consult relevant employees, service users and others (including trade unions);
    - ensure implementation of the scheme objectives.

- implement the scheme and their actions for gathering and using information within three years of publication of the scheme, unless it is unreasonable or impracticable to do so;

- review and revise the scheme at least every three years;

- report on progress annually.

Gender Equality Objectives
During the period covered by this Gender Equality Scheme (April 2007 – March 2010) the London Ambulance Service intends to achieve the following specific Gender Equality Objectives:

- Continue to make progress in gender representation of the workforce through recruitment of women to the range of roles available in the LAS;
- Make use of positive action initiatives, where appropriate, to increase the percentage of women in senior management posts, including operational management, and in departments and roles where there is a significant degree of gender segregation;
- Carry out an audit of pay grades by gender and identify the average pay for women and for men;
- Develop appropriate actions to eliminate or reduce any inequalities in pay between women and men;
- Using Impact Assessments (including current data and research), to identify health issues that the LAS can reasonably be expected to make an impact on, and which affect men and women disproportionately, and where appropriate and possible, to adapt our policies and practices to help those most affected.

Accountability
The London Ambulance Service has a Race Equality and Diversity (READ) Implementation Team, made up of representatives from across the Trust, which is responsible for monitoring compliance with equality legislation. The READ Implementation Team includes Trade Union representation, as well as representatives from the LAS Patients' Forum.

The Race Equality and Diversity (READ) Strategy Group includes the Director of Human Resources and Organisation Development, and the Director of Operations. The Group is responsible for setting out the Trust's strategic direction in regards to equality and diversity legislation and good practice, and addresses both workforce and service delivery issues.

Quarterly reports from the READ Implementation Team, and the READ Strategy Group are presented to the Clinical Governance Committee. This is a Trust Board level committee. This group is chaired by a non-executive director who is the Board focus for equality and diversity issues.

The Director Human Resources and Organisation Development provides the executive lead for equality and diversity on the Trust Board and the Chief Executive, is responsible for its overall direction.

The Trust has in place a Diversity Team, consisting of a Diversity Manager and two Diversity Officers, who provide the specialist advice and guidance on equality and diversity matters across the organisation. The Diversity Manager is a member of the Trust's Strategic Steering Group. This is the body that develops the annual Service Plan and the longer-term Strategic Plan for delivering ambulance services across London.

The Government sets standards for all healthcare providers through it's "Standards for Better Health" policy. These standards, which include various equality and diversity components, are monitored and inspected by the Healthcare Commission, through an Annual Health Check and additional 'themed' inspections.

The Trust is also open to scrutiny from the statutory commissions, including the Commission for Equality and Human Rights.

Gathering Information

We will use various sources of information to assess our success in achieving out gender equality duties:

Government Data. The Government carries out a national census every ten years. The most recent data is taken from the 2001 Census. This shows that around 51% of Londoners are female, and 49% are male.

Workforce Data. The Trust's workforce data shows that 38% or our staff are female and 62% are male (2006), recruitment figures for 2005-06 showed that 50% of recruits were female. We will be able to publish the numbers of staff, by gender, for recruitment and promotion, the distribution of women and men in the workforce by seniority and by types of work, harassment, access to training, grievance and disciplinary procedures and leavers. We can also provide data regarding harassment of staff and service users, and of complaints by and against our staff, by gender. The Trust can also show return rates for women on maternity leave and whether they are returning to jobs at the same level of responsibility and pay.

Service Data. Using information processed by our Management Information Unit from Patient Report Forms, call data and other service data, we will be able to produce a profile of

our patients and service users broken down by gender. We will then be able to see how these data compare against expectations arising from population data and other research data to determine if we are achieving gender equality in our service delivery.

Research. The Trust's Clinical Audit and Research Team uses patient data recorded by our own staff, as well as data from other healthcare organisations, questionnaires, focus groups and other published research data to gauge the effectiveness of clinical and organisational procedures, equipment and other inputs. Their work results in recommendations for changes and improvements to clinical practice. We also carry out patient and staff satisfaction surveys, which provide primarily qualitative data.

Consultation and Involvement

The Trust consults key stakeholders on an ongoing basis. Views, comments and recommendations, and in particular those concerning matters related to gender, have been considered in the development of the scheme.

The following outlines some of the involvement initiatives to date:

Service Improvement Programme. The Trust carried out a stakeholder consultation process prior to launching our Service Improvement Programme. In 2005 we identified eight key stakeholder groups: Patient and Public; Greater London Authority/London Boroughs; Staff; Primary Care Trusts; Strategic Suppliers; NHS Partners; Blue Light Emergency Services; and Department of Health/Strategic Health Authority. In September of that year the Patient and Public stakeholder event took place, which brought together a range of people from across London. Participants were asked to define what the Trust's vision meant to them:

> *LAS 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.*

The final product was a stakeholder goal statement as follows:

> *An organisation which provides the right response, in the right place, at the right time to satisfy patients' needs, balancing response time targets with what patients really want and need. This requires:*

- 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;

- 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;

- Continuous engagement, two way communication and feedback from the many communities of London to ensure that patients and their carers drive continuous service improvement;

- Staff treating all patients and public according to the LAS Values, sensitively and with awareness of diversity in cultural norms.

Once all the stakeholders had been consulted, a final set of stakeholder goals was established:

- An accessible service…
  Accessible to Patients and Partners: Easy to contact; recognising diversity; responding to partners with right level of authority

- 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.

- 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.

- provides greater options for patients…
  New Outcomes for Patients: Fewer go to hospital Accident and Emergency departments; staff skilled & confident to use alternative care pathways; career pathways in place

- continues to focus on delivery…
  Delivery Focused: National targets; Government frameworks; Standards & guidance; cost effectiveness.

- 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.

The Trust's Diversity Manager is the specialist lead for all equality and diversity related matters, including gender issues. Each of the four programme boards includes the Diversity Manager.

Patients' Forum. The London Ambulance Service Patients' Forum provides regular valuable feedback on the Trust's performance from a patients' perspective. They take a keen interest in equality and diversity issues in particular, and receive regular briefings on developments in this area. Patient's Forum members attend various Trust Board committee meetings, and other planning meetings.

Obstetrics Audit. The Trust's Clinical Audit and Research team are conducting a major audit into the experiences of women who use our services as they go into labour.

Patient and Public Perceptions. During 2006 the Trust commissioned a major piece of research into the perceptions of the London Ambulance Service. The research forms part of the evidence base for evaluating our current service, and for developing our service for the

future. We were also able to discern the views of women and men where they significantly differ.

Local Events. As well as centrally organised events, local managers and staff organise community involvement and engagement events at borough level. We keep records of these events on the Patient and Public Involvement (PPI) database, which is maintained by the PPI Manager.

The future. This record of involvement, engagement and consultation will continue into the future. The Access and Connecting for Health programme includes plans for a number of projects addressing access issues. Stakeholder involvement is a central part of the programme and project methodology in use within the Trust.

These initiatives, and others that will develop later, will enable people to have a real influence on the development of the Trust's policies, procedures, and more importantly our practice, as we work through our Gender Equality Scheme. We see this scheme as a live document that will evolve and improve.

Impact Assessment

The Trust's functions have been listed and prioritised according to their relevance to Gender Equality. This list enables us to identify which functions should be targeted for carrying out an impact assessment. This process is designed to identify if any policy, procedure or function might have an unjustifiable and disproportionate negative impact on women, men or transsexual people, and to put in place an action plan to eliminate or reduce that negative impact.

We will publish the results of our impact assessments as they are completed, to demonstrate progress towards our Gender Equality objectives.

Procurement

We will ensure that we use Gender Equality as a factor when selecting external contractors, as well as in our decision making when purchasing goods and services from outside the Trust.

Equal Pay Review

The Trust will carry out a review of staff pay. This will include identifying the average pay for men and for women, and if necessary, developing actions to reduce any pay gaps which might be uncovered.

Recruitment and Selection

It is already an aim of the Trust to become more reflective of the London population we serve. This currently means we need to recruit more women, especially into our front-line roles, and senior management. In 2006 we set ourselves a target to recruit at least 50% women for each intake, in order to move towards greater representation of women overall. This target was achieved.

Training, Education and Development
The Trust has developed an equality and diversity training programme for staff, called Promoting Best Practice in the Workplace. The programme covers all aspects of equality, including gender and transgender issues. So far over 750 front-line staff have attended the one-day course, all in-house trainers have undertaken a one-week course, plus we have a team of 19 in-house trainers who have undertaken a further one-week Diversity Trainers' Facilitation course to enable them to deliver the one-day course to the rest of our staff.

The NHS Knowledge and Skills Framework consists of various competencies which staff must demonstrate for their particular roles. One of the six core competencies, which all staff regardless of role must possess, is Equality and Diversity. Each member of staff takes part in a Performance Development Review at least once a year where their competencies are reviewed and a Personal Development Plan is put in place.

All new staff take part in a Corporate Induction programme which includes a session on Managing Diversity. The session includes information on health inequalities, including those that affect women and men differently.

All front-line staff have a Diversity module during their foundation training courses, including courses for newly selected operational managers.

The Trust is developing a comprehensive Management and Leadership Development programme for all levels of management. This will include an equality and diversity module and will cover the duties under the Sex Discrimination Act.

Transgender Equality
The London Ambulance Service has in place a Transgender Policy that provides information to managers and staff about the legal framework under the Gender Reassignment Regulations. It also provides practical advice in how to support staff who are currently undertaking, intend to undertake or who have already undertaken gender reassignment treatment. The Policy makes clear that transgender staff, in common with all other staff, are entitled to work in an environment free from discrimination, bullying or harassment.

Action Plan
This Scheme will have an accompanying Action Plan setting out specific actions needed to meet our duties under the relevant legislation and achieve our Gender Equality objectives. The Action Plan will highlight the responsibilities of named individuals and will include time frames for completion.

Monitoring, Reporting and Reviewing
Progress against the objectives of this Gender Equality Scheme will be monitored through the lines of accountability outlined earlier in this document, in particular through the Trust's Clinical Governance Committee.

An Annual Report will be published alongside this Gender Equality Scheme outlining the progress to date, and the work still to be completed, plus updates to workforce and service data.

The Gender Equality Scheme will be reviewed after three years, and if required, a revised scheme will be published.

Comments, complaints or enquiries regarding our services

Wherever possible, we encourage patients, their carers and families, and members of the public to raise any concerns or issues they may have with the relevant staff at local level. We aim to be responsive to concerns expressed by patients, their carers and families or members of the general public. Our Patient Advice and Liaison Service (PALS) can act as a facilitator in relation to any concerns or issues by negotiating solutions or resolution as speedily as possible. PALS is responsible for acting as first point of contact for formal complaints, records of appreciation, and enquiries about the services we provide. We take steps to ensure that compliments and records of appreciation are fed back to the relevant staff. Complaints will be investigated with the aim of providing a response within 20 days.

You can write to them at:

Patient Advice and Liaison Service (PALS)
London Ambulance NHS Trust
St Andrews House
St Andrews Way
London E3 3PA

Telephone: 020 7887 6678
Fax: 020 7887 6655, Email: pals@lond-amb.nhs.uk

Gender Equality Scheme. Specific queries in relation to the Gender Equality Scheme should be addressed to:

Caron Hitchen, Director of Human Resources
London Ambulance Service
Headquarters
220 Waterloo Road
London, SE1 8SD

Telephone: 020 7921 5223

List of Relevant Functions

	Gender Equality General Duty Requirements Does the policy/function assist in these duties?		Priority
	Eliminate Unlawful Discrimination and Harassment	**Promote Equality of Opportunity between Men and Women**	**High** / Low **H** / L
1. Accident and Emergency (A&E) Sectors			
1.1 Assessing, treating and transporting patients	✓	✓	**H**
1.2 Liaison with other services, e.g. NHS Trusts, local authorities, emergency services	✓	✓	**H**
1.3 Educational role – schools, GPs, public events	✓	✓	**H**
1.4 Attendance at public events – carnivals, football matches etc	✓	✓	**H**
1.5 Patient Public Involvement	✓	✓	**H**
2. Emergency Operations Control			
2.1 Receive emergency/999 calls	✓		L
2.2 Prioritise calls			L
2.3 Give pre-arrival advice	✓		L
2.4 Dispatch resources	✓		L
3. Urgent Operations Control			
3.1 Receive urgent and non-urgent calls	✓		L
3.2 Provide clinical telephone advice	✓		L
3.3 Dispatch resources	✓		L
4. Patient Transport Service			
4.1 Plan journeys for patients	✓	✓	**H**
4.2 Transport patients to and from hospitals / clinics	✓	✓	**H**
4.3 Provide care to patients en route and in the waiting areas	✓	✓	**H**
4.4 Liaise with hospital staff	✓		**H**
5. Emergency Bed Service			
5.1 Allocate beds to patients, liaising with GPs, hospitals and patients as required			L
5.2 Take out of hours calls for district nursing services and Red			L

	Gender Equality General Duty Requirements Does the policy/function assist in these duties?		Priority
	Eliminate Unlawful Discrimination and Harassment	**Promote Equality of Opportunity between Men and Women**	**High** / Low **H** / L
Cross			
5.3 Liaise with other services, e.g. NHS Trusts, local authorities, Control			L
5.4 Demonstrate work of the service to users and other parties	✓	✓	**H**
6. Service Development			
6.1 Service development – development of clinical care, policy development	✓	✓	**H**
6.2 Commissioning arrangements	✓	✓	**H**
6.3 Clinical audit	✓	✓	**H**
6.4 Clinical research	✓	✓	**H**
6.5 Service planning	✓	✓	**H**
6.6 Prepare business cases	✓	✓	**H**
6.7 Programme and project support			L
7. Communications Directorate			
7.1 Internal communications, e.g. LAS News, bulletins	✓	✓	**H**
7.2 External communications, e.g. media, annual report, LAS website	✓	✓	**H**
7.3 Public events, e.g. LAS museum, visits to schools and colleges, exhibitions and other public events	✓	✓	**H**
7.4 Media resources, e.g. photography, videos	✓	✓	**H**
7.5 Miscellaneous – organising award ceremonies, managing international visits, staff funerals, staff recognition initiatives	✓	✓	**H**
7.6 Managing Patient Public Involvement	✓	✓	**H**
7.7 Liaison with Patient's Forum and patient representatives	✓	✓	**H**
8. Human Resources			

	Gender Equality General Duty Requirements Does the policy/function assist in these duties?		Priority
	Eliminate Unlawful Discrimination and Harassment	**Promote Equality of Opportunity between Men and Women**	**High** / Low **H** / L
Directorate			
8.1 Equality and Diversity	✓	✓	**H**
8.2 Recruitment and selection	✓		**H**
8.3 Education and development	✓	✓	**H**
8.4 Organisation development	✓	✓	**H**
8.5 HR Policies and procedures and projects	✓	✓	**H**
8.6 Terms and conditions of service	✓	✓	**H**
8.7 Staff support	✓	✓	**H**
8.8 Workforce monitoring and information	✓	✓	**H**
8.9 Safety and risk	✓	✓	**H**
8.10 Payroll	✓		**H**
8.11 Grievances, discipline and dismissals	✓	✓	**H**
8.12 Providing emergency life support training both internally and externally	✓	✓	**H**
9. Finance Directorate			
9.1 Procurement and contracting	✓	✓	**H**
9.2 Management of the Crown Agents contract for services	✓	✓	**H**
9.3 Investigate and manage legal claims against the Trust	✓	✓	**H**
9.4 Collect, collate, analyse and store information on patients	✓	✓	**H**
9.5 Provide information as requested to internal and external parties	✓	✓	**H**
9.6 Maintain High Risk Register	✓	✓	**H**
10. Patient Advice and Liaison Service			
10.1 Give advice to the public about the services the LAS provides	✓	✓	**H**
10.2 Act as first point of contact for complaints and for thanks	✓	✓	**H**
10.3 Investigate complaints about the services provided	✓	✓	**H**

	Gender Equality General Duty Requirements Does the policy/function assist in these duties?		Priority
	Eliminate Unlawful Discrimination and Harassment	**Promote Equality of Opportunity between Men and Women**	**High** / Low **H** / L
10.4 Collate and publish data on complaints	✓	✓	**H**
10.5 Responding to Freedom of Information requests	✓	✓	**H**
11. Governance Development Unit			
11.1 Coordinate Trust's governance arrangements	✓	✓	**H**
11.2 Facilitate the development of LAS policies and procedures	✓	✓	**H**
11.3 Manage the Trust Risk Register and prepare the Trust for external risk management audits	✓	✓	**H**
11.4 Prepare the Trust for external operational and clinical inspections, e.g. by the Healthcare Commission, Strategic Health Authority etc.	✓	✓	**H**
11.5 Maintains responsibility for document control			L
12. Information Management and Technology			
12.1 Provide support to users of internal IT systems, including training	✓		L
12.2 Specify requirements for new premises and acquire new premises	✓		L
13. Miscellaneous / Common Functions			
13.1 Complaints handling	✓	✓	**H**
13.2 Management of staff	✓	✓	**H**
13.3 Communications internally and externally	✓	✓	**H**
13.4 Policy and procedure development and review	✓	✓	**H**
13.5 Public education / information and liaison	✓	✓	**H**

Enclosure 11

London Ambulance Service NHS TRUST

TRUST BOARD March 27th 2007

Pan London Emergency Planning

1. Sponsoring Executive Director: Chief Executive

2. Purpose: For noting

3. Summary

The service is near to reaching agreement with the SHA/NHS London to undertake, on their behalf, the Emergency Planning obligations for London. This pan London responsibility will fit well with existing structures and allow LAS strategic oversight for health in the region.

A Service Level Agreement is nearing completion and is presented in Part 2 of the Board meeting for approval due to the nature of its function.

4. Recommendation

THAT the Board note the intention to sign a three year Service Level Agreement with NHS London.

Enclosure 12

London Ambulance Service NHS TRUST

TRUST BOARD 27 March 2007

Individual Performance Monitoring and Reviews

1. Sponsoring Executive Director: Martin Flaherty

2. Purpose: For noting

3. Summary

A software product has been provided to Complex Management Teams, to assist with performance management across a range of measures, on an individual basis.

As it is not possible to remove individual names from the system/presentation it is proposed that a demonstration of the software is given in the confidential part of the meeting.

4. Recommendation

THAT the Board note the report.

Individual Performance Monitoring

Individual performance monitoring is not new to the LAS. Station management teams have always had the ability to monitor the performance of clinical staff in many areas including attendance, clinical skills, response-time performance and average time spent on calls. The Individual Performance Monitoring project has brought this ability up to date, by delivering a software solution to make data collection and analysis easy, accurate and quick.

Specifically, this project produces data about individual 999 calls and allocates the performance to the individual staff members who carried out the call.

The performance of individual staff members is collected in relation to:

- time to 'turn out' to the call;
- time to drive to the call;
- time at the scene of the call;
- time at hospital
- overall time to complete the call.

To ensure staff are fairly measured and not measured against arbitrary targets, the performance of each individual is measured against colleagues at the same station. Management teams have been asked to speak to the best performers in key measures, to recognise their excellence and to capture best practice. They will also see the weakest performers in specific measure, to give support and encouragement to improve.

When discussing performance matters with staff members, managers will consider the individual 'in the round', by also considering patient treatment performance (which is already captured electronically) and clinical supervision reports from Team Leaders.

In summary, this project allows us to recognise excellence, encourage improvement and identify development needs.

Russell Smith
Deputy Director of Operations
21 March 2007

Enclosure 13

London Ambulance Service NHS TRUST

TRUST BOARD 27th March 2007

Annual report regarding Infection Control

1. Sponsoring Executive Director: Fionna Moore

2. Purpose: For noting

3. Summary

The report summarises the activities co-ordinated by the Infection Control Steering Group. This is split into four broad areas – Audit, Education and Communications, Products and Facilities, and Occupational Health.

The significant development during the last year has been the establishment of a Code of Practice by the Department of Health for the Prevention and Control of Health Care Associated Infections. To assess progress a self-assessment was carried out from which an action plan has been devised. The actions revolve around improved policies, training requirements, cleaning standards, and procurement of vehicles and products.

New disposable medical items have been introduced. The introduction of the new safety cannula has been achieved with an objective of reducing needle stick injuries.

The Make Ready Scheme continues to produce good swabbing results. Swabs of vehicles indicate no presence of MRSA.

4. Recommendation

THAT the Trust Board note the contents of the Infection Control Annual Report.

Annual Report of the
Infection Control Steering Group
March 2007

1. Infection Control Steering Group

Background

1.1 The LAS has well developed infection control procedures which were introduced throughout the organisation during 2001. They have all been incorporated into an easy to use reference manual, which integrates relevant background information with procedural instructions for all operational staff and managers of the Service. The manual has been provided on an individual issue basis, and was designed both as the key training tool in the new procedures, as well as a follow-up reference source for staff whilst on duty. Its presentation and format allows for easy update and replacement of any page or section, as future changes may dictate.

1.2 The topic of Infection Control is included as an integral element of all LAS clinical training programmes, and also forms part of the Corporate Induction programme for all new members of staff. Furthermore, the subject is utilised within the new entrant selection process for candidates wishing to enter the Emergency Medical Technician grades of staff.

1.3 The Health Act 2006 established a Code of Practice for the Prevention and Control of Health Care Associated Infections. The Code lays down a number of requirements to ensure there are appropriate management systems in place. These include risk assessment, providing an appropriate environment, and provision of information. The Code also requires an Infection Control Programme is implemented and monitored.

1.4 To assess the compliance of the Service with the Code of Practice, a self assessment exercise was carried out. The Department of Health "Essential Steps to Safe, Clean Care" was utilised. This highlighted a number of areas which the Service needs to address. These include audits, education and training, the health care environment and decontamination of reusable medical devices. The areas identified will be addressed as part of the Infection Control programme.

1.5 The Medical Director holds overall responsibility for infection control arrangements. The sponsor for infection control, with day to day responsibility for developing and implementing the infection control action plan, is the Head of Operational Support with a Practice Learning Manager acting as clinical lead.

1.6 The Infection Control Steering Group reports on progress with infection control arrangements to the Medical Director through the Clinical Governance Group. The Medical Director, who a member of the Trust Board, includes a summary of infection control arrangements within her formal report.

2. Terms of Reference

2.1 The purpose of the Infection Control Steering Group is:

To provide a robust mechanism for assuring infection control arrangements, providing advice on infection control matters and providing a framework for improving infection control arrangements in order to improve patient care.

2.2 The group comprises staff representatives, senior managers from the Department for Education and Development, Governance Development Unit, an external Infection Control Nurse Consultant, Human Resources, Occupational Health, PTS, Logistics Department, A&E management and Estates Department.

2.3 The group submits records of meeting minutes to the Clinical Governance Group and an annual report on behalf of the Medical Director to the Trust Board. A summary of infection control matters is also included in the Medical Director's report to the Trust Board.

2.4 The four broad areas of work covered by the ICSG are:

- Audit
- Education and Communications
- Products and Facilities
- Occupational Health

3. Audit

3.1 Essential Steps to Safe, Clean Care – Self Assessment Tool for Ambulance Services

The Department of Health provides a self assessment tool for Ambulance Services to assess their compliance with infection control measures. The assessment is based on the following key challenges:-

Challenge 1 – Engage with staff throughout the organisation to promote and secure the implementation of best practice in the prevention and control of infection.

Challenge 2 – Review the patient journey in order to reduce the risk of transmission of infection.

Challenge 3 – Ensure that written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance.

Challenge 4 – Ensure effective auditing of infection-control standards across the care providers through monitoring and implementation of new findings

Challenge 5 – Ensure the organisation has a programme of education and training for infection-control that is tailored to the needs of care delivery

Challenge 6 – Ensure that healthcare environments reflects best practice design for infection-control and effective cleaning services are available

Challenge 7 – Implement an organisation-wide policy / procedure for the decontamination of re-usable medical devices including but not limited to surgical instruments

3.2 As a result of the assessment the following actions have been identified:-

- Responsibility for Infection Control to be included in all job descriptions
- Ensure Infection Control leads have appropriate training
- To formally develop an Infection Control Prevention Programme and record work carried out
- Formalise systems to review policies and procedures every two years
- Review results of infection control audits and incorporate these in improvement plans
- Instigate ongoing training programme for infection prevention and control
- Ensure infection control is included in all staff induction programmes
- Ensure infection control is included in annual mandatory training programmes
- Ensure infection control is included in staff appraisals/PDR's
- Ensure that infection control issues are taken into consideration at the planning, design, and procurement stage of buildings and vehicles by representation on project groups
- Check LAS is compliant with national scheduled vehicle cleaning guidelines
- Roll Out Make Ready Scheme to PTS and RRU vehicles
- Check LAS is cleaning ambulances in line with national guidelines
- Ensure that cleaning staff have infection control training
- Ensure that there is an appropriately trained decontamination lead for reusable medical devices in the LAS
- Ensure that the Vehicle and Equipment Working Group takes account of infection control issues when considering procurement of medical devices

3.3 These actions will form the basis of the Infection Control Programme for 2007/08. This will be co-ordinated as a Prince 2 project with formal milestones and objectives set and regularly monitored.

4. Infection Control Co-ordinator

The Infection Control Steering Group has recommended that the Trust employs a full time co-ordinator, such as a Clinical Nurse Specialist, to take forward the programme and develop policies. They would form a link with the Department of Health MRSA/Cleaner Hospitals team and develop the application of controls at local station level.

5. Other Audit Activity

5.1 The Governance Unit carried out a further baseline audit during 2006. The results of the audits were reported to each AOM to take the necessary local action. The audits examined a number of areas including the cleanliness of vehicles and premises, disposal of clinical waste and general waste, and compliance with the Trust's infection control policies.

5.2 The Governance Unit are formulating their plans for audit of Infection Control with clinical audit and operational staff input to produce a more analytical format of the audit tool. This will enhance clinical ownership and evidence improvement through detailed outcome reports. The audit will tie in closely with the action plan prepared following the Essential Steps to safe clean care self assessment

6. Education and Communications

6.1 Plans to develop a CPD module are still being pursued. A CPD module would be deliverable either at a university site or at one of our own education and development centres. A six week interactive CPD module programme with web based support has been considered in partnership with Kingston University.

6.2 A programme of service wide training is still underway to familiarise staff with the "six steps" hand washing technique. This is reinforced by the poster campaign being undertaken throughout the service

6.3 The ICSG has identified the need for local infection control "champions" to be established on each Complex. This could be a member of staff or a local manager. The "champion" would develop an expertise in infection control issues and act as co-ordinator for promoting the CPD programme and as a link for other corporate initiatives and audit activities. This objective will be a key part of the Infection Control programme for 2007/08.

7. Products and facilities

7.1 The ICSG has initiated a range of projects to improve practical infection control arrangements. These include the following:

- Disposable laryngoscope blades, masks and bacterial filters added to consumables catalogue.
- Disposable Bag and Mask kit to be rolled out early in 2007 following evaluation
- New safety cannula introduced
- New latex free gloves introduced
- Inoculation storage fridges purchased for local sites
- New contractor appointed to collect clinical waste measured against KPI's

7.2 The ICSG will continue to work closely with the Vehicle and Equipment Working Group to identify suitable products. New arrangements have been introduced for streamlining product assessment, dispensing with lengthy trials where there is a low clinical risk. Better use will also be made of products which have been assessed and approved by the NHS Purchasing and Supply Agency

8. Occupational Health

8.1 The Service continues to work with Occupational Health to improve arrangements for recall of staff for boosters and inoculations. Appointment letters sent direct to staff have a limited effect, so work has been carried out to establish a network of clinics on LAS premises with regular visits by OH nurses. Line managers are being provided with a list of staff that require vaccinations along with the schedule of clinics and appointments, and will be asked to ensure that appointments are made and attendance is facilitated / monitored.

8.2 The contract for provision of occupational health services is to be re-tendered in 2007 with a view to having new arrangements in place in the Autumn.

9 Infection Control Risk Register

9.1 The ICSG monitors risks that appear on the Trust risk register that relate to infection control matters. The risk register is tabled at each meeting of the group to monitor and report on progress in reducing each risk. The group also monitors any trends in reported incidents to identify new risks.

10 Make Ready Update

10.1 The Make Ready Scheme is the method by which the Trust ensures that ambulances are clean, fully equipped and ready for operation. The scheme was fully rolled out to all 25 station complexes in the Spring of last year.

10.2 The scheme is monitored through a set of 13 Key Performance Indicators. Weekly performance data against KPIs is produced. Make Ready performance is reported to the Make Ready Contract Group on a monthly basis. The Operational Support Units also monitor performance on a local basis at their weekly meetings. Operational Support Forums have been established in each of the three areas. These Forums, which provide a platform for support departments and operational colleagues to plan and discuss issues of mutual concern, have been expanded to include discussion of Make Ready issues.

10.3 Four of the 13 KPIs are directly relevant to the ICSG:

- KPI 1 – Every available ambulance Made Ready once every 24 hours
- KPI 2 – Standard of ambulance cleanliness
- KPI 3 – Conformity to ambulance inventory
- KPI 5 – Standards of station cleanliness

All KPI targets are set at 100%.

10.4 Additional performance measurements have also been developed to monitor the number of vehicles made ready from total allocation. This helps to maintain an oversight as to any factors which are restricting the numbers of vehicles being made available to the Make Ready Teams. This may be due to vehicles having insufficient equipment, being in Workshops, or not being released by Operations.

10.5 Performance against the KPI's remains robust. Additional effort is being made to ensure a higher percentage of vehicles from the total allocation are made ready every night. Consideration is also being given to adding RRU's and PTS vehicles to the scheme during 2007/08.

10.6 Regular swab tests are taken on vehicles subject to Make Ready from four fixed locations subject to change every three months. The swabs are processed by an independent laboratory and reported on monthly.

10.7 Results indicate that the total viable count of all bacterial types on the rear drop down step of an ambulance dropped from more than 30,000 to 3,000. The range of bacteria including E Coli and Salmonella on the trolley bed dropped from 510 to less than 10. All swabbed areas effectively indicated a zero count of staphylococcus bacteria (MRSA) both before and after Make Ready cleaning.

11 Patient and Public Involvement

11.1 The Patient & Public Involvement (PPI) Manager has been in post since July 2005. She holds a database of reported PPI activity across the Trust and is responsible for implementing the PPI Strategy, and encourages / supports LAS staff and managers to involve patients in their developments and activities.

11.2 A presentation was given to the LAS Patients' Forum in early 2006 about the Made Ready Scheme. Forum members were supportive of the Scheme. Information about the Scheme has also been presented to the Deptford Care of the Elderly Action Group.

12 Next Steps

12.1 An Infection Control Programme for 2007/08 will be agreed with the Medical Director. This will include an action plan to address the issues raised by the Self Assessment exercise described in paragraph 3.2. The following issues will be fully addressed in the first phase of the programme and will be cost neutral:-

- Responsibility for Infection Control to be included in all job descriptions
- Formalise systems to review policies and procedures every two years
- Review results of infection control audits and incorporate these in improvement plans
- Ensure infection control is included in all staff induction programmes
- Ensure infection control is included in annual mandatory training programmes

- Ensure infection control is included in staff appraisals/PDR's
- Ensure that infection control issues are taken into consideration at the planning, design, and procurement stage of buildings and vehicles by representation on project groups
- Check LAS is compliant with national scheduled vehicle cleaning guidelines
- Check LAS is cleaning ambulances in line with national guidelines
- Ensure that cleaning staff have infection control training
- Ensure that the Vehicle and Equipment Working Group takes account of infection control issues when considering procurement of medical devices

12.2 Resolution of the following issues will be addressed over a longer timescale:-

- Ensure Infection Control leads have appropriate training
- Instigate ongoing training programme for infection prevention and control
- Ensure that there is an appropriately trained decontamination lead for reusable medical devices in the LAS
- Roll out Make Ready Scheme to PTS and RRU vehicles

12.3 All these longer term initiatives will require some degree of funding for which appropriate bids will be made. The development of CPD training and extension of the Make Ready scheme will be part of wider initiatives.

12.4 A bid has been made as part of the SPPP process for an Infection Control Co-ordinator. Estimated annual salary costs are around £30,000.

12.5 The estimated annual usage of disposable bags and masks and laryngoscope blades will cost approximately £46,000. The annual usage costs of reusable versions of these items is around £33,000. By phasing in the disposable bags and masks some of the extra costs can be absorbed in the first year of introduction.

Chris Vale
Head of Operational Support
March 2007

Enclosure 14

London Ambulance Service NHS TRUST

Trust Board – 27th March 2007

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

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

3. ❑ **Approved:**

- The Committee's workplan for 2007 (attached for information)
- The revised format of the risk information report
- That the proposed Compliance Register should be reviewed by the RCAG rather than the Clinical Governance Committee.
- That Risk 267 (delay in activating vehicles due to the unavailability of vehicles) be regraded from 16 to 20

❑ **Noted:**

That a number of SPPPs have been submitted: (1) for the employment of an Infection Control Officer; (2) additional staff in connection with the administrative requirements of implementing the Children and Vulnerable Adults Policy; (3) for a specialist vehicle which will be able to transport bariatric patients, hospital beds and IAPB equipment and (4) for lost property' bags with patient identification

Risk being referred to RCAG for addition to the Trust Risk Register: the checking of driving licences

The risk information report highlighted themes and trends with common links and point to the need to develop management strategies. The main themes identified were problematic inquests where the staff may be criticised and public liability claims when crews have had to affect a forced entry. It was agreed that the risk information report will be shared with ADOs and AOMs.

The Head of Complaints gave a presentation on SUIs and reported the Complaints Group meeting on 7th February. The target for answering complaints within 24 days is 80%; to date the Trust is achieving 69%. There has been a slight decrease in the number of complaints received; the largest number of complaints relate to attitude and behaviour. The Head of Complaints is analysing them & will present his findings to the next meeting.
Action: Complaints Manager

The clinical risks on the Risk Register; all but one of the proposed regradings were not approved and it was noted that a few of the risks should be reworded to reflect legislative changes e.g the recertification of paramedics is no longer a requirement

❑ **Presentation**

The Medical Director gave a presentation on 'Safety First'; a report commissioned by the CMO highlighting the inadequacies within the NHS regarding patient safety.

The Medical Director highlighted the issues within LAS:

(1) Staff are happy to report equipment failure;

(2) Staff will raise concerns about other healthcare professionals;

(3) The number of reported clinical incidents or near misses is very low;

(4) A blame culture still prevalent;

(5) There is a better understanding of safety issues

(6) A small number of formal complaints or problematic inquests have highlighted concerns regarding patient safety.

The ADOs are to consider what are the 3 greatest patient safety issues facing the LAS, what is being done about them and how this information is being shared

- **Minutes Received:** **Training Services Committee, 2nd February**
  Complaints Panel, 9th February
  PPI Committee, 19th December

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

Clinical Governance Committee
2007 Workplan

Core Meeting

12th February

1. New risks
2. Lessons from complaints
3. Policies
4. Area Governance Report - South
5. Update on compliance with healthcare standards preparation for annual health check
6. Feedback from workshop preparation for NHSLA visit
7. Risk Information report
8. Annual report re. Infection Control

11th June

1. New risks
2. Annual Clinical Governance Report
3. Area Governance Report – ADO EOC
4. CARSAG Audit Report CPIs
5. Training needs assessment review
6. Complaints - Aged complaints reports from each area
7. Preparing for developmental standards and Annual Health Check 2007/08
8. Action plans progress report for risks in clinical risk category
9. Risk Information Report
10. Report from groups

15th October

1. Annual Clinical Governance Report Draft
2. Area Governance report – ADO West
3. Mid year report on complaints
4. Update of action plans on risks
5. Progress with Training needs assessment
6. Risk Information Report
7. New risks
8. Report from groups

Full Meeting

16th April

1. HCC – Final Declaration
2. Position paper on NHSLA pilot of new assessment
3. 1st quarterly report from progress achieved by Area Governance Committee
4. Annual Complaints report 06/07
5. Risk Register – actions
6. Clinical policies for consideration
7. CARSAG/ Audit Report/ CPIs
8. PPI & PALS
9. Lessons learn from complaints
10. New risks
11. High level risk information report
12. Area Governance Report – ADO East

13th August

1. Assurance Framework
2. Area Governance Report – ADO UOC
3. Training needs assessment – audit of uptake course attendance
4. Risk Register -% of new actions progress since last meeting
    - quality of action plans
    - gaps in assurance
5. 6 month review of complaints % for national targets. No. with health care commission
6. PPI & PALS
7. Lessons learn from complaints
8. New risks
9. High level risk information report
10. Report from groups
11. Area governance reports

18th December

1. Risk Information Report
2. Review of progress with the developmental standards of annual health check
3. Highlights for 06/07 annual Clinical Governance Report

	4. PPI &PALS 5. Lessons learn from complaints 6. New risks 7. Report from groups 8. Area governance report – ADO South

LONDON AMBULANCE SERVICE NHS TRUST

Core Clinical Governance Committee Meeting
12th February 2007, Committee Room, LAS HQ

DRAFT Minutes

Present:

Beryl Magrath (Chair)	Non-Executive Director
Ingrid Prescod	Non-Executive Director
Fionna Moore	Medical Director
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
John Wilkins	Head of Governance
Malcolm Alexander	Chairman, LAS Patients' Forum
Dipak Chauhan	Ergonomics Adviser Manager (representing Claire Thomas)
Keith Miller	Acting Head of Education & Development
Chris Vale	Head of Operational Support
Mike Boyne	Assistant Director of Operations, East
Lyn Sugg	Senior Operations Officer, Planning and Risk
Nicola Foad	Head of Legal Services
Ralph Morris	Head of Complaints
Stephen Moore	Records Manager
Russell Smith	Deputy Director of Operations
Mike Boyne	ADO, South
Christine McMahon	Trust Secretary (minutes)

Apologies

Sarah Waller	Non-Executive Director
Julian Redhead	Consultant in Emergency Medicine, St Mary's, Paddington
Claire Thomas	Safety & Risk Health & Safety Adviser

01/07 **Minutes of the Clinical Governance meeting held on Monday 11th December 2006**

Agreed **The minutes of the Clinical Governance Committee meeting held on 11th December 2006.**

02/07 **Matters Arising**

Minute 40(2): **A SPPP has been submitted with regard to employing an Infection Control manager in 2007/08.**

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 44(7): **Work is being undertaken to review the information regarding addresses deemed to be high risk. The Committee was informed by the Senor Operations Officer, Planning & Risk that a robust system is in place for new high risk addresses being added to the Register. When the High Risk Address Register has been fully reviewed and updated the task of managing the Register will be passed to the AOMs. ACTION: Senior Operations Officer, Planning & Risk.**

Minute 56(2): specialist vehicle – the Head of Operational Support confirmed that a SPPP has been submitted for a specialist vehicle which will be able to transport bariatric patients and be able to transport; hospital beds and IAPB pumps.

Minute 52: Quality Assurance PSIAM; a progress update will be given at the next Committee meeting. ACTION Senior Operations Officer, Planning & Risk

Minute 57: The NHSLA has not finalised the KPIs. The Head of Governance is meeting with an NHSLA Inspector on 7th March to discuss what level of compliance the Trust could realistically be assessed at in April 2007. The final draft of KPIs will include the Healthcare Standards and the requirements of the Local Auditors Evaluation (ALE); it was recognised that there are some standards common to both regulatory bodies. ACTION: Head of Governance to present an update to the next CGC meeting.

Minute 58: The Senior Operations Officer, Planning & Risk has submitted a SPPP for additional staff in connection with the administrative requirements of implementingof implementing the Children and Vulnerable Adults Policy.

Minute 58: Senior Operations Officer, Planning & Risk confirmed that she and the Head of PALS are drafting guidance for staff regarding the use of LA20 to raise concerns regarding Children and Vulnerable Adults.

Minute 61(2): aA risk assessment has been undertaken regarding licence checks and will be presented to the RCAG on 28th February.

Minute 63(1): The Medical Director confirmed that she will be submitting a risk to the RCAG regarding the sending of a technician crewed the sending of technician only vehicles.

POST MEETING NOTE: a risk will not be submitted for addition to the Risk Register regarding the sending of technician crewed ambulances but one will be submitted concerning the risk associated with EOC not identifying crews' skill levels when they are responding to particular incidents.

Minute 65: a Risk Management Awareness session is to be presented to the Service Development Committee in February. ACTION: Head of Governance

Minute 67 (3): New cannulas have been introduced but concerns have been expressed by some crews that the new product is not as good as previous equipment. An audit was to be undertaken to monitor the impact of the introduction of the new cannulas with regard to the number of needle stick injuries.

POST MEETING NOTE: the Infection Control Working Group met on 22nd February and noted that there has been a modest decrease in needle stick injuries.

03/07 **Draft work plan for the Clinical Governance Committee**

The Committee considered the draft work plan. It was commended by the Chairman as a good framework for the Committee.

Agreed: **1. The draft work plan.**

Noted: **2. That the Safety & Risk report scheduled for the May meeting will be changed as Claire Thomas is leaving the LAS and it would be unfair to her successor to have to do a presentation at his/her first meeting.**

04/07 **Risk Information Report**

Nicola Foad, Head of Legal Services, introduced the Risk Information Report. The report presented to the Committee included sections concerning claims, incidents and complaints. Some sections have identified themes and trends that have common links and point to the need to develop management strategies. Those sections that have not identified trends or produced detailed analysis will be enhanced when the next edition is presented to the Committee.

The Head of Legal Services said that she attended the last East Governance Committee meeting to share with Operational colleagues the contents of the Risk Information Report.

Claims The main themes to emerged have been:

(1) problematic inquests where the Trust may be criticised e.g. a delayed response, when there have been delays due to staff fearing for their safety or when patients were not conveyed and communications regarding the removal and carrying of a deceased person.

(2) Public liability claims when crews have had to affect a forced entry. A number of issues have been identified concerning forced entry.

The Head of Legal Services said that the number of problematic inquests have risen compared to the previous six months reviewed.

She drew the Committee's attention to the round table discussions that have taken place at which details of cases were discussed and actions identified to ensure that any lessons to be learnt have been shared. There has been some progress achieved as the actions associated with two cases have beingbeen completed and work is ongoing to implement the outstanding actions connected to the other five cases. The round table discussion of cases for July-December did not take place and the next session is scheduled to take place in March 2007. Nominations have been sought from East and South Areas for operational staff to attend the round table discussions. Feedback is given to staff following the round table discussions.

Open Clinical Negligence Case: the Medical Director has undertaken a feedback session with the crew involved; the lessons that could be learnt from the incident have been disseminated via a Medical Director's Bulletin and discussed at the Team Leader's' Conference.

In response to a question from the Chairman the Head of Legal Services said that the treatment of neurological illness and death in custody are two areas of concern for the Trust. The ADO South said that more work is needed to ensure that crews are confident in asserting themselves with the Police and with Doctors on scene.

Incidents Dipak Chauhan, representing Claire Thomas (Safety & Risk Health & Safety Adviser) reported that some cosmetic changes had been made to the report with the most frequent incidents being reported at the beginning of the report.

He asked about the process for ensuring there is a proper feedback loop to ensure that learning from the issues highlighted in the incident reporting are implemented. He asked how or who should be dealing with that. The ADO South said that the Practice Learning Managers should have a role with ensuring that lessons are learnt and implemented. **ACTION: ADO South and Senior Ergonomics Adviser (representing Safety & Risk Health & Safety Manager)Adviser to discuss further.**

Control Services The Senior Operations Officer, Planning & Risk presented a report to the Committee which focussed on complaints received by the Control Services.

Control Services had received 94 complaints in the last six months (107 the previous six months). The majority of complaints concerned delayed response; of the 85 that were solely concerned with Control Services, three concerned Category A calls, 23 Category B calls and 69 concerned Category C calls. Of these, 83 were concerned with delayed response because

there were insufficient staffed vehicles available at periods of high demand. Three complaints were received concerning the attitude of the call taker. One complaint was received because a call was mis-triaged as a Category C when it should have been given higher priority.

The Senior Operations Officer, Planning & Risk said that she is preparing a report for the Coroner with regard to a Category B call (a diabetic) who later died.

The following actions have been identified:

1.Improving the interface between UOC and Central Services so that EOC can respond if there is an undue delay or any deterioration in the patient's condition

2. Work has been undertaken to address the delays incurred that involved CTA contacting patients.

3. Further work is needed with EOC staff regarding the changes around reporting methods; lower limb injuries and being aware of the consequences of patients who are elderly being left lying on the floor for too long a period.

In response to a question from Ingrid Prescod about the consequences of delays in responding to calls the Senior Operations Officer, Planning & Risk said that she could only think of one incident where a call had been kept waiting &and required a blue light to hospital.

The Medical Director said that crews were confident in using the LA52s to report incidents. She said that currently it is not possible to obtain outcome data from hospitals; however the future introduction of Electronic Patient Records (ePRF) will enable the audit loop to be completed

In response to a question from Malcolm Alexander the Senior Operations Officer, Planning & Risk said that it is not standard practice to inform GPs when patients are transported to hospital. If a patient who has had a fall is not conveyed and is left at home then crews are expected to complete do a LA280 (Children and Vulnerable Adult) form which should ensure that GP and local Falls team are notified.

PALS The Director of Communications drew the Committee's attention to the root cause analysis section of the report.

Lost property bags: in answer to a question from Malcolm Alexander he said that the Trust has not yet addressed the long standing issue of having 'lost property' bags. A revised bid for funding has been submitted for 2006/07. The Head of Operational Support said that the trial undertaken at Hillingdon has been very positive and work is being undertaken to identify a cost effective way to implementing a similar system across the Trust.

Overshoes: The Deputy Director of ADO, Operations said that audits were being undertaken to ensure that overshoes had been placed on ambulanceson ambulances and at mosques.

Training Voluntary Staff: this concerned the inappropriate deployment of a voluntary member of staff. Voluntary Staff are provided by the Red Cross & St Johns Ambulance. The Senior Operations Officer, Planning & Risk said that a Memorandum of Understanding exists between the LAS and the two organisations. **ACTION: Senior Operations Officer, Planning & Risk to investigate and liaise with the Head of PALS.**

Data Cards for ECG training: an issue has been identified with obtaining ECG data for patients that have survived cardiac arrest following LAS treatment. Local stations are expected to obtain and download data cards from attending crews. **ACTION: AOMS to ensure stations have a supply of data cards in stock..**

Complaints The Head of Complaints gave a presentation re. Serious Untoward Incidents. The SUI policy was rewritten and presented to the Trust Board in January 2007 and has been posted on the PULSE.

Quality assurance work is being undertaken with the Head of Governance. The complaints procedure had been s being rewritten so as to move away from adversarial methods and introduce a more conciliatory approach. The Head of Complaints said that the concerns raised by Malcolm Alexander at the Complaints Panel will be incorporated in the policy. The Head of Complaints said that a guidance notes had been issued to managers regarding the handling of complaints; ADO South commended the notes as being a 'superb document'.

Approved: **1. The revised format of the report.**
Noted: **2. The contents of the report.**
3. That the report will be circulated to the ADOs and AOMs. ACTION: Head of Governance
4. That the Trust Board in January 2007 had approved the following policies: Hhabitual & Vexatious & CComplaints Policy; 'Being Open' and the revised Complaints Policy.

05/07 **Update on Risk Register**

The Head of Governance presented the Risk Register which included risks identified as operational and clinical. The Committee focussed its attention on the clinical risks included in the Register.

Risk 31: the Committee **did not agree** to the proposal to downgrade this risk as there have recently been a number of obstetric cases due in part to fully staffed maternity units being down graded to midwife run "Birthing Units" without informing the LAS.

Risk 267: it was proposed that this should be regraded from High/16 to High/20; the Committee **did not agree** to the proposal to upgrade the risk but felt it should remain unchanged.

Risk 34: it was recognised that a lot of work remains to be done to mitigate the risk of Techniciansof Technicians failing to meet the IHCD requirements. It was estimated that to date approximately 745/2500 staff have received training. However the risk statement needs to be rewritten as there is no longer the requirement for IHCD. **ACTION: : JW to discuss with A/Head of Education & Development.KM**

Risk 138: the risk relating to failing to appreciate the significance and urgency of psychiatric illness. There is considerable training on mental health issues on 5 day CPD course which is being rolled out over 2 year period from April 2005. However it was **agreed** that the risk should remain unchanged.

Risk 20: failure to fully complete the Patient Report Form. It was noted that 94% of the PRF documentation audited does not include data regarding ethnicity. The ADO South said that the clinical theme for South in the third quarter of 2006/07 has been PRF completion and the importance of recording ethnicity. Risk to remain unchanged

Risk 22: the risk relating to failure to undertake comprehensive clinical assessment is to remain unchanged; to date approximately 400 people have undertaken the EMT 4 Course which is being rolled out over a two year period.

Risk 207: the risk regarding being unable to download information is to remain unchanged. The Committee wished to know how many reports are being received. **ACTION: CARU to provide a report.**

Risk 188: As there is no longer the need for paramedics to qualify for registration the risk needs to be reworded. **ACTION: Medical Director and Acting Head of Education & Development Head of Governance to discuss.**

Risk 211: risk regarding to drug errors and adverse events not being report is to remain unchanged.

Risk 165: delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones is to remain unchanged

Risk 133: risk of potential legal action/negative publicity due to staff being unaware of how to report suspected abuse of children is to remain unchanged

Risk 194: the risk of patients after handover and to the viability of research projects with financial ethical and reputational impacts is to remain unchanged. It was recognised that there is a high degree of awareness in relation to this risk.

Risk 179: which related to the Trust failing to meet its responsibilities under the Race Relations Act to remain unchanged.

Risk 46: the risk of infection to staff due to needle-stick injury – the new cannulas are now in use which should hopefully reduce the number of injuries. The Head of Legal Services reported that at the recent Health & Safety Group it was noted that the new safety cannulas have been used inappropriately. An Audit is to take place to provide evidence as to whether the risk can be downgraded.

Risk 63: the risk relating to the re-use of single use items is to remain unchanged.

Risk 202: risk of cross infection from uniforms is considered to be very low.

06/07 **Presentation: 'Safety First'**

The Medical Director gave a presentation on 'Safety First' a report commissioned by the CMO following the report published by the National Audit Office in 2000 that highlighted that more needed to be done regarding improving patient safety. The presentation highlighted the important recommendations contained in the report.:

The Medical Director said that LAS staff are confident reporting equipment failure and raising concern about other healthcare professionals. However the number of personal reported clinical incidents or near misses is very low and a blame culture is still prevalent. She said that there is a better understanding of safety issues and there are a low number of formal complaints or problematic inquests that highlight concerns regarding safety.

She proposed that:

*LAS identified the 3 greatest patient safety issues prevalent within the organisation

*Identified what was being done about them

*Considered with whom the information should be shared

ACTION: The ADOs will consider what are the 3 greatest patient safety issues facing the LAS, what are we doing about them and how are we sharing the information.

In response to a question from Malcolm Alexander it was confirmed that the relationship with NPSA is currently unsatisfactory as little feedback is received on the data submitted by the Trust. The Head of Governance undertook to raise the matter of benchmarking at the meeting of corporate leads for NHS Ambulance Trusts that he will be attending. **ACTION: Medical Director and Head of Governance to discuss further.**

Noted: **The report.**

07/07 **Operation Governance Reports**

ADO South presented his report outlining clinical governance in the South Area. Clinical Governance has been incorporated within the regular management meetings held at complex and area level. He pointed out that of the AOMs' objectives only one is non-clinical.

CPI Checks: following sustained focus the level of CPI checks has improved in quarters two and three. The year to date figure is 62% but he was confident that the target of 80% would

be reached by March 2007. He said this might be hampered by the necessity of focusing on achieving performance in quarter four with Team Leaders being required to staff vehicles instead of their office duties. He reported that the completion rate for CPIs is uneven across the Area with some complexes performing really well (Croydon 96%) with others being disappointing (Waterloo 46%). He said that possible contributing factors for poor completion of the CPIs are Team Leader and/or AOM vacancies; as appointments have recent been made he is confident that the situation will improve albeit in the environment of the challenge of achieving performance targets.

In response to a question from the Head of Legal Services he confirmed that there is no data on the number of feedback sessions taking place following CPI checks; he estimated that approximately 50% receive of staff receive feedback.

The ADO South raised the possibility that data is being input which is not being recorded. The which the Director of Service Development said that this may be due to because Team Leaders are not following the guidance that was issued regarding the concerning the completion of CPIs.

The Chairman said that the increase in lone working will require additional focus on clinical governance.

PDR: as of 31st October PDR was successfully implemented with the exception of two stations St Hellier (which will be completed by the end of November) and Waterloo (which still had 28 outstanding). He emphasised that PDR is not appraisal.

An Area Human Resources Officer sat in on PDR interviews in order to give some assurance as to the quality of the interaction; the findings of the observations are being collated into a best practice guide which will be issued to Managers. One outcome of the PDR reviews is the identification of training needs, both Area and Trust wide. Training for managers has also been identified to enable them to have 'difficult' conversations. The ADO South said that there has been some very positive feedback received from staff and managers regarding PDR.

A range of initiatives have been identified across the Area: 12 lead ECG training; trauma care; HEMs development; development to become ECPs; reflective practice awareness in response to Team Leader ride outs and to complaints received. The ADO South said that one impressive initiative (New Malden AS) was that crews were taking blood for laboratory testing prior to admission to hospital, with no tangible impact on performance, which improved patient care by reducing shortening a patient's waiting time at the hospital. The phlebotomy equipment used by crews is provided by Kingston Hospital

In response to a question from Malcolm Alexander concerning the taking of bloods being standard practice across the LAS the matter is being given consideration. One possible impediment to introducing it across the Trust is the lack of uniformity of equipment across London hospitals, however it was recognised that most crews do not go to more than two hospitals so this could be managed.

Cardiac Survival rate: Waterloo AS cardiac survival rate improved from 13.3% to 36.7%. The possible explanation for the improvement was the fast response of the central London to MRUs (4-5 minutes) and ready access to PCI centres at St Thomas and Kings. **ACTION: CARU to undertake an investigation and report back to the CommitteeCGU.**

Frequent Users: Work has been undertaken to engage with PALS at complex level with AOMs expected to address the needs of at least one of the their frequent users. The ADO South has nominated a team leader to work with PALS to address the needs of those patients who frequently use the service.

Complaints are discussed at weekly and monthly meetings. The South is currently responding to 71% of complaints within 25 days, he was hopeful that the target of 80% would be reached by year end. He said that a small number of complaints have taken an excessive long time to resolve. Malcolm Alexander suggested that the Trust might approach ICAS to

help with mediation. **ACTION: The Head of Complaints to forward ICAS's contact details to ADO, South.**

An analysis of the complaints had not revealed any significant lessons for dissemination trust wide.

General Area Governance Report was delivered by Russell Smith, Deputy Director of Operations.

CPIs: it is unfortunate but the expected improvements have not been realised with 42% completed in November and 43% in December. It is clear from the individual performance data that the level of completion is very variable for Team Leaders across the Trust.

There was a discussion as to the advisability of publishing the CPI rates of completion. The ADO Operations said that sometimes it is difficult to discuss the rate of completion as staff challenge the validity of the CPI data. It continues to be an ongoing process of changing the culture of the organisation to ensure that all staff appreciate the necessity of good paperwork (the standard of which has improved) and the need to undertake CPI checks, to give feedback on treatment to promote learning. For the purposes of an article the Director of Service Development said that CARU will have data available re. cardiac cases, if aspirin was given etc and this could be used to demonstrate the clinical need for good PRF documentation and the CPI checks. It was suggested that an article should be written for LAS News highlighting why completing CPI paperwork is important as a professional. **ACTION: Deputy Director of Operations..**

The ADO South suggested that just as performance data is included on the front page of the Pulse so should CPI performance plus clinical themes e.g. pain management in the second quarter.

The Medical Director said that she had recently visited 12 complexes, six of which were in the South. She said she had been impressed by the standard of clinical care of the management team. She also said that since CPI checks have been introduced the standard of documentation has improved across the Trust. The Head of Governance suggested that the Medical Director append the findings of her station visits to the ADO Operation's overview of clinical governance. **ACTION: Medical Director.**

Complaints: the Complaints Panel on 7th February discussed the introduction of a new document, Investigation Outcome Report to be used which will record the outcome of a complaint and monitor implementation. The Head of Complaints said that the Revised Complaints Policy changes the emphasis from a disciplinary approach to one where lessons can be learnt on a Trust wide basis. Where possible a complaint will be resolved at a local level.

It is proposed that the Forms 279/280 will be held on front line vehicles to enable crews to report Children at risk and Vulnerable Adults.

The Deputy Director of ADO Operations said that attitude and behaviour continues to be the highest number of case of complaints. The Head of Complaints said he is undertaking an analysis of complaints received regarding the attitude and behaviour to identify causes. It was recognised that it is often difficult to discuss complaints with staff days or weeks after an incident which they may not remember as being of significance. **ACTION: Head of Complaints.**

Frequent Users: The Deputy Director of ADO Operations reported that there is a lot of good work is being undertaken at station level to address the clinical needs of frequent users through liaison with PALS, local Social Services and Local Authorities.

PDR: The Deputy Director of ADO Operations reported that PDR has been well received; various training needs have been identified as a result of PDR training e.g., 12 lead refresher training.

SUI: There have been three in the last eight months including Paul Coker who died in police custody and a child who was tragically killed during an ambulance visit. Reports are being prepared for the Coroners. The third SUI concerned the system crash in EOC in July which has been resolved.

Rest breaks: 70% of staff are receiving rest breaks with over 90% of cars being allocated rest breaks. The impact on Category A performance was predicted to be around 5% but it has been closer to 10%

Shift change over: The ADO Operations reported that 70-80% of FRUs are staggering their change over shifts at 7am – 7pm.

Noted: **The report**

08/07 **Annual Report – Infection Control**

The Head of Operational Support reported that the Annual Infection Control Report is currently being drafted prior to its presentation to the Trust Board in March 2007. The Report will contain information regarding: infection control audits; education and communications; occupational health; Make Ready and risks that have been identified with regard to infection.

A workshop held in January, which was attended by representatives of the Department of Health's 'MRSA Cleaner Hospital Team', proved to be very useful. A self-assessment was tool was used undertaken to which identifiedy key areas that required attention and gave a compliance rating of 55%, which was considered a rather disappointing result. An action plan is being drafted to address the areas identified as weak.

Noted: **The report.**

09/07 **Compliance Register**

The Head of Governance presented the Compliance Register which is a work in progress devised to monitor that the Trust was meeting legislative and reporting requirements as an NHS organisation.

Ingrid Prescod said that the language relating to the Race Relations and Sex Discrimination Act should be reviewed so that the language used in both is action orientated. It was suggested that Ingrid and Paul Carswell (Head of Diversity) should discuss the matter outside the meeting. **ACTION: Ingrid Prescod and Paul Carswell.**

The Head of Governance reported that confirmation is awaited from NHSLA regarding a final set of criteria.

Agreed: **That the proposal for the the Compliance Register should be will be ppresented to the next meeting of RCAG and it was suggested that the RECAG receives updates on the as a regular report to the RCAG.Register.**

10/07 **Update re. Safety Alert Bulletin and NICE**

Dipak Chauhan highlighted the following:

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

Safety & Risk has been told by the Head of Fleet that there is a system in place to monitor equipment.

NPSA/2007/015: colour coding hospital cleaning materials and equipment.

The Trust is currently not meeting NPSA guidance regarding the colour co-ordination for non-clinical products. The Make Ready contractors will be asked to implement.

Noted: **1. The Safety Alert Bulletin report.**
2. That there has been no guidance issued by NICE relevant to Ambulance Trusts.

11/07 **Reports from groups/committees**

Complaints Panel: 9th February 2007

The Head of Complaints reported that 69% (target is 80%) of complains are being responded to within 25 days which does not include the complaints dealt with in January.

He undertook a review of complaints received in the last six month period in comparison to the same period in 2005/06; in July – December 2006 262 complaints were received compared to 266 in July – December 2005. 43% of complaints concerned attitude and behaviour. He said that the slight decrease in complaints should be put in the context of increased numbers of patient contact. The largest number of complaints concerned delays in responding.

SUI: Death of individual in police custody from positional asphyxia. An article was placed in LAS news, changes were made to refresher training and changes were made to the JRCALC Guidelines concerning positional asphyxia.

The Internal Auditors have undertaken an audit of Complaints; the findings of which will be reported at the next Committee meeting. **ACTION: Head of Complaints**

In response to a question from the Medical Director the Head of Complaints said that only nine complainants have chosen to ask the Healthcare Commission for an independent review; two of these requests required the Service to take no further action. Of the remaining complaints five have had the case papers sent to the relevant HCC Case Managers, one independent review was sent back back with three out of four points requiring further action from the Service, a letter has since been sent back to the complainant actioning these but the HCC has been back in touch requesting additional information as the complainant is not not satisfied.happy. The final Independent Review has been sent back to the Service by the HCC as they feel further concerns have been added and need to be looked into.

Malcolm Alexander said that it would be useful for this Committee to receive a report regarding the outcome of the complaints. He suggested that the letter to the complainant should identify how the complaint has resulted in a change to the organisation andorganisation and should include an invitation to meet with Senior Staff to bring a complaint to an early conclusion. **ACTION: Head of Complaints.**

Outcome of inquests: any recommendations that are made by the Coroner will be iembedded in the new system for managing complaints and monitoring actions. There were 40 recommendations that came out of the investigation into the circumstances of Andrew Jordan's death from positional asphyxia; the majority of which have been implemented.

The Head of Governances said that although the Healthcare Commission is unlikely to visit the LAS during the next two months it is important that focus is not taken off improving the reporting of outcomes from complaints handling management.

Noted: The report.

Training Services Committee: 2nd February 2007

The Medical Director reported that the Committee, which is an operations based group, discussed the training planned for the remainder of the year. The Training Services Committee agreed to defer some training until the new financial year. The Committee is considering how paramedic recertification is delivered as there is no longer the requirement to do it. One approach being considered is to may be to deliver paramedic training on a

modular basis, and linked in with St Georges, which would mean that the course could be badged as accredited by a higher education establishment.

Race, Equality & Diverse Strategy Group – 1st February.

Noted: That this meeting was cancelled.

PPI Committee: 19th December 2006

The Director of Communications presented the summary and the minutes of the PPI Committee. He highlighted the following from the minutes: that PPI will continue in some form or other regardless of whether the Government decides to abolish the NHS Trust Patients Forums. He said that the monthly patient meetings are very helpful and are well attended. Work is being undertaken with the Bangladeshi community in East London.

Malcolm Alexander, Chairman of the LAS Patients' Forum, reported that the members of the Forum have agreed to set up a company, with the intention of applying for charitable status at a later date, in order that the work of the forum can continue in the event that the Government abolishes the NHS Trust's Patients' Forums.

Noted: **The report**

12/07 **Dates of next meeting:**

Full: Monday, 16th April 2007 at 9.30 in the Conference Room, HQ.
Core: Monday, 11th June 2007 at 9.30 in the Conference Room, HQ.

Meeting concluded at 12.35

Enclosure 15

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 27th February 2007 at 10:00 a.m.
Held in the First Floor Conference Room, LAS HQ

Draft minutes

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Barry MacDonald	Non Executive
	Sarah Waller	Non Executive
	Beryl Magrath	Non Executive
	Ingrid Prescod	Non Executive
	Roy Griffins	Non Executive (until 12.00pm)
	Caroline Silver	Non Executive (until 12.20pm)
In attendance:	Caron Hitchen	Director of Human Resources & Organisation Development
	Fionna Moore	Medical Director
	Mike Dinan	Director of Finance
	Russell Smith	Deputy Director of Operations (deputising for Director of Operations).
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development (until 1.05pm)
	John Wilkins	Head of Governance
	Margaret Vander	Head of Patient & Public Involvement
Apologies:	Martin Flaherty	Director of Operations

Due to other commitments Caroline Silvers and Roy Griffins left the Service Development Committee meeting at 11.00am. They subsequently rejoined the meeting at 11.10 via telephone conference. Roy Griffins signed off at noon and Caroline Silver signed off at 12.20pm

01/07 Minutes of the last meeting of the Service Development Committee, held on 19th December 2006.

The Chairman **signed** the Minutes as a correct record of the meeting held on 19th December 2006.

Matters Arising

Minute 49/06: in response to a question from Beryl Magrath the Chairman said that Bromley PCT had not applied to be an early adopter for the Summary Care Record. When he spoke to the Chairman of the Bromley PCT, she expressed surprise that her Trust had not applied to be an early adopter site, and said she would find out why. The Chairman also spoke to Dr Simon Eccles, one of the clinical leaders of the Connecting for Health programme, who is very keen to have a PCT included in the project.

Minute 50/06: the HR Director confirmed that Payroll is tracking the impact of rest breaks on crews' total pay and a report will be presented to the Trust Board in March. **ACTION: HR Director.**

Minute 53/06: the Director of Information Management & Technology said that he had confirmed with the Olympics Co-ordinator that the London Olympics

Committee do not have a mandated lock down for partner organisations such as the LAS. The mandated lock down applies to the Olympic Committee's internal processes.

02/07 Chairman's Update

The Chairman said that the SHA is continuing to recruit permanent members of staff. Paul Baumann has been appointed Director of Finance and Performance and has had an extensive career in the private sector, mainly with Unilever. Anne Rainsberry has been appointed HR Director.

Lord Warner has been appointed to be the Chair of the Provider Agency, which is potentially good news for the LAS given Lord Warner's previous role as Junior Health Minister. Malcolm Stamp has been appointed Chief Executive of the Provider Agency; he was previously Chief Executive of Addenbrookes.

The Chairman expressed disappointment with the reply he received from Anna Walker, Chief Executive of the Healthcare Commission, in response to his query about the definition of breakeven. (The Department of Health requires that Trusts break even over a rolling three year period but the Healthcare Commission's insists that Trusts break-even each year on pain of being branded 'weak' on resource management).

The discussions between the Ambulance Service Association and the NHS Confederation are proceeding and could lead to a merger being agreed this year. Separately, the NHS Confederation is consulting its members on a proposal to alter the status of non-NHS provider organisations, which would enable all organisations supplying goods and services to the NHS to become full members of the Confederation.

It was noted that NHS Direct and Guys & St Thomas' are recruiting a new Chief Executive. Barts & the London NHS Trust and Epsom & St Helier University Hospital NHS Trust are both recruiting new Chairmen and Chief Executives. Julie Dent, formerly Chief Executive of South West London Strategic Health Authority, has been appointed Chair of the London Probation Board.

03/07 Performance update

Russell Smith, Deputy Director of Operations, reported that Category A 8 minute performance during December 2006 was 71.1%, which was considered to be relatively good considering the difficulties experienced by the Trust in December. Category A8 minutes performance in January was 73.1% and 68.4% in February.

Several factors contributed to this disappointing performance: the reduction in overtime spending; the introduction of rest breaks (which had had a 3-5% impact on performance) and an increase in Category A demand. In July 2006, when London experienced a heat wave, the Trust received 837 Category A calls a day; in February 2007 it received 950 such calls a day. The increase in Category A demand has been attributed in part to the heightened awareness of the danger of heart attack following the British Heart Foundation's poster campaign. The Category A 8 minute performance for the year to date is 74.6%.

The Director of Operations recently declared the Service to be at REAP 3 and the Gold Suite had been set up in the Conference Room. Gold Suite's function is to optimise vehicle location; position mangers that are on rota between 11am-4pm to offset the impact of rest breaks on performance; actively manage hospital waits and monitor the number of vehicles off the road. In addition some training courses have been deferred. The Category A 8 minute performance for the last seven days had been above 75%.

The Trust is unlikely to achieve its Category B19 and Urgent targets for 2006/07; this forecast was shared with the Commissioners yesterday (26th February 2007).

The Deputy Director of Operations said that although technically A&E is at full establishment, 60 members of staff are still in training and will not be available until late February /early March; there are also unfunded secondments (e.g. HART) and limited overtime (year to date overtime has fallen by 20%).

The Chief Executive said that another factor in the recent disappointing performance had been a high level of absence; during the first week of the school holidays in February front line staffing was 77% due to high sickness, no overtime and school holidays.

The HR Director reported that rest breaks were introduced in mid-December 2006 and approximately 75% of front line crews were receiving rest breaks. The first review of the Rest Break Policy occurred last week. It was agreed with Staff Side representatives that, as a temporary measure, crews who are not offered a rest break during their shift can be offered overtime if they choose not to finish work early. This will help with the performance shortfall experienced at shift change over. It was recognised that the offering of overtime for the last 30 minutes of a shift is simply another way of the Trust buying overtime at a time when it is specifically required. It will be used as and when needed across the Trust depending on local conditions. The Chief Executive said that such overtime will be closely monitored.

In response to a question from Barry MacDonald, the Deputy Director of Operations said that although hard facts and figures are difficult to obtain with regard to increased efficiencies in allocating and managing rest breaks, the operation in the Control Room does feel like it is improving on an incremental basis as Control staff gain confidence and experience.

Managers were being deployed between 11am-4pm to help offset rest breaks having a detrimental impact on performance and ensure good clinical care for patients. When necessary, refresher training is being offered to managers so that they are confident in being deployed.

The Chief Executive said that ECPAG is meeting in two weeks time to review the Category A codes; a number of Category A codes will be reclassified as Category B and Category B as Category Cs.

Noted: The update on performance and rest breaks.

04/07 Finance report – Month 10

The Finance Director presented the finance report for Month 10. He drew the Committee's attention to the Expenditure trends report (page 10). The Trust made a modest surplus of £122k in Month 10. This was £500k less than forecasted due to a number of unexpected expenditures; mainly due to increase in vehicle costs (accident damage and vehicle maintenance) and training (National Clinical Guidelines). Total expense for January was £17,797k compared to a forecast of £17,222k.

The Finance Director is forecasting an overspend of £560k for year end, which he said was a prudent forecast. Further savings have been identified in both 'Other Income' and 'Interest Received'.

The Chief Executive said he had received a commitment from the SHA that the LAS will receive £800k of the money brokered in 2005/06; this will enable the Trust to achieve break even and spend the necessary amount on overtime during the remaining months of the year to help achieve 75% for the year as a whole.

In reply to Beryl Magrath's question regarding the term WTEs (page 13/14), the Director of Finance said it referred to 'whole time equivalent' and related to the equivalent number of full time staff employed and overtime offered in January.

In response to a question from Barry MacDonald regarding CBRN funding, the Finance Director said that he is continuing to make the argument to NHS London that the Trust receive the £700k which had been 'top sliced'.

The Director of Finance said that the CBRN item in the 2006/07 budget had assumed an inflationary uplift and the continuation of non-recurrent MAIAT funding (£400k). However, some of the activities included in the budget were accruals from the previous year. The Committee recognised that the issue around CBRN was a very complicated matter, with a number of different components, some of which were recurring, some of which were not.

The Director of Finance said that the Trust is reviewing its accounting treatment of CAD2010 costs. It may be that some items of expenditure, which were treated as capital, will be required to be treated as revenue as part of the normal annual balance sheet reconciliation.

The Chief Executive said that at the Commissioners meeting he attended on the 26th February, the Finance Manager for Operations presented data on Category A call volume (2002/03-2006/07). In 2004/05 the LAS received 207,106 Category A calls; in 2006/07 it will have received an estimated 307,023 calls; an increase of nearly 50%. He said this data puts into context the achievement of 76.6% Category A8 performance in 2004/05 and 75.05% in 2005/06.

In response to a question from Beryl Magrath regarding Emergency Care Practitioners (ECPs), the Finance Director said that the ECP programme will not be rolled out in Sutton & Merton PCT and Greenwich PCT as they were unwilling to fund the initiative. The ECPs who would have worked in those PCTs will instead be redeployed elsewhere in the Trust.

Noted: The finance report for Month 10.

05/07 2007-10 Budget and 2007/08 Workforce Plan

The Director of Finance presented the draft 2007-10 budget for approval by the Committee under delegated authority from the Trust Board in January 2007.

He outlined the basic assumptions behind the draft. Firstly, the increased resources needed to reach 75% of Category A calls within 8 minutes of the new earlier clock start had not been offered by London PCTs and have not been included. Discussions are taking place with the Department of Health as to when the new Clock Start will be implemented, and pressure may be brought to bear by the Department on PCTs to provide this funding. The Trust will continue to be required to deliver existing national targets.

The Committee considered the Income and Expenditure Summary; the detail of the A&E core contract; a breakdown of the Trust's major expenditure item (pay) and the Cost Improvement Programme as it relates to Operations. The Finance Director also outlined the major risks to the financial plan (additional PCT funding not being received; Cost Improvement Programme not realising savings, top slicing of CBRN funding and unfunded HART activity), all of which were estimated to have a value of £4m.

The presentation concluded with a statement of what the Trust's objectives would be in 2007-10. The list included the following objectives: development of referral pathways, clinical leadership and a new approach to clinical education; supporting operations in high impact changes; changes to working practices, and identifying

and winning business opportunities and new income. Sarah Waller suggested that the objectives should be grouped so that their strategic impact could be more clearly see. The Director of Service Development said she would review the presentation of the list. **ACTION: The Director of Service Development**

In response to a question from the Chairman, the Medical Director said that it was important not to confuse non-conveyance with the utilisation of alternate clinical pathways; currently only a small number of patients are being left at home. In the future ECPs will focus on providing clinical leadership as well as attending those patients who are not emergencies but have been triaged as requiring a highly skilled response due to their often complicated illnesses. A review of training is being undertaken following the restructure of the IHCD. There will also be an increased focus on improving assessment skills of EMT4s and Paramedics, so that they are more confident that it is clinically safe to leave a patient at home with the knowledge that the patient can be treated at home through accessing alternate care pathways.

The HR Director presented the 2007-08 Workforce Plan; its focus is consolidation of the existing workforce and the mainstreaming the Emergency Care Practitioners (ECPs). It is intended that the number of ECPs will remain unchanged; that EMT4s will over time become Paramedics, with the number of Paramedics increasing by 121 (from 815 to 936) and that support staff (the title of Emergency Care Assistants is under-review) will be recruited, and the number of Clinical Telephone Advisers employed will increase from 28 to the existing establishment of 50. The plan is that the workforce will be the same overall numerically, but with changes in the skill mix. The Long Term Workforce Plan will be presented to the Trust Board in March 2007. **ACTION: HR Director.**

The role of the ECPs will be mainstreamed which should maximise their utilisation and ensure that their enhanced clinical skills are more effectively deployed.

The Committee considered the draft budget and wished for a number of changes to be made. The Committee wished for a stronger position to be taken with the Commissioners regarding funding, in particular the variable activity formula which relates to increased funding when the number of Category A calls rises above an agreed level as the current threshold is too high.

The Committee also wished the Trust to make a case for receiving an increase in funding due to the increased salary costs resulting from AfC; staff that are not at the top of their bandings will receive an increment in 2007/08 which the Trust is expected to absorb. Unlike the rest of the NHS this issue has uniquely affected Ambulance Trusts as prior to AfC the majority of staff did not receive annual salary increments and this is therefore an extra cost for the Trust.

The Chairman recommended that when staffing is being reviewed as part of the budgetary process, the Senior Management Group undertake an Overhead Value Analysis exercise.

Barry MacDonald said that although the Government is stating the NHS is receiving an increase in funding of 6-7% per annum to 2008; the reality is that it is not receiving an inflationary uplift.

It was recognised that the implementation of high impact changes proposed as part of the Cost Improvement Programme for Operations will be challenging. There will be additional focus on actively managing attendance as the Trust has been seriously affected by high levels of sickness and unauthorised leave.

The Chairman said that he wanted the budget to incorporate significant innovations, which would in the long term address operational issues, e.g. using ECPs and

EMT4s as single responders who can leave patients at home or put them on other pathways when it is clinically safe to do so, thereby reducing double staffed ambulances being despatched to unnecessarily transport patients to A&E hospitals.

Barry MacDonald referred to the New Front End Model (NFEM), presented to the Committee in April 2006, and asked why the high impact changes included in the NFE Model were not more in evidence in the budget. The Director of Finance said that the purpose of the NFEM is to provide some 'head room' for Operations in meeting the national targets. He said that the financial impact of the changes can be considered for inclusion in the plan. **ACTION: Finance Director.**

Barry MacDonald commended the presentation; he said it was an improvement on what the Board had received in previous years.

The Finance Director said he would revise the budget in line with the Committee's comments and the outcome of negotiations with the Commissioners. He will circulate the revised budget for the Committee's approval prior to the submission deadline of 9th March 2007. **ACTION: Finance Director.**

The Chairman said that, if necessary, a telephone conference could be held for Board Members to discuss the draft budget prior to its submission to the SHA.

Agreed: 1. That the 2007-10 budget will be revised to incorporate the comments made by the Committee and the outcome of negotiations with the Commissioners.

2. That the Director of Finance will circulate an amended budget to the Committee for approval prior to its submission to NHS London by the deadline of 9th March 2007.

06/07 SHA Service Plan Board Self-certification

The Finance Director presented the SHA Service Annual Plan Self-Certification which contained statements regarding governance; services provided; quality and safety and overall compliance.

He said that the Trust will report that it is not compliant in the following areas:

- 'Contracts have been agreed with Commissioners' – in fact, negotiations are ongoing.
- Core standard – the Thrombolysis target is unlikely to be achieved due to the Trust's decision, based on clinical evidence, to focus on primary angioplasty.
- Category B target will not be achieved.

The Finance Director said that the Self-Certification document will be submitted to the SHA by the deadline of 9th March 2007.

Agreed: To approve, with delegated authority from the Trust Board, the SHA Service Plan Board Self Certification.

07/07 CAD 2010 Gateway 'Gate 2' Review

Noted: The report.

08/07 Implications of IP Telephony for our ability to locate callers

Noted: The report.

09/07 **Governance Arrangements for Foundation Trusts.**

The Chairman said that following the presentation given by Dr Penny Dash to the Trust Board in September 2006 which focussed on the financial aspects of becoming a Foundation Trust, he has invited the Head of Patient, Public Involvement (PPI) to present a report concerning an aspect of the governance arrangements associated with foundation trusts, membership. He said that, as yet, no decision has been made as to whether Ambulance Services should become Foundation Trusts.

The Head of PPI outlined the findings of the information gathering exercise she undertook in preparation that the LAS may be required to become a Foundation Trust. She specifically looked at the issue of establishing a membership and compared the experience of three existing foundation trusts in London (Guy's and St Thomas'; Moorfields and Royal Marsden) which have a much wider catchment population than their local areas.

As no guidance has yet been issued on what would be the membership requirements for Ambulance Services the Head of PPI referred to the guidance issued to Acute Hospital Trusts. Acutes are required to be accountable to the local population served by the Trust, all of whom are eligible to be members of the Trust. The membership is required to have a number of constituents: public; patient; staff (further sub-divided into different constituents) and partner organisations (academic bodies and local networks). Members are eligible to be elected to the Board of Governors; the Board of Governors is required to be involved in reviewing all strategy plans and decisions made by the Trust. One key piece of advice she received was the importance of highly qualified legal advice when setting up constituents. A key outcome of the information gathering exercise was that setting up and running membership is expensive and requires dedicated resources. Apart from the often mentioned financial freedoms associated with being a Foundation Trust the research suggested that the obligation to create a membership and keep it involved offered a good source of PPI and forced the Trust to look 'outward'.

In terms of membership, the challenges associated with becoming a Foundation Trust include the cost, the staff time and the difficulty of running the membership scheme, which will be even more significant for the LAS as it is the only pan London NHS organisation. There are a number of costs associated with having membership: average cost per member per year was estimated to be £4.00-£5.00 (approximately £70k); £45-50k computer share (in-house costs would probably be higher); £10k per annum membership of FT network; marketing resource £20-30k. The level of participation by members, staff and partner organisations was variable across the three Trusts that were consulted. In addition, other associated costs in becoming a Foundation Trust would be advertising membership to London's population; holding elections, holding meetings; legal advice and signage i.e. changing the signage on all the Trust's vehicles, properties and stationery.

The Head of PPI said that, regardless of whether the Trust is required to become a Foundation Trust, more focus should be placed on engaging with the public. If the LAS is required to become a Foundation Trust she advised adopting a local model based around the London boroughs. This would also be in line with the Government's proposal to replace the current Patients' Forums with Local Involvement Networks, as it is intended that they will be borough based.

The associated costs of becoming a Foundation Trust and recruiting members, as well as the ongoing costs of maintaining the membership was of concern to the Committee.

Beryl Magrath said that one piece of advice she had received when undertaking her governance review was the advisability of having a reserve list, should there be any resignations from the Board of Governors.

Sarah Waller said that she thought the Department of Health was undertaking a review of Foundation Trusts.

Noted:
1. **The report**
2. **That a decision is still awaited as to whether Ambulance Services will be expected to become Foundation Trusts.**
3. **That it would be expensive for the LAS to recruit members pan London and to maintain the membership lists**

10/07 Presentation regarding the incorporation of the "Intelligent Ambulance Service Board" indicators

The Finance Director presented the indicators outlined in the 'Intelligent Ambulance Service Board', the majority of which were already reported to the Trust Board. Two of the indicators that were not currently reported were patient safety and clinical outcomes. The reporting pack to the Board will be amended and presented to the Board in May 2007 for approval. **ACTION: Chief Executive.**

Noted:
1. **The 'Intelligent Ambulance Service Board' indicators**
2. **That the information pack presented to the Trust Board will be amended with effect from May 2007 to reflect the recommendations of the 'Intelligent Ambulance Service Board'.**

11/07 Board training on risk management and ethics framework

The Finance Director reviewed the current Risk Management Policy and the Code of Conduct and Accountability. It is a requirement of NHSLA and the Audit Commission that Members of the Board receive training regarding risk and ethics. He proposed to deliver further training at the Away Day on 23rd April, including an interactive exercise.

Sarah Waller asked whether the Code of Conduct & Accountability had been updated since 1994. **ACTION: Trust Secretary.** Sarah Waller recommended 'the Standard on Public Life', recently published by the Department of Health.

Noted:
1. **The current arrangements**
2. **That further training may be provided at the Away Day on 23rd April.**

12/07 Away day agenda

Following on from a discussion that arose during the Chief Executive's bi-monthly briefing of the Non-Executive Directors, it was proposed that a possible theme for the away day could be whether the Trust has the right balance between 'loose' and 'tight' approaches to management. This was in recognition that during recent years a number of levers (e.g. the amount and use of overtime) have been centralised to ensure more effective control over costs. The Chairman said that he will seek speakers and material that will contribute to the discussion. **ACTION: the Chairman.**

Other suggestions for discussion at the Away day were the Olympics; Risk Management and High Impact Changes.

Noted: That the Chairman will circulate a draft agenda for the Away Day.

13/07 Any Other Business

Noted: That there was no other business.

14/07 Date of future meetings:

The next meeting of the Service Development Committee will be the evening of the 23rd and all day 24th April 2007, Holiday Inn, Regents Park, London.

The meeting concluded at 13.20pm

Enclosure 16

London Ambulance Service NHS TRUST

Trust Board – 27th March 2007

1. **Chairman of the Committee** **Barry MacDonald**

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

Agreed:

1. The template for the Committee's annual report. The Head of Governance will circulate the final draft to the Audit Committee for comment prior to the report's presentation to the Trust Board in May 2007.
2. The Internal Audit plan for 2007/08. In addition to the areas suggested by the Finance Director, the Committee wished the Internal Auditors to review Urgent Operations Centre as a whole, all the High Impact Changes and Complaints.
3. The Counter Fraud Work Plan for 2007/08.
4. The Scheme of Delegation with some amendments; this will be presented with the revised Standing Orders and Financial Instructions to the Trust Board for approval in March 2007.
5. That the Audit Recommendations report should contain the recommendations of the Internal Auditors (Bentley Jennison); the Audit Commission and the Local Counter Fraud Specialist. A summary report outlining progress in implementing 'merits attention' recommendations will be included with the report.
6. That Bentley Jennison's contract is extended for one year whilst the Trust reviews how the internal audit function will be provided. The Finance Director will undertake further investigation into the practicality of the Trust employing in-house internal auditors, possibly in partnership with other Ambulance Services.

Noted:

7. The Internal Auditor's Progress Report. Two audits outstanding from the 2005/06 audit plan (Emergency Care Practitioners and Urgent Care) received limited levels of assurance. Since the audits were undertaken in May 2006 there have been a number of changes introduced to both these areas. A further audit of Urgent Operations will be undertaken in 2007/08 reviewing the interfaces between EOC and UOC as well as the different facets of UOC (EBS, PTS Central Services, ECPs, CTA).
8. That substantial level of assurance given to the completed audits (2006/07 audit plan) which were concerned primarily with finance. Two audits received adequate level of assurance: overtime & expenses and business continuity & planning. In each case the Auditors made two significant recommendations which have been accepted by Management. No audits undertaken in 2006/7 received limited assurances.
9. The Interim Audit Report from the Audit Commission. Work on the Auditors Local Evaluation is progressing and a draft report is expected in April with the final report being issued in October. The ALE is used by the Healthcare Commission to ascertain Trust's 'use of resources'.
10. The report of the Local Counter Fraud Specialist; six investigations of possible fraud were undertaken in 2006/07. The detailed report of an investigation into possible fraud involving a volunteer ambulance driver's mileage claims.

11. The Risk Register, which evidenced progress in risks being regraded and deleted. The Committee asked that the deletion of two risks be reviewed; the Finance Director explained that the deletion was due to their being a duplication of risks on the Register but undertook to review the matter.

12. The progress to date in implementing the recommendations of the Governance Review, e.g. the Clinical Governance Committee is receiving regular reports from Operations regarding clinical governance (CPI checks, complaints, clinical initiatives etc).

13. The update regarding NSH Litigation Authority and Healthcare Commission from the Head of Governance. The LAS are participating in the NHSLA's pilot of the new ambulance standard from April 2007. Work is being undertaken to evidence compliance with the 24 Healthcare Standards and the Trust's Declaration of Compliance will be presented for the Board's approval in May 2007.

14. The Chairman of the Audit Committee said that given the requirement for NHS Trusts to be more responsive to their service users the Trust Board needed to give consideration as to how the LAS could obtain user feedback.

Standing items:

15. Noted the hospitality declared by Directors of the Trust and that there had been no waivers of Standing Orders since the last Audit Committee meeting.

Presentation

16. A presentation was given by the Head of Operational Support outlining the response of the Trust to the findings of the audits undertaken of Medical Devices and Drug Control. Each area received significant and fundamental recommendations from the Auditors. A further audit of the two areas will be undertaken in 2007/08 when asset tracking has been fully implemented. The Auditor's recommendations concerning introducing a process whereby all drug packs issued should have a life expectancy of at least one month was not accepted by Management. The Auditors accepted Management's explanation why this recommendation would not be possible to implement and how the Trust was managing this risk.

Minutes Received:

17. Noted the minutes and the work plans of the Clinical Governance Committee (12th February 2007) and the Risk Compliance & Assurance Group (28th February 2007).

18. The Audit Committee said it wished to see more evidence that the Clinical Governance Committee was using the Risk Register as a management tool to question action being taken to mitigate clinical risk.

19. The Risk Information Report, which is considered by the RCAG and CGC, has been circulated to the members of the Committee for information.

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

LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE

DRAFT MINUTES

Monday 12th March 2007

Present:	Barry MacDonald	Non-Executive Director (Chair)
	Sarah Waller	Non-Executive Director
	Caroline Silver	Non-Executive Director (from 2.40pm)
	Roy Griffins	Non-Executive Director
In Attendance:	Peter Bradley	Chief Executive (until 4.35pm)
	Mike Dinan	Director of Finance
	Peter Suter	Director of Information Management & Technology
	John Wilkins	Head of Governance
	Eleanor O Hare	A&E Finance Manager (until 5.25pm)
	Chris Rising	Bentley Jennison (until 5.25)
	Keeley Saunders	Audit Commission (until 5.25pm)
	Robert Brooker	Bentley Jennison, Local Counter Fraud Specialist
	Michael Musgrave	Bentley Jennison, Local Counter Fraud Specialist
	Christopher Vale	Head of Operational Support (until 3.05pm)
	David Selwood	Corporate Logistics Manager (until 3.05pm)
	Ian Todd	Assistant Director of Operations, Urgent Operations Centre & Clinical Development (until 3.40pm)
	Christine McMahon	Trust Secretary (Minutes)

01/07 Minutes of the last Audit Committee meeting 4th December 2007

Agreed: The minutes of the last audit committee meeting held on 4th December 2007

02/07 Matters Arising

Minute 26/06: The Finance Director reported that the interpreting service provided by Language Line is being re-tendered. Consideration is being given on whether it would be feasible for the LAS to participate in the London Procurement Project Tender and a specification is currently being drafted. The Finance Director circulated data provided by Language Line on what languages have been required during 2006. Sarah Waller asked for the information to be presented as bar charts. **ACTION: Finance Director.**

With regard to feedback from service users, the Committee was informed that this has been primarily obtained via the extensive PPI work undertaken by the PPI Managers and through the survey undertaken by MORI in 2006. It was suggested that the Trust Board should consider how the Trust acquires feedback from Users; this is an area being considered across the NHS. **ACTION: Chairman of the Audit Committee**

Minute 29/06: the Chief Executive had investigated the Internal Auditor's two recommendations received in connection with the audit of the Child Protection and Vulnerable Adults. Until recently the Trust was not deemed to require the checks as it did not have significant sustained access, this has now been resolved and new staff are receiving the enhanced check done. The enhanced check will not be undertaken for existing staff as the cost would be prohibitive; the Chief Executive said he would speak to the HR Director for her view as to the advisability of getting enhanced checks done for existing staff. The Chairman said that it might be useful to find out what level of checks are undertaken by similar organisations. **ACTION: Chief Executive.**

03/07 Presentation: drug control and medical devices.

At the last Audit Committee meeting (5th December 06) the Internal Auditors reported that they had made significant and fundamental recommendations following the audits of medical devices and drug control. The Chief Executive suggested that a presentation be given to the Committee, outlining what action has been taken in response to the Auditor's findings.

Chris Vale (Head of Operational Support) and David Selwood (Corporate Logistics Mangers) gave a detailed presentation of how the department had responded to the recommendations. The majority of the recommendations have been implemented, e.g. stock takes are being undertaken at store level and the process is being reinforced at station level through the issue of a bulletin to all stations. Make Ready is being utilised to undertake some of the checking e.g. audit defibrillators. The introduction of a hand held asset tracking device will enable the Trust to address the majority of the recommendations. The software is currently being trialled; the target date for introduction of the asset tracking procedure is May 2007 subject to available technical support.

Noted:

1. **That the Head of Operational Support attends operational meetings with AOMs and complex groups, at which he reinforces the messages being disseminated via bulletins regarding checking/auditing.**
2. **That the Make Ready operatives and the personnel responsible for stores at complex level are in daily contact and that feedback loops are in place to ensure checks are being undertaken and procedures adhered to.**
3. **That Managers did not accept the recommendation that the Trust introduce a process whereby all drug packs issued should have a life expectancy of at least one month. The life span of some drugs is very short and the Head of Operational Support said there was a robust system in place to ensure out of date drug packs are not issued. The Internal Auditor accepted the rationale and recognised that there was a monitoring process in place to mitigate the risk.**
4. **That Bentley Jennison will be auditing Medical Devices and Drug Control in 2007, after the asset tracking device has been introduced.**

04/07 Draft Annual Audit Committee report

The Head of Governance presented the template for the annual report. The template was recently put forward at a recent conference for new Audit Committee members; it has been successfully trialled by other NHS trusts.

The Internal Auditor said he was satisfied with the proposed annual report; he said that reference should be made to the internal and external auditors' recommendations considered by the Audit Committee. When audits have received limited assurance it has been highlighted to the Trust Board via the Audit Committee's minutes. The Head of Governance said the final draft will include specific examples of the Committee's activities.

Agreed:

1. **The format of the report, with the proviso that in the section 'achievements', the report regarding self-assessment be moved to the end of the section.**

Noted: **2. That the Head of Governance will circulate the final draft for the Committee's views prior to the report's presentation to the Trust Board in May 2007. ACTION: Head of Governance**

05/07 Internal Audit

Progress Report:

The Internal Auditor presented the progress report, which comprised the following audits:

2005/06 audit plan: Emergency Care Practitioners (five significant recommendations) and Urgent Care (seven significant recommendations); both received limited assurance from the Internal Auditors.

2006/07 audit plan: overtime and expenses, and business continuity and planning received adequate level of assurance. Both of these received two significant recommendations which have been accepted by management.

Creditors (1 significant recommendation), trust funds, general ledge and treasury management received substantial level of assurance, and with the exception of creditors there were no significant recommendations.

The Committee considered the reports regarding Emergency Care Practitioners and Urgent Care; there were five significant recommendations made in respect of ECPs in relation to compliance with controls in place and a perceived weakness in the control environment itself. Seven significant recommendations were made regarding Urgent Care; five related to weaknesses in respect of the control processes and two arose from compliance weaknesses. It was recognised that the audit was undertaken in May 2006 and there have been a number of changes made in relation to ECPs and Urgent Care. Agreed that a further audit will be undertaken of Urgent Care in 2007-08 to review the interfaces between the different areas of Urgent Care and EOC and to follow the process from beginning to end.

The Chairman asked that when the Auditors give a limited level of assurance the Committee receive a detailed report rather than the usual abbreviated report so as to enable the Committee to form a judgement as to the risks facing the Trust. **ACTION: Internal Auditor**

Draft Audit Plan 2007/08

The Finance Director presented for discussion the draft internal audit plan; he said that he had shared the draft audit plan with the Senior Management Team. The Committee was asked for its views as to what it would like the Internal Auditors to review in 2007/08.

Agreed: **1. That, in addition to those outlined in the draft plan, the following audits should be undertaken in 2007/08: UOC (encompassing the different facets of UOC including ECPs and CTA); all High Impact Changes (not just those concerned with EOC) and Complaints.**

Noted: **2. That what is being proposed by an audit of 'distribution reporting/analysis' will be further clarified. There was a need for work on performance management including data for individuals which could be covered by this heading, later in the year. ACTION: Finance Director**

3. That there were no limited assurances given or fundamental recommendations made in relation to audits undertaken as part of the 2006/07 audit plan.

06/07 Audit Commission

Kelley Saunders, Audit Commission, presented the progress report (previously known as the interim audit report). The report summarised the progress to date of the 2006/07 audit;

all of the work has either been completed or is in progress. This includes work on three of the five themes under the Auditor's Local Evaluation (ALE): financial management, internal control and value for money.

In response to a question from Sarah Waller the Auditor undertook to ascertain if the Audit Commission had reviewed the benefits realised by the new GP contract and new Consultants contract. **ACTION: Audit Commission**

Noted:

1. **That the Audit Commission in its review of the NHS financial management and accounting report to the Secretary of Health said that resource accounting and budgeting (RAB) should not be applied to NHS trusts because it is incompatible with their financial regime. No decision has yet been made as to when RAB will cease.**
2. **That there has been nothing discovered to date which would significantly affect the Auditor's opinion of the Trust's good financial standing.**
3. **That the draft findings of the ALE will be issued in April with the final version issued in October; it will be used by the Healthcare Commission to ascertain the Trust's use of resources.**
4. **That the Audit Commission will present reports concerning Managing Resources for Improvement and Workforce Contracts to the Committee in June 2007.**
5. **That the Audit Commission is undertaking a review of the benefits realised by the implementation of Agenda for Change; this is a national review and the findings will be published in due course.**

07/07 Report of the Local Counter Fraud Specialist

Robert Brooker, Local Counter Fraud Specialist (LCFS), presented his progress report to the Committee. The report outlined six investigations undertaken since July 2006; one has been reported to the Metropolitan Police and individuals have been charged with receiving stolen goods; one is being dealt with internally as a performance issue (not carrying out duties in agreement with the contract); the Trust is seeking to recover monies paid to a Bank member of staff who had not registered with Health Professional Council as a paramedic and who was consequently overpaid. Two investigations are ongoing.

A member of the public who has made an allegation of theft concerning the LAS marching band has been advised to contact the Police as the marching band is not connected to the Trust. The Chief Executive undertook to investigate the marching band and ensure that it is not using insignia that could identify it with the LAS. **ACTION: Chief Executive.**

The LCFS presented an investigation closure report that detailed the investigation undertaken into a volunteer ambulance driver's mileage claim.

Agreed:

1. **The 2007/08 Counter Fraud Plan**

Noted:

2. **The report of the LCFS**
3. **That the Trust had the option, if the fraud involved substantial sums, to pursue volunteer staff through the civil courts.**

08/07 Future provision of Internal Audit Services

The Committee considered the proposal from the Director of Finance regarding the future provision of internal audit services in which he outlined three options: continue

outsourcing, in-house provision and hybrid (outsource financial systems audit and bring operational audit in-house). This item was discussed in private at the end of the Committee meeting.

Following discussion it was proposed that Bentley Jennison's contract be extended for one year whilst the Finance Director investigate the practicality of the Trust working in partnership with other Ambulance Trusts and employing internal auditors to undertake non-financial audits. The Finance Director said he will undertake further work to identify what would be the added value of having an in-house internal audit function, possibly shared with other Ambulance Trusts. If it did not prove to be viable the Trust would be ready to tender the internal audit function during the Summer 2007.

Noted:

1. **That the Finance Director will undertake further work to refine the proposal to having in-house internal audit function whilst retaining external internal auditors to undertake financial audits.**
2. **The Audit Commission representative said she would give her comments directly to the Finance Director as she had to leave the Committee before this item was discussed. ACTION: Audit Commission.**

09/07 Approval of Scheme of Delegation

The Committee considered the Scheme of Delegation and made a number of amendments which have been incorporated into the Scheme; including (8: ex-gratia payments) that the Trust, when making ex-gratia payments, will rely on legal *opinion* as to the existence of a possible case against LAS which would need to be opposed in a court or tribunal with all payments being reported to the Audit Committee. Consultants' contracts in excess of £100,000 are to be authorised by the Trust Board. Any tenders submitted by the Trust in excess of £1 million (e.g. PTS contracts) should be approved by the Board, as should all new revenue contracts over £1million. The Director of Finance will report budget virements of over £100,000 to the Audit Committee as part of the standard reporting arrangements.

Noted:

1. **The role of SSG in making collective capital expenditure decisions up to £1 million.**
2. **That the revised Scheme of Delegation, the Standing Orders and the Financial Instructions will be presented for the Trust Board's approval in March 2007.**

10/07 Risk Register Update

The Committee considered the Risk Register and commented on the progress being made in managing the risks on the Register.

During the discussion of the Risk Register it was suggested that there should be a forecast statement included as to what the responsible manager thought the position of the risk would be in 12 months time. Caroline Silver said that there were two types of risk on the register; those that were inherent in being an emergency ambulance service and those that were not inherent and could be reduced over time and removed from the Register. The Committee suggested that the Clinical Governance Committee could have a more explicitly questioning approach to their level of satisfaction with the management of clinical risks and the progress being made. Most of the high level risks were clinical.

It was recognised that the register is a 'live' document; and that it is only as good as the input received from managers and staff. One of the challenges for managers is to push back down through the Trust to front line staff, by function and area, ownership of risks.

The Head of Governance said he would contact other Ambulance Trusts and propose sharing risk registers so as to identify what are the 'inherent' risks so that work can be undertaken on how these could be further mitigated. **ACTION: Head of Governance.**

Noted:

1. **The procedure for managing risk; both the RCAG and the Clinical Governance Committee review clinical and non clinical risks on the register. The RCAG considers what new risks should be added, regraded or deleted based on evidence provided to that group.**
2. **That the front sheet accompanying future reports will highlight what reviews have been undertaken by management and staff since the Register was last presented to the Committee. ACTION: Head of Governance.**
3. **That the Clinical Governance Committee in its review of clinical risks should address whether it is satisfied with the management action being taken to manage the risks and whether the situation is getting better or not**

11/07 Governance Review Update

The Head of Governance reported that the Clinical Governance Committee is now receiving better information about local governance via the reports of the Assistant Director of Operations. At each meeting an Assistant Director of Operations has presented a governance report related to what has been taking place in their Area. In addition the Deputy Director of Operations presents a general report, giving an overview of governance in the remainder of the Areas. The reports include information regarding complaints, CPI checks, performance monitoring and PDR.

Noted: **The progress to date in implementing the recommendations of the Governance Review.**

12/07 Standing Committee Items

Noted:

1. **The hospitality received declared by Peter Suter, Mike Dinan and Fionna Moore.**
2. **That there were no waivers of the Trust's Standing Orders since the last Audit Committee meeting.**

13/07 External Accreditation reports

NHSLA: The Head of Governance reported that the NHSLA had visited the LAS on 7th March 2007; a full report will be included in the Medical Director's report to the March Trust Board.

The NHSLA are running a pilot to test the new Ambulance Standard. Unfortunately it recently tendered the audit work and the current provider, Willis, has not been reappointed. The new provider will take responsibility from 1st April and it may be that some of what has been agreed will change. The new assessment comprises five standards, each with ten criteria. There are three levels; the Trust will be assessed initially at Level 1 and at Level 2 in the Autumn. Until the new Standard has been agreed the Trust retains the Level 2 it was assessed under the previous standard. A gap analysis will be undertaken following each assessment and an action plan drafted to address any areas of concern.

Healthcare Commission: work is being undertaken to assess the Trust's compliance with the Healthcare Commission's 24 Healthcare Standards and to identify what evidence is available to demonstrate compliance. The Senior Management Group receives regular

progress reports. The declaration will be presented to the Trust Board in May for approval prior to its submission to the Healthcare Commission.

The Head of Governance will be seeking agreement from the 31 Boroughs' Overview and Scrutiny Committees in London that they agree with the Trust's statement of compliance.

Noted: The work being undertaken with regard to the NHSLA and the HCC.

14/07 Audit Recommendations

The Committee reviewed the Audit Recommendations report.

Members commented on the greater clarity and much improved presentation of this report. Future reports to the Committee will contain detail on fundamental and significant recommendations.

Agreed: 1. That future report should combine the recommendations from the Internal Auditors, the External Auditors and the LCFS.

Noted: 2. That the 'merit attention' recommendations should be summarily reported on one sheet as an addendum to the main report.

3. That the ADO Urgent Care will check R19 (the Trust should review the No Send Policy in respect of green 1 and 2 calls ACTION: Head of Governance.

15/07 Draft minutes of the Clinical Governance Committee and the Risk Compliance & Assurance Group.

Clinical Governance Committee minutes (12/2/07): the Committee noted that CPI completion is variable across the Trust.

Sarah Waller asked how a PDR meeting between staff and their managers can not be an appraisal. The Finance Director said that PDR is a performance development review, during which core development is considered, weaknesses identified that can be addressed through further training. This is a new system for the Trust and it is still early days. A representative of HR Directorate is a member of the Committee and will be in attendance at the next meeting and can expand on this further if necessary. **ACTION: Head of Governance.**

The Committee noted Minute 02/07 which proposed that a new risk be added to the register regarding EOC being aware of staffing on ambulances/FRUs in relation to calls received (i.e. being able to identify what calls require a Paramedic). In view of a recent SUI there was a clear need to look at all aspects of this problem. This risk will be discussed at the next Clinical Governance Committee.

Risk Compliance & Assurance Group: the Director of Finance chaired the meeting on 28th February 2007 at which a number of risks were proposed for regrading or deletion. Sarah Waller queried the deletion of Risk 17 (lack of crewed ambulance on Friday, Saturday and Sunday nights); the Director of Finance said that it was felt that this risk was a repetition of what is being included in other risks and the risk itself was part of risk 265.

The Director of IM&T said that the risks proposed for regrading and deletion were put forward by the Deputy Director of Operations with knowledge of what is happening operationally and what risks the Trust is managing. Caroline Silver said that one of the functions of the Audit Committee are to assure itself that it is satisfied with how risk is being managed.

The Chairman of the Committee felt that the deletion of risk 248 (EOC staff not checking logs of Category C calls) was perhaps premature until there is fully controlled process in place. **ACTION: the Finance Director will investigate and report back**.

Noted:
1. **That the 'risk information report' considered by the Clinical Governance Committee and RCAG will be circulated to the Audit Committee for information. ACTION: Trust Secretary.**
2. **That the Committee wished to see the CGC and RECAG recording more of their review of their satisfaction with current management actions on risk and whether the situation was improving or not.**
3. **That two new risks had been added to the Register: equal pay claims and driving licence checks.**

16/07 Work plans for the Clinical Governance Committee and the Risk Compliance & Assurance Group

Noted:
1. **The work plans for the CGC and the RCAG.**
2. **That the Assurance Framework will be presented twice a year to Trust Board and/or the Audit Committee.**
3. **That there should be a clear rota of ADOs reporting to the CGC.**

17/07 Audit Committee's workplan

Noted:
1. **That the Committee will consider the financial matters including the 2008/09 budget in November 2007.**
2. **That the private meeting between the Committee and the Auditors is to be stated in the workplan.**

Meeting finished at 5.45

Enclosure 17

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 27th March 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 have been 3 tenders received since the last Trust Board meeting.

Alternation to first floor at Waterloo HQ	Consiton Ltd. Russell Crawberry Mitie Property TCL Granby Ltd
Tender for the provision of management storage and supply of uniform and Personal Protection Equipment.	Alexandra Dimensions HR Denne Kashkett Lim Apparell Simon Jersey Hunter
Print Services for the LAS News	Aldridge Print Group Stabur Graphics

3. Use of the Seal

There has been 1 entry, reference 104 since the last Trust Board meeting. The entries related to:

No. 104 Agreement for minor building works between LAS and Mitie Property Services in regard to Hillingdon AS to provide office and staff facilities.

Recommendations

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

Christine McMahon
Trust Secretary