London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 14th December 2010
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			TAB
1.	**Welcome and apologies for absence**		
2.	**Minutes of the Part I meeting held on 30th November 2010** To approve the minutes of the meeting held on 30th November 2010		TAB 1
3.	**Matters arising** 3.1 Actions from previous meetings	All	TAB 2
4.	**Chairman's Report** To receive a report from the Trust Chairman on key activities	RH	Oral
5.	**Update from executive directors** To receive reports from Executive Directors on any additional key matters		
	6.1 Chief Executive Officer 6.2 Finance Director	PB MD	Oral To follow
6.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety	FM	Oral

STRATEGIC AND BUSINESS PLANNING

7.	**Balanced scorecard** To receive a presentation by Christine McMahon on the balanced scorecard	CM	Presentation
8.	**2011/12 planning process** 8.1 Quality Innovation Prevention and Productivity (QIPP) 2011/12 8.2 Cost Improvement Programme 2011/12 – 2012/13	 LB MD	 To follow To follow
9.	**Business Case for Single Tender Authority for Mobile Data Terminals** To approve the Single Tender Authority to proceed to procure mobile data terminals	PS	TAB 3

FOUNDATION TRUST PROCESS

10.	**Integrated Business Plan and Long Term Financial Model** 10.1 To approve the next draft of the Integrated Business Plan based on the responses to the SHA comments 10.2 To note the progress made with the Long Term Financial Model	SA/ MD	To follow
11.	**Action plan from historical due diligence** To review progress against the action plan since 30th November 2010	SA	TAB 4

GOVERNANCE

12.	**CommandPoint update** To receive assurance on the project in terms of: • Budget • Progress against the action plan • Implementation plan and in particular staff training	PS	TAB 5
13.	**Clinical Response Model** To receive the evaluation plan for the CRM	CH	TAB 6
14.	**Governance structure** To approve the updated structure chart in light of the HDD review and in-year developments	SA	TAB 7
15.	**Board development programme** To note the updated Board Development Programme	CH	TAB 8
16.	**Board process review** To review the processes and information supporting Trust Board meetings	RH	TAB 9
17.	**Forward Planner** To review the Trust Board forward planner and agree items for future meetings	SA	TAB 10
18.	**Questions from members of the public**		
19.	**Any other business**		
20.	**Date of next meeting** **The next public Trust Board meeting will be held on Tuesday 25th January 2011**		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 30th November 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Chair
Peter Bradley	Chief Executive Officer
Mike Dinan	Director of Finance
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
Sarah Waller	Non-Executive Director
Nigel Walmsley	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Jessica Cecil	Associate Non-Executive Director
Francesca Guy	Committee Secretary (minutes)
Steve Lennox	Director of Quality and Health Promotion
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Richard Webber	Director of Operations
Members of the Public:	
Joseph Healy	Chair of Patients Forum
Mark Brice	NHS London
Simon Crawford	NHS London
Carmel Dodson-Brown	Assistant Director of Corporate Services
Neil Kennett-Brown	North West London Commissioning Partnership

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133/10. <u>Welcome and Apologies</u> — **<u>Action</u>**

There were no apologies.

134/10. <u>Minutes of the Part I meeting held on 28th September 2010</u>

The minutes of the meeting held on 28th September were agreed subject to two minor amendments. **<u>FG</u>**

135/10. <u>Matters Arising</u>

The following matters arising were considered:

- <u>101/09: LAS Foundation Trust Membership Strategy</u> Sandra Adams reported that it had been agreed that a partnership governor place would be offered for a representative from the staff council. The Trust Board would be asked to approve

the Membership Strategy at today's meeting;

- 97/10: Matters Arising from the meeting on 31st August 2010 Mike Dinan reported that the Integrated Business plan for the Trust Board meeting on 14th December would be update to include the age profile of the fleet; **MD**
- 117/10: Report from the Director of Finance The Trust Board asked for clarity about whether the trust would be held to each line of the budget and the Cost Improvement Plan or the overall total. This action was carried forward. **MD**

Sarah Waller asked about the joint LAS/Metropolitan Police DVD which gave guidance on protecting the safety and well being of persons taken into police custody. Fionna Moore responded that LAS would be making copies of the DVD to circulate to operational staff. Fionna Moore and Angie Patton agreed to follow this up. Joseph Healy commented that the Patients Forum would also be interested in seeing this DVD. **AP/FM**

136/10. Formal Reports from the sub-committees

Audit Committee on 8th November 2010

Caroline Silver reported that this meeting of the Audit Committee was usually an internal meeting, but due to the fact that there had been some key issues arising from the recent HART audit, it had been agreed that both internal and external audit would attend this meeting to give an update. This meeting of the Audit Committee was observed by Grant Thornton and NHS London. Caroline Silver reported that the following was discussed at the meeting:

- HART internal audit and how the Audit Committee would ensure that the recommendations were followed up;
- The risks relating to the Foundation Trust application and the new commissioning arrangements. It was agreed that these risks should be incorporated into the corporate risk register;
- The review of the audit process which was currently being undertaken by Frances Wood. Training would be rolled out across the trust to ensure that all managers with responsibility for audit recommendations were following the new process;
- The Audit Committee held a separate session on the business plan and the Long Term Financial Model and in particular discussed payment by results and liquidity and cash management;
- The proposal to establish a Finance and Investment Committee.

The Audit Committee had also discussed the need to meet more frequently.

Quality Committee on 24th November 2010

Beryl Magrath reported that the Quality Committee discussed the following:

- The terms of reference for the Quality Committee, Learning from Experience Group and Risk Compliance and Assurance Group which had been updated following feedback from the recent NHSLA assessment;
- The Quality Committee had received a report from the Learning from Experience Group which had reviewed all SUIs declared since 2005 and had discussed the procedure for ensuring that learning points were embedded within the organisation. The Group had also received a report on all complaints received from 1st April 2010 and had identified key themes;
- The Quality Committee received a report from the Risk Compliance and Assurance Group which had reviewed the corporate risk register and the risk implications of

version 8 of the Information Governance toolkit;
- The Quality Committee reviewed the corporate risk register and Board Assurance Framework (BAF). Feedback from NHSLA and Grant Thornton was that the risk register and BAF should be presented to the Trust Board more frequently than the current process of twice a year. It was agreed that the BAF should be presented to the Trust Board quarterly and at any meeting where neither the Audit Committee nor the Quality Committee had met in the preceding month.

Beryl Magrath noted that an additional meeting of the Quality Committee would be held on 14th December following the Trust Board meeting.

137/10. Chairman's Report

The Chair noted the following:

- The Chair and Peter Bradley had attended the London Mayor's Health Summit at City Hall. There was an increasing interest in the LAS and a proposal for further scrutiny of the trust by the London Assembly;
- The Chair had given a presentation on the LAS at the King's Fund;
- The Chair had attended the Ambulance Service Network which had agreed to continue to meet nationally;
- The Chair had formed part of the interview panel for the CEO of Central London Community Healthcare;
- The Chair had attended the CommandPoint conference;
- The Chair and Peter Bradley had attended the Saving Londoners' Lives dinner;
- The Chair had visited Chase Farm and Edmonton sites and would continue to visit other sites across London.

Peter Bradley commented that he would need to meet with the Greater London Authority as it was clear that the LAS was increasingly going up on their agenda. There had been a proposal that the LAS should report to the GLA rather than the NHS, but this proposal had been rejected.

138/10. Update from Executive Directors

Chief Executive Officer

Peter Bradley reported that the trust had won an award for the European Control Centre of the year and had shown significant improvements in its cardiac survival rates.

Peter Bradley noted the following:

- 10/11 contract negotiations were being finalised in terms of CQUINs;
- Performance remained a challenge following a recent significant increase in demand, which was in part due to the London Underground strikes, the London Fire Brigade strike and the student protests. However performance should be better in spite of these additional challenges;
- Work was being undertaken to reduce hospital turnaround times;
- Clinical Response Model was progressing in Barnehurst and Greenwich;
- Good progress had been made against the action plan which was drawn up following the Health and Safety Executive Improvement noticed was issued;
- Progress had been made against the London Bombings 7/7 action plan;
- The Quality Committee had received a report on all SUIs declared since 2005. More work needed to be done to improve the quality and consistency of reporting;

- An operational and IT debrief was being undertaken following the recent fire at the HQ building. The findings and lessons learnt would be presented to the Trust Board in January;
- Frontline consultation meetings had taken place and the staff survey was currently underway. Feedback on any issues that could be improved would be taken on board;
- SMG was working to improve reporting arrangements on workforce and logistics and hoped to provide more comprehensive measures to the Trust Board in the future;
- The terrorist threat in London remained high and Peter Bradley was attending regular meetings with NHS to ensure that the LAS was as prepared as possible;
- Finance would remain a key challenge for the trust;
- The trust would increasingly need to focus on its Foundation Trust application;
- The operating framework for the trust would shortly be received from the Department of Health.

Peter Bradley noted that the corporate balance scorecard was attached as an annex to his report. Christine McMahon would attend the next meeting of the Trust Board to give a presentation.

Richard Webber highlighted key points from the performance report:

- Graphs 19 – 24 showed that ambulance utilisation was currently too high and the trust needed to focus on bringing this down;
- Staffing was currently up;
- The LAS component of hospital turnaround time had dropped but more partnership working needed to be done to ensure that the overall time was reduced.

There followed a discussion about whether the Trust Board would need to revisit the demand predictions as stated in the Integrated Business Plan (IBP) in light of the recent increase in demand. The LAS was playing an active role in try to reduce demand on the service and this was something for further debate outside of the Trust Board meeting.

There followed a discussion about restbreaks. Peter Bradley commented that either a new agreement should be agreed with the unions or the existing arrangements needed to be implemented more robustly. Caron Hitchen reported that the trust was currently in discussions with staffside on this issue.

Nigel Walmsley commented that it would be useful to contextualise and benchmark the statistics. It would also be useful to have information on employee morale and a regular review of the state of industrial relations. Caroline Silver added that it would be beneficial for the Trust Board to understand the linkages between operational performance and finance.

Jessica Cecil noted that there was currently a lack of appetite for operational staff to work on first responder units (FRU). Caron Hitchen reported that staff had expressed greater job satisfaction after working in an FRU and therefore they should become more popular.

Joseph Healy reported that the Patients Forum had expressed concerns about hospital turnaround times and the arrangements for Patient Transport Services (PTS) in South London. The Forum had noted the increasing levels of sickness absence amongst PTS staff. Caron Hitchen agreed to find out more information on the causes of sickness in this staff group. Peter Bradley added that he had been disappointed about the recent comments from South London PCT stating that the key reason for awarding the PTS

CH

contract to Savoy Ventures was patient safety. It was clear that the primary reasons for changing the contract were financial.

Director of Finance

Mike Dinan noted the following:

- Expenditure was over forecast which was largely due to an under-accrual of overtime hours for the month 6;
- Non-pay spend was lower than forecast;
- Overtime hours had been reprofiled to increase in November and December;
- The financial risk was currently estimated at £1.5 million;
- The trust was set to deliver the largest Cost Improvement Plan it had ever delivered at £18.6 million.

Mike Dinan stated that the liquidity ratio, as detailed on page 3 of his report, would be addressed as part of the Foundation Trust application.

The Chair summarised the key issues, which were:

- Overtime hours;
- The Cost Improvement Plan, which might be delivered differently than originally planned. This would need to be discussed further by the Trust Board;
- Demand versus targets.

139/10. Clinical Quality and Patient Safety Report

Fionna Moore noted that the key issues were:

- The management of drugs. In particular, there was an issue around the tracking of drug bags, which had been highlighted by a recent incident where drug packs had been stolen from a station, but had not been identified as missing;
- The difficulties crews had experienced in differentiating between two fluid bags;
- The difficulty operational staff had in keeping up to date with the amount of information that had been sent out from the Medical Directorate. The Medical Directorate was working to index all this information to make it more accessible to operational staff.

Steve Lennox commented that, with regards to drugs management, it was not unusual for hospital ward managers to be disciplined if a member of staff was not adhering to policies. Fionna Moore responded that the paramedic role was a relatively new role and there was room for improvement. The risk to the patient was minimal, but improvements needed to be made nonetheless. Caroline Silver added that this issue had been identified by the Audit Committee and would be tracked and monitored by the Audit Committee and the Risk Compliance and Assurance Group.

140/10. Emergency Preparedness Strategy

Richard Webber noted that the Emergency Preparedness Strategy had been approved by the Senior Management Group, however a recent national audit had highlighted that it was a requirement of the Trust Board to also approve the Strategy.

The Trust Board approved the Emergency Preparedness Strategy.

142/10. Service Improvement Programme

Sandra Adams highlighted the key issues in relation to the Service Improvement Programme.

There followed a discussion about the Clinical Response Model and the need to manage public expectation. The Chair commented that he would like the Trust Board to discuss a long-term communications strategy at a future meeting. Caron Hitchen commented that the evaluation of the CRM would consider patient feedback and would look at staff influencing skills.

143/10. Feedback from Historical Due Diligence Assessment

Sandra Adams reported that the first stage of Historical Due Diligence had taken place between 8th and 12th November. A draft report had been received on 22nd November and had been discussed by the Chairman, Chief Executive, Director of Finance and the Director of Corporate Services.

The key feedback was as follows:

- The trust might wish to establish a Finance and Investment Committee which would be helpful in the context of the future financial challenges of the organisation;
- The trust should model the impact of the 2012 Olympics on the core service provision;
- Liquidity issues and the impact of low levels of cash;
- Historic non-delivery of Category B was likely to be rated as red/amber, however it was noted that this target might not exist in the future;
- The Estates Strategy needed to be updated to reflect the IBP and issues around resilience regarding the control room arrangements.

Sandra Adams noted that these issues were already being addressed and therefore should meet the proposed timetable. 44 action points had been identified, 15 of which would need to be completed before the end of the due diligence process. Sandra added that overall the trust had received a good outcome.

The Chair commented that the key issue was achieving the agreed timeline to become a Foundation Trust by September 2011. The Trust Board should agree any deviation from this plan.

The Chair added that the Cost Improvement Plan would be discussed in more detail at the next Trust Board meeting.

144/10. Integrated Business Plan and Long Term Financial Model

Sandra Adams reported that the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) were being updated to reflect comments from the Strategic Health Authority. Version 3.2 of the IBP had been included in the papers for the Part II meeting of the Trust Board.

Sandra added that the next couple of versions of the IBP would need to be close to the final version.

145/10. Membership Strategy

Sandra Adams noted that the Membership Strategy had been presented to the Trust Board at its September meeting and that it was a requirement of the Trust Board to approve the strategy prior to the application for Foundation Trust status. The strategy set out how the Trust would develop a membership base that reflected the London population and how those areas which were currently underrepresented would be targeted through the publicity campaign.

Steve Lennox commented that the ethnicity section was not detailed enough to accurately reflect the London population. Sandra Adams responded that the ethnic groups listed in the strategy had been provided by Monitor, but they could be broken down further if appropriate. Sandra Adams and Steve Lennox agreed to discuss this further outside of the meeting. **SL/SA**

Sarah Waller noted that the age brackets were wide. Lizzy Bovill commented that it would be useful to break down these age brackets further, especially considering that demand profiling showed that younger people placed higher demand on the service. Sandra Adams agreed to review this. **SA**

The Chair suggested amendments to the wording on the diagrams on page 6. **SA**

Subject to these comments, the Trust Board approved the Membership Strategy.

146/10. Board Assurance Framework and Corporate Risk Register

Sandra Adams reported that the Board Assurance Framework (BAF) had been updated and reviewed by both the Risk Compliance and Assurance Group and the Quality Committee. The BAF had been mapped to the Care Quality Commission requirements, the Corporate Objectives and the Strategic Risks and each risk had been assigned to a lead director. The BAF therefore provided the Trust Board with a comprehensive picture on how key risks were managed and what controls were in place.

Peter Bradley commented that the feedback from the recent consultation meetings should be mapped against the risk register and in particular the drop in performance from 12.00 – 3.00 am on Friday and Saturday nights as these were the hours where patients were most at risk due to high demand.

Roy Griffins commented that the Trust Board needed to ensure that the feedback from the NHSLA assessment and from Grant Thornton had been taken on board.

Sandra Adams reported that the Quality Committee had agreed that the BAF would be reviewed by the Trust Board quarterly and that new risks or newly-rated risks would be highlighted through the Chief Executive Officer's report to the Trust Board. The Trust Board would also be asked to conduct a more formal review of the BAF and risk register at meetings where neither the Quality Committee nor the Audit Committee had met in the preceding month.

Steve Lennox commented that he was the owner of safeguarding and infection control risks and would be reviewing these risks and any changes would be considered by RCAG and the Quality Committee.

Mike Dinan commented that the establishment of a Finance and Investment Committee would allow the Audit Committee to spend less time on financial matters and more time on risk management.

147/10. Safeguarding Update

Steve Lennox reported that the trust had made significant progress in managing safeguarding risks on the risk register and the initial risk had now been removed. An action plan had been developed to address a new clinical risk that staff might fail to recognise safeguarding indicators and therefore not make a timely referral. The trust had invited the Safeguarding Improvement Team at NHS London to undertake a review of safeguarding processes at the trust. A full report would be provided to the Trust Board.

Lizzy Bovill reported that safeguarding had been part of the Emergency Bed Service presentation at the recent Senior Managers Conference. It was therefore expected that the trust would experience a rise in the number of referrals made. Lizzy added that the procurement of call-recording system had been approved which would make it easier for crews to make referrals.

Joseph Healy reported that the Patients Forum would be discussing safeguarding at its next meeting.

The Trust Board noted the update on safeguarding.

148/10. Charitable Funds Annual Report and Accounts for year-ending 31st March 2010

The Trust Board noted that the Charitable Funds Annual Report and Accounts for year-ending 31st March 2010 had been reviewed in detail by the Charitable Funds Committee and the Audit Committee. The Trust Board approved the Charitable Funds Annual Report and Accounts for year-ending 31st March 2010.

Beryl Magrath commented that most Foundation Trusts had active charities and asked whether the LAS would therefore be looking to set up a separate charity once it received Foundation Trust status. Mike Dinan responded that as the existing charity was staff-related, it was likely that a separate charity would be established.

149/10. Q2 Governance and Finance Declaration

Sandra Adams noted that this was the last Governance and Finance Declaration that the LAS would be required to submit to the Strategic Health Authority. As a Foundation Trust, the trust would be required to submit quarterly reports on governance and finance to Monitor.

Sandra Adams reported that the Quality Risk Profile had been published by the Care Quality Commission in September and would be sent every month to each trust. The report gave a RAG rating against risk indicators based on data from various different sources. In September, the LAS had scored 1 green, 3 amber and 1 red. The red score was primarily based on the Information Governance toolkit and the NHSLA rating from 2008.

The SMG would be reviewing the Quality Risk Profile and the results had been used internally to map against the corporate risk register. It was agreed that the Quality Risk Profile would be submitted to the Quality Committee and a summary provided to the Trust Board in the Chief Executive Officer’s report.

150/10. Report from Trust Secretary

The Trust Board noted the tenders received for works for Deptford Ambulance Station.

151/10. Forward Planner

Sandra Adams noted the items for the forward planner which had been discussed at today's meeting:

- Safeguarding Declaration – January/March
- Patient Experience Report – January
- Update on Clinical Response Model – January/March
- Interim update on CommandPoint
- Quality Indicators Dashboard

The forward planner would be updated to reflect these new items of discussion. **SA/FG**

152/10. Questions from members of the public

There were no questions from members of the public.

153/10 Any other business

The Chair noted that this was Sarah Waller's last meeting as a non-executive director at the LAS. The Chair therefore proposed that Roy Griffins be appointed as Deputy Chair following Sarah's departure. The Chair also proposed that Nigel Walmsley become the senior independent non-executive director. The Trust Board agreed both these proposals.

The Chair and Chief Executive Officer gave a presentation to Sarah Waller and expressed their gratitude, on behalf of the Trust Board, for her contribution to the LAS over the past ten years.

154/10. Date of next meeting

The next public meeting of the Trust Board will be held on 14th December 2010.

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Signed by the Chair

ACTIONS

from the Meeting of the Trust Board of Directors of

LONDON AMBULANCE SERVICE NHS TRUST

held on 30th November 2010

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/09/09	102/10	**Proposed governance arrangements and draft constitution for the LAS NHS Foundation Trust** Further discussion to be held at the Service Development Committee in October with an update to the November Board meeting.	SA	Open
31/08/10	97/10	**Matters Arising** The Chair asked that the Trust Board be provided with an age profile of the fleet.	MD	To be included in the IBP presented to the Trust Board on 14th December
28/09/10	117/10	**Director of Finance** The Trust Board asked for further clarification on the forecast figure for agency spend and what was contained within this figure.	MD	Open
28/09/10	117/10	**Director of Finance** Trust Board asked for clarity on whether the Trust would be held to each line of the budget or the overall budget total.	MD	Open
30/11/10	134/10	**Minutes of the Part I meeting held on 28th September 2010** Francesca Guy to update the minutes to reflect comments made.	FG	Complete
30/11/10	135/10	**Matters Arising** Angie Patton and Fionna Moore to follow up on the action to ensure that the joint LAS/Metropolitan Police DVD which gave guidance on protecting the safety and well being of persons taken into police custody was copied and distributed.	AP/FM	
30/11/10	138/10	**Update from Chief Executive Officer** Caron Hitchen agreed to find out more information on the causes of sickness amongst Patient Transport Staff.	CH	

30/11/10	**145/10**	**Membership Strategy** Sandra Adams and Steve Lennox to discuss the ethnicity section of the membership strategy. Sandra Adams to review the age brackets in the membership strategy. Sandra Adams to amend working on page 3 to reflect comments from the Chair.	**SA/SL** **SA** **SA**	
30/11/10	**151/10**	**Forward Planner** The forward planner to be updated to reflect the following items: • Safeguarding Declaration – January/March • Patient Experience Report – January • Update on Clinical Response Model – January/March • Interim update on CommandPoint • Quality Indicators Dashboard	**SA/FG**	

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14 DECEMBER 2010

PAPER FOR NOTING

Document Title:	Business Case for Single Tender Authority for MDT's
Report Author(s):	John Downard
Lead Director:	Peter Suter / mike Dinan
Contact Details:	Peter.suter@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Authority for single tender action.
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To approve the single tender action

Executive Summary

The aim of this document is to secure an acceptable procurement route for the bulk purchase of mobile data terminals sufficient to retrofit the London Ambulance Service (LAS) operational vehicle fleet.

Key issues for the Trust Board

Based upon the argument of the technical complexity to replace the current product, as advised in Regulation 14 of the public contracts, single tender authority is given to procure 570 MDT units from Microbus Ltd.

Attachments

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

☐ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways
X To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper links to the following strategic risks:

☐ There is a risk that we fail to effectively fulfil care/safety responsibilities
X There is a risk that we cannot maintain and deliver the core service along with the performance expected
☐ There is a risk that we are unable to match financial resources with priorities

☐ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

NHS Constitution

This paper supports the following principles that guide the NHS:

X 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☐ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
X 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
X 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
X No

Key issues from the assessment:

BUSINESS CASE FOR SINGLE TENDER AUTHORITY FOR MDT's

Document structured:

Aim	-	what the paper is seeking to achieve
The Argument	-	the problem we face and how it needs to be addressed
Options and Costs	-	how the requirement could be met cost-effectively
Funding	-	how the requirement will be paid for.
Conclusions	-	drawn from 'The Argument' and 'Costed Options'
Recommendations	-	what we want the appropriate authority to do.

Section 1 - The Aim

The aim of this document is to secure an acceptable procurement route for the bulk purchase of mobile data terminals sufficient to retrofit the London Ambulance Service (LAS) operational vehicle fleet.

Section 2 - The Argument

Background

LAS instigated an OJEC 'Supply Contracts – Open Procedure' tender process in October 2001 for the '*Provision of in-vehicle microcomputers, navigation equipment and associated communications equipment and services'*. Microbus Ltd were selected as the most appropriate supplier. An order was placed in 2002 for the supply of vehicle based mobile data terminals (MDT); the MPC product. An initial quantity of 400 units were ordered. Bespoke software (MIT) was developed by the LAS to operate on the MDT to enable crew interaction and data interchange with the Trust Computer Aided Dispatch system (CTAK).

Current Situation

MDTs have been installed in wide variety of Trust front line response vehicles requiring specific engineering per vehicle type to achieve functional and safe fitment. The installed base totals some 700+ units.

There is tight integration of MDT hardware and peripherals with the MIT software.

MIT functionality has been constant developed and tuned to the specific operational requirements of the Trust. Location awareness (GPS integration) and auto status are two features in particular that contribute to the Trusts operational efficiency and hence KPIs.

One trust technician provides the expertise in support and development of the entire MDT fleet; it is acknowledged that this is a risk but whilst it exists it is impractical to embark on a fundamental redesign of the solution that would be necessary should the Trust attempt to introduce an alternative product.

The current supplier has a good understanding of the Trusts requirements and provides a good service in terms of engineering advice, supply lead time and maintenance turn around.

The CommandPoint™ project has a premise that the MDT environment to which it must interface will not change during the implementation phase of the project. This containment of scope is essential to the successful introduction of the new CAD system.

Requirement

The originally supplied MDT is end of life and certain internal components are no longer available; maintenance requires cannibalisation.

Fleet expansion requires the supply of new Trust standard MDTs, screens and SatNav units.

Rapid deployment of replacement units is needed to deliver operational software functionality (not possible on old units due to lack of processing power), correct malfunctions that occur at twice yearly clock changes and to prevent loss of vehicle position data (used for specialist MI applications) when CommandPoint is introduced.

A direct 'form and fit' 'plug compatible' replacement is required in order to avoid major (physical) re-engineering of each different vehicle installation. Equally full software and interface compatibility is required to prevent redesign of software or introduction of conflict with CommandPoint™ (with likely resultant slippage of that project).

Maintenance arrangements must be reinstated to allow the Trusts 3rd Party Maintainer (currently CTS) to manage the diagnosis and replacement of failed MDTs.

Proposed Way Forward

The manufacturer provides a product solution that meets the requirements outlined above. The MPC-2 product is a direct replacement for the former model and it has been proved that the Trust MIT software operates successfully on it. For maintenance and support purposes it has been possible to build a common software configuration that runs on either version of the hardware (old and new), essential whilst two models coexist in live use (upgrade transition will take several months). These configurations have been successfully tested during CommandPoint™ User Acceptance Testing.

LAS Procurement advise that*: Regulation 14 of the public contracts regulations covers the "use of the negotiated procedure without the prior publication of a contract notice", a process suitable for our needs. Specifically Section 14 (1) (b) (ii) states that this may be used when:*

(ii) subject to paragraph (3), when the goods to be purchased or hired under the contract are required by the contracting authority as a partial replacement for, or in addition to, existing goods or an installation and when to obtain the goods from a supplier other than the supplier which supplied the existing goods or the installation would oblige the contracting authority to acquire goods having different technical characteristics which would result in—

(aa) incompatibility between the existing goods or the installation and the goods to be purchased or hired under the contract; or

(bb) disproportionate technical difficulties in the operation and maintenance of the existing goods or the installation;

Paragraph 3 limits the contract term to 3 years "unless there are reasons why it is unavoidable that this period should be exceeded"; It is believed the product life will cover us here in that we are unlikely to want to replace all units in 3 years time assuming they are still functioning as expected.

It is proposed that this procurement route is utilised as justified as above on the grounds of technical complexity.

Further that the warranty/maintenance arrangements with Microbus be renegotiated to identify cost savings and efficiency improvements.

Section 3 - Options and Costs

The unit cost of an MPC-2 (processor unit only) is £2,231. Two previous orders have been raised for 50 and 110 units some of these must be held for MDT support, CommandPoint™ test/train and CTS spares; total 30. For planning purposes the fleet is considered to be 700 vehicles, 130 upgrades are planned therefore 570 units are required to complete the retrofit.

Additional per vehicle costs are £15 for data cable, £10 for Text to Speech software licence and £90 for SatNav map/road update. Total project cost is therefore of **£1.34M**.

The annual support and maintenance cost (built into 22650 cost centre) is £142K subject to renegotiation.

Options are not presented as by the very nature of this single tender justification they are non viable on the grounds of technical complexity.

Section 4 - Funding

Funding would be from within the Trust's current capital budget.

Section 5 - Conclusion

The argument above outlines the technical imperative for procurement of MDTs from the current Trust supplier on the grounds of technical complexity.

Section 6 - Recommendations

It is recommended that authority is granted for a 'single tender action' as outlined above. Specifically that purchase order(s) be raised urgently with Microbus for the supply of sufficient MPC-2 units and peripherals to refit the entire fleet.

John Downard
Head of Software Support & Development

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14TH DECEMBER 2010

PAPER FOR NOTING

Document Title:	**Action plan from historical due diligence stage 1**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To note the progress made with the action required to move to stage 2 due diligence in January 2011**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the progress made in moving towards stage 2 due diligence which is scheduled to start in January 2011

Executive Summary

The action plan and outcomes report from Stage 1 due diligence were presented to, and discussed by the Trust Board on 30th November 2010. At that time it was noted that out of 44 recommended actions, 15 needed completion before stage 2 of the diligence process could commence.

The attached plan shows the progress made since 30th November:
4 items are shown as completed: GT-LAS-001/002/012/022;
GT-LAS-003 has moved from Amber to Green and will be completed in January 2011;
GT-LAS-023 has moved from Red to Amber and should move to Green in January 2011;
The items shaded Grey in the comments column are due for Trust Board discussion today.

Key issues for the Trust Board

Progress is needed against the remaining items (shaded grey) before stage 2 due diligence can commence.
If the Trust Board is not assured of the progress made and cannot sign off a number of items on the plan this may delay the start of Stage 2 and therefore impact upon the rest of the FT application timetable.

Attachments
HDD action plan v3

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☐ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways

☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper links to the following strategic risks:

☐ There is a risk that we fail to effectively fulfil care/safety responsibilities
☐ There is a risk that we cannot maintain and deliver the core service along with the performance expected
☐ There is a risk that we are unable to match financial resources with priorities
☒ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

NHS Constitution
This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:

APPENDI FRP ACTION PLAN

FRP ACTION PLAN

Organisation: Leader:	Foundation Trust Executive	Chief	Last Updated:	24.11.10	Next Update: 07.12.10			
Task ID	Section	Description of Task / Action	Accountability	Links to	Timescale	Due Date	Status at Stage 1	Comments
GT-LAS-001	Corporate Governance	The Board should confirm arrangements regarding the Vice Chair role and consider appointing a Senior Independent Director	RH	p16	Before HDD	Completed 30th Nov	Complete	Agreed. Board minutes as evidence.
GT-LAS-002	Corporate Governance	The Trust should consider the structure of the Board to ensure that the decision making process is clear (particularly the role of the voting and non voting EDs) and that there is balance between the EDs and NEDs	RH/SA	p16	Before HDD	Completed 30th Nov	Complete	Agreement on the role of voting and non-voting directors and that the Board wishes for non-voting directors to attend. Board minutes as evidence.
GT-LAS-003	Corporate Governance	The Trust should consider the requirement for a Finance Committee following authorisation as a Foundation Trust to support the delivery of Trust's financial agenda and ensure the Audit Committee has sufficient time to focus on assurance issues	RH/MD	p19	Before HDD	14th Dec	Green	Agreed to establish Board committee. Terms of reference to be drafted. Implement from January 11. Link to Audit Committee.
GT-LAS-004	Corporate Governance	The Board should ensure that suitable succession plans are developed for key Board roles	RH/PB	p16 and 17	Before HDD	14th Dec	Amber	No specific comment in the report but it is a requirement within the Code of Governance
GT-LAS-005	Corporate Governance	The Board should review purpose and content of the forward plan for Board Development sessions to ensure that these provide Board members with adequate support and knowledge of key issues	CH/SA	p16	Before HDD	14th Dec	Amber	Trust Board agenda 14th December
GT-LAS-006	Corporate Governance	As the Trust moves towards NHSFT status the Chairman needs to continue to assess the performance of the NEDs group to identify any areas that may required strengthening	RH	p18	ongoing	01-May-11	Green	
GT-LAS-007	Corporate Governance	The Trust should assess its proposed governance arrangements and sub committee structure against best practice guidance and ensure that they are compliant with the Monitor Foundation Trust Code of Governance, the Integrated Governance handbook, the Audit Handbook and the NHS Act 2006	SA	p19	Before HDD	14th Dec	Green	Review structure chart and add Finance and Investment Committee. Trust Board agenda 14th December
GT-LAS-008	Corporate Governance	The TOR for the Remuneration Committee should be further developed and updated to reflect the nominations function	SA	p19	Before Working Capital	01-Apr-11	Amber	
GT-LAS-009	Corporate Governance	The Trust should review the effectiveness of its new dashboard card once it is embedded to ensure that is providing the necessary level of assurance to the Board	PB	p28 and 29	Before Working Capital	01-Apr-11	Green	Also the development of the quality dashboard

APPENDI FRP ACTION PLAN

FRP ACTION PLAN

Organisation: Leader:	Foundation Trust Executive	Chief	Last Updated:	24.11.10	Next Update: 07.12.10			
Task ID	Section	Description of Task / Action	Accountability	Links to	Timescale	Due Date	Status at Stage 1	Comments
GT-LAS-010	Corporate Governance	The Board should review of the effectiveness of the new committee structure it has put in place once it has had time to bed in, to ensure it is working effectively particularly with regard to the interface between the Quality and Audit Committees	SA	As 007 above	Before HDD	14th Dec	Green	Agreed to hold more Audit and Quality Committee meetings. Review structure chart. Trust Board agenda 14th December
GT-LAS-011	Corporate Governance	The Trust should consider whether any changes are required to the structure of the Board of Governors to reflect any changes to commissioning arrangements	SA		Before Working Capital	01-May-11	Green	or as details become available regarding commissioning arrangements (JG comment)
GT-LAS-012	High Level Control	The Board should ensure that a process is put in place to review and update the BAF on a more regular basis in order to actively manage the risks of the organisation	SA	p20	Before HDD	30th Nov	Complete	Discussed at Quality Committee on 24th Nov snd Board on 30th Nov. BAF to be reviewed by TB quarterly. QC to review at each meeting.
GT-LAS-013	High Level Control	The Director of Finance should further review the narrative content and structure of the finance report, to include trend analysis for key cost areas, risk impact quantification and Service Line Reporting to focus debate	MD	p21	Before working capital	01-May-11	Green	
GT-LAS-014	High Level Control	The Trust should prepare a detailed CIP programme for a 2 year period, supported by appropriate evidence that schemes are deliverable and agreed by Divisional Directors	PB	p21 and 24	Before HDD	14th Dec	Red	FY12 and FY13. FY 14 will be required should the authorisation date extend beyond October 2011. Trust Board agenda 14th December
GT-LAS-015	High Level Control	The Trust should prepare a higher level yet still comprehensive CIP plan for years 3-5 should be identified	PB	p21 and 24	Before working capital	01-Apr-11	Amber	See above
GT-LAS-016	High Level Control	The Trust should consider how an appropriate level of clinical sign off and quality KPIs can be included in CIP development and monitoring processes	FM/SL	p21	Before HDD	14th Dec	Red	Trust Board agenda 14th December
GT-LAS-017	High Level Control	The Trust should consider further developing the CIP tracking tool to give more detail on the build up and delivery of schemes based on monthly profiles and the split between recurrent / non recurrent and pay and non pay elements	MD	p21	Before HDD	01-Jan-11	Red	Trust Board agenda 14th December
GT-LAS-018	High Level Control	The Trust should ensure that SLR is developed rapidly to strengthen the controls over key cost categories and to support local decision and accountability	MD	p21 and 22	ongoing	01-Apr-11	Green	
GT-LAS-019	High Level Control	The Trust should ensure the refreshed Estates Strategy is prepared and approved and ensure all issues are appropriately reflected in the IBP and the LTFM	MD	p26	Before Working Capital	31st March 2011	Amber	

APPENDI FRP ACTION PLAN

FRP ACTION PLAN

Organisation: Leader:	Foundation Trust Executive	Chief	Last Updated:	24.11.10	Next Update: 07.12.10			
Task ID	Section	Description of Task / Action	Accountability	Links to	Timescale	Due Date	Status at Stage 1	Comments
GT-LAS-020	High Level Control	The Trust should prepare and approve a detailed medium term capital programme which reflects the updated Estates Strategy	MD	p26	ongoing	31st March 2011	Amber	
GT-LAS-021	Risk Management	Any changes to the capital programme should be modelled within the LTFM to ensure that there is clarity about the financial impact of the capital programme on the Trust's finances	MD	p26	Before Working Capital	31st March 2011	Amber	
GT-LAS-022	Risk Management	The Board should consider whether newly emerging red rating risks should be reviewed by the Board on a monthly basis	SA		Before HDD	30th Nov	Complete	Agreed that new red rated risks will be reported to the TB each month through the CEO report. Detailed review and monitoring through QC and RCAG.
GT-LAS-023	Risk Management	The Trust should consider the appropriate forum and frequency for the review of the detailed CIP programme in order to provide assurance to the Board that the projected delivery of 100% recurrent CIPs is being achieved.	PB		Before HDD	14th Dec	Amber	Finance and Investment committee to be established. See 003 above. Trust Board agenda 14th December
GT-LAS-024	Risk Management	The Trust should ensure that a range of LTFM down side scenarios are modelled regarding income growth and CIPs to ensure that the Board has sufficient assurance regarding the ability to achieve financial balance	MD		Before Working Capital	01-Apr-11	Red	
GT-LAS-025	Risk Management	The Trust should continue to work towards level 2 NHSLA grading in 2012	SA	p22	ongoing	01-Jan-12	Green	
GT-LAS-026	Risk Management	The Trust should ensure that robust evidence is collected to support the business case for the move to the CRM model and ensure that the anticipated benefits are deliverable	CH	p25	ongoing	31st December 2010	Red	Trust Board agenda 14th December
GT-LAS-027	Risk Management	The Trust should ensure that a plan is put in place to deal with any issues arising from the 7/7 enquiries and that the implications, (operational, financial, reputational) are appropriately addressed in key strategic documentation and reflected in the LTFM	RW	p26	ongoing	28th February 2011	Amber	
GT-LAS-028	Risk Management	The Trust should ensure that an action plan is put in place to implement the recommendations in the Emergency Preparedness audit and that any changes required to the governance arrangements are accurately reflected in key governance documents	RW	p27	Before Working Capital	31st March 2011	Amber	3rd bullet - need to understand this further
GT-LAS-029	Management Reporting and Control	The Trust should undertake a review of information provided to the Board to ensure it is compliant with the requirements of the Monitor Code of Governance and the Intelligent Board MDS	PB/SA	p43 and p30	Before HDD	14th Dec	Amber	Trust Board agenda 14th December

APPENDI FRP ACTION PLAN

FRP ACTION PLAN

Organisation: Leader:	Foundation Trust Executive	Chief	Last Updated:	24.11.10	Next Update: 07.12.10			
Task ID	Section	Description of Task / Action	Accountability	Links to	Timescale	Due Date	Status at Stage 1	Comments
GT-LAS-030	Management Reporting and Control	The Director of Finance should further consider the content and presentation of the finance report to ensure it is compliant with Monitor's reporting requirements	MD	p30	Before Working Capital	31st March 2011	Green	
GT-LAS-031	Financial Controls and Reporting	The Trust should ensure that there is sufficient capacity and resilience within the Finance Department particularly in respect of key roles within the department to support the needs of a Foundation Trust	MD	p31	Before HDD	14th Dec	Amber	Deloitte to be appointed to 31st Jan 11
GT-LAS-032	Financial Controls and Reporting	The Trust should ensure that succession plans are prepared for key members of the finance team	MD	p31	Before Working Capital	31st March 2011	Amber	
GT-LAS-033	Financial Controls and Reporting	The Trust need to review the Treasury Management Policy and ensure that this is compliant with the requirements of a Foundation Trust	MD	p33	Before Working Capital	7th March 2011	Green	This was approved by Audit Committee in November but updates will need to go to AC on 7th March?
GT-LAS-034	Financial Controls and Reporting	The Trust should consider how forecasting can be improved and develop rolling forecasts where possible	MD		Before Working Capital	31st March 2011	Green	
GT-LAS-035	Financial Controls and Reporting	The Trust should ensure that suitable arrangements are put in place to secure a working capital facility prior to authorisation	MD	p33	Before Working Capital	31st March 2011	Amber	
GT-LAS-036	Financial Controls and Reporting	The Trust should ensure that the contract term for A&E services supports the working capital opinion	MD	p25	Before Working Capital	31st March 2011	Green	
GT-LAS-037	Financial Controls and Reporting	The Trust should seek to rapidly progress negotiations regarding funding for the Olympics to ensure that these are accurately reflected in demand and operational modelling and in the LTFM	RW	p14, 25	Before Working Capital	31st March 2011	Red	
GT-LAS-038	Financial Controls and Reporting	The Audit Committee should ensure that recommendations made by internal audit are recorded and that action tracking (for example Performance Accelerator) is used to ensure that actions are actively implemented and managed in the organisation	CS/SA	p36	Before Working Capital	7th March 2011	Red	Already in place through the work led by Frances Wood
GT-LAS-039	Audit Arrangements	The Trust should undertake a review to establish the extent to which a compliance culture has been established within the organisation particularly in individual stations. An action plan should be developed to address any issues identified	SA	p36	ongoing	31st August 2011	Green	Linked to the development of local risks registers
GT-LAS-040	Audit Arrangements	The Trust should undertake a review to establish the extent to which a counter fraud culture has been embedded within the organisation and to consider the effectiveness the LCF service. An action plan should be developed to address any issues identified	MD	p34 and 37	Before Working Capital	6th June 2011	Amber	Audit Committee date
GT-LAS-041	Audit Arrangements	The Audit Committee should review the external audit service and consider tendering out the service following authorisation as a Foundation Trust involving the Governors appropriately in the process	CS/MD/SA		Before Working Capital	7th March 2011	Amber	Audit Committee date

APPENDI FRP ACTION PLAN

FRP ACTION PLAN

Organisation: Leader:	Foundation Trust Executive	Chief	Last Updated:	24.11.10	Next Update: 07.12.10			
Task ID	Section	Description of Task / Action	Accountability	Links to	Timescale	Due Date	Status at Stage 1	Comments
GT-LAS-042	IT Arrangements	The Trust should consider IM&T resilience arrangements in respect of its control room and server locations following recent business continuity issues. Any financial implications should be accurately costed and reflected in the LTFM	PS	p38, 39	Before Working Capital	31st March 2011	Red	
GT-LAS-043	IT Arrangements	The Board should ensure that it has robust plans in place for the implementation of the Command Point system to mitigate potential impacts on performance and quality during this period	PS	p38	Before Working Capital	1st June 2011	Red	Go live is 8th June 2011
GT-LAS-044	Standards and Targets	The Trust should seek assurance through the Internal Audit process that the correct calculation and definitions of targets are being used for reporting purposes	SA	p41, 43	Before Working Capital	31st March 2011	*Green*	

Key

Red	High Importance
Amber	Medium Importance
Green	Low Importance
Complete	Completed

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14 DECEMBER 2010

PAPER FOR NOTING

Document Title:	CommandPoint Project Update: December 2010
Report Author(s):	Peter Suter
Lead Director:	Peter Suter
Contact Details:	Peter.suter@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Regular project update.
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	The Trust Board are asked to note the contents of this report and progress of he CommandPoint Project.

Executive Summary
The CommandPoint project is currently on track for go-live with the new CAD system on 8 June 2011. Key points from the detailed project work, end user training, transition planning and the budget are included within the report.

Key issues for the Trust Board
From a planning perspective to note the key dates for the project.

Attachments

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☐ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways
X To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper links to the following strategic risks:

☐ There is a risk that we fail to effectively fulfil care/safety responsibilities
X There is a risk that we cannot maintain and deliver the core service along with the performance expected
☐ There is a risk that we are unable to match financial resources with priorities
☐ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

NHS Constitution

This paper supports the following principles that guide the NHS:

X 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
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X 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
X 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
X No

Key issues from the assessment:

COMMANDPOINT PROJECT UPDATE: DECEMBER 2010

1. PROGRESS AGAINST PLAN

The CommandPoint project is currently on track for go-live with the new CAD system on 8 June 2011. Key points from the detailed project work are briefly described below.

The second iteration of Release 1.0 User Acceptance Testing (UAT) was completed on schedule on 22nd October. The testing has identified a number of software defects that have been reported to Northrop Grumman for investigation and resolution.

Northrop Grumman are currently completing development of CommandPoint Release 1.1 for which Factory Acceptance Testing (FAT) is scheduled to commence on 13 December. Three members of the project team are travelling to Chantilly, Virginia USA to witness the testing as has been done in previous test/release cycles.

The second, three week, Train the Trainer Course was delivered by Northrop Grumman between 1st and 19th November. They also delivered the System Administration course during the same period. Six additional Work Based Trainers (WBTs) have joined the project to support the Skills Maintenance Training.

Northrop Grumman have provided two additional instances of the Training System to allow for the operation of two independent classroom environments and a third environment for Skills Maintenance Training.

Two half day briefing sessions for LAS Senior Managers and Board Members took place at Milwall on 23rd and 24th November. They included presentations on the approach to operational transition and, from Northrop Grumman on training and the actual CommandPoint system. Feedback from these sessions was very positive.

2. ENF USER TRAINING & TRANSITION PLAN

End User Training is scheduled to commence on 6th January. There will be separate three day courses each for call taking and dispatch with a 1 day 'Abridged' course for other users who need access. Staff will be trained in their primary discipline and a selection (by AOMs) of those that undertake both duties will undertake both training courses. There are two training rooms at Southwark Bridge Road that will operate in parallel six days a week. Currently training is scheduled to complete in May 2011. This will allow a small amount of contingency prior to go live.

Detailed planning is currently underway with regard to the Transition plan. This will cover all the activities necessary to ensure governance and assurance arrangements. The actual Cut Over is planned to take place between midnight and 07:00 hours on Wednesday 8 June 2011.

The outline plan showing key milestones is shown below:

CommandPoint- High Level Plan		
Description	**Deliverables**	**Date**
FAT 1.1	Commence FAT of Release 1.1 (Note this is not on the critical path)	13/12/10
Commence Pre Go-Live End User Training	17 week programme, to train all control services staff.	6/1/11
Gateway 4	Full gateway review to assess 'readiness for service'	March 2011
Release 1.1	Start of use of Release 1.1 used in the	March

	training environment.	2011
Complete Pre Go-Live End User Training	All staff trained in their primary job function (Call Taking or Dispatch). A number of staff on each watch trained in both Call Taking and Dispatch Functions.	May 2011
Trust Board Approval for Go live.	Final approval given by Trust Board to go live. Authority for operational decision to proceed passed to Deputy CEO who will strategically oversee the actual cut over.	24 May 2011
Final approval	Final technical and operational preparations for transition to CommandPoint. The Final Cut Over Readiness Review before the final 'go' decision is sought from Deputy CEO	7/6/2011
Transition Date	The actual go live date for CommandPoint.	8/6/11
+60 Days	Post go live focus to ensure; • Bug fixes • Embedded working practices • Return operational performance back to previous levels	8/8/11
Post Go Live releases	The current plan has a requirement to build an interface to PSIAM for CTA. The details of this work and timetable have yet to be specified. The project is now collecting all user aspirations for changes desired post go live, together with a comprehensive list of any bugs that remain outstanding at go live. With the help of Senior users this will be organised into a prioritised list that the Business as Usual (BAU) environment will take forward, prior to go live, with NG to develop an agree timetable for development.	TBC
Post Go-Live Training	Follow-up training to ensure that all staff have received training in both Call Taking and Dispatch Functions	TBC
Project closure	Formal closure and handover to in-life team.	TBC

3. BUDGET.

The project remains within the overall budget agreed by the Trust Board. Some spend profiling has been amended due to the movement of the go-live date to 8 June 2011. High level details are shown in the table below.

	FBC Approval (Issue 3.1)	Budget Adjust-ments	Revised Budget	Previous Years Spend	Current Year		Fut-ure Years	Total Project	
					Spend	Fore-cast		Spend	Vari-ance
Capital									
Northrop Grumman Costs	8,315	751	9,066	7,495	137	1,031	403	9,066	(0)
LAS Costs	5,897	(245)	5,651	3,843	619	1,048		5,510	142
Total Capital	14,212	505	14,717	11,338	756	2,079	403	14,576	141
Revenue									
Northrop Grumman Costs	1,493	(108)	1,385			1,385		1,385	0
LAS Costs	4,592	(1,663)	2,929	936	991	1,041		2,968	(39)
Total Revenue	6,085	(1,771)	4,314	936	991	2,426	0	4,353	(39)
Project Board Budget	**20,296**	**(1,265)**	**19,031**	**12,274**	**1,747**	**4,505**	403	**18,929**	**102**
Contingency	5,228	(190)	5,039	0	0	0	0	0	5,039
Total	**25,525**	**(1,455)**	**24,070**	**12,274**	**1,747**	**4,505**	**403**	**18,929**	**5,141**

4. RECOMMENDATION

The Trust Board are asked to note the contents of this report and progress of he CommandPoint Project. .

Peter Suter

Director of IM&T

London Ambulance Service **NHS**
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28TH SEPTEMBER 2010

PAPER FOR NOTING

Document Title:	Clinical Response Model Evaluation Plan
Report Author(s):	Robert Cowan, Evaluation Manager
Lead Director:	Caron Hitchen
Contact Details:	Caron.hitchen@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Historic Due Diligence recommendation
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Other Clinical Response Model Project Board
Recommendation for the Trust Board:	To note the plan for ensuring that robust evidence is collected to support the business case for the move to the CRM model and ensure that the anticipated benefits are deliverable

Executive Summary

The attached project initiation document provides the details of the Clinical Response Model evaluation project and overarching business case.

Full evaluation of the model will commence in January 2011 when all three South East London complexes have introduced the associated working practices and the dispatch regime is fully implemented. The evaluation period will run for a period of three months.

The objective of the evaluation is to inform the development of the CRM by analysing information gathered from the pilot.

The evaluation seeks to inform the development of CRM in the following ways:

i. Find whether the pilot achieved the CRM's objectives
ii. Find whether the pilot was operating as intended
iii. Find how the CRM could become more effective and efficient
iv. Find the cost and operational implications of the CRM.

The CRM objectives are to improve patient outcomes by two main methods –

i. more appropriate care as exhibited by increased safe and appropriate use of appropriate care pathways
ii. faster and more appropriate care to time-critical calls

Section 5.2 of the evaluation plan provides the list and description of each of the measures to be used in the evaluation.

Key issues for the Trust Board

A full evaluation report will be produced and presented to the Trust Board together with associated recommendations for roll out of the model based on the findings of the evaluation.

Attachments

Clinical Response Model Project Initiation Document
Clinical response Model Evaluation Plan

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

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Risk Implications
This paper links to the following strategic risks:

☒ There is a risk that we fail to effectively fulfil care/safety responsibilities
☒ There is a risk that we cannot maintain and deliver the core service along with the performance expected
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☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:
An Equality Impact Assessment is planned to be undertaken during the evaluation period.

London Ambulance Service NHS
NHS Trust

CRM Pilot Evaluation Plan

November 2010

Robert Cowan, Evaluation Manager

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2. Clinical Response Model 2

2.1 What's the difference to current practice?
2.3 Programme logic and Objectives

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7. Appendix A: Alternative Care Provider Feedback Forms 12

1. Policy Background

More customised care, delivered within the community when possible, was recommended by Lord Darzi in his London healthcare review[1]. This approach provides better healthcare to the patient and is more efficient. This model is also recommended in the Department of Health's review of the London Ambulance Service (LAS)[2].

The research undertaken by the Department of Health and Lord Darzi showed that the LAS could provide more customised care than it has traditionally. A significant number of patients are taken to an Accident and Emergency Department (A&E) unnecessarily and would be better served by being referred to an Appropriate Care Pathway (a service provider other than an A&E – for example a Minor Injuries Unit or GP).

The LAS is also under considerable pressure with growing demand and limited resources to respond to time critical incidents. Responding to calls safely and appropriately by means other than a front-line[3] ambulance means this resource will be more readily available to respond to life-threatening incidents.

2. Clinical Response Model

The proposed Clinical Response Model (CRM) is a new way of responding to calls whereby incidents will be attended to initially by a Clinical Assessment Unit (CAU) – a single clinician in a car who has advanced patient assessment skills – and not a two manned ambulance. Only Red 1 and 2 calls will receive both a CAU and Advanced Life Support (ALS) [4] response (dual response). This contrasts to current practice where *all* Red *and* Amber calls receive an automatic dual response.

For Red 3, Amber and Green calls, the CAU on scene will assess the patient and request an ambulance only if required as opposed to one being sent by default – as is current practice.

The mandate of the CAU will be to assess patients on scene and arrange for the appropriate response. The range of potential responses consists of:

i. an immediate Advanced Life Support (ALS) vehicle and crew, in the case of life threatening incidents, to convey the patient to an A&E
ii. an immediate Basic Life Support (BLS)[5] crew, in the case of urgent but not immediately life threatening incidents, to convey patients to an ED, or Appropriate Care Pathway (ACP)[6]
iii. a scheduled / delayed conveyance by a BLS crew, for when the single responder does not consider a face to face handover is required
iv. a scheduled / delayed conveyance by an Urgent Care crew[7], for patients with minor illnesses or injuries, to an ACP
v. referring the patient to an ACP that is available in the community that does not require a LAS conveyance
vi. or, leaving the patient on-scene to self-care.

2.1 What's the difference to current practice?

The CRM differs from current practice in two main ways:

i. The CRM clinician has advanced training and is equipped with Pathway Protocols
ii. Under the CRM an ambulance will not be automatically dispatched to Red 3, Amber calls or Green calls as is currently the practice
iii. Green incidents, that have not been dedicated an Urgent Care response (via CTA or Health Care Professional) will be attended by a CAU, as opposed to a front-line ambulance.

2.3 Programme logic and Objectives

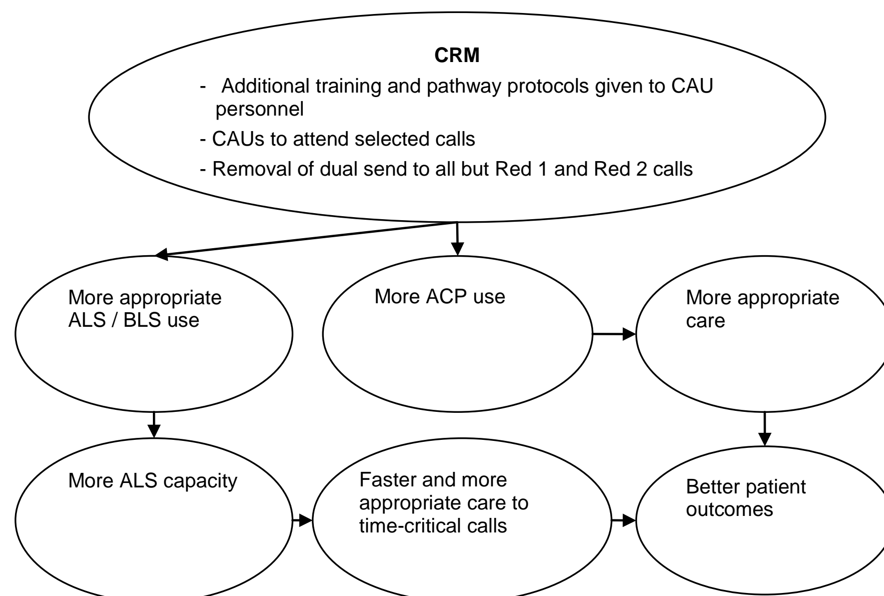
It is envisaged that with advanced training, pathway protocols and removal of the pressure of an ambulance crew on scene (dual send), the CAU will be able to safely identify more incidents that do not require conveyance to A&E. Instead more patients will be provided with more appropriate care in the form of conveyance or referral to an ACP.

Also due the increased training, protocols and removal of the pressure of an ambulance on-scene, in conjunction with the support of CRM operational protocols (i.e. CAU to choose secondary crew), the CAU on scene will chose a more appropriate crew to convey. It is believed that the ALS resource is currently over-used (i.e. used when another crew would be more appropriate) and therefore with the CRM in place ALS resources will be used less (as a proportion of all incidents), and increase in capacity.

The increased ALS capacity will mean faster ALS responses to time-critical calls, i.e. Red 1 and 2 graded calls.

Both more appropriate care, in the form of more ACP use, and faster ALS care to time-critical calls will lead to better patient outcomes.

Figure 1: Intended outcomes of CRM



3. CRM PILOT

3.1 Background - The first and second Barnehurst trials

The CRM model has been trialled previously in Barnehurst on two separate occasions, the first trial limited to 12 hours and the second to 24 hours. Evaluation of the 24 hour trial revealed a significant reduction in the proportion of incidents that were conveyed to A&E, but the trial complex was also provided with a large number of CAU resources (10 during the day and 8 in the evening). Results from the second trial also showed a significant increase in the job-cycle time of the CAUs and an increase in the dual send rate. Although the increase in dual send rate needs to be taken in consideration with the observed increase A&E Support use, i.e. the while more vehicles attended, more of them were A&E support as opposed to ALS/BLS crews.

Neither evaluation revealed any significant clinical concerns relating to Paramedic CAUs' assessment and care, although the relatively small and discrete sample of patients within the studies needs to be taken into account.

3.2 Lead-in time

CRM is being rolled out gradually to the South East Sector. Initially the CRM was implemented in Barnehurst and will be rolled out to Greenwich and Bromley respectively. By January 3 2011 all three complexes within the South East sector will be operating under the CRM.

3.3 CRM pilot

The CRM pilot is to run in the South East Sector from January 3 to April 3 and implemented with no additional budget.

4. CRM EVALUATION'S OBJECTIVES AND SCOPE

4.1 CRM Evaluation's objective

The objective of the evaluation is to inform the development of the CRM by analysing information gathered from the pilot.

The evaluation seeks to inform the development of CRM in the following ways:

i. Find whether the pilot achieved the CRM's objectives
ii. Find whether the pilot was operating as intended
iii. Find how the CRM could become more effective and efficient
iv. Find the cost and operational implications of the CRM.

The CRM objectives are to improve patient outcomes by two main methods –

i. more appropriate care as exhibited by increased safe and appropriate use of ACPs
ii. faster and more appropriate care to time-critical calls

4.2 Evaluation Scope, Risks and Limitations

Pilot Resourcing

The pilot is to be implemented with no additional budget. However some borrowing of cars and paramedics from other complexes as well as substantial training has occurred to gain the required CRM fleet mix, i.e. more cars and fully CAU trained paramedics.

Recording of ACP use

Work is ongoing with the Trust and particularly within the Pilot (South East) sector to improve the reliability of the ACP recording processes. Therefore an observed increase in ACP use during the pilot period may be due to improved recording processes as opposed to an actual increase in ACP use. As such any observed change in ACP use should be taken in consideration with the A&E conveyance rate, for which recording processes are not being changed.

Staff availability and the threat of increased REAP levels

Several operational staff are required for the evaluation, namely clinical reviewers and also staff to gain their feedback on the pilot. If REAP levels are raised there is the risk that staff will be used to respond to the increased demand and as such unavailable to participate in the evaluation.

This risk can be mitigated by clarifying the REAP level at which certain staff will be needed to respond operationally to meet demand and gain a commitment from director level operations managers to this (Staff requirements TBC – Clinical Peer Review).

Publication of an interim report without clinical findings included

It is proposed that two reports are released, one being an interim the other the final. The interim report will contain a selection of measures for which results and findings will be able to found quicker than others. The reason for releasing this report is to respond to the organisational demand for evaluation findings as soon as possible. The risk is that the findings of the interim report will not be accompanied and tempered by a raft of clinical findings and as such could provide a distorted depiction of the impact of CRM.

This risk can be mitigated by providing clear statements of limitations within the interim report and managing the timing of the release of the final to occur less than 6 weeks following the release of the interim.

5. METHODS

Methods to achieve evaluation objectives

A total of 23 methods will be used to achieve the objectives of the evaluation. The methods and which objectives they seek to achieve are outlined in Figure 2: Methods and corresponding evaluation objectives.

5.1 Control

A differences within differences control will be used whereby the difference in measures between the South East sector and the rest of London in the period January 3 2010 – April 3 2010 will be compared to the difference between the South East and rest of London throughout the pilot period January 3 2011 – April 3 2011.

This approach seeks to control for changes than have taken place between the two time periods (e.g major trauma networks, NWoW, demand) that may affect the measures.

Where appropriate the measures will be compared to the control period, with statistical significance, power and effect identified (see 5.2.3 Measures compared to control.)

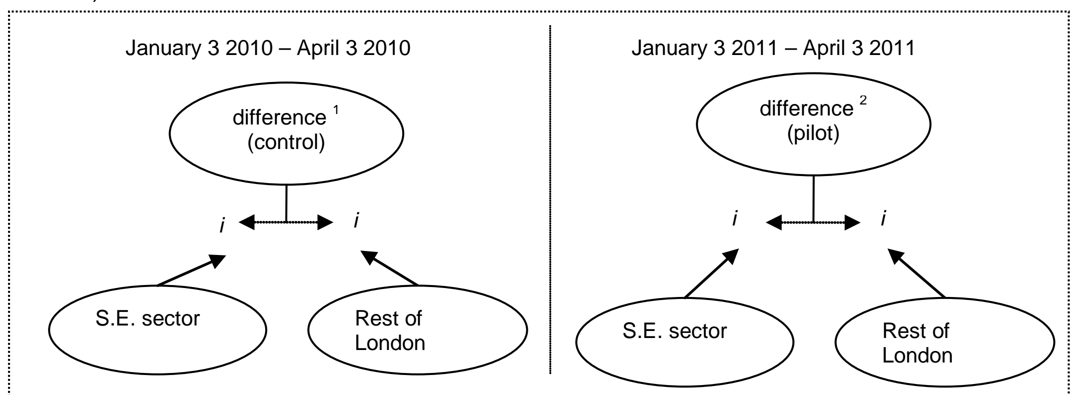


Figure 2: Methods and corresponding evaluation objectives

Evaluation Objective	CRM objective	Method
Find whether the pilot achieved the CRM objectives	More appropriate care as exhibited by increased safe and appropriate use of ACPs	Observing ACP use rate
		Observing A&E conveyance rate
		Clinical Review
		Secondary vehicle crew request accuracy
		Secondary vehicle request and actual arrival time variance
		Operational staff experience
		ACP Provider experience
		Patient experience
	Faster and more appropriate care to time-critical calls	Observing Response times
		Observing Call-to-Door times
		Secondary vehicle request accuracy
		Operational staff experience
		ACP Provider experience
Find whether the pilot was operating as intended	CAU call allocation	
	Patient left on scene before secondary vehicle arrival	
	Operational Staff experience	
	EOC Staff experience	
	Patient experience	
	CAU call allocation	
Find how the CRM could become more effective and efficient	Conveyance crew type use rate	
	Clinical review of request of secondary vehicle - TBC	
	Operational Staff experience	
	EOC Staff experience	
	Patient experience	
	Staff reported ACP unavailability	
	EOC Staff experience	
Find the cost and operational implications of the CRM	EOC Staff experience	
	Multiple send rate	
	Multiple attendance rate	
	Review of roaming clinician	
	Cross border net-migration	
	Job cycle time	
	Time on scene	
	Conveyance crew type use rate	
	CSV dispatches	
	CSD advice requests	

5.2 Methods

Below is a list and description of each of the measures to be used. Measures will be compared to the control unless otherwise stated.

1. Observing ACP use rate

The ACP use rate difference for the 3 month pilot period will be compared to the control's and assessed for statistical significance, power and effect. The ACP use rate will also be plotted on a Statistical Process Control chart with daily data points.

2. Observing A&E conveyance rate

The same analysis applied to the ACP use rate will be applied to the A&E conveyance rate

3. Clinical review

…. TBC by Fenella…

4. Secondary vehicle type request accuracy

The proportion of secondary vehicle crew types that are the same as what the crew requested, i.e. crew that was asked for by the clinician on scene. No comparison to a control will be made for this measure as secondary vehicle requests do not occur on a routine basis as part of normal operations.

5. Operational staff experience

Staff will be invited to focus groups, as part of regular team meetings and NWoW training, and be instructed to complete a questionnaire (TBC). The questionnaire will be based of the content of staff exception reporting that is occurring in the lead up time to the formal CRM pilot and the objectives of this measure.

Following the completion of the questionnaire a focus group will be held in which a semi-structure discussion will be facilitated on the basis of a discussion guide (TBC).

There is no control to compare to but questioning will search for the perception of the impact of CRM.

6. Emergency Operations Centre (EOC) staff experience

The same approach as used for Operational staff experience will be adopted.

7. ACP Provider experience

All ACP providers are given exception reporting forms (Appendix A) in which they note whether or not the patient referred or conveyed to them was clinically appropriate and if a secondary transfer was made.

The forms are completed by the ACP clinician that sees the patient and are collected by the Community Involvement Officer on a weekly basis.

There is no control available for this measure.

8. Patient experience

A sample (TBC) of patients will be selected and provided with a questionnaire (TBC) One crew every x days (TBC) days will be randomly nominated (TBC) to distribute the questionnaire to all the patients they attend.

There is no control available for this measure.

9. Secondary vehicle request and arrival time variance

The average and median difference between the time that the secondary vehicle was requested by the crew on scene and the time that the secondary vehicle actually arrived – with daily data points. No comparison to a control will be made for this measure as secondary vehicle requests do not occur on a routine basis as part of normal operations.

10. Observing response times

The response time achievement rate (i.e. arrive on scene withn 8 minutes of Red calls and 19 minutes for Amber calls), median and average response time will be observed with daily data points.

11. Observing call-to-door times

Including the median and average call-to-door with daily data points.

12. Conveyance crew type use rate

This measure will observe which crew types are used to convey patients, both in number and proportion of total conveyances. The analysis will also be done by call grade.

13. Clinical review of request of secondary vehicle

TBC

14. CAU call allocation

What calls, by grade, a CAU attends and whether they are the first crew on scene. This will not be compared to control as CAUs are intrinsic to CRM – i.e. no control available.

15. Patient left on scene waiting for secondary vehicle

The number and proportion of calls where a CAU attends and leaves the scene before a secondary vehicle arrives.

16. Staff reported ACP unavailability

All staff within the pilot complexes are provided an ACP 'Evidence for Change' form (Appendix B) which they are instructed to complete when they attempt / wish to refer or convey a patient to an ACP but the ACP is unavailable (due to operational hours, capacity etc.).

This will not be compared to the control as this reporting does not occur across the South East sector at present.

17. Multiple send rate

The average send rate with daily data points.

18. Multiple attendance rate

The average attendance rate with daily data points.

19. Cross border net migration

The number of crews drawn from the South East sector to other sectors minus the number of crew drawn from other sectors to the South East sector - with daily data points.

20. Job cycle time

The median and average job cycle time (time from the point that a crew sets their status from unavailable – on way to incident - to the time when they set their status to available again) – with daily data points.

21. Time on scene

Same approach as job cycle time.

22. CSV dispatches

The number of incidents for which a Clinical Support Vehicle is dispatched to – daily data points, for each complex, as well as the daily median for each complex and the sector and the total number for the sector for the entire pilot period. This will not be compared to control as this is a new aspect of operations.

23. CSD advice requests

The number of times CSD advice is given – daily data points, for each complex, as well as the daily median for each complex and the sector the entire pilot period.

5.2.3 Methods compared to control

The below table identifies which measures will be compared to the control and which will not.

Compared to control	Not compared to control
ACP use rate	Operational staff experience
A&E conveyance rate	EOC staff experience
Response Times	Patient experience
Call-to-Door Times	ACP Provider experience
Job-cycle Times	Clinical Review
Time-on scene	CSV requests
Cross border net migration	Staff reported ACP unavailability
Multiple attendance rate	Patient left-on-scene waiting for secondary vehicle
Multiple send rate	CAU call allocation
CSD advice requests	Secondary vehicle request and arrival time variance
Cross-border net migration	Secondary vehicle crew type request and actual variance
Conveyance crew-type use rate	

6. GOVERNANCE

6.1 Roles

The following staff will perform the following roles:

Role	**Staff member**
Project Executive	Caron Hitchen (HR Director)
Project Board	Caron Hitchen Richard Webber Steve Sale Johnny Piggott Fenella Wrigley Gerard Murray Peter Suter
Project Manager	Robbie Cowan
Senior Users	Phillip de Bruyn Darren Farmer Caron Hitchen Gerard Murray Fenella Wrigley Khaled Kassem-Toufic
Senior Suppliers	Tony Buckler Margaret Vander Jo Lynn Fenella Wrigley Jane Worthington Gurkamal Virdi Maurice Clayton Julie Carpenter
Work Packages and Team Managers	M.I. work package : Tony Buckler Patient Experience : Margaret Vander Staff experience : Jo Lynn Clinical Review : Fenella Wrigley ACP exception reports: Julie Carpenter Staff reported ACP unavailability: Julie Carpenter

Project Group (bracketing Project Manager, Senior Users, Senior Suppliers, Work Packages and Team Managers)

6.2 Stages and Products

Stage 2: Data gathering (Jan 3 2011 – May 3 2011)	Time Tolerance: none
M.I. data extraction	3 weeks
Staff (Operational and EOC) experience data collected and entered	13 weeks
Staff experience analysis	3 weeks
Patient experience distribution and collection	4 months
ACP exception report distribution and collection	3.5 months
ACP exception report data entering	+2 weeks after dist. and collection
Staff reported ACP unavailability distribution and collection	3.5 months
Staff reported ACP unavailability data entering	+2 weeks after dist. and collection
Stage 3: Data analysis (May 3 2011 – June 3 2011)	Time Tolerance: +/- 2 weeks
Statistical analysis of M.I. data	3 weeks
Draft interim report written	2 weeks
Staff experience analysis	3 weeks
Staff experience results and findings write up	2 weeks
Patient experience data entering	+3 weeks after dist. and collection
ACP exception reporting analysis	2 weeks
Staff reported ACP unavailability analysis	2 weeks
Staff reported ACP unavailability results and findings write up	1 week
Stage 4: Initial Report (June 3 2011 – July 3 2011)	Time Tolerance: +/- 2 weeks
Interim report internal consultation	3.5 weeks
Interim report to Caron	*22/06/2011*
Patient experience analysis	3 weeks
Patient experience statistical analysis	3 weeks
Patient experience results and findings write up	2 weeks
ACP exception report results and findings write-up	1 week
Clinical Review Report	*10/06/2010*
Stage 5: Final Report (July 3 2011 – August 8 2011)	Time Tolerance: +/- 2 weeks
Write draft final report for internal consultation	2 weeks
Final report internal consultation	4 weeks
Final report for Caron	*9/08/2011*

6.3 Internal reporting

The Project Manager will report highlight reports to Project Board once every two weeks, either in person or written, expressing any risks or issues that may threaten the stage times or quality / scope of the interim or final evaluation report.

The Project Manager will monitor the delivery of the work packages and will receive updates at least fortnightly from Team Managers via the regular CRM Project Group meeting. Risks and Issues will only be raised to Project Board when stage or quality / scope of the interim or final evaluation report is threatened; otherwise matters will be dealt within the Project Group.

7. REPORTING

The evaluation results and findings will be published in a report for the audience of CRM project board and LAS Directors and Managers. Two versions of the report will be issued, firstly an interim report and then the final report. The reason for this being that the results for certain measures will be able to be gained quicker than results for others and the organisational demand for evaluation findings as soon as possible. This report is expected to be published June 22 2011.

Interim report

The interim report will be published by end of July (see Appendix C: Time Lines) and will include the results and findings of all measures that are compared to the control (see 5.2.3 Measures compared to control above). As such, it will exclude all Experience related measures, all Clinical measures and others.

Final report

The final report will include the results and findings of all measures. It is expected to be published August 9 2011.

APPENDIX A: ALTERNATIVE CARE PROVIDER FEEDBACK FORMS

APPROPRIATE CARE PATHWAY

PROVIDER FEEDBACK FORM

Please complete One sheet for each referral made.

Provider Name	
Call sign of the crew referring	
Date of referral	
Time of referral	
Appropriateness of referral	
Was the patient subsequently transferred to another facility	

APPENDIX B: STAFF REPORT ACP UNAVAILABILITY

Evidence For Change

Do you find it a struggle getting a GP to attend a patient? Are there times a district nurse visit would be more appropriate, especially out of hours?

To be able to create new referral pathways and improve our out of hours responses we need to collect and provide evidence to prove to various agencies that current services are not adequate and require improvement.

If you attend patients where A&E is not the most appropriate care pathway however you are unable to arrange alternative care due to unavailability of services please take time to fill in this form with a brief outline of the problems faced.

Date:________ CAD:__________ Callsign:__________

Crew 1:_______________________ Crew 2:_____________________

Problems faced:

____
____
____
____
____
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____
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____
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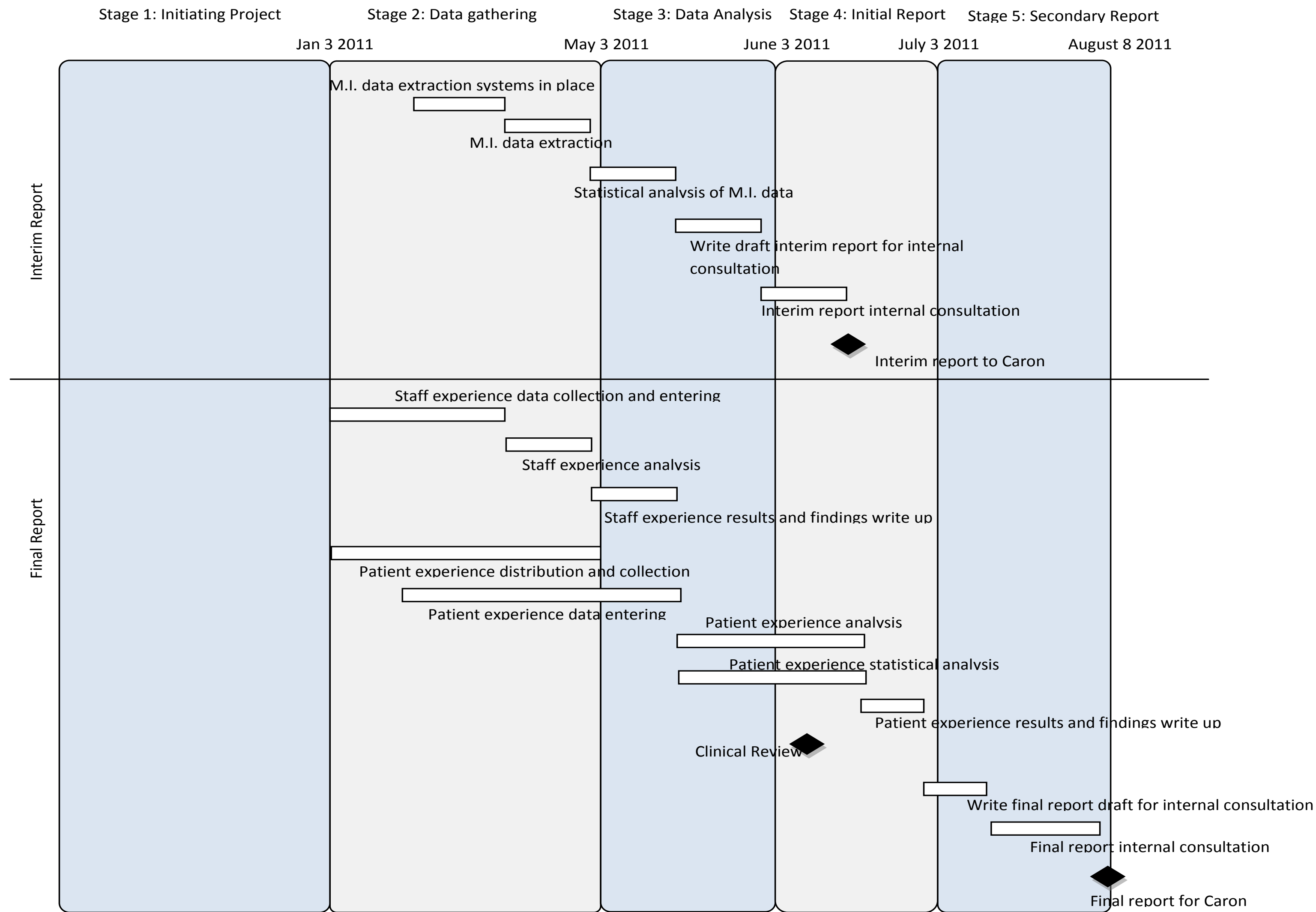
____

Please return completed forms to Julie Carpenter, Community Involvement Officer

APPENDIX C: MAIN TIMELINES[8]



[1] Darzi, A., *A Framework for Action*, Healthcare for London, July 2007.

[2] Bradley, P., *Taking Healthcare to the Patient*, Department of Health, June 2005.

[3] 'Front-line' refers to two-manned ambulances that run on blue lights, manned by paramedics and/or EMT 3 or 4s.

[4] A front line ambulance manned with a paramedic and an EMT – a resource allocated to time critical calls.

[5] A front-line ambulance manned with 2 EMTs.

[6] This can include: GP, Walk in Centre, Falls Unit, Mental Health Unit etc.

[7] This can include an A&E Support crew or a PTS crew.

[8] This does not include ACP exception report collection, entering, analysis and write up. Nor does it include Staff reported ACP unavailability collection, entering, analysis and write up. These work pieces can be seen in 6.2 Stages and Products.

Programme & Project Management Office

Project Initiation Document

Programme/Project:	Clinical Response Model
First Draft Author:	Johnny Pigott
Configuration Owner:	Steve Sale

Version History

Version*	**History**	**Author**	**Date**
0.1	Outputs from pre-planning workshops	Johnny Pigott	07.09.2009
0.2	Incorporating SS's comments	Johnny Pigott	16.09.2009
0.3	Feedback from initiation project meeting	Johnny Pigott	15.12.2009
1	Agreed at Project Initiation meeting	Johnny Pigott	12.01.2010
1.1	With Daryl Mohammed & Grenville Gifford's comments	Johnny Pigott	27.01.2010
1.2	Amended to Clinical Response Project	Johnny Pigott	18.03.2010
2.0	Incorporated changes from 24hr evaluation report	Johnny Pigott	13.08.2010

* Version Control Note: All documents in development are indicated by minor versions i.e 0.1, 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

Authorisation

Programme/Project Role	**Name**	**Date**
Project Executive	Caron Hitchen	12.01.2010

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The Project Initiation Document gives the direction and scope of the project and forms the 'contract' between the project management team and corporate or programme management.

1 INTRODUCTION

Within the ethos of Healthcare for London there is a move toward the provision of health care in the community and a lesser reliance on attendance at Accident and Emergency departments. The ambulance service has in recent times looked at ways of reducing the number of patients taken into A&E particularly for patients who have been triaged as being within category C or Green calls. With the emergence of a greater number of patient care pathways there is now the opportunity to introduce a new clinical response model that will fundamentally change the way this ambulance service responds to our 999 calls. This model will be centred around paramedics who will be the first response on scene in a car, Clinical Assessment Units (CAUs), to most emergency calls. There will still be some determinants that will require an immediate response of both the CAU and an ambulance. Using their assessment and decision making skills, they will asses the patient's needs and will be able to consider a number of options for the best outcome for the patient. The options may include a referral to a GP, arranging for an ECP to attend and treat the patient at home, attendance at a minor injuries unit or attendance at A&E for example (the list is not exhaustive). The paramedic will also decide on the best method of transportation, if required. This may be a paramedic ambulance response or an A&E support vehicle, or they may opt to transport the patient themselves by car. Supporting these paramedics will be the clinical leadership and support necessary to give them the confidence to use the most appropriate pathways. The overall aim will be to target our front line ambulance fleet to those patients who truly need it; to improve the patients experience by providing a greater number of options for their needs; and to reduce the attendance of patients presenting at A&E by ambulance.

2 PROJECT DEFINITION

2.1 Project Objectives

The objective of this project is;

> "to develop and pilot the clinical response model in order to evaluate its impact on clinical care and patient experience, as well as the operational arrangements of the LAS".

This will inform the recommendations for the full roll out across the Trust.

2.2 Project Deliverables

- Development of the clinical response model;
    - Paramedic role and competencies – job description and KSF outline.

  - The education standards for the role and career pathways.
  - Delivery options for training, education and support. Recommendations for the appropriate clinical support for the role (i.e. team leaders, training for control room staff).
- Operational plans to undertake phased testing and piloting of the model that include the identification of the required numbers for the model (in due consideration of the overall workforce plan).
- A fleet plan that is linked in with the workforce plan and that considers;
  - total number of vehicles
  - vehicle types
  - recommendations for vehicle configuration to reflect the model
- The dispatch regime and infrastructure requirements to support the introduction of the model.
- The agreement of the definitive patient / clinical pathways for the model.
- Achievement of a signed agreement with staff-side colleagues for the model.
- Clinical and patient experience evaluation metrics, plan and outputs
- Options for rolling out the model and all associated infrastructure and support. This is likely to be aligned to NWoW roll out.
- Workforce transition plan and implementation to facilitate the model as part of pilot site.
- Contingency plans to roll out the full implementation of the model at Barnehurst, Greenwich and Bromley as well as the option not to roll it out.
- A comprehensive communication plan for internal and external audiences.

2.3 Benefits

Detail the expected benefits from the project implementation including any relationships to enabling programme benefits i.e. where a project benefit will contribute to the realisation of a programme benefit.

- Improved match of workforce skills to patient needs
- Reduced conveyance to A&E departments
- Increased use of alternative / referral pathways
- Better care for the patient
- Improved capture of patient outcome measures
- Improved utilisation of resources
- Improved match of vehicle type to patient need

- Reduced multiple sends
- Increased opportunity for clinical staff to access career progression
- Higher skilled workforce
- Enhanced staff morale / satisfaction

The improvements from productivity and efficiency gains will also result in an overall cost saving from the model.

2.4 Scope

2.4.1 Inclusions

- The development of the clinical response model.
- The education and training commitment to facilitate the paramedic role within the model.
- Developing an appointment entry route to the role
- Identify and the clinical support to support the new role.
- Provision of a statement of need for EOC to implement.
- The identification of administrative support for the training and placements.
- Agreeing the definitive pathways (referral and conveyance to appropriate care pathways) available for the role.
- The fleet plan recommendations to support the model.
- The staged testing of the model
- The pilot of the model
- The evaluation of the effectiveness of the model (patient experience & outcome)
- Recommendations for Trust-wide roll out of the clinical response model
- The development of a communication plan.

2.4.2 Exclusions

- Changes to EOC (to be managing through “Future Proofing Control” Project).
- The development of the full workforce plan (yet to be agreed).
- Future ECP strategy.
- The Trust-wide implementation of the clinical response model.
- The business changes to implement the clinical response model.
- The development of referral and alternative care pathways.

2.5 Constraints

- There are not sufficient paramedics (training to level 3) to operate the model.
- The current skill mix and workforce profile on the NWoW complexes means a transitional model will need to be put in place in order to move towards the full model.
- The training days available to train all staff as part of the model.
- Total fleet requirements for the pilot.
- There will be limited ability to make changes to CTAK until Command Point comes in.
- There may also be constraints on the flexibility of FRED / FERDA to operate two response models simultaneously and for the systems themselves to be adapted.

2.6 Dependencies

- The referral pathway project and its delivery of standardised care pathways and their communication.
- The implementation of NWoW at pilot sites; a critical path analysis of this focuses on recruitment of clinical tutor, their delivery of the NWoW training plan, as well as recruitment to CIOs
- Delivery by EOC of the necessary infrastructure and business change to support the clinical response model.

3 APPROACH

The project approach is;

- ➢ to develop the model and undertake a number of trials at Barnehurst to test the clinical model as well as dispatch requirements.
- ➢ Undertake an extended pilot at NWoW sites in the South East.
- ➢ Evaluate the effectiveness of the new model for patient outcomes, for area operations and EOC.
- ➢ Compile recommendations for a full roll out.
- ➢ Conduct an Equality Impact Assessment prior to agreement of the roll out plan.
- ➢ Develop a comprehensive communication strategy.
- ➢ Hand over the recommendations for a full clinical response model review to the business change manager / project manager.

Project management arrangements for this project will conform to the principles of Prince2.

4 BUSINESS CASE

Insert business case or AFA narrative. Where no business case exists, please state this.

4.1 Cash Flow Statement

If appropriate insert cashflow here otherwise state it is not applicable.

4.2 Income and Expenditure Statement

If appropriate insert cashflow for Income and Expenditure, otherwise state it is not applicable.

5 PROJECT TOLERANCE

Timetable: + or - 2 weeks

6 PROJECT ORGANISATION

The project will be controlled using the PRINCE 2 methodology with the following defined roles and named personnel.

Project Board

The Project Board are jointly responsible for the project viability within the objectives and constraints handed down by the Board of Directors.

Executive – *Caron Hitchen*

The Executive role provides overall project guidance, and assesses the project continuously from a business, financial and senior management point of view.

Senior User – *Richard Webber*

The Senior User represents the interests of the end users of the system for the major products which the project will deliver.

Senior Supplier – *Bill O'Neill / Gill Heuchan / Paul Webster / Finance*

The Senior Supplier role represents interests of those who have the responsibility for supplier implementation and delivery of the products.

Project Manager – *Steve Sale*

The Project Manager reports to the Project Board and has responsibility for delivering the products of the whole project, within time, cost and quality considerations as delegated by the Project Board.

Team Managers - *Philip De Bruyn (Operational planning), Jane Worthington (educational requirements) Gerard Murray (EOC changes) Julie Carpenter Pathway Protocols*

The Team Managers report to the Project Manager and are responsible for delivering their specific products or a stage, within time, cost and quality constraints which are acceptable by the Project Board.

Project Support – *(TBA)*

The Project Support member is not a full time position and reports to and assists the Project Manager with project administration as the focal point for providing administrative controls to the project. This can include setting up and maintaining the project files; updating project plans; administer change control and document control; administer Quality reviews and assist with compilation of reports.

Project Assurance – *Johnny Pigott*

Project Assurance is not a full time position within the project and is a function of the Project Board which can be delegated to a nominated person to act on behalf of the Project Board interests. Should the Project Manager also require independent assurance of the project controls and management (project health check) he can also nominate a person to carry out this reporting function.

Business Change Manager – *Paul Woodrow*

The role of the business change manager is to ensure that the products and capabilities delivered by the project are implemented and deliver benefits to the organisation. The Business Change Manager takes forward ‘operationalising’ the products. The business change manager may sit within the project board is share the role as the senior user, but they must be part of the start up of the project.

7 PRODUCTS

The high level products from this project are:

- An agreed clinical response model.
- Paramedic role with agreed skill requirements
- A training programme to equip staff with the skills to perform in the role
- A staff identification process into the role.
- A proposed long-term workforce plan reflecting the new role and its impact upon others.
- A training plan to deliver this role.
- An associated dispatch regime to reflect the new role and the determinants that will be addressed by the new skill set.
- Recommendations for the support infrastructure for the role, including the impact upon other supervisory and clinical roles.
- Recommendations for the vehicle requirements to support the role.

- An evaluation plan for the role.
- A communication plan.
- Recommendations for an implementation plan to be handed over to operations / NWoW for delivery if agreed by SMG.

8 QUALITY POLICY

Project management requirements - the project quality plan will be detailed in the project plan. As a minimum, quality criteria will be identified for milestone products and detailed in product descriptions.

The project manager is responsible for developing and managing the quality process though the project assisted by the project team's members and any quality assurance roles. The project board will approve the quality plan and process and delegate any project or quality assurance roles as required.

9 CONTROLS

9.1 Project Controls

Management milestones will be the formal assessment and control points as follows:

Management Milestones	Who Exercises Control	Triggering Event
Project Initiation	Project Board	Authorisation of Project by PMB
Project Assessments	Project Board	Planned at mid project or when an exception plan is required
Project Closure	Project Board	All products have been delivered
Quality Reviews	Project Manager	A product has been completed
Checkpoint meetings	Project/Team Manager	Weekly or as determined by the Project Manager
Highlight Reports	Project/Team Manager	Monthly or as determined by the Project Board.

9.2 Product Controls

In order to control unplanned situations concerning the specification, performance or delivery of products, the project will be subject to configuration and exception control.

9.2.1 Configuration Control

Define the change control procedure in place. The procedure should ensure the controlled change to products of the project by:

- *To record, assess and manage all exceptions.*
- *To ensure that proposed changes to the products are recorded and monitored for approved.*
- *To ensure related stages or other projects and services are informed of any changes to specifications and/or performance of the final product.*

9.2.2 Exception Control

There are three Exception Control documents which are raised to alert the Project Board and Team of a potential or real problem.

a) Project Issue Report

b) Off Specification Report

c) Requests for Change

Where the exception has an irrevocable effect on the Project stages outside of the agreed tolerances then an Exception Report is to be raised by the Project Manager for assessment by the Project Board. Stages or products may be delivered earlier, providing the implications at the time are assessed and in the opinion of the Project and Team Managers the impact is minimal to the other stages or products of the project.

10 PROJECT PLAN SUMMARY

Detail the main aspects of the project plan or refer to separate plan as appropriate.

The table below may be used as a suggested format or you may refer to a separate plan and attach in the appendices.

Task / Milestone	***Start***	***Finish***	***Dependency***

11 RISKS

A risk is defined as a situation which may have a negative impact on delivering the project.

An initial risk assessment has been carried out and is included within this plan. The results are to be monitored by the Project Manager and managed as part of the Checkpoint Meetings. Risk assessment will be an on-going process and reported by means of Risk Reports. The Project Manager is to take initial action on all Risk Reports and a Risk Log will be maintained.

Risk	**Impact**	**Prevention Actions**	**Limitation Actions**
Define the risk	*What is the impact to patients and or the service if the risk materialises*	*What steps can be taken to prevent or minimise the possibility of the risk occurring*	*If the risk does occur what action can be taken to reduce the impact of the risk*
Clinical care may suffer during the testing of the model	Clinical risk to patient safety Reputational risk to LAS		
there are insufficient numbers of staff with the right skill mix to operate the model			
The model may require further changes to the rota that may be revisited due to recent changes			
There may be insufficient vehicles to pilot the model			
Changes to Command Point may impact on the ability to influence CTAK changes			
The dispatch regime may not be fully implemented due to restrictions on FRED & FREDA			
The core deliverables from NWoW implementation may not be there to time			
Grade drift of paramedic role and clinical supervisory role			
Staff-side support is not secured for the new role		Early engagement with staff side of the purpose of the role. Ensure that the role is well publicised across the Trust via the communication	

		plan.	

Appendix A – Project Plan

CLINICAL RESPONSE MODEL

Plan Key	
Planned	
Complete	
Risk	
Slippage	

CLINICAL RESPONSE MODEL – Implementation Plan (2010/11)

March, April, May, June, July, August, September, October, November, December, January, February (each: W1 W2 W3 W4 W5)

Ref.	Tasks	Start date	Finish date	Owner
1	***PRE-PROJECT PHASE***			
1.1	Planning workshops			SS
1.2	Project initiation			CH
1.3	Project board meetings			SS
2	***MODEL TRIAL***			
2.1	Review outputs of 12 hr trial			JW / PW
2.2	Develop criteria for model			SS
2.3	Develop criteria for the trial			
2.4	Consult with staff-side			
2.5	Engage with NWoW management teams			SS / PW
2.6	Develop Barnehurst trial plan			DF
2.7	Operational preparation			DF
2.8	Agree care options (for top 10 presentations)			JW
2.9	Agree clinical care pathways (local)			JW / JC
2.1	Sign off by medical directorate			FM
2.11	Education & training preparation			KD
2.12	Tasking preparation			PWe
2.13	Develop evaluation criteria			JW / RC
2.14	Readiness assessment			
2.15	Barnehurst briefing			PWe
2.16	24 hr trial			DF
2.17	Evaluate			JW / Pwo / RC
2.18	Agree clinical response model to pilot			CH
3	***ROLE DEVELOPMENT***			
3.1	Agree clinical skill mix model			Caron Hitchen
3.2	Identify role competencies / skills			GH
3.3	Develop JD			SS
3.4	Achieve initial banding outcome			SS
3.5	Develop KSF Outline			SS
3.6	Agree Career pathway			GH
3.8	Agree selection criteria			GH
3.9	Agree selection process			AB
3.10	Identify training requirements for role			
3.11	Identify training delivery options			GH
3.12	Source route for delivery and capacity requirements			GH
3.13	Analysis of HEIs to determine preferred option			GH
3.14	Commissioning training contract (if ext.)			GH
3.15	Agree training course / pathway			GH
3.15	Train cohort of staff for pilot site			GH
4	***PILOT***			
4.1	Planning for pilot			DF
4.2	Agree staffing for pilot			DF / Resourci
4.3	Conduct training needs analysis			JW
4.4	Develop training plan			JW
4.5	Fleet review & allocation			CV
4.6	Control services processes agreed			PWe
4.7	Validate all pathways			JW
4.8	Stakeholder engagement complete			SS
4.9	Readiness assessment			SS
4.1	Pilot			PWo
4.11	Evaluation			PWo
5	***IMPLEMENTATION***			
5.1	Agreement of workforce plan			
5.2	Complete training needs analysis @ NWoW sites			
5.3	Develop training programme			
5.4	Agree w'force / training plan to enable transition model			
5.5	Tasking and technology requirements agreed			
5.6	Org. wide workforce / implementation plan developed			
5.7	Fleet requirements agreed			
5.8	Consultation complete			
5.9	Recommendations / plan / new protocol agreed by SMG			
6	***PROJECT CLOSURE***			
6.1	Full implementation plan handed to NWoW / fleet / Operations			
6.2	Project closure →			

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14TH DECEMBER 2010

PAPER FOR DISCUSSION AND APPROVAL

Document Title:	**Governance arrangements and committee structure**
Report Author(s):	Sandra Adams
Lead Director:	Richard Hunt and Peter Bradley
Contact Details:	Sandra.adams@lond-amb.nhs.uk
Why is this coming to the Trust Board?	A recommendation from the historical due diligence review that the governance structure should be assessed to ensure compliance with best practice guidance; and to agree the addition of the Finance and Investment Committee as Board committee.
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To discuss and approve the governance arrangements and revised committee structure.

Executive Summary

The current governance structure was implemented in April 2010 and is due for a full review in April 2011. A recommendation from the historical due diligence process was that the Trust Board undertakes an in-year assessment of the structure to ensure it captures any key concerns or issues and can make any relevant adjustments to the structure.
In addition to this, a recommendation was made – corresponding with the discussions at the Audit Committee on 8th November – that the Trust establishes a Finance and Investment Committee that would support the delivery of the financial strategy and ensure the Audit Committee has more time to focus on assurance issues.
The Trust Board agreed on 30th November to such a committee being established with effect from January 2011. Draft terms of reference are being prepared and the committee has been added to the structure.
The Associate Directors Group has been established since the structure was implemented and supports the Senior Management Group. This committee has been added to the structure.

Key issues for the Trust Board

The committee structure was established in April 2010 to reflect good governance practice and the quality and safety agenda facing the NHS. Guidance reviewed at the time was: Monitor's Code of Governance, The Audit Committee Handbook 2007, and The Healthy NHS Board.

The attached document reviews the level of compliance of the structure with the guidance identified through the historical due diligence process. Guidance does not include the Quality Committee however this was recommended good practice in The Healthy NHS Board.

The committee structure has been updated to incorporate 2 new committees: Finance & Investment (board committee to be chaired by a non-executive director); Associate Directors Group reporting to the SMG.

Attachments
Governance and committee structure
Governance arrangements and committee structure compliance schedule

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper links to the following strategic risks:

☒ There is a risk that we fail to effectively fulfil care/safety responsibilities
☒ There is a risk that we cannot maintain and deliver the core service along with the performance expected
☒ There is a risk that we are unable to match financial resources with priorities
☒ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

NHS Constitution
This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:

Governance Structure – December 2010

Trust Board
Chair:
Trust Chair

Audit Committee
Chair:
Non-executive Director

Charitable Funds Committee
Chair:
Non-executive Director

Quality Committee
Chair:
Non-executive Director

Strategy Review & Planning Committee
Chair:
Trust Chair

Finance & Investment Committee
Chair:
Non-executive Director

Senior Management Group
Chair:
Chief Executive

Remuneration Committee
Chair:
Trust Chair

Clinical Quality, Safety & Effectiveness
Chair:
Medical Director

Learning from Experience Group
Chair:
Deputy CEO

Risk Compliance & Assurance Group
Chair:
Director of Finance

Equality & Inclusion Steering Group
Chair: Assistant Director of Human Resources

Finance & Business Investment including risk
Chair: Director of Finance

Associate Directors Group
Chair:
Rotated

Area Governance Committees
Chair: Assistant Directors of Operations

Patient Public Involvement Committee
Chair: Head of PPI

Business Continuity & Emergency Preparedness
Chair: Deputy CEO

Information Governance Data & Quality Assurance
Chair: Director of IM&T

Strategic Steering Group
Chair: Director of Service Development

Vehicle Equipment Working Group
Chair: Director of Finance

Infection Control (HCAI)
Chair: Head of Operational Support

Clinical Audit & Research
Chair:
Medical Director

Corporate Health & Safety
Chair: Director of Human Resources & Organisation Development

Motor Risk
Chair:
Director of Finance

Safeguarding
Chair: Director of Health Promotion & Quality

Business group reviewing specific risks/clinical governance issues
Chair: tbc

Training Strategy Group
Chair: Director of Human Resources & Organisation Development

Medicines Management Committee
Chair: Senior Clinical Advisor to the MD

Clinical Steering Group (Senior London Clinicians)
Chair: Medical Director

Formal Trust Board Committee

Governance arrangements and committee structure: December 2010

Committee	Best practice guidance source	Membership	Information supporting compliance
Nominations Committee	Monitor's Code of Governance 2010. Paragraph C.I.I.	Non-executive directors (NEDs) for the appointment of executive directors. Majority of governors for the appointment of NEDs.	• Should give all consideration to succession planning • Established for the appointment of EDs as and when required – last appointment – Director of Health Promotion & Quality • Upon authorisation as an FT, a Nominations Committee will be established for the appointment of NEDs (see governance rationale and draft constitution).
(Appointments Committee)	Integrated governance handbook 2006 – Department of Health 2.3.	Not specified.	See last section.
Remuneration Committee	Monitor's Code of Governance 2010 Paragraph E.I.	NEDs including at least 3 independent NEDs.	Comprises solely of NEDs, chaired by Trust Chairman attended by CEO and supported by Director of Corporate Services.
	Integrated governance handbook 2006 – Department of Health 2.3.	Not specified.	See attached.
	NHS Act 2006 – schedule 7, paragraph 18(2).	NEDs.	For the review of remuneration and allowances of executive directors.
Audit Committee	Monitor's Code of Governance 2010 Paragraph F.3.	At least 3 independent NEDs; 1 member to have recent and relevant financial experience.	4 members to 30th November 2010 moving to 3 from 1st December 2010. 1 member has recent and relevant experience.

			F.3.2. Terms of reference – do not yet include policy on engagement of external auditors to carry out non-audit services. See attached.
	Integrated governance handbook 2006 – Department of Health 2.3.	Not specified.	
	Audit Handbook 2007 – HM Treasury	Independent NEDs Principle 1 Independent external members where there are insufficient independent NEDs.	5 principles: 1. Role 2. Membership, independence, objectivity and understanding. 3. Skills – appropriate skill mix. 4. Scope of work – Terms of reference enabling committee to meet the assurance needs of the Board and Accounting Officer; and the work of internal/external auditors and financial reporting. 5. Communication – Board; Head of Internal Audit; External Auditor; other stakeholders
	NHS Act 2006 – schedule 7, paragraph 23 (6)	NEDS	-------

Integrated Governance Handbook 2006

2.3 Board committee structure and support;

Audit

Remuneration and review

Appointments

Others may be: Risk, Compliance and Assurance; Clinical Governance; Health & Safety.

Trust Board should undertake an annual review of its committee structure.
Formal and rigorous annual evaluation of its own performance and that of its committees.
Review the committee structure to reflect corporate need.
Clarity of terns of reference, delegated powers and reporting requirements.
Ensure individuals appointed to committees have skills, abilities and support to discharge their duties as directors.

Sandra Adams

Director of Corporate Services

7th December 2010

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14TH DECEMBER 2010

PAPER FOR NOTING

Document Title:	Board Development Programme
Report Author(s):	Caron Hitchen
Lead Director:	Caron Hitchen
Contact Details:	Caron.hitchen@lond-amb.nhs.uk
Why is this coming to the Trust Board?	This relates directly to the development of the Trust Board and supports the plans to progress application to Foundation Trust status
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	The Board are asked to note the updated Board Development Plan

Executive Summary

At the April Trust Board meeting, board members reviewed and agreed key development areas which had been delivered in the previous 18 months together with future development needs. Historic development includes:

- Market Strategy development
- Corporate Manslaughter legislation
- Strategic risk workshops
- Becoming a Foundation Trust Board
- Counter Fraud awareness

Further discussion was initiated with regard to future board development both in terms of whole board and the induction and integration of two new Non Executive Directors.

Recently, the Board has been fully involved in the development of the Integrated Business Plan which has included development sessions particularly in relation to service development plans and the Long Term Financial Plan. This has allowed for robust discussion and challenge around the Trust's future plans, the planning assumptions, the supporting financial model and associated risks.

As part of our continued progression to Foundation Trust, Board members have participated in interviews conducted by the SHA and through the Historic Due Diligence (HDD) process. We have received feedback from both these exercises and a set of specific recommendations have been

received from Grant Thornton following the HDD, which continue to inform Board development requirements.

In addition to the Board's own self assessment, the results of which were presented to the September Board meeting, arrangements are currently being finalised to conduct an externally facilitated diagnostic exercise in January which will inform the next stage of board development, including preparation for the Board to Board meeting with Monitor.

This has now been incorporated in the Board Development Plan attached. Further activity will be included as appropriate following the diagnostic exercise in January 2011.

Key issues for the Trust Board

Key updates to the Board Development Programme are the inclusion of an externally facilitated diagnostic process in January 2011and preparation for future Board to Board meetings.

Attachments

Updated Board Development Plan

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Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper links to the following strategic risks:

☒ There is a risk that we fail to effectively fulfil care/safety responsibilities
☒ There is a risk that we cannot maintain and deliver the core service along with the performance expected
☒ There is a risk that we are unable to match financial resources with priorities
☒ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

NHS Constitution
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Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Board Development proposal

Development topic	Delivery method	Timescale
1. INFORMATION AND KNOWLEDGE		
Clinical development for non clinicians	Literature (Clinical updates) & presentation updates	On-going
Demand management	Presentation – Deputy Chief Executive	June 2010
Understanding the NHS financial frameworks	Presentation – Director of Finance	October 2010
Commissioning arrangements	Update	May 2010
External environment & key stakeholders	Presentation and team discussion	October/December 2010
Employment appeals	Session with relevant NEDs and active participation	On-going
Understanding the Performance Management process within the Trust	This was an audit recommendation relating to the understanding of operational performance (and in particular under performance). This development will be achieved through the delivery and explanation of the performance data and associated KPIs by the Chief executive and Director of Operations.	During induction for new Non Executive Directors and on-going through Trust Board reports
2. WAYS OF WORKING		
Teambuilding)	Facilitated session – Awayday)	TBC (post October)
Understanding our shared responsibilities)	Incorporated into the session above)	As above
Communication methods	Discussion	June 2010
Ride outs and site visits	To include TB meetings on other sites	2-3 times per year

3. TRUST BOARD PRIORITIES		
Health and Safety responsibilities	**Institute of Directors “Leading Health and Safety” document**	**May 2010**
Quality Governance	**Taking it on Trust – The Healthy NHS Board – Monitor’s guide. Detail and delivery to be determined.**	**Range of sessions delivered over the next 12 months.**
Independent Analysis of Board capability/capacity	**External provider**	**January 2011**
Preparation for Board to Board	**External provider**	**January 2011**
Mock Board to Board	**External provider**	**May 2011**

Incorporates induction for new Non Executives

Complete

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

14TH DECEMBER 2010

PAPER FOR NOTING

Document Title:	**Review of information provided to the Trust Board**
Report Author(s):	Sandra Adams
Lead Director:	Peter Bradley
Contact Details:	Sandra.adams@lond-amb.nhs.uk
Why is this coming to the Trust Board?	The recent historical due diligence review recommended that the Trust should review the information provided to the Trust Board to ensure compliance with the requirements of Monitor's Code of Governance and with the Intelligent Board.
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To review the good practice guidance framework for information for the Trust Board in order to determine compliance and any future information requirements.

Executive Summary

Context: the historical due diligence recommendations included a review of the information provided to the Trust Board in order to assess the level of compliance with good practice governance guidance. The attached document provides the background to this guidance and is intended to stimulate discussion about the information that comes to the Trust Board. The document also highlights the reporting requirements of the Trust Board.

Highlights:

- Good governance is underpinned by intelligent information;
- Strategic information should be structured around the Trust's strategic goals;
- Operational information should focus on the most important measures and highlight exceptions;
- All information should be clearly and simply presented, accurate and timely, and of a high quality appropriate to the respective functions of the board and relevant to the decisions directors have to make;
- Information should direct the Board's attention to significant risks, issues and exceptions.

Key issues for the Trust Board

To determine whether the information provided to the Trust Board complies with good practice guidance and whether there are any additional areas of good practice that have been implemented to support:

- the effective and efficient use of information thereby allowing more time on strategic discussions; and
- a more balanced focus of scrutiny on current and recent operational performance.

To identify any gaps in information that, when addressed, will enhance the knowledge and familiarity of directors with the Trust enabling them to fulfil their responsibilities on the Board and on any relevant committees.

To note the reporting responsibilities of the Trust Board.

Attachments

1. The Intelligent Board – summary of ‘Intelligent Information’
2. Monitor’s Code of Governance – headlines from Section D.1 on ‘Information and professional development.’

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Strategic Goals 2010 – 13

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Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:

From the Intelligent Board series: both generic and the Intelligent Ambulance Board: 2006[i]

1. Intelligent information

Good governance is underpinned by intelligent information, which enables the board to:
- Set an appropriately challenging, but achievable, strategic direction.
- Identify the strategic issues that require discussion or decision, and distinguish these issues from operational detail.
- Provide constructive challenge.
- Make sure that tax payers are receiving value for money.
- Identify trends in performance.
- Enable comparisons with the performance of similar organisations.
- Understand the needs, views and experiences of users and non-users from all backgrounds and communities.
- Make sure that users are receiving a high-quality service.
- Anticipate the potential impact of key policy, technological and socioeconomic developments.
- Assure themselves that the organisation is complying with standards and other regulatory requirements.

The key tests of the success of any information resource for the board will be the extent to which it:
- Prompts relevant and constructive challenge.
- Supports informed decision-making.
- Is effective in providing early warning of potential financial or other problems.
- Develops all directors' understanding of the organisation and its performance.

2. Principles of intelligent information

Strategic information for the board should:
- Be structured around an explicit set of strategic goals.
- Show trends in performance in terms for finance *and business development*, quality and the experience and satisfaction of patients.
- Provide forecasts and anticipate future performance issues.
- *Encourage an external focus*.

Information about operational performance should:
- Provide an accurate and balanced picture of current and recent performance – including financial, clinical, regulatory and patient perspectives.
- Focus on the most important measures of performance – and highlight exceptions.
- Be appropriately standardised in order to take account of known factors that affect outcomes, such as the age and deprivation profile of patients.
- Enable comparisons with the performance of similar organisations.

All information should:
- Be clearly and simply presented, including graphic overviews as well as brief commentary.
- Be updated in a timely manner.
- Direct the board's attention to significant risks, issues and exceptions.
- Provide a level of detail appropriate to the board's role.

Ideally, directors should be able to access key information about the Trust's contemporary and historical performance online, off the premises and in between meetings.

3. The framework for considering strategy and operational performance at board level

Boards should make a clear distinction between strategic and operational matters, focusing their attention on a limited number of key aspects of each. The framework seeks to fulfil a number of important purposes:

- Supporting boards to make more efficient and effective use of information – and to spend more time on strategic matters.
- Structuring the process of formulating strategy, shaping plans and reviewing progress.
- Enabling a balanced focus when scrutinising current and recent operational performance.

The framework is flexible enough to:

- Balance the crucial ingredients of success in financial, operational and quality terms.
- Cover the perspectives of patients, commissioners, clinical staff and managers, along with regulatory requirements.
- Allow trusts to select and modify those indicators that are most relevant to them in light of their own particular strategic priorities and/or trends and issues in their own performance.

4. Proposed minimum data sets

Regular strategy discussions should, as a minimum, focus on:

- *Market and business development – in the context of patient choice and Payment by Results, boards increasingly need to think in terms of understanding their trust's markets, analysing the competition and developing the trust's business. They also need to be anticipating the needs of patients in their community.*
- *Key trends and forecasts in relation to key aspects of trust performance: finance (resources and HR capacity to deliver), efficiency, patients' experiences, clinical quality.*
- *Future developments in terms of policy, technology and other changes in the external environment, and their potential impact.*

Foundation trust boards will also need to take into account the views and advice of their governors, the needs of the members and the wider community, and on longer term direction.

Routine oversight of operational performance should focus on exception reporting in terms of current and recent performance against targets and peer benchmarks in relation to:

- Context/strategy: current and future activity and local intelligence.
- Patients' experience (including feedback from patients and their relatives on staff attitude, responsiveness and communication).
- Clinical quality; in particular, measures of clinical outcome.
- Access/targets, including PTS targets.
- Finance including income and expenditure and cash flow.
- Efficiency, such as use of alternative responders and call timings.
- Workforce; including workforce planning, violent incidents, and staff satisfaction.

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[i] Text in italics is taken from the generic Intelligent Board guidance. All other text is common to the Intelligent Ambulance Board or common to both sets of guidance.

Monitor's Code of Governance 2010

Information (and professional development) section D.1.

To the Board:

- Accurate, timely, concise, objective and clear information for directors, accompanied by clear explanations of complex issues.
- Good information flow between the Trust Board and committees, and between the Senior Management team and non-executive directors.
- Directors, and in particular non-executive directors, to have access to independent professional advice where necessary to discharge responsibilities as directors (D.2.).

By the Board:

- Financial, quality and operational reporting (F.1.). Board of directors should present a balanced and understandable assessment of the Trust's position and prospects.
- Annual report and accounts including a statement by external auditors about their reporting responsibilities (F.1.1.).
- At least annually:

- Clearly set out financial, quality and operating objectives, disclosing sufficient information, both qualitative and quantitative, including clinical outcome data, to allow (members and governors) to evaluate its performance (F.1.4.).

- Review effectiveness of the system of internal control and report this – all material controls including financial, clinical, operational and compliance controls and risk management systems (F.2.).

- Disclosure – Schedule A – the LAS reports against all currently except those pertaining to governors.

Sandra Adams

Director of Corporate Services

7th December 2010

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	2010/11 Budget for approval	Service-wide Rota project		Balanced scorecard	Full update on core standards compliance 2009/10		
Date	**Strategic and Business Planning**	**Items for approval (eg Policies and Business Cases)**	**Performance and Other**	**Governance**	**Standing Items**	**Apologies**	**Committee dates**
25 January 2011 TB	Formal IBP and LTFM sign off pre-submission	CommandPoint Update	Quality Indicators Dashboard	Q3 integrated governance and finance declaration	Report from CEO including balanced scorecard and performance reports		RCAG 10th Jan
SMG 12 Jan				Key risks	Report from Finance Director		CQSE 18th Jan
	Tom Coffey - presentation				Report from Sub-Committees		
	Update on Clinical Response Model				Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		
1 March 2011 TB	Approve FT application	CommandPoint Update		Key risks	Report from CEO including balanced scorecard and performance reports		Qual 2nd Feb
SMG 16 Feb	Annual Business Plan and Budget			Safeguarding Declaration	Report from Finance Director		LFE 25th Feb
	Corporate objectives			Patient Experience Report	Report from Sub-Committees		
	Cycle Response Unit (Tom Lynch)				Clinical Quality and Patient Safety Report		
	Update on Clinical Response Model				Report from Trust Secretary		
29 March 2011 TB	Annual Business Plan and Budget	CommandPoint Update		Risk management policy and strategy review	Report from CEO including balanced scorecard and performance reports		Audit 7th Mar
SMG 16 Mar				Annual Review of Standing Orders and Standing Financial Instructions	Report from Finance Director		CQSE 9th Mar
				BAF and Risk Register	Report from Sub-Committees		
					Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		
26 April 2011 SRP	Review of balanced scorecard			Governance structure review			
SMG 13 April							
24 May 2011 TB	FT application update	CommandPoint Update		2010/11 Annual Report and Accounts (including Quality Report)	Report from CEO including balanced scorecard and performance reports		RCAG 11th April

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SMG 11 May				KA34 Compliance Statement	Report from Finance Director		Qual 27th April
				2010/11 Annual Infection Prevention and Control Report	Report from Sub-Committees		LFE 10th May
				Q4 integrated governance and finance declaration	Clinical Quality and Patient Safety Report		
				2009/10 Annual Equality Report			
				Corporate Social Responsibility Report 2010/11	Report from Trust Secretary		
				Key risks			
28 June 2011 TB	FT application update	CommandPoint Update		Audit Committee Annual Report 2010/11	Report from CEO including balanced scorecard and performance reports		Audit 6th June
SMG 15 June				Patient Experience and Complaints Report	Report from Finance Director		CQSE 7th June
				Audit and Research Annual Report	Report from Sub-Committees		
				BAF and corporate risk register	Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		
26 July 2011 SRP	Review of balanced scorecard						Qual 6th July
SMG 13 July							RCAG 11th July
23 Aug 2011 TB	FT application update			Q1 integrated governance and finance declaration	Report from CEO including balanced scorecard and performance reports		CQSE 2nd Aug
SMG 10 August				Key risks	Report from Finance Director		LFE 9th Aug
					Report from Sub-Committees		
					Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		
27 Sept 2011 TB	FT application update			Annual Trust Board effectiveness Review 2010/11	Report from CEO including balanced scorecard and performance reports		Qual 7th Sept
SMG 14 Sept				BAF and risk register	Report from Finance Director		Audit 12th Sept
					Report from Sub-Committees		

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					Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		
1 November 2011 SRP awayday - all day	Review of balanced scorecard						
29 Nov 2011 TB				Q2 integrated governance and finance declaration to Monitor	Report from CEO including balanced scorecard and performance reports		RCAG 10th Oct
SMG 9 Nov				Patient and Complaints Experience Report	Report from Finance Director		CQSE 26 Oct
				Key risks	Report from Sub-Committees		Qual 2nd Nov
					Clinical Quality and Patient Safety Report		Audit 7th Nov
					Report from Trust Secretary		LFE 15th Nov
13 Dec 2011 TB				Charitable Funds Annual Report and Accounts 2010/11	Report from CEO including balanced scorecard and performance reports		
SMG 7 Dec				BAF and corporate risk register	Report from Finance Director		
					Report from Sub-Committees		
					Clinical Quality and Patient Safety Report		
					Report from Trust Secretary		

Presentations
Approval
Compliance
FT items