LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 31st January 2006 at 10am

Main meeting room, Loman Street SE1

A G E N D A

1.	Declarations of Further Interest.	
2.	Opportunity for Members of the Public to ask Questions.	
3.	Minutes of the Meeting held on 29th November 05. Part 1 and II	Enclosure 1& 2
4.	Matters arising	
5.	Chairman's remarks	
6.	Report of the Chief Executive	Enclosure 3
7.	Month 9 Financial Report.	Enclosure 4
	➢ Estates – Tottenham AS	" 4b
	➢ Rapid response vehicles business case	" 4c
8.	Report of the Medical Director	Enclosure 5
9.	Draft governance & risk management arrangements	Presentation
10.	Business Continuity Policy – for approval	Enclosure 6
11.	Review workforce plan	Enclosure 7
12.	Update Seven Year Plan	Presentation
13.	Estates update	Presentation
14.	Patient Advice and Liaison Service (PALS) report	Enclosure 8
15.	Quarterly report re. Assurance Framework	Enclosure 9
16.	Report from Trust Secretary on tenders opened since last board meeting.	Enclosure 10
17.	Draft Audit Committee minutes – 5th December 2005	Enclosure 11
18.	Draft Risk Management Committee minutes – 5th December 2005	Enclosure 12
19.	Draft Service Development Committee minutes – 20th December 2005	Enclosure 13
20.	Draft Minutes of the Clinical Governance Committee –16th January 2006	Enclosure 14
21.	Any Other Business.	
22.	Opportunity for Members of the Public to ask Questions.	
23.	Date and Venue of the Next Trust Board Meeting.	
	28th March 2006, 10.00am at 220 Waterloo Road, London SE1	

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 29th November 2005

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

Present:

Sigurd Reinton	Chairman
Peter Bradley	Chief Executive
Non Executive Directors	
Barry MacDonald	Non Executive Director
Sarah Waller	Non Executive Director
Beryl Magrath	Non Executive Director
Colin Douglas	Non Executive Director (arrived 10.05)
Lord Toby Harris	Non Executive Director
Executive Directors	
Mike Dinan	Director of Finance
Fionna Moore	Medical Director
Caron Hitchen	Director of Human Resources & Organisation Development
Martin Flaherty	Director of Operations

In Attendance:

Malcolm Alexander	Chairman, LAS Patients' Forum
David Jervis	Director of Communications
Peter Suter	Director of Information Management & Technology
Kathy Jones	Director of Service Development
Colin Hill	Member of the public
John Hopson	ACAO CAC
Martin Brand	Head of Programmes and Projects
John Trenfield	Observer (SPR in emergency medicine)
Chris Vale	Acting Head of Operational Support
Ian Pentland	Consultant - IT
Christine McMahon	Trust Secretary (Minutes)

108/05 Declarations of Interest

There were no declarations of interests.

109/05 Opportunity for Members of the Public to ask Questions

There were no questions.

110/05 Minutes of the Meeting held on 27th September 2005

Agreed:

1. **The minutes of the meeting held on 27th September 05 as a correct record of that meeting with the following amendments:**
2. **Clarification was sought as to 'each year that amount would be increased by reduced in real terms be used when ambulance services are implementing Payment by Results'.**
3. **The Complaints Panel will meet again on 5th October 2005 not 52005.**

111/05 Report of the Chairman

The Chairman referred to the reforms that had been proposed under the recent Department of Health paper 'Commissioning a Patient Led NHS' - though no formal decision has been made it now appears that there will be one Strategic Health Authority for London and thirty two Primary Care Trusts (PCTs). The roles and responsibilities of PCTs will probably be redefined, however.

Discussions are taking place between the NHS Confederation and the Ambulance Service Association as to how the two organisations can work closer together. The Board will be kept informed of progress.

The Chairman, on behalf of the Trust Board, thanked Lord Toby Harris for his contribution and efforts on behalf of the LAS over the last eight years. The Chairman referred to Lord Harris's long and illustrious career and on behalf of the Trust Board wished him well for the future. The Chairman felt that the Board had been fortunate to have Lord Harris as a member and he was sorry that Lord Harris had declined a third term. Lord Harris's constructive and thoughtful contributions to discussions have been greatly appreciated.

Lord Harris said that he had enjoyed being a member of the Trust Board for eight years, during which time he had seen the organisation transformed. He paid tribute to the Chief Executive and his team for the work they have done. He felt that the Trust Board has been kept well informed which compared favourably with other committees/boards he has been member of.

112/05 Report of the Chief Executive

The Chief Executive highlighted the following from his report to the Trust Board:

Activity remains high, 4% increase in demand on this time last year which meant an additional 60,000 999 calls. The performance year to date is 73% for Category A 8 minute (Department of Health target of 75%) and 95% for Category A 14 minute calls (Department of Health target of 95%).

The Chief Executive referred the Board to Graph 9 of the information pack attached to the report; it showed the performance targets being achieved in August when levels of crewing were higher than the previous two years. The increase in Category A 8 minute calls and the level of cover in terms of front line crews staffing ambulances and cars has had a serious impact on performance. The Trust will seek to address this issue in part by recruiting an additional 300 plus staff over the next few years.

The Board was informed that there have been intermittent technical issues during the last eight weeks which will be referred to in more detail when the Director of Information Management and Technology spoke about CAD (minute 122).

The Chief Executive expressed confidence that the Trust will be back on target by March 2006 and will achieve the Category A 8 minute target of 75% for the year. The Director of Operations is developing an escalation plan which will include pre-agreed responses to certain levels of activity. The plan may include the possibility that the Trust cease to respond to Category C calls, that training sessions are postponed and that managers crew ambulances.

The Urgent Operations Centre (UOC) is opening on the 30th November; new software has been purchased for the Clinical Telephone Advisers and additional staff are being recruited to deliver clinical advice by telephone; the Emergency Bed Service personnel are moving into the UOC on 30th November 2005.

The Chief Executive said that as a result of the UOC starting to function as planned, he expected to see greater utilisation of Whitework and ECPs with a decrease in Category C calls being responded to by front line A&E crews.

Central Control (CAC) is changing its name and will in future be known as the Emergency Operations Centre (EOC).

The Trust will look to employ a midwife for a year to advise on maternity cases and give telephone advice in a clinically safe way for that group of patients.

The Chief Executive confirmed that he had been advised that the Trust will receive £10m CBRN funding and an additional £5m to support increased resilience due to the terrorist threat. He is working hard with the South West London Strategic Health Authority and the Department of Health to secure the promised funding.

The Board was informed that PTS is not going to break even this year; in recent months there has been some loss of control regarding the use of third party transport. A new management board for PTS is in place and includes the Director of Operations and the Director of Finance.

Workforce planning – the Trust is looking to recruit a large number of staff during the next twelve months to fill vacancies and meet the requirements of Agenda for Change. The plan will be presented to the Trust Board in January 2006. It is intended that the additional staff will mean less reliance on overtime. **ACTION: the HR Director & Organisation Development.**

There has been good progress on Agenda for Change; paramedics and team leaders have been assimilated. Staff retention is high with only 7% turnover of front line crew.

The Board was informed that the Communications Department has been very busy. On the 28th November 2005 'Tonight with Trevor McDonald' featured the LAS in a programme reviewing the impact of the recent change in licensing laws. The Chief Executive said that anecdotal evidence suggested that demand has increased from 11pm to 4am; in the same period of time four staff were assaulted.

The Chief Executive's consultation meetings have been going well and good feedback is being received from front line crews. One of the issues raised by front line crews is the relationship with the Metropolitan Police. There is a view that the Police are not always as responsive as we would like. There were also comments about the way the CAD link is used to prioritise calls and to dispatch ambulances. Senior LAS staff will be meeting with senior officers of the Metropolitan Police within the next ten days to try to address some of the issues raised at the consultation meetings.

There has been a lot of good work undertaken by the Estates Department. The following works have been recently completed: Rotherhithe Ambulance Station, Streatham Ambulance Station, a purpose built logistics unit at Deptford and the opening of the Urgent Operations Centre. For Streatham, Rotherhithe and the UOC, opening ceremonies will be held and board members will be invited to attend. **ACTION: The Director of Communications.**

Patient Public Involvement Margaret Vander, the Head of PPI, is leading on this work. A large number of staff are involved and working with the LAS Patient Forum.

The Patient Advice & Liaison Service (PALS) has been extremely busy. The Chief Executive suggested that a presentation regarding the Service be given to Trust Board in 2006. **ACTION: Director of Communications**

Professional Standards Unit – a review is being undertaken of the Professional Standards Unit (PSU) and a report will be presented to the January Trust Board. The report will include recommendations on how complaints will be managed in future.

Colin Douglas asked about the 4 assaults on staff and whether there has been an increase over the year. The Chief Executive said that overall the trend has been downward; the recent incidents co-incided with a film crew accompanying front line crew also being assaulted. The situation will continue to be carefully monitored.

In response to Colin Douglas's question about PTS and the lengthy waiting times that some patients have to endure, the Chief Executive said that management is looking at a new scheduling system for PTS. The Finance Director pointed out that the vehicles are relatively small (capacity 6 people) and consequently there is a lot of shuttling.

Beryl Magrath asked whether the plan to recruit an additional 300 plus staff included fully trained staff from other parts of the NHS. The HR Director confirmed that a recently placed national advertisement was aimed at recruiting staff to the LAS that are fully trained. Beryl Magrath referred to her recent visit to East Anglia Ambulance Service, who use nurses to deliver Clinical Telephone Advice (CTA) and wondered whether that was something the LAS might investigate. The Director of Service Development said that East Anglia have always used nurses to assist CTA. The Management Team are working on an escalation plan which may include not responding to Category C and may include employing General Practitioners to deliver CTA when appropriate. If the escalation plan is implemented it would be offering a short term solution, not a long term solution, to the challenges that the LAS faces.

The Chairman of the LAS Patients' Forum was assured that the review of PSU will include a review of the internal relationship between PSU and PALS.

The Chairman of the LAS Patients' Forum enquired whether the tender documents for PTS included clinical safety. The Director of Finance confirmed that although clinical safety is included in the tender documentation, he felt the final decision by acute trusts is heavily influenced by cost – the cost per patient per journey. PTS is an expensive service and its competitors are able to provide a cheaper service, in part due to the fact that they have not had to implement AfC terms and conditions. Under Department of Health regulations every contractor in business with the NHS is required to implement AfC terms and conditions; consequently Acute Trusts may find their external contractors may have to increase their price as a result.

Barry McDonald queried the information in the graphs which showed an increase in Category A responses but fewer ambulance hours staffed. The Chief Executive said that the graphs were incorrect and not up to date. The graph for Category A does not include red calls. In November, December and January calls increased by 700 not 50%. The staffing graph does include staff who worked overtime and the additional cost will be due to the double time paid.

The Director of Operations pointed out that on a busy day the Trust responds to 950 Category A 8 minute calls whereas previously it responded to 500 calls. The margin for error is different in terms of the increased number of patients who need to receive care within 8 minutes. In response to a question from Barry McDonald the Director of Operations said that a new team of Assistant Directors of Operations (ADOs) had been appointed (in post from 24th October); part of their role will involve working with Ambulance Operations Manages on the current challenges facing the Trust. To some degree the AOMs have been adversely affected by the

impact of vacancies and the negative impact of AfC. The ADOs will be working with the AOMs to focus on areas they can impact rather than focussing on areas where they cannot i.e. vacancy level.

Sarah Waller was assured that no complaints had been received as a result of the recent CAD failures.

In response to a question from Toby Harris the Director of Information Management and Technology explained that the recent failures were as a result of two separate issues. One concerned the ongoing public interface data base which has experienced 20-30 disruptions. The Trust is working with IBM to address this issue; the latest change was implemented last week and the situation is being carefully monitored. The second matter was due a fundamental upgrade of the CAD system not being transferred correctly in August. The system was down for 5 hours. Now that the reason for failure is known steps have been taken to ensure non-reoccurrence.

Toby Harris thought it was an excellent idea for the high level meetings to take place with the Metropolitan Police. The Chairman endorsed this suggestion and the Chief Executive thought that the ADOs would be the most appropriate people to take forward. **ACTION: The Chief Executive to put this liaison in place.**

Noted: The report

113/05 Month 7 Finance Report

Insurance for CBRN staff: the Director of Finance reported that the Trust has purchased insurance cover as a last resort for CBRN staff so that in the event that staffs' own mortgage companies invalidate their policies as a result of a CBRN incident staff have some protection. The cover is capped at £5m for annual cover and capped at £250,000 per individual. This type of insurance has never been underwritten in the UK insurance market before. Every effort will be made to ensure that the Government take on this responsibility with effect from November 2006 as the CBRN personnel of all the emergency services are potentially affected.

Month 7 Finance Report: the Trust's income was £346k lower than expected in month 7 due to an under recovery on ECP income since there was a delay in the roll out of ECPs in the North West.

The payment of double time was higher than forecasted for October as there were 5 weeks in the month which meant an additional £95,000 on the salary bill. The payment of double time for overtime will cease at the end of December 2005.

The Trust is forecast to have an end of year surplus of £1.3m.

PTS is forecast to have £700,000 deficit (the worst case scenario); an action plan has been implemented to ameliorate the situation so that the deficit may be £350,000. The Director of Finance reported that, whilst he has provided for bad debts, every effort will be made to recoup any outstanding debts. With regard to the profitability of contracts the East sector has three which are unprofitable and the West has six that are unprofitable. The two contract managers have been tasked with ensuring that contracts are brought back under control. A further report regarding PTS will be presented to the SDC in December. **ACTION: Finance Director.**

There was a discussion concerning the additional funding the Trust is expecting to receive. (£10m recurrent CBRN funding and £5m additional emergency funding). Every effort is being made to ensure that the additional funds are received as soon

as possible and discussions are being held with the South West London Strategic Health Authority and the Department of Health. The Director of Finance confirmed that the Department of Health has been invoiced for both sets of funding.

In response to a query from Sarah Waller the Finance Director confirmed that the Trust has received confirmation in writing that any monies brokered in March 2006 will be received back in the following financial year.

In response to a question from Beryl Magrath the Director of Finance confirmed that a report regarding accidental damage will be presented to the Trust Board in December. **ACTION: the Finance Director.**

Noted The report

114/05 Report of the Medical Director

The Medical Director reported that the Trust has submitted the draft declaration of compliance with 'Standards for Better Health' to the Healthcare Commission. The declaration was supported by the Internal Auditors, Bentley Jennison who found "a suitable assessment had been made in respect of the degree of compliance with each of the standards". A final declaration on how the Trust meets the Standards for Better Health will be required in April 2006. A number of policies are being presented for approval to the Trust Board in November in support of the declaration and to also meet the requirements of the NHS Litigation Authority Level 3 risk management standard for pre-hospital care.

Clinical aspects of the Medical Director's report included:

- All Lifepak 12 monitor/defibrillator have been checked and serviced in line with a warning through the Safety Alert Bulletin System (SABs).
- Disposable items of equipment (for example laryngoscope blades and masks) are replacing reusable ones out across the Trust;
- New ambulances will be fitted with the Ferno Pegasus stretcher which is 10kg lighter than existing stretchers.

The Medical Director is raising clinical issues with staff at the Chief Executive's consultation meetings e.g. a professional approach to the management of the recently introduced morphine. She is also endeavouring to show how complaints can be viewed in a positive light. Feedback from crews included Category A calls being incorrectly over prioritised and concern that some Category C calls were being under prioritised. Emergency Medical Technicians(EMTs) are been assured that the Trust will continue to invest in staff training; some EMTs had expressed concern that the Service intended to recruit paramedics solely through higher education rather than selecting and training existing members of staff.

The Trust Board was informed that the new Resuscitation Guidelines were published on 28th November 2005. The recommended changes will be rolled out across the Trust over the next few months; one of which is the need to reprogram all defibrillators to deliver one not three shocks to patients. A further update will be given to the Trust Board in January 2006. **ACTION: The Medical Director.**

A three month trial is being carried out whereby CTA and ECPs can call on Consultant Physicians at the National Poisons Information Service for advice. The trial is being audited by the Clinical Audit and Research Unit.

The Board's attention was drawn to appendix one which contained two summaries.

Patient Report Form – an audit was conducted of 362 patients who in 2004/05 were diagnosed by LAS crews using a 12-lead ECG as suffering an ST Elevation Myocardial Infarction. The audit found that that documentation was good though it could be improved. Pain Management was found to require more attention; however since the audit was conducted the Service has introduced morphine as an analgesic. The audit found that the LAS has high levels of aspirin administration.

The Trust is under significant pressure in North East London regarding call to door time – average time for call to door is 40 minutes. It is highly unlikely that this figure can be improved. Work is being done with other healthcare colleagues to remind them that the national target is 60 minutes call to needle time and that is a target shared by ambulance services and acute trusts.

Clinical Patient Information Work has been done to improve the process whereby team leaders undertake an audit of Patient Report Forms and feedback information to crews. The procedure will be web-based and simpler to use. In addition staff once they have received feedback from team leaders will be able to access information to support their PDR and developmental profiles.

The Patient Care Conference in September was well attended by patients, staff and other healthcare professionals. The feedback from attendees was that the conference was a success though the venue was unpopular.

Under the 7th domain (public health) the Medical Director reported that she is highlighting public health issues with staff at consultation meetings, in particular the expected flu pandemic and the possible implications for the Service.

Driving Licence Policy The Trust Board was asked to approve the Driving Licence Policy. Sarah Waller raised a number of concerns e.g. are driving licences checked on appointment, if so the policy needs to state this. Are staff going to be informed when their licences are going to be checked and where information is going to be recorded? The Finance Director confirmed that the information is held on PROMIS which is the scheduling system used by the Trust.

Beryl Magrath was informed that team leaders are rostered one week in the office in order to undertaken their administrative duties such as audit of PRFs (approximately 30% of their time). The level of completion is currently poor and it is hoped that the new web based process will improve matters.

The Chairman of the Patients' Forum asked whether the number of defibrillators in public places in London is likely to increase. The Medical Director responded by saying that London currently has approximately 50% of the defibrillators placed in public places around the country. The deployment of defibrillators is based on the cardiac arrest database and the scheme is overseen by the Department of Health.

Approved: 1. The Driving Licence Policy with the amendments suggested by Sarah Waller.

Noted: 2. The Medical Director's report

115/05 Infection Control policy

The Infection Control policy was presented to the Trust Board for approval.

Beryl Magrath enquired whether all equipment in contact with patients were single-use and was informed that only those that have been in contact with bodily fluid. If equipment is not contaminated it is re-used.

Approved: The Infection Control Policy

116/05 Infection Control Annual Report

Chris Vale, the Acting Head of Operational Support, presented the Annual Infection Control report to the Trust Board. He outlined the work that has been undertaken in audit; education and communication; make ready; occupational health; products and facilities. Ambulances that are swabbed as part of the Make Ready scheme have shown some excellent results for low levels of infections; there has been no evidence of MRSA. The Infection Control Steering Group meets regularly and monitors the Infection Control risk register.

Beryl Magrath was informed that at the moment PTS vehicles are not part of the Make Ready scheme though that may change in the future. She was also informed that staff are responsible for cleaning their uniforms, if the uniforms are badly stained they can be sent out to be laundered but this is a rare occurrence. There are no plans to change this element of the Infections Control policy.

The Medical Director assured the Chairman of the Patients' Forum that although there is no way of knowing that a patient has an infectious ailment such as MRSA, hospital staff will inform the Service is there is a risk to crews and medical treatment is required.

The Chief Executive said that he was very pleased with the report and felt it showed how the LAS is one of the leading ambulance services in the country in terms of infection control.

Noted: The annual infection control report.

117/05 Agreement with Metropolitan Police

The Medical Director outlined the agreement which has been recently reached with the Metropolitan Police. It is a statement of intent and best practice with regard to the transfer of all patients and in particular addresses issues around those patients with mental health problems. It is hoped that the agreement will reinforce with staff that they are effectively advocates for patients who have mental health issues.

Noted: The agreement with Metropolitan Police with regard to the appropriate transportation of patients, Section 136 of the Mental Health Act and emergency treatment of patients without capacity who withhold consent.

118/05 Incident Reporting Procedure

The Trust Board was informed that paragraph 2.3 had been amended – the NHS Security Management Service requires the Police be informed of all incidents of physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort.

In response to a comment from Barry McDonald the Director of Information Management and Technology said that one of the Senior Management Team's objectives for 2005/06 is that five basic processes be made web-based. It is intended that over the next few years an increasing number of policies and processes will be web-based.

Approved: The Incident Reporting Procedure.

119/05 Serious Untoward Incident Policy

The Serious Untoward Incident policy was presented to the Board for approval. Following the recent NSHLA assessment the following appendices have been added to the policy: guidance, process, description of the role of family liaison officer and the National Patient Safety Authority's checklist 'being open' guidance.

A number of grammatical errors were identified and it was suggested that these be addressed prior to the policy's release.

Barry McDonald thought the Serious Untoward Incident policy very thorough but queried the process for deciding when an incident was considered to be a Serious Untoward Incident. The Chief Executive responded that a review of the Professional Standards Unit is to be undertaken which will address this issue as well as how complaints are managed by the Trust.

Agreed: The Serious Untoward Incident Policy

120/05 Records Management Policy

The Trust Board considered the policy and had no comments or questions. It was recognised that the policy will provide the Head of Records Management with a framework with which he can proceed.

Agreed: The Records Management Policy

121/05 Claims Policy and Procedure

The Trust Board was informed that the Claims policy and procedure had been updated to incorporate the feedback of the NHS Litigation Authority's Assessor. The guidance is required to state when external agencies are involved in the investigation process and not simply informed.

Sarah Waller asked for confirmation that the delegated authority to make special payments does not exceed the delegated authority previously agreed by the Trust Board. **ACTION: Trust Secretary**

Agreed: 1 The amended policy and procedure.
Noted: 2 The factual amendments to the policy and procedure.

122/05 CAD User Requirements

The Director of Information Management and Technology (IM&T) outlined the plan for CAD 2010. The report included 'CAD, the way forward', 'user requirements' and 'business options'. The CAD 2010 workshops conducted with end users have resulted in 1452 individual user requirements being collated.

The Board was informed that there is no CAD system in the current market place which would replace the LAS's CAD system without sacrificing important functionality that we have today. Work will be undertaken between now and July 2006 to produce a business case suitable for approach to the SHA. Further research will be done to try and identify suppliers in Europe or the United States that might be suitable for the LAS.

It was recognised that whichever strategy was chosen there would be inherent risks for the Trust. To mitigate the risk for the Trust the Director of IM&T suggested that a modular approach be adopted, whereby different elements of the system were purchased off the shelf and were interfaced. He also suggested that the new CAD system be introduced in stages.

The Board were reminded that London is in many ways unique because of the complexity, size and diversity of the population and the number of calls it receives every day.

The Board was assured that the lessons of CAD failure in 1992 have not been forgotten. There are a number of senior staff on the CAD 2010 Project Board who have been allocated specific 'lessons' from the Page report which followed the investigation into the 1992 CAD failure. These senior staff will use the recommendations of the Page report to monitor the project and ensure that lessons are applied and mistakes not repeated.

A Communications Strategy will be drafted to ensure that staff are kept informed of progress over the next few years. **ACTION: the Director of IM&T and Director of Communications.**

The Director of IM&T invited Board Members to contact him if they had any enquires about CAD 2010 or wished to meet with the project team.

Agreed:
1. **The project approach for the period December 2005 to July 2006**
2. **The user requirements, noting there is further work to do to refine them**
3. **That the project should proceed assuming that its scope will require SHA authority.**

Noted:

4. **The delivery of the project against the plan and the progress to date**
5. **The scale and complexity of project (being far greater than first envisaged)**

123/05 <u>Service Improvement Programme</u>

The Head of Programmes and Projects presented an update on the Service Improvement Programme; of the 283 projects 56 are currently live. With regard to the outcomes (patients/people/ performance) it was forecasted that by March 2006 19 will be green, 12 amber and 9 red.

He explained the circumstance for three of the outcomes being red.

30 The manual system of Vehicle off Road (VOR) reporting via CAC is not producing reliable information. An interim measure has been introduced to address the issue in the short term. A manual trawling of data by Logistics indicated that actual levels of vehicle related VOR was less than the target of 2%.

35 Category B activation are significantly below target of 95%, it is currently approximately 55%. Sector controllers have been focussing on Category A calls and performance is ambulance resource dependent. With the new despatch procedure in place Fast Response Units (FRUs) could be despatched to Category B calls. Arrangements are being made to re-incorporate FRU under the Sector desk.

36 The requirement that Doctors' calls are answered in 30 seconds is at risk, however the introduction of new procedures have started to show improvement. Achievement of the 95% target is expected to be achieved in July 2006.

In response to a concern voiced by Sarah Waller regarding Clinical Performance Indicators/information it was suggested that the Head of Research be invited to give

a presentation to the SDC in December. The Medical Director suggested that before implementing any other measures to address the issue the Trust should wait and measure the impact of the recently revised CPI process.

Noted: 1 **The update regarding the Service Improvement Programme.**
2 **That a presentation on the changes to the CPI database will be presented to the SDC in December 2005.**

124/05 Progress on Governance Review

Beryl Magrath reported that as part of the governance review the following work has been undertaken: views have been collated from Directors and senior members of staff, supporting paper from external bodies such as the Healthcare Commission have been examined, three other Trusts were visited (two foundation trusts and one three star ambulance service). The agendas and minutes of the Trust Board, its Committees and other groups (2003/04) were also reviewed.

A draft report will be presented to the SDC in December with a final report to the Trust Board in January 2006.

Noted: The report

125/05 Report from the Trust Board Secretary – tenders opened since the previous board meeting.

Register no.	Details of tender:	Tenders Received From
16/05	The provision and supply maintenance of photocopiers	Canon UK Imagistics NRG Group Danwood Group Xerox
17/05	Extension works at Hayes AS	Axis Europe plc Griffiths Construction Diamon Build Ltd Neilcott Special Works Mitie Property Services
18/05	Provision of CRAMM Risk Assessment	Mott McDonald (Vega) Insight Consulting Tribal Yale

Noted: The report

126/05 Draft Minutes of the Service Development Committee

The Finance Director informed the Board that a report, which he has discussed with Barry McDonald, regarding overtime will be presented to the SDC in December.

Sarah Waller asked that a report which outlined a list of key roles and bandings/pay under Agenda for Change be presented to the SDC in December.

Noted: The draft minutes of the Service Development Committee – 25th October 2005.

127/05 Draft Minutes of the Clinical Governance Committee

The Chair of the Clinical Governance Committee referred the Trust Board to the covering paper which highlighted the discussion at the Clinical Governance Committee meeting on 31st October. In particular she referred to the 68% of staff who are currently attending training courses – the Head of Training and Development has been asked to investigate why 32% of staff fail to attend and a report presented at the next Clinical Governance committee meeting in January 2006.

Noted: The draft minutes of the Clinical Governance Committee – 31st October 2005.

128/05 Any Other Business

The Chairman of the Patients' Forum informed the Board that representatives of the Forum met with representatives of the Central London Mosque, who expressed interest in learning resuscitation techniques and offered the use of the Mosque's website for placing recruitment advertisements. Work is also being undertaken with Asthma UK, a survey of asthmas sufferers is being undertaken and their views sought about the LAS and Primary Care Trusts. He welcome the action being taken by the Department of Health to ensure that the LAS livery is not used by private ambulance organisations.

129/05 Opportunity for Members of the Public to ask Questions

Colin Hill asked whether there the Trust will be entering into a similar agreement with the City of London Police as it had with the Metropolitan Police. The Medical Director said that this had not been considered necessary given that relatively few people live in the City but it would be considered. **ACTION: the Medical Director.**

130/05 Date and Venue of the next Trust Board Meeting

Tuesday, 31st January 2006 in the Conference Room, LAS Headquarters, 220 Waterloo Road, London, commencing at 10.00 am.

The meeting concluded at 12.30pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 29th November 2005

Held in the Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1

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

On the 29th November 2005 in Part II the Trust Board briefly discussed:

- Potentially commercially sensitive information regarding CAD 2010,
- Patient Forum representation on the Audit and Risk Management Groups (it was agreed that this would be deferred until the completion of the Governance Review currently being undertaken)
- the possible implications for the Trust of a Coroner's inquest scheduled to be held January 2006.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 31 JANUARY 2006

CHIEF EXECUTIVE'S REPORT

1. ACCIDENT & EMERGENCY SERVICE

1.1 999 Response Performance

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

	CAT A 8	CAT A 14	CAT B 14	Urgent within 15 mins of STA
Standard	75%	95%	95%	95%
YTD*	73.4%	94.4%	74.2%	52.1%
04/05 year	76.6%	95.9%	79.7%	58.1%
03/04 year	76%	89.3%	77.6%	50%

*As of 23rd January 2006

Key highlights

i. Final performance for October was 72.7% and November 72.9.%

ii. We continue to input data for December which was particularly challenging in terms of resource availability. Final performance for December is likely to be circa 72% once all the data is complete.

iii. The year to date position at time of writing is at 73.4% but given that we are currently some four weeks behind with data entry the true figure is likely to be circa 73.7%

iv. Emergency responses rose by +3.3% in October and + 4.0% in November. December saw a small reduction in workload compared to last year at -1.2% .The year to date figure (Apr- Dec) is +3.6 % compared with the same period last year.

v. The Christmas period was the most challenging as had been predicted and resourcing across the Holiday weekend was poor despite some very attractive enhanced pay packages being made available to staff. It is clear that a combination of AfC back pay and vacancies combined to make it very difficult to encourage the high levels of overtime working that were required.

vi. I am pleased to report that the first three weeks of January have shown considerable recovery and the month to date is running at circa 76.5% once all of the data has been entered. This includes several days which will finally reach 80% or better.

vii. Recovery plans as outlined in the previous Trust Board report continue to be progressed and this report contains an update on these initiatives and on the remaining areas which will add further improvements during the coming nine weeks.

viii Real time performance management continues to be achieved through the 'GOLD' suite and the hours of this unit have been extended to provide a 24/7 operation.

ix PCT performance remains challenging and we have now completed recovery plans for the lowest six areas which are under 70% year to date and shared these with local commissioners.

x We continue to be focussed principally on CAT A performance recovery and detailed discussions with SWLHA continue in order to share our recovery plans and keep them informed as to progress.

1.2 Operational Impact of Agenda for Change

The operational impact of AfC which was discussed at length in the last Trust Board report are beginning to show signs of abating. There are still some staff morale issues but feedback within consultation meetings indicates that these are beginning to recede.

There will be some additional back pay issues as Technicians receive some arrears payments in January. These payments are not of the same magnitude as the paramedic payments made in December and it is hoped that they will have a less pronounced affect on the willingness to work overtime.

1.3 Resourcing

Resourcing remains our biggest challenge in terms of maintaining staffing levels at a sufficient level to achieve performance at or above 75%.The reasons for this were outlined in detail within the last Trust Board report and essentially remain the same.

Ambulance hours produced rose from 4024 per day in October to 4221per day in November but fell back markedly in December as overtime working dropped and ended at an average of 4000 hrs per day. FRU staffing held up better and remained at circa 1300 hrs per day throughout November and December.

As predicted resourcing in December was especially difficult across the Xmas weekend and on Christmas Day and Boxing Day overall resourcing was at circa 73% leading to significant performance difficulties particularly on nights.

Traditionally our overtime budgets are seasonally profiled to make sure that the greatest number of hours are available for use in December. However, over recent years there has been a marked reluctance by staff to work overtime during December and this trend continued this year with a steady decline in overtime working as the month progressed. Obviously this situation was worsened by the fact that many staff had received or were due to receive

arrears payments in respect of Agenda for Change, which again reduced the appetite for overtime earnings.

Whilst there are plans in place to recruit more staff to reach full establishment, the lead time involved in recruitment means that we continue to struggle with high vacancies. Some 47 additional staff will be posted to operations prior to end March and then from April onwards new staff become available in larger numbers and we are predicting full establishment by circa end October 06.

Overall sickness rates for the year are broadly on target , however, December saw a high incidence of short term absence. Compared to the average weekly number for the first quarter of the year, during December the number of staff reporting sick each day was between 50% to 75% higher. Clearly these absences of between 2 – 4 days duration are extremely disruptive and difficult to cover at short notice. Sickness in January has continued to be high at circa 8% and Area management teams are now very focussed on addressing these increases by robust local management

In order to manage resourcing within the context of overall performance management the Trust has introduced a revised 'Capacity Plan'. This Resource Escalatory Action Plan (REAP) plan is designed to be constantly in play and allows the service to declare one of five REAP levels from level 1 Routine through level 3 Severe Pressure to level 5 Potential Service failure.

An assessment is made weekly by the Director of Operations against a broad set of criteria as to which level currently applies and then a number of set actions follows in order to recover the position. These levels and the associated actions are now published throughout the Trust and will allow us to react in a more structured way to both 'Rising Tide' type problems and sudden events which then affect performance.

With the activation of the Resource Escalatory Action Plan (REAP plan) in December the service has been operating at Level 3 Severe Pressure and the relevant associated actions have been implemented. This has resulted in an improvement in overall staffing during January to an average of 4236 Ambulance hrs per day and 1323 FRU hrs per day.

1.4 Performance Recovery

As reported at the last Board we are very aware that with some 9 weeks of the year remaining we still have a significant challenge to reach our key performance targets.

Modelling has shown that we need to reach an average of circa 80% for the remainder of the year to achieve the 75% target for the 2005/6 financial year.

I have detailed below in summary form progress against the actions described in detail to the Board at its meeting on 29th November:

- The internal recruitment programme is on track and we expect full establishment by end October 2006.
- New staff are now beginning to be placed on the new weekend relief roster.
- External recruitment of qualified staff is ongoing but to date the number of applicants has been disappointing.
- We continue to maximise the use of Bank Staff
- Enhanced overtime at weekends has now been extended until the end of March subject to being able to maintain the funding.
- Non Essential training has been deferred until the new financial year.
- All non essential staff abstractions have been stopped and those staff returned to operational duties.
- We continue to utilise Team Leaders to staff vehicles for 100% of their working hours.
- Training managers and operational managers continue to be used to staff vehicles as much as possible.
- Improved Call taking procedures continue to produce improvements in activation times for ambulances.
- The Urgent Operations Centre continues to enhance its ability to deal with Green workload by maximising the use of CTA and PTS to support the A&E core fleet.
- We continue to actively deploy vehicles from standby points.
- We continue to improve the utilisation of ECPs .
- The Gold performance management suite has extended its hours of operation to 24/7.

There are a number of additional initiatives which will be introduced over the next few weeks to improve performance still further:

- We are still actively working on revising our control room processes to reduce the number of times that multiple responses are sent to the same call. The technical issues associated with this change are considerable and we now understand that a package of software changes to achieve this will be available for introduction on the 28th February.These changes will allow us to operate all resources from the current Sector Desks so allowing more balanced judgements to be made about the most appropriate resource to send to each call.

  We are still determining how best to utilise these enhancements given that their introduction is now going to be very late in the financial year. There will be an operational judgement to make about how best to balance the risks of disruption due to new working practices against potential performance gain and the A&E Senior Team are considering this issue at the present time.

- We are beginning to target a small number of complexes that exhibit high workload and poor performance. Specific recovery plans for these

complexes are being developed and will principally involve providing additional FRU and Ambulance resources to improve these areas by circa 5% from their current base. This will be difficult to achieve as staffing any new vehicles remains a challenge given in post figures and sickness levels. Nevertheless we are convinced that this can be done by adopting some innovative approaches and by staffing these new units from across the service as a whole rather than from the challenged complexes themselves. The new FRUs arriving during January will be used to provide additional vehicles for these complexes.

- We will continue to refine the operation of the GOLD suite in terms of overall performance management . In particular we will develop plans which allow a better real time assessment of hour by hour performance against that which needs to be delivered to achieve an overall full days performance of over 80%. This should allow more proactive steps to be taken when performance is at variance with that expected in each hourly slot.

- We are now compiling a further list of initiatives which may have to be considered in March should we find that performance has not recovered sufficiently.

1.5 Emergency Operations Centre

Recruitment to positions in EOC is on track with the next two courses full. A new advertising campaign will be launched in early February aimed at attracting new staff for 2006/7, to reflect the diverse population we serve.

Work continues on the re-structure documentation. It is envisaged that the process will start late spring 2006. Senior managers in Control Services are aware of the re-structure, and there are development workshops continuing to best prepare the managers for the re-structure process.

The changes to the call taking procedures described in the last report continue to have a beneficial effect on both call answering times and activation times. Call answering times for 999 calls have risen to 85% in 5 secs during January with some individual days at 95%. Call answering times for Urgent calls have also improved to 77% in 30 seconds. There is still much more to be done but these results are encouraging.

New Years Eve presented a significant challenge this year due to a technical failure in the setting up of the back up control at Bow. Our planning for several years has allowed for both the main control room and the back up control room to be used in tandem enabling us to increase significantly the numbers of call taking positions available to us. During the setup process this year problems became apparent and a decision was finally taken by GOLD before midnight to close the Bow control room and run the entire operation from HQ. Whilst this presented a significant operational challenge the service coped well and no major difficulties were experienced.

A number of de-briefs are underway to understand what went wrong with the setup process and lessons learnt will be factored into planning for 2006.

On the 19th of January, Lawrence Dallaglio, opened the new Incident Control Room (formally Gold Control). The ceremony was hosted by the Chairman and the event was attended by staff who were working in EOC during the bombings on the 7th July. Representatives from Heath, St John Ambulance and the London Fire Brigade were also in attendance. After a tour of the new facility, Mr Dallaglio spent time talking to staff and guests, before a visit to the EOC. He was very gracious in his comments and was very impressed by all the EOC staff he met and thanked them for their dedication and professionalism.

1.5 Urgent Care Service

The Urgent Operations Centre was opened on track at the end of November and has been working well . We are already seeing some benefits as a result of the co-location of various staff group and as relationships develop over the coming weeks we are confident that this will continue.

As reported to the Board in November there are a number of EMT1 vacancies at present and it has still been proving difficult to recruit to these posts. The re-design of the EMT 1 role continues and will report early in February.

It is likely that we will then develop a level of training which is more aligned with an enhanced PTS role rather than an EMT1 role. It will be part of the more general review of the overall Urgent Care workforce and once complete will allow us to develop a more focussed recruitment campaign for Urgent Care staff.

We have also taken some 20 PTS staff from the Chase Farm area into Urgent Care following loss of a local PTS contract and these staff will become solely dedicated to Urgent Care workload from the 6th February. In addition we are working with PTS to potentially absorb further PTS staff from 'at risk' contracts over the coming months.

CTA staff numbers increased as planned to 30 in December and staff are now utilising the new CTA software package to good effect. In the first four weeks of using the new software the number of calls dealt with has risen to over 4000 which compares to an average of 2000 a month on the old TAS system. The non send rate for CTA calls is still at 50% and some 2000 responses were therefore saved in the period 16th December 05 to 16th January 06.

We continue to explore options for adding further GP support to Urgent care and talks are ongoing with various GP Co-ops .

The ECP programme continues to progress and 4 further PCTs areas will be live by the end of January. We are also looking to begin training a further 15 ECPs before the end of the financial year.

1.6 Emergency Planning

The Emergency Planning Unit (EPU) continues to work with our partners in Health and the London Resilience Team to ensure that once a Pan-London FLU plan has been developed and agreed the LAS's plan is fully integrated with this piece of work..

Major Incident training at various levels is continuing and the EPU delivered a Gold Level training package in January for the recently appointed ADOs.

New Years Eve 2005 presented challenges this year due to a technical failure described in detail in 1.4 above. Lessons learned from the NYE Debrief will be factored into the planning for 2006.

Following the events of 7 July '05, five debrief sessions were held, to create a 'knowledge file' of the events, from the perspective of those involved. Following this process, two documents were produced:

- Summary of Lessons Identified – Areas of Best Practice
- Summary of Lessons Identified – Areas for Improvement

The 'Areas for Improvement' document is the subject of an action plan, broken down into Red, Amber and Green actions. Red actions are reviewed monthly, Amber are reviewed quarterly and Green, annually.
One 'quarter' has elapsed since the report was completed (7 September '05).

In total, some 99 Areas for Improvement were identified. These have been developed into 207 'actions required'. A steering group has been established to move forward the actions.

For the first quarter, the primary focus has been on addressing the Areas for Improvement rated as 'Red'. There were 29 Red items, which have developed into 33 actions. Ten actions have been fully completed, a further nine are underway. Four 'Amber' actions have also been completed.

Significant items have been addressed first, including: a rebuild of the Incident Control Room; a reconfiguration of the Gold Command Suite; issuing pagers to managers and the acceleration of the new digital radio system to bring LAS forward in terms of the implementation timetable.

Whilst the 'Areas for Improvement' document is the focus of activity at present a communications strategy is being devised to also share the best practice that was apparent on the day.

2. Patient Transport Service

2.1 PTS Trajectory Management

Focus for the last two months has been largely on the provision of training and development for all the control staff with courses held in November and December to help maintain focus and momentum. We have two final courses to be run in January for our Cluster Planners, Central Services Co-ordinators and Site Mangers.

Work continues to be undertaken by PTS operational managers to work more closely with commissioning trusts in an effort to improve arrival, departure and time on vehicle performance. Initiatives such as, flexible appointment times, appointment staggering and defined drop off and ready times should provide improved performance in the coming months.

Summary of Impact August to November

Month	August	September	October	November
Arrival Time	**74.6**	**78.2**	**80.7**	**82.5**
Departure	**85.1**	**85.4**	**85.3**	**88.5**
Productivity	**11.3**	**11.6**	**11.6**	**11.8**
Updation	**92.0**	**89.9**	**95.0**	**94.0**

- Arrival time increase by 7.9% (74.6% to 82.5%)
- Departure time increased by 3.4% (85.1% to 88.5%)
- Productivity (average person) increased by 0.5% (11.3 to 11.8)
- Updating increased by 2.0% (92% to 94.0%)

2.2 PTS Hospital arrival time

Overall performance has **improved** from 74.6 to **82.5%.**

2.3 PTS Hospital Departure time

Overall performance has **improved** from 85% to **88.5%.**

2.4 Patient time on PTS vehicle

Performance in this measure has been maintained at an average of **93%** per month compliance, which is the eighth **consecutive month to hold above 91%.**

2.5 Operations

Implementation of the new AfC 37.5 hour Rotas started in December 2005. This has given us the opportunity to consult with staff and review all contract rotas and introduce staggered rota patterns to match individual contract daily activities to assist in the control and use of overtime.

Central Services control staff successfully moved from Greenwich to the new Urgent Care Control in Waterloo in November with almost immediate benefits with closer integration working leading to significant increase in the number of A&E referrals.

Working closely with the Gold suite on the REAP plan we have been able to support a number of initiatives during December and January offering 3 x Blue Light vehicles and staff providing day cover with a paramedic on each vehicle.

The most notable of these initiatives being the ambulance working in the West End footprint, on Thursday, Friday and Saturday nights through the build up to Christmas and on into New Year, taking intoxicated patients to hospital instead of using front line ambulances. The work of this vehicle was extensively reported by the media over this period.

We have also provided, a Blue Light ambulance manned with one AP to work in the Central London Footprint transporting a DSO and supplies on Thursday, Friday and Saturday nights to improve turnaround at hospital sites and incident scenes.

We also supported the New Years Eve Operation providing five Blue Light PTS ambulances manned by double crews who carried 40 patients of which 34 would have been normally been carried by a front line vehicle. This was run from the new Urgent Care Control Room.

We are currently short listing for the Site Manager post for Kingston and Wandsworth PCT

Sickness was 5.2% YTD (April to November) Sickness for the month of November was up at 5.86%.

2.6 Contracts Update

2.6.1 Queen Elizabeth/Queen Mary Sidcup

There is no more progress on the arbitration issue. We have met with the trust on 3 occasions, with a view to extending the contract for 2 years. The stumbling block remains the marginal invoice charges we apply to the contract and if these issues can be resolved they have indicated that they would be prepared to extend the contract for two years.

2.6.2 Chase Farm Hospital

The contract ended on 31 October 2005 with staff transferring to Urgent Care. We continue to deliver a service to BEH Mental Health Trust which will run till February 2006

2.6.2 BEH

It is still proving difficult to gain any firm commitment from the trust as to their intentions regarding the contract which is due to end on February 28th. There is also an outstanding issue regarding payment for excess activity which is being pursued by Mike Dinan directly with their FD.

2.6.3 Charing Cross & Hammersmith

We have presented a number of late arrival final invoices to the Trust and we continue to work with them to agree and resolve the final financial position.

2.6.4 Hillingdon & Mount Vernon

Hillingdon Hospital has agreed to sign a Service Level Agreement for 2006-07 giving us an extension for a further year. The Trust has also advised that they would like to extend for a further three years but with a different patient activity profile. They will provide details later in year for us to submit a revised costing.

2.6.5. Stanmore

RNO have signed the new Service Level Agreement until mid 2007. The new LAS bus shuttle service started at the beginning of November and we continue to work closely with the Trust on timetables and hours of operation.

2.6.6 Chelsea & Westminster

The current SLA ended at the end of December and we have been in negotiations with the Trust to agree a new SLA to extend for a further six months or for two years. Offers have been presented and we are awaiting the Trusts decision. The Trust is looking to go out to tender in 2006, so the likely outcome may be an extension of six months.

2.6.7 Whipps Cross

Whipps Cross has requested a "**Feasibility Study"** to be undertaken to assess their transport requirements. They have asked the LAS to assist them in looking at a "One Stop Shop" approach to cover all their transport needs. This includes specimen, internal, in house, courier, inter hospital transfers and out of hours cover. This is an excellent opportunity and could be in the region of a £2m contract.
They have asked for the **"Active Demand Management"** to be lifted and have agreed to a contract to the tune of £830k. This price will run to the end of the financial year and will roll over until the feasibility study has been completed. The view then will be to award the contract to LAS, without going to tender.
However all outstanding debts are still liable and await arbitration decision.

2.6.8 Oxleas

Notice was given and contract ends 31st March 2006. We will then support the contract through Central Services as a more cost effective method.

2.6.8 UCLH

UCLH have advised that they will be market testing in 2007 following their move into new hospital building. Presentations have been given by LAS in December on our service and we are in negotiations re increased activity in support of their aim to reduce their number of transport providers. We have developed a good and close working relationship with this trust.

2.7 Tenders & New Business

2.7.1 Wandsworth PCT

A proposal has been submitted for the internal mail services. Tender process is currently in the evaluation stage and a decision should follow shortly.

2.7.2 Lewisham University Hospital

We were not short listed for the second stage of the tender process and are still seeking clarification as to why this. We believe a part award was made to Thames Ambulances.

2.7.3 St Georges NHS Trust

A proposal has been submitted, the tender process is currently in the valuation stage and a decision should follow shortly. We understand that GSL have done a presentation to the Trust and appear to be the favourite to win tender.

2.7.4 Bromley Hospitals

We have just been advised that we have been successful in regaining the Bromley PTS contract . This represents £1.8m of new business.

2.7.5 Expressions of Interest have been submitted for the following upcoming tenders

Royal Free Hospital
Kingston Hospital
North West London Hospitals
North Wick Park OOH
Tower Hamlets

3. Complaints update – January 2006

Comparison of complaints received between April and December, 2004/2005

	All Complaints		**Written Complaints**	
	01/04/05 to 31/1205	**01/04/04 to 31/12/04**	**01/04/05 to 31/12/05**	**01/04/04 to 31/12/04**
East Sector	101	108	42	49
West Sector	103	84	42	38
South Sector	20	0	11	0
Emergency Operations Centre (EOC)	122	103	71	60
Patient Transport Service (PTS)	32	24	23	19
Unknown	0	0	0	0
Not Our Service (NOS)	20	8	1	0
Non-Operational (NOP)	2	4	1	3
Total	400	331	191	169

The Trust received 400 complaints between 1 April and 31 December 2005, an increase of 69 on the previous year. However, there was an increase of 12 complaints that were categorised as 'not our service'. 361 complaints have now been closed, 8

complaints led to recommendations of disciplinary process and 353 are being dealt with under local resolution. The main cause of complaint remains concerns regarding attitude and behaviour. This category, at present, represents 44% of total complaints received.

Whilst there has been an overall increase in complaints the only category which has shown an actual increase regarding total complaints received is that of 'non-conveyance' of patients. This has increased from being the main subject of 9% of complaints last year to 11% of this year.

There were no requests for Independent Review on cases received in the year ending March 05, however since April 05 the Healthcare Commission have requested paperwork for 10 cases following requests for Independent Review though to date no reviews have been undertaken by the Healthcare Commission. Two cases were closed by the Healthcare Commission as already having a complete investigation and we have recently received recommendations from one other case which are being undertaken at present.

The service is currently delivering 66% of written complaints resolved within 20 days (against a target of 80%). It is recognised that there is a need to improve complaint handling and the lessons we learn from complaints and to assist in achieving this we are:

- Reviewing the structure and role of PSU
- Implementing a Managers' 'prompt sheet' to assist sector investigating staff in achieving a timely and methodical investigation.
- Implementing a revised Serious Untoward Incident Procedure (TP/006)
- Having a Complaints Panel meet regularly. This was set up in accordance with Complaints Procedure (TP/004).
- Reviewing the Complaints Procedure (TP/004) following review of PSU
- Reviewing the training delivered to Duty Station Officers and Senior Officers
- A review of the outcome report form for complaints to ensure recommendations are actioned and lessons learnt

4. COMMUNICATIONS

Patient and Public Involvement (PPI)

PPI Manager Margaret Vander and Events, Schools and Media Resources Manager Richard Walker are leading a piece of work on the future of LAS public education activity. Thirty LAS staff who are currently involved in public education attended a workshop recently, to discuss how this activity should be developed for the future. The information collected will be used to produce recommendations and an action plan. This is likely to include ensuring that we make best use of our resources, and that those participating in public education activities give consistent messages which are in line with the organisation's strategy and goals.

The PPI database now lists more than 90 Service activities or pieces of work involving patients. These range from Patients' Forum members being on LAS

committees to LAS staff participation in multi-agency training events for children and young people.

At December's PPI Committee there was a discussion about access to the LAS for deaf people. Currently, unless they have TypeTalk equipment and are at home, profoundly deaf people cannot call 999 for an ambulance and communicate with the call-handler. Most deaf people communicate by text, but have been told that it is not possible to use SMS technology in an emergency because of potential delays in their messages being received. The Committee agreed to explore technological solutions to this problem, as well as liaising with the Royal National Institute for Deaf People (RNID) and other organisations.

People within the deaf community have also expressed interest in the use of Visual Translator Cards to help them communicate with ambulance crews. This is being explored jointly between the LAS, the Patients' Forum and RNID.

Patients' Forum members welcome input from LAS managers at their monthly meetings. Director of Operations Martin Flaherty attended in October to give a presentation and answer questions about the July bombings. In November Head of Education and Development Bill O'Neill and Diversity Manager Paul Carswell attended to talk about diversity - both in terms of staff recruitment and educational input. Operational Support Services Manager Gadge Nijjar attended in January to talk about the Make Ready Scheme.

A recent example of some joint work between the LAS and the Patients' Forum has been a survey, sent to people in the Camden area who are known to Asthma UK. The purpose of the survey was to find out if they had ever used the ambulance service and, if so, whether they had any comments about their experience. Although there was only a 10% response rate, all comments made about the ambulance service were very positive. A small number of people said they would be prepared to respond to a more detailed survey. A series of face-to-face interviews is now being planned, to find out more in-depth information about people's experience of the ambulance service, about their asthma, and about the other services they use.

If this exercise is found to be useful, it may lead to similar surveys being carried out in other areas of London, perhaps in areas of high ambulance service demand. It is possible that, where there is high usage of the ambulance service for people with asthma, this might indicate gaps in other (preventative or monitoring) services in the community. Finding out more about this group of patients and the services they use may also be helpful when developing the LAS chronic conditions strategy.

Communications

Service pressures: During December, a communications programme was initiated to help alleviate pressures placed on the Service by increasing demand and resourcing problems. This work supports the Service’s revised Capacity Plan, and the need to maintain levels of patient care and recover performance during the winter period.

From an internal perspective, all staff have been made aware of the current pressures and frontline staff have been encouraged to work additional overtime shifts, respond

more quickly and try to reduce turnaround times at hospital. The Chief Executive shared these messages in a short video, published on the Service's intranet, which was viewed by over 2,000 staff. He also sent a personal letter to all frontline staff about Service pressures, and this has been supported through a number of operational bulletins.

Externally, the Communications Department focused on raising awareness of a range of issues that have placed pressure on the Service, through a sustained media campaign. Extensive media coverage has been achieved regarding the impact of alcohol-related calls, increased demand during the festive season and pressures placed on the Service during cold weather.

In late November when the new licensing laws came in, filming with the BBC and Tonight with Trevor McDonald highlighted the demand that alcohol-related calls put on the Service. This was supported by articles in a number of national newspapers. Then, ahead of the traditional office party night (the last Friday before Christmas), the message to revellers to use the ambulance service wisely was widely conveyed through broadcast and print media. It is estimated that interviews with London Today, LBC radio and BBC London reached over 7.5 million viewers/listeners.

Further regional and national coverage on alcohol-related issues was secured with the story that the Service was introducing a new response to alcohol-related calls in central London, dubbed by the media as the 'booze bus'. Coverage on BBC Breakfast News alone, which explained the reasons behind the initiative and also reiterated that the ambulance service's priority is to attend life-threatening and vulnerable patients, reached an estimated 9.53 million viewers. Viewing/readership and listening figures for additional coverage in national/regional papers (e.g. Daily Telegraph, Daily Mail, Evening Standard), radio (Radio 5 Live, BBC London, LBC) and local television (London Tonight) is estimated to be an additional 16 million people.

During the Christmas period, media liaison was undertaken to pre-empt a spell of cold weather, and people were advised how to keep warm and well and how they should use their ambulance service. Coverage was secured on LBC radio, London Tonight, BBC London radio and in the Evening Standard, enabling the Service's messages to reach over three million Londoners.

New Year's Eve once again proved to be the Service's busiest night of the year, and work with the media enabled key messages to be conveyed before and after the event. In the run-up, as well as explaining that this would be the busiest night of the year, national and local media (a reach of 10 million) detailed how cold weather and the anticipated tube strike would put additional pressure on the Service. Post event, coverage from a "ride-out" by Sky News triggered widespread media interest with the focus being on the high number of stabbings attended by crews on New Year's Eve. As well as the extent of the demand placed on the Service that night, media reported the Service's horror that there was such a high level of violence on what was an evening of celebration for most people, and that most calls received were alcohol-related. Audience figures for this coverage were an estimated 18 million.

Communication support will continue to be given to pressure issues as the Service strives to protect patient care and improve performance levels over coming months.

Chief Executive's charities: The Communications Department worked with the Chief Executive's three charities to produce this year's Christmas card. Children from the three hospices were invited to design a Christmas card for the Service, with the winning entry being submitted by three-year-old Ashantia who attends Richard House Children's Hospice based in the Docklands. The card, featuring Santa with his ambulance sleigh, was sent to 2,000 partner organisations and suppliers.

As the London Marathon approaches, twenty staff who have secured places through the Service have agreed to run for the three children's hospices, and have been encouraged to seek sponsorship for their efforts.

New Year Honours: The news that the Chief Executive received his CBE from the Queen in December and six members of staff were recognised in the New Year Honours' list received widespread media interest.

In recognition of their roles during the tragic events of 7 July, Paramedic William Kilminster, Acting Duty Station Officer Peter Swan, Contract Operations Manager Roy Webb, Paramedic and UNISON trade union representative Jim Underdown were awarded MBEs, and Director of Operations, Martin Flaherty, was awarded an OBE. Awards Manager Trevor Vaughan received an MBE for his 42 years of service with both the LAS and the Metropolitan Police special constabulary.

Coverage of individual's achievements has been achieved in national, regional and local media.

In connection with 7 July, staff attended a special 'thank you' event at City Hall in December which honoured staff from the emergency and transport services for their heroic actions on the day. Chief Executive Peter Bradley, Islington Paramedic Stacy Rixon and her husband Medical Technician Paul Rixon accepted a plaque from the Mayor of London on behalf of the Service.

Other media issues: The sentencing in January of a former member of staff, Nicholas Colclough, for making and possessing indecent photographs of children received some local media attention. A statement issued confirmed that Colclough was dismissed from the Service for gross misconduct in July 2005 following an internal disciplinary investigation.

Interest from the media, including The Times, was triggered following the arrest of a doctor this month on suspicion of manslaughter. The Service confirmed that following a call to a 78-year-old woman in Enfield in December, it had raised concerns about the treatment of the patient prior to the crew's arrival. Crews treated the patient, who was experiencing breathing difficulties, and made efforts to resuscitate her both at the scene and on the way to hospital.

Communication support is being provided to the ongoing inquest into the death of 28-year-old Andrew Jordan from Erith who died in police custody on 7 October 2003. A strategy has been developed for managing internal and external communication following the outcome of the inquest.

Chief Executive consultation meetings

The latest series of Chief Executive consultation meetings ended on January 25 although extra events may be organised for those emergency operations centre (EOC) and urgent operations centre (UOC) staff who were unable to attend any of their three events.

Over 1500 staff and managers attended the 37 meetings and a wide variety of issues were raised and discussed.

As stated in a previous report to the Trust Board, strong views were expressed but always in a professional and courteous manner. It is clear that these events are important and valuable opportunities for staff in all areas of the Service to have direct, open and honest dialogue with the Chief Executive and Medical Director.

Concerns were expressed about the Agenda for Change implementation process; increases in workload; call categorisation; staffing levels; use of the 999 service by the public, other NHS professionals and the police; availability of training and opportunities for career development.

All views are being collated and a plan comprising actions to be taken on many of these issues will be prepared and implemented.

5. HUMAN RESOURCES

5.1 Agenda for Change

Despite the challenges that have impacted on the entire Ambulance sector's AfC assimilation performance, LAS is now well-placed to ensure that all its employed staff are assimilated onto AfC terms and pay not later than March 2006. Emergency Medical Despatch (EMD) staff, because of the nature of their existing employment contracts, will be offered a staged option of transferring to AfC terms. As a result of this option, there may be a small ongoing stream of AfC assimilations running forward into 2006/07.

The Trust's current position is:

- 3711 posts (98.4% band matched)
- 2919 staff (77.4% of employed staff) assimilated to AfC terms and pay
- 3133 KSF outlines (covering 83.0% of employed staff) now prepared and agreed

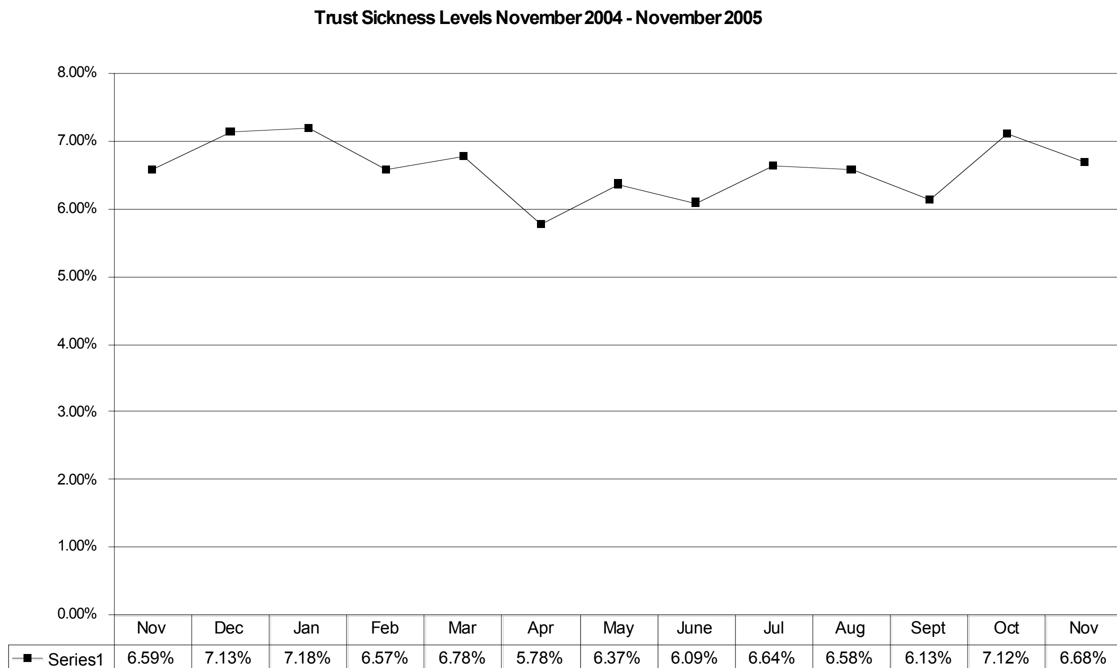
A number of staff have appealed their bandings. These currently cover 18 job variants. A further 2 vacant posts were subject to banding appeals by their sponsoring manager and all the EMD grades are subject to a collective appeal submitted by Staffside. Anecdotally, we understand that the level of appeals is considerably below the average for a Trust of this size.

By end-January 2006, the Trust will have paid all arrears (save for a credit due to some staff in compensation for the reduction in working week) to all staff

assimilated before 31st December 2005. LAS is well placed, therefore, to meet the DH target of paying all identifiable arrears before 31st March 2006.

5.2 Attendance Management

The sickness levels for the year up to November 2005 are shown below. Whilst overall sickness has reduced in the month of November in relation to that in October, it is slightly above that experienced in November 2004 - demonstrating the need to maintain management focus.



November 2005 Absence	
Staff Group	**%**
A & E	7.61%
CAC (Watch Staff)	7.34%
PTS	5.86%
A & C	3.24%
SMP	2.38%
Fleet	8.96%
Total (Trust)	**6.68%**

5.3 Workforce Information

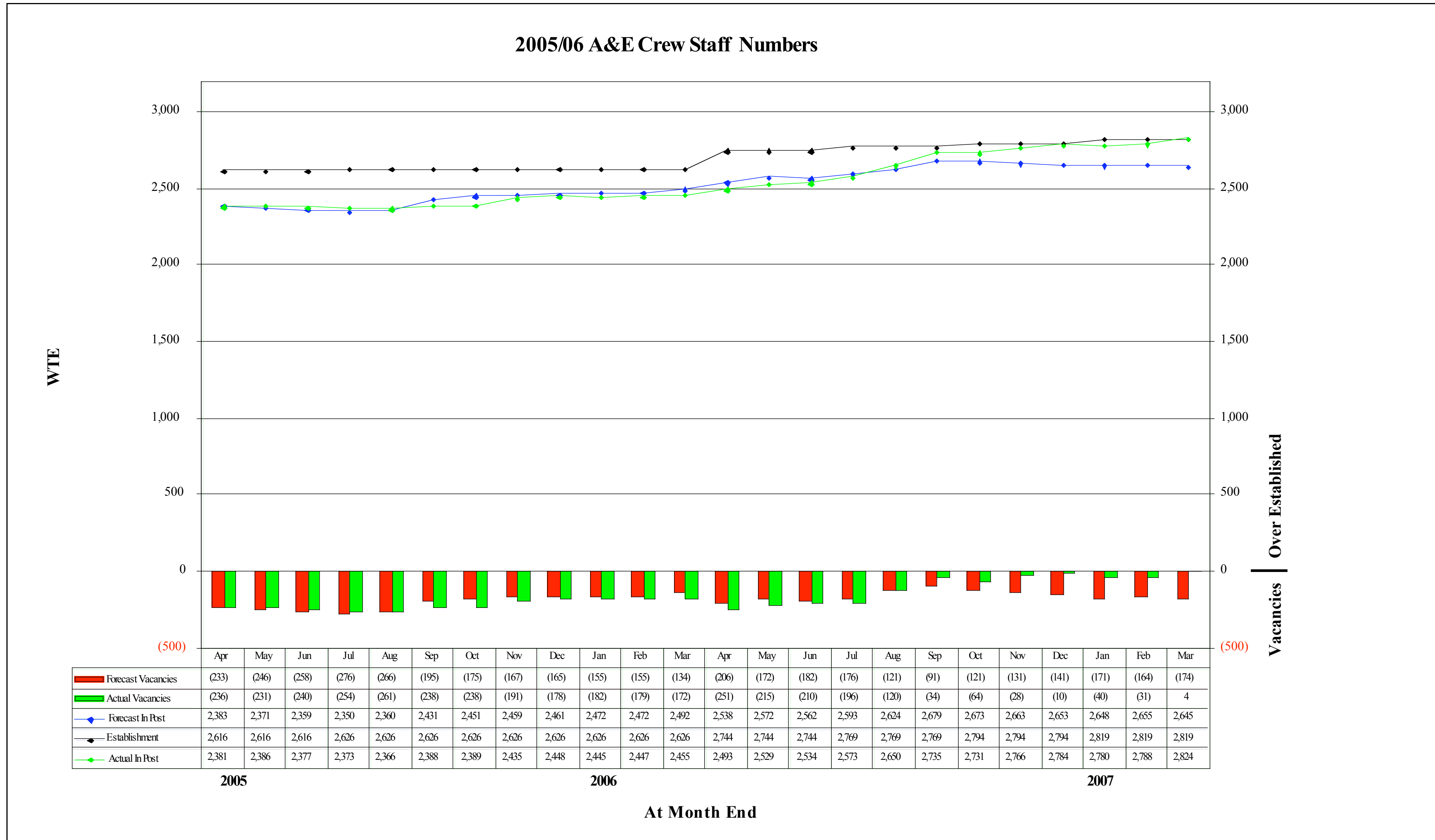
(i) A&E Staff Numbers – Progress against Trajectory for 2005/2006 by Month

Table 1 shows progress against the trajectory for staff in-post as at November 2005. Actual staff in post is slightly below the forecast for November though concerted recruitment activity has been good with high numbers being recruited into training school from the end of October resulting in an increase of 94 operational staff on duty by May 2006 with continued sustained increase thereafter.

(ii) CAC Staff Numbers – Progress against Trajectory for 2005/2006 by Month

Table 2 shows progress against the trajectory for staff in-post against agreed establishment as being on target.

Table 1



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(233)	(246)	(258)	(276)	(266)	(195)	(175)	(167)	(165)	(155)	(155)	(134)
Actual Vacancies	(236)	(231)	(240)	(254)	(261)	(238)	(238)	(191)	(178)	(182)	(179)	(172)
Forecast In Post	2,383	2,371	2,359	2,350	2,360	2,431	2,451	2,459	2,461	2,472	2,472	2,492
Establishment	2,616	2,616	2,616	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626
Actual In Post	2,381	2,386	2,377	2,373	2,366	2,388	2,389	2,435	2,448	2,445	2,447	2,455

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(206)	(172)	(182)	(176)	(121)	(91)	(121)	(131)	(141)	(171)	(164)	(174)
Actual Vacancies	(251)	(215)	(210)	(196)	(120)	(34)	(64)	(28)	(10)	(40)	(31)	4
Forecast In Post	2,538	2,572	2,562	2,593	2,624	2,679	2,673	2,663	2,653	2,648	2,655	2,645
Establishment	2,744	2,744	2,744	2,769	2,769	2,769	2,794	2,794	2,794	2,819	2,819	2,819
Actual In Post	2,493	2,529	2,534	2,573	2,650	2,735	2,731	2,766	2,784	2,780	2,788	2,824

Table 2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(44)	(48)	(39)	(43)	(34)	(38)	(41)	(33)	(36)	(28)	(31)	(23)
Actual Vacancies	(42)	(46)	(46)	(49)	(48)	(46)	(32)	(30)	(26)	(12)	(15)	(7)
Forecast In Post	330	326	335	331	340	336	333	341	338	346	343	351
Establishment	374	374	374	374	374	374	374	374	374	374	374	374
Actual In Post	332	328	328	325	326	328	342	344	348	362	359	367

6. OVERSEAS TRAVEL

The Board are requested to approve travel outside of the EU for 5 members of staff.

I am pleased that LAS has been invited to participate in a worldwide clinical competition being held at the prestigious JEMS conference in Maryland USA. In addition to participating in the competition our staff will attend conference meetings, lectures and visit operational ambulance facilities whilst abroad. We intend for DSO Alan Payne, Training Officer Stephen Hines and three operational colleagues to participate and report back.

Costs are expected to be in the region of £4,500
Travel is from 19th March and returning from the USA on 26th March.

Manchester Business School, Boston, Massachusetts USA

Formal approval is sought from the Board for Ann Ball, Deputy Director of Human Resources, and Sue Watkins, Superintendent, Control Services, to attend the NHS United States Elective Module, in co-operation with Harvard University's School of Public Health and PricewaterhouseCoopers LLP. 20-24 March 2006. This will form part of their studies towards the MSc – Leadership through Effective HR Management.

The Module enables participants to experience and understand the lessons learned from the US system, and reflect on practice in the UK in light of the US model. The course will focus on the question of "how does this improve patient care?". The content will be delivered through seminars, syndicate discussions, and field visits.

Costs to the Trust for travel and accommodation are expected to be approximately £1,200 per person. The tutorial costs of the programme (£1,500 per person) are funded by the Department of Health.

Recommendation

THAT the Board note my report and approve the travel requested under section 6.

Peter Bradley CBE
CHIEF EXECUTIVE OFFICER

25 January 2006

Enclosure 4b

LONDON AMBULANCE SERVICE NHS TRUST BOARD
TRUST BOARD 31ST JANUARY 2006

PROPOSED TRANSFER AND PURCHASE OF TOTTENHAM AMBULANCE STATIONS.

1. **Sponsoring Executive Director**: Mike Dinan

2. **Purpose of report**

   To seek the Trust Board 's approval for the transfer and purchase of Tottenham Ambulance Station, St Anns Road, LondonN15, to the London Ambulance Service NHS Trust.

3. **Background.**

   When the Ambulance Service became a Trust in 1996 the freehold titles for Tottenham Ambulance station remained with the Secretary of State for Health. The Freehold interest was then transferred to the adjacent hospital trust by mistake. Once NHS Estates had rectified this problems it was discovered that the unregistered title deeds in respect of the Ambulance station had been lost. All these issues have now been resolved the Department for health is ready to transfer the property to the London Ambulance Service NHS Trust.

   The ambulance station has remained operational since 1996 and is located in an area of high demand. The Trust has made several improvements to the property over the last 3 years to increase the level of accommodation at the site in order to provide more space for additional staff. The Trust has also taken a short term lease of some land form the adjacent Hospital Trust to provide additional car parking.

4. **Proposals.**

   The Department of Health has confirmed that the ambulance station is not part of any disposal package and that they are willing to transfer the property to the Trust at the existing use value.

   The existing use value for Tottenham Ambulance Station has been set at £437,479.

5. Financial Implications.

This proposal has a nil cost to the NHS as a whole and as such, special arrangements operate to ensure that the assets appear on the Trust's balance sheet.

On the same date that the LAS pays NHS Estates for the ambulance station the Trust's Capital Resource Limit (CRL) and External Financing Limit (EFL) will be increased. This means the Trust's does not have to change its capital expenditure plans. NHS estates have their CRL and EFL reduced accordingly.

The Trust will incur a small additional revenue cost, as we will be liable for depreciation and dividend contribution on these assets.

6. Recommendations.

It is recommended that the Trust Board approve the transfer and purchase of Tottenham Ambulance Stations.

Enclosure 4c

London Ambulance Service NHS TRUST

TRUST BOARD 31 January 2006

RAPID RESPONSE VEHICLES

BUSINESS CASE

1. Sponsoring Executive Director: Michael Dinan

2. Purpose: For approval

3. Summary

This Business Case has been written in response to the SIP Line item 39 and Primary Care Trust, Strategic Health Authority, Department of Health & LAS Board requirements for increasing the procurement of Fast Response Units.

Through detailed analysis it has been determined that procurement of an additional 114 FRUs, and the replacement of 58 RRUs, are required to meet the Trust's strategic and business objectives.

4. Recommendation

THAT the Trust Board approve the business case.

Enclosure 5

London Ambulance Service NHS TRUST

TRUST BOARD 31st January 2006

REPORT OF THE MEDICAL DIRECTOR

1. Sponsoring Executive Director: Dr Fionna Moore

2. Summary

The report updates the Board on progress against the seven domains of the Standards for Better Health, with a particular focus on clinical issues, including the recent introduction of morphine, the plans for implementing the revised resuscitation Guidelines and feedback from the Consultation Meetings. Updates from the Clinical Audit and Research Unit are included.

3. Recommendation:

THAT the Trust Board:

1. APPROVE the implementation of the revised Resuscitation Council (UK) Guidelines from April 2006;

2. APPROVE foreign travel for four senior managers in the Trust;

3. NOTE the forthcoming visit by the Healthcare Commission;

4. NOTE the assessment at level 3 by the NHSLA and to note progress against the seven domains of Standards for better Health.

LONDON AMBULANCE SERVICE NHS TRUST
Trust Board 31st January 2006

Report of the Medical Director

Standards for Better Health

The Healthcare Commission had announced its intention to undertake an audit of the following core standards; C1a, C14c, C17, C21 and C22a and c, in line with the intention to inspect 10% of Trusts to assess their evidence of compliance. They will undertake this on 7th February.

The NHSLA are undertaking an assessment of the Trust's compliance at level 3 of the Standard on 23rd and 24th January. Although some of the evidence produced for the Healthcare Commission is relevant to this assessment, a significant amount of documentation is concerned with the Service's risk management arrangements.

1. First Domain – Safety

Safety Alert Broadcasting System (SABS):

The first alert continues to be assessed for relevance to the trust (MDA/2005/063: Lancing devices – including Roche accu-chek softclix, softclix II, softclix plus and multiclix lancing devices). The remaining alert (MDA/2005/069: Blood pressure monitors and sphygmomanometers) relates to calibration and accuracy checks of blood pressure monitors and sphygmomanometers. It has been identified that this equipment is used by the Trust and therefore requires further action. To date, the manufacturers have been contacted for details of their recommended maintenance checks. Once established this alert will need to be discussed further.

2. Second domain – Clinical and Cost Effectiveness

Chief Executive's Consultation Meetings

Clinical presentations have now been made to all but three complexes to date. Feedback on clinical issues has continued to focus on increased demand, over prioritisation of Category A calls, risks around delays in responding to lower priority calls and issues around maternity cases. Interest has been expressed in the proposed training for the EMT 4 role and in progression to paramedic status.

New drugs

Morphine is in use in 23 of our 25 complexes. Not all Complex management teams yet feel confident in their use of the procedures around the introduction of a Category a drug. 6 Complexes have experienced problems in the implementation, both because

of limited management capacity to undertake daily stock takes, and, in a small number of instances, through loss of ampoules. Work is ongoing to address these issues. One complex has given a go live date of 6th Feb. Feedback from staff utilising the drug has been very positive.

The anticipated date for the introduction of amiodarone, hydrocortisone and chlorphenamine is May 2006.

Cardiac Care update

A London wide protocol for identifying patients with ST elevation myocardial infarction has been agreed with all nine participating centres. From April 2006 the two centres which currently offer a limited hours service will extend this to 24/7. Thereafter crews from across London are encouraged to take patients to the nearest centre offering primary angioplasty.

Changes to the Resuscitation guidelines

The revised European Resuscitation Council and Resuscitation Council (UK) guidelines were published on 28th November 2005. The most important aspect is the focus on high quality chest compressions. The LAS is planning to introduce these Guidelines as soon as practicable.

Full implementation of the guidelines requires reprogramming of Automated External Defibrillators, along with changes to resuscitation training courses and introduction of Version 2006 of the National Clinical Practice Guidelines. To ensure a consistent approach across London the LAS has approached the network of hospital Resuscitation Training Officers to suggest that the Guidelines are fully implemented on 1st April. This is in keeping with the introduction of the new Advanced Life Support course and the publication of the next version (2006) of the Guidelines.

The Board is asked to approve the implementation of the revised Resuscitation Council (UK) Guidelines from April 2006.

Telephone advice

New clinical decision software support was introduced into the Urgent Operations Centre on 16th December 2005. This system (PSIAM) replaces the outdated version of TAS and was selected on the basis of safety and shorter times to call completion. Feedback from the Clinical Telephone Advisers, who were involved in the evaluation of the product, has been positive. Early analysis of the data shows a call volume of over 4000 calls in one month (double that previously achieved under TAS), 50% of which resulted in saved ambulance response.

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

These are included in Appendix 1and include an audit on PRF Documentation (Jan-Dec 2005) and ASA/JRCALC National Out-of-hospital Cardiac Arrest Project 2004.

3 Third Domain – Governance

Risk Management:

Work is under way to reframe the reporting formats of the Risk Register so that they include more visible information about progress made with action plans to reduce risks and what are high priority risks that require urgent attention within the governance processes of the service. Current work on the Service Plan for the next seven years also includes a section to further develop risk management and achieve compliance with NHS requirements year on year.

In addition to the work described above the focus on risk management will also be determined by the feedback from the NHSLA and the Healthcare Commission when they have appraised the assurance given to the Board and other evidence including policies, training course material and case studies reflecting outcomes generated from the case management systems operated by PALs and PSU.

Fourth Domain – Patient Focus

The Patient Advice & Liaison Service (PALS) team continues to focus on resolving enquiries and concerns raised by patients, LAS staff and people from other organisations. One aspect of their role is to work with other health and social care agencies to ensure vulnerable patients' needs are met (see separate PALS report). .

Other examples of work under this domain are mentioned in the PPI section of the Chief Executive's report.

Complaints Procedure:

The PALS team can often resolve people's concerns so that they do not go on to make a formal complaint. One example of this is a recent case where a patient with a heart condition asked an ambulance crew to take her to the hospital responsible for her care, but they declined. The PALS team explained LAS policy to her, and provided a letter agreeing that she should be conveyed to the hospital of her choice, subject to clinical assessment of the level of urgency at that time. The PALS team also liaised with her local ambulance station, reminding staff of the policy (also see PALS report).

Fifth Domain – Accessible and Responsive Care

The organisation is working hard to ensure patients receive care promptly in emergency situations.

A number of LAS committees now include Patients' Forum members, who can offer their own expertise and represent the interests of patients. The Patients' Forum has also been involved in the evaluation of new equipment (i.e. carry chairs) and it is hoped that patient involvement will be requested and welcomed in all new and future developments.

A piece of work is planned between the PPI Committee, the Patients' Forum and RNID, to ensure that deaf people have equal access to the Service. This will include both access to the EOC and the ability of crew staff to communicate effectively with deaf patients when they arrive at the scene.

Locally agreed guidelines or protocols, such as transportation of patients to Walk in Centres are now in place. The LAS has also negotiated direct admission to Oxleas Mental Health Trust for a small number of selected patients.

Other examples of work under this domain are mentioned in the PPI section of the Chief Executive's report.

Sixth Domain – Care environment and Amenities

Make Ready is now live on 19 Complexes. All remaining complexes are programmed for roll out by 31 March 2006 when the project phase will be complete. The scheme continues to perform well against Key Performance Indicators and feedback from operational staff and managers remains generally positive. Two pilot schemes are due to commence in January. Flexible Fleet Management will seek to achieve better utilisation of spare vehicles. A further pilot will also be undertaken aimed at improved asset tracking and stores management.

The Make Ready Scheme is improving the cleanliness of ambulances and equipment. Regular swab tests are taken on vehicles which are being Make Ready from four fixed locations subject to change every three months, the swabs are processed by an independent laboratory and reported on monthly.

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

Seventh Domain – Public Health

A representative from the Emergency Planning Unit attended a meeting of the London Emergency Medicine Consultants on 18th January to seek their views on the new DH guidance on major incident management and the deployment of Medical Incident Officers and Medical Emergency Response teams (MERIT)

Approval of Foreign Travel

The Head of Clinical Audit and Research, the Clinical Practice Manager, the Education Development Manager and the Medical Director have been invited to attend the forthcoming European Resuscitation Congress in Stavanger in May 2006. Flights and conference fees will be met by Laerdal, with whom the Service undertook

the international ‘Sister’ project, providing evidence for the review of resuscitation guidelines.

Recommendation

THAT the Board:

- Note the report.
- Approves the introduction of the revised Resuscitation Council (UK) Guidelines from April 2006
- Approves foreign travel for four members of staff

Fionna Moore

23rd January 2006

Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board:

- Summary findings of the ASA/JRCALC National Out-of-Hospital Cardiac Arrest Project 2004
- Executive Summary of the Annual Clinical Audit of the Quality of Patient Report Form Documentation (2005).

Summary findings of the ASA/JRCALC National Out-of-Hospital Cardiac Arrest Project 2004

Dr Rachael Donohoe, Dave Clarke; Clinical Audit & Research Unit

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This report summarises selected findings of the first ASA/JRCALC national clinical audit of cardiac arrest patients from 1st January – 31st December 2004. All 32 ambulance trusts in England and Wales took part in the audit, submitting data on a total of 47,923 patients. The LAS contributed data on 3,269 patients who had resuscitation attempted following an out-of-hospital cardiac arrest of a presumed cardiac aetiology.

The table below compares LAS figures with the national averages.

Indicator	2004 LAS Figures	2004 National Average
Total cardiac arrests*	3,269	20,963
Bystander witnessed arrests	1,593 (49%)	7,324 (35%)
Initial rhythm VF/VT	893 (27%)	5,490 (26%)
Bystander CPR	989 (30%)	6,126 (29%)
Resuscitation stopped on scene	286 (9%)	6,339 (30%)
Any ROSC (return of spontaneous circulation)	562 (17%)	3,091 (15%)

* Based on those patients that had a cardiac arrest of presumed cardiac aetiology where resuscitation was commenced.

Figures from the table above demonstrate that the LAS treated around 16% of the total number of cardiac arrest patients that had an out-of-hospital cardiac arrest in England and Wales in 2004.

The LAS had a higher percentage of bystander witnessed arrests than the national average (49% vs. 35%). In addition, the proportion of LAS patients whose initial arrest rhythm was VF/VT exceeded the national average by 1%.

Thirty percent of LAS patients were documented as having CPR performed by a bystander; this again was just above the 2004 national average of 29%. It would be interesting to

examine the possible impact of public CPR training undertaken by each trust on their rates of bystander CPR.

The number of LAS patients that were documented as having an ROSC (return of spontaneous circulation) was 2% higher than the 2004 national ROSC figure of 15%. This may be a result of the LAS having more bystander witnessed arrests, more patients in a 'shockable' rhythm and a higher rate of bystander CPR than the national average.

The percentage of resuscitations terminated on scene by the LAS (9%) was substantially less than the national average of 30%. More patients are perhaps being considered viable for on-going resuscitation by the LAS than other trusts due to the close proximity and numbers of A&E departments that are available.

The difference in the number of resuscitations terminated on scene between the LAS and the national average should hopefully prompt discussion and exploration into the factors behind this apparent disparity.

Survival data is not currently available through the ASA/JRCALC National Cardiac Arrest Annual Report. However, the LAS collects and reports its own survival figures and these will be presented in the LAS Cardiac Arrest Annual Report 2004-2005, which will be published in early 2006. This report will also make recommendations aimed at improving cardiac care and survival from out-of-hospital cardiac arrest.

Annual Clinical Audit of the Quality of Patient Report Form Documentation (2005) - Executive Summary

Yolanda Mapes, Dr Rachael Donohoe; Clinical Audit & Research Unit

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Introduction

This snapshot clinical audit examined the quality of documentation by LAS crews on Patient Report Forms (PRFs). All PRFs must be completed by crew members in attendance accurately and professionally, covering all information relating to the call, including patient details, clinical care and basic documentation such as date and crew details.

Methods

The monitoring of documentation across the whole Service was achieved by randomly sampling 5% of all PRFs as it is not feasible to audit all patient records due to the large number of patients that the LAS attends each year. Data was collected by Team Leaders as part of their audit duties. In total, data relating to 10,177 PRFs were received and analysed for the period January – December 2005.

Results

Overall, the standard of documentation across the LAS was high. However, there were some areas where PRF documentation failed to achieve an acceptable standard, and are, therefore areas that need improvement.

At Barnehurst Complex 91% of PRFs had documentation regarding compliance with a training protocol/extended training order, suggesting that for 9% of the PRFs audited the crew treated the patient out of line with protocol and no justification for this was documented.

Several Complexes achieved low levels of documentation of a time log for a treatment or intervention which indicates that crews at these Complexes are not fully documenting the treatment that they are giving their patients.

There was poor documentation by Romford Complex on a number of areas of the PRF. Of particular concern is the documentation of personal/offensive comments about the patient or carer. The results indicate that at this complex 11% of PRFs potentially contained offensive comments about the patient or carer.

Basic incident information was generally poorly documented across the LAS. The full documentation of crew details was less than 80% at 4 Complexes and one Complex documented full crew details on only 47% of PRFs audited. In addition, over 20% of all PRFs audited for 2 Complexes did not complete full details of activation and/or response details.

Recommendations

- Issues raised in this audit need to be urgently addressed by Complex management teams.
- The LAS must ensure that all staff are made aware of the importance of documenting all relevant information on the PRF and documenting exceptions where necessary.
- Team Leaders on Complexes need to provide prompt feedback to staff on areas of concern in the completion of the PRFs as part of their commitment to the Clinical Performance Indicator process and in order to achieve change/improvements in documentation.
- The LAS must facilitate and encourage the Team Leaders to complete the CPI audits so that the Service can audit documentation to encourage improvements to be made.

Action Plan

- The results of this audit will be disseminated to all LAS staff through the Clinical Audit and Research Unit's dissemination strategy.

- The Clinical Audit Facilitator will disseminate the results of this audit to Team Leaders and Ambulance Operations Managers (AOMs), and will attend meetings with the AOMs to discuss local action plans.
- Recommendations from this audit will be reported to the Clinical Audit and Research Steering Committee and the Clinical Steering Committee for action.
- Actions will be monitored for completion by the Clinical Audit Co-ordinator, and progress will be reported to the Clinical Audit and Research Steering Committee, the Clinical Risk Committee and the Clinical Steering Committee.
- The Clinical Audit Facilitator will undertake the continuous monitoring of data that is submitted monthly by Team Leaders and highlight any problematic areas to individual Complex management teams to deal with locally.

Enclosure 6

London Ambulance Service NHS TRUST

TRUST BOARD 31st January 2006

Business Continuity Policy

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For approval

3. Summary

   The Business Contingency Policy attached has been drafted in accordance with the requirements of the Civil Contingency Act 2004.

4. Recommendation

   THAT the Board approve the Business Continuity Policy.

	London Ambulance Service NHS Trust **Business Continuity Policy** **Version 1b – circulated 3rd January 2006** **For Use By: All staff**

Introduction

The Civil Contingencies Act 2004 (CCA)

The CCA and associated statutory Regulations and Guidance that came into force on 14th November 2005 form the legal background that requires the London Ambulance Service NHS Trust (LAS) to produce and maintain a comprehensive Business Continuity Plan that will enable the LAS to continue providing critical services to the public (e.g. A&E, Patient Transport Services (PTS) and the Emergency Bed Service (EBS)), as is reasonably practicable, whilst dealing with an 'Emergency' as defined below (see also Appendix 1).

An '**Emergency'** as defined in Section1of the Act is "an **Event or Situation** which threatens serious damage to human welfare in a place in the United Kingdom – *an Event or Situation threatens human welfare only if it involves, causes or may cause – loss of human life, human illness or injury, disruption of money, food, water, energy or fuel, systems of communication, facilities for transport or disruption to services relating to health,* and other non-health related matters."

The LAS **Business Continuity Policy** supported by the LAS **Business Continuity Plan** (BCP) is intended to anticipate, prepare for, prevent and or respond to and/or recover from an 'Emergency' and to initiate a number of actions addressing the risks or threats to the ability of the LAS in maintaining patient care through A&E, PTS and the EBS. Whilst the sources of such disruption are limitless, their impacts and effects are much fewer in number. Examples may include:

a) a mass casualty incident, either spontaneous (transportation accident, act of terrorism, civil disorder or natural disaster) or,
b) a 'slowburn'/ 'rising tide', typically a health emergency, e.g. an influenza pandemic, or an activity is identified that could lead to a surge in emergency calls or in-service sickness/absence or,
c) a combination of (a) & (b), e.g. severe weather when notice may or may not be received,
d) loss of a strategic headquarter building and/or other significant parts of the LAS estate,
e) IT loss (including voice, Mobile Data Terminals (MDTs), landline and mobile phones, pagers, R/T and R/T aerial sites), and/or Emergency Operations Centre (EOC) failure,

g) Logistic failures – fleet, equipment, consumables,
external contractual failures, including the loss of public utilities,

f) a critical single point failure (internal or external) that threatens the operational ability of the service,

In summary, any denial or loss of services or facilities that effects the LAS response to London's public and communities in terms of either or all of A & E, PTS or EBS.

Some aspects of Business Continuity already exist and support the A&E and Emergency Operations Centre (EOC) facilities and services and can be found in the 'EOC - LAS/Metropolitan Police Service Recovery Procedure' (OP/008), or in the Major Incident Plan and EOC Extreme Pressures Plan. Additionally, the LAS Capacity Plan & Heat Wave Plan are good examples of specific plans designed to cater with 'pressure & continuity'. These plans deal with the day to day pressures that are placed on the LAS and are practiced / invoked on a regular basis. Neither this policy nor the Plan supersede those arrangements mentioned above, but in effect takes the LAS into the next stage of continuity or recovery on the basis that the incident / event causing concern has passed through the usual and/or anticipated stages and into the extraordinary.

The BCP will also consider other aspects of business continuity that includes 'internal major incidents' ranging from the 'loss of a Headquarters (HQ) building', extensive sickness among personnel to failures in the supply chain.

1.0 <u>Risk Assessment</u>

1.1 The events identified above that may pose or threaten significant risks to the performance of critical functions have been subjected to a Risk Analysis, with the result that an all risks approach has been adopted in respect of this policy. The LAS Risk Register has been consulted and as a result a BCP Risk Matrix has been prepared. Thus it is not necessary to plan separately for each of the eventualities that may arise or to cater specifically for the wide range of threats identified, for example, evacuation of the HQ building, excessive sickness among personnel and large scale mechanical vehicle failure.

1.2 Once a Major Incident or 'Emergency' has been declared or anticipated, it will be a matter for the Business Continuity Group (see below), or the Business Continuity representative of the Strategic Coordinating (Gold) Group (SCG), to undertake a dynamic risk assessments on an on-going basis, taking into account threats to the maintenance of the LAS's core functions.

1.3 If information or intelligence is received that an 'Emergency' is likely to occur, Gold will convene a meeting, attended by the Chair of the Business Continuity Steering Group (or their nominee) and a dynamic risk assessment relating to Business Continuity will be produced based on the information available.

1.4 During the course of every Major Incident or Emergency, Business Continuity Management will form a part of the core strategy and the Risk Assessment in respect of Business Continuity must be produced, kept under regular review and amendments recommended to Gold, as necessary.

2.0 <u>The Business Continuity Plan (BCP)</u>

2.1 The LAS Business Continuity Plan is an overarching generic plan that may be implemented totally or in part. The LAS BCP will be supported by other 'Business Continuity Plans' produced by Directorates or Departments that provide direct and vital support to the maintenance of both core and Emergency response.

2.2 The underpinning intention of the BCP is to ensure that the LAS:

- will continue to exercise its 'civil protection function' (Major Incident and related plans) and 'ordinary core functions' (A&E, PTS & EBS),

- will implement the BCP as necessary to ensure that the LAS can deliver the capabilities/functions required.

2.3 The legislation also requires the LAS to make provision for ensuring that their ordinary functions can continue to the extent required. The LAS BCP must therefore not only include internal structures but those organisations that it relies upon to deliver goods and services through the supply of utilities, equipment, drugs and other goods etc. and the involvement of Voluntary Aid Societies and other agencies as necessary.

2.4 It is necessary to ensure that the plan is regularly reviewed and updated and that appropriate training and exercise is provided to relevant personnel, together with the opportunity to exercise all or some elements of the plan.

2.5 Funding: The LAS will apply for appropriate additional and continued funding to support all elements of BCP.

3.0 <u>Management of the Business Continuity Plan (BCP)</u>

3.1 The Business Continuity Plan must be 'signed off' by the Chief Executive Officer.

The LAS has appointed the Director of Finance to be responsible for the maintenance of the Business Continuity Plan, including reviewing, updating, training and exercising the plan.

The Director will be assisted by a **Business Continuity Steering Group.**

A Coordinator will be appointed, who will have responsibility for the day-to-day administration of the Plan including;

- reviewing, updating, planning,
- implementing Service training,
- exercise and maintenance of the audit trail relating to the fore-going,
- providing advice to departments in the construction of their department BCPs including department training and exercise.

The coordinator will report directly to the Director.

The coordinator will also act as Secretary to the Steering Group and represent the LAS, as appropriate, at pan-London groups including the London Resilience Forum.

4.0 BCP Steering Group & Objectives

Membership of the Steering Group will comprise an appropriate representative from relevant Directorates (those providing core services plus those that provide vital support), empowered to make decisions on behalf of their Directorate and to act as a coordinator for the departments in the production of the Department Tactical Plan, training and exercise.

4.2 Group members:

- will ensure that Terms of Reference for the Group are produced and agreed,
- will identify and bring forward for discussion, recommendation, and adoption both strategic and tactical matters emanating from their department that are liable to have an impact on the BCP,
- will ensure that the BCP Coordinator is informed of any amendments and,
- of the need for members of their Directorate to receive relevant training and/or exercise,
- will ensure the maintenance of their Directorate's part of the Plan and
- additionally;
- the Group will meet at least quarterly or as necessary to deal with 'urgent business',
- the BCP Coordinator will act as Secretary to the Group,
- an agenda will be produced prior to a meeting; minutes will be recorded and circulated within the time frames agreed within the Terms of Reference.

Invoking the Business Continuity Plan

5.1 The need to invoke the **Business Continuity Plan** may emanate from a spontaneous event (the declaration of a major incident) or other "Emergency",

or

threat of an "Emergency".

The decision to invoke the **Business Continuity Plan** rests with **GOLD** and based on any, some, or all of the circumstances described above or as advised by the Chair of the Business Continuity Group or their nominee.

Once invoked an **Emergency Business Continuity Group (EBCG) (**drawn from the Business Continuity Steering Group) will be convened to identify the threat / risk and suggest remedial actions to **Gold** for the short, medium and long term. The nature of the continuity / recovery will depend on the nature of the challenge and the **EBCG** will, in its make-up, reflect the nature of the risk and the departments / personnel required to remediate and return to normality.

The **EBCG** will be chaired by the Director of Finance, (or Deputy Director of Finance or Deputy Director of Operations).

5.5 The **EBCG's Objectives** will be**:**

To recommend to Gold a well defined set of options that will initially maintain core functions and/or deal with the emergency and thus aid the restoration of normality as quickly as possible.

In achieving (1) the Group will identify personnel, resources and functions that will assist either or both of the functions identified above and thus aid the return to normality.

Prepare recommendations that deal with recovery in 'the immediate', short term (less that 8 hours), medium term (less than 24 hours) and long term (greater than 24 hours).

All recommendations will be based on information and intelligence gleaned from the widest possible sources and risk assessed for relevance to the LAS and specifically 'Business Continuity'.

The EBCG will meet as necessary or as directed by Gold and will work to an agenda, record minutes, actions and decisions and maintain close liaison with Gold, who may be dealing with wider issues.

The Chair of the EBCG (or a nominee) must be a member of the Strategic Co-ordinating Group (SCG / Gold Group) if one has been convened. On any occasion that a 'Major Incident' is declared and a SCG convened, a nominated member of the Business Continuity Group should always attend solely in order to monitor resilience throughout the Service and make recommendations to Gold at the earliest opportunity respecting the formal establishment of the Emergency Business Continuity Group.

The EBCG on its own or on behalf of Gold, will formally task various parts of the Service to assist in maintaining the critical services (previously identified) or the 'return to normality'. It is vitally important to ensure that Gold is appraised of any such taskings that may have been initiated in order to prevent duplication, to record these tasks within EBCG and for the receiving departments. to maintain a full audit trail and decision log relating to each tasking, and a comprehensive log relating to the whole event.

Each department in receipt of a tasking must ensure that the Emergency Business Continuity Group is updated on a regular basis and always in good time for any notified SCG/Gold meeting.

The EBCG, will, among others, and based on agreed processes, be in a position to recommend to Gold that 'normality has returned' It should be noted that 'normality' may not be the situation that pertained prior to the 'emergency' but a new and satisfactory state of affairs (e.g. if HQ were lost for an extended period, 'normality' may be deemed to exist when all parts of HQ are accommodated elsewhere and have resumed their work).

The Business Continuity Group must ensure that a de-brief is held by the EBCG post 'Emergency' or whenever an EBCG is convened. In the event the 'Emergency' embraces an 'external major incident' it may be appropriate to conduct the de-brief as a part of the LAS wider process. Once the report has been received the contents will be considered and necessary action taken, including incorporation into the BCP, information to personnel, training and exercise as necessary in respect of any new procedures that are adopted.

Administration

6.1 The Departments shown below are those that will be required to support the Business Continuity Plan, and their arrangements will form a part of the **Operational Plan**, arranged in sections in the order as shown below.

6.1.1 Critical Services

EOC - call handling, Fall Back Control (FBC) and EOC Resource Centre
A&E Personnel and Resource Centres
Patient Transport Services
Emergency Bed Service

6.1.2 Support for Critical Services (vital functions)

Finance (including Estates & Procurement)
Human Resources (Safety & Risk, Welfare, Payroll)
Operational Support (Fleet, workshops & logistics)
Emergency Planning Unit
Information Management & Technology
Communications (Press & Public Affairs)
Service Development (Project Support)
Office of the Chief Executive Officer

Audit

7.1 The BCP will be the subject of a number of audit points, both external and internal, for example:

- externally by The Audit Commission,
- Health Commission - Standards for Better Health,
- internally by way of regular and routine audit,
- de-brief – identification of best practice,
- Steering Group Review,
- results from review, training, exercise & updates.
- Benchmarking against the British Standards Institute publicly available specification (BSI PAS 56), adapted to suit LAS needs.
- 'Emergency Preparedness' chapter 13 para 317 et seq. Use of Self Assessment Sheets (relating to chapter 6 Business Continuity Management).

Review

8.1 The coordinator will be responsible through the Steering Group for identifying changes to LAS structures, policy and practices that will affect any element of the BCP, ensuring that the necessary amendments are approved by the designated Director prior to adoption and circulation.

Departmental Leads will be responsible for informing the coordinator of any local changes to their part of the BCP (e.g. Changes of location, personnel, and phone numbers). The coordinator will ensure that these changes are circulated.

The coordinator will conduct a Strategic Review, Business Impact Analysis and Risk Assessment as necessary or at least annually and recommend any changes to the Steering Committee and Director for adoption prior to amendment being made to the BCP for circulation, training, exercise etc.

Changes may also be recommended for adoption as the result of debriefs following 'live events', training, exercise etc.

Training – Exercise

9.1 An annual training programme will be required to ensure that the BCP, its strengths and challenges, are embedded into the LAS.

The coordinator will produce for the approval of the BCP Steering Group an annual 'training plan' that must involve all those departments:

- that provide 'core services' and vital support, as identified above, and
- as a minimum raise the awareness of all members of the service who may become involved in support to the core services or find their personal work space and working practices disrupted, at least in the short term, by for example, relocation.
- Training could consist of the whole range of opportunities, including briefings, command post exercise, table top, live and inter-agency exercises. Details must be maintained of the dates, participants and the nature of the training for audit purposes,
- awareness of the BCP must be introduced into 'Induction Training'.

Updates

10.1 To be conducted in accordance with the principles set down in paragraph 7.0 above.

Strict audit process must apply in each case and version numbers used when providing updates. It is, however, vitally important that a copy of each version is retained centrally together with its dates of currency in order that a 'relevant copy' can be produced when required by a law court or other authority.

Publication and Circulation – Communication – Internal – External – Partners

11.1 **Internal:**

11.1.1 Copies, both electronic and printed must be retained under secure conditions.

Electronic copies should be retained by:

Chairman & Chief Executive	Designated BCM Director	All Directors & Asst Directors of Operations
PTS lead	EBS lead	Nominated Dept Leads
Senior Resourcing Manager	Senior Emergency Planning Manager	EOC
South West London SHA	Ambulance Operations Managers (AOM)	BCP co-ordinator ** (when appointed)

BCM Coordinator, Designated BCM Director, Asst. Directors of Operations & EOC will hold electronic and printed copies as 'master copies'.

(Future - The LAS will aspire to hold an e-copy on the discreet X-drive, or eventually/possibly on an e-page held external to the Trust)

11.2 **External:**

The Act requires the LAS to publish aspects of the BCP in so far as this is necessary or desirable for the purpose of dealing with emergencies. The purpose of this requirement is to ensure that the LAS make relevant information available to the public about what will happen in the event of an "Emergency". There are three basic principle classes of information that the LAS should consider communicating to the public:

- A descriptive account of the BCP that they have in place for the purpose of reassuring the public
- Information about the implications of emergencies for the continuity of ordinary services (critical function)
- Source of information and advice about service continuity issues that the public could consult in the event of an Emergency

Partners:

11.3.1 It is incumbent upon the LAS to inform partner organisations of an event that may threaten the ability of the LAS to maintain its 'critical functions as far as is reasonably practicable',

It must be borne in mind that this information should be passed in order to prevent, reduce, control or mitigate the effects or take action in connection with the Emergency.

Whilst it is not possible to produce a comprehensive list of the partners that may need to be contacted there is a core list of partners that must be considered, these include:

- Strategic Health Authority (SHA), Health Protection Agency (HPA), London Resilience Team (LRT) - all of whom can forward information to other organizations,
- London Emergency Services Liaison Panel including the emergency services
- Voluntary Aid Societies (typically St. John Ambulance, British Red Cross Society, Women's Royal Voluntary Service, Salvation Army)
- Transport for London (TfL) and other transport agencies as required
- Local Resilience areas in London, including appropriate local authorities.

References & acknowledgements:

The Civil Contingences Act 2004
The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005
Emergency Preparedness – Statutory Guidance (Particularly Chapter 6, 4, 5, 13, & 14)
Response & Recovery (published 23.9.05)
The DH NHS Emergency Planning Guidance 2005 (published 13.10.05)
London Ambulance Service NHS Trust Major Incident Plan
London Ambulance Service Operational Procedure – LAS/MPS Recovery - OP/008.
London Prepared – Business Continuity Advice – Organizations with 250 staff or more
London Ambulance Service – Capacity Plan
British Standards Institute - Publicly Available Specification (PAS) 56
The Heath Review of LAS BCM Preparedness conducted Autumn 2004

Signature:

Peter Bradley CBE
Chief Executive Officer

Appendix 1

The Civil Contingencies Act 2004 (CCA)

The CCA, and associated statutory regulations and guidance form the legal background that identifies an extended group of organisations as 'Category 1 Responders' to 'Emergencies'. Category 1 Responders include all emergency services and thus all Ambulance Trusts. Briefly stated the Act requires a Category 1 Responder, in an 'Emergency', to continue to perform all of its functions as far as is practicable.

(An '**Emergency'** – as defined in Section.1. of the Act is an **Event or Situation** which threatens serious damage to human welfare in a place in the United Kingdom – *an Event or Situation threatens human welfare only if it involves, causes or may cause – loss of human life, human illness or injury, disruption of money, food, water, energy or fuel, systems of communication, facilities for transport or disruption to services relating to health,* and other none health related matters*.)*

Section 2 of CCA and the statutory guidelines contained within the document 'Emergency Preparedness' (as reproduced below) requires Category 1 Responders to assess, plan and advise under the umbrella of Business Continuity Management and thus undertake the following:

- Maintain plans to ensure that they can continue to exercise their functions in the event of an emergency as far as is reasonably practicable. The duty relates to all functions, not just their emergency response functions.
- Must have regard to assessments of both internal and external risks when developing and reviewing Business Continuity Plans.

Business Continuity plans may take the form of generic plans –which set out the core of a Category 1 Responder's response to any BCM event – or specific plans dealing with particular risks, sites or services.

There must be a clear procedure for invoking the Business Continuity Plan.

BCPs must include arrangement for exercises for the purpose of ensuring the plan is effective, and arrangements for the provision of training to those involved in implementing the plan. Plans must be reviewed and kept up to date.

Category 1 Responders are required to publish aspects of their BCPs insofar as making this information available is necessary or desirable for the purpose of dealing with emergencies.

The Business Continuity Institute's five stage business continuity management cycle provides a useful framework to help Category 1 Responders to fulfill their duties. However, Responders may adopt other models to deliver the legal requirements where there is a compelling case to do so.

Examples of good practice drawn from Category 1 Responders already active in Business Continuity Management may help others with developing and reviewing their own BCPs

Enclosure 7

London Ambulance Service NHS Trust

Trust Board Meeting 31 January 2006

DRAFT A&E OPERATIONAL WORKFORCE PLAN FOR YEAR 2006/07

1. **Sponsoring Executive Director:** Caron Hitchen

2. **Purpose:** For discussion and noting

3. **Introduction**

The attached table shows the preliminary A&E operational workforce plan for the year 2006/07.

This plan is being supported by the work underway on long term workforce planning over the next seven years. This twelve month plan is aimed at achieving the right staffing levels and skill base with which to meet our immediate capacity pressures and from which to develop the workforce profile to meet our future service delivery requirements.

4. **A&E sectors**

The A&E sector workforce includes, all EMTs, Paramedics, Team Leaders and ECPs.

We intend recruiting 376 frontline staff over the next financial year. The aim is to get to a position where we have as few a vacancies as possible by the end of the 2006/2007 financial year to reduce our reliance on overtime.

Planning assumptions include the loss of 9 staff per month and the intention to increase the number of front line staff by 93 (funded) in response to the requirement under Agenda for Change to reduce the working week from 39 hours to 37.5 hours per week and increase annual leave entitlement for all front line staff whilst providing appropriate levels of patient response and meeting our performance targets. In addition we have planned to recruit an additional 25 ECPs per quarter during 2006/2007. This will be subject to securing funding with individual PCTs in line with our agreed funding model.

Modelling work to establish how many additional staff are required to achieve the new clock start arrangements indicates an additional 150 staff will be needed. This has not been factored into the draft workforce plan attached, however, once we are clearer on the funding position for 2006/2007 with our commissioners we will update the plan. They have been advised of our requirement.

Discussions are currently underway to understand how best we would deal with recruiting and training these additional staff given known capacity issues.

5. Emergency Operations Centre

The Emergency Operations Centre workforce includes all EMDs and Sector Controllers.

Planning assumptions include the loss of three staff a month and the intention to recruit 30 additional in this financial year. As part of the new clock start arrangements the EOC will need to answer 999 calls within 5 seconds 95% of the time by hour of day. Current performance is at 88% over a 24 hour period. Modelling work is currently underway to understand if there are any additional resource implication for EOC both at the call taking end of the room and in dispatch.

6. Urgent Operations Centre

The Urgent Operations Centre workforce includes Clinical Telephone Advisors and the former greenbase and whitework staff. The EMT1 and PTS elements of Urgent Care staffing are currently embedded in the A&E Sectors figures but we are working to split these out and include them in the Urgent care figures as soon as possible. Modelling is underway to ascertain the precise workforce mix required to deal with 80% of existing Green workload, all non-urgent activity and all Doctors Urgents which require a response time of greater than one hour. Once this modelling is completed we will work to flex the recruitment programmes to recruit and train these staff.

7. Overtime

As in 2005/6 we are planning to hold a central budget for overtime which is funded by vacancies and funded secondments. This budget will be profiled to reflect seasonal spending needs and the existing vacancy rate and will fall as in post numbers increase. The overriding intention is to move to a situation where overtime spend is very much reduced and the Trust operates on a near full establishment basis at all times.

8. Next steps

As per the Board forward planner, it is intended to bring the final 2006/2007 workforce plan back to the Board for approval at the March meeting as part of the budget approval and service plan approval process. The longer term workforce plan will be brought to the Board in May as part of the seven year workforce plan.

9. Recommendation

That the Trust Board notes the progress to date on the annual A&E operational workforce plan for 2006/07 ahead of final approval in March 2006.

Enclosure 8

London Ambulance Service NHS Trust

TRUST BOARD January 31 2006

PATIENT ADVICE AND LIAISON SERVICE (PALS) ACTIVITY UPDATE

1. Sponsoring Executive Director: Peter Bradley

2. Purpose: For noting

3. Summary

This report is to inform the Trust Board of the work of the LAS Patient Advice and Liaison Service (PALS) giving details of the increasing number of people accessing the service and providing brief case studies demonstrating the variety of work undertaken by PALS and how the involvement of this service benefits both patients and the LAS.

4. Recommendation

THAT the Trust Board note the work done to date and the progress achieved

Introduction

In accordance with government policy to introduce a new patient-centred service throughout the NHS, a comprehensive PALS was established across the Trust in June 2003 and is now regarded both as an important and valuable service provided by the LAS and a powerful source of learning for the organisation.

PALS principal aims are to advise and support service users, staff and other health and social care professionals in their experience of using the LAS and to act as catalyst for improvement by identifying issues of significance and emerging themes for action by the Trust, reporting principally through the Clinical Governance Committee (CGC).

Through its work with a variety of stakeholders PALS seeks to *"move away from a system of patients being on the outside, to one where the voices of patients, their carers and the public generally are heard and listened to through every level of the service, acting as a lever for change and improvement"* (Department of Health, "Involving Patients and the Public", 2001).

PALS sits within the framework of clinical governance and is integral to the Trust's responsibilities under Patient & Public Involvement (PPI). As a method for service users to feedback on their experience of the LAS, PALS is one of the building blocks for developing effective and meaningful PPI throughout the LAS.

PALS activity

PALS have to date received 11000 inquiries, amounting to a 31% year on year increase (2004 to 2005). Using comparative figures for the period April 2004 – January 2005, the projected increase in demand for 2005/06 is 26%.

Since April 2003 the main sources of inquiries to the service include clinicians (1491 inquiries), patients (1051), relatives (1173), social services (200) and other agencies (800) , although this data is incomplete owing to variations in Datix upgrades not capturing prior information.

PALS have responded to 769 requests for clarification of events when LAS have responded to an emergency call, ranging from patient and relative inquiries to those placed by health and social care professionals. PALS have also facilitated 738 requests for medical records.

In relation to patient tracking, PALS have been able to resolve 953 requests without incurring a single complaint over any patient confidentiality issues.

PALS have dealt with 158 incidents in which concerns have been raised about LAS staff attitude and behaviour. The preferred method of working is to use these cases as learning opportunities by the use of a reflective practice model. In this way, we seek to move from a 'blame' to a 'learning' culture and negate what would otherwise have resulted in formal complaints against the Trust. Similarly, PALS have managed 62 inquiries relating to patient choice of destination, using the opportunity to support the Trust's declared policy on this issue; 99 inquiries where delay in a response arriving

to the patient has been at issue; 350 cases involving conveyance issues and 232 cases were the clinical care provided has been in question. As far as we are aware, only four cases have resulted in the enquirer being dissatisfied with the PALS response and proceeding to the formal complaint process. 100 cases have been referred to the Independent Complaints Advocacy Service(ICAS) or our Professional Standards Unit (PSU), where the inquirer expressed a preference to pursue matters in this way.

285 responses have been made to inquiries from all around the world regarding LAS policy and practice. PALS have also responded to 134 Social Services inquiries in respect of vulnerable adults/child protection investigations, and 1335 requests for information across a wide diversity of issues, internal and external to the LAS. PALS have facilitated 1722 expressions of appreciation, with an additional 94 inquiries regarding the London Bombings.

External agencies

PALS continues to work very closely with the Medical Directorate in respect of concerns raised by LAS staff about external agencies. Since June last year, when PALS took over responsibility for this work, 105 such referrals have been received. Some of these cases have achieved notable outcomes – see case examples below. A further role is to enable cooperative working where external agencies conduct totality of care reviews, which also enables the flagging of potential serious untoward incidents to the Medical Director.

Lost property

1354 cases of lost property have been recorded, with only 248 (18%) of these resulting in the missing item being located. This issue continues to be a significant issue for service-users and a major drain on PALS and LAS resources, as well as a source of complaints and claims being made against LAS. We have initiated a pilot project, using the Smart Evidence & Baggage System (SEBS) – see www.smartmci.com – which was introduced at Hillingdon complex in December. The evaluation has produced extremely positive results and we anticipate that the introduction of this system across the LAS and London Acute Trusts would produce major benefits to patients and significant savings to the LAS.

Frequent callers

PALS have effected cross-agency working with Social Services, PCTs, mental health and acute Trusts and other relevant agencies towards devising specific care plans in relation to 112 referrals involving service-users who often present with highly complex health and social care needs. Where appropriate, patient care plans have been achieved, sometimes involving making information available electronically at our Emergency Operations Centre (EOC), so that any call received may be actioned accordingly.

Using a projection based on previous use over a 12 month period, a (crude) estimate is that that this work has resulted in saving resources being deployed in excess of 5000 calls (including one individual who had placed 998 calls alone). Financially, this

reflects a conservative estimate of a saving of £825,000 or 5000 hours of resource deployment time.

Although a programme has been devised that would encompass a systematic mechanism for managing this patient group, we have not been able to achieve the implementation of that. Whilst we continue to work on these cases on an ad hoc basis, a proposal is being prepared for additional resourcing with this area of work specifically in mind.

Freedom of Information (FOI)

112 FOI enquiries were received during 2005. Of these, only six may reasonably be held to have necessarily been made under FOI. 37 of the total were placed by students/academics and, disconcertingly, 24 by commercial interests seeking a business opportunity. These remain a common problem to the NHS and the effort involved in complying with the response deadlines continues to be to the detriment to core PALS work. Accordingly, we have submitted a number of recommendations to the Information Governance Panel.

Open cases

452 cases remain open at the time of writing, including 138 'frequent caller' referrals and 74 external agency cases.

Case examples

1. Mr D is a Chronic Obstructive Pulmonary Disease (COPD) patient with asthma & bronchitis, who also displayed an acute anxiety condition. Mr D made 238 calls for an ambulance within a period of two months. Whilst Mr D invariably reported severe breathing difficulties, these did not prove to be clinically significant, in terms of requiring an emergency admission to hospital. Having been alerted to the situation by a local Team Leader, PALS were able to liaise with Mr D's GP, the local hospital 'Fast Response' Team and the community social worker. Using the evidence of the frequency of calls to LAS, it was arranged for Mr D to be admitted to a rehabilitation ward, where he received support to promote independent living. The evidence of the calls to attend Mr D was also used to refer Mr D to Social Services Panel and funding was subsequently agreed for Mr D to be placed at an enhanced sheltered housing scheme with access to 24 hour staff support.

2. Mr M is a patient with mental health problems and a history of chronic alcohol abuse. He does not engage with services. He is also known to have had weapons at his home. At times when Mr M experienced a crisis and became suicidal, repeated calls were made by the police and NHS Direct for LAS to attend, whereas Mr M did not wish LAS to do so. Following a case conference, it was agreed to place Mr M on LAS Special Register, so that his allocated key worker and social worker could be contacted when LAS were requested to attend. This enabled the care professionals to be alerted to the situation and intervene accordingly, towards negating an exacerbation of the crisis Mr M experienced and enabling him access to appropriate care provision.

3. Having established a relationship with an acute Trust, PALS were invited to attend a case conference in respect of a frequent caller who had multiple admissions at A&E. The DSO who attended was able to identify that the calls were being made by Mr M's carers and always occurred around late afternoon. As Mr M is a diabetic, it emerged that dietary needs were the cause. A care plan was designed to include support from the diabetic nurse and additional carer input from Social Services to address the identified problem.

4. An obese elderly patient had placed 65 emergency calls over the previous 12 months, involving the deployment of 150 LAS resources at a cost of in excess of £25,000. PALS arranged a case conference and it was agreed with the patient that he would enter respite care towards a permanent residential care placement. Since that time we have received only 2 further calls.

5. An A&E Crew highlighted our frequent attendance to an elderly insulin dependant diabetic female who had a number of used syringes and needles lying around her home, suggesting the patient were not coping very well with managing her condition and additionally posing the risk of sharps injury. A referral was made to Social Services who arranged for a district nurse to review the patient's clinical needs.

6. Concerns were raised by a GP following the failure of an ambulance to attend a patient who the GP had booked to attend A&E for a sub-arachnoid haemorrhage. The patient did not get to hospital until the following day. Inquiries revealed that of the cause of the failure was a computer system problem. The issue was highlighted to EOC Managers towards ensuring robust measures are in place to negate this type of scenario reoccurring. An explanation and apology were offered to the GP and the patient.

7. A crew completed an Incident Report regarding a patient's medication being left on the doorstep. The patient was subsequently found to be seriously ill, having also incurred ammonia burns after having collapsed and lain undiscovered in urine and excreta for a prolonged period. An approach to the PCT led to the establishment of core practice standards being introduced in every pharmacy within the PCT area.

8. An LA52 referral was received in respect of 40 attendances to a hypoglycaemic insulin dependent diabetic male who continued to decline conveyance to hospital following LAS administration of Glucagon. PALS contacted the Diabetic Clinic at the hospital who were unaware of the patient's repeated calls to LAS. The Diabetic nurse arranged for the patient's Consultant to review patient's medication and to discuss management of his condition.

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9. Information about a patient having a serious infection was not provided by a Care home at time of the booking. In the light of this incident, and with liaison assistance of a Team Leader, the care home agreed to review their booking and handover procedures.

10. A patient with ongoing back problems complained to her GP about the failure of the attending ambulance staff to provide adequate care. The patient elected to ask PALS to respond rather than proceed with a formal complaint. On receipt of PALS response, the assessment provided was clarified and it was established that a request

had been made to a deputising doctor who had indeed contacted the patient. This example also enabled the GP an insight into LAS practice where a patient declines to be conveyed to hospital.

11. PALS responded to concerns expressed by a patient who has a heart condition that her request for her to be conveyed to the hospital responsible for her care was declined by the attending ambulance staff. The matter had been destined to become a formal complaint but the patient elected to seek PALS intervention. PALS were able to explain the LAS policy and provide a letter agreeing that the patient should be conveyed to the hospital of her choice, subject to clinical assessment of the urgency of need. PALS also requested that local station staff be reminded of the policy.

12. Following the completion of an incident report, a care home agreed that procedures had not been followed on this specific occasion and that care home staff would be reminded of those and the importance of an adequate handover of care emphasised.

13 PALS received a number of concerns from front-line staff about the lack of handover and/or continued practice by the National Hospital for Neurology to decline to receive patients, despite an arrangement having been agreed with the hospital concerned to admit stroke patients. PALS were able to arrange a meeting between the hospital, a Team Leader and the Cardiac Lead to ensure improved reciprocal management of the agreement.

14. Mrs Y is an elderly patient, aged 91, who is of Greek nationality. A crew reported that Mrs Y was very vulnerable to falls, but had refused to be taken to hospital, against the crew's advice. PALS ensured that the warden and GP were aware of the situation, to ensure Mrs Y's safety, and made contact with Social Services. PALS also contacted the PCT PALS who were able arrange for an interpreter to assist Mrs Y at a review meeting with Social Services. As a result of that, Social Services have agreed to place Mrs Y at a Greek-speaking residential care facility.

15. PALS were asked to assist in respect of a review of care provided to a patient with mental health difficulties. The agencies involved were a mental health unit and an acute trust. LAS had been called to attend the patient, who was assessed as requiring hospital treatment. However, the acute trust A&E had refused to accept the patient without a CPN being present, which meant that the ambulance crew had been forced to take the patient to another hospital, which was not as appropriately equipped to treat the patient. As a consequence of the review exercise, the acute trust agreed to procedural change in respect of admissions practice with regard to patients with mental health difficulties and to implement additional training for A&E nursing staff. The review also enabled greater mutual understanding of the role of the differing health professionals involved.

16. PALS undertook a review of events following an incident concerning the booking of an emergency transfer patient who was in cardiac arrest from OPD to A&E. The booking had not been managed using the prioritisation process AMPDS. Learning was actioned by highlighting the issues raised in Priority Dispatch News and a Team Briefing. The hospital was also advised to ensure that hospital staff are made aware of the appropriate information to be imparted when making emergency 999 calls.

17. PTS left a missed appointment card after the patient failed to answer the door when PTS arrived to convey the patient to an outpatient clinic appointment. The patient contacted PALS as she had no knowledge of the appointment. PALS ascertained that incorrect details of the patient's address were being held by the clinic but that, in any event, the clinic was discharging the patient on the grounds of her difficult behaviour. PALS liaised with the PCT – the patient's GP was concerned that the patient received ongoing treatment. PALS spoke with the hospital PALS to arrange a new appointment for the patient, and to ensure that the acute trust clinic staff were aware of the difficulties the patient experienced which evidently promoted her erratic behaviour, so that there would not be any barrier to her future treatment. PALS also ensured PTS were made aware of the patient's mobility difficulties which effected her not being able to answer her door very quickly.

18. At the parents' behest, PALS facilitated a meeting between LAS staff and the parents of several young people who had sadly died in an RTA. Although the persons concerned were already receiving bereavement counselling, they said that the meeting provided an opportunity for a clarification of a number of issues of importance to them, which they as assisting them to cope with their bereavement. .

19. PALS were able to provide a North American ambulance service with LAS policy, protocols and data in respect of conveying patients to MIUs. The receiving service is to use this information this as part of their proposal to expand patient care with their regional Health Authority.

20. Mr P was placed on the Special Register following an apparent assault on a member of staff in approximately 2001/02. Mr P evidently received a conviction, although is unclear whether this was in relation to this incident or a further episode involving an assault on a member of hospital staff. Mr P has multiple physical health problems and a personality disorder. Mr P was always maintained his innocence and persistently claimed that he has been discriminated against on any subsequent occasion he has required an emergency ambulance. Mr P made a formal complaint and episodically bombarded LAS with letters and moreover telephone calls, often filling up the voicemail of the Executive Office, PSU, etc.

PALS were able to prevent escalation to further formal complaints on at least 3 occasions. These could not have been considered vexatious as they involved wholly separate incidents, although naturally there were common themes involved. After careful consideration and assistance from an AOM, Mr P was removed from the Register. However, Mr P remains prone to episodic heightened anxiety and remains reluctant to call 999 as he has become consumed with fears about being castigated by ambulance staff and negative information about him being passed to hospital staff, and that he will not be afforded appropriate treatment. As a means of trying to bring this matter to a satisfactory conclusion we are currently involved in working to achieve a specific care plan. Mr P is a very challenging patient but we very much hope that this work will enable EOC to advise operational staff of appropriate information and restore Mr P's confidence in LAS, thus preventing any problems occurring.

Gary Bassett – Patient Advice and Liaison Service (PALS) Manager
January 31 2006

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD 31st January 2006

ASSURANCE FRAMEWORK

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For information

3. Summary

This Exception Report from the Assurance Framework attached includes guidance from the Healthcare Commission on what they are looking for, when awarding compliance with the core standards.

4. Recommendation

THAT the Trust Board:

1. Consider and endorse the recommendations the Assurance Framework process highlights, as principal to threatening the achievement of the organisation's objectives.

2. Agree that further updates on the Assurance Framework be presented at every meeting of the Board as part of its continuous risk management function.

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th March 2005

ASSURANCE FRAMEWORK

1. Introduction

The Assurance Framework was first developed for the reporting year 2003/04, since then the Board has noted that it would be developed and refined further year on year. Work is currently underway to format the document so that it supports the Standards for Better Health which will be launched by the Healthcare Commission in April 2005.

The Framework provides a functional tool for the Board to use and through its revision over the course of this financial year the information from it will give an assurance to Board members, that risks threatening the achievement of our objectives and compliance with the Standards for Better Health are being adequately managed. It is hoped that this approach will embed the Assurance Framework into a mechanism that the Board can use as part of its regular monitoring role.

It is expected that this important communication mechanism will be supplemented by the Framework's contribution to designing the internal audit programme; specifically, that internal audit work is planned to be undertaken where there are gaps in the assurances recorded in the Assurance Framework. This proposal is being considered by the Audit Committee on the 21st March.

2. Risks that have Increased/ Threaten the Achievement of Principal Objectives

These risks on the Framework must be considered by the Board as a priority. The following recommendations refer to areas of risk that we are not managing adequately, either because there is a lack of controls/ robustness of controls or where there is limited assurance available to evidence how well we are managing.

Records Management

It is essential that the LAS have an integrated records management system in place in order to comply with the Freedom of Information Act which came into force on the 1st January 2005. A recent internal audit made the following recommendations to address this;

- Produce and implement a Records Management Strategy that links to existing policies and procedures.
- Formal links between the Caldicott Guardian and local records managers should be made.
- A Records Manager should be appointed to oversee the work required to manage this risk, interim arrangements have been made but long term arrangements need to be considered.

A draft Records Management Strategy has been produced which is currently out for consultation. The recruitment process is underway and interviews take place in April. After the Head of Records Management has been appointed the other actions recommended by internal audit can be progressed.

Lack of crewed ambulances on Saturday/Sunday nights
The ability to maintain control of this risk may be threatened by the implementation of Agenda for Change. Current controls involve the application of enhanced rates and the use of targeted overtime between 2300 and 0300 at weekends together with improved use of Bank Staff and had largely resolved this issue. The new Agenda for Change pay arrangements may have a negative effect as they do not allow the service to continue to pay double time for overtime worked in this particularly unsocial time period, consequently making it difficult to maintain the levels of cover currently provided. A solution is being sought through the Agenda for Change negotiations.

Delay in activating vehicles due to inability to answer calls promptly
There has been a continued focus on attendance management in CAC, and careful monitoring of their performance. Additional staff are to be recruited to address the increased demand and it is anticipated that this tool will improve times for activating vehicles.

Delays in responding to urgent calls
CAC staff are being trained in the use of the Health Professionals questioning protocol. This tool will provide prioritisation for calls from Doctors and Hospitals, resulting in CAC being able to prioritise urgent calls relatively alongside emergency calls so that the criteria for conveyance is clinical need for all patients. A service-wide group is working on this and new regimes are being introduced to ensure speedy dispatch of urgent calls. Call vectoring has also been changed and there are call handlers who are dedicated to taking calls from Doctors.

3. Risks where progress has been made and controls are in place that the Board is asked to note that assurances tell us are under control

The risk of failure to reduce reported risks through incident information not being systematically shared with all relevant departments and committees etc. thus limiting the scope of the investigation, or the identified investigation actions, not being implemented has recently been assured by an internal audit report on Incident Reporting. The report produced 3 recommendations, 2 of which have been dealt with and the remaining action is minor.

4. Conclusion

The Board is asked to consider and endorse the recommendations the Assurance Framework process has highlighted, as principal to threatening the achievement of the organisation's objectives.

The Board is asked to agree that further updates on the Assurance Framework are routinely received by the Board as part of its continuous risk management function.

Enclosure 10

London Ambulance Service NHS Trust Board
31st January 2006

Report of the Trust Secretary

TENDERS RECEIVED

1. Purpose of Report

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

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

2. Tenders Received

Register no.	Details of tender:	
19/05	Provision of Information Technology Infrastructure Library (ITIL) compliant service desk software	Front Range Solutions Computacenter Hornbill
01/06	Works at St Andrews House, Bow	TL Granby Plc Coniston Mitie Property Services Russell Crawbery Ltd Crispin & Borst

It is proposed that the tenders listed above be analysed by the appropriate department and the results of that analysis be reported in due course to this Board.

3. Recommendations

THAT the Board note this report regarding tenders received

Christine McMahon
Trust Secretary

Enclosure 11

LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE

Monday 5th December 2005

Present: Barry McDonald (Chair), Sarah Waller, Colin Douglas (from 3.40pm)

In Attendance: Beryl Magrath, Peter Bradley, Mike Dinan, Christine McMahon, Peter Suter, Michael John, John Wilkins, Laverne Harris

Tim Merritt (Bentley Jennison), Chris Rising (Bentley Jennison), Gary Belcher (Audit Commission), Terry Blackman(Audit Commission), Robert Brooker (Bentley Jennison Local Counter Fraud Specialist)

27/5 Minutes of the last Audit Committee meeting 4th July 2005

Agreed: The minutes of the last audit committee meeting held on 4th July 2005

28/05 Matters Arising

Feedback to station managers: the Audit Committee was assured that feedback to AOMS and Station Officers is routinely undertaken.

Tax Liability relating to staff subsistence payments to staff: the Director of Finance reported that this matter has not yet been resolved. It is expected that a decision will be made following the Inland Revenue's PAYE audit in February/March 2006. Price Waterhouse have been engaged to support the Trust in this audit: a prudent provision of £7m has been made should the Inland Revenue decide that the Trust has liability. The provision includes a back to back agreement with the PCTs. If the Trust is found liable the 'bottom line' will not be affected thought there might be a timing issue with regard to recovering money from the PCTs.

10% check on compliance with drug control: the Chief Executive undertook to follow this up outside the meeting; he reported that there have been incidences of drugs going missing and measures are being put in place to address. **ACTION: Chief Executive**

Revised internal audit work plan: This has been deferred until the governance review is completed. The Chairman commented that as there is only 4 months remaining of 2005/06 he presumed that the internal audit plan will go ahead as originally reported in July 2005. The Head of Governance reported that work is being done to ensure that the internal audit plan is aligned to the risk framework. It was reported that the Internal Auditors had reviewed the draft declaration for the Standards for Better Health; they found that the Trust Board could be assured that the statements in the draft declaration were fully supported by evidence of compliance with the Standards.

Noted: The update regarding the matters arising from the previous meeting held on 4th July 2005.

29/05 Internal audit

The Internal Auditors reported that with regard to the 2004/05 Audit Plan, a final report on corporate governance has been concluded and an executive summary was included with the agenda.

Three reports were at draft stage – Payroll, VAT and Performance Management.
In response to the Chairman's question regarding a reason for the delay it was explained that one of the reports concerned Payroll had been deferred until changes introduced in Payroll had bedded down. It was expected that the 3 reports would move into final stage very shortly.

With regard to the 2005/06 Audit Plan two final reports have been issued (Standards for Better Health, General Ledger). At present there are 4 draft reports (Patient Transport Services, Training and Development, Debtors and Emergency Care Practitioners). The Head of Governance reported that the Head of Education and Development had recently signed off the Training and Development report.

The Standards for Better Health audit included a review of the quality of evidence supporting the draft declaration. The Internal Auditors had been impressed with the evidence. The Chairman said he was pleased that the Internal Auditors had been able to offer very good substantial assurance with regard to Corporate Governance and Standards for Better Health. The internal auditors were asked about benchmarking and reported that they had compared the draft statements of Trusts regarding compliance with the Standards for Better Health of 15 Trusts; the LAS was the only Trust not to receive any recommendations for improvement.

In response to a query from Sarah Waller about the fact that the Auditors had undertaken 80 of the agreed 208 audit days and a number of audits were still to be undertaken, it was explained that a number of audits were scheduled for the fourth quarter. The Internal Auditors were confident that all of the remaining audit days would be used and the audits completed.

Noted:

1. **The audits completed to date**
2. **The substantial assurance given for the draft declaration for the Standards for Better Health**
3. **That the PTS internal audit report would be circulated between meetings of the Audit Committee. <u>ACTION: Governance Manager</u>**
4. **That the Internal Audit Plan for 2006/07 will include ECPs and Urgent Care.**

30/05 Audit Commission

<u>Audit Commission Management Letter</u>

Terry Blackman presented the Auditor's management letter which included a summary of the 2004/05 audit. He highlighted the following key messages:

- Agenda for Change has been a challenge for the Trust;
- The Trust was commended for the two stars it had been awarded in recognition of its performance in 2004/05;
- Accounts received an unqualified opinion from the Auditors

The Finance Director commented that the reference to £56,000 surplus for 2005/06 has changed and at Month 7 it is expected to be £1.3m.

Sarah Waller queried the reference on page 8, para 19 to £8m CBRN funding to be received in 2005/06; it was explained that the £10m CBRN funding contains two elements – £8m recurrent funding (£8m) and £2m non-recurrent funding.

The Chairman pointed out that the new plan for the Trust will be a seven year plan and not a five year plan as stated in the management letter.

The Director of Finance noted that the Audit Commission's fee in 2005/06 will remain the same as in 2004/05.

Noted: 1. **That the Audit Commission were satisfied with the Trust's internal audit arrangements and were confident that reliance could be placed on the work undertaken by the Internal Auditors.**
2. **That the Auditor's recommendations will be added to the schedule of audit recommendations for the Committee to monitor implementation**

Final Accounts

The final accounts were presented at the July meeting and presented at the Trust's Annual Public Meeting in September 2005. It was explained that the Committee received a summary of the final accounts which enabled the Audit Commission to raise any issues that might have arisen since July 2005 and included findings on the audit itself.

Sarah Waller queried the reference to material reclassification £11.2m and was informed this referred to the Agenda for Change liability.

Noted: 1. **The report**
2. **That the recommendations will be added to the schedule of Audit Recommendations.**

Information Management and Governance

Terry Blackman presented the report which included a detailed action plan which will be added to the schedule of Audit Recommendations.

The Chairman queried the estimate in the introduction which suggested that the NHS spends approximately a third of its revenue on collection, analysising and distribution of information in the NHS. The Auditors were not able to say what the percentage of funding is spent by the LAS. Sarah Waller thought the estimate high for the NHS and suggested that whatever the figure was it is likely to increase when Payment by Results is introduced.

The Committee considered the findings of the survey regarding training; of the 140 people who had responded to the survey which had been sent to all active users, 48% felt that training was adequate. It was reported that IT training is application specific; training needs are identified as part of individual's PDP. The Committee thought that although the sample size was small the survey was nonetheless a useful indicator.

The Committee was concerned that there were three different systems holding information on operations and pay. The Director of IM&T confirmed that there is currently very little interaction between the different systems; interfacing across the different systems will be introduced when Electronic Staff Records (ESR) is implemented in July 2006. One of the Auditor's recommendations is that a system map be done and the Director of IM&T agreed that this was something that needed to be addressed. **ACTION: Director of IM&T**

The Director of Finance felt that once ESR is introduced it will be possible to attain a benefits realisation from the introduction of Agenda for Change; that the process for managing information will be re-engineered so as to understand complex's costs and variables such as overtime on a daily basis.

Sarah Waller was informed that ESR has been piloted at St Georges and Hampshire Ambulance Trust and that the Payroll manager regularly liaises with the pilot sites. In preparation for the implementation of ESR a dedicated project manager has been appointed. and a project board established; it is recognised that one of the key tasks that requires action is the 'cleaning up' of data.

Noted: **The report**

31/05 Presentation re. Auditors Local Evaluation (ALE) Framework.

Terry Blackman gave a brief presentation regarding Auditors Local Evaluation (ALE) which will allow the external auditor's opinion of a NHS organisation to be quantified. It will enable comparisons between health organisations and drives improvements in arrangements and outcomes. Though it will be applicable to NHS Trusts, PCTs and SHAs it will not apply to Foundation Trusts as they are regulated by Monitor.

ALE will cover financial reporting, financial management, financial standing, internal control and value for money – each area will be scored on a 1-4 basis. A score of 1 will mean 'below minimum requirements – inadequate performance while a score of 4 will mean 'well above minimum requirements – performing strongly'. The ALE scores are linked to the Healthcare Commission annual health check as part of the use of resources along with core standards, existing targets, new national targets and improvement reviews.

With regard to the LAS it was felt that :

- The Trust had a good track record with regard to financial reporting
- In recent years the Trust has been 'sound' with regard to financial standing and internal control
- The LAS would need to address previously identified weaknesses in financial management and value for money. The finance team are currently undertaking the optional self-assessment.

During the discussion regarding ALE it was recognised that it will be a useful tool in preparing for Foundation Trust status, which the majority of Trusts, including the LAS, will be expected to attain by 2008. The ALE assessment will feed into the assessment undertaken by Monitor. It was commented that if a Trust has a financial deficit it will outweigh other work done by the Trust. The Director of Finance commented that some consideration will need to be given to cases where a deficit has been incurred because of payment disputes between Trusts and PCTs.

The final assessment will be completed by August 2006, published as part of annual health check in September 2006 and a report on the findings will be presented in the annual audit letters in September-December 2006.

In response to Colin Douglas's question as to what level the Trust is now - the Director of Finance suggested 3-4, the Head of Finance thought 3 as he felt there were still some further work to be done e.g. service level controls need to be in place prior to 31st March 2006.

The Chief Executive commented that, based on his experience of the NHSLA assessments, verification work will be required as he felt there may be an issue surrounding the reliability of information provided by some Trusts.

Noted:
1. **That ALE will be introduced in the next audit round i.e. the 2005/06 audit.**
2. **That the Audit Committee will receive assessments on how the Trust is performing against each area as set out above.**

32/05 Audit Committee Handbook

The Committee considered the recently issued Audit Committee Handbook; it contains a number of possibly controversial suggestions for Audit Committees. The Head of Governance commented that the governance review being undertaken by Beryl Magrath encompasses the recommendations of the Audit Committee Handbook; the findings of her review will be presented to the Trust Board in the January/March 06. It will be a Trust Board decision as to the Audit Committee's terms of reference.

There was some discussion regarding the recommendation that the Audit Committee should oversee clinical governance – it was felt this is addressed by the LAS through the current practice of the Audit Committee receiving the minutes of the Clinical Governance Committee.

The Head of Governance observed that at the moment different aspects of the Trust's risk register are assigned to different committees to monitor. It was commented that if the Audit Committee does take on the aspect of the Risk Management Committee the risk register could be considered as a whole by one committee.

Agreed:
1. **That the implications of the handbook will be further considered as part of the discussions to be held when the governance review is presented to the Trust Board.**
2. **That the checklist at the rear of the handbook will be circulated via email for Committee members and attendees to forward their comments to the Director of Finance. ACTION: Trust Secretary**

Noted:
3. **That it was requested that it be verified whether the NHSLA had any input into the Audit Committee handbook and whether it would disagree with any of the proposals. ACTION: Head of Governance**

33/05 Audited Accounts of Charitable Funds

The Committee considered the audited accounts.

Noted:
1. **That income had risen by £9,000 in 2004/05, which included £2,000 received through legacies.**
2. **That the budget in 2006/07 will be reviewed to ensure that the funds are run down in line with the stated policy of the Charitable Funds Committee.**

34/05 Report of the Local Counter Fraud Specialist

Robert Brooker presented his report to the Committee.

As part of the national counter fraud exercise he sampled 60 staff records which included a review of individual career histories from when advertisement was placed for the post, the job description, references presented, qualification of each staff against requirement and qualifications required of the post. When the report is finalised it will form part of the national programme. The report is due to be completed by mid 2006.

The Committee considered the Counter Fraud Specialist's report which included lessons learnt from investigations.

LAS 07-04/05 – the investigation is ongoing

LAS 01/05-06 - an investigation was conducted into a claim for mileage and a number of suggestions made as postcode and station post code are not always included on the claim form, forms should be rejected unless counter signed, mileage readings should be taken from the vehicle so which would assist when spot checks are undertaken.

LAS 02/05-06 – a tender vehicle was stolen mid July 2005 and remains missing. A number of lessons have been identified from this incident: safe storage of vehicles' keys, installation of security cameras, access to site i.e. key pad or swipe card, satellite tracking on all vehicles. The Director of Finance felt that there had been insufficient appreciation of the seriousness of the issue when it was first reported. It is thought the vehicle was stolen during the night and not discovered until the next day; the police were not informed until the second day.

Noted: **The report**

35/05 Risk Register Update

The Governance Manager presented the risk register to the Committee; there were no updates to report, updates will be presented at the next meeting in March 2006.

Following some discussion it was suggested that a new format for the risk register be circulated between meetings for comment. In response to a comment from Colin Douglas, the Chairman felt that the Committee had been challenged to consider the content, and not the format, of the risk register when it met again in March 2006. Amongst the changes suggested for the format of the risk register were: the report to focus on high level risks for the Trust, bigger font to be used, the register to include greater analysis and the numbering to be correct to enable cross referencing to be undertaken and some type of risk scoring.

In response to Sarah Waller's question why the risk about staffing of ambulances had been downgraded to medium the Chief Executive confirmed that the Risk Management Group had considered the risk and felt that there was sufficient evidence of mitigating actions to support the regrading. It was suggested that the risk register be accompanied by a cover sheet which explained what risks had been regarded and why.

Post meeting note: at the Risk Management Committee the Chief Executive apologised as another risk report showed that although considered for regrading, crewing levels at the weekends was still a high risk for the Trust. The updated risk register will include this risk as being high.

Noted:

1. **That the Committee wishes the format of the report to be revised and this will be circulated between meetings for comment.**
2. **That the high level risks will be presented on quarterly basis with the full risk register presented on an annual basis.**

36/05 Standing Committee Items

Noted:

1. **That since the December meeting there have been 2 entries into the Director's Hospitality Register. (1) The Chief Executive received hospitality from CapGemini on 7th September 05 (approximate value of lunch - £75.00). (2) The Director of IM&T received hospitality from Vega on 21st October 05 (approximate value of lunch - £25.00).**
2. **That there have been one waiver of the Standing Orders or Standing Financial Instructions in that an envelope containing a tender was mistakenly opened, resealed and opened again when the official tender opening concerned with photocopiers was undertaken the next day.**

37/05 Audit Recommendations

The Committee reviewed the report and commented that it needed to include the recommendations recently received from the Internal Auditors and the Audit Commission. It was also suggested that the schedule be reviewed as a number of the recommendations had outstanding due dates which may need to be revised.

Noted: **The report, which would be updated and reviewed prior to the next Committee. ACTION: the Governance Manager to update the schedule and circulate it for information prior to the next Audit Committee meetings.**

38/05 Workplan and timetable for meetings 2005/06

Noted:

1. **That the workplan will need to be reviewed in the light of the recommendations contained in the Audit Handbook and the Governance Review currently being undertaken.**

2. **That the dates of future meetings have been circulated – 20th March and 3rd July 2006.**
3. **That there may need to be an increase in the frequency of the audit committee meetings should its terms of reference be expanded to include risk management.**

39/05 Any Other Business

Noted: **That the minutes of the Complaints Panel were circulated for information.**

40/05 Date of next meeting: 20th March 2006 at 2.30pm, conference room HQ

Meeting finished at 4.45pm

Enclosure 12

LONDON AMBULANCE SERVICE NHS TRUST

RISK MANAGMENT COMMITTEE

Monday 5th December 2005

Present:	Barry McDonald (BMc)	Non Executive Director (Chair)
	Sarah Waller	Non Executive Director
In Attendance:	Beryl Magrath (BMa)	Non Executive Director
	Peter Bradley	Chief Executive
	Fionna Moore	Medical Director
	Mike Dinan	Finance Director
	Peter Suter	Director of IM&T
	Caron Hitchen	HR Director
	John Wilkins	Head of Governance
	Laverne Harris	Governance Manager
	Nicola Foad	Head of Legal Services
	Christine McMahon	Trust Secretary (minutes)
Apologies:	Tony Crabtree	Head of Employee Services

14/05 The Minutes of the last Risk Management Committee on 5th July 2005

Agreed: 1. The minutes of the last Risk Management Committee meeting on 5th July 2005

Noted: 2. Minute 10/05 – risk 8, *failure to fully complete the Patient Report Form with details of drugs given, treatment provided and a detailed record of all LAS interventions offered.* SW was concerned that only 5% of obstetric emergency CPI audits had been completed. The Chief Executive reported that the CPI process has been re-launched with effect from 1st December 2005 and it is anticipated that it will significantly improve the percentage of CPI audits completed by Team Leaders. The Committee were informed that the Service is endeavouring to recruit a midwife to deliver telephone advice to obstetric patients and front line crews.

3. Minute 10/05 – risk 131, *risk to staff, patients and organisation of staff working excessive overtime/hours when benchmarked against the Working Time Directive.* The HR Director reported that guidance had been published in September advising staff about the dangers of working excessive hours. At the recent Risk Management Group meeting on 27th November it was agreed that the risk remains a high priority for the Trust.

15/05 Assurance Framework

The Assurance Framework provides supporting evidence for the Statement of Internal Control and that the Trust has systems that are safe and are subject to appropriate scrutiny. The Assurance Framework will be presented to the Trust Board in order that it can be confident that it is informed about all aspects of risk in the Trust.

The Chairman suggested that some attention be paid to nomenclature as there are references to prioritising, priority work etc and felt that the use of some terms needed to be

reviewed. This would enable the reader to be clear on how we use the terms and what they mean.

A requirement under 2.1(principle objectives) is that the Trust Board identifies LAS objectives, clinical, financial and generic. The current principle objectives from the Service Plan are included in Appendix one.

As part of the governance review which is currently being undertaken efforts are being made to ensure that there is minimum duplication of information to the Trust Board and Committees.

Noted: **1. The report**
2. That the appendices of the Assurance Framework will be revised and updated – e.g. actions ascribed to some individual will need to have the initials updated.

16/05 NHSLA Level 3 Assessment report

The Head of Governance presented the report which set out the current position of the Trust in relation to the assessment by the NHSLA for Level 3**.** It was commented that 6.2.1 *'clear evidence of clinical audit of record keeping standards within the 12 months prior to the assessment in 25% of the service'.* This addresses legibility, identifiable signature and completion of standard fields'. The Head of Governance will be presenting evidence on the day to show audit of PRFs have been undertaken and contain recommendations and action plans. He will also explain that there is a new CPI process which is now simpler to use and is web-based. He was hopeful that the Trust will meet the 6.2.1 criterion.

Noted: **1. The report**
2. That attaining Level 3 will mean some financial savings on the annual insurance premium paid to the NHSLA; that the management of risk also fed into the National Healthcare Standards.

17/05 Compliance with health care standards

The Committee was informed that the draft declaration had been submitted on time with all but two signatures of Executive Directors and Non-Executive Directors. There has been some inconsistency across the country as other Trusts have required only the signatures of the Chairman and Chief Executive. The Head of Governance reported that plans are being put in place for the Internal Auditors to check the Trust's level of compliance in areas previously identified as problematic in preparation for the final declaration in April 2006.

It was thought likely that the LAS will be inspected by the Healthcare Commission as it is the only pan London healthcare organisation and the only Ambulance Service not undergoing a reconfiguration. The Trust will receive 48hrs notice of an inspection by the Healthcare Commission.

Noted: **The report.**

18/05 Update Report on Claims

The Committee consider the report on claims which included a summary analysis of the clinical negligence, staff personal injury and employment tribunal claims, third party public liability and road traffic accident claims against the Trust. The report also set out the actions taken to reduce the incidences of such claims in the future.

It was queried whether work had been done to differentiate between accidents involving ambulances and FRUs. The Finance Director confirmed that the matter was being investigated and the risk was being monitored by the Motor Risk Group.

There was a discussion regarding damage to vehicles. Found on Inspection (FOI) is the second biggest type (Check) of reported accident.. The Motor Risk Group are reviewing the current system of allowing people 7 days to report damage and introducing the requirement that the damage be reported within 24 hours. Work is being done on how the complexes could take more ownership/responsibility for damage to vehicles. There is data available regarding damages/accidents per complex which will be analysis and followed up.

The Head of Legal Services wished to record her thanks to colleagues in the IT department who were able to provide her with statistical information when the Trust's motor insurance company were unable to provide the information.

Noted: 1. The report.
2. That there is a downward trend in claims being received by the Trust.

19/05 Risk Register Update

The Chief Executive commented that an error had taken place and that risk 1 (*lack of crewed ambulances on Saturday and Sunday nights*) should have been on the high risk register earlier discussed at the Audit Committee. The risk register will be reviewed outside the meeting.

The Chairman was pleased to see that a number of really good practical actions were taking place to mitigate the various risks facing the Trust. He noted that risk 68 (*risk of loss of PRF or inappropriate access to patients related information, due to lack of security while forms are kept on stations and in departments or dung transportation between stations and departments*) has been solved and that risk 97 (*inability to either oxygenate or nebulise neck breather patients to the same standards as any other patient due to no specific equipmen*t) has been addressed by the introduction of neck breathers.

Noted: That the risk register would be updated and the format reviewed.

20/05 Minutes from Meetings

1. Information Governance Panel – 26th April 2005

The Director of IM&T reported that he was pleased with the progress being made by the Information Governance Panel. Beryl Magrath commented that there were some areas of concern regarding the storage of documents and data and that there was no formal registry. It was confirmed that this would be part of the IT strategy and would also involve the Records Manager. A number of web sites have been blocked; the most frequently requested site is the National Lottery. To date no requests for a change of access has been granted. In 2006 individual email accounts will be introduced.

NOTED: The minutes of the Information Governance Panel.

2. Clinical Governance Committee – 15th August and 31st October 2005

Beryl Magrath highlighted the main topics of discussion at the August Clinical Governance meeting: CPI, record keeping and drug management.

In October the Clinical Governance Committee was concerned that only a few of the Oversight Borough Committees had responded in time for inclusion in the draft statement of compliance with the Standards for Better Health. The Head of Governance reported that

at a recent meeting, the Regional manager for the Healthcare Commission had expressed surprise that the LAS had needed to liaise with 31 Borough Oversight Committees.

The Clinical Governance Committee had expressed disquiet that only 69% of places were being taken up on training sessions and the Head of Education and Development was asked to provide a further report to the meeting in January 2006.

Work has been initiated on how patients with advance directives can be recognised and suitably treated by LAS staff – possibly by using a system similar to the Medicalert system.

NOTED: The minutes of the Clinical Governance Committee.

3. Risk Management Group – 27th July and 28th September 2005

The Director of Finance presented the minutes of the Risk Management Group. He reported that as yet 'black boxes' have not been trialled. It is planned that they will be trialled in January/February 2006 and probably in one sector. It was anticipated that the trial would pay for itself in terms of cost-benefit analysis.

Beryl Magarath asked whether members of staff who drive FRU vehicles on an ad-hoc basis receive a driving assessment. The Medical Director explained that a training course had been designed for regular drivers of FRUs and this being rolled out across the Trust. By virtue of the fact that ad hoc drivers only occasionally drive FRU vehicles it is difficult to ensure they are assessed. The Clinical Risk Group is monitoring this risk and will keep the Committee advised as to progress. The Medical Director mentioned that part of the ECPs' training includes a secondment at the Royal London Hospital (out of which HEMS operates) and this involves a 5 day driving course.

NOTED: The Risk Management Group minutes.

21/05 Any Other Business

1. **The Chairman informed the members of the Risk Management Committee that the Audit Committee discussed the Audit Handbook recently published by the NHS. It had been agreed that the checklist at the back of the handbook would be circulated for comments which should then be forwarded to the Director of Finance. Further discussion on the role of the Audit Committee will take place when Beryl Magrath presents her governance review to the Trust Board.**

2. **The Chairman explained that the Audit Committee had agreed that the format of the risk register be reviewed; the GDU will circulate the new format for comments.**

22/05 Date of next meeting of the Risk Management Committee

Monday, 20th March 2006 at 4.15pm, Conference Room

The meeting concluded at 5.35pm

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Enclosure 13

LONDON AMBULANCE SERVICE

SERVICE DEVELOPMENT COMMITTEE

Tuesday 20th December 2005

Held in the Burns Room, Union Jack Club, Waterloo SE1

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Barry MacDonald	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Executive Directors	
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
	Martin Flaherty	Director of Operations
Apologies:	Colin Douglas	Non Executive Director
	Mike Dinan	Director of Finance
In Attendance:		
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development
	Martyn Salter	Deputy Director of Finance
	Mark Whitbread	Clinical Practice Manager
	Rachael Donohoe	Head of Clinical Research Unit
	Mary Halter	Senior Research Fellow
	Tom Marlow	Senior Statistician
	Christine McMahon	Trust Secretary (Minutes)

43/05 Minutes of the Meeting held on 25th October 2005

Agreed: The minutes of the meeting held on 25th October 2005 as a correct record of that meeting.

44/05 Matters Arising

Minute 38: The HR Director confirmed that the Trust had been successful in its bid to participate in the national long term workforce project which will be completed by February 2006. The tool for testing and access to potential support was discussed at a recent meeting of the participants in the national project. The HR Director thought that it would be a very useful project to be involved with at the beginning of the seven year plan.

45/05 Chairman's update

The Chairman explained that the Committee were meeting at the Union Jack Club due to the conference room at HQ being used temporarily during December and January as a Gold Control Room. This is part of the plan to improve performance during the difficult months of December and January.

The Chairman referred to the uncertainty that exists at the moment in the Department of Health and NHS due to a backbench backlash against some of the key reforms set out in 'Commissioning a Patient Led NHS' allied to the uncertain future of many key figures in the new scheme of things. It was anticipated that the transitional directors for the proposed new Strategic Health Authorities will be appointed by mid January. As soon as the new senior appointments in London are announced every effort will be made to ensure that they are made aware of the case for a strategic funding of Emergency Care Practitioners (ECPs) as a potential means of saving money in the London healthcare service.

To date, the LAS has not received any of the £15 million it has been promised to fund expenditure that has already been incurred to strengthen anti-terrorism defences (£10m CBRN funding and £5m for emergency contingency funding). Unless the funding is received the Trust will go into deficit, and there will be a serious cash flow problem in February and March 2006. A number of options were discussed whereby the resulting deficit for the year could be reduced in the limited time remaining. The most effective way to cut costs in the short term is to cut back e overtime, which would have a dramatic effect on patient care and the attainment of performance targets. It was recognised that unless the outstanding funding is received the Trust will not break even and it will not be able to contribute the requested surplus to the South West London Strategic Health Authority (SWLSHA) in March 2006. The Chief Executive is meeting with John Bacon on the 5th January 2006 and will be making the strongest case possible for the Service to receive the entire £15m. The Chairman requested that Non-Executives and Executives make themselves available at 10am on the 10th January 2006 for an Extra Ordinary Trust Board meeting should the meeting with John Bacon prove unsatisfactory.

Noted: That an extraordinary meeting of the Trust Board may be held on Tuesday, 10th January 2006.

Performance

The Director of Operations reported that a major effort is being undertaken to achieve the performance target of 75% for Category A 8 minute calls for 2005/06. Since crews have received the back pay due to them under 'Agenda for Change' there has been a week-on-week fall in staff available to work overtime; this was anticipated and had been discussed at previous Committee and Trust Board meetings. The Chief Executive informed the Committee that a number of ambulance services around the country are reporting difficulties in achieving performance targets; due in part to an increase in Category A calls but also to poor industrial relations and poor staff morale. Agenda for Change has led to the seemingly impossible result of greatly increasing pay (and therefore costs) while lowering staff morale and hurting relationships between management and staff representatives that had been carefully rebuilt over the last few years.

The Pulse is now showing performance for the month/year to date in 'real time' as it is updated every five minutes. The Director of Information Management and Technology reported that it may soon be possible for real time performance data to be relayed to mobile phones on a regular basis.

A communications strategy is being implemented to reinforce the need for all available staff to work overtime. The Director of Operations has issued an Operations Bulletin to all front line staff, setting out how they can help and pointing out how much money is being paid for overtime (a Paramedic could potentially earn £500 if covering a rostered shift). The Chief Executive has recorded a video message, available via the Pulse, which stresses the performance challenges the Service is facing. The Director of Communications has received positive feedback regarding the video, with members of staff expressing approval of the message and the medium used. In addition, the Chief Executive has written a personal note, reiterating the message in the video, to all front line staff. A letter will also be sent to support staff asking for their assistance in meeting the challenges.

The Director of Operations reported that staffing for 25th and 26th December are currently presenting a major challenge.

Noted: The update regarding performance.

46/05 Agenda for Change

The HR Director reported that to date 70% of staff have been assimilated onto Agenda for Change (AfC) terms and conditions. In November EMT3s were assimilated and back pay was paid to Team Leaders and Paramedics. Payroll is under considerable pressure in December as the salaries are being paid a week early (23rd December). In December the Payroll team have focussed on validating unsocial hours payment for Emergency Medical Technicians, Team Leaders and Paramedics and staff should receive their corrected pay in December.

Work will be undertaken in January to complete matching and evaluation of all outstanding posts. The last 3-4 months has been a very busy time for the Payroll Team and it is likely that January will be also be an equally intense month.

Nationally there has been deterioration since the revised definition of assimilation onto AfC – a number of Trusts have reported little progress in assimilating staff. The Trust has reported its progress to date to the Strategic Health Authority who has expressed satisfaction with the work undertaken to date. With regard to the Recovery and Support Unit no special interest has been shown in the Trust apart from the enhanced technician role.

In response to a question from Sarah Waller the HR Director confirmed that the remaining members of staff (which includes 40% of Administrative & Clerical and all of Emergency Operations Centre (EOC) staff) will be assimilated in January and February, with back pay paid in February and March.

Key Skills Framework: 70% of outlines have been agreed. The majority of front line crews have outlines. Some Trusts have reported that no KSFs have been completed for staff.

Meal breaks: the use of meal breaks will depend to some extent on the agreement reached with staff representatives. There is considerable variation around the country regarding the implementation of meal breaks.

Emergency Operations Control (EOC): to date there has been no success in matching EMD1s and EMD2s and this is being reviewed. It may be that although EOC staff might not be financially disadvantage or advantaged by AfC the improved terms and conditions might encourage current staff to choose to be assimilated. New staff recruited to EOC will automatically be on AfC terms and conditions. EMD3s have been job matched and were financially better off under AfC however consistency checking still needs to be undertaken.

It is expected that job matching, consistency checking etc for EOC staff will be undertaken in January 2006.

Noted: The report.

47/05 Finance report - Month 8

The Deputy Director of Finance presented the Month 8 finance report. In Month 8 the Trust's income was £17.5m and expenditure £16.4m. A surplus of £1.1m was due in part to £400,000 which will be received from the Multi-Agency Task Force (MIATT). PTS continued to overspend in Month 8, though at a lower rate than previously. He was confident that, as long as we receive the promised anti-terrorism funding, there are sufficient funds to pay for Agenda for Change, which was gratifying given that the Finance Team had had to make an estimate regarding bandings when drafting the 2005/06 budget.

The Committee's attention was drawn to the analysis by function; when the budget was drawn up it was anticipated that the meal break issue would have been addressed by November 2005. The continuation of payments for meal breaks will be shown as an adverse payment in subsistence. Payment for overtime continues to be high though it decreased in Month 8 by approximately 15%. It has been increasingly difficult trying to forecast overtime given that the Resources Centre has been uncertain as to how many hours will be worked and what the skill mix will be and therefore the level of payments required. The Finance team are endeavouring to extrapolate the payments figure from the identifiable trends.

Though there has been an increase in Category A 8 minute demand it has not been sufficient to trigger extra funding from the Commissioners. In order to receive additional funding the increase in activity needs to be for all categories of calls and not just Category A 8 minute.

The LAS has been proactive in pursuing monies owed; payment has been received from all but three Primary Care Trusts (PCTs). It was thought likely that the three PCTs will be instructed by the SWLSHA to pay. The dispute had arisen because the PCTs are disputing the funding they received to pay for London Weighting under AfC.

PTS: payment has been received from the majority of the small debtors. There is an outstanding debt of approximately £350,000 from the Queen Elizabeth and Queen Mary Hospitals. As some of this debt was incurred in 2002-03 it has been prudently provided for and therefore any payment received will be a bonus.

Beryl Magrath was informed that double time for overtime would cease at the end of December. The Director of Operations thought it likely that an enhanced payment will continue to be required for 23.00-03.00 at the weekends. Under AfC overtime is paid at time and a half.

It was reported that members of finance, logistics, AOMS and representatives of British Oxygen Company are endeavouring to identity a more efficient, effective and economical way of working together.

Noted: The report

48/05 **Progress report on Governance Review**

Beryl Magrath updated the Committee on the governance review she has undertaken in recent months. A lot of information has been gathered from both internal and external sources; she commented that some of the advice regarding governance is conflicting and this will be highlighted in her report to the Trust Board in January 2006.

She thought that the Chief Executive demonstrated good governance. She felt the Trust could be justifiably proud of its communications systems which included the Chief Executive's annual consultation meetings, the induction course for new staff, the Continuing Professional Development course (CPD), the weekly Routine Information Bulletin (RIB) and the intraweb site, the Pulse.

She highlighted the following areas of concern – poor performance of Clinical Performance Indications (CPI) audit which will hopefully improve with the recent improvements to the process; the fact that 32% of our people are not attending training courses they have been booked on and that 25% of damages to vehicles is found on inspection rather than being reported by staff. These examples suggest that governance is not as embedded at ground level as it might be. The Chairman suggested that no organisation could wholly rely on formal processes for the implementation of good governance. He urged the NEDs to continue to go out with crews so as to gauge for themselves what is happening in the Trust. Barry McDonald recently undertook a shift with a front line ambulance crew based in Westminster and his report has been circulated for information by the Chairman.

Noted: The progress report regarding the governance review being undertaken by Beryl Magrath.

49/05 **Changes to CPI database**

The Medical Director introduced Rachel Donohoe, Head of Clinical Audit and Research, who gave a presentation explaining the recent changes, introduced with effect from 1st December, to the audit of Clinical Performance Indicators (CPI). The process is now web based, easy to use and of clinical benefit to staff as well as the organisation. Once staff have received feedback from their Team Leaders, they will be able to access information directly, download it and use it as part of their Personal Development Record (PDR). The Head of Clinical Audit & Research paid tribute to James Cook in Management Information, who had been extremely helpful with the design of the new process. She received very positive feedback about the new process from Team Leaders who recently attended refresher training.

The Chief Executive commented that the review of the Sector Operating Model suggested that the ratio of staff to managers required further consideration. The Head of Education and Training has been asked to emphasise the role of Complex Training Officers – this will be an opportunity to clarify the respective roles of Training Officers and Team Leaders. There are currently 155 Team Leaders in post whose role is to undertake on the road clinical supervision and CPI audits. To date the completion rate for the CPI audit has been poor, with operational pressures being cited as the main reason.

The Chairman thanked the Head of Clinical Audit Research for her presentation and hoped that there would be demonstrable improvements by the summer and looked forward to an update then.

Noted: The changes to the CPI database and that an update will be presented in June 2006.

50/05 **Discussion regarding LAS strategic alliances**

The Committee considered a paper by the Director of Service Development, which outlined the immediate challenges facing the LAS in meeting current and future national performance targets. The paper also described the key changes necessary for delivery of the Trust's Seven Year Plan and the scope for greater involvement in other services such as Out of Hours Primary Care.

The Director of Service Development informed the Committee that as London GP Co-ops have not opted out of Out of Hours there has not been the significant pressure experienced elsewhere in the country for the LAS to take on Out of Hours work. Nevertheless, she felt there continues to be a strong argument for the Trust to be involved in Out of Hours work.

The Chief Executive reported that ECPs will be introduced across North West London sector in 6-9 months time; this will be an opportunity to change the North West London sector's infrastructure. The Director of Service Development reported that the Assistant Director of Operations – Urgent Care, has had talks with Out of Hours Providers with regard to them assisting the Trust by taking on the management of Category C work. It was reported that none of the Providers were in a position at this time to provide the necessary resources.

The Director of Operations informed the Committee that the modelling recently undertaken by ORH suggested that the Trust required three times the number of single responders to respond to red and amber calls (850 staff) and in a perfect world they would all be ECPs. This was felt by some to be somewhat daunting; as it provoked the question as to whether the Trust currently has 850 staff with the right skills and mindset to be an ECP. In the short term additional clinical support is being sought for EOC through the employment of GPs.

The Chairman felt that to date the number of ECPs have been insufficient to make the necessary impact; additional funding is required to pump prime the initiative. He suggested that when the new management of the single London Strategic Health Authority is appointed the case should be made for a strategic approach to be taken with regard to the SHA funding the development of ECPS. There is potentially immense savings to be made for the London health economy as a whole through the widespread introduction of ECPs. He also suggested that the Trust needed to focus on ideas of how it will meet numerous challenges it faced and that money should not be a restraining force – if the ideas are feasible, funding can be found. As an example he suggested that nurses, EMT4s, Paramedics should be encouraged to do a conversion course to become ECPs so as to increase the number of ECPs available to the Trust. Another possibility was that GPs could be employed in hubs to give clinical advice via the telephone, resulting in improved productivity and more patients being left at home in a clinically safely way.

The Chief Executive outlined the step changes that will be necessary for the Trust between now and April 2007 – green calls dealt with by frontline ambulances to be decreased by 10,000 per month and for the A&E to achieve full establishment.

381 staff will be recruited in 2006/07 and work is being undertaken regarding the composition of that additional workforce. Management will be in talks with the Trade Unions as to how these step changes will affect staff.

The Chairman commented that it appeared from the paper and the ensuing discussion that the Trust was looking less at forming strategic alliance and more at doing it for ourselves, though being open to any advantages that could be gained from possible alliances. It was recognised that the Trust needed to be 'fleet of foot' tactically to respond to any opportunities that might arise.

Noted: The report which set out the potential for LAS involvement in out of hours – achieving the balance between short and long term challenges.

51/05 Evaluation of ECP scheme

The Director of Service Development introduced Mary Halter (Senior Research Fellow, St George's Medical School) and Tom Marlow (Senior Statistician) who presented the findings of an evaluation of the ECP scheme.

The evaluation found that ECPs had responded to 11,000 calls, which on average ECPs spent 82 minutes with patients (20 minutes longer than A&E crews). During the course of the evaluation utilisation rates have steadily improved; in April 2005 this was 41% and it has improved sine then. Feedback from patients is generally very positive, especially from those patients left at home. Feedback from patients of black or minority ethnic groups and younger age groups was less positive than other categories of patients. This is a trend experienced by all public service organisations. ECPs generally convey approximately 20% of their patients to hospital compared with A&E ambulances who convey 75%.

Sarah Waller suggested that it would be useful for ECPs work to be mapped so as to have a better understanding of the pattern of practice. **ACTION: Senior Research Fellow.**

Noted: The evaluation of ECPs undertaken by MH and TM.

52/05 Update on proposed EMT 4 role – education and development

The Medical Director introduced Mark Whitbread, Clinical Practice Manager, who presented the proposed education and development for the new EMT4 role.

The Clinical Practice Manager presented the draft programme for EMT3s to become EMT4s, which will entail successfully undertaking a five day course and passing an exam at the end (with the possibility of one re-sit). In addition there will be a two day placement at a hospital perfecting airway management skills. There is an expectation that staff attending this programme will have undertaken the CPD course and other relevant or mandatory training. St Georges Medical School has reviewed the content of the programme and is satisfied that it forms part of the developmental programme for a technician to become a paramedic.

Sarah Waller requested that a mapping be undertaken to demonstrate the skills escalator. **ACTION: Clinical Practice Manager**

In response to a query as to how the Trust would manage a situation whereby someone appointed as an EMT4 proved unsatisfactory it was stated that this would be addressed in the usual way for anyone whose clinical skills were found wanting – in the first instance by additional training or placements.

Sarah Waller was informed that application to become an EMT4 had to be supported by the individual's manager and that there are currently 600 eligible members of staff. Beryl Magrath, who thought the programme very good, was informed that although the teaching on the course will be of a diploma level, no diploma will be awarded.

Noted: The report regarding EMT4

53/05 Estates update

This report was rescheduled for consideration at the Trust Board in January 2006

54/05 Date and Venue of the next Service Development Committee Meeting

Tuesday, 28th February 2006 at the Union Jack Club, Sandell Street commencing at 10.00 am.

The meeting concluded at 13.00

Enclosure 14

London Ambulance Service NHS TRUST

TRUST BOARD 31st January 2006

SUMMARY OF THE MINUTES
CLINICAL GOVERNANCE COMMITTEE, 16th JANUARY 2006

1. Chairman of the Committee Beryl Magrath

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

3.
- **Terms of reference & including membership reviewed**
- **The Committee noted:**
  - The Clinical Governance Development plan
  - Work undertaken for NHSLA level 3 visit 23/24th January
  - Work undertaken for Healthcare Commission visit 7th February
  - Education & Development Plan
  - PPI report-considerable work has been undertaken since appointment of PPI manager
  - PALS report-time consumption on FOI, 112 enquiries, 6 reasonable, 24 commercial interests.
    - -Issues around illegible and incomplete PRFs
    - -Lost property-success of SEBs (Smart Evidence & Bag System) at Hillingdon. Rollout across LAS to be costed
  - Recruitment and Selection Review by HR & READ group to improve the diversity of LAS workforce
  - Access to Trust for deaf & non-English speakers is being reviewed & improved
- **Presentation:** Use of CIRIS software to support recording of information for SfBH. Agreed: Alternative approaches to be examined
- **Records Manager reported on:**
  - Records Management Strategy- comprehensive and essential work leading to the development of an EDRMS (Electronic Document Records Management System) at LAS by 2010. Agreed in principle. Will need Board approval.
  - Summary status report of 26 incomplete policies & procedures. Sponsors have been asked to revise or cancel these
- **Clinical Risk Register for 12 high priority risks.** Agreed: This needs to be more user friendly with clear colour coded status & changes highlighted.
- **Minutes Received:** Training Services Committee
Clinical Risk Group
Clinical Audit & Research Group
Clinical Steering Committee.

4. **Recommendation** **That the Trust Board NOTE the minutes of the Clinical Governance Committee (TO FOLLOW).**

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 29th November 2005

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Barry MacDonald	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Colin Douglas	Non Executive Director (arrived 10.05)
	Lord Toby Harris	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
	Martin Flaherty	Director of Operations
In Attendance:		
	Malcolm Alexander	Chairman, LAS Patients' Forum
	David Jervis	Director of Communications
	Peter Suter	Director of Information Management & Technology
	Kathy Jones	Director of Service Development
	Colin Hill	Member of the public
	John Hopson	ACAO CAC
	Martin Brand	Head of Programmes and Projects
	John Trenfield	Observer (SPR in emergency medicine)
	Chris Vale	Acting Head of Operational Support
	Ian Pentland	Consultant - IT
	Christine McMahon	Trust Secretary (Minutes)

108/05 Declarations of Interest

There were no declarations of interests.

109/05 Opportunity for Members of the Public to ask Questions

There were no questions.

110/05 Minutes of the Meeting held on 27th September 2005

Agreed:

1. **The minutes of the meeting held on 27th September 05 as a correct record of that meeting with the following amendments:**
2. **Clarification was sought as to 'each year that amount would be increased by reduced in real terms be used when ambulance services are implementing Payment by Results'.**
3. **The Complaints Panel will meet again on 5th October 2005 not 52005.**

111/05 **Report of the Chairman**

The Chairman referred to the reforms that had been proposed under the recent Department of Health paper 'Commissioning a Patient Led NHS' - though no formal decision has been made it now appears that there will be one Strategic Health Authority for London and thirty two Primary Care Trusts (PCTs). The roles and responsibilities of PCTs will probably be redefined, however.

Discussions are taking place between the NHS Confederation and the Ambulance Service Association as to how the two organisations can work closer together. The Board will be kept informed of progress.

The Chairman, on behalf of the Trust Board, thanked Lord Toby Harris for his contribution and efforts on behalf of the LAS over the last eight years. The Chairman referred to Lord Harris's long and illustrious career and on behalf of the Trust Board wished him well for the future. The Chairman felt that the Board had been fortunate to have Lord Harris as a member and he was sorry that Lord Harris had declined a third term. Lord Harris's constructive and thoughtful contributions to discussions have been greatly appreciated.

Lord Harris said that he had enjoyed being a member of the Trust Board for eight years, during which time he had seen the organisation transformed. He paid tribute to the Chief Executive and his team for the work they have done. He felt that the Trust Board has been kept well informed which compared favourably with other committees/boards he has been member of.

112/05 **Report of the Chief Executive**

The Chief Executive highlighted the following from his report to the Trust Board:

Activity remains high, 4% increase in demand on this time last year which meant an additional 60,000 999 calls. The performance year to date is 73% for Category A 8 minute (Department of Health target of 75%) and 95% for Category A 14 minute calls (Department of Health target of 95%).

The Chief Executive referred the Board to Graph 9 of the information pack attached to the report; it showed the performance targets being achieved in August when levels of crewing were higher than the previous two years. The increase in Category A 8 minute calls and the level of cover in terms of front line crews staffing ambulances and cars has had a serious impact on performance. The Trust will seek to address this issue in part by recruiting an additional 300 plus staff over the next few years.

Comment [SER1]: Check with Peter

The Board was informed that there have been intermittent technical issues during the last eight weeks which will be referred to in more detail when the Director of Information Management and Technology spoke about CAD (minute 122).

The Chief Executive expressed confidence that the Trust will be back on target by March 2006 and will achieve the Category A 8 minute target of 75% for the year. The Director of Operations is developing an escalation plan which will include pre-agreed responses to certain levels of activity. The plan may include the possibility that the Trust cease to respond to Category C calls, that training sessions are postponed and that managers crew ambulances.

The Urgent Operations Centre (UOC) is opening on the 30th November; new software has been purchased for the Clinical Telephone Advisers and additional staff are being recruited to deliver clinical advice by telephone; the Emergency Bed Service personnel are moving into the UOC on 30th November 2005.

The Chief Executive said that as a result of the UOC starting to function as planned, he expected to see greater utilisation of Whitework and ECPs with a decrease in Category C calls being responded to by front line A&E crews.

Central Control (CAC) is changing its name and will in future be known as the Emergency Operations Centre (EOC).

The Trust will look to employ a midwife for a year to advise on maternity cases and give telephone advice in a clinically safe way for that group of patients.

The Chief Executive confirmed that he had been advised that the Trust will receive £10m CBRN funding and an additional £5m to support increased resilience due to the terrorist threat. He is working hard with the South West London Strategic Health Authority and the Department of Health to secure the promised funding.

Deleted: requested

The Board was informed that PTS is not going to break even this year; in recent months there has been some loss of control regarding the use of third party transport. A new management board for PTS is in place and includes the Director of Operations and the Director of Finance.

Deleted: it was felt that

Workforce planning – the Trust is looking to recruit a large number of staff during the next twelve months to fill vacancies and meet the requirements of Agenda for Change. The plan will be presented to the Trust Board in January 2006. It is intended that the additional staff will mean less reliance on overtime. **ACTION: the HR Director & Organisation Development.**

Deleted: anticipated

There has been good progress on Agenda for Change; paramedics and team leaders have been assimilated. Staff retention is high with only 7% turnover of front line crew.

The Board was informed that the Communications Department has been very busy. On the 28th November 2005 'Tonight with Trevor McDonald' featured the LAS in a programme reviewing the impact of the recent change in licensing laws. The Chief Executive said that anecdotal evidence suggested that demand has increased from 11pm to 4am; in the same period of time four staff were assaulted.

The Chief Executive's consultation meetings have been going well and good feedback is being received from front line crews. One of the issues raised by front line crews is the relationship with the Metropolitan Police. There is a view that the Police are not always as responsive as we would like. There were also comments about the way the CAD link is used to prioritise calls and to dispatch ambulances. Senior LAS staff will be meeting with senior officers of the Metropolitan Police within the next ten days to try to address some of the issues raised at the consultation meetings.

Deleted: and

There has been a lot of good work undertaken by the Estates Department. The following works have been recently completed: Rotherhithe Ambulance Station, Streatham Ambulance Station, a purpose built logistics unit at Deptford and the opening of the Urgent Operations Centre. For Streatham, Rotherhithe and the UOC, opening ceremonies will be held and board members will be invited to attend. **ACTION: The Director of Communications.**

Patient Public Involvement Margaret Vander, the Head of PPI, is leading on this work. A large number of staff are involved and working with the LAS Patient Forum.

The Patient Advice & Liaison Service (PALS) has been extremely busy. The Chief Executive suggested that a presentation regarding the Service be given to Trust Board in 2006. **ACTION: Director of Communications**

Professional Standards Unit – a review is being undertaken of the Professional Standards Unit (PSU) and a report will be presented to the January Trust Board. The report will include recommendations on how complaints will be managed in future.

Colin Douglas asked about the 4 assaults on staff and whether there has been an increase over the year. The Chief Executive said that overall the trend has been downward; the recent incidents co-incided with a film crew accompanying front line crew also being assaulted. The situation will continue to be carefully monitored.

In response to Colin Douglas's question about PTS and the lengthy waiting times that some patients have to endure, the Chief Executive said that management is looking at a new scheduling system for PTS. The Finance Director pointed out that the vehicles are relatively small (capacity 6 people) and consequently there is a lot of shuttling.

Beryl Magrath asked whether the plan to recruit an additional 300 plus staff included fully trained staff from other parts of the NHS. The HR Director confirmed that a recently placed national advertisement was aimed at recruiting staff to the LAS that are fully trained. Beryl Magrath referred to her recent visit to East Anglia Ambulance Service, who use nurses to deliver Clinical Telephone Advice (CTA) and wondered whether that was something the LAS might investigate. The Director of Service Development said that East Anglia have always used nurses to assist CTA. The Management Team are working on an escalation plan which may include not responding to Category C and may include employing General Practitioners to deliver CTA when appropriate. If the escalation plan is implemented it would be offering a short term solution, not a long term solution, to the challenges that the LAS faces.

The Chairman of the LAS Patients' Forum was assured that the review of PSU will include a review of the internal relationship between PSU and PALS.

The Chairman of the LAS Patients' Forum enquired whether the tender documents for PTS included clinical safety. The Director of Finance confirmed that although clinical safety is included in the tender documentation, he felt the final decision by acute trusts is heavily influenced by cost – the cost per patient per journey. PTS is an expensive service and its competitors are able to provide a cheaper service, in part due to the fact that they have not had to implement AfC terms and conditions. Under Department of Health regulations every contractor in business with the NHS is required to implement AfC terms and conditions; consequently Acute Trusts may find their external contractors may have to increase their price as a result.

Barry McDonald queried the information in the graphs which showed an increase in Category A responses but fewer ambulance hours staffed. The Chief Executive said that the graphs were incorrect and not up to date. The graph for Category A does not include red calls. In November, December and January calls increased by 700 not 50%. The staffing graph does include staff who worked overtime and the additional cost will be due to the double time paid.

The Director of Operations pointed out that on a busy day the Trust responds to 950 Category A 8 minute calls whereas previously it responded to 500 calls. The margin for error is different in terms of the increased number of patients who need to receive care within 8 minutes. In response to a question from Barry McDonald the Director of Operations said that a new team of Assistant Directors of Operations (ADOs) had been appointed (in post from 24th October); part of their role will involve working with Ambulance Operations Manages on the current challenges facing the Trust. To some degree the AOMs have been adversely affected by the

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Comment [SER2]: Improve clarity of what was said, please.

Comment [SER3]: Can this really be true? If taken literally it would mean the whole country being on AfC!

Comment [SER4]: Red? Cat A?

impact of vacancies and the negative impact of AfC. The ADOs will be working with the AOMs to focus on areas they can impact rather than focussing on areas where they cannot i.e. vacancy level.

Sarah Waller was assured that no complaints had been received as a result of the recent CAD failures.

In response to a question from Toby Harris the Director of Information Management and Technology explained that the recent failures were as a result of two separate issues. One concerned the ongoing public interface data base which has experienced 20-30 disruptions. The Trust is working with IBM to address this issue; the latest change was implemented last week and the situation is being carefully monitored. The second matter was due a fundamental upgrade of the CAD system not being transferred correctly in August. The system was down for 5 hours. Now that the reason for failure is known steps have been taken to ensure non-reoccurrence.

Toby Harris thought it was an excellent idea for the high level meetings to take place with the Metropolitan Police. The Chairman endorsed this suggestion and the Chief Executive thought that the ADOs would be the most appropriate people to take forward. **ACTION: The Chief Executive to put this liaison in place.**

Noted: The report

113/05 Month 7 Finance Report

Insurance for CBRN staff: the Director of Finance reported that the Trust has purchased insurance cover as a last resort for CBRN staff so that in the event that staffs' own mortgage companies invalidate their policies as a result of a CBRN incident staff have some protection. The cover is capped at £5m for annual cover and capped at £250,000 per individual. This type of insurance has never been underwritten in the UK insurance market before. Every effort will be made to ensure that the Government take on this responsibility with effect from November 2006 as the CBRN personnel of all the emergency services are potentially affected.

Month 7 Finance Report: the Trust's income was £346k lower than expected in month 7 due to an under recovery on ECP income since there was a delay in the roll out of ECPs in the North West.

The payment of double time was higher than forecasted for October as there were 5 weeks in the month which meant an additional £95,000 on the salary bill. The payment of double time for overtime will cease at the end of December 2005.

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The Trust is forecast to have an end of year surplus of £1.3m.

PTS is forecast to have £700,000 deficit (the worst case scenario); an action plan has been implemented to ameliorate the situation so that the deficit may be £350,000. The Director of Finance reported that, whilst he has provided for bad debts, every effort will be made to recoup any outstanding debts. With regard to the profitability of contracts the East sector has three which are unprofitable and the West has six that are unprofitable. The two contract managers have been tasked with ensuring that contracts are brought back under control. A further report regarding PTS will be presented to the SDC in December. **ACTION: Finance Director.**

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There was a discussion concerning the additional funding the Trust is expecting to receive. (£10m recurrent CBRN funding and £5m additional emergency funding). Every effort is being made to ensure that the additional funds are received as soon

as possible and discussions are being held with the South West London Strategic Health Authority and the Department of Health. The Director of Finance confirmed that the Department of Health has been invoiced for both sets of funding.

In response to a query from Sarah Waller the Finance Director confirmed that the Trust has received confirmation in writing that any monies brokered in March 2006 will be received back in the following financial year.

In response to a question from Beryl Magrath the Director of Finance confirmed that a report regarding accidental damage will be presented to the Trust Board in December. **ACTION: the Finance Director.**

Noted The report

114/05 Report of the Medical Director

The Medical Director reported that the Trust has submitted the draft declaration of compliance with 'Standards for Better Health' to the Healthcare Commission. The declaration was supported by the Internal Auditors, Bentley Jennison who found "a suitable assessment had been made in respect of the degree of compliance with each of the standards". A final declaration on how the Trust meets the Standards for Better Health will be required in April 2006. A number of policies are being presented for approval to the Trust Board in November in support of the declaration and to also meet the requirements of the NHS Litigation Authority Level 3 risk management standard for pre-hospital care.

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Clinical aspects of the Medical Director's report included:

- All Lifepak 12 monitor/defibrillator have been checked and serviced in line with a warning through the Safety Alert Bulletin System (SABs).
- Disposable items of equipment (for example laryngoscope blades and masks) are replacing reusable ones out across the Trust;
- New ambulances will be fitted with the Ferno Pegasus stretcher which is 10kg lighter than existing stretchers.

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The Medical Director is raising clinical issues with staff at the Chief Executive's consultation meetings e.g. a professional approach to the management of the recently introduced morphine. She is also endeavouring to show how complaints can be viewed in a positive light. Feedback from crews included Category A calls being incorrectly over prioritised and concern that some Category C calls were being under prioritised. Emergency Medical Technicians(EMTs) are been assured that the Trust will continue to invest in staff training; some EMTs had expressed concern that the Service intended to recruit paramedics solely through higher education rather than selecting and training existing members of staff.

The Trust Board was informed that the new Resuscitation Guidelines were published on 28th November 2005. The recommended changes will be rolled out across the Trust over the next few months; one of which is the need to reprogram all defibrillators to deliver one not three shocks to patients. A further update will be given to the Trust Board in January 2006. **ACTION: The Medical Director.**

A three month trial is being carried out whereby CTA and ECPs can call on Consultant Physicians at the National Poisons Information Service for advice. The trial is being audited by the Clinical Audit and Research Unit.

The Board's attention was drawn to appendix one which contained two summaries.

Patient Report Form – an audit was conducted of 362 patients who in 2004/05 were diagnosed by LAS crews using a 12-lead ECG as suffering an ST Elevation Myocardial Infarction. The audit found that that documentation was good though it could be improved. Pain Management was found to require more attention; however since the audit was conducted the Service has introduced morphine as an analgesic. The audit found that the LAS has high levels of aspirin administration.

The Trust is under significant pressure in North East London regarding call to door time – average time for call to door is 40 minutes. It is highly unlikely that this figure can be improved. Work is being done with other healthcare colleagues to remind them that the national target is 60 minutes call to needle time and that is a target shared by ambulance services and acute trusts.

Clinical Patient Information Work has been done to improve the process whereby team leaders undertake an audit of Patient Report Forms and feedback information to crews. The procedure will be web-based and simpler to use. In addition staff once they have received feedback from team leaders will be able to access information to support their PDR and developmental profiles.

The Patient Care Conference in September was well attended by patients, staff and other healthcare professionals. The feedback from attendees was that the conference was a success though the venue was unpopular.

Under the 7th domain (public health) the Medical Director reported that she is highlighting public health issues with staff at consultation meetings, in particular the expected flu pandemic and the possible implications for the Service.

Driving Licence Policy The Trust Board was asked to approve the Driving Licence Policy. Sarah Waller raised a number of concerns e.g. are driving licences checked on appointment, if so the policy needs to state this. Are staff going to be informed when their licences are going to be checked and where information is going to be recorded? The Finance Director confirmed that the information is held on PROMIS which is the scheduling system used by the Trust.

Beryl Magrath was informed that team leaders are rostered one week in the office in order to undertaken their administrative duties such as audit of PRFs (approximately 30% of their time). The level of completion is currently poor and it is hoped that the new web based process will improve matters.

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The Chairman of the Patients' Forum asked whether the number of defibrillators in public places in London is likely to increase. The Medical Director responded by saying that London currently has approximately 50% of the defibrillators placed in public places around the country. The deployment of defibrillators is based on the cardiac arrest database and the scheme is overseen by the Department of Health.

Approved: 1. **The Driving Licence Policy with the amendments suggested by Sarah Waller.**

Noted: 2. **The Medical Director's report**

115/05 Infection Control policy

The Infection Control policy was presented to the Trust Board for approval.

Beryl Magrath enquired whether all equipment in contact with patients were single-use and was informed that only those that have been in contact with bodily fluid. If equipment is not contaminated it is re-used.

Approved: The Infection Control Policy

116/05 **Infection Control Annual Report**

Chris Vale, the Acting Head of Operational Support, presented the Annual Infection Control report to the Trust Board. He outlined the work that has been undertaken in audit; education and communication; make ready; occupational health; products and facilities. Ambulances that are swabbed as part of the Make Ready scheme have shown some excellent results for low levels of infections; there has been no evidence of MRSA. The Infection Control Steering Group meets regularly and monitors the Infection Control risk register.

Beryl Magrath was informed that at the moment PTS vehicles are not part of the Make Ready scheme though that may change in the future. She was also informed that staff are responsible for cleaning their uniforms, if the uniforms are badly stained they can be sent out to be laundered but this is a rare occurrence. There are no plans to change this element of the Infections Control policy.

The Medical Director assured the Chairman of the Patients' Forum that although there is no way of knowing that a patient has an infectious ailment such as MRSA, hospital staff will inform the Service is there is a risk to crews and medical treatment is required.

The Chief Executive said that he was very pleased with the report and felt it showed how the LAS is one of the leading ambulance services in the country in terms of infection control.

Noted: The annual infection control report.

117/05 **Agreement with Metropolitan Police**

The Medical Director outlined the agreement which has been recently reached with the Metropolitan Police. It is a statement of intent and best practice with regard to the transfer of all patients and in particular addresses issues around those patients with mental health problems. It is hoped that the agreement will reinforce with staff that they are effectively advocates for patients who have mental health issues.

Noted: The agreement with Metropolitan Police with regard to the appropriate transportation of patients, Section 136 of the Mental Health Act and emergency treatment of patients without capacity who withhold consent.

118/05 **Incident Reporting Procedure**

The Trust Board was informed that paragraph 2.3 had been amended – the NHS Security Management Service requires the Police be informed of all incidents of physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort.

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In response to a comment from Barry McDonald the Director of Information Management and Technology said that one of the Senior Management Team's objectives for 2005/06 is that five basic processes be made web-based. It is intended that over the next few years an increasing number of policies and processes will be web-based.

Approved: The Incident Reporting Procedure.

119/05 Serious Untoward Incident Policy

The Serious Untoward Incident policy was presented to the Board for approval. Following the recent NSHLA assessment the following appendices have been added to the policy: guidance, process, description of the role of family liaison officer and the National Patient Safety Authority's checklist 'being open' guidance.

A number of grammatical errors were identified and it was suggested that these be addressed prior to the policy's release.

Barry McDonald thought the Serious Untoward Incident policy very thorough but queried the process for deciding when an incident was considered to be a Serious Untoward Incident. The Chief Executive responded that a review of the Professional Standards Unit is to be undertaken which will address this issue as well as how complaints are managed by the Trust.

Agreed: The Serious Untoward Incident Policy

120/05 Records Management Policy

The Trust Board considered the policy and had no comments or questions. It was recognised that the policy will provide the Head of Records Management with a framework with which he can proceed.

Agreed: The Records Management Policy

121/05 Claims Policy and Procedure

The Trust Board was informed that the Claims policy and procedure had been updated to incorporate the feedback of the NHS Litigation Authority's Assessor. The guidance is required to state when external agencies are involved in the investigation process and not simply informed.

Sarah Waller asked for confirmation that the delegated authority to make special payments does not exceed the delegated authority previously agreed by the Trust Board. **ACTION: Trust Secretary**

Agreed: 1 The amended policy and procedure.
Noted: 2 The factual amendments to the policy and procedure.

122/05 CAD User Requirements

The Director of Information Management and Technology (IM&T) outlined the plan for CAD 2010. The report included 'CAD, the way forward', 'user requirements' and 'business options'. The CAD 2010 workshops conducted with end users have resulted in 1452 individual user requirements being collated.

The Board was informed that there is no CAD system in the current market place which would replace the LAS's CAD system without sacrificing important functionality that we have today. Work will be undertaken between now and July 2006 to produce a business case suitable for approach to the SHA. Further research will be done to try and identify suppliers in Europe or the United States that might be suitable for the LAS.

It was recognised that whichever strategy was chosen there would be inherent risks for the Trust. To mitigate the risk for the Trust the Director of IM&T suggested that a modular approach be adopted, whereby different elements of the system were purchased off the shelf and were interfaced. He also suggested that the new CAD system be introduced in stages.

Comment [SER5]: Get Peter Suter to clarify.

Comment [SER6]: We have missed the point about the need, given that the timescale for CAD2010 has been extended, to make the existing system serve us for longer than originally thought, and therefore to be made capable of accepting more modifications as required to meet the service's operational needs.

The Board were reminded that London is in many ways unique because of the complexity, size and diversity of the population and the number of calls it receives every day.

The Board was assured that the lessons of CAD failure in 1992 have not been forgotten. There are a number of senior staff on the CAD 2010 Project Board who have been allocated specific ‘lessons’ from the Page report which followed the investigation into the 1992 CAD failure. These senior staff will use the recommendations of the Page report to monitor the project and ensure that lessons are applied and mistakes not repeated.

A Communications Strategy will be drafted to ensure that staff are kept informed of progress over the next few years. **ACTION: the Director of IM&T and Director of Communications.**

The Director of IM&T invited Board Members to contact him if they had any enquires about CAD 2010 or wished to meet with the project team.

Agreed:
1. **The project approach for the period December 2005 to July 2006**
2. **The user requirements, noting there is further work to do to refine them**
3. **That the project should proceed assuming that its scope will require SHA authority.**

Noted:
4. **The delivery of the project against the plan and the progress to date**
5. **The scale and complexity of project (being far greater than first envisaged)**

123/05 Service Improvement Programme

The Head of Programmes and Projects presented an update on the Service Improvement Programme; of the 283 projects 56 are currently live. With regard to the outcomes (patients/people/ performance) it was forecasted that by March 2006 19 will be green, 12 amber and 9 red.

He explained the circumstance for three of the outcomes being red.

30 The manual system of Vehicle off Road (VOR) reporting via CAC is not producing reliable information. An interim measure has been introduced to address the issue in the short term. A manual trawling of data by Logistics indicated that actual levels of vehicle related VOR was less than the target of 2%.

35 Category B activation are significantly below target of 95%, it is currently approximately 55%. Sector controllers have been focussing on Category A calls and performance is ambulance resource dependent. With the new despatch procedure in place Fast Response Units (FRUs) could be despatched to Category B calls. Arrangements are being made to re-incorporate FRU under the Sector desk.

36 The requirement that Doctors’ calls are answered in 30 seconds is at risk, however the introduction of new procedures have started to show improvement. Achievement of the 95% target is expected to be achieved in July 2006.

In response to a concern voiced by Sarah Waller regarding Clinical Performance Indicators/information it was suggested that the Head of Research be invited to give

a presentation to the SDC in December. The Medical Director suggested that before implementing any other measures to address the issue the Trust should wait and measure the impact of the recently revised CPI process.

Noted: **1 The update regarding the Service Improvement Programme.**
2 That a presentation on the changes to the CPI database will be presented to the SDC in December 2005.

124/05 Progress on Governance Review

Beryl Magrath reported that as part of the governance review the following work has been undertaken: views have been collated from Directors and senior members of staff, supporting paper from external bodies such as the Healthcare Commission have been examined, three other Trusts were visited (two foundation trusts and one three star ambulance service). The agendas and minutes of the Trust Board, its Committees and other groups (2003/04) were also reviewed.

A draft report will be presented to the SDC in December with a final report to the Trust Board in January 2006.

Noted: The report

125/05 Report from the Trust Board Secretary – tenders opened since the previous board meeting.

Register no.	Details of tender:	Tenders Received From
16/05	The provision and supply maintenance of photocopiers	Canon UK Imagistics NRG Group Danwood Group Xerox
17/05	Extension works at Hayes AS	Axis Europe plc Griffiths Construction Diamon Build Ltd Neilcott Special Works Mitie Property Services
18/05	Provision of CRAMM Risk Assessment	Mott McDonald (Vega) Insight Consulting Tribal Yale

Noted: The report

126/05 Draft Minutes of the Service Development Committee

The Finance Director informed the Board that a report, which he has discussed with Barry McDonald, regarding overtime will be presented to the SDC in December.

Sarah Waller asked that a report which outlined a list of key roles and bandings/pay under Agenda for Change be presented to the SDC in December.

Noted: The draft minutes of the Service Development Committee – 25th October 2005.

127/05 **Draft Minutes of the Clinical Governance Committee**

The Chair of the Clinical Governance Committee referred the Trust Board to the covering paper which highlighted the discussion at the Clinical Governance Committee meeting on 31st October. In particular she referred to the 68% of staff who are currently attending training courses – the Head of Training and Development has been asked to investigate why 32% of staff fail to attend and a report presented at the next Clinical Governance committee meeting in January 2006.

Noted: The draft minutes of the Clinical Governance Committee – 31st October 2005.

128/05 **Any Other Business**

The Chairman of the Patients' Forum informed the Board that representatives of the Forum met with representatives of the Central London Mosque, who expressed interest in learning resuscitation techniques and offered the use of the Mosque's website for placing recruitment advertisements. Work is also being undertaken with Asthma UK, a survey of asthmas sufferers is being undertaken and their views sought about the LAS and Primary Care Trusts. He welcome the action being taken by the Department of Health to ensure that the LAS livery is not used by private ambulance organisations.

129/05 **Opportunity for Members of the Public to ask Questions**

Colin Hill asked whether there the Trust will be entering into a similar agreement with the City of London Police as it had with the Metropolitan Police. The Medical Director said that this had not been considered necessary given that relatively few people live in the City but it would be considered. **ACTION: the Medical Director.**

Comment [SER7]: Agreement about what?

130/05 **Date and Venue of the next Trust Board Meeting**

Tuesday, 31st January 2006 in the Conference Room, LAS Headquarters, 220 Waterloo Road, London, commencing at 10.00 am.

The meeting concluded at 12.30pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 29th November 2005

Held in the Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1

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

On the 29th November 2005 in Part II the Trust Board briefly discussed:

- Potentially commercially sensitive information regarding CAD 2010,
- Patient Forum representation on the Audit and Risk Management Groups (it was agreed that this would be deferred until the completion of the Governance Review currently being undertaken)
- the possible implications for the Trust of a Coroner's inquest scheduled to be held January 2006.

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 31 JANUARY 2006

CHIEF EXECUTIVE'S REPORT

1. ACCIDENT & EMERGENCY SERVICE

1.1 999 Response Performance

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

	CAT A 8	CAT A 14	CAT B 14	Urgent within 15 mins of STA
Standard	75%	95%	95%	95%
YTD*	73.4%	94.4%	74.2%	52.1%
04/05 year	76.6%	95.9%	79.7%	58.1%
03/04 year	76%	89.3%	77.6%	50%

*As of 23rd January 2006

Key highlights

i. Final performance for October was 72.7% and November 72.9.%

ii. We continue to input data for December which was particularly challenging in terms of resource availability. Final performance for December is likely to be circa 72% once all the data is complete.

iii. The year to date position at time of writing is at 73.4% but given that we are currently some four weeks behind with data entry the true figure is likely to be circa 73.7%

iv. Emergency responses rose by +3.3% in October and + 4.0% in November. December saw a small reduction in workload compared to last year at -1.2% .The year to date figure (Apr- Dec) is +3.6 % compared with the same period last year.

v. The Christmas period was the most challenging as had been predicted and resourcing across the Holiday weekend was poor despite some very attractive enhanced pay packages being made available to staff. It is clear that a combination of AfC back pay and vacancies combined to make it very difficult to encourage the high levels of overtime working that were required.

vi. I am pleased to report that the first three weeks of January have shown considerable recovery and the month to date is running at circa 76.5%

once all of the data has been entered. This includes several days which will finally reach 80% or better.

vii. Recovery plans as outlined in the previous Trust Board report continue to be progressed and this report contains an update on these initiatives and on the remaining areas which will add further improvements during the coming nine weeks.

viii Real time performance management continues to be achieved through the ‘GOLD’ suite and the hours of this unit have been extended to provide a 24/7 operation.

ix PCT performance remains challenging and we have now completed recovery plans for the lowest six areas which are under 70% year to date and shared these with local commissioners.

x We continue to be focussed principally on CAT A performance recovery and detailed discussions with SWLHA continue in order to share our recovery plans and keep them informed as to progress.

1.2 Operational Impact of Agenda for Change

The operational impact of AfC which was discussed at length in the last Trust Board report are beginning to show signs of abating. There are still some staff morale issues but feedback within consultation meetings indicates that these are beginning to recede.

There will be some additional back pay issues as Technicians receive some arrears payments in January. These payments are not of the same magnitude as the paramedic payments made in December and it is hoped that they will have a less pronounced affect on the willingness to work overtime.

1.3 Resourcing

Resourcing remains our biggest challenge in terms of maintaining staffing levels at a sufficient level to achieve performance at or above 75%.The reasons for this were outlined in detail within the last Trust Board report and essentially remain the same.

Ambulance hours produced rose from 4024 per day in October to 4221per day in November but fell back markedly in December as overtime working dropped and ended at an average of 4000 hrs per day. FRU staffing held up better and remained at circa 1300 hrs per day throughout November and December.

As predicted resourcing in December was especially difficult across the Xmas weekend and on Christmas Day and Boxing Day overall resourcing was at circa 73% leading to significant performance difficulties particularly on nights.

Traditionally our overtime budgets are seasonally profiled to make sure that the greatest number of hours are available for use in December. However, over recent years there has been a marked reluctance by staff to work overtime during December and this trend continued this year with a steady decline in overtime working as the month progressed. Obviously this situation was worsened by the fact that many staff had received or were due to receive arrears payments in respect of Agenda for Change, which again reduced the appetite for overtime earnings.

Whilst there are plans in place to recruit more staff to reach full establishment, the lead time involved in recruitment means that we continue to struggle with high vacancies. Some 47 additional staff will be posted to operations prior to end March and then from April onwards new staff become available in larger numbers and we are predicting full establishment by circa end October 06.

Overall sickness rates for the year are broadly on target , however, December saw a high incidence of short term absence. Compared to the average weekly number for the first quarter of the year, during December the number of staff reporting sick each day was between 50% to 75% higher. Clearly these absences of between 2 – 4 days duration are extremely disruptive and difficult to cover at short notice. Sickness in January has continued to be high at circa 8% and Area management teams are now very focussed on addressing these increases by robust local management

In order to manage resourcing within the context of overall performance management the Trust has introduced a revised ‘Capacity Plan’. This Resource Escalatory Action Plan (REAP) plan is designed to be constantly in play and allows the service to declare one of five REAP levels from level 1 Routine through level 3 Severe Pressure to level 5 Potential Service failure.

An assessment is made weekly by the Director of Operations against a broad set of criteria as to which level currently applies and then a number of set actions follows in order to recover the position. These levels and the associated actions are now published throughout the Trust and will allow us to react in a more structured way to both ‘Rising Tide’ type problems and sudden events which then affect performance.

With the activation of the Resource Escalatory Action Plan (REAP plan) in December the service has been operating at Level 3 Severe Pressure and the relevant associated actions have been implemented. This has resulted in an improvement in overall staffing during January to an average of 4236 Ambulance hrs per day and 1323 FRU hrs per day.

1.4 Performance Recovery

As reported at the last Board we are very aware that with some 9 weeks of the year remaining we still have a significant challenge to reach our key performance targets.

Modelling has shown that we need to reach an average of circa 80% for the remainder of the year to achieve the 75% target for the 2005/6 financial year.

I have detailed below in summary form progress against the actions described in detail to the Board at its meeting on 29th November:

- The internal recruitment programme is on track and we expect full establishment by end October 2006.
- New staff are now beginning to be placed on the new weekend relief roster.
- External recruitment of qualified staff is ongoing but to date the number of applicants has been disappointing.
- We continue to maximise the use of Bank Staff
- Enhanced overtime at weekends has now been extended until the end of March subject to being able to maintain the funding.
- Non Essential training has been deferred until the new financial year.
- All non essential staff abstractions have been stopped and those staff returned to operational duties.
- We continue to utilise Team Leaders to staff vehicles for 100% of their working hours.
- Training managers and operational managers continue to be used to staff vehicles as much as possible.
- Improved Call taking procedures continue to produce improvements in activation times for ambulances.
- The Urgent Operations Centre continues to enhance its ability to deal with Green workload by maximising the use of CTA and PTS to support the A&E core fleet.
- We continue to actively deploy vehicles from standby points.
- We continue to improve the utilisation of ECPs .
- The Gold performance management suite has extended its hours of operation to 24/7.

There are a number of additional initiatives which will be introduced over the next few weeks to improve performance still further:

- We are still actively working on revising our control room processes to reduce the number of times that multiple responses are sent to the same call. The technical issues associated with this change are considerable and we now understand that a package of software changes to achieve this will be available for introduction on the 28th February.These

changes will allow us to operate all resources from the current Sector Desks so allowing more balanced judgements to be made about the most appropriate resource to send to each call.

We are still determining how best to utilise these enhancements given that their introduction is now going to be very late in the financial year. There will be an operational judgement to make about how best to balance the risks of disruption due to new working practices against potential performance gain and the A&E Senior Team are considering this issue at the present time.

- We are beginning to target a small number of complexes that exhibit high workload and poor performance. Specific recovery plans for these complexes are being developed and will principally involve providing additional FRU and Ambulance resources to improve these areas by circa 5% from their current base. This will be difficult to achieve as staffing any new vehicles remains a challenge given in post figures and sickness levels. Nevertheless we are convinced that this can be done by adopting some innovative approaches and by staffing these new units from across the service as a whole rather than from the challenged complexes themselves. The new FRUs arriving during January will be used to provide additional vehicles for these complexes.

- We will continue to refine the operation of the GOLD suite in terms of overall performance management . In particular we will develop plans which allow a better real time assessment of hour by hour performance against that which needs to be delivered to achieve an overall full days performance of over 80%. This should allow more proactive steps to be taken when performance is at variance with that expected in each hourly slot.

- We are now compiling a further list of initiatives which may have to be considered in March should we find that performance has not recovered sufficiently.

1.5 Emergency Operations Centre

Recruitment to positions in EOC is on track with the next two courses full. A new advertising campaign will be launched in early February aimed at attracting new staff for 2006/7, to reflect the diverse population we serve.

Work continues on the re-structure documentation. It is envisaged that the process will start late spring 2006. Senior managers in Control Services are aware of the re-structure, and there are development workshops continuing to best prepare the managers for the re-structure process.

The changes to the call taking procedures described in the last report continue to have a beneficial effect on both call answering times and activation times. Call answering times for 999 calls have risen to 85% in 5 secs during January with some individual days at 95%. Call answering times for Urgent calls have also improved to 77% in 30 seconds. There is still much more to be done but these results are encouraging.

New Years Eve presented a significant challenge this year due to a technical failure in the setting up of the back up control at Bow. Our planning for several years has allowed for both the main control room and the back up control room to be used in tandem enabling us to increase significantly the numbers of call taking positions available to us. During the setup process this year problems became apparent and a decision was finally taken by GOLD before midnight to close the Bow control room and run the entire operation from HQ. Whilst this presented a significant operational challenge the service coped well and no major difficulties were experienced.

A number of de-briefs are underway to understand what went wrong with the setup process and lessons learnt will be factored into planning for 2006.

On the 19th of January, Lawrence Dallaglio, opened the new Incident Control Room (formally Gold Control). The ceremony was hosted by the Chairman and the event was attended by staff who were working in EOC during the bombings on the 7th July. Representatives from Heath, St John Ambulance and the London Fire Brigade were also in attendance. After a tour of the new facility, Mr Dallaglio spent time talking to staff and guests, before a visit to the EOC. He was very gracious in his comments and was very impressed by all the EOC staff he met and thanked them for their dedication and professionalism.

1.5 Urgent Care Service

The Urgent Operations Centre was opened on track at the end of November and has been working well . We are already seeing some benefits as a result of the co-location of various staff group and as relationships develop over the coming weeks we are confident that this will continue.

As reported to the Board in November there are a number of EMT1 vacancies at present and it has still been proving difficult to recruit to these posts. The re-design of the EMT 1 role continues and will report early in February.

It is likely that we will then develop a level of training which is more aligned with an enhanced PTS role rather than an EMT1 role. It will be part of the more general review of the overall Urgent Care workforce and once complete will allow us to develop a more focussed recruitment campaign for Urgent Care staff.

We have also taken some 20 PTS staff from the Chase Farm area into Urgent Care following loss of a local PTS contract and these staff will become solely dedicated to Urgent Care workload from the 6th February. In addition we are

working with PTS to potentially absorb further PTS staff from ‘at risk’ contracts over the coming months.

CTA staff numbers increased as planned to 30 in December and staff are now utilising the new CTA software package to good effect. In the first four weeks of using the new software the number of calls dealt with has risen to over 4000 which compares to an average of 2000 a month on the old TAS system. The non send rate for CTA calls is still at 50% and some 2000 responses were therefore saved in the period 16th December 05 to 16th January 06.

We continue to explore options for adding further GP support to Urgent care and talks are ongoing with various GP Co-ops .

The ECP programme continues to progress and 4 further PCTs areas will be live by the end of January. We are also looking to begin training a further 15 ECPs before the end of the financial year.

1.6 Emergency Planning

The Emergency Planning Unit (EPU) continues to work with our partners in Health and the London Resilience Team to ensure that once a Pan-London FLU plan has been developed and agreed the LAS’s plan is fully integrated with this piece of work..

Major Incident training at various levels is continuing and the EPU delivered a Gold Level training package in January for the recently appointed ADOs.

New Years Eve 2005 presented challenges this year due to a technical failure described in detail in 1.4 above. Lessons learned from the NYE Debrief will be factored into the planning for 2006.

Following the events of 7 July ’05, five debrief sessions were held, to create a ‘knowledge file’ of the events, from the perspective of those involved. Following this process, two documents were produced:

- Summary of Lessons Identified – Areas of Best Practice
- Summary of Lessons Identified – Areas for Improvement

The ‘Areas for Improvement’ document is the subject of an action plan, broken down into Red, Amber and Green actions. Red actions are reviewed monthly, Amber are reviewed quarterly and Green, annually.
One ‘quarter’ has elapsed since the report was completed (7 September ‘05).

In total, some 99 Areas for Improvement were identified. These have been developed into 207 ‘actions required’. A steering group has been established to move forward the actions.

For the first quarter, the primary focus has been on addressing the Areas for Improvement rated as 'Red'. There were 29 Red items, which have developed into 33 actions. Ten actions have been fully completed, a further nine are underway. Four 'Amber' actions have also been completed.

Significant items have been addressed first, including: a rebuild of the Incident Control Room; a reconfiguration of the Gold Command Suite; issuing pagers to managers and the acceleration of the new digital radio system to bring LAS forward in terms of the implementation timetable.

Whilst the 'Areas for Improvement' document is the focus of activity at present a communications strategy is being devised to also share the best practice that was apparent on the day.

2. Patient Transport Service

2.1 PTS Trajectory Management

Focus for the last two months has been largely on the provision of training and development for all the control staff with courses held in November and December to help maintain focus and momentum. We have two final courses to be run in January for our Cluster Planners, Central Services Co-ordinators and Site Mangers.

Work continues to be undertaken by PTS operational managers to work more closely with commissioning trusts in an effort to improve arrival, departure and time on vehicle performance. Initiatives such as, flexible appointment times, appointment staggering and defined drop off and ready times should provide improved performance in the coming months.

Summary of Impact August to November

Month	August	September	October	November
Arrival Time	74.6	78.2	80.7	82.5
Departure	85.1	85.4	85.3	88.5
Productivity	11.3	11.6	11.6	11.8
Updation	92.0	89.9	95.0	94.0

- Arrival time increase by 7.9% (74.6% to 82.5%)
- Departure time increased by 3.4% (85.1% to 88.5%)
- Productivity (average person) increased by 0.5% (11.3 to 11.8)
- Updating increased by 2.0% (92% to 94.0%)

2.2 PTS Hospital arrival time

Overall performance has **improved** from 74.6 to **82.5%.**

2.3 PTS Hospital Departure time

Overall performance has **improved** from 85% to **88.5%.**

2.4 Patient time on PTS vehicle

Performance in this measure has been maintained at an average of **93%** per month compliance, which is the eighth **consecutive month to hold above 91%.**

2.5 Operations

Implementation of the new AfC 37.5 hour Rotas started in December 2005. This has given us the opportunity to consult with staff and review all contract rotas and introduce staggered rota patterns to match individual contract daily activities to assist in the control and use of overtime.

Central Services control staff successfully moved from Greenwich to the new Urgent Care Control in Waterloo in November with almost immediate benefits with closer integration working leading to significant increase in the number of A&E referrals.

Working closely with the Gold suite on the REAP plan we have been able to support a number of initiatives during December and January offering 3 x Blue Light vehicles and staff providing day cover with a paramedic on each vehicle.

The most notable of these initiatives being the ambulance working in the West End footprint, on Thursday, Friday and Saturday nights through the build up to Christmas and on into New Year, taking intoxicated patients to hospital instead of using front line ambulances. The work of this vehicle was extensively reported by the media over this period.

We have also provided, a Blue Light ambulance manned with one AP to work in the Central London Footprint transporting a DSO and supplies on Thursday, Friday and Saturday nights to improve turnaround at hospital sites and incident scenes.

We also supported the New Years Eve Operation providing five Blue Light PTS ambulances manned by double crews who carried 40 patients of which 34 would have been normally been carried by a front line vehicle. This was run from the new Urgent Care Control Room.

We are currently short listing for the Site Manager post for Kingston and Wandsworth PCT

Sickness was 5.2% YTD (April to November) Sickness for the month of November was up at 5.86%.

2.6 Contracts Update

2.6.1 Queen Elizabeth/Queen Mary Sidcup

There is no more progress on the arbitration issue. We have met with the trust on 3 occasions, with a view to extending the contract for 2 years. The stumbling block remains the marginal invoice charges we apply to the contract and if these issues can be resolved they have indicated that they would be prepared to extend the contract for two years.

2.6.2 Chase Farm Hospital

The contract ended on 31 October 2005 with staff transferring to Urgent Care. We continue to deliver a service to BEH Mental Health Trust which will run till February 2006

2.6.2 BEH

It is still proving difficult to gain any firm commitment from the trust as to their intentions regarding the contract which is due to end on February 28th. There is also an outstanding issue regarding payment for excess activity which is being pursued by Mike Dinan directly with their FD.

2.6.3 Charing Cross & Hammersmith

We have presented a number of late arrival final invoices to the Trust and we continue to work with them to agree and resolve the final financial position.

2.6.4 Hillingdon & Mount Vernon

Hillingdon Hospital has agreed to sign a Service Level Agreement for 2006-07 giving us an extension for a further year. The Trust has also advised that they would like to extend for a further three years but with a different patient activity profile. They will provide details later in year for us to submit a revised costing.

2.6.5. Stanmore

RNO have signed the new Service Level Agreement until mid 2007. The new LAS bus shuttle service started at the beginning of November and we continue to work closely with the Trust on timetables and hours of operation.

2.6.6 Chelsea & Westminster

The current SLA ended at the end of December and we have been in negotiations with the Trust to agree a new SLA to extend for a further six months or for two years. Offers have been presented and we are awaiting the Trusts decision. The Trust is looking to go out to tender in 2006, so the likely outcome may be an extension of six months.

2.6.7 Whipps Cross

Whipps Cross has requested a "**Feasibility Study"** to be undertaken to assess their transport requirements. They have asked the LAS to assist them in looking at a "One Stop Shop" approach to cover all their transport needs. This includes specimen, internal, in house, courier, inter hospital transfers and out of hours cover. This is an excellent opportunity and could be in the region of a £2m contract.
They have asked for the **"Active Demand Management"** to be lifted and have agreed to a contract to the tune of £830k. This price will run to the end of the financial year and will roll over until the feasibility study has been completed. The view then will be to award the contract to LAS, without going to tender.
However all outstanding debts are still liable and await arbitration decision.

2.6.8 Oxleas

Notice was given and contract ends 31st March 2006. We will then support the contract through Central Services as a more cost effective method.

2.6.8 UCLH

UCLH have advised that they will be market testing in 2007 following their move into new hospital building. Presentations have been given by LAS in December on our service and we are in negotiations re increased activity in support of their aim to reduce their number of transport providers. We have developed a good and close working relationship with this trust.

2.7 Tenders & New Business

2.7.1 Wandsworth PCT

A proposal has been submitted for the internal mail services. Tender process is currently in the evaluation stage and a decision should follow shortly.

2.7.2 Lewisham University Hospital

We were not short listed for the second stage of the tender process and are still seeking clarification as to why this. We believe a part award was made to Thames Ambulances.

2.7.3 St Georges NHS Trust

A proposal has been submitted, the tender process is currently in the valuation stage and a decision should follow shortly. We understand that GSL have done a presentation to the Trust and appear to be the favourite to win tender.

2.7.4 Bromley Hospitals

We have just been advised that we have been successful in regaining the Bromley PTS contract . This represents £1.8m of new business.

2.7.5 Expressions of Interest have been submitted for the following upcoming tenders

Royal Free Hospital

Kingston Hospital

North West London Hospitals

North Wick Park OOH

Tower Hamlets

3. Complaints update – January 2006

Comparison of complaints received between April and December, 2004/2005

	All Complaints		**Written Complaints**	
	01/04/05 to 31/1205	**01/04/04 to 31/12/04**	**01/04/05 to 31/12/05**	**01/04/04 to 31/12/04**
East Sector	101	108	42	49
West Sector	103	84	42	38
South Sector	20	0	11	0
Emergency Operations Centre (EOC)	122	103	71	60
Patient Transport Service (PTS)	32	24	23	19
Unknown	0	0	0	0
Not Our Service (NOS)	20	8	1	0
Non-Operational (NOP)	2	4	1	3
Total	400	331	191	169

The trust received 400 complaints between 1 April and 31 December 2005, an increase of 69 on the previous year. However, there was an increase of 12 complaints that were categorised as 'not our service'. 361 complaints have now been closed, 8 complaints led to recommendations of disciplinary process and 353 are being dealt with under local resolution. The main cause of complaint remains concerns regarding attitude and behaviour. This category, at present, represents 44% of total complaints received.

Whilst there has been an overall increase in complaints the only category which has shown an actual increase regarding total complaints received is that of 'non-conveyance' of patients. This has increased from being the main subject of 9% of complaints last year to 11% of this year.

There were no requests for Independent Review on cases received in the year ending March 05, however since April 05 the Healthcare Commission have requested paperwork for 10 cases following requests for Independent Review though to date no reviews have been undertaken by the Healthcare Commission. Two cases were closed by the Healthcare Commission as already having a complete investigation and we have recently received recommendations from one other case which are being undertaken at present.

The service is currently delivering 66% of written complaints resolved within 20 days (against a target of 80%). It is recognised that there is a need to improve complaint handling and the lessons we learn from complaints and to assist in achieving this we are:

- Reviewing the structure and role of PSU
- Implementing a Managers' 'prompt sheet' to assist sector investigating staff in achieving a timely and methodical investigation.
- Implementing a revised Serious Untoward Incident Procedure (TP/006)
- Having a Complaints Panel meet regularly. This was set up in accordance with Complaints Procedure (TP/004).
- Reviewing the Complaints Procedure (TP/004) following review of PSU
- Reviewing the training delivered to Duty Station Officers and Senior Officers
- A review of the outcome report form for complaints to ensure recommendations are actioned and lessons learnt

4. COMMUNICATIONS

Patient and Public Involvement (PPI)

PPI Manager Margaret Vander and Events, Schools and Media Resources Manager Richard Walker are leading a piece of work on the future of LAS public education activity. Thirty LAS staff who are currently involved in public education attended a workshop recently, to discuss how this activity should be developed for the future. The information collected will be used to produce recommendations and an action plan. This is likely to include ensuring that we make best use of our resources, and that those participating in public education activities give consistent messages which are in line with the organisation's strategy and goals.

The PPI database now lists more than 90 Service activities or pieces of work involving patients. These range from Patients' Forum members being on LAS committees to LAS staff participation in multi-agency training events for children and young people.

At December's PPI Committee there was a discussion about access to the LAS for deaf people. Currently, unless they have TypeTalk equipment and are at home, profoundly deaf people cannot call 999 for an ambulance and communicate with the call-handler. Most deaf people communicate by text, but have been told that it is not possible to use SMS technology in an emergency because of potential delays in their messages being received. The Committee agreed to explore technological solutions to this problem, as well as liaising with the Royal National Institute for Deaf People (RNID) and other organisations.

People within the deaf community have also expressed interest in the use of Visual Translator Cards to help them communicate with ambulance crews. This is being explored jointly between the LAS, the Patients' Forum and RNID.

Patients' Forum members welcome input from LAS managers at their monthly meetings. Director of Operations Martin Flaherty attended in October to give a presentation and answer questions about the July bombings. In November Head of Education and Development Bill O'Neill and Diversity Manager Paul Carswell attended to talk about diversity - both in terms of staff recruitment and educational input. Operational Support Services Manager Gadge Nijjar attended in January to talk about the Make Ready Scheme.

A recent example of some joint work between the LAS and the Patients' Forum has been a survey, sent to people in the Camden area who are known to Asthma UK. The purpose of the survey was to find out if they had ever used the ambulance service and, if so, whether they had any comments about their experience. Although there was only a 10% response rate, all comments made about the ambulance service were very positive. A small number of people said they would be prepared to respond to a more detailed survey. A series of face-to-face interviews is now being planned, to find out more in-depth information about people's experience of the ambulance service, about their asthma, and about the other services they use.

If this exercise is found to be useful, it may lead to similar surveys being carried out in other areas of London, perhaps in areas of high ambulance service demand. It is possible that, where there is high usage of the ambulance service for people with asthma, this might indicate gaps in other (preventative or monitoring) services in the community. Finding out more about this group of patients and the services they use may also be helpful when developing the LAS chronic conditions strategy.

Communications

Service pressures: During December, a communications programme was initiated to help alleviate pressures placed on the Service by increasing demand and resourcing problems. This work supports the Service’s revised Capacity Plan, and the need to maintain levels of patient care and recover performance during the winter period.

From an internal perspective, all staff have been made aware of the current pressures and frontline staff have been encouraged to work additional overtime shifts, respond more quickly and try to reduce turnaround times at hospital. The Chief Executive shared these messages in a short video, published on the Service’s intranet, which was viewed by over 2,000 staff. He also sent a personal letter to all frontline staff about Service pressures, and this has been supported through a number of operational bulletins.

Externally, the Communications Department focused on raising awareness of a range of issues that have placed pressure on the Service, through a sustained media

campaign. Extensive media coverage has been achieved regarding the impact of alcohol-related calls, increased demand during the festive season and pressures placed on the Service during cold weather.

In late November when the new licensing laws came in, filming with the BBC and Tonight with Trevor McDonald highlighted the demand that alcohol-related calls put on the Service. This was supported by articles in a number of national newspapers. Then, ahead of the traditional office party night (the last Friday before Christmas), the message to revellers to use the ambulance service wisely was widely conveyed through broadcast and print media. It is estimated that interviews with London Today, LBC radio and BBC London reached over 7.5 million viewers/listeners.

Further regional and national coverage on alcohol-related issues was secured with the story that the Service was introducing a new response to alcohol-related calls in central London, dubbed by the media as the 'booze bus'. Coverage on BBC Breakfast News alone, which explained the reasons behind the initiative and also reiterated that the ambulance service's priority is to attend life-threatening and vulnerable patients, reached an estimated 9.53 million viewers. Viewing/readership and listening figures for additional coverage in national/regional papers (e.g. Daily Telegraph, Daily Mail, Evening Standard), radio (Radio 5 Live, BBC London, LBC) and local television (London Tonight) is estimated to be an additional 16 million people.

During the Christmas period, media liaison was undertaken to pre-empt a spell of cold weather, and people were advised how to keep warm and well and how they should use their ambulance service. Coverage was secured on LBC radio, London Tonight, BBC London radio and in the Evening Standard, enabling the Service's messages to reach over three million Londoners.

New Year's Eve once again proved to be the Service's busiest night of the year, and work with the media enabled key messages to be conveyed before and after the event. In the run-up, as well as explaining that this would be the busiest night of the year, national and local media (a reach of 10 million) detailed how cold weather and the anticipated tube strike would put additional pressure on the Service. Post event, coverage from a "ride-out" by Sky News triggered widespread media interest with the focus being on the high number of stabbings attended by crews on New Year's Eve. As well as the extent of the demand placed on the Service that night, media reported the Service's horror that there was such a high level of violence on what was an evening of celebration for most people, and that most calls received were alcohol-related. Audience figures for this coverage were an estimated 18 million.

Communication support will continue to be given to pressure issues as the Service strives to protect patient care and improve performance levels over coming months.

Chief Executive's charities: The Communications Department worked with the Chief Executive's three charities to produce this year's Christmas card. Children from the three hospices were invited to design a Christmas card for the Service, with the winning entry being submitted by three-year-old Ashantia who attends Richard House

Children's Hospice based in the Docklands. The card, featuring Santa with his ambulance sleigh, was sent to 2,000 partner organisations and suppliers.

As the London Marathon approaches, twenty staff who have secured places through the Service have agreed to run for the three children's hospices, and have been encouraged to seek sponsorship for their efforts.

New Year Honours: The news that the Chief Executive received his CBE from the Queen in December and six members of staff were recognised in the New Year Honours' list received widespread media interest.

In recognition of their roles during the tragic events of 7 July, Paramedic William Kilminster, Acting Duty Station Officer Peter Swan, Contract Operations Manager Roy Webb, Paramedic and UNISON trade union representative Jim Underdown were awarded MBEs, and Director of Operations, Martin Flaherty, was awarded an OBE. Awards Manager Trevor Vaughan received an MBE for his 42 years of service with both the LAS and the Metropolitan Police special constabulary.

Coverage of individual's achievements has been achieved in national, regional and local media.

In connection with 7 July, staff attended a special 'thank you' event at City Hall in December which honoured staff from the emergency and transport services for their heroic actions on the day. Chief Executive Peter Bradley, Islington Paramedic Stacy Rixon and her husband Medical Technician Paul Rixon accepted a plaque from the Mayor of London on behalf of the Service.

Other media issues: The sentencing in January of a former member of staff, Nicholas Colclough, for making and possessing indecent photographs of children received some local media attention. A statement issued confirmed that Colclough was dismissed from the Service for gross misconduct in July 2005 following an internal disciplinary investigation.

Interest from the media, including The Times, was triggered following the arrest of a doctor this month on suspicion of manslaughter. The Service confirmed that following a call to a 78-year-old woman in Enfield in December, it had raised concerns about the treatment of the patient prior to the crew's arrival. Crews treated the patient, who was experiencing breathing difficulties, and made efforts to resuscitate her both at the scene and on the way to hospital.

Communication support is being provided to the ongoing inquest into the death of 28-year-old Andrew Jordan from Erith who died in police custody on 7 October 2003. A strategy has been developed for managing internal and external communication following the outcome of the inquest.

Chief Executive consultation meetings

The latest series of Chief Executive consultation meetings ended on January 25 although extra events may be organised for those emergency operations centre (EOC) and urgent operations centre (UOC) staff who were unable to attend any of their three events.

Over 1500 staff and managers attended the 37 meetings and a wide variety of issues were raised and discussed.

As stated in a previous report to the Trust Board, strong views were expressed but always in a professional and courteous manner. It is clear that these events are important and valuable opportunities for staff in all areas of the Service to have direct, open and honest dialogue with the Chief Executive and Medical Director.

Concerns were expressed about the Agenda for Change implementation process; increases in workload; call categorisation; staffing levels; use of the 999 service by the public, other NHS professionals and the police; availability of training and opportunities for career development.

All views are being collated and a plan comprising actions to be taken on many of these issues will be prepared and implemented.

5. HUMAN RESOURCES

5.1 Agenda for Change

Despite the challenges that have impacted on the entire Ambulance sector's AfC assimilation performance, LAS is now well-placed to ensure that all its employed staff are assimilated onto AfC terms and pay not later than March 2006. Emergency Medical Despatch (EMD) staff, because of the nature of their existing employment contracts, will be offered a staged option of transferring to AfC terms. As a result of this option, there may be a small ongoing stream of AfC assimilations running forward into 2006/07.

The Trust's current position is:

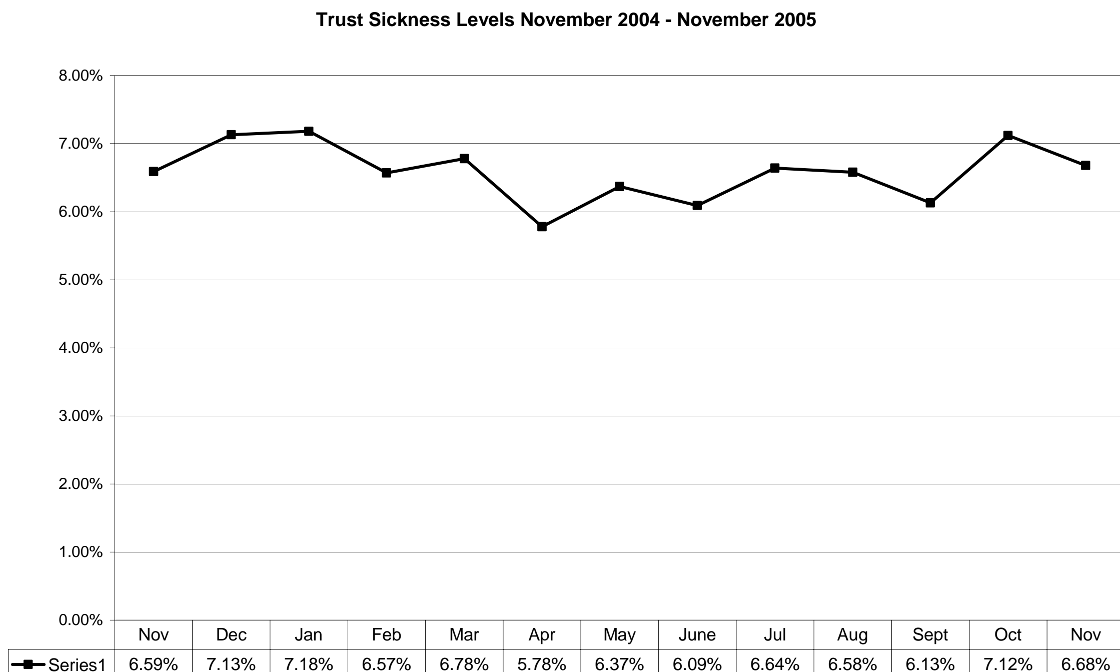
- 3711 posts (98.4% band matched)
- 2919 staff (77.4% of employed staff) assimilated to AfC terms and pay
- 3133 KSF outlines (covering 83.0% of employed staff) now prepared and agreed

A number of staff have appealed their bandings. These currently cover 18 job variants. A further 2 vacant posts were subject to banding appeals by their sponsoring manager and all the EMD grades are subject to a collective appeal submitted by Staffside. Anecdotally, we understand that the level of appeals is considerably below the average for a Trust of this size.

By end-January 2006, the Trust will have paid all arrears (save for a credit due to some staff in compensation for the reduction in working week) to all staff assimilated before 31st December 2005. LAS is well placed, therefore, to meet the DH target of paying all identifiable arrears before 31st March 2006.

5.2 Attendance Management

The sickness levels for the year up to November 2005 are shown below. Whilst overall sickness has reduced in the month of November in relation to that in October, it is slightly above that experienced in November 2004 - demonstrating the need to maintain management focus.



November 2005 Absence	
Staff Group	**%**
A & E	7.61%
CAC (Watch Staff)	7.34%
PTS	5.86%
A & C	3.24%
SMP	2.38%
Fleet	8.96%
Total (Trust)	**6.68%**

5.3 Workforce Information

(i) A&E Staff Numbers – Progress against Trajectory for 2005/2006 by Month

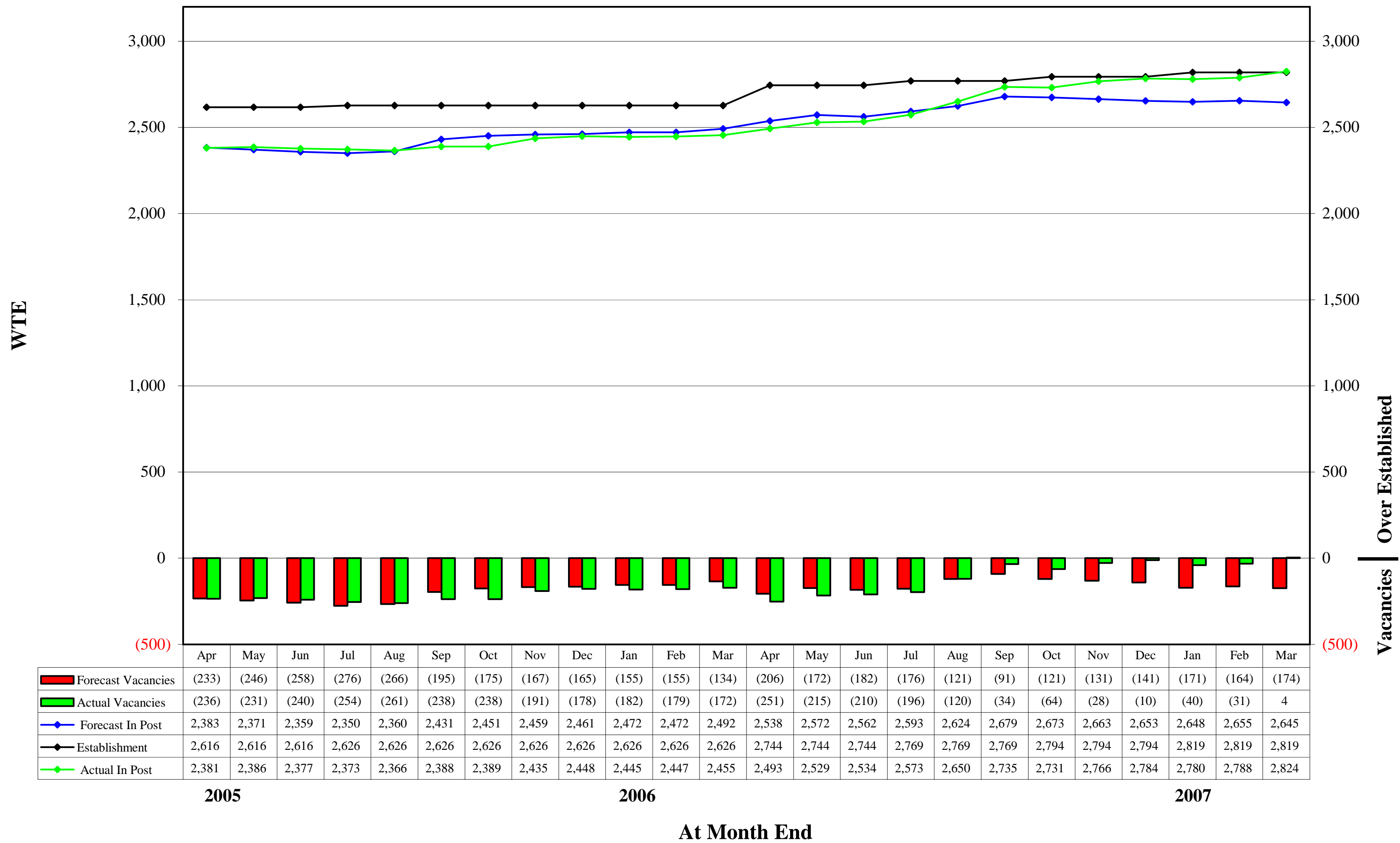
Table 1 shows progress against the trajectory for staff in-post as at November 2005. Actual staff in post is slightly below the forecast for November though concerted recruitment activity has been good with high numbers being recruited into training school from the end of October resulting in an increase of 94 operational staff on duty by May 2006 with continued sustained increase thereafter.

(ii) CAC Staff Numbers – Progress against Trajectory for 2005/2006 by Month

Table 2 shows progress against the trajectory for staff in-post against agreed establishment as being on target.

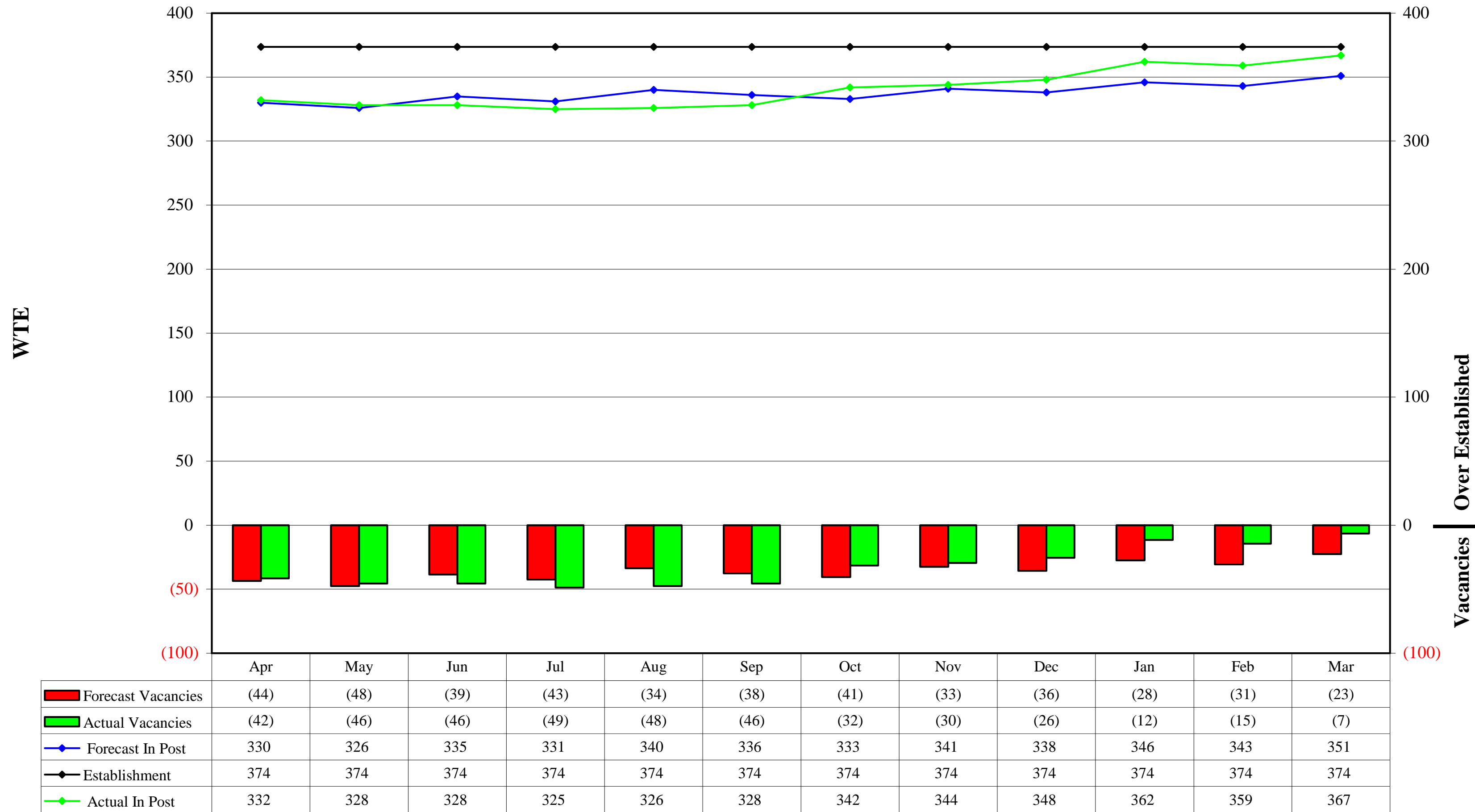
Table 1

2005/06 A&E Crew Staff Numbers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(233)	(246)	(258)	(276)	(266)	(195)	(175)	(167)	(165)	(155)	(155)	(134)	(206)	(172)	(182)	(176)	(121)	(91)	(121)	(131)	(141)	(171)	(164)	(174)
Actual Vacancies	(236)	(231)	(240)	(254)	(261)	(238)	(238)	(191)	(178)	(182)	(179)	(172)	(251)	(215)	(210)	(196)	(120)	(34)	(64)	(28)	(10)	(40)	(31)	4
Forecast In Post	2,383	2,371	2,359	2,350	2,360	2,431	2,451	2,459	2,461	2,472	2,472	2,492	2,538	2,572	2,562	2,593	2,624	2,679	2,673	2,663	2,653	2,648	2,655	2,645
Establishment	2,616	2,616	2,616	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,744	2,744	2,744	2,769	2,769	2,769	2,794	2,794	2,794	2,819	2,819	2,819
Actual In Post	2,381	2,386	2,377	2,373	2,366	2,388	2,389	2,435	2,448	2,445	2,447	2,455	2,493	2,529	2,534	2,573	2,650	2,735	2,731	2,766	2,784	2,780	2,788	2,824

Table 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(44)	(48)	(39)	(43)	(34)	(38)	(41)	(33)	(36)	(28)	(31)	(23)
Actual Vacancies	(42)	(46)	(46)	(49)	(48)	(46)	(32)	(30)	(26)	(12)	(15)	(7)
Forecast In Post	330	326	335	331	340	336	333	341	338	346	343	351
Establishment	374	374	374	374	374	374	374	374	374	374	374	374
Actual In Post	332	328	328	325	326	328	342	344	348	362	359	367

6. OVERSEAS TRAVEL

The Board are requested to approve travel outside of the EU for 5 members of staff.
I am pleased that LAS has been invited to participate in a worldwide clinical competition being held at the prestigious JEMS conference in Maryland USA. In addition to participating in the competition our staff will attend conference meetings, lectures and visit operational ambulance facilities whilst abroad. We intend for DSO Alan Payne, Training Officer Stephen Hines and three operational colleagues to participate and report back.

Costs are expected to be in the region of £4,500
Travel is from 19th March and returning from the USA on 26th March.

Manchester Business School, Boston, Massachusetts USA

Formal approval is sought from the Board for Ann Ball, Deputy Director of Human Resources, and Sue Watkins, Superintendent, Control Services, to attend the NHS United States Elective Module, in co-operation with Harvard University's School of Public Health and PricewaterhouseCoopers LLP. 20-24 March 2006. This will form part of their studies towards the MSc – Leadership through Effective HR Management.

The Module enables participants to experience and understand the lessons learned from the US system, and reflect on practice in the UK in light of the US model. The course will focus on the question of "how does this improve patient care?". The content will be delivered through seminars, syndicate discussions, and field visits.

Costs to the Trust for travel and accommodation are expected to be approximately £1,200 per person. The tutorial costs of the programme (£1,500 per person) are funded by the Department of Health.

Recommendation

The Board is asked to note my report and approve the travel requested under section 6.

Peter Bradley CBE
CHIEF EXECUTIVE OFFICER

25 January 2006

Valuation Office Agency
District Valuer Services

Jo Coll BSc MRICS
District Valuer London

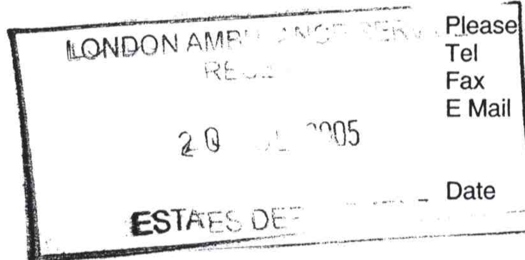
Ramsden House
New Street
Huddersfield
West Yorkshire HD1 2UU

DX 725950 HUDDERSFIELD

London Ambulance Service
NHS Trust
Estates Department
Barnehurst Ambulance Station
164 Erith Road
Bexleyheath
Kent
DA7 6BZ

Our Reference : 927240/DJI/SC18a
Your Reference :

Please ask for : Mr D J Inglis
Tel : 020 7445 0729
Fax : 020 7445 0799
E Mail : duncan.j.inglis@voa.gsi.gov.uk



Date : 18 July 2005

FAO: Nichola Smith

Dear Ms Smith,

RE: TOTTENHAM AMBULANCE STATION, ST ANNS ROAD, TOTTENHAM, N15

I am writing with regard to the above on your instructions dated 24 June 2005 originally sent by email.

Instructions

I confirm my instructions are to provide advice regarding the above property to include: -

My opinion of the Open Market Value of the property.

The existing use value, i.e. the value which is shown in the assets register.

Description

The property is situated on St Anns Road, adjacent to the hospital. This is an area, which is predominately residential apart from the hospital, and apart from local shops there is little commercial presence.

The property is detached and extends to two storeys in parts and has onsite parking. It has a garage, which is large enough to house two ambulances and accommodation for staff, which extends to a lounge, kitchen and office and on the first floor has a shower and locker rooms.

Inspection

The property was inspected by Mr Inglis on 5 July 2005 at 10am.

Services No structural survey has been carried out nor have the services been tested and my valuation is on the assumption that no major defects exist and all major services are provided to the property.

Condition Although no structural survey has been carried out the property appears to be in good condition and was not in the want of any immediate repairs. There were no indications that the building is likely to cause any present or future liability in respect of need of works.

Contamination I have assumed that no deleterious or hazardous materials or techniques were used in the construction of the building or have since been incorporated. Furthermore no environmental assessment of the building has been provided nor am I instructed to arrange consultants to investigate any matters with regard to contamination. I have assumed that the building and neighbouring properties are not contaminated nor is the building situated in an underground mining area

Outgoings, easements, restrictive covenants, rights of way I am not aware of any such incumbrance which would have an effect on value.

Planning I have assumed that there is planning permission for the present use and there are no restrictions which would prevent this continuing use as an ambulance station.

For the purposes of the Open Market Value I have had to make assumptions with regard to the potential for gaining planning permission on the site, as there has not been time to make formal enquiries to the local planning department. I have assumed that should the site become redundant and surplus to requirements that it could be sold with the benefits of planning permission for residential development. I have also assumed that there may be height restrictions with regard to this sight and any development may be restricted to two storeys.

Basis of valuation My opinion of value is reflected in the Open Market Value of the property as at the date of this report.

My valuations have been carried out in accordance with the Practice Statements of the Royal Institution of Chartered Surveyors. My valuations are to Open Market Value, which is defined in the manual as: -

a) A willing seller.

b) That prior to the date of valuation there had been a reasonable period (having regard to the nature of the property and the state of the market) for the proper marketing of the interest for the agreement of the rent and other lettings terms and for the completion of the letting.

c) That the state of the market, levels of values and other circumstances were on any assumed date of entering into agreement for lease the same as on the date of valuation.

d) That no account is taken of any additional bid by a prospective lessee with a special interest.

e) That both parties to the transaction had acted knowledgeably, prudently and without compulsion.

Liability to third parties and limits on publication

This report has been prepared for your use only and no liability has been accepted to any third party. Furthermore the contents of this report may not be disclosed or published in whole or in part without first referring the matter back to me.

Validity

This report should not be considered valid for a period in excess of three months from the date of issue. Particular attention should be drawn to this as part of the valuation is based on residential development.

RICS Appraisal and Valuation renewal

This report has been prepared in accordance with the practise statements in the RICS Appraisal and Valuation Manual. It has been prepared by District Valuer Services who can be described as external valuers who are not directors or employers of the London Ambulance Service NHS trust and do not have a financial interest therein. Nor does the London Ambulance Service NHS trust have any financial interest in District Valuer Services.

Opinion of Value

I am of the opinion that the Open Market Value of the property as at the date of this report is £200,000 (two hundred thousand pounds).

The existing use value as shown in the assets register is £437,479 (four hundred and thirty seven thousand, four hundred and seventy nine pounds). If the property is to be transferred to another NHS body then this is the book value at which the property should be transferred.

Fees

My fees as confirmed in my letter of 4 July 2005 will be based on time cost plus VAT. An invoice for my fees will be forwarded under separate cover to you.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

DUNCAN INGLIS
FOR DISTRICT VALUER LONDON

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report

For the Month Ending 31 December 2005 (Month 09)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	17,205	17,174	31F	158,777	158,779	(2)U	0.0 U	213,780	211,639	2,141F
Total Expenditure	18,981	18,222	(759)U	158,684	156,458	(2,226)U	1.4 F	213,530	211,639	(1,891)U
Trust Result	(1,776)	(1,048)	(728)U	93	2,321	(2,228)U	(96.0)U	250	0	250F

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report

For the Month Ending 31 December 2005 (Month 09)

1. **Month**

1.1. Trust income was £31k higher than expected in the month of December. This is mainly due to unanticipated income for the Multi-Agency Task Force until March 2006.

1.2. Trust expenditure was £759k higher than budget, this was expected and was in line with previous forecasts. It is mostly as a result of the payment of double time rates over the Christmas period plus the offer of one day off taken in lieu or paid; for accounting purposes it is assumed that all staff who worked on the 3 applicable days (Christmas Day, Boxing Day and Holiday Tuesday) will take the payment option for the additional day in lieu.

1.3. PTS also contributed to the adverse movement in the month due to an under recovery on Extra Contractual Journeys in the month and expenditure on third party transport.

2. **Year to Date**

2.1. Overall income is on target for the year to date.

2.2. Expenditure is higher than budget to date by £2.226 million or 1.4%. This is due largely to A&E overtime double time weekend payments, the payment of enhanced rates to crew staff over the Christmas period and PTS which has reported high levels of expenditure on agency staff and third party transport.

3. **Annual**

3.1 The forecast at Month 9 is £250K underspent, this takes into account the following:

- Receipt of £10m CBRN funding, recurrent from 2004/05.
- Receipt of £3m relating to the terrorist incidents in July (this has been revised downwards from £5m in previous months).
- The achievement of £2.0m savings in the year (this has been revised upwards from £1.5m in previous months).
- Additional AfC costs for EMT4 (£1.3m).
- Weekend double time payments to crew staff are assumed to continue to the end of the financial year, this is estimated to cost in the region of £500k.

3.2 The Trust continues to actively pursue the Department of Health to secure the £10m CBRN and the £5m additional emergency funding.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 31 December 2005 (Month 09)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	%Variance	Forecast	Budget	Variance
Income	16,387	16,301	86F	149,800	149,792	8F	0.0F	202,494	200,033	2,461F
A&E Operations Cost										
Sector	11,886	11,263	(623)U	95,678	93,743	(1,935)U	0.0U	126,673	125,965	(708)U
Control Services	1,051	1,044	(7)U	10,160	10,163	3F	0.0F	13,639	14,009	370F
A&E Operational Suppo	673	645	(28)U	7,124	7,230	106F	0.0F	10,303	10,300	(3)U
Education and Developmen	779	694	(85)U	5,749	5,797	48F	0.0F	8,105	8,285	180F
Total Operations Cost	14,389	13,646	(743)U	118,711	116,933	(1,778)U	0U	158,720	158,558	(162)U
A&E gross surplus/(deficit)	1,998	2,655	(657)U	31,089	32,860	(1,771)U	0U	43,774	41,474	2,300F
A&E Gross Margin	12.3%	16.4%	(4.1)%U	20.8%	22.0%	(1.2)U	5.4%U	21.6%	20.8%	(0.8)U
Corporate Support										
Medical Director	10	12	2F	89	104	15F	0.1F	121	139	18F
Service Development	62	80	19F	565	590	25F	0.0F	811	811	0F
Communications	114	118	4F	993	1,015	22F	0.0F	1,369	1,370	1F
Human Resources	352	351	(1)U	3,039	3,200	161F	0.1F	4,129	4,204	75F
IM&T	587	586	(2)U	4,803	4,977	174F	0.0F	6,719	6,976	257F
Finance	1,146	1,171	26F	11,627	11,626	(1)U	0.0U	15,391	15,422	31F
Chief Executive	124	116	(8)U	1,032	1,034	2F	0.0F	1,373	1,368	(5)U
Centrally Held Funds	1,306	1,306	0F	8,322	8,322	0F	0.0F	12,873	11,178	(1,695)U
Total Corporate	3,700	3,740	40F	30,469	30,868	399F	0F	42,786	41,468	(1,318)U
A&E net surplus/(deficit)	(1,702)	1,085	(617)U	620	1,992	(1,372)U	68.9U	988	6	982F
A&E Net Margin	(10.4%)	(6.7)%	(3.8)%U	0.4%	1.3%	(0.9)U	68.9%U	0.5%	0.0%	0.5F
PTS										
Income	818	873	(55)U	8,977	8,987	(9)U	0.0U	11,286	11,606	(320U)
Expenditure	892	836	(56)U	9,504	8,658	(846)U	0.1U	12,024	11,612	(412U)
Surplus / (Deficit)	(74)	37	(111)U	(527)	329	(856)U	(260)U	(738)	(6)	(732)U
Margin	(9.0)%	4.3%	(13.3)U	(5.9)%	3.7%	(9.5)U	260.4U	6.5%	0.1%	6.5F
Trust Result	(1,776)	1,048	(728)U	93	2,321	(2,228)U	(96)U	250	0	250F

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 31st December 2005 (Month 09)

Notes

1. **Income**
   - The favourable movement on income in the month is mainly due to unanticipated income for the Multi-Agency Task Force until March 2006, along with a significant level of income due to staff on secondment. This is reduced slightly by income being well below target on PTS and Community Resus training.
2. **A&E Sectors**
   - The majority of the overspend on Sectors stems from the impact of the enhanced rates paid over Christmas (double time plus one day off in lieu). Booked overtime hours per week averaged 8201 for December compared to 10256 for November.
   - Almost 600 wte crew staff moved to EMT 4 in month from EMT3 with the associated budget transferred from reserves.
   - DSOs are overspent £258K ytd due to Decon/MAIAT (£126k), spine point increments (£36K) and additional DSO support (£94K). This is in part offset by an underspend on Stadia payments to managers (£149K).
   - Admin staff are £276K underspent YTD due to vacancies.
   - Subsistence moved £80K adverse in the month due budget profiling rather than increased spend. The profile assumed the mid-year introduction of meal breaks.
   - 3rd Party transport is overspent £130K ytd due to private ambulance and PTS support for A&E performance.
   - Medical equipment is underspent £125K ytd due mostly to Decon.
   - Oxygen Cylinder rental continues to be problematic and cylinder quantities and type are under investigation (£69K ytd). This overspend is offset in part by an underspend on gasses (£40K ytd). Medical and Surgical items are overspent across most complexes (£50K ytd) and due to 7/7 purchases (£29K).
   - Accident repairs continues to exceed budget. The variance is £345K adverse ytd.
   - Capital items on the EBS project have now been moved to capital codes which has led to a £48K favourable movement on IT in the month.
   - The forecast for Sectors has moved adverse due to the assumed extension of double time payments to crew staff at week-ends until 31st March 2006. The forecast is very dependent on hours worked and skill mix used.
3. **A&E Control**
   - Pay is underspent mainly due to vacancies on EMDs (£75K ytd). £150K excess budget has been transferred to the efficiency savings budget in reserves.
   - The favourable 3rd Party movement is due to an adjustment to the Cross Boundary Charges accrual.
   - The forecast underspend is due to staff vacancies.
4. **Education & Development**
   - Pay is overspent £61K ytd due to a frontloaded ambitious savings target £311K (£272k ytd). In the month there is an overspend due to the commencement of new trainees in December.
   - Staff related costs are underspent £43K due to uniforms which will be spent later in the year.
   - Course fees are overspent £103K in the month due to a recode of IHCD course costs (£52K) from consultancy fees to course fees.
   - Fleet costs are underspent £53K ytd due to low accident rates.
   - Information Technology is overstated (£54K ytd) awaiting a transfer of expenditure to a capital project. There has also been expenditure of £30k on furniture & fittings some of which also relates to the Learning Resource Centre project.
   - The underspent forecast is dependent on management development and CPD. £45K expenditure has been included in the forecast for outstanding fees for Kingston University.
5. **A&E Operational Support**
   - The overspend in the month stems from both Fleet and Logistics. Expenditure on vehicle maintenance within Fleet increased in December as was expected with the pressures of winter. Within Logistics there is a small overspend due to the re-profiling of the budget for the stocking of new A&E ambulances. The year to date position is underspent

due to an underspend on vehicle maintenance. Expenditure on vehicle maintenance is expected to continue to increase towards the end of the year which is reflected in the overall forecast financial position.

6. Service Development

- The monthly favourable swing stems from a budget addition to account for funding received for a research project which will be spent in the last quarter of the financial year. The year to date variance is explained by admin vacancies in the directorate.

7. Communications

- The year to date underspend stems from the conference and corporate induction budget. This is expected to be spent by the end of the financial year and this is reflected in the forecast, which is breakeven.

8. Human Resources

- The year to date position is due to unproductive salaries where number of staff classed a “permanently unfit for work” is less than planned. The forecast position reflects this trend.

9. IM&T

- The directorate has a breakeven position for the month of November. The year to date position reflects underspends within some non pay budgets (primarily Systems & Networks) and vacant posts. The forecast position reflects further expenditure expected on ISoN and on IM&T consultants currently working on the CAD project and others.

10. Finance

- The underspend in the month is due to the level of legal provisions and claims expenditure being less than originally anticipated. It is assumed that the legal provisions expenditure will spend to budget for the rest of the year and this is reflected in the forecast.

11. PTS

- The main cause of the negative contribution in the month is Central Services, which makes up £41k of the £74k negative contribution in PTS. Activity levels for Extra Contractual Journeys have not been as high as anticipated and staffing levels and private ambulance usage have not been adjusted to reflect this. In addition, there are one-off charges in the month of £16k and £8k, for backdating a reduced contract price on one of the contracts and for a write-off of uniform stock.

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type

For the Month Ending 31 December 2005 (Month 09)

£000s

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Forecast Variance
Payroll Expenditure										
A&E Operational Staff	8,500	8,386	(114)U	67,767	67,582	(186)U	0.3U	92,740	93,510	770F
A&E Overtime	1,740	1,178	(562)U	12,759	11,871	(888)U	7.5U	15,861	13,949	(1,912)U
PTS Operational Staff	563	565	2F	5,478	5,363	(115)U	2.1U	7,238	7,010	(228)U
Corporate Support	2,785	2,785	(1)U	24,616	24,819	204F	0.8F	32,323	33,399	1,076F
	13,588	12,913	(675)U	110,620	109,635	(984)U	0.9U	148,162	147,867	(295U)
Non Pay Expenditure										
Staff Related	446	333	(114)U	3,773	3,669	(104)U	2.8U	5,127	4,728	(399)U
Staff Welfare	31	34	2F	305	302	(2)U	0.8U	410	403	(7)U
Training	265	152	(114)U	1,503	1,579	77F	4.9F	2,006	2,244	238F
Medical & Ambulance Equipment	(82)	(9)	73F	833	959	127F	13.2F	1,408	1,673	265F
Medical Consumables	284	249	(34)U	2,201	2,047	(153)U	7.5U	2,947	2,706	(241)U
Fuel & Oil	331	351	20F	2,819	2,898	79F	2.7F	3,749	3,836	87F
Third Party Transport - A&E	36	37	1F	612	466	(145)U	31.2U	852	660	(192)U
Third Party Transport - PTS	84	53	(31)U	1,322	625	(697)U	111.4U	1,592	774	(818)U
Vehicle Maintenance	202	167	(35)U	1,609	1,673	64F	3.8F	2,263	2,308	45F
Other Fleet Costs	564	612	48F	5,289	4,987	(301)U	6.0U	7,291	7,078	(213)U
Rent, rates & utilities	219	192	(27)U	1,945	1,999	54F	2.7F	2,399	2,503	104F
Office and Station cleaning	162	156	(6)U	1,321	1,402	82F	5.8F	1,889	2,009	120F
Security & Fire Safety	3	20	17F	181	180	(1)U	0.3U	242	240	(2)U
Estates Maintenance	13	71	58F	1,161	1,217	56F	4.6F	1,587	1,645	58F
Other Estates Costs	51	27	(24)U	292	244	(48)U	19.8U	382	325	(57)U
Telephones	185	178	(8)U	1,874	1,967	93F	4.7F	2,573	2,721	148F
Information Technology	26	73	47F	861	727	(133)U	18.3U	1,108	1,017	(91)U
Office & Station Expenses	159	140	(18)U	1,443	1,442	0U	0.0U	1,952	1,942	(10)U
Legal Expenses	93	135	42F	1,253	1,170	(84)U	7.2U	1,658	1,554	(104)U
Consultancy	(17)	34	51F	223	151	(72)U	47.4U	291	229	(62)U
Advertising & PR	59	17	(43)U	263	169	(94)U	55.6U	374	226	(148)U
Catering & Hospitality	30	15	(15)U	194	123	(71)U	57.3U	245	165	(80)U
Depreciation	537	536	(1)U	4,801	4,814	13F	0.3F	6,260	6,470	210F
Reserves	1,285	1,278	(7)U	8,140	8,027	(113)U	1.4U	11,531	10,904	(627)U
Radio Equipment	121	130	9F	996	1,023	27F	2.7F	1,386	1,412	26F
Others	(9)	0	9F	34	0	(34)U	100.0U	25	51	26F
	5,079	4,980	(99)U	45,247	43,864	(1,383)U	3.2U	61,547	59,827	(1,720U)
Financial Expenditure										
Interest Payable	15	15	0	137	137	0	0.0	183	183	0
Interest Receivable	(35)	(18)	17F	(326)	(161)	164F	102.0U	364	(215)	149F
PDC Dividend	311	311	0	2,800	2,800	0	0.0	3,733	3,733	0
Others	22	20	(2)U	206	183	(24)U	13.0U	269	244	(25)U
	314	329	15 F	2,818	2,959	141 F	4.8F	3,821	3,945	124F
Total Trust Expenditure	18,981	18,222	(759)U	158,684	156,458	2,226U	(1.4)F	213,530	211,639	(1,891)U
WTE	3,763.07	4,214.34	451.27 F							

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Expense Type

For the Month Ending 31st December 2005 (Month 09)

Notes

1. **A&E Operational Staff**
   - 600 EMT4 have been assimilated on AfC rates which was covered by a transfer of budget from reserves. The unfavourable swing in the month stems mostly from CAC and A&E Trainees. Within CAC, budget was transferred to the Trust's efficiency reserve to account for YTD savings made on vacant posts, causing and unfavourable swing. Within Training, expenditure has increased due to new trainees which started in December.
2. **A&E Overtime**
   - The overspend in the month is a result of the double time paid over the Christmas period plus the additional day paid as time off in lieu.
3. **PTS Operational Staff**
   - Crew staff pay continues to be above budget, with overtime, some over-establishment and Central Services agency usage presenting a continued problem
4. **Corporate Support Staff**
   - The biggest area of underspend continues to be within Admin & Clerical staff. Vacancies continue amongst the station administrators and in the Recruitment Centre.
5. **Staff Related**
   - Subsistence is over budget due to non allocation of crew staff meal breaks.
6. **Training**
   - Course fees are overspent in the month due to IHCD courses and a foundation degree course costs.
7. **Medical & Ambulance equipment**
   - The favourable swing in the month stems from a change to the budget profile for the A&E ambulance equipment budget, correcting the year to date position.
8. **Medical Consumables:**
   - Medical consumables are overspent on sectors across most complexes.
9. **Third Party Transport – PTS**
   - Third party transport expenditure continues to trend with an average unfavourable position of approximately £40k per month.
10. **Vehicle Maintenance**
    - Expenditure is less than planned so far this year. This is expected to increase in the latter quarter of the year due to winter pressures**.**
11. **Other Fleet costs**
    - Both accident damage and 3rd party continues to be problematic for A&E operations. Accident damage is £354K overspent year to date and the year to date position exceeds the annual budget. 3rd Party accident damage moved £50K favourable in the month due to amended liability data from ZMI.
12. **Rent Rates and Utilities**
    - The overspend in the month is due to the transfer of budget out of the Fixed Satellite Units budget to the Trust's efficiency reserve. This ISoN will not spend as much as originally estimated in 2005/06.
13. **Office & Station Cleaning.**
    - The year to date favourable position is due to an underspend on the Make Ready budget. This budget is not expected to be considerably underspent at the end of the year.
14. **Legal Expenses**
    - The cumulative overspend is as a result of the level of legal provisions made to date being higher than planned. Provisions are made for staff retiring through ill heath and for third party claims (staff claims or members of the public). The last four months has seen the level of claims fall compared to the first five months of the financial year.
15. **Telephones**
    - The year to date underspend is on land line calls and mobile calls & rental.
16. **Information Technology**

- IT has had a favourable move in month on EBS and training due to the move of expenditure to capital projects

17. Consultancy

- Consultancy has underspent in the month as miscoded IHCD course fees were moved from consultancy to course fees.

18. Advertising

- Advertising reports an overspend because there is no budget for all non A&E and PTS crew staff adverts. Adverts are normally funded from the "spare" budget created by a person leaving the Trust where their replacements starts at a later date.

19. Reserves

- The overspend on reserves in the month is represented by the Finance Directorate efficiency savings target; where actual savings are lower than budget. The forecast on reserves reflects further expenditure on EMTs as a result of Agenda for Change.

LONDON AMBULANCE SERVICE NHS TRUST

Analysis of Income

For the Month Ending 31st December 2005 (Month 09) **(£000s)**

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Forecast Variance
A&E Income										
A&E Services Contract	15,093	15,093	0U	137,140	137,140	0U	0.0U	182,419	182,420	(1)U
A&E Variable Activity Formula	0	0	0	0	0	0	100.0	0	816	(816)U
CBRN Income	789	744	44F	7,121	6,854	267F	(3.9)F	12,800	9,087	3,713F
ECP Revenue	3	0	3F	758	988	(231)U	23.3U	1,135	1,427	(292)U
BETS & SCBU Income	34	47	(14)U	341	427	(85)U	20.0U	440	569	(129)U
A & E Long Distance Journey	42	22	20F	336	335	0F	(0.1)F	441	488	(47)U
Stadia Attendance	38	38	0	448	448	0F	0.0F	582	582	0U
Heathrow BAA Contract	24	24	0U	184	184	0U	0.1U	255	256	(1)U
Resus Training Fees NHS	18	11	7F	116	99	16F	(16.6)F	170	132	38F
Resus Training Fees Non NHS	2	16	(14)U	6	142	(136)U	95.6U	11	189	(178)U
HEMS Funding	2	2	0	21	21	0	0.0	27	28	(1)U
A&E Income	**16,045**	**15,997**	**47 F**	**146,471**	**146,639**	**(168)U**	**0.1 U**	**198,280**	**195,994**	**2,286F**
PTS Income	**818**	**873**	**(55)U**	**8,977**	**8,987**	**(10)U**	**0.1 U**	**11,286**	**11,606**	**(320)U**
Other Income	**343**	**304**	**39 F**	**3,329**	**3,153**	**176 F**	**5.6 F**	**4,214**	**4,039**	**175F**
Total Income	**17,205**	**17,174**	**31 F**	**158,777**	**158,779**	**(2)U**	**0.0 U**	**213,780**	**211,639**	**2,141F**

Notes

1. **ECP Revenue**
   - The £231k adverse variance year-to-date is due to a delay in the roll-out of ECPs in the North-West (Brent, Hillingdon, Ealing). These will now be going live in January.
2. **CBRN Income**
   - Favourable movement in the month of £44k relates to unbudgeted income for the extension of a Multi-Agency Task Force until March 2006. The forecast has been reduced by £2m to reflect the expected reduction in the successful value of the bid.
3. **BETS and SCBU Income**
   - The year to date adverse variance of £85k is due to actual journeys not running at the expected level.
4. **A&E Long Distance Journeys**
   - The £20k favourable movement in the month reflects the change to the budget to take account of the lower number of journeys.
5. **Resus Training Fees Non-NHS**
   - The £135k adverse variance year to date is due to an ambitious income target. The Performance Improvement Manager is currently working on a strategy to increase the level of income generated in this area.
6. **PTS Income**
   - The £55k unfavourable movement in the month is a combination of the ECJ targets not being met, along with an adjustment to reflect the reduction in value of one of the contracts.
7. **Other Income**
   - The favourable year to date variance on other income is due to pension indexation income of £28k, not included in the income budget as well as a higher number of chargeable secondments than originally planned.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Staff Numbers

For the Month Ending 31 December 2005 (Month 09)

	Last Month Actual Paid WTE	This Month Actual Paid WTE	Variance
A&E Operations			
Sector	3,289.36	3,288.68	(0.68)
Control Services	411.37	387.38	(23.99)
A&E Operational Support	97.91	84.05	(13.86)
Education & Development	148.55	186.77	38.22
	3,947.19	3,946.88	(0.31)
Corporate Support			
Medical Director	0.00	1.80	1.80
Service Development	12.72	12.72	0.00
Communications	22.68	22.88	0.20
Human Resources	96.32	103.58	7.26
IM&T	49.76	45.93	(3.83)
Finance	57.74	58.24	0.50
Chief Executive	20.37	22.71	2.34
Total Corporate	259.59	267.86	8.27
PTS	316.06	298.92	(17.14)
Trust Total	4,522.84	4,513.66	(9.18)

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Staff Numbers

For the Month Ending 31 December 2005 (Month 09)

1. **A&E Sectors**
   - Overtime hours decreased in December compared to November but this has been offset by the increased double time at Christmas. Hours paid for the extra day off in lieu day given over the Christmas period are not included in these figures.
2. **A&E Control**
   - The change stems from the reduced OT hours in December.
3. **A&E Operational Support**
   - The decrease stems from week 36 pay which wasn't entered into the ledger. The associated expenditure has been accrued for in the accounts but the wte adjustment was not, hence the decrease.
4. **A&E Education Development & Support**
   - The wte increase is due to EMT trainee courses commenced in December
5. **Medical Director**
   - The change reflects a correction to last month's data
6. **Communications**
   - The increase is due to the full time effect of recruitment into the PALS receptionist being realised in month 9.
7. **Human Resources**
   - The movement stems from an increase in hours worked in Payroll and an increase in staff on maternity leave within unproductive salaries.
8. **IM&T**
   - The decrease is mostly due to reduction in overtime hours in MI.
9. **Finance**
   - The increase stems from a new member of staff in the Accounts Payable Department.
10. **Chief Executive**
    - The increase stems from an increase in admin staff within the secretarial pool. and within the PSU.
11. **PTS**
    - A reduction of 17.14 paid WTE in PTS relates to a reduction in overtime levels for crew and control staff of 17.75, offset slightly by a net increase in contracted WTE of 0.61.

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 31 December 2005 (Month 09)

Cost Centre	Cost centre description	Total Project Budget	CURRENT YEAR: Annual Budget	YEAR TO DATE: Budget	YEAR TO DATE: Spend	YEAR TO DATE: Variance	Goods Ordered/ Not Received	TOTAL PROJECT: Spend	TOTAL PROJECT: Variance
S91	**Total Vehicle Projects**								
80234	Replacement RRU 2005/06	400,000	400,000	400,000	615,005	(215,005)U	1,128,764	1,743,769	(1,343,769)U
S933	Minor Fleet Projects	49,404	49,404	893	893	0 F	53,729	54,622	(5,218)U
	Total Vehicle Projects	**449,404**	**449,404**	**400,893**	**615,898**	**(215,005)U**	**1,182,493**	**1,798,391**	**(1,348,987)U**
S92	**Total Equipment Projects**								
80055	Defibrillator Purchase	2,338,165	413,165	386,023	386,023	0 F	883,297	4,015,080	(1,676,915)U
80237	New Equipment Store: Fixtures	99,875	99,875	79,492	79,492	0 F	87,411	166,903	(67,028)U
	Total Equipment Projects	**2,438,040**	**513,040**	**465,515**	**465,515**	**0 F**	**970,707**	**4,181,982**	**(1,743,942)U**
S93	**Total Estates Projects**								
80045	Buckhurst Hill - Disposal	9,033	0	0	0	0	0	26,111	(17,078)U
80062	Streatham Improvement	1,173,287	788,080	777,381	777,382	(1)U	7,251	1,186,827	(13,540)U
80158	Whipps Cross Workshop Impro	520,000	169,116	167,116	177,960	(10,844)U	1,203	528,539	(8,539)U
80176	Poplar Ambulance Station Rep	265,000	0	0	0	0 F	0	265,000	0 F
80179	Bow Office Changes	728,000	496,625	292,785	292,785	0 F	8,041	532,201	195,799 F
80192	Bounds green addtional accomo	156,875	154,129	0	1,035	(1,035)U	0	3,781	153,095 F
80197	Relocate Central Store	235,000	135,000	114,599	114,244	355 F	2,401	210,645	24,355 F
80204	Relocation Of Isleworth Ambul	200,000	200,000	0	0	0	0	0	200,000 F
80222	New Brixton Ambulance Stat	500,000	500,000	0	0	0	0	0	500,000 F
80225	Newham - Relocate messroom	186,825	186,825	148,817	148,607	210 F	0	149,642	37,183 F
80228	New Rotherhithe Station	155,100	155,100	135,306	135,306	0 F	1,350	136,656	18,444 F
80238	Barnehurst Roof Replacement	210,000	210,000	165,273	165,273	0 F	0	165,273	44,727 F
80240	Gold Control	211,500	211,500	105,113	105,113	0 U	8,307	113,421	98,079 F
80242	Croydon Refurbishment	315,000	315,000	91,293	91,293	0 F	0	91,293	223,707 F
80246	Station Fire Alarms	150,000	150,000	7,755	7,755	0	0	7,755	142,245 F
80247	Camden replacement of boiler	125,500	125,500	81,483	81,483	0 F	0	81,483	44,017 F
80248	Edmonton Roof Replacement	125,000	125,000	38,000	38,000	0	0	38,000	87,000 F
80253	Purchase of Tottenham A/s	452,000	452,000	0	981	(981)U	0	981	451,019 F
80255	Hayes semi open ambulance ga	160,975	160,975	0	0	0	0	0	160,975 F

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 31 December 2005 (Month 09)

Cost Centre	Cost centre description	Total Project Budget	CURRENT YEAR					TOTAL PROJECT	
			Annual Budget	YEAR TO DATE			Goods Ordered/ Not Received		
				Budget	Spend	Variance		Spend	Variance
80256	ARRP Accomodation	483,039	483,039	0	0	0	0	0	483,039 F
80259	ISoN 92 Establish Learning Re	174,066	174,066	83,493	83,493	0 U	0	83,493	90,573 F
S932	Minor Estates Projects	410,416	377,416	181,731	181,373	358 F	476	186,820	223,596 F
	Total Estates Projects	**6,946,616**	**5,569,371**	**2,390,145**	**2,402,082**	**(11,937)U**	**29,029**	**3,807,918**	**3,138,698 F**
S94	**Total Technology Projects**								
80226	Dynamic Veh Coverage	123,528	123,528	94,940	94,940	0	247,056	341,996	(218,468)U
80227	Cabling for Urgent Control	135,000	135,000	123,882	123,882	0 U	69,567	193,449	(58,449)U
80232	ISON 50 Define CAD 2010	212,736	212,736	130,588	75,988	54,600 F	-2,341	73,646	139,090 F
80252	ISON 51 CAD Phase 1 Capital	129,350	129,350	9,649	6,315	3,334 F	2,985	9,300	120,050 F
S934	Minor Technology Projects	280,899	280,899	233,105	272,871	(39,766)U	416,224	689,095	(408,196)U
	Total Technology Projects	**881,513**	**881,513**	**592,164**	**573,996**	**18,168 F**	**733,489**	**1,307,486**	**(425,973)U**
S97	**Approved ISoNs not Committe**								
89998	Approved ISONs not Committe	3,922,174	3,805,174	0	0	0	0	0	3,922,174 F
	Approved ISoNs not Committed	**3,922,174**	**3,805,174**	**0**	**0**	**0**	**0**	**0**	**3,922,174 F**
S98	**Total Old Projects**								
	Total Old Projects	**9,447,902**	**0**	**0**	**614,539**	**(614,539)U**	**34,880,891**	**62,304,567**	**(52,856,665)U**
S99	**Un Allocated Capital Funds**								
S99	Un Allocated Capital Funds	972,901	210,998	0	0	0	0	0	972,901 F
	Un Allocated Capital Funds	**972,901**	**210,998**	**0**	**0**	**0**	**0**	**0**	**972,901 F**
	Total Programme	**25,058,550**	**11,429,500**	**3,848,717**	**4,672,030**	**(823,313)U**	**37,796,610**	**73,400,344**	**(48,341,794)U**

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 31st December 2005 (Month 09)

Notes

1. The two main area of capital overspend are on Replacement RRUs and Old Projects (2004/05 and before):

    - Replacement RRU's are overspent since more vehicles are being ordered than was assumed in the original business case. The business case is being revised to reflect the increased number and the budget will be revised.
    - The Old Projects overspend is on PTS vehicles. These vehicles will be sold on a "sale and leaseback" agreement and therefore will be moved out of capital and the associated lease cost will be a revenue cost.

2. Forecast
    - The forecast financial position on Capital is an underspend of £698k. This arises due to the delay in starting some estates projects. It has been agreed to broker our capital underspend to the SWL SHA.

LONDON AMBULANCE SERVICE NHS Trust

Balance Sheet

For the Month Ending 31 December 2005 (Month 09)

	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Fixed Assets											
Intangible assets	415	429	414	388	382	384	458	405	397	441	
Tangible assets	104,707	103,910	107,076	107,310	107,590	107,965	107,851	107,749	107,655	108,159	
	105,122	104,339	107,490	107,698	107,972	108,349	108,309	108,154	108,052	108,600	
Current Assets											
Stocks & WIP	1,938	1,933	1,933	1,933	1,933	1,936	1,936	1,935	1,933	1,933	
Debtors A&E	2,776	1,604	2,795	3,789	6,804	6,341	8,744	7,322	7,734	8,063	£628k > 60 days (40.18%), Nov - £572k > 60 days (32.94%)
Debtors PTS	1,796	1,464	1,767	1,038	808	625	943	851	570	573	£230k > 60 days (40.14%), Nov - £152k > 60 days (26..72%)
Prepayments, Vat Recoverable, Other Debtors	2,467	2,979	3,409	2,754	1,959	2,461	2,472	3,124	2,691	2,831	
Back to Backed Debtors - PCTs	9,902	10,517	10,299	10,682	10,517	10,864	9,683	9,355	9,376	9,429	
Investments - Short Term Deposits	0	1,600	3,000	5,100	6,800	6,700	4,300	8,800	7,000	3,000	
Cash at Bank and in Hand	664	471	91	46	429	308	1,805	344	-513	301	
Total Current Assets	19,543	20,568	23,294	25,342	29,250	29,235	29,883	31,731	28,791	26,130	
Creditors: Amounts falling due within one year											
Bank Overdraft	101	40	22	340	36	31	13	93	26	35	
Creditors - NHS	2,774	2,408	2,103	2,012	2,077	2,212	2,133	2,427	3,349	3,027	PSPP - This month (81%), Last month (73%), Ytd (72%)
Creditors - Other	12,213	9,495	9,547	8,623	9,994	9,552	11,718	10,639	13,036	11,925	PSPP - This month (80%), Last month (83%), Ytd (83 %)
Dividend Provision	0	311	622	933	1,244	1,555	0	311	622	933	
Total Current Liabilities	15,088	12,254	12,294	11,908	13,351	13,350	13,864	13,470	17,033	15,920	
Net Current Assets	4,455	8,314	11,000	13,434	15,899	15,885	16,019	18,261	11,758	10,210	
Total Assets less current liabilities	109,577	112,653	118,490	121,132	123,871	124,234	124,328	126,415	119,810	118,810	
Creditors: Amounts falling due after more than one year											
Provisions for Liabilities & Charges	24,422	26,453	28,323	30,999	31,932	33,822	33,925	36,877	29,782	30,109	
Total Net Assets	85,155	86,200	90,167	90,133	91,939	90,412	90,403	89,538	90,028	88,701	
Capital & Reserves											
Donated Assets	698	698	676	658	639	621	603	585	566	563	
Income & Expenditure account	4,595	5,427	5,996	6,083	7,907	6,398	6,494	5,647	6,156	4,861	
Other Reserves	10	10	10	10	10	10	10	10	10	10	
Public Dividend Capital	39,977	39,977	39,977	39,977	39,977	39,977	39,977	39,977	39,977	39,977	
Revaluation Reserve	39,875	40,088	43,508	43,405	43,406	43,406	43,319	43,319	43,319	43,290	
Total Capital & Reserves	85,155	86,200	90,167	90,133	91,939	90,412	90,403	89,538	90,028	88,701	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement

For the Month Ending 31 December 2005 (Month 09)

	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Opening Cash Balance	563	2,031	3,069	4,806	7,193	6,977	6,091	9,051	6,461
Operating Activities									
Trust I&E	1,159	885	299	1,940	-1,222	292	-565	1,404	-1,650
Depreciation	524	498	542	544	537	533	531	543	357
(Increase)/Decrease in Stocks	5	0	0	0	-3	1	1	1	0
(Increase)/Decrease in Debtors	367	-1,706	2	-1,819	-203	-1,552	1,191	280	-524
Increase/(Decrease) in Creditors	-383	1,670	800	-9,034	1,610	-7,204	-715	3,311	-1,558
Increase/(Decrease) in Stocks	0	0	0	0	0	0	0	0	0
Other	0	-121	322	11,983	-106	9,372	2,937	-7,727	929
Net Cashflow from operating activities	1,672	1,226	1,965	3,614	613	1,442	3,380	-2,188	-2,446
Financial Activities									
Interest received	25	27	33	42	39	43	46	49	35
Interest paid	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0
Net Cashflow from financial activities	25	27	33	42	39	43	46	49	35
Capital Expenditure									
Tangible fixed assets acquired	-229	-215	-261	-1,269	-868	-504	-466	-451	-784
Tangible fixed assets disposed	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0
Net Cashflow from capital expenditure	-229	-215	-261	-1,269	-868	-504	-466	-451	-784
PDC Dividends paid	0	0	0	0	0	-1,867	0	0	0
Financing - PDC Capital	0	0	0	0	0	0	0	0	0
Closing cash balance	2,031	3,069	4,806	7,193	6,977	6,091	9,051	6,461	3,266

Finance Risk Register Items - 2005/06 Risks

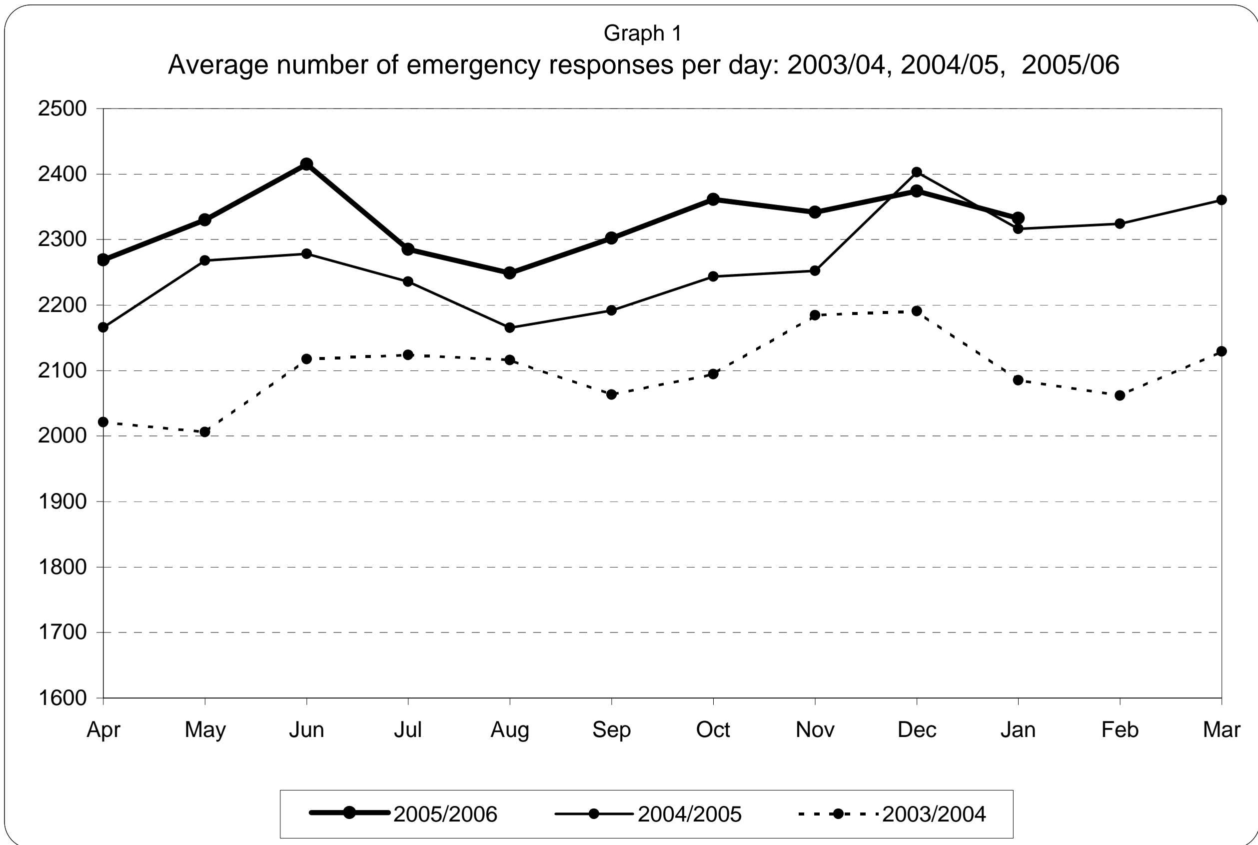
	Risk	Priority *(High, Medium or Low)*	Lead Person *(OMG Member)*	Action Plan	Timescale
1.	The funding for the increase for Agenda for Change is not sufficient to cover the additional costs the Trust will incur.	M	CH	Manage the implementation of Agenda for Change tightly	During 2005/06
2.	The trust requires savings to be achieved to clear the efficiency target. These may not be achieved or yield sufficient funds.	H	SMG	Work up realistic plans. Make the most of other funding opportunities in 2005/06.	During 2005/06
3.	The recurrent CBRN funding is not secured, but needs to be as this has been used to fund recurrent staffing costs.	H	SMG	Pursue SHA.	During 2005/07
4.	Trust may not manage crew overtime within budget.	H	MF	Monitor closely and manage in year	During 2005/06
5.	Any new and unforeseen cost pressures.	M	SMG	Hold contingency reserve	During 2005/06
6.	Fuel prices in excess of the sums held in budgets, and Centrally Held Funds.	M			
7.	Failing to manage and control third party expenditure.	H	MF/MD	Monitor closely and manage in year	During 2005/06
8.	PTS: The demanding income levels within the central services budget may not be achieved.	M	MD	Monitor closely and manage in year	During 2005/06
9.	Until more details of some capital projects are known, the levels of VAT and its recovery cannot be forecast accurately.	L			
10.	Until tenders for each project are received, there is the possibility that costs will increase. That was the Trust's experience in 2003/04.	M	MD	Hold some capital back for this uncertainty	During 2005/06
11	The £5 million additional funding (terrorist incidents) will not be secured.	H	MD	Pursue SHA.	During 2005/06
12	Subsistence budget will materially overspend by up to £375K due to the non-introduction of meal breaks from 1st Oct 2005	H	MD		During 2005/06

Information pack for Trust Board

December 05 / January 06

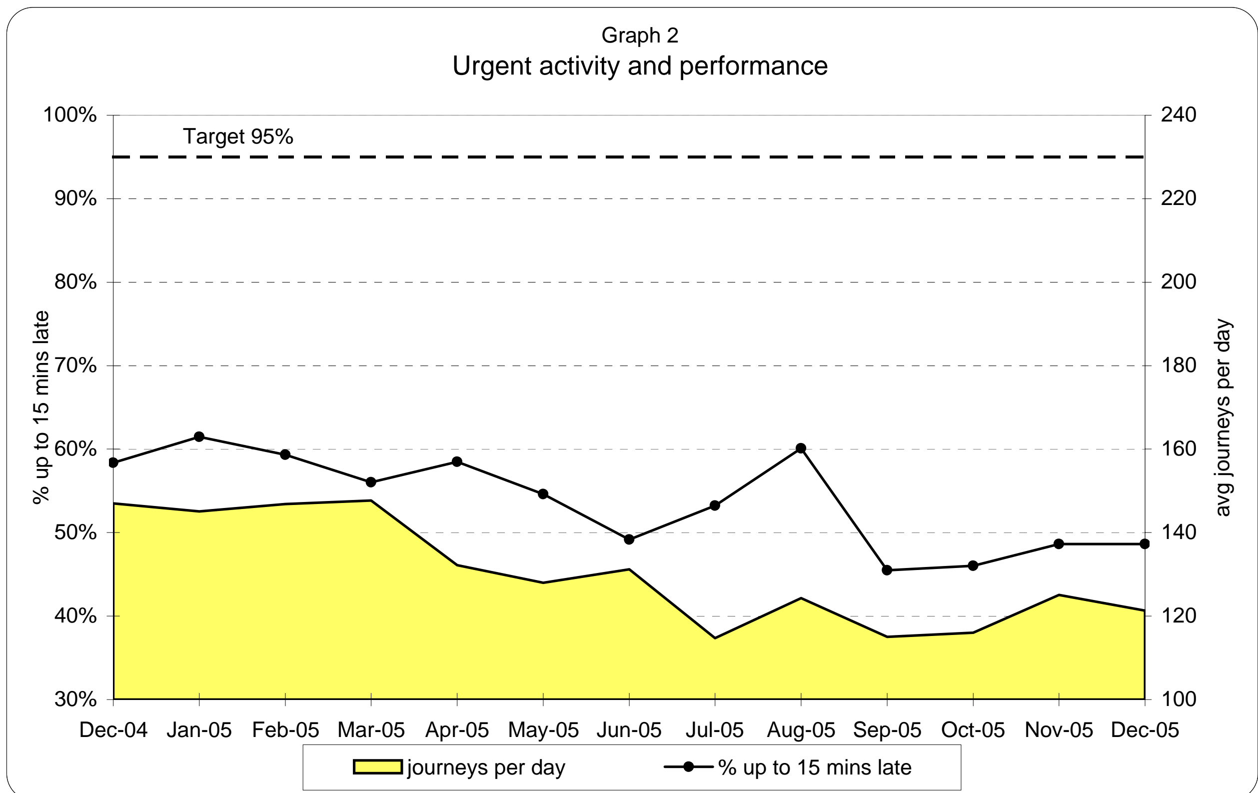
Note: **PRF data entry is up to 14th December 2005**
Manning data entry is up to 16th January 2006
MDT data is up to 19th January 2006
CAC manning is up to 22nd January 2006

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



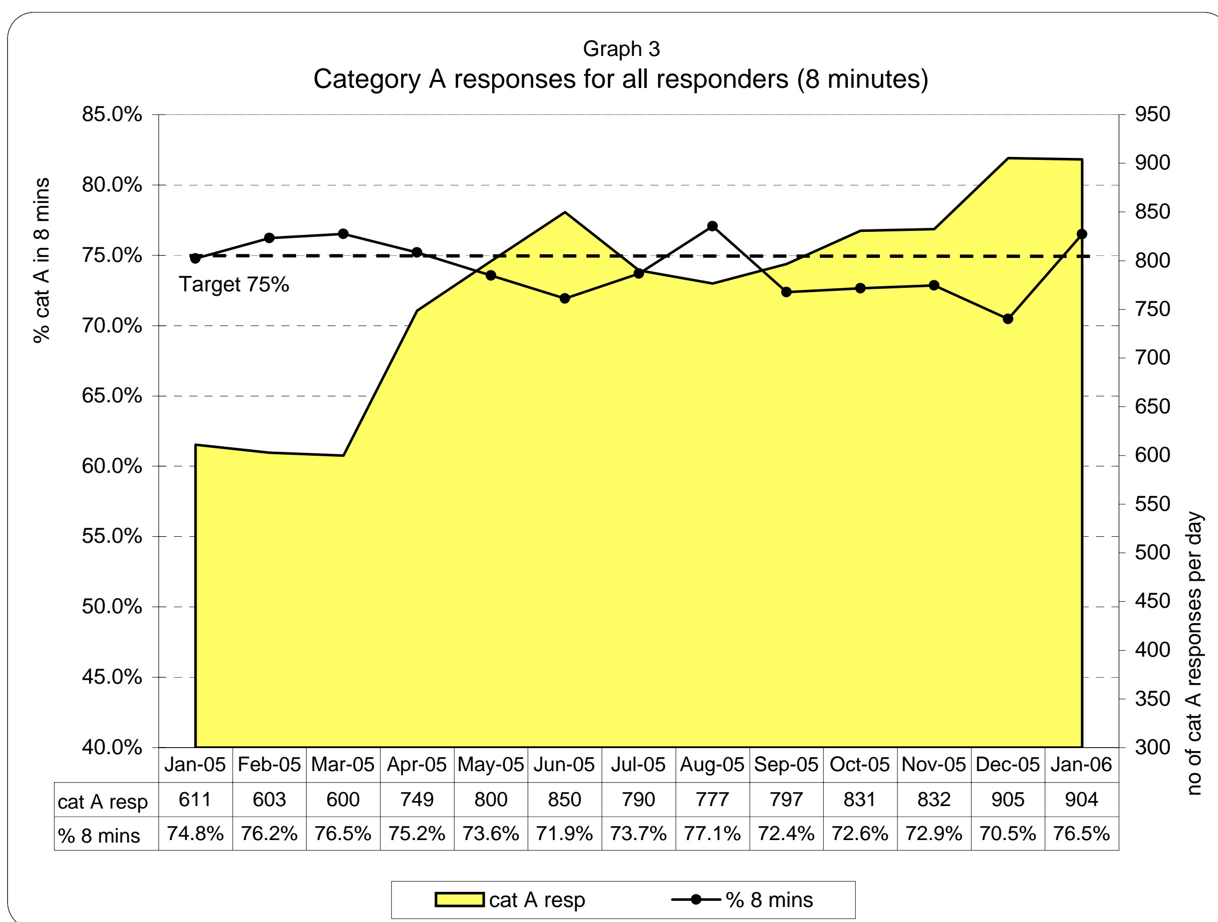
Emergency responses: monthly and year to date comparison

Dec 05 v Dec 04	Apr 05-Dec 05 v Apr 04-Dec 04
-1.2%	+3.6%



Note: Urgent performance measures the arrival at hospital time against requested arrival time (target=95% of patients to arrive no more than 15 mins after time requested)

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



	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06
cat A resp	611	603	600	749	800	850	790	777	797	831	832	905	904
% 8 mins	74.8%	76.2%	76.5%	75.2%	73.6%	71.9%	73.7%	77.1%	72.4%	72.6%	72.9%	70.5%	76.5%

Table 1
8 minute response by Strategic Health Authority (cat A, for all responders)

	North West London Strategic HA	North Central London Strategic HA	North East London Strategic HA	South East London Strategic HA	South West London Strategic HA	Total LAS
Apr-05	73%	75%	72%	75%	73%	**75%**
May-05	73%	75%	72%	75%	73%	**74%**
Jun-05	70%	74%	70%	74%	73%	**72%**
Jul-05	73%	76%	73%	75%	72%	**74%**
Aug-05	76%	80%	77%	79%	74%	**77%**
Sep-05	72%	74%	70%	74%	72%	**72%**
Oct-05	72%	74%	69%	75%	74%	**73%**
Nov-05	74%	74%	71%	73%	71%	**73%**
Dec-05	73%	72%	68%	71%	69%	**70%**
Jan-06	75%	75%	71%	77%	75%	**76.5%**
Feb-06						
Mar-06						
YTD	**73%**	**75%**	**71%**	**75%**	**73%**	**73%**

London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency responses: 14 minute response activity and performance (cat A)

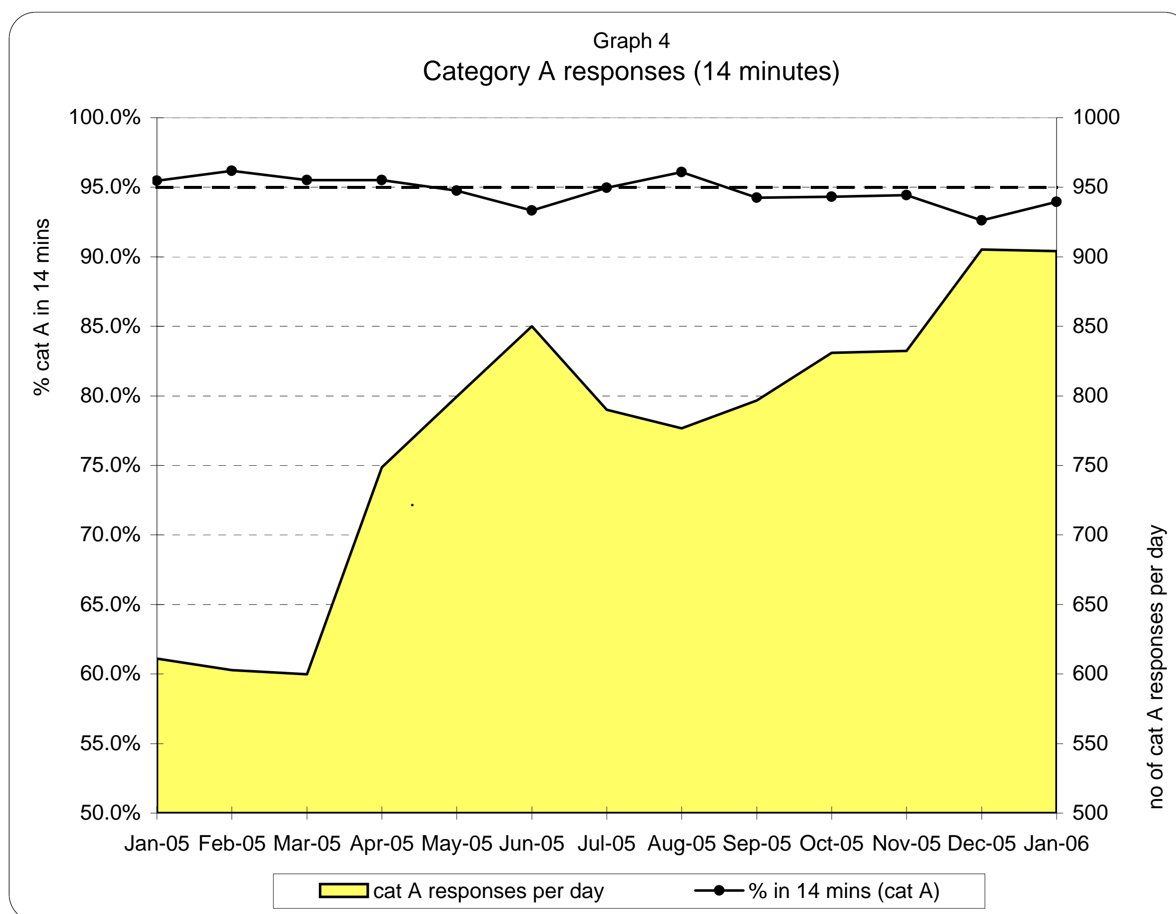
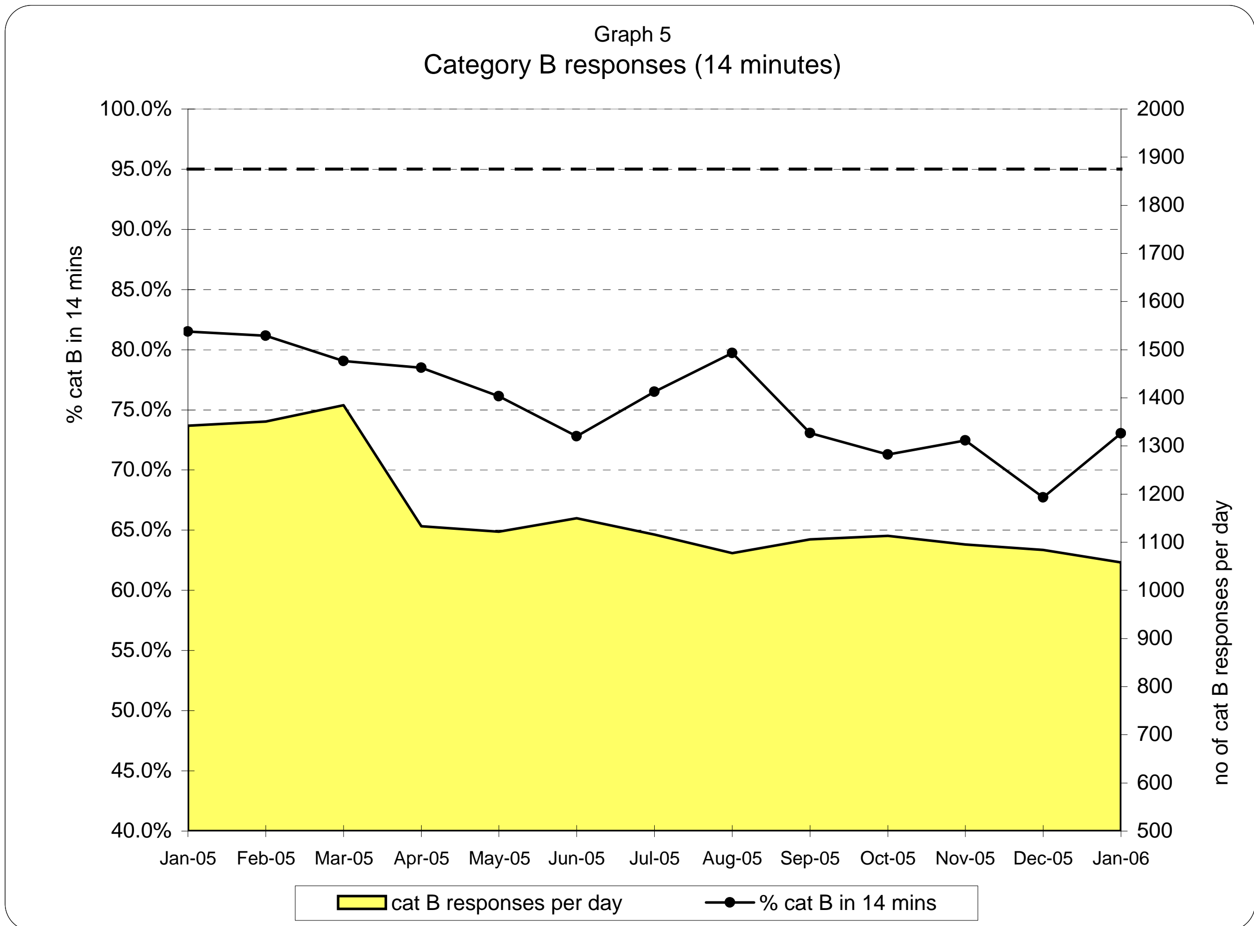


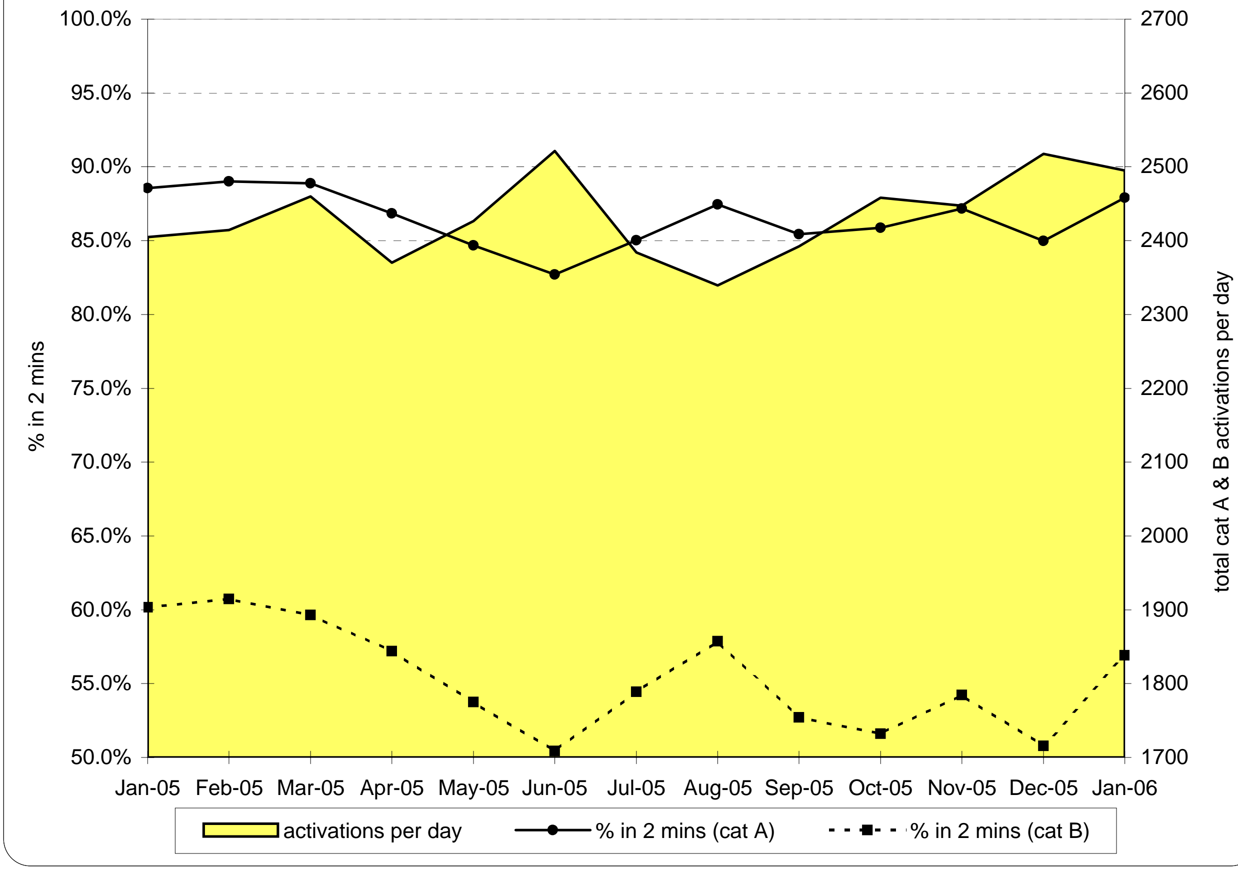
Table 2
14 minute response by Strategic Health Authority (category A)

	North West London Strategic HA	North Central London Strategic HA	North East London Strategic HA	South East London Strategic HA	South West London Strategic HA	Total LAS
Apr-05	95%	95%	93%	96%	96%	**96%**
May-05	95%	95%	93%	96%	96%	**95%**
Jun-05	93%	94%	92%	95%	94%	**93%**
Jul-05	95%	96%	94%	96%	95%	**95%**
Aug-05	96%	97%	96%	96%	96%	**96%**
Sep-05	95%	95%	94%	94%	94%	**94%**
Oct-05	95%	94%	93%	95%	95%	**94%**
Nov-05	96%	95%	93%	94%	95%	**94%**
Dec-05	94%	92%	91%	93%	93%	**93%**
Jan-06	94%	94%	92%	95%	95%	**94%**
Feb-06						
Mar-06						
YTD	**95%**	**95%**	**93%**	**95%**	**95%**	**94%**

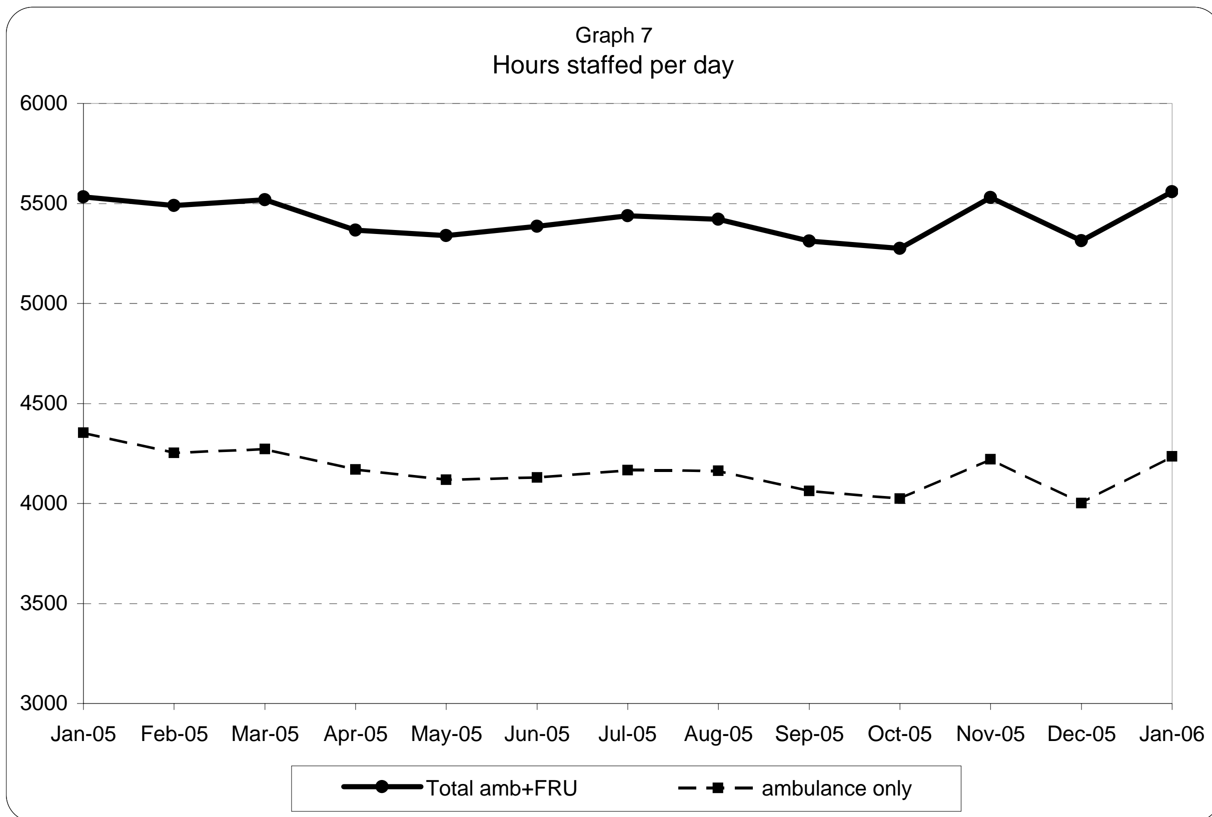
London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency responses: 14 minute response activity and performance (cat B)

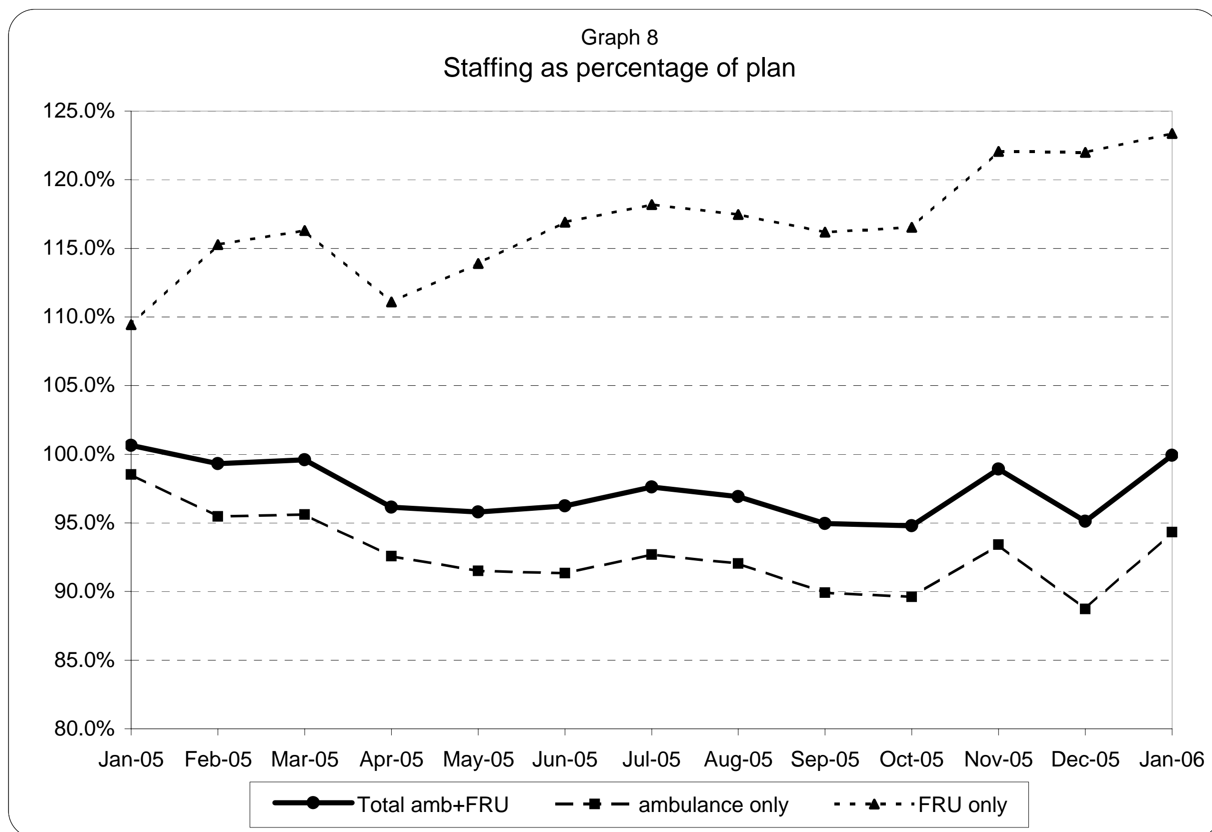


London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency activations: activity and performance



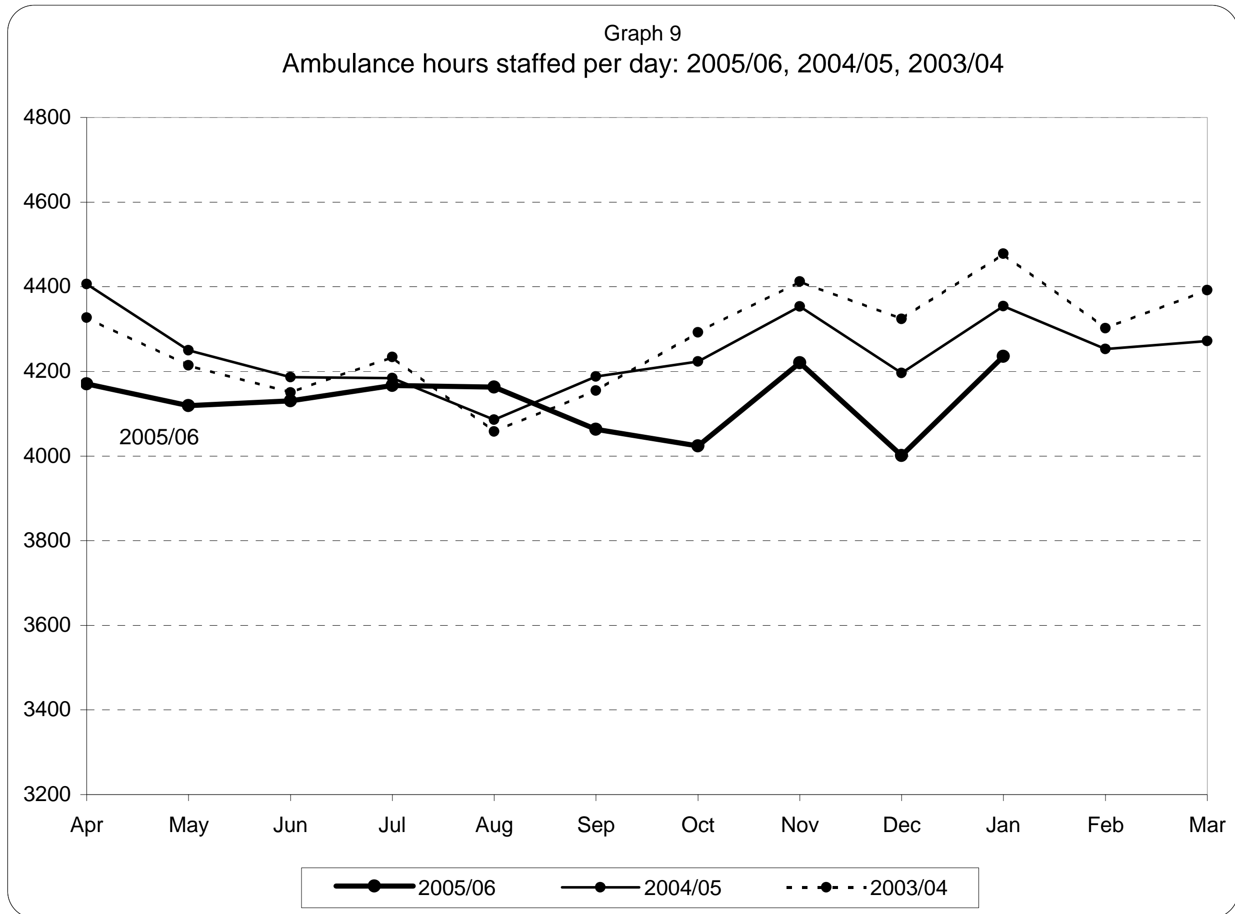
London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance and FRU staffing





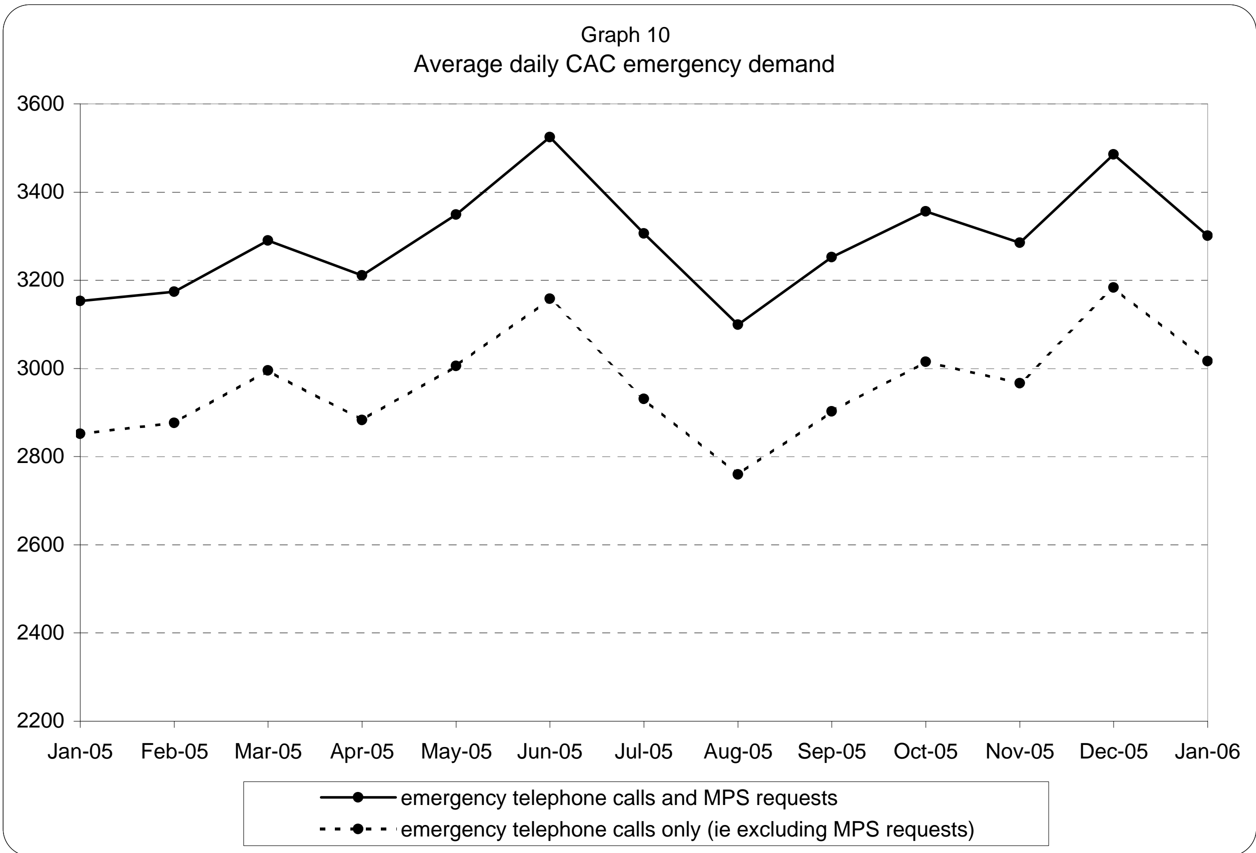
Note:
1) staffed = plan + additional - unmanned - single

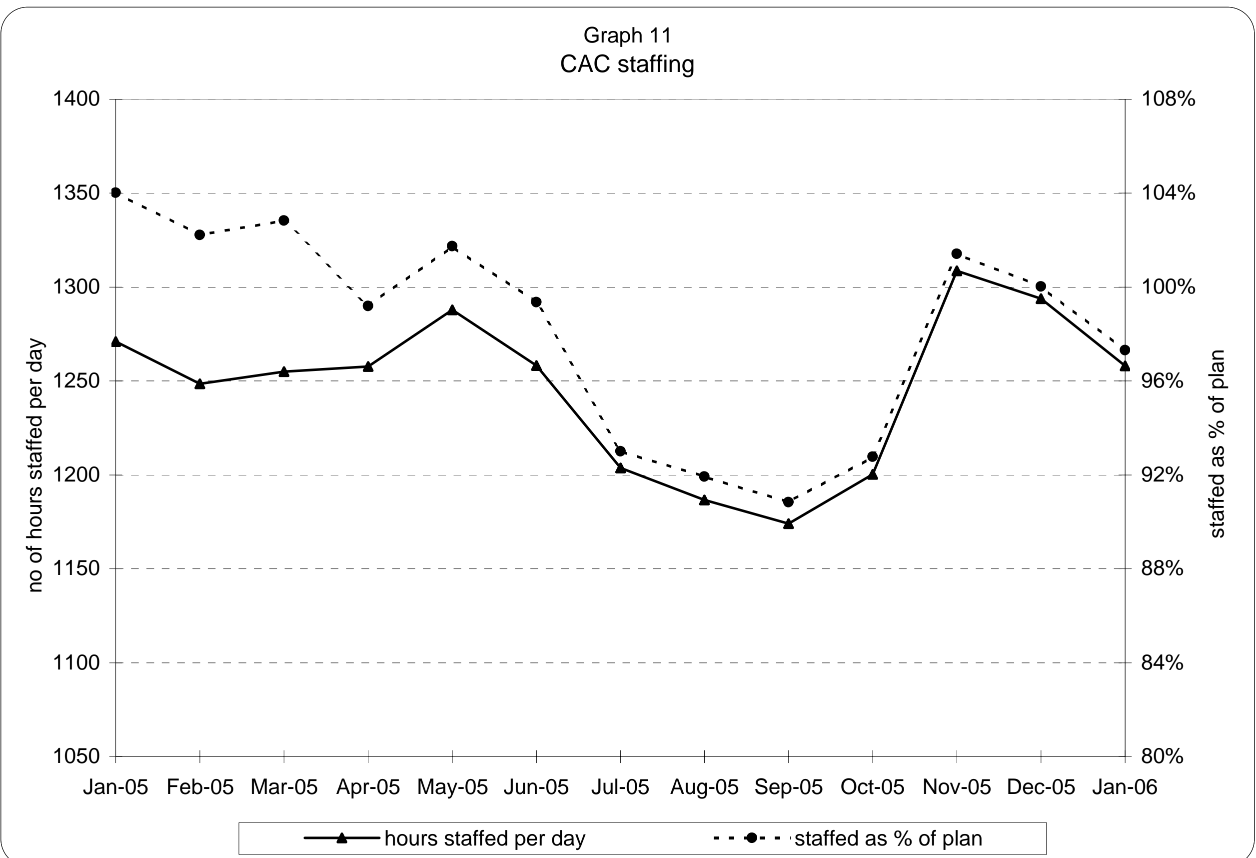
London Ambulance Service NHS Trust
Accident and Emergency Service
Yearly comparison of ambulance staffing



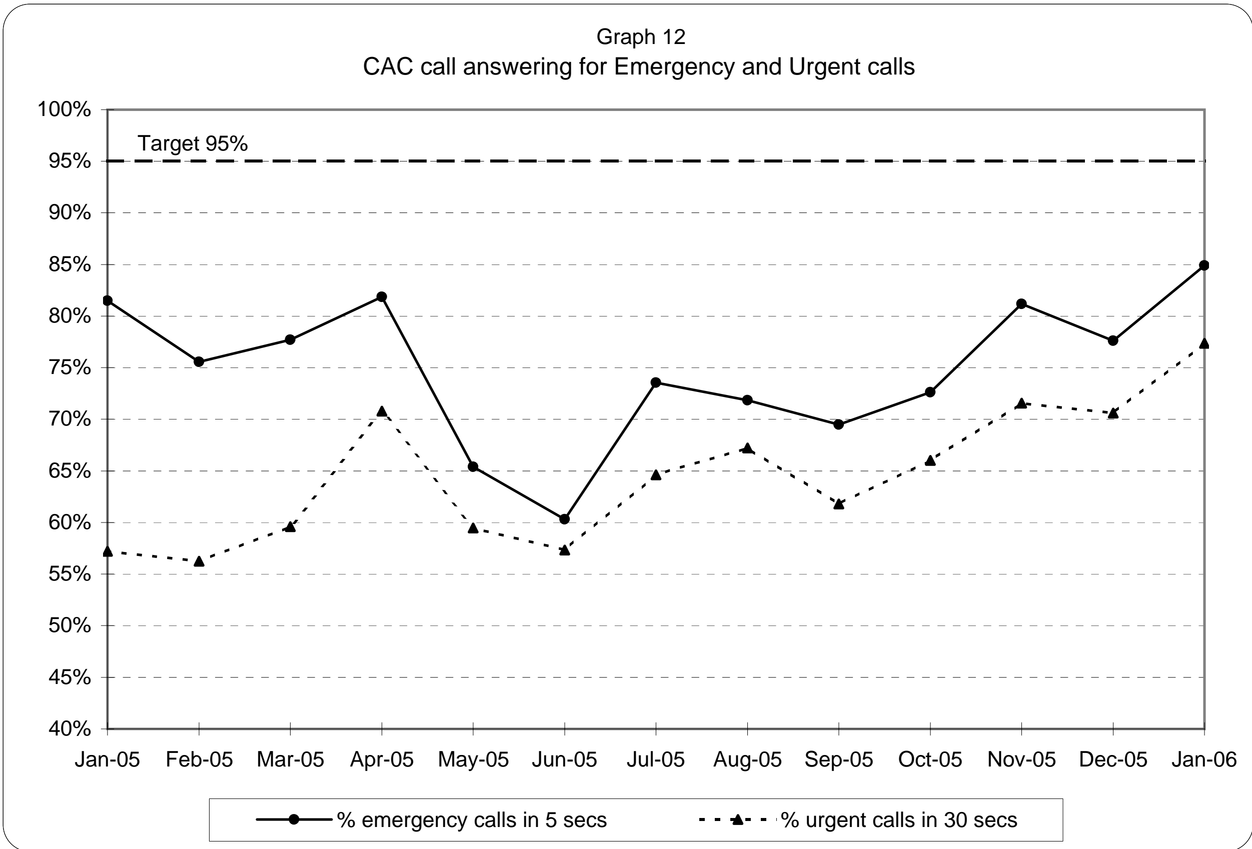
Note:staffed = plan + additional - unmanned - single

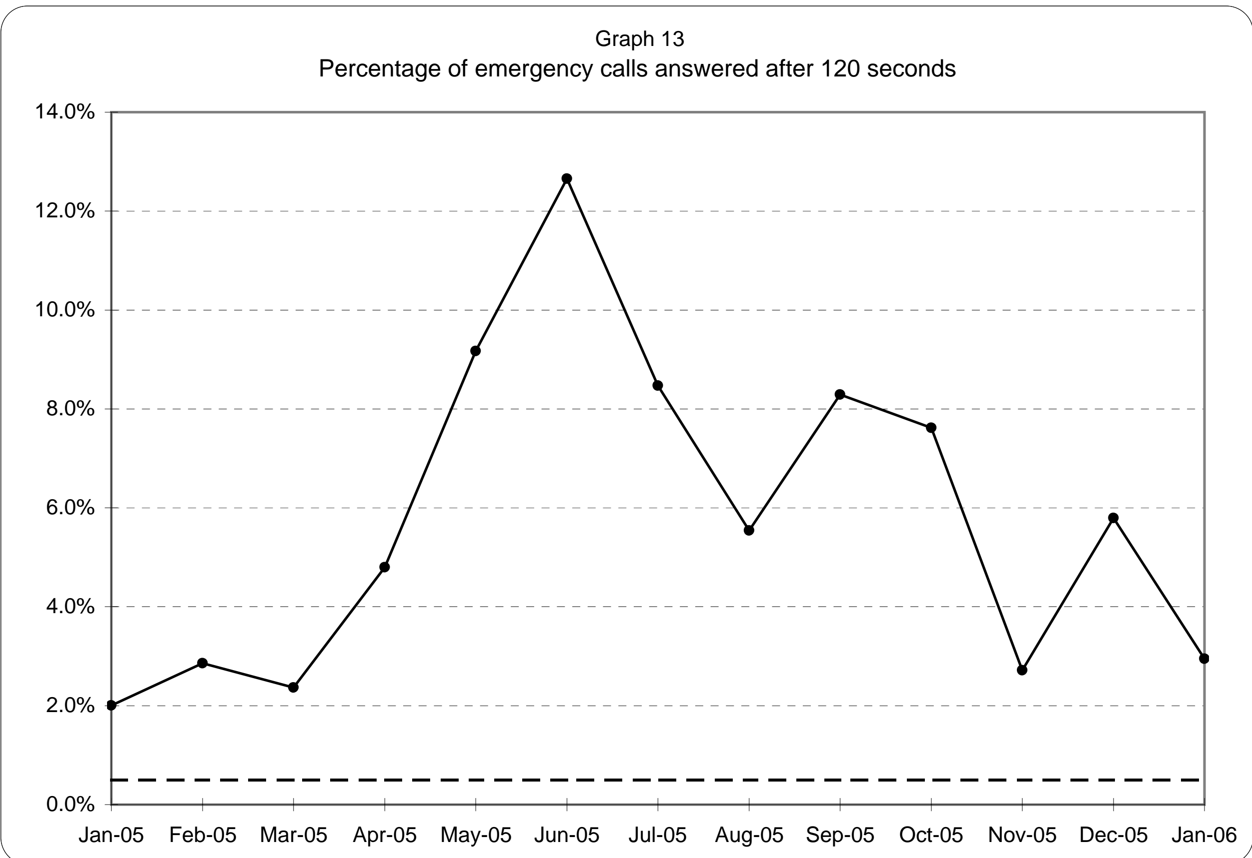
London Ambulance Service NHS Trust
Accident and Emergency Service
CAC activity and staffing





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





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

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

Table 3

		November 2006		December 2005		January so far 2006		Year to date	
		Cat A resp	% cat A resp in 8 mins	Cat A resp	% cat A resp in 8 mins	Cat A resp	% cat A resp in 8 mins	Cat A resp	% cat A resp in 8 mins
5K5	Brent PCT	921	75%	1,044	68%	596	74%	9,140	68%
5HX	Ealing PCT	975	70%	1,130	67%	629	72%	9,752	69%
5H1	Hammersmith & Fulham PCT	557	82%	642	79%	361	76%	5,602	79%
5K6	Harrow PCT	601	79%	685	79%	421	80%	5,860	78%
5AT	Hillingdon PCT	933	74%	1,015	73%	594	75%	8,649	72%
5HY	Hounslow PCT	707	76%	739	74%	463	75%	6,909	74%
5LA	Kensington & Chelsea PCT	461	74%	480	74%	298	74%	4,365	75%
5LC	Westminster PCT	1,139	72%	1,184	74%	692	76%	10,868	77%
North West London Strategic HA		**6,294**	**74%**	**6,919**	**73%**	**4,054**	**75%**	**61,145**	**73%**
5A9	Barnet PCT	899	67%	989	65%	549	66%	8,540	66%
5K7	Camden PCT	812	83%	964	82%	510	81%	8,276	84%
5C1	Enfield PCT	940	71%	1,055	71%	569	75%	8,695	74%
5C9	Haringey PCT	844	73%	1,032	68%	545	72%	8,412	73%
5K8	Islington PCT	719	80%	776	74%	478	80%	7,243	80%
North Central London Strategic HA		**4,214**	**74%**	**4,816**	**72%**	**2,651**	**75%**	**41,166**	**75%**
5C2	Barking & Dagenham PCT	678	72%	748	70%	433	73%	6,329	71%
5C3	City & Hackney PCT	883	69%	1,071	67%	580	74%	9,052	70%
5A4	Havering PCT	600	69%	763	62%	450	66%	6,069	69%
5C5	Newham PCT	1,020	71%	1,046	68%	573	71%	9,606	71%
5NA	Redbridge PCT	763	74%	780	72%	507	71%	6,975	74%
5C4	Tower Hamlets PCT	834	70%	986	64%	593	70%	8,229	70%
5NC	Waltham Forest PCT	788	73%	865	72%	504	71%	7,175	74%
North East London Strategic HA		**5,566**	**71%**	**6,259**	**68%**	**3,640**	**71%**	**53,435**	**71%**
5AX	Bexley PCT	568	76%	703	74%	409	79%	5,659	78%
5A7	Bromley PCT	837	73%	903	67%	498	76%	7,559	73%
5A8	Greenwich PCT	811	75%	981	74%	529	75%	8,076	74%
5LD	Lambeth PCT	1,035	68%	1,150	69%	613	76%	10,337	73%
5LF	Lewisham PCT	827	72%	986	69%	564	76%	8,285	74%
5LE	Southwark PCT	1,116	77%	1,159	73%	639	80%	10,326	78%
South East London Strategic HA		**5,194**	**73%**	**5,882**	**71%**	**3,252**	**77%**	**50,242**	**75%**
5K9	Croydon PCT	1,091	66%	1,271	62%	663	69%	10,144	67%
5A5	Kingston PCT	378	73%	470	74%	265	77%	3,784	74%
5M6	Richmond & Twickenham PCT	413	74%	498	68%	272	72%	3,988	69%
5M7	Sutton & Merton PCT	959	75%	1,077	73%	640	80%	9,002	78%
5LG	Wandsworth PCT	808	70%	835	71%	483	76%	7,549	74%
South West London Strategic HA		**3,649**	**71%**	**4,151**	**69%**	**2,323**	**75%**	**34,467**	**73%**
	Lowest (excl out of London)		66%		62%		66%		66%
	Highest (excl out of London)		83%		82%		81%		84%
	Range		16%		20%		16%		17%

RAPID RESPONSE VEHICLES

2005/06 to 2007/08

BUSINESS CASE

Authorisation:

Proposed by:

	Head of Operational Support	**Date**
Concurrence:		
	Director of Finance	**Date**
	Medical Director	**Date**
Approved By:		
	Chief Executive	**Date**

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1. EXECUTIVE SUMMARY

1.1. Introduction

1.1.1. The purpose of this Combined Business Case (CBC) is for internal LAS use only where combining the relevant sections of the Outline and & Full Business Cases requirements reduces duplication, saves time & reduces duplication. This business case confirms the strategic direction and business objectives of the Trust, reviews the current position, analyses the market and details the service requirements.

1.1.2. This Business Case has been written in response to the SIP Line item 39 and Primary Care Trust, Strategic Health Authority, Department of Health & LAS Board requirements for increasing the procurement of additional Emergency Care Practitioner units & replacing existing Rapid Response Units.

1.1.3. Through detailed analysis it has been determined that procurement of an additional 114 new ECP vehicles, and 58 replacement RRUs, are required to meet the Trusts strategic and & business objectives.

1.1.4. At the time of writing the Trust awaits an analysis of how many single responder units (ECP vehicles & RRUs) are required to meet the changed performance targets and response regime from 1 April 2007. this business case reflects the minimum number of single responder vehicles that will be required over the next three years.

1.2. Strategic Case

1.2.1. The LAS investment in ECP vehicles is reinforced by the three key investment objectives driving this business case:

1.2.1.1. Patient - To maximise patient care by having the correct increasing the number of ECP response unit’s for responding to all categories of call. The ECP service has high patient satisfaction ratings in terms patient assessment, the information provided & outcomes. ECPs also maximise the usage of care pathways thus providing care appropriate to need for patients.

1.2.1.2. Consultants reviewed the current establishment against the calls.

1.2.1.3. Performance –Because the vehicles are people carriers they can transport patients so reducing the need for dual crewed vehicles unless necessary. The vehicles assist the LAS in delivering a service, which safely & appropriately reduces unnecessary A&E conveyance whilst supporting delivery of LAS core targets.

1.2.1.4. This case will also assist in maintaining an efficient, effective and sufficient fleet of ECP units with reduced vehicle downtime (servicing, peak day periods, winter pressures) by provision of a reserve establishment.

1.2.1.5. The consultants also established that performance is currently negatively affected due to the lack of spares when core vehicles were being serviced. A reserve of therefore at least 10% is required as a reserve spare to provide maintenance cover

1.2.1.6. **People -** The vehicles provide staff with high visibility, appropriate and safe vehicles and equipment.

1.3. Economic Case

1.3.1. From the four options reviewed and the benefits analysis, the preferred option is to procure and convert 172 Vauxhall Zafiras. The sensitivity analyses demonstrate that this is a robust choice.

1.3.2. As NHS capital is available, no alternative funding options were considered.

1.4. Financial Case

1.4.1. The preferred option generates additional revenue costs of £1.1million on average. This will be funded by a transfer from the centrally held depreciation reserve. The investment is on-balance sheet.

1.5. Commercial Case

1.5.1. The LAS have identified funding for this project as part of the capital allocation up to 2008. The LAS has previously assessed vehicles for this role and as a result, the Vauxhall Zafiras will be procured and converted using the current NHS framework agreements. This project will therefore not go to OJEU.

1.5.2. The project will use the NHS framework agreement as the basis to invite a single tender action on ATT Papworth for conversion. This is based on their similar conversions for LAS RRU and DSO vehicles and therefore design costs will be kept to the minimum.

1.6. Management Case

1.6.1. The Project Support Office using the PRINCE2 methodology standard will manage this project. The project will have an Executive & Senior Supplier and Senior User representation. The respective Project Manager will manage all configuration/change control through the PSO. At the end of the project, a Benefits Realisation plan will be set to monitor the progress of the benefits.

1.6.2. The timescale for the project is estimated to be 20 weeks from placement of orders. However, that timeframe cannot be specific until contracts are placed on the individual vehicle manufacturer, vehicle converter and equipment suppliers for their production schedules to be confirmed.

2. STRATEGIC CASE

2.1. LAS Organisational Overview

2.1.1. Summary of LAS Organisation

2.1.1.1. The London Ambulance Service NHS Trust provides services to the public across the Greater London area. Its services are purchased by the 32 London Primary Care Trusts (PCTs) for some 7.5 million residents, increasing by approximately by 700,000 per day with commuters and & visitors. The London Ambulance Service is the largest & busiest ambulance service in the world. The main functions of the Trust are to:

- Provide care appropriate to need for 999 callers.
- Convey patients, declared by a clinician to be urgent, on a scheduled basis to hospital and/or between hospitals.

- Provide transportation services to and & from hospitals for non-urgent patients.
- Provide both emergency planning and responses to major incidents, e.g. bombings, train crashes, and to plan and provide services for events such as Notting Hill carnival, anti globalisation marches.
- Provide the Emergency Bed Service.

2.1.1.2. The Trust works from 70 locations around across the London area. It has its main control facilities at are at its Waterloo HQ with fallback facilities in East London. There are 69 stations across the Metropolis from which paramedics, and technician and ECP crew staff are dispatched to calls, processed through its control centre.

2.1.2. **Business Goals**

2.1.2.1. The primary National target is to reach 75% of Category “A” (life-threatening) calls within eight minutes of the primary diagnosis of the call being identified. Other targets include reaching Category B (non-life threatening but urgent) calls within 14 minutes, Category C class (non-urgent) within 30 minutes and doctors urgent calls with 15 minutes of agreed times.

2.1.2.2. There is a new DH policy aim to reduce ambulance conveyance to A&E departments from its current level of 75% to 50%. ECPs will provide a key delivery mechanism for the LAS to achieve this aim through exploitation of alternative care pathways and increasing ‘treat & leave’ rates where safe and appropriate.

2.1.2.3. The business goals for the LAS are set out in its five-year Service Improvement Programme. This programme has the support of both commissioners and Strategic Health Authorities (SHAs). These goals encompass national performance targets, stakeholder requirements, LAS improvement and efficiency goals.

2.1.2.4. The LAS is achieving the national target for Category A calls by reaching 76%of those calls within 8 minutes in 2004/05. This was achieved through a combination of Rapid Response Unit (cars), ambulances, motor cycles, pedal cycles and other responders close to the scene such as ECPs. The exceeding of the 75% target does not change the need for this investment.

2.1.2.5. There are no other LAS performance improvement projects, either underway or in preparation, that will affect or have any impact on this investment initiative. This investment is seen as a crucial aspect towards the success of the overall LAS programme of improvements.

2.2. **Investment Overview**

2.2.1. **Current Facilities (ECP Vehicles)**

2.2.1.1. ECP cars currently operate in the following areas. The cars are between 1 & 2 years old.

Table 1

PCT	Number
Wandsworth	1
Havering	2
Hounslow	1
Croydon	1
Bromley	2
Total	**7**

2.2.1.2. This small number of vehicles does not allow expansion of the service to new Primary Care Trust areas across London. Additionally there are no spare vehicles to cover for routine maintenance or repair. Where ECP vehicles are off the road for accident repair this results in the use of a double-crewed ambulance so increasing staffing and vehicle costs.

2.2.1.3. Emergency Care Practitioners have now taken 15000 calls since commencement. ECPs have increased the use of care pathways and reduced A&E take rates for Patients seen by ECPs from 75% to 42%.

2.2.2. **Current Facilities (RRUs)**

2.2.2.1. RRUs are allocated to each main station to respond to Category A calls within their complex operational area plus one allocated to CAC.

2.2.2.2. There are 63 vehicles which are available for sector roster during any 24 hour period and 7 spare vehicles (1 per sector) to cover RRUs which are being serviced or repaired. The CAC vehicle is used by paramedics manning the single responder Desk in CAC

2.2.2.3. The age of the RRUs is as follows:

Table 2

Sector	5 Years of Age	4 Years of Age	3 Years of Age	Under 1 Year of Age
NE	2	3	4	3
SE	2	2	3	3
SW	2	2	3	2
W	2	3	4	1
NW	2	3	3	1
C	2	2	4	
EC	1	4	4	2
CAC				1
TOTALS	**13**	**19**	**25**	**13**

2.2.2.4. One 5 year old vehicle and one 4 year old vehicle were written off and both were replaced by the last RRU procurement (13 vehicles).

2.2.3. Proposed Facilities (ECP Vehicles)

2.2.3.1. The DH's Reforming Emergency & Urgent Care Project is proposing additional ECP staff across London over the next 5 years. In addition, the DoH Change Agent Team is actively promoting ECPs as best practice role re-design. The programme also fits with the direction and detail of the recommendations of the draft Bradley National Ambulance Review.

2.2.3.2. SHAs, commencing with the North West London & North East London, in collaboration with their Workforce Development Confederations, are developing sector-wide ECP rollout plans with their Primary Care Trusts.

2.2.3.3. The London Ambulance Service has committed to additional ECP staff over the next three years subject to financial support from PCTs.

2.2.3.4. The number of ECP vehicles needs to be increased in line with the recruitment rate of ECP staff over the three year period. This will mean an additional 114 vehicles will need to be procured over an above the current 7 vehicles.

2.2.4. Proposed Facilities (RRUs)

2.2.4.1. 13 of the RRUs, which are 5 years of age and are showing signs of unreliability and requiring increased maintenance. One RRU was written off post approval of the Additional RRU Business case therefore year 1 requires the purchase of 14 RRUs. The other Vauxhall Astras are of the old design and will require to be replaced as they reach 5 years of age.

2.2.4.2. Additional ECP first single responder units to cover London will assist the Trust to sustain its 75%+ performance level and improve patient care.

2.2.4.3. Therefore, this business case also sets out the case for the replacement of the remaining Astra RRUs.

Table 3

	A	B	C	D	E	F
27	**Option 2 - Purchase 172**	2006/07	2007/08	2008/09	2009/10	2010/11
28	**Zaferas**	1	2	3	4	5
29						
30	Replacement RRUs	14	33	58	58	58
31	Additional ECP Vehicles	4	88	88	88	88
32	Further ECP Vehicles	11	22	26	26	26
33	**Total**	**29**	**143**	**172**	**172**	**172**

2.3. Investment Objectives and Targets

2.3.1. The role of the ECP

2.3.1.1. The mission statement for the new role is to develop a new community based role for ECPs integrated into local health services. They will provide rapid, high quality, treatment and referral for people in crisis situations.

Programme objectives are:

• Improved range of appropriate & defined care pathways available to ECPs.

• Reduced usage of double-crewed ambulances.

• Less A&E attendance.

• Improved patient care.

• Integration of the new role with primary & community care services.

• Development of a new role/career option for paramedical & other staff.

2.3.1.2. This mission and these objectives will support the delivery of core LAS targets, and the new aim of reduced A&E attendance through an intensified single response service. Increased density of ECP vehicle and replacement RRU vehicles being to the same design will allow increasing cross cover, which will assist with target delivery and cost containment.

2.3.1.3. Each investment objective closely aligns with each other and links strongly to the Category A response times target providing care appropriate to need

2.3.1.4. This initiative aligns with the SIP 39 ECP ISON 85.

2.3.2. **The role of the RRU**

2.3.2.1. RRUs are primarily for the first response to Category A calls. The equipment the vehicles carry is similar to that carried by the ECP vehicles and therefore the design of the equipment section is the same.

2.4. **Scope of Investment**

2.4.1. The vehicle procurement programme for both additional ECPs and replacement RRUs will be phased over three years and the combined purchased will be as follows:

Table 4

	A	B	C	D	E
8	**Option 2**	**YR1**	**YR2**	**YR3**	**Total**
9	RRUS	14	19	25	58
10	ECPS	4	84		88
11	ECPS	11	11	4	26
12	**Annual Total**	29	114	29	**172**
13	**Cumulative**	**29**	**143**	**172**	

2.4.2. This investment covers the scope of the capital costs, which includes purchasing 172 base vehicles over 3 years plus costs to convert and fit out the vehicles with standard LAS communications, livery, clinical equipment and diagnostic equipment where required.

2.4.3. The investment includes the scope of non-recurrent revenue such as on-road costs of the vehicle and procurement of vehicle and clinical equipment.

2.4.4. This investment does not include the purchase of any maintenance spare parts nor any minor or major changes to the current ECP/RRU vehicle specification.

2.4.5. It is imperative that the final product must be delivered as a whole, with

minimised delays caused by failure to deliver sub products. To demonstrate the success factors/achievement of investment objectives the final product must incorporate all sub products as each plays a role in determining the level of success of the investment objectives.

2.5. Constraints and Dependencies

2.5.1. Constraints

2.5.1.1. **Internal Constraints** – This project will be constrained by the resource ability and & capacity to provide services, time and information on a timely basis to enable the Project Manager to deliver the agreed number of vehicles each year. With the exception of clinical equipment procurement and the final fitting of technology equipment the majority of the vehicle conversion work will be completed at one of the NHS approved vehicle Converters.

2.5.1.2. External Constraints - This project will be constrained by:

- The Vauxhall 'order bank' periods, which determine when the next production dates start and require an 8-10 week vehicle build lead-time.
- The introduction of the New Zafira model on the production line
- The vehicle converter lead-time (at least 6-weeks from receipt of the order) to the first vehicle being available for acceptance.
- Production slots for the remaining vehicles, each taking approx three weeks from start to complete production.

2.5.2. Dependencies

2.5.2.1. There is an inherent reliance on third parties for vehicle projects and even more so on this project given the outsourcing of the conversion design work and delivery of components from a variety of suppliers including some LAS free issued items. Most of this work is outside of the LAS control and therefore the interdependency between the main suppliers and the LAS is inherently one of good communication.

2.5.2.2. Delays in ECP vehicle delivery could affect the timescales for training and recruitment of ECPs and negotiations with PCTs therefore a realistic implementation programme with indicative dates will be important.

2.5.2.3. There is no other SIP programme or other initiatives or dependencies that will affect this project.

3. ECONOMIC CASE

3.1. Objectives

3.1.1. The objectives defined below and the benefit criteria have been developed based on current ECP & RRU use. The objectives are scripted concentrating on requirements rather than the means for achieving the results.

3.1.2. The investment objectives are:

- Patient – Maximising patient care through ensuring the appropriate range of clinical equipment can be carried safely on the vehicle.
- Performance – The correct establishment of core ECP and RRU vehicles are available for responding to calls through provision of a dedicated

reserve establishment to cover vehicle unavailability (e.g. servicing and unscheduled maintenance).

- People – A vehicle, which is fit for purpose, can safely store all the clinical equipment and has the required communications.

3.2. **Benefits**

3.2.1. From the investment objectives and scope of the investment the following benefit criteria were developed:

- **Improved patient care** achieved through an increase of the core ECP vehicle establishment to meet the calculated demand, and replacement of aging RRU vehicles.
- **Vehicle equipment storage** is sufficient to carry safely the current defined first responder ECP and RRU equipment and has capacity for future equipment additions and changes during the vehicle life.
- **Transporting of ambulant patients** safely to the hospital or appropriate care centre thereby enabling double-crewed vehicles to be available for responding to other calls.
- **Improved performance** resulting through better vehicle reliability as a result of procuring modern vehicles.
- **Improved professional image** of the Trust through improved quality of vehicles suitable for London conditions.
- **No increase in the vehicle manufacturer range** thereby no additional training and tooling required for fleet to maintain the vehicles.

3.2.2. The reasoning behind the benefit weight calculation and option scores are included as Appendix A.

3.3. **Generating Options**

3.3.1. **Long List**

3.3.1.1. The investment scope requirement to procure vehicles to an existing LAS vehicle specification means that a long list of vehicle options is not required. Therefore, five options are considered**:**

- Do Nothing.
- Purchase 104 Vauxhall Astras
- Purchase 46 new design Vauxhall Zafiras for ECP use to the revised combined ECP/RRU base vehicle specification and original conversion specification.
- Purchase 58 new design Vauxhall Zafiras for RRU use to the revised combined ECP/RRU base vehicle specification and original conversion specification.
- Purchase 172 new design Vauxhall Zafiras for ECP and RRU use to the revised combined ECP/RRU base vehicle specification and original conversion specification

3.3.2. Short Listing Options

3.3.2.1. Each option included in the long list of options was reviewed against its ability to deliver the investment objectives, their practicality for current and future in-service use and ability to meet proposed timescales.

3.3.2.2. The option to purchase 104 Vauxhall Astras was rejected because:

- The reduced boot capacity does not provide sufficient space in the vehicle to carry the currently identified equipment for a first response vehicle.
- Reduced accessibility for patients due to vehicle height and door width.

3.3.2.3. The option to purchase 47 new design Vauxhall Zafiras for ECP use was rejected because of the LAS priority need to maintain current RRU establishment numbers to maintain Category A performance.

3.3.3. Short Listed Options

3.3.3.1. Therefore the options, which remained are:

3.3.3.2. **Do Nothing/Do Minimum** - This option fails to achieve any of the investment objectives, it does not align with the LAS strategic plan, and it fails to meet the consultant's recommendations to provide any reserve vehicle establishment. However, the LAS will continue to function and respond to category A calls. This option is only retained for comparison purposes.

3.3.3.3. **Option 1 - Purchase 104 Zaferas**

3.3.3.4 This involves replacing the RRUs as they reach 5 years of age. This will maintain patient care for category A patients and maintain the national performance targets. The specification will be to the agreed ECP/RRU specification thus maximising possible inter-changeability with ECP users and related cost containment.

3.3.3.5. **Option 2 - Purchase 172 Zaferas**

3.3.3.6. This involves procuring vehicles for the rollout of 41 new ECP teams and maintaining the RRU capacity through replacement of vehicles that are more than 5 years old. The specification will be the same for all vehicles thus maximising inter-changeability and related cost containment.

3.3.3.7. The specification for options 1 & 2 is the same as the recent ECP/RRU procurements with the exception of the clinical equipment storage rack, which has had minor changes.

3.3.3.8. The procurement and conversion risks for Option 1 & 2 are few as both the ECP and RRU vehicles already safely respond to Cat A calls.

3.3.3.9. Whichever option is chosen it is essentially a repeat procurement project of the latest 14 additional RRU vehicles. However, effective management of the users is required to ensure the specification does not suffer any unnecessary scope creep.

3.3.4. Option Ranking

3.3.4.1. The objectives have been ranked and then assigned percentage weights

through the pairing comparison techniques as shown in Table 5 below:

Table 5

Benefit Criteria	Rank	Pairings 1st	2nd	3rd	4th	5th	6th	Raw % Weights	% Weights
Improved patient care	1	100						100	26.5
Improved performance	2	90	100					90	23.9
No increase in vehicle range	3		80	100				72	19.1
Vehicle equipment storage	4			70	100			50	13.4
Transporting of ambulant patients	5				80	100		40	10.7
Improved professional image	6					60	100	24	6.4
								377	100

3.3.4.2. Each option was then scored out of 10 to demonstrate how close each came to achieving the benefits. The reason for each score is given in Table 6 and explained more fully in Appendix 1.

Table 6

		Options					
Benefits	**Weight**	**Do Nothing**		**1**		**2**	
		score	WxS	score	WxS	score	WxS
Improved patient care	26.5	0	0	5	133	8	212
Improved performance	23.9	0	0	7	167	8	191
No increase in vehicle range	19.1	10	191	10	191	10	191
Vehicle equipment storage	13.4	0	0	6	80	6	80
Transporting of ambulant patients	10.7	2	21	8	86	8	86
Improved professional image	6.4	0	0	6	39	6	39
Total	**100**		212		695		799

3.3.4.3. The Alternative Response Steering Group (ARSG) independently conducted a staff survey of the users for their opinions on the selection of a suitable replacement vehicle for the Vauxhall Astra cars. Eighty staff responded to the survey and they favoured an MPV. The ARSG agreed with that decision and had a preference for the Vauxhall Zafira over the Vauxhall Minerva due to the load carrying capacity. Both survey and ARSG decision supports the above options. A summary of the survey showing the average scores is attached as Appendix B.

3.4. **Identification and Quantification of Option Costs**

3.4.1. **Opportunity Costs**

3.4.1.1. There is no opportunity costs identified against either of the options.

3.4.2. **Residual Value Costs**

3.4.2.1. Currently, the Trust disposes of existing vehicles, by auction, at the end of their life. It is assumed that this would continue under all three options. In the 'do minimum' option it is assumed that the existing vehicles will have a

residual value of £100 when they are disposed of. This figure is net of auction fees.

3.4.3. **Capital Costs**

3.4.3.1. There are no capital costs associated with the 'Do Minimum' option.

3.4.3.2. The capital costs associated with Option 1 are set out in Table 7, Table 8 and Table 9 for each of the financial years 2005/06 to 2007/08.

Table 7

2005/06					
Option 1 - Purchase 104 Zaferas	**Number of Units 29**				
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	380,306	446,860
Vehicle conversion	7,825	1,369	9,194	226,925	266,637
Technology purchase & Fit for 15 vehicles	6,473	1,133	7,606	97,102	0
Installation costs of MDT and phone for 14 vehicles	513	90	603	7,182	0
Improved Suspension		0	2,500	72,500	162,500
Other Capital Costs					
Clinical capital equiptment	3,165	554	3,719	55,783	
Total Capital Costs	**31,090**	**5,441**	**39,031**	**839,798**	**875,996**

Table 8

2006/07					
Option 1 - Purchase 104 Zaferas	**Number of Units 35**				
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	458,990	539,313
Vehicle conversion	7,825	1,369	9,194	273,875	321,803
Technology purchase & Fit for 16 vehicles	6,473	1,133	7,606	103,575	266,221
Installation costs of MDT and phone for 19 vehicles	513	90	603	9,747	21,097
Improved Suspension		0	2,500	87,500	162,500
Other Capital Costs					
Clinical capital equiptment for 16 vehicles only	3,165	554	3,719	59,502	
Total Capital Costs	**31,090**	**5,441**	**39,031**	**993,189**	**1,310,935**

Table 9

2007/08					
Option 1 - Purchase 104 Zaferas	**Number of Units 40**				
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	524,560	1,001,582
Vehicle conversion	7,825	1,369	9,194	313,000	597,634
Technology purchase & Fit for 15 vehicles	6,473	1,133	7,606	97,102	494,411
Installation costs of MDT and phone for 25 vehicles	513	90	603	7,695	39,180
Improved Suspension		0	2,500	100,000	162,500
Other Capital Costs					
Clinical capital equiptment for 15 vehicles only	3,165	554	3,719	55,783	
Total Capital Costs	**31,090**	**5,441**	**39,031**	**1,098,140**	**2,295,307**

3.4.3.3. The costs shown in Table 7, Table 8 and Table 9 have been derived using the following information:

- Base Vehicles - Costs are based on quotations from the relevant supplier.
- Technology Purchase and Fit - MDT and service equipment must be purchased for all vehicles.
- Clinical Capital Equipment – These will be purchased for all new vehicles.

3.4.3.4. The capital costs associated with Option 2 are set out in Table 10, Table 11 and Table 12 for each of the financial years 2005/06 to 2007/08.

Table 10

2005/06					
Option 2 - Purchase 172 Zaferas	**Number of Units 29**				
	Unit Cost			**Cost for GEM**	**Total Cost**
	Net Cost	**VAT**	**Gross**		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	380,306	446,860
Vehicle conversion	7,825	1,369	9,194	226,925	266,637
Technology purchase & Fit for 15 vehicles	6,473	1,133	7,606	97,102	114,095
Installation costs of MDT and phone for 14 vehicles	513	90	603	7,182	8,439
Improved Suspension		0	2,500	72,500	85,188
Other Capital Costs					
Clinical capital equiptment for 15 vehicles	3,165	554	3,719	55,783	65,545
Total Capital Costs	**31,090**	**5,441**	**39,031**	**839,798**	**986,763**

Table 11

2006/07					
Option 2 - Purchase 172 Zaferas	**Number of Units 114**				
	Unit Cost			**Cost for GEM**	**Total Cost**
	Net Cost	**VAT**	**Gross**		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	1,494,996	1,756,620
Vehicle conversion	7,825	1,369	9,194	892,050	1,048,159
Technology purchase & Fit for 95 vehicles	6,473	1,133	7,606	614,979	722,600
Installation costs of MDT and phone for 19 vehicles	513	90	603	9,747	11,453
Improved Suspension		0	2,500	285,000	334,875
Other Capital Costs					
Clinical capital equiptment for 95 vehicles	3,165	554	3,719	353,293	415,119
Total Capital Costs	**31,090**	**5,441**	**39,031**	**3,650,065**	**4,288,826**

Table 12

2007/08					
Option 2 - Purchase 172 Zaferas	**Number of Units 29**				
	Unit Cost			Cost for GEM	Total Cost
	Net Cost	VAT	Gross		
Initial Capital Costs					
Base Vehicles	13,114	2,295	15,409	380,306	446,860
Vehicle conversion	7,825	1,369	9,194	226,925	266,637
Technology purchase & Fit for 4 vehicles	6,473	1,133	7,606	25,894	30,425
Installation costs of MDT and phone for 25 vehicles	513	90	603	12,825	15,069
Improved Suspension		0	2,500	72,500	85,188
Other Capital Costs					
Clinical capital equiptment for 4 vehicles	3,165	554	3,719	14,876	17,479
Total Capital Costs	**31,090**	**5,441**	**39,031**	**733,325**	**861,657**

3.4.3.5. The costs shown in Table 10, Table 11 and Table 12 have been derived using the following information:

- Base Vehicles - Costs are based on quotations from the relevant supplier.
- Technology Purchase and Fit - MDT and service equipment must be purchased for all vehicles.
- Clinical Capital Equipment – These will be purchased for all new vehicles.

3.4.4. Lifecycle Costs

3.4.4.1. There are no lifecycle costs associated with this investment.

3.4.5. Revenue Costs

3.4.5.1. The DH guidance requires that all relevant costs are included in the economic analysis. For the purposes of this business case, the costs associated with running the vehicles have been included but crew & dispatch costs have not as they remain the same irrespective of which vehicles are used.

3.4.5.2. The costs for the 'Do Nothing' option reflect the costs built into existing (2005/06) budgets and are shown in Table 13, below.

Table 13

Continue with Existing Vehicles	Unit Cost	Cost Driver	Cost Driver Units	Annual Cost per Vehicle	Cost for GEM	VAT (or other taxes)	Total Cost
Recurrent							
Fuel	0.1723	per mile	20,000	3,445	199,813	34,967	234,780
Vehicle maintenance (including labour)				2,993	173,594	30,379	203,973
Communications equiptment maintenance				433	25,114	4,395	29,509
Vehicle Insurance				654	37,929	6,637	44,566
RAC recovery costs				458	26,536	4,644	31,180
Accident damage				1,789	103,762	18,158	121,920
3rd party accident damage				1,256	72,848	12,748	85,596

3.4.5.3. The costs of Options 1 and 2 are based on the same annual cost per vehicle as continuing with the existing vehicles. In calculating the revenue costs of each option the cumulative numbers of vehicles, shown in Table 14 and Table 15 have been used.

Table 14

	A	B	C	D	E	F	G	H
20	**Option 1 - Purchase 104**	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
21	**Zaferas**	1	2	3	4	5	6	7
22								
23	Replacement RRUs	14	33	58	58	58	44	25
24	Additional ECP Vehicles	15	31	46	46	46	31	15
25	**Total**	**29**	**64**	**104**	**104**	**104**	**75**	**40**

Table 15

	A	B	C	D	E	F	G	H
27	**Option 2 - Purchase 172**	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
28	**Zaferas**	1	2	3	4	5	6	7
29								
30	Replacement RRUs	14	33	58	58	58	44	25
31	Additional ECP Vehicles	4	88	88	88	88	84	0
32	Further ECP Vehicles	11	22	26	26	26	15	4
33	**Total**	**29**	**143**	**172**	**172**	**172**	**143**	**29**

3.4.5.4. In addition to the recurrent running costs, each new vehicle will incur non-recurrent costs associated with bringing these into service. Such costs for replacement RRUs are diminished as some equipment can be reused on the new vehicles.

3.4.5.5. The overall revenue costs of each option are shown in

Table 16

Option 1 - Purchase 104 Zaferas	**Annual Cost per Vehicle**	**2006/07 Year 1**	**2007/08 Year 2**	**2008/09 Year 3**	**2009/10 Year 4**	**2010/11 Year 5**	**2011/12 Year 6**	**2012/13 Year 7**
Non-Recurrent								
Initial Clinical Equiptment	4,920	73,800	78,720	73,800	0	0	0	0
Commissionning costs of vehicles	4,804	139,316	168,140	192,160	0	0	0	0
Recurrent								
Fuel	3,445	199,813	251,488	306,609	358,285	358,285	358,285	306,609
Vehicle maintenance (including labour)	2,993	173,594	218,489	266,377	311,272	311,272	311,272	266,377
Communications equiptment maintenance	433	25,114	31,609	38,537	45,032	45,032	45,032	38,537
Vehicle Insurance	654	37,929	47,738	58,201	68,010	68,010	68,010	58,201
RAC recovery costs	458	26,536	33,399	40,719	47,582	47,582	47,582	40,719
Accident damage	1,789	103,762	130,597	159,221	186,056	186,056	186,056	159,221
3rd party accident damage	1,256	72,848	91,688	111,784	130,624	130,624	130,624	111,784

Table 17

Option 1 - Purchase 172 Zaferas	Annual Cost per Vehicle	2006/07 Year 1	2007/08 Year 2	2008/09 Year 3	2009/10 Year 4	2010/11 Year 5	2011/12 Year 6	2012/13 Year 7
Initial Clinical Equiptment for 16 vehicles only	4,920	73,800	467,400	19,680	0	0	0	0
Commissionning costs of vehicles	4,805	139,316	686,972	826,288	0	0	0	0
Recurrent								
Fuel	3,445	199,813	251,488	540,872	540,872	540,872	540,872	527,092
Vehicle maintenance (including labour)	2,993	173,594	218,489	469,901	469,901	469,901	469,901	457,929
Communications equiptment maintenance	433	25,114	31,609	67,981	67,981	67,981	67,981	66,249
Vehicle Insurance	654	37,929	47,738	102,669	102,669	102,669	102,669	100,053
RAC recovery costs	458	26,536	33,399	71,830	71,830	71,830	71,830	70,000
Accident damage	1,789	103,762	130,597	280,873	280,873	280,873	280,873	273,717
3rd party accident damage	1,256	72,848	91,688	197,192	197,192	197,192	197,192	192,168

3.4.5.6. In developing the existing Recurrent Costs' shown in Table 16 and Table 17 the following assumptions have been made.

- Fuel – The fuel costs used are those pertaining in May 2005, i.e. 88.04p per litre. The fuel consumption is based on a sample of actual performance of the existing vehicles.
- Vehicle Maintenance – The costs of maintaining the existing vehicles with reference to existing Fleet records and the professional judgements of Fleet Managers.

3.4.5.7. Other Costs – The other revenue costs are based on 2005/06 budgets.

3.4.6. **Optimism Bias**

3.4.6.1. It is not appropriate to include any optimism bias in this business case.

3.4.7. **Lifecycle Costs**

3.4.7.1. There are no lifecycle costs associated with this investment.

3.4.8. **Transitional Costs**

3.4.8.1. There are no transitional costs associated with the 'Do Minimum' option.

3.4.8.2. Options D incur transitional costs associated with decommissioning the old vehicles (£150 each, excluding VAT)

3.4.9. **External Costs**

3.4.9.1. There are no external costs associated with any of the options.

3.5. **Discounted Cashflow Analysis of Options**

3.5.1. The costs identified in section have been entered into the DH's Generic Economic Model (GEM) and using the prevailing HM Treasury discount rate of 3.50% has generated the following analysis of the short listed options.

Table 18

SUMMARY	Appraisal Period	EAC
		£'000
OBC Do Minimum Continue with Existing Vehicles	3 Years	639.6
OPTION 1 Purchase 104 Zaferas	8 Years	1,446.6
OPTION 2 Purchase 172 Zaferas	8 Years	2,347.6

3.5.1.1. Table 18, above, indicates that the 'Do Nothing' option provides the lowest EAC.

3.6. **Option Cost Benefit Analysis**

3.6.1. **Cash Releasing Benefits**

3.6.1.1. The preferred option is unlikely to generate any revenue savings.

3.6.2. **Non-Cash Releasing Benefits**

3.6.2.1. There are no non-cash releasing benefits associated with any of the options

3.6.3. **Quantifiable Benefits**

3.6.3.1. There are no quantifiable benefits.

3.6.4. **Non-Quantifiable Benefits**

3.6.4.1. The expansion in the number of ECPs will generate benefits in patient care and a reduction in conveyances to hospital A&E departments. However, they must be listed as non-quantifiable benefits because it is not possible to identify the savings to be made by the LAS, London PCTs or acute hospitals. Certain estimates have been used elsewhere but they are subjective and not considered reliable.

3.6.5. **Summary of Option Cost Benefit Analysis**

3.6.5.1. At this point in the analysis, the EACs shown in Table 18 are divided by the weighted benefit score, shown in Table 6 and an EAC per weighted benefit point is calculated. These are shown in Table 19, below.

Table 19

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score
		£'000		£'000
OBC Do Minimum Continue with Existing Vehicles	3 Years	639.6	212.4	3.0110
OPTION 1 Purchase 104 Zaferas	8 Years	1,446.6	695.2	2.0810
OPTION 2 Purchase 172 Zaferas	8 Years	2,347.6	798.6	2.9396

3.6.5.2. The results in Table 19 indicate that Option 1 generates the lowest EAC per weighted benefit score. Option 2 also provides a better option than continuing with the existing vehicles.

3.7. Assessing Risk

3.7.1. Risk Identification

3.7.1.1. The generic risk register at the time of approval of this document are contained Appendix D**.**

3.7.2. Risk Transfer

3.7.2.1. There are no risks that can be transferred to the supplier.

3.7.2.2. The project finance is at a level where penalty clauses would be inappropriate to apply.

3.7.3. Assessing the Impact of Risk on Option Ranking

3.7.3.1. Using the identified generic risks the individual options were scored together with the assessed cost per risk resulted in the overall risk adjustment for each option. These tables are contained Appendix D.

3.7.3.2. The risks set out above have been quantified for each option and discounted to produce an EAC. The impact on the discounted cash flow of the risk analysis is:

Table 20

SUMMARY	Appraisal Period	EAC	Weighted Benefit Score	EAC per Weighted Benefit Score	Risk Adjustment	Risk Adjusted EAC	Risk Adjusted EAC per Weighted Benefit Score
		£'000		£'000	£'000	£'000	£'000
OBC Do Minimum Continue with Existing Vehicles	3 Years	639.6	212.4	3.0110	62.1	701.7	3.3034
OPTION 1 Purchase 104 Zaferas	8 Years	1,446.6	695.2	2.0810	295.8	1,742.4	2.5065
OPTION 2 Purchase 172 Zaferas	8 Years	2,347.6	798.6	2.9396	295.8	2,643.4	3.3100

3.8. Preferred Option Analysis

3.8.1. Identifying the Preferred Option

3.8.1.1. The results of the risk adjusted cost benefit analysis of the options shown in Table 20 indicate that Option 2 remains the preferred option. However, if a risk adjusted cost per weighted benefit score is calculated for each vehicle the preferred option changes to Option 2 with a cost per vehicle of £19.24 compared to £24.10 for Option 1.

3.8.2. Funding Route Option

3.8.2.1. NHS capital has been set aside in the Trust's next three years capital programmes to cover this investment.

3.8.2.2. Therefore, no other funding option has been considered.

3.8.3. Public Sector Comparator (PSC)

3.8.3.1. Not applicable, see paragraph 3.8.1.1 above.

3.8.4. Preferred Funding Route

3.8.4.1. See paragraph 3.8.2.2 above**.**

3.9. Sensitivity Analysis

3.9.1. A sensitivity analysis has been carried out to identify the robustness of the preferred option.

3.9.2. Only one scenario has been considered. The Switch Point has been calculated, which indicates that initial capital costs of Option 2 would have to increase by 60.3% before Option 1 would become the preferred option. This is unlikely as the costs used in the option appraisal are based on quoted prices from the supplier.

3.9.3. The sensitivity analysis indicates the preferred option is robust.

3.10. Summary of the Economic Case

3.10.1. The short listed options were subjected to the standard tests to establish the

one, which provided the best value for money. Table 20 summarised the cost benefit analysis and demonstrated that Option 2 gives the best value for money.

4. FINANCIAL CASE

4.1. Financial Position

4.1.1. The LAS has a track record of achieving all its statutory financial duties each year. It is likely that in the current year this position will be maintained. The proposed investment will be funded from additional income provided by London PCTs as they decide to introduce ECPs into the health economy. The capital costs will be funded from the Trust's CRL. The investment will only proceed if this income is forthcoming and, as such, it will not have a material impact on the Trust's financial standing.

4.2. Impact of Preferred Option

4.2.1. Table 21 below sets out the net impact of the proposed investment on the Trust's Income & Expenditure (I&E) Account and CRL positions. It should be noted that the figures used are those from the GEM but with non-recoverable VAT added, where appropriate.

Table 21

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
	£000	£000	£000	£000	£000	£000	£000	£000
Non Recurrent Costs								
Initial Clinical Equiptment	73.8	467.4	19.7					
Commissionning costs of vehicles	139.3	687.0	826.3					
Total Non Recurrent Costs	**213.1**	**1,154.4**	**846.0**					
Recurrent Recent Costs/(Savings)								
Fuel	199.8	251.5	540.9	540.9	540.9	540.9	527.1	237.7
Vehicle maintenance (including labour)	173.6	218.5	469.9	469.9	469.9	469.9	457.9	206.5
Communications equiptment maintenance	25.1	31.6	68.0	68.0	68.0	68.0	66.2	29.9
Vehicle Insurance	37.9	47.7	102.7	102.7	102.7	102.7	100.1	45.1
RAC recovery costs	26.5	33.4	71.8	71.8	71.8	71.8	70.0	31.6
Accident damage	103.8	130.6	280.9	280.9	280.9	280.9	273.7	123.4
3rd party accident damage	72.8	91.7	197.2	197.2	197.2	197.2	192.2	86.7
Total Recurrent Costs	**639.6**	**805.0**	**1,731.3**	**1,731.3**	**1,731.3**	**1,731.3**	**1,687.2**	**760.9**
Financing Costs								
Depreciation	168.0	898.0	1,044.6	1,044.6	1,044.6	1,044.6	1,044.6	1,044.6
Dividend Contribution	23.5	119.8	108.9	85.9	85.9	85.9	85.9	85.9
Total Financing Costs	**191.5**	**1,017.8**	**1,153.6**	**1,130.5**	**1,130.5**	**1,130.5**	**1,130.5**	**1,130.5**
Total Revenue Costs	**1,044.2**	**2,977.2**	**3,730.9**	**2,861.8**	**2,861.8**	**2,861.8**	**2,817.7**	**1,891.4**
Source of Funding								
Existing Budgets	639.6	639.6	639.6	639.6	639.6	639.6	639.6	639.6
Contribution from PCTs	196.8	2,013.1	3,387.6	1,506.8				
Total Source of Funds	**836.4**	**2,652.7**	**4,027.2**	**2,146.4**	**639.6**	**639.6**	**639.6**	**639.6**
Additional Costs / (Net Savings)	**207.8**	**324.5**	- **296.4**	**715.5**	**2,222.2**	**2,222.2**	**2,178.1**	**1,251.8**

4.2.2. Within the preferred option, the revenue costs of the replacement RRUs are covered by existing budgets. The additional revenue costs incurred in the procurement of the ECP vehicles will be partially covered in the same way as other ECP costs. The funding regime for ECPs is that PCTs pay a minimum of 75% in the first year, 50% in the second year and nothing there after. This arrangement is to allow the LAS to integrate ECPs into the

normal operating regime of the Trust.

4.3. **Public Capital/PFI Funding**

4.3.1. As the preferred option is funded from NHS capital the Trust will incur capital charges on the investment. These rise to £1,044,638 for depreciation and £85,871 for dividend charges by the end of the third year.

4.4. **Benefits**

4.4.1. The preferred option does not generate any savings.

4.5. **Affordability Gap**

4.5.1. The affordability gap, shown in Table 21 has been created by the level of ECP costs which the Trust has agreed to absorb. SMG will need to decide, as part of its overall ECP strategy, how the Trust is to fund this.

4.6. **Sensitivity Analysis**

4.6.1. The sensitivity test performed does not affect the affordability.

4.7. **Links with Build**

4.7.1. Not applicable

4.8. **Commissioner Support**

4.8.1. This is not required as the preferred option is affordable within LAS resources.

4.9. **Balance Sheet**

4.9.1. There is no impact on the balance sheet.

5. COMMERCIAL CASE

5.1. **Assessment of the Market**

5.1.1. The LAS have assessed vehicles for emergency response roles in previous business cases. The existing NHS Framework Agreements will be used both to procure the base vehicle and convert them therefore this project will not be require to go to OJEU.

5.2. **Alternative Procurement Methods**

5.2.1. See paragraph 3.8.2.2 above.

5.3. **PFI/PPP/Public**

5.3.1. This project is not suitable for the PFI or PPP route. The contract to supply will follow the guidelines as set out in the framework agreement.

5.3.2. There will be a separate contract for conversion work on the vehicles; this will follow the contract to supply vehicles.

5.3.3. The vehicle conversion will be single tender action in accordance with the LAS Standing Financial Instructions on ATT Papworth who are familiar with the LAS emergency vehicle conversion requirements for a Vauxhall Zafira. The financial impact of this will be to save on design costs, as the majority of the conversion work will be the same as the DSO vehicles.

5.4. **Concurrent Contracts**

5.4.1. This project is not linked to or dependent upon any another vehicle procurement activity.

5.5. **Procurement Options/Strategy**

5.5.1. This is not appropriate, as the capital funding has already been allocated for the project.

5.6. **Bid Criteria**

5.6.1. This is not appropriate, as there are no tender bids for evaluation.

5.7. **Evaluation Model**

5.7.1. This is not appropriate, as there are no tender bids for evaluation.

5.8. **Procurement Process**

5.8.1. The Vauxhall Zafira Auto 5 door will be procured from Vauxhall public sector operations to the current Specification for the ECP/RRU vehicles.

5.8.2. The vehicle conversion will be allocated to ATT Papworth who are approved on the NHS framework agreement and have known capabilities as they have converted the previous DSO, ECP and RRU Zafiras following tendering.

5.9. **Key Principles for Contract Type**

5.9.1. As stated above this project covers 104 vehicles and are subject to break at 12 vehicle intervals clauses.

5.9.2. The LAS terms and conditions of contract for vehicle procurement are in accordance with the TTF principles.

5.9.3. For reasons stated in the Economic Case and 5.1.2 above an OJEU, notice is not required.

5.10. **Initial Assessment of the Transfer of Risk**

5.10.1. There are no risks identified for transfer from the LAS.

5.11. **TUPE**

5.11.1. There are no staff being transferred into or out of the LAS because of this project, therefore the Trust considers there are no TUPE implications.

5.12. **Procurement Timetable**

5.12.1. From approval of this business, case the delivery of the first vehicle for the project is expected to take 20 weeks in broad terms covering:

Table 22

	Complete	**Week 1**	**Week 13**	**Week 18 to 20**	**Week 20 to completion**
Conversion Specification Definition					
Procurement of Base vehicles					
Design confirmation with converter					
Delivery of base vehicles					
First RRU ECP vehicle build acceptance and delivery					
Delivery of remaining response units to LAS					
LAS PDI and CTS Technology fit					

5.13. OJEU Advertisement

5.13.1. This is not appropriate in this case see 5.1.2 above.

6. MANAGEMENT CASE

6.1. Project Management

6.1.1. The project will be managed by the Programme & Project Support Office (PSO) and follows the structures and controls of PRINCE 2.

6.1.2. The Trust Board has charged the Director of Finance with the responsibility of being the Executive of the Project Board to oversee the project management arrangements.

6.1.3. The Project Manager will be supported by Team Managers who will control the concurrent stages of the project under the direction of the Project Manager. The Project Manager will ensure that Team Managers deliver their stages and components to the required cost, timescale and quality criteria. If necessary, the Project Manager will invoke project support from the PSO as required.

6.1.4. Project Assurance is the responsibility of each Project Board Member, and no formal external Quality Assurance function has been nominated. However, the Project Initiation Document (PID) draws to each Project Board Member's attention the facility to delegate this function to an appropriate person (not the Project Manager) in a case of need.

6.1.5. Roles and Responsibilities Descriptions of the project team are detailed in the PID.

6.1.6. The project will be managed at the three levels of Project Board, Project Management and Team Management through formal assessment controls as follows:

Management Monitoring	Responsibility	Triggering Event
Project Board Management		
Project Initiation	Project Board	Authorisation of Project by Chief Ambulance Officer.
Project Assessments	Project Board	Planned at mid project or when an exception plan is required.
Project Closure	Project Board	All products have been delivered.
Project Management		
Highlight Reports	Project Manager	Monthly, or as determined by the Project Board.
Checkpoint meetings	Project Manager/Team Manager	Weekly or as determined by the Project Manager.
Stage Quality Management		
Quality Reviews	Quality Chairman	A product has been completed.

6.2. **Resources**

6.2.1. The Trust Board has charged the Head of Operational Support with the responsibility of being the Executive of the Project Board to oversee the project management arrangements

6.2.2. The resources for the project will be confirmed when the project is initiated. As this is a straight procurement there is little involvement for the Project Board therefore the role of Executive is combined with the Senior Supplier role.

6.2.3. The project structure is shown in Appendix B and the Roles and Responsibilities of the Project Members are defined in Appendix C

Project Executive & Senior Supplier	Mike Boyne - Head of Operational Support
Senior User	John Pooley Assistant Chief Ambulance Officer/Bamber Postance – ECP Manager for Operations
Project Manager	Richard Bulmer/Roy Hopkinson –Project Manager PSO

6.3. Change Management

6.3.1. To control unplanned situations concerning the specification, performance, delivery of products etc. and the project will be subject to configuration and exception control.

6.3.2. The PRINCE 2 change-control approach will be used to ensure that all changes are properly managed during the project. All specification changes, queries and off specifications can be raised by anyone working on the project as a Project Issue with the author indicating their priority for the query. All Project Issues are passed to the Project Manager for assessment and progressing through the PRINCE 2 change-control approach.

6.4. Project plan

6.4.1. The detailed tasks of the project will be defined in the Project Plan, which forms part of the Project Initiation Document.

6.4.2. The procurement timescale of the project covers an estimated 20 X week period from placement of orders to delivery of the last vehicle into service.

6.5. Risk management

6.5.1. It is recommended that a low risk strategy be adopted for this project particularly given this is a repeat vehicle procurement project and the conversion will completed by the same converter ATT Papworth.

6.5.2. The low risk strategy means there is a low tolerance for the occurrence of risk or willingness not to accept losses or being prepared to change strategy/project.

6.5.3. As there are third party partners/suppliers involved, it will be essential to have a shared understanding of any risks and the agreed plans for managing them. The Project Manager and Head of Operational Support (Project Executive) will be responsible for the management of all risks identified in this business case or as the project progresses.

6.5.4. For the duration of the project, the Project Board will examine the Risk Log at each of its meetings to ensure any risk identified is under control and where necessary appropriate actions have been taken.

6.5.5. The Project Board will consider if any of the identified risks could arise post project and these will be handed over to the appropriate Senior Manager for monitoring post project closure and for inclusion in the LAS Risk Register.

6.6. Security and Confidentiality

6.6.1. There is no involvement of the patient before, during or post project and therefore there are no security or confidentiality issues regarding Caldicott or the Data protection Act.

6.7. Benefits Realisation Plan

6.7.1. To ensure that the envisaged benefits materialise to the greatest possible extent, the Trust has charged the Project Board with monitoring Benefits Realisation.

6.7.2. The Project Board will monitor the benefits as these vehicles are introduced into service. However, it is expected that none of the listed benefits will have a significant change during the project implementation. The Senior Users will be responsible for collating and analysing the information needed to carry out benefit realisation analysis. This information should relate directly to the benefits identified in this business case.

6.7.3. On Project Closure, the responsibility for monitoring and managing achievement of individual benefits will be transferred to the manager nominated in the Benefits Realisation table.

Benefit	Performance Indicator	Responsibility
		Who is responsible for monitoring achievement
Improved patient care	All agreed PCTs have ECP vehicles allocated. All rostered RRU vehicles are available for response. Staff do not use spares for station responding.	John Pooley / Paul Webster / Bamber Postance
Improved performance	Sectors use the reserve establishment vehicles correctly and not as another response vehicle	John Pooley and Bamber Postance
No increase in vehicle range	No retraining of fleet staff required for these vehicles	Roy Hopkinson
Vehicle equipment storage	Staff can fit all identified equipment in vehicle leaving space for additionally agreed equipment for the future.	John Pooley / Paul Webster / Roy Hopkinson
Transporting of ambulant patients	ECP RRU vehicles have allocated space for transporting patients. Staff not to use the space for storage of personal or other bags.	John Pooley and Bamber Postance
Improved professional image	Vehicle meets the staff expectations	Michael Boyne

6.8. **Training**

6.8.1. From previous experience, only minimal vehicle familiarisation is required for RRU and ECP crews covering vehicle controls and layout.

6.9. **Contract Management**

6.9.1. The main external delivery contracts are:

- Procurement of Vauxhall Zafira from Vauxhall and delivery to ATT Papworth
- Vehicle conversion by ATT Papworth and delivery of the converted vehicle to the LAS.
- Complete fitting of vehicle communications and MDT by CTS and

delivery to service.

6.9.2. These will all be managed by the LAS Project Manager.

6.9.3. The Technical and User Acceptance and delivery aspects of all the products are controlled by the LAS Project Manager who will advise the LAS Finance Department when financial payment can be made for full or part delivery of completed products

6.10. Advisors

6.10.1. External advisors will not be required on this project.

6.11. Post Project Evaluation

6.11.1. During the three months post vehicle delivery in have service the Project Manager will undertake a Post-Project Evaluation Review and present the report at the Project Closure Meeting.

6.11.2. In particular, it will look at:

- What went right?
- What went wrong?
- Lessons learnt.

6.11.3. The Project Closure Meeting will set dates for a Benefits Realisation Meeting described in Section 6.7. The Project manager will be responsible for co-ordinating those meetings with the managers nominated within section 6.7

APPENDICES

APPENDIX A BENEFIT WEIGHTS AND SCORES

Benefit Weighting

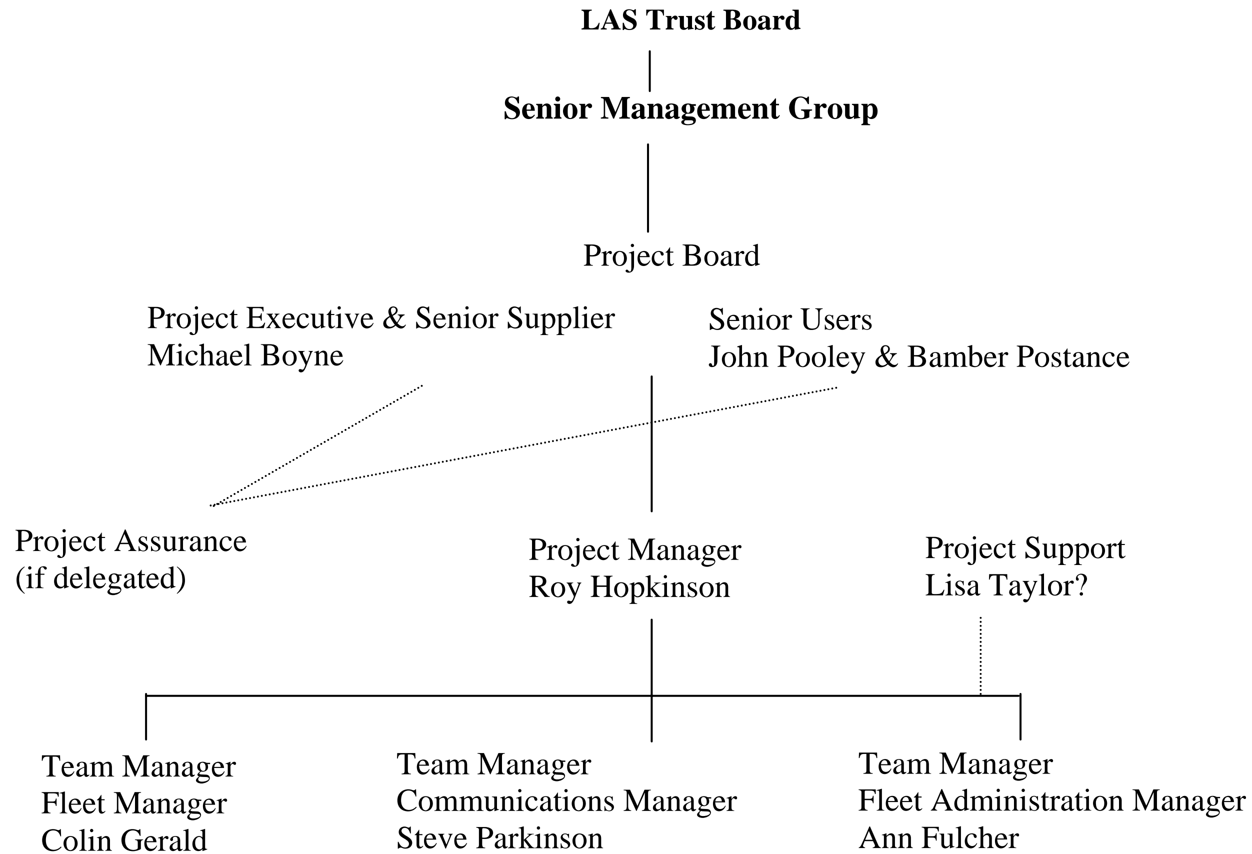
The Benefits were first ranked in importance to the project delivery.

Then using the pairing technique (which is less subjective than just allocating a number), the following weights were calculated out of 100 for each of the ranked benefits.

- Improved patient care through increased establishment of vehicles to respond to current demand.
- Reduced impact on performance during RRU downtime (maintenance etc.) through vehicle reliability.
- Storage capacity is sufficient to safely carry the defined first responder equipment and have capability for future equipment additions and changes during the vehicle life.
- Better-quality vehicle standards suitable for London conditions leading to improving staff morale and the professional image of the Trust
- No increase in the type of vehicle range for fleet to maintain.

The two options were then scored for how completely they met the benefits.

APPENDIX B PROJECT STRUCTURE



APPENDIX C ROLES AND RESPONSIBILITIES

1 PROJECT BOARD RESPONSIBILITIES

1.1 Common Responsibilities

Prime Responsibility

Ensure project viability within the objectives and constraints handed down by the Senior Management Group (SMG) of the London Ambulance Service NHS Trust.

Common Tasks

The Project Board have joint responsibilities but each member also has individual ones, which reflect the respective interests from a Business, User and Technical viewpoint.

- Provide overall guidance and direction to the project.
- Authorise project initiation.
- Appoint Project Manager, Team Managers and Project Assurance Team members, define their responsibilities and set their objectives.
- Ensure that plans take account of the strategy and constraints set by the SMG, and that changes to these are reflected in the project.
- Review and sign-off Project Initiation Documents, Project Plans, Stage Plans and Exception Plans having ensured continued viability from their particular interest.
- Set stage tolerances and ensure they are consistent with the authorised project resources and time scale.
- Assign resources to the project.
- Assist in the resolution of pre-requisites and risks, which are outside the Project Manager's authority.
- Respond as required to problems notified in Highlight Reports.
- Review and recommend action for Project Issue Reports.
- Authorise or reject proposals for major changes to specifications, designs and other significant.
- Attend all Project Board Meetings.
- On behalf of their particular interest, sign-off each completed stage and authorise the start of the next stage or recommend the suspension or termination of the project.
- Brief project progress to relevant senior management.

1.2 Executive Role

Prime Responsibility

To ensure that the project continues to be a viable investment for the business; that it will achieve the expected benefits; and that it will be completed within the budget and schedule agreed with the SMG.

Specific Responsibilities

The Executive has responsibilities in common with other members of the Project Board but also has the following specific responsibilities.

- Agree the scope, budget, schedule and tolerances of the project with the SMG.
- Authorise expenditure.
- Chair Project Board meetings.
- Arbitrate in situations where there is a difference in opinion between other members of the Project Board.
- Act as final arbiter on important potential changes, which significantly affect the Business interest of the LAS.
- Sign-off completed stages having ensured continued project viability.
- Recommend future action on the project to the SMG if the project tolerance is forecast to be exceeded (e.g. terminate, allocate more funds or allow a longer time to complete).
- Complete the Business Acceptance Letter and other relevant Acceptance Letters upon completion of the project.
- Confirm successful completion of the project at the Project Closure meeting.
- Provide reports, as required, to the Board of Directors and brief senior management on all project matters.

Direction To:

All project personnel.

Direction From:

The SMG.

1.3 Senior User Role

Prime Responsibility

To represent their respective user interests affected by the project; and to provide agreed user resources for the project.

Specific Responsibilities

The Senior Users have responsibilities in common with other members of the Project Board but also has the following specific responsibilities.

- Approve on behalf of the users the User Specification and Acceptance Criteria.
- Assign respective user resources required by the project at the earliest point and are continued to be considered throughout the life of the project.
- Approve Product Descriptions for those products, which will be used by users, or will affect them directly.
- Agree quality criteria for those products, which will have a direct impact on users (for example the Specification of User Requirement) and agree objectives for installation and training.
- Resolve respective user requirements and priority conflicts.
- Attend Stage Assessments and Project Closure meetings and sign-off on

behalf of all user departments.
- Together with the other Senior Users, sign the User Acceptance Letter other relevant Acceptance Letters at the end of the appropriate stage and Project.
- Act as final arbiter for all users on important potential changes, which significantly affect all user interests.
- Review technical Exceptions for user impact.
- Brief User Management on all project matters.

Direction To:

All respective user interests.

Direction From:

Project Executive, when acting in Project Board capacity.

1.4 Senior Technical Role

Prime Responsibility

To represent all technical interests; to provide technical awareness at the Project Board level; and to assign the technical resources for the project.

Specific Responsibilities

The Senior Technical Member has responsibilities in common with other members of the Project Board but also has the following specific responsibilities.

- Approve Product Descriptions for technical products.
- Assign technical resources required by the project.
- Resolve technical priority or resource conflicts.
- Sign-off Project Technical Plan and Stage Technical Plans.
- Attend Stage Assessment and Project Closure meetings and sign-off on behalf of technical development.
- Write the Technical Acceptance Letter other relevant Acceptance Letters at the end of the appropriate stage.
- Act as final arbiter on important potential changes, which significantly affect the technical interests.

Brief management on the technical aspects of the project.

Direction To:

All affected technical interests.

Direction From:

Project Executive, when acting in a Project Board capacity.

2 Project Management

2.1 Project Manager

Prime Responsibility

To ensure that the project as a whole produces the required products, to the

required standard of quality and within the specified constraints of time and cost.

Main Activities

• Attend all Project Board Meetings
• Plan the project and agree the Plan with the Project Board.
• Liaise with related projects to ensure that work is neither overlooked nor duplicated.
• Prepare Stage Plans for the next stage before submission to the Project Board for approval.

- Define objectives and responsibilities for each Stage / Team Manager.
- Monitor overall progress and use of resources and initiate corrective action where necessary.
- Advise the Project Board of all deviations from plan at either stage or project level and of any corrective action taken.
- Where corrective action cannot be completely accommodated within stage tolerances, recommend appropriate action and submit appropriate Exception Plans to the Project Board.
- Present regular Highlight reports to the Project Board, collating the Checkpoint Reports of the Stage Managers.
- Monitor the results of all control meetings and liaise with the Project Assurance Team to assure the overall direction and integrity of the project.
- Monitor project Risks and bring to the attention of the Project Board any that require management attention.
- Prepare the End Project Evaluation Report.
- Attend all Stage Assessments and the Project Closure meeting.
- Agree technical and quality strategy with those in the department who have responsibility for departmental policy (e.g. Quality Assurance function).
- Create a Configuration Management structure and identification scheme for the products produced by the project.

Direction to:

Stage / Team Managers.

Direction from:

Project Board for matters related to the project.

2.2 Team / Stage Manager

Prime Responsibility

To ensure completion of user / technical products are of appropriate quality, in a time scale and at a cost acceptable to the Project Board.

Main Activities

- Define and agree objectives, responsibilities and work plans for Teams with the Project Manager.
- Manage and provide guidance to team members as necessary.

- Assist the Project Manager to prepare the User / Technical Plan and Resource Plan for the next stage.
- Prepare Detailed Plans as necessary.
- Monitor progress and resource utilisation of Teams and initiate corrective action where necessary.
- Advise the Project Manager of deviations from plan, recommend corrective action and help prepare appropriate Exception Plans.
- Attend Project Manager Checkpoint Meetings (the Team Manager need not attend every Checkpoint).
- Prepare and present regular Checkpoint Reports to the Project Manager.
- Attend all Stage Assessment meetings.
- Plan all stage control meetings.
- Liaise with the Project Assurance, if appointed by the Project Board, to ensure the business, technical and data integrity of the stage.
- Ensure all Exceptions are properly reported, evaluated and (if within tolerance) actioned.
- Ensure that Team Quality Reviews are held as planned.

Direction to:

Team Members.

Direction from:

Project Manager for matters related to the project.

3 Project Assurance and Support

3.1 Project Assurance

Requirement Outline

The Project Board members do not work full-time on the project; therefore, they place a great deal of reliance on the Project Manager. Although they receive regular reports from the Project Manager, there may always be the questions at the back of their minds:

- Are things really going as well as we are being told?
- Are any problems being hidden from us?
- Is the solution going to be what we want?
- Are we suddenly going to find that the project is over-budget or late?

There are other questions. The Supplier may have a quality assurance function charged with the responsibility to check that all projects are adhering to the Quality System.

All these points mean that there is a need within the project organisation for independent monitoring of all aspects of the project's performance and products. This is the Project Assurance function.

Project Assurance is a function of each Project Board member. According to the needs and desires of the Project Board, any of these assurance responsibilities can be delegated, as long as they are independent of the Project Manager and all members of the Project Management Team. Any appointed assurance role can

give surety of the project on behalf of one or more members of the Project Board.

It is not mandatory that all assurance roles are delegated. Each of the assurance roles, which are delegated, may be assigned to one individual or shared. The Project Board decides when an assurance role needs to be delegated. It may be for the entire project or only part of it. The person or persons filling an assurance role may be changed during the project at the request of the Project Board. Any use of assurance roles needs to be planned at Initiation Stage, otherwise resource usage and costs for assurance could easily get out of control.

Each Project Board member retains accountability for his or her role in the project and the overall project. Any delegation should be documented. The assurance role could include verification by an external party that the Project Board is also performing its functions correctly.

Project Assurance covers all Business, User and Supplier interests of a project.

Specific Responsibilities

Each project is different therefore prior to the execution of introducing Project Assurance the Project Board need to be clear on `What is to be assured?`

A list of assurance tasks could include:

- Ensure maintenance of 'thorough' liaison throughout the project life between the Supplier and the User.
- User needs and expectations are being met or managed.
- Risks are being controlled.
- Adherence to the objectives of the Business Case.
- Constant reassessment of the value-for-money solution.
- Project continues to fit within the overall programme strategy.
- The right people are being involved.
- An acceptable and viable solution is continued to be developed.
- The Project remains viable.
- The scope of the project is not 'creeping up' unnoticed.
- A focus on the business need is being maintained.
- Internal and external communications are working.
- Applicable documentation standards are being used.
- Any legislative constraints are being observed.
- The needs of specialist interests, e.g. security, are being observed.
- Adherence to applicable quality assurance standards.

Direction from:

Project Board for matters related to the project.

3.2 Project Support

The provision of any project support on a formal basis is optional. It is driven by the needs of the individual project and Project Manager. Project Support could be in the form of advice on project management tools, guidance and administrative services such as filing, and the collection of actuals, to one or more related projects. Where set up as an official position (e.g. Project Support office), project support can act as the repository for lessons learned, and a central source of expertise in specialist support tools.

One support function, which must be considered by all projects, is that of Configuration Management. Depending on the project size and environment, there may be a need to formalise this, as it could quickly become a role on which the Project Manager relies heavily on its support.

Specific responsibilities

The following is a suggested list of Project Support tasks:

- Administration
- administer change control
- set up and maintain project files
- establish document control procedures
- compile, copy and distribute all project management products
- collect actuals data and forecasts
- update plans
- administer the Quality Review process
- administer Project Board meetings
- assist with the compilation of Reports
- Advice
- specialist knowledge (e.g. estimating, risk management)
- specialist tool expertise, e.g. planning and control tools, risk analysis
- specialist techniques
- Standards.

Direction from:

Project Manager for matters related to the project.

APPENDIX D RISK LOG

The Generic Risks below are assessed using the LAS Risk management Framework TP/005

Unique Risk Identifier	Date Raised	Business or Project Risk?	Description	Impact	Probability	Risk Level	Risk Status	Risk Owner	Action
ECP1	April 10th 2005	B	PCTs not supplying revenue or capital on time	Delays to programme at phased intervals	Possible chance of occurring	Medium	O	RH	Gain firm commitment on delivery date from the outset Monitor progress closely with supplier senior management.
ECP2	April 10th 2005	P	3rd party workload may impact ability to complete work on schedule	Minor Quality single failure to meet internal standard	Unlikely to occur more than once	Very Low	O	RH	Gain firm commitment on delivery date from the outset Monitor progress closely with supplier senior management.
ECP3	April 10th 2005	P	Risk of scope increase as vehicle is more adaptable for change	Moderate failure to meet internal standard	Possible chance of occurring more than once	Medium	O	RH/MB	Manage any proposed change through strict configuration control.
ECP4	April 10th 2005	B	The vehicle storage is not large enough to cope with additional equipment required to treat patients	Moderate repeated failure to meet standards of care	Possible chance of occurring more than once	Medium	O	RHJP/ MB	Ensure additional equipment proposed is suitable for vehicle use and there is sufficient space for it to be fitted.
ECP5	April 10th 2005	B	Users absorb reserve establishment vehicles into core roster and therefore downtime problems continue	Moderate Repeated failure to meet internal standards and national coverage	Certain as it is more likely to occur frequently	Medium	O	JP/MB BP	Senior Managers agree not to pressurise sector staff to use vehicles as an additional core resource. Sector Managers control use of spare vehicles as reserve establishment
ECP7	April 10th 2005	P	Agreement of users to define equipment racks takes too long and project over runs	Moderate Finance for conversion will be spent in wrong financial year	Possible chance of occurring	Medium	O	JP/MB BP	FRU team control discussion with users and limit timescale for design

Generic Risk reassessed for Cost Impact per vehicle on the vehicle Options

Risk Description	Probability	Impact	Risk Score	Estimated Cost	Risk Adjustment Cost per vehicle
				£000	£000
Continue with Existing Vehicles					
3rd party workload may impact ability to complete work on schedule	4	4	16	5.0	0.8
Risk of scope increase as vehicle is more adaptable for change	0	0	0	0.0	0.0
The vehicle storage is not large enough to cope with additional equipment required to treat patients	10	6	60	4.9	3.0
Users absorb reserve establishment vehicles into core roster and therefore downtime problems continue	10	6	60	4.9	3.0
Agreement of users to define equipment racks takes too long and project over runs into next financial year	0	0	0	0.0	0.0
Total adjusted Risk cost for Option					**6.8**
Option 1 - Purchase 104 Zaferas					
3rd party workload may impact ability to complete work on schedule	4	4	16	5	0.8
Risk of scope increase as vehicle is more adaptable for change	6	6	36	4.9	1.8
The vehicle storage is not large enough to cope with additional equipment required to treat patients	8	6	36	4.9	2.4
Users absorb reserve establishment vehicles into core roster and therefore downtime problems continue	6	10	60	4.9	3.0
Agreement of users to define equipment racks takes too long and project over runs into next financial year	6	6	36	6	2.2
Total adjusted Risk cost for Option					**10.2**
Option 2 - Purchase 172 Zaferas					
3rd party workload may impact ability to complete work on schedule	4	4	16	5	0.8
Risk of scope increase as vehicle is more adaptable for change	6	6	36	4.9	1.8
The vehicle storage is not large enough to cope with additional equipment required to treat patients	8	6	36	4.9	2.4
Users absorb reserve establishment vehicles into core roster and therefore downtime problems continue	6	10	60	4.9	3.0
Agreement of users to define equipment racks takes too long and project over runs into next financial year	6	6	36	6	2.2
Total adjusted Risk cost for Option					**10.2**

APPENDIX E STAFF SURVEY RESULTS

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE EVALUATION RECORD

RAPID RESPONSE UNIT

Name____________________________ Station/Sector____________________

Date____________________________

The purpose of this exercise is to create the vehicle pre-selection criteria in preparation for future RRU purchases.

There were 80 replies to this survey from staff across the Service
The individual scores were averaged as indicated below:
1 = poor 2 = moderate 3 = acceptable 4 = good 5 = excellent

	Average Score
Driver Perspective	
1. Range of driver seat adjustment	
a) height	**4.35**
b) backwards/forwards	**4.13**
c) lumber support adjustment	**4.46**
d) arm rest	**1.91**
2. Relationship between steering wheel, gear lever, pedals and h/brake	**4.58**
3. Safety features	
a) Driver and front passenger air bags only	**3.95**
b) Driver and front passenger air bags and side impact air bags	**4.2**
4. Visibility from driver's seat	
a) front screen and front side windows only	**3.28**
b) all round vision	**4.9**
5. Door mirrors	
a) heated	**2.92**
b) split view	**4.01**
6. Brakes – ABS/ESP	**4.72**

7. Ride in vehicle / comfort **4.33**

8. Steering – feel **4.72**

9. Steering – manoeuvrability **4.77**

10. Gear change – auto **4.3**

11. Gear change – “manual” **3.12**

12. Acceleration **3.45**

Equipment Access

13. Tailgate
    a) access to rear storage area **4.27**
    b) door height when open allows access without risk of head injury **4.75**

14. Space for storage of approved equipment list items only **4.25**

Comfort

15. Number of available passenger seats
    a) front passenger only (provision for equipment to be fastened on both rear seats) **3.98**
    b) up to two passengers (provision for equipment to be fastened on only one rear seat) **3.68**
    c) up to three passengers (no provision for equipment on any seat) **1.41**

16. Air conditioning **4.68**

17. In-car entertainment **4.37**

WORKFORCE PLAN A & E OPERATIONS DECEMBER ’05 – MARCH 07

A & E SECTORS

	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Establishment	2626	2626	2626	2626	2744	2744	2744	2769	2769	2769	2794	2794	2794	2819	2819	2819
Actual in post	2448	2445	2447	2455	2493	2529	2534	2573	2650	2735	2731	2766	2784	2780	2788	2824
Actual variances	178	182	179	172	251	215	210	196	120	34	64	28	10	40	31	-4

Emergency Operations Centre

	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Establishment	326	326	326	326	326	326	326	326	326	326	326	326	326	326	326	326
Actual in post	309	323	320	328	325	333	342	338	335	343	340	348	345	341	350	346
Actual variances	17	3	6	-2	1	-7	-16	-12	-9	-17	-14	-22	-19	-15	-24	-20

Urgent Operations Centre

	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Establishment	48	48	48	48	48	48	48	48	48	48	48	48	48	48	48	48
Actual in post	39	39	39	39	39	39	39	39	39	39	39	39	39	39	39	39
Actual variances	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9